NHS
Cheshire and Wirral Partnership
NHS Foundation Trust

Meeting of the Trust Board of Directors held in Public
1.00pm on Wednesday 27 March 2019
Boardroom, Redesmere

Item no.	Title of item	Objectives/desired outcome	Process	Item presenter	Time allocated (approx.)
18/19/138	Apologies for absence	Receive apologies	Verbal	Chair	1.00pm (2 mins)
18/19/139	Declarations of Interest	Identify and avoid conflicts of interest	Verbal	Chair	1.02pm (2 mins)
18/19/140	Meeting Guidelines	To note	Paper	Chair	1.04pm (1 mins)
18/19/141	Minutes of the previous meeting held 30 January 2019	Confirm as an accurate record the minutes of the previous meetings	Paper	Chair	1.05pm (3 mins)
18/19/142	Matters arising and action points	Provide an update in respect of ongoing and outstanding items to ensure progress	Paper	Chair	1.08pm (5 mins)
18/19/143	Board Meeting Business Cycle 2018/19 and draft 2019/20 Cycle	To note	Paper	Chair	1.13pm (2 mins)
18/19/144	Chair's announcements	Announce items of significance not elsewhere on the agenda	Verbal	Chair	1.15 (10 mins)

Item no.	Title of item	Objectives/desired outcome	Process	Item presenter	Time allocated (approx.)
18/19/145	Chief Executive's announcements *(including overview of items discussed in closed meeting)*	Announce items of significance not elsewhere on the agenda	Verbal	Chief Executive	**1.25pm (20 mins)**
Strategic Change					
18/19/146	West Cheshire Integrated Care Partnership (ICP) Integration Agreement	To approve	Paper	Chief Executive	**1.45pm (15 mins)**
Quality of Care/ Quality Improvement					
18/19/147	Monthly Ward Staffing update January and February 2019	To note	Verbal	Director of Nursing, Therapies and Patient Partnership	**2.00pm (10 mins)**
Operational Performance, Finance and Use of Resources					
18/19/148	Operational Plan / Board Performance Dashboard	To note performance	Paper	Director of Finance	**2.10pm (10 mins)**
Well-led (leadership and quality improvement capability)					
18/19/149	Staff survey results	To note results and recommendations	Presentation	Director of People and OD	**2.20pm (20 mins)**
18/19/150	Strategic Risk Register and Board Assurance Framework	To note assurance framework	Paper	Medical Director	**2.40pm (10 mins)**

Item no.	Title of item	Objectives/desired outcome	Process	Item presenter	Time allocated (approx.)
18/19/151	Information Governance Toolkit and SIRO report 2018/19	To approve report	Paper	Medical Director	**2.50pm (10 mins)**
18/19/152	Guardian of Safe Working report	To approve report	Paper	Medical Director	**3.00pm (10 mins)**
Governance and Regulation (Assurance and escalation reports from Board Sub-committees (discussion by exception only)					
18/19/153	Chair's Report of the Quality Committee held on 6 March 2019	Review Chair's Report and any matters for note/ escalation	Paper	Chair of Quality Committee	**3.10pm (5 mins)**
18/19/154	Chair's Report of the Audit Committee held on 12 March 2019	Review Chair's Report and any matters for note/ escalation	Paper	Chair of Audit Committee	**3.15pm (5 mins)**
Closing Business					
18/19/155	Any other business	Consider any urgent items of other business	Verbal	Chair	**3.20pm (3 mins)**
18/19/156	Review of risk impacts of items discussed	Identify any new risk impacts	Verbal	Chair/ All	**3.23pm (2 mins)**

Item no.	Title of item	Objectives/desired outcome	Process	Item presenter	Time allocated (approx.)
18/19/157	Key messages for communication	Agree items of particular importance to communicate to staff, governors or other key stakeholders	Verbal	Chair	**3.25pm (2 mins)**
18/19/158	Review of meeting performance	Review the effectiveness of the meeting (achievement of objectives/desired outcomes and management of time)	Verbal	Chair/All	**3.27pm (2 mins)**
18/19/159	Date, time and place of next meeting: **Wednesday 29 May 2019 Redesmere**	Confirm arrangements for next meeting	Verbal	Chair	**3.29pm (1 min)**

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DRAFT Minutes of the Open Board of Directors Meeting
Wednesday 30 January 2019
Boardroom Redesmere - commencing at 1.00p.m.

PRESENT	Sheena Cumiskey	Chief Executive
	Avril Devaney	Director of Nursing, Therapies and Patient Partnership
	David Harris	Director of People Services and Organisational Development
	Dr Anushta Sivananthan	Medical Director, Quality, Compliance and Assurance
	Andy Styring	Director of Operations
	Tim Welch	Director of Finance
	Rebecca Burke-Sharples	Non-Executive Director
	Andrea Campbell	Non-Executive Director
	Lucy Crumplin	Non-Executive Director
	Edward Jenner	Non-Executive Director
	Dr James O'Connor	Non-Executive Director (Chair)
IN ATTENDANCE	Suzanne Christopher	Corporate Affairs Manager (mins)
	Katherine Wright	Associate Director of Communications and Engagement
	Justin Pidcock (for items 18.19.119)	Associate Director of Infrastructure and Estates
	Gary Flockhart (for item 18.19.120 - 123)	Associate Director of Nursing.
	David Pearson (for item 124)	Head of Facilities
	Dr Freya Ball	Higher Trainee - Observing
	Keith Millar	Governor - Observing
	Peter Ashely-Mudie	Governor - Observing
APOLOGIES	Mike Maier	Chairman
	Dr Faouzi Alam	Medical Director, Effectiveness, Medical Education and Medical Workforce & Caldicott Guardian
	Louise Brereton	Head of Corporate Affairs

	MINUTES	**ACTION**
18/19/111	**APOLOGIES AND ABSENCE** Dr J O'Connor took the role of Chair for the meeting in the absence of M Maier (Chairman). The Chair welcomed all to the meeting. The meeting was quorate. Apologies were noted as above. Observers to the meeting (as noted above) were warmly welcomed.	
18/19/112	**DECLARATIONS OF INTEREST** None were declared.	
18/19/113	**MEETING GUIDELINES**	

	The meeting guidelines were noted.	
18/19/114	**MINUTES OF PREVIOUS MEETINGS** The minutes of the Open Board Meeting held on the **28 November 2018** were **approved** as a correct record.	
18/19/115	**MATTERS ARISING AND ACTION POINTS** The action schedule was reviewed as follows:- Item 18.19.61 – was agreed as closed Item 18.19.72 – this action remains open and will be reported to the next meeting. Item 18.19.94 – was agreed as closed.	
18/19/116	**BOARD MEETING BUSINESS CYCLE 2018/19** The Board of Directors **noted** the business cycle.	
18/19/117	**CHAIR'S ANNOUNCEMENTS** The Chair gave the following announcements: **Non-Executive Director Recruitment Process** Board members were reminded that Ann Pennell had stepped down from her positon of Non-Executive Director with effect from 31st December 2018. Board Members were also advised that Lucy Crumplin would not be re-standing following her current period of office further to her re-locating. Given the above, plans are in place to commence a recruitment process shortly. The remuneration and nominations committee of the Council of Governors are due to meet on the 21 February 2019 to move the plans forward. It is hoped that following a recruitment process a recommendation of appointments can be made to the April Council of Governors meeting with the individual taking up office in the Summer. **NHS Long Term Plan** Board Members were advised that the plan is now published. The document is to act as a blueprint to make the NHS fit for the future, encouraging local NHS organisations to work with their partners to turn the ambitions in the plan into improvements in services. From a CWP point of view, the Trust is currently considering the document and its implications. **CANDDID** Board Members were advised that the first annual conference for CANDDID (Centre for Autism, Neuro-Developmental Disorders and Intellectual Disability) will take place on the 10 May at The Double Tree Hilton Hotel in Chester. This year the theme for the conference will be "Autism Spectrum Conditions". The Trust has planned an exciting and informative programme. Details of times and an agenda will be released soon.	
18/19/118	**CHIEF EXECUTIVE ANNOUNCEMENTS**	

	The Chief Executive provided the following summary of the discussions held during closed board:- The Board Members began by discussing a patient story which outlined the experience of a young patient with Learning Disability and Mental Health needs. Board Members considered the care that was delivered by the Intensive Care Team. The story was largely a positive one. However, it also identifies areas for learning to ensure that we continually improve as a Trust. During the closed meeting, Board Members also; • Considered developments in the implementation of the transforming people's lives agenda and the work taking place within CWP. • Reviewed the Trust's dynamic risk register and were alerted to new and emerging risks. • Received an update in respect of the Operational Plan that has further built on the work undertaken with the Council of Governors at their recent meeting. • Received an update on serious incidents and the work to support patients, families and staff affected by such incidents. • Heard about the Place Based plans for Cheshire East. • Heard that the Trust is on track against its planned 18/19 financial performance and on target to achieve its control total. The Chief Executive then also provided the following updates; **Wirral IAPT services** A Styring reminded Board Members that the Trust is part of a strategic partnership in providing IAPT services in the Wirral area. A Styring advised that the recent tender for these services had been awarded to the Partnership. The contract has a start date of 1 April 2019 for a period of three years, with the option to extend for two further years. Reports will be provided to future Board meetings. **Public Services Hub - Ellesmere Port, Coronation Road** Board Members were advised that the premises would be formally opened on Friday 1 February 2019 by the local MP, Justin Madders. **Shadowing Experience** The shadowing experience is an initiative that enables Executive Directors to shadow teams and for them to shadow Executive Directors. S Cumiskey advised that she has visited a Mental Health Community Health Team recently and was impressed by their skill and compassion. The Team were clearly thinking about how they deliver person-centred care and how they meet the needs of the local population. This was an extremely positive experience and thanks was offered to the Team. **Director of Nursing** Board Members were advised that A Devaney, Director of Nursing had formally advised the Trust that she planned to retire from her position with effect from September 2019. This was a life decision to allow her to spend more time with her young family. Board Members wished Avril Devaney all the best for her future plans. Recruitment processes will commence shortly.	

18/19/119	**ADULT & OLDER PEOPLE'S SPECIALIST MENTAL HEALTH REDESIGN: EAST/SOUTH CHESHIRE/VALE ROYAL** *J Pidcock joined the meeting.* J Pidcock introduced the item. Board Members were reminded that the business case had been presented to the CCG's Committee in Common on the 22 November 2018. The overview and Scrutiny Committee has also met to consider the business case and requested a further period of consultation to address the further consideration of Option 2 plus. At the end of that period, the panel concluded that no material or substantial feedback had been received. The consultation process was then confirmed as concluded and instruction was provided to proceed with the plans. CWP has, therefore, commenced implementation of Option 2 Plus. Staff consultation processes commenced in January 2019, as well as practical plans to undertake the redesign and relocation of services. People accessing specialist rehabilitation services in East Cheshire have also been kept fully informed of progress. A Project Board has now been established who will meet regularly and will escalate to Board as appropriate. A programme structure has also been developed and leads and resources identified to support the programme work. Formal reporting will be provided via the CWP programme management office. A local Resident engagement event has been arranged for the 7 February 2019 at which local residents will have an opportunity to meet with the project group and consider any concerns they have regarding the extension of Lime Walk House. Implementation of all these plans is due to be concluded by September 2019. Board Members were asked to note the agreement of the CCG to approve Option 2 Plus, acknowledge that consultation processes have now concluded, note the positive support received from the Overview and Scrutiny Sub-Committee and from the Mental Health Forums, and approve the next steps and timescales. A Styring noted thanks to all those who have been part of the journey to date. A Styring reminded Board Members and Members of the Public observing that the consultation process highlighted the preference from the local public to retain some beds in the East area. Option 2 Plus has responded to this request. It was noted that overall the outcome has been positive and responds to meet the needs of the local population. Board Members echoed the thanks given by A Styring to all those who have contributed to the process and been part of the consultation to influence the outcome. A discussion took place in regards to the reaction of staff members. It was confirmed that staff are on-board with the plans and morale has increased.	

	Staff also feel that their views have been considered as part of this process. Concerns were raised in respect of the implementation period, and if this was now realistic. It was acknowledged that although the additional period of consultation has impacted on the implementation phase, it has also allowed time for the team to further consider the planning and design work. The Planning Board will monitor progress on a monthly basis. The Board of Directors **noted** the update and **approved** the next steps and timescales. *J Pidcock left the meeting*	
18/19/120	**SUICIDE PREVENTION STRATEGY** *G Flockhart joined the meeting.* G Flockhart introduced the item and provided a presentation to Board Members regarding an up-date on CWP's suicide prevention strategy and associated work streams. A Campbell enquired to the potential challenges that face the Trust. Dr A Sivananthan advised that the Trust does not have 24/7 crisis teams across Cheshire. Consideration also needs to be given to what can be done across Primary Care to support this agenda within Communities. Currently commissioning gaps do exist. It is hoped that these gaps will be addressed as part of the five year forward view. A Styring noted the success of the programme to date and how this links with other initiatives implemented by the Trust. The Board of Directors **noted** the strategy.	
18/19/121	**SIX MONTHLY WARD STAFFING REPORT** G Flockhart introduced the item. The six monthly report is provided to Board Members in line with requirements. This is the ninth occasion that the report has been presented to Board, and it is clear that the report has developed during that period further to feedback from Board Members. Thanks was offered to M Gould who led the 6 monthly review on this occasion. Overall the review concludes that the Trust remains very responsive in its approach to ward staffing. It is also worth noting that Bollin Ward scored high on this occasion. On average the Trust has 6% nursing and 3% support worker vacancies. This demonstrates the proactive approach taken by the Trust to recruitment of staff. The Trust now has its first registered nursing associates in place who are due to graduate in July. The Trust also has approximately 15 Advanced	

	Nurse Practitioners in Training. Work continues to consider broader cross skilling approaches, to consider staffing differently and more creatively. Board Members were asked to note the report and approve the recommendations. D Harris echoed the comments that the report was now much more developed and advocated the approach of the Trust to be more creative when considering staffing. A discussion took place in respect of fill rates and if an improvement in fill rates could be identified over a number of years. A Devaney commented that fill rates are likely to have remained the same. However, the report is now more detailed and provides evidence of supporting work taking place. R Burke-Sharples drew the Boards attention to page 7 of the report and asked if there were different ways of enabling individuals to access supervision. D Harris advised that a task and finish group is considering supervision processes currently. This can be fed back to them for consideration. S Cumiskey offered thanks to G Flockhart for the work he had done to improve the report provided to Board Members. It was noted that the Trust is developing much more effective methods of deploying staff. The Board of Directors **noted** the report and **approved** the recommendations.	
18/19/122	**MONTHLY WARD STAFFING UP-DATE NOVEMBER AND DECEMBER 2018** G Flockhart introduced the item. Board Members were reminded that it is a requirement that monthly staffing reports are reported to Open Board meetings. CQC stipulate that the reports also need to be published. Board Members were reminded of the bed pressures recently experienced by the Trust. However, despite that, the Trust has consistently achieved a fill rate of 95% during November and December. This is reflective of the responsiveness and flexibility of CWP staff. Capacity within the system also remains good. A Styring noted that recent pressures were overcome as a result of good clinical leadership which was maintained throughout the process. The complexity of the situation cannot be underestimated as well as the importance of supporting people to focus on this work. Non-Executive Directors commented that it should be recognised how well the organisation responds to such situations. The Board of Directors **noted** the report.	
18/19/123	**DEVELOPING WORKFORCE SAFEGUARDS: CWP POSITION STATEMENT**	

	G Flockhart introduced the item. The report provided a positon statement against the NHS Improvement Developing Workforce Safeguards published in October 2018. The report informs that compliance will be assessed and stipulates that workforce decisions must promote patient safety. The report focuses on three areas, and the guidance states that providers; • Must deploy sufficient suitably qualified, competent, skilled and experienced staff to meet care and treatment needs safely and effectively; • Should have a systematic approach to determining the number of staff and range of skills required to meet the needs of people using the service and keep them safe at all times. • Must use an approach that reflects current legislation and guidance where it is available. The SBAR outlined CWP's position against each of the recommendations stipulated within the publication. It was noted that staff Governance processes must be included as part of the Annual Governance Statement. The Director of Nursing and Medical Director must confirm to Board Members that staffing is safe, which is done via the monthly staffing reports. Workforce planning will be included for the May Board meeting. Board Members are asked to; • Receive the finding of the positon statement, accept the statement from the Director of Nursing and Medical Director, in conjunction with the six monthly safer staffing reviews, • Confirm that they are satisfied with the outcomes of the assessments that staffing is safe, effective and sustainable, • Note that the forthcoming annual governance statement will include a section detailing the staffing governance processes and the extent of compliance with the NQB guidance, • Confirm that the business cycle for the public meeting includes the workforce plan for approval in April 2019, • Acknowledge and seek assurance through the People and Organisational Development Sub-Committee (rather than Operational Committee as stated in the SBAR) that all service changes, inclusive of redesign and introduction of new roles are subject to a quality impact assessment. A Devaney advised that going forward the minutes of Open Board will explicitly record the statement from herself as Director of Nursing and the Medical Director. Discussion took place in respect of the recent Central and East Cheshire redesign consultation process. It was noted that in this case the quality impact assessment will be used to reflect on the process. Going forward, the quality impact assessment will inform the process. The Board of Directors **noted, acknowledged** and **confirmed** the areas as listed above. *G Flockhart left the meeting.*	

18/19/124	**PLACE 2018/19 REPORT** *D Pearson joined the meeting.* D Pearson introduced the item and advised that the Place Assessment had been completed for this year. Board Members were reminded that the assessment is a requirement of NHSI and NHSE and assesses non-clinical areas against a number of criteria. Historically the Trust has performed well. It is worth noting that year on year the assessments are becoming more challenging. Overall the 2018 visits recorded an improvement in all areas with the exception of one (the Millbrook Unit). Plans are in place to improve that environment. All other areas are recorded as higher than the national standards. A discussion took place in respect of the Millbrook unit and the support to staff. It was acknowledged that the issues raised are out of the ward staff's control and relate to issues of privacy and dignity. They are aware of the Trust's intentions moving forward. Board members acknowledged that despite the limitations of the building, the scores are still very good. The report links to the quality spot check reports provided to Audit Committee by the Trust's internal Auditors. D Pearson advised that further to the request made last year by Board, external validation by external partners has also been undertaken this year. The Board of Directors **noted** the report. *D Pearson left the meeting.*	
18/19/125	**OPERATIONAL PLAN / BOARD PERFORMANCE DASHBOARD** T Welch introduced the item. The report was taken as read and areas discussed at the recent Operational Committee were highlighted to Board Members. • CYP – CHEDS 4 week target. Board Members were advised that a relatively small number of patients are referred to this service. Therefore, only one or two targets need to be missed to have a large impact on the achievement rate. The Team have worked through the non-attendance issues, and a significant improvement is now evident. • Bed State – significant improvements are evident is this area that have previously been discussed during this meeting. • Staff attendance – continues to be a challenge. Discussions were held in respect of how this could be supported going forward. The	

	People Services teams continue to provide support to services in this area. A deep dive approach will be taken at Operational Committee (3 monthly reviews) and it will form part of the new dashboards. 6 monthly reports will be provided to Board (via Board Seminars). • Efficiencies – discussions are taking place regarding efficiency targets, how we reduce burden and how we link this work to the quality improvement strategy. This work is being taken forward within the care groups. It was highlighted that the report suggests that staff vacancies are becoming increasingly concerning. D Harris clarified that the target for this is internally set. Compared to other Trusts we are performing well in this area. As stated previously at Board, consideration needs to be given to the threshold we set ourselves to avoid this being escalated to Board too early. Workforce planning sessions are being arranged that will also consider this. The Board of Directors **noted** the report.	
18/19/126	**STRATEGIC RISK REGISTER AND BOARD ASSURANCE FRAMEWORK** Dr A Sivananthan introduced the item and confirmed that this is a report that is provided regularly to Open Board. The risks are considered in depth at Quality Committee. Audit Committee also consider risks in depth as part of their terms of reference. 12 risks were recorded on the register for this reporting period. All risk treatment plans are in place. 3 risks were reported as in scope, as follows:- Ligature risk – that was identified via the National Nurses Network and relates to individuals with very low body weight. The biggest area of concern for CWP is its eating disorder wards. Mixed sex accommodation – this has been re-escalated and relates particularly to the East and Central Redesign. Inconsistent reporting of data –this risk was escalated from the Operational Committee of the Board. Risk Treatment plans are in progress. A task and finish group will oversee the work and will report to Quality Committee in March. The Board of Directors **noted** the report and **approved** the amendments.	
18/19/127	**LEARNING FROM EXPERIENCE EXECUTIVE SUMMARY (TRIMESTER 2, 2018/19)** A Devaney introduced the report and advised that those who attend Quality Committee are aware that this report is scrutinised in depth. The following areas were highlighted to Board Members by way of	

	escalation; Complaints - It was noted that the number of complaints has increased. This was as a direct result of the addition of the All Age Disability Services into CWP. Work will be undertaken to fully understand the level of complaints. It is worth noting that this may in fact be positive. Compliments – It was noted that compliments have decreased slightly. Processes are being considered to ensure these are robust and all compliments are being collated accordingly. Place Based Reporting – need to consider the method of reporting in this area. This will be taken forward via the learning from experience group. It was also noted that the reporting now also demonstrates the difference between reporting types as well as the areas for continuous improvement. Learning from Deaths – there has been a significant focus in this area. Reporting has increased from 35% to 61%. The Trust is actively checking reporting against the national reporting from NHS digital to ensure all deaths are appropriately reported. The Trust is also reviewing which incidents require formal investigation to ensure all learning is appropriately captured. All deaths recorded as a serious incident are recorded and investigated. Work also continues to improve our response to families. Learning from External Reviews - the report now also includes learning from external reports (such as the NHS Resolution Report). The SBAR outlined the progress made against the recommendations of the previous report and listed new recommendations from this reporting period. These had recently been considered at Quality Committee. The Board of Directors **approved** the report and **endorsed** the recommendations.	
18/19/128	**QUALITY IMPROVEMENT REPORT (EDITION 2, 2018/19)** Dr A Sivananthan introduced the report advising that this was the second of three reports for the reporting year 18/19. Board Members were reminded that Quality Improvement is everyone's responsibility. It is, therefore, important to ensure we engage with people effectively. To assist with that a portal has been developed by Safe Services Staff (Alison Reavy and Ben Lee). Work is taking place to also secure this on the Trust internet site. Safety Huddles – this initiative has supported the improvement of observations within ward settings. Eating disorder services – work has taken place to connect with young people to consider the positive and negative impact of social media. LD coffee morning drop in's – demonstrates how staff go the extra mile. The coffee mornings were held at a time convenient to patients, and so undertaken out of hours at weekends. S Cumiskey commented on the work around social media and how this could be used in a positive way.	

	ACTION – consider how this work can be shared nationally. The Board of Directors **noted** the report.	**Katherine Wright**
18/19/129	**CQC STATEMENT OF PURPOSE** Dr A Sivananthan introduced the item. Board Members were advised that the Trust is required to register all sites from which we provide healthcare activities with the CQC. Within the most recent return, Westminster surgery had been updated to state that it provided surgical interventions (this includes injections). Given the recent transfer of All Age Disability services to CWP, the Millennium Centre on the Wirral has also been registered. Thorn Heys' registration now also includes personal care. This will allow for flexibility should models of care change in the future. The Board of Directors **noted** the report and **approved** the changes.	
18/19/130	**CHAIR'S REPORT OF THE QUALITY COMMITTEE HELD ON 9 JANUARY 2019** L Crumplin introduced the item, advising that a number of presentations were provided to the last committee that demonstrated person-centred care. The strategic risk register was considered that demonstrated a dynamic, moving picture. However, the Committee did question why some risks seemed to sit on the register for some time. Deep dives were agreed to consider why these had failed to move off the register to date. Work continues to improve CWP data. The timeliness of data received by teams was noted by the Committee which allows teams to identify and address areas of concern efficiently (e.g. the Bed Hub). Dr A Sivananthan advised that the CQC have been commissioned under section 48 of their regulatory framework to review restricted practices. The Committee will, therefore, consider long term placements. This will include some bespoke data collection. The Board of Directors **noted** the report.	
18/19/131	**CHAIR'S REPORT OF THE AUDIT COMMITTEE HELD ON 15 JANUARY 2019** E Jenner introduced the item, highlighting the following areas to the Board Members; Patient safety improvement review process – A new approach is in place that takes a much more dynamic and holistic view. This should provide a more rounded picture of the issues going forward. Quality spot check – The Audit was reviewed. The Committee added to	

	the scope of the audit in terms of the standards that the Non-Executive Directors would wish to see going forward. MIAA updated the Committee on the internal audit programme. External audit – it was noted that KPMG will be working their final weeks with the organisation. A presentation was received on anti-fraud work – all aspects of the programme were reported as on track. Workforce Planning – a discussion took place regarding assurance to Board in respect of people planning processes. This also links with other reports presented to Board during this meeting. The Board of Directors **noted** the report.	
18/19/132	**ANY OTHER BUSINESS** None noted.	
18/19/133	**QUESTIONS FROM OBSERVERS OR MEMBERS OF THE PUBLIC** Keith Millar – Safer Staffing report and Safeguarding report – what is the overall objective and how are these linked to patient experience? A Devaney commented that there are a number of indicators taken into consideration when considering safe staffing levels. It is important to use the tools available to us and to also ensure professional judgement is appropriately applied. Staffing is considered in all reviews and learning is fed into the safer staffing reports. Keith Millar – In December 2018 the Department of Health and Social Care Services published the taskforce report. Has that report been helpful to Board for supporting ladies with mental health issues? It was noted that the Trust was aware of the report, but a detailed review of this report had not yet taken place. However, work is already being undertaken by the Trust that relates to this area. Keith Millar – in respect of Suicide Prevention, Keith noted a personal concern regarding junction 3 on the M53 given the historical events and the risk this presents being in close proximity to Springview. A Devaney commented that CWP has raised the same concerns at appropriate forums. The Trust has been advised that the bridge has been re-assessed. A Devaney suggested that this may be an issue that the Mental Health Forum also wish to raise. CWP can provide appropriate contact details should this be helpful.	
18/19/134	**REVIEW OF RISK IMPACTS OF ITEMS DISCUSSED** None were noted	
18/19/135	**KEY MESSAGES FOR COMMUNICATION** • IAPT approach re partnership working • Celebrating the PLACE report • Implementation phase of the Central and East Redesign – and	

	thanks to staff	
18/19/136	**REVIEW MEETING PERFORMANCE** The meeting was confirmed as effective.	
18/19/137	**DATE, TIME AND PLACE OF NEXT MEETING**: Wednesday 27 March 2019, Board Room, Redsmere.	

Signed

Mike Maier, Chair

Date:

NHS
Cheshire and Wirral Partnership
NHS Foundation Trust

Action points from Board of Directors Meetings January 2019

Date of Meeting	Minute Number	Action	By when	By who	Progress Update	Status
30/01/2019	18/19/128	**QUALITY IMPROVEMENT REPORT (EDITION 2, 2018/19)** Consider how recent achievements can be shared nationally.	March 2019	Katherine Wright	Big Book of Best Practice shortlisted for the HSJ value awards. Comms have also launched a new version of On the Pulse which provides regular updates on how news is being shared.	Closed

Cheshire and Wirral Partnership NHS Foundation Trust
Board of Directors meeting Business Cycle 2018/19 - meeting in public

No:	Agenda Item	Executive/ Non Exec Lead	Responsible Committee/ Subcommittee	25/04/2018 Seminar	30/05/2018	27/06/2018 Seminar	25/07/2018	26/09/2018	31/10/2018 Seminar	28/11/2018	20/12/2018 Seminar	30/01/2019	27/02/2019 Seminar	27/03/2019
Strategic Change														
1	**Chair and CEO report and announcements**	Chair and CEO	N/A		✓		✓	✓		✓		✓		✓
2	**ICP Board/s (minutes)**	CEO	Operational Committee		✓		✓	✓		✓		✓		✓
Quality of Care														
3	**Receive Chair's Report of the Quality Committee**	Non Executive Director	Quality Committee		✓		✓	✓		✓		✓		✓
4	**Freedom to speak up six monthly report**	Director of Nursing, Therapies and Patient Partnership	Quality Committee		✓					✓				
5	**Quarterly Infection Prevention Control Report**	Director of Infection Prevention and Control	Quality Committee		✓					✓		✓		
6	**Director of Infection Prevention and Control Annual Report inc PLACE**	Director of Infection Prevention and Control	Infection Prevention and Control sub committee (Quality Committee, Operational Board re PLACE)				✓ May in 2019							
7	**Safeguarding Adults and Children Annual Report**	Director of Nursing, Therapies and Patient Partnership	Quality Committee					✓						
8	**Accountable Officer Annual Report inc. Medicines Management**	Medical Director Compliance, Quality and Assurance	Quality Committee					✓ May in 2019						
9	**Monthly Ward Staffing update (monthly and six monthly reporting)**	Director of Nursing, Therapies and Patient Partnership	Operational Committee		✓		✓	✓		✓		✓		✓
10	**Research Annual Report**	Medical Director Effectiveness, Medical Education and Medical Workforce	Quality Committee							✓				

11	**Medical Appraisal Annual Report and annual declaration of medical revalidation**	Medical Director Effectiveness, Medical Education and Medical Workforce	Operational Committee				✓							
Finance and Use of Resouces/ Operational Performance														
12	**Operational Plan/ Board performance dashboard (incorporating Operational and Quality dashboard)**	Director of Finance	Operational Committee/ Quality Committee		✓		✓	✓		✓		✓		✓
13	**Chair's Report of the Operational Committee**	Chief Executive	Operational Committee		✓		✓	✓		✓		✓		✓
14	**Annual Report, Accounts and Quality Account**	Director of Finance	Audit Committee (Quality Committee for QA)		✓									
15	**Health and Safety Annual Report and Fire and link certification**	Director of Nursing, Therapies and Patient Partnership	Operational Committee				✓							
Well-led (leadership and improvement capability)														
16	**Board Assurance Framework**	Medical Director Compliance, Quality and	Quality Committee		✓			✓				✓		✓
17	**Learning from Experience Report, inc Learning from Deaths (executive**	Director of Nursing, Therapies and Patient	Quality Committee		✓			✓				✓		
18	**Quality Improvement Report**	Medical Director Compliance, Quality and	Quality Committee				✓			✓				✓
19	**Integrated Governance Framework**	Medical Director Compliance, Quality and	Quality Committee									✓		
20	**CQC Community Patient Survey Report (themes and improvement plan)**	Director of Nursing, Therapies and Patient	Quality Committee							✓				
21	**NHS Staff survey (themes and improvement plan)**	Director of People and OD	Operational Committee											✓
22	**Equality Act Compliance inc. WRES**	Director of Nursing, Therapies and Patient	Operational Committee					✓						
23	**Guardian of Safe Working quarterly report**	Medical Director Effectiveness, Medical Education	Operational Committee		✓		✓			✓		✓		
Governance														
24	**Provider Licence Compliance**	Director of Finance	Audit Committee		✓					✓				

25	**CQC Statement of Purpose**	Medical Director Compliance, Quality and	Quality Committee							✓				
26	**Information Governance Toolkit**	Medical Director Effectiveness, Medical Education and Medical Workforce	Operational Committee											✓
27	**Register of Sealings**	Director of Finance	Audit Committee					✓						
28	**CEO/ Chair Division of Responsibilities**	Chair	N/A		✓									
29	**Corporate Governance Manual**	Director of Finance	Operational Committee									✓		
30	**Chair's Report of the Audit Committee**	Non Executive Director	Audit Committee		✓		✓	✓		✓		✓		✓
31	**BOD Business Cycle**	Chair	N/A											✓
32	**Terms of reference of Quality Committee and Operational Committee**	Non Executive Director/ CEO	Quality Committee/ Operational Committee		✓									
32	**Review risk impacts of items**	Chair/ All	N/A		✓		✓	✓		✓		✓		✓
33	**AOB (including matters that are NOT commecial-in-confidence)**	Chair/ All	N/A		✓		✓	✓		✓		✓		✓

Cheshire and Wirral Partnership NHS Foundation Trust

#cwpQI

Board of Directors
Business Cycle 2019/20 (Public Meeting)

	Item	Lead	Scope	Apr	May	Jun	Jul	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Part 1: ASSURANCE	Chair and CEO report and Announcements	MM/SC			✓		✓	✓		✓		✓		✓
	ICP Board/s (minutes)	SC			✓		✓	✓		✓		✓		✓
	Receive Chairs of Quality Committee	JOC			✓		✓	✓		✓		✓		✓
	Freedom to speak up six monthly report	AD			✓					✓		✓		
	Quarterly Infection Prevention Control Report	Director of IPC			✓					✓		✓		
	Director of Infection Prevention and Control Annual Report Inc. PLACE	Director of IPC			✓									
	Safeguarding Adults and Children Annual Report	AD						✓						
	Accountable Officer Annual report Inc. Medicines Management	AS			✓									
	Monthly Ward Staffing update (monthly and six monthly reporting)	AD			✓		✓	✓		✓		✓		✓
	Research Annual Report	FA								✓				
	Medical Appraisal Annual Report and annual declaration of Medical revalidation	FA					✓							

	Item	Lead	Scope	Apr	May	Jun	Jul	Sep	Oct	Nov	Dec	Jan	Feb	Mar
	Operational Plan/Board performance dashboard (incorporating Operational and Quality Dashboard)	TW			✓		✓	✓		✓		✓		✓
	Chair's report of Operational Committee	SC			✓		✓	✓		✓		✓		✓
	Annual Report, Accounts and Quality Account	TW			✓									
	Health and Safety Annual Report and Fire and Link Certification	AD					✓							
	Board Assurance Framework	AS			✓			✓				✓		✓
	Learning from Experience report, Inc. Learning from Deaths	AD			✓			✓				✓		
	Integrated Governance Framework	AS										✓		
	Equality Act Compliance Inc. WRES	AD						✓						
	Guardian of Safe Working quarterly report	FA			✓		✓			✓		✓		
	Provider Licence Compliance	TW			✓					✓				
	CQC Statement of Purpose	AS								✓				
	Information Governance toolkit	FA												✓

	Item	Lead	Scope	Apr	May	Jun	Jul	Sep	Oct	Nov	Dec	Jan	Feb	Mar
	Register of Sealings	TW						✓						
	Corporate Governance Manual	TW										✓		
	Chair's Report of the Audit Committee	EJ			✓		✓	✓		✓		✓		✓
	Terms of Reference of Quality Committee and Operational Committee	JOC/SC			✓									
	Review risk impacts of items	MM/SC			✓		✓	✓		✓		✓		✓
Part 2: IMPROVEMENT	Quality Improvement report	AS					✓			✓				✓
	CQC Community Patient Survey Report (themes and improvement plan)	AD								✓				
	NHS Staff Survey (themes and improvement plan)	DH												✓
	CEO/Chair Division of Responsibilities	MM/SC			✓									
	BOD Business Cycle	MM/SC												✓
	AOB (including matters that are NOT commercial in-confidence	MM/SC			✓		✓	✓		✓		✓		✓

NHS
Cheshire and Wirral Partnership
NHS Foundation Trust

STANDARDISED SBAR COMMUNICATION

REPORT DETAILS	
Report subject:	Integration Agreement - Cheshire West Integrated Care Partnership
Agenda ref. number:	18.19.146
Report to (meeting):	Board of Directors (meeting in public)
Action required:	Discussion and Approval
Date of meeting:	27/03/2019
Presented by:	Sheena Cumiskey, Chief Executive

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

Which NHSI Single Oversight Framework themes this report reflects:	
Quality	Yes
Finance and use of resources	Yes
Operational performance	Yes
Strategic change	Yes
Leadership and improvement capability	Yes

CWP Quality Framework:		
Patient Safety	Safe	Yes
Clinical Effectiveness	Effective	Yes
	Affordable	Yes
	Sustainable	Yes
Patient Experience	Acceptable	Yes
	Accessible	Yes
http://www.cwp.nhs.uk/media/4142/quality-improvement-strategy-2018.pdf		

Does this report provide any information to update any current strategic risks? If so, which?	
Contact the corporate affairs teams for the most current strategic risk register.	No
N/A	

Does this report indicate any new strategic risks? If so, describe and indicate risk score:	
See current integrated governance strategy: CWP policies – policy code FR1	No
N/A	

REPORT BRIEFING

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

Partners of the Cheshire West ICP (CWICP) have been requested to sign the attached integration agreement (Appendix 2) ahead of commencement of the 2019/20 financial year. This agreement sets out the governance framework for CWICP and is an underpinning key driver to enable the ICP to progress on its developmental journey. CWICP is an alliance of organisations working in partnership to meet the needs of the Cheshire West population. Whilst these partners remain constituted as standalone organisations and therefore their legal, statutory and regulatory obligations remain unchanged, this framework will strengthen the already collaborative and integrated working arrangements across Cheshire West. The final version attached represents the final 'clean' version that all partnership Board meetings (or their equivalents) have been requested to approve at their meetings in public. Appendix 1 provides a 'common narrative' that has been provided to all Board meetings (or their equivalents) so that there is consistency in understanding regarding what all partners are agreeing.

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

The integration agreement is not legally binding, but in signing the agreement, the CWP Board will be reaffirming its current stance that it will continue to act in a system focused way, and that it will align the decisions that the Board makes taking into account a vision that is common to all CWICP partners. It is also recognised that the CWICP and its governance arrangements will evolve and the integration agreement will be reviewed at least annually to ensure it remains fit for purpose and reflects the way in which the ICP operates.

Assessment – *analysis and considerations of the options and risks*

Key points:

• Appendix 1 sets out the key messages and recommendations for all CWICP partners.

• Appendix 2 sets out the integration agreement. The benefit of this integration agreement is that the governance framework it sets out enables joined up working to be transacted safely and effectively so that the aim of (and accountability for) delivering improved outcomes is not compromised. In particular, this agreement will enable oversight of the implementation, via the CWICP Board, of the system-wide transformation plan setting out what needs to change to help drive health and care integration for the people of Cheshire West.

• The agreement is clear that CWP's clinical governance framework remains unchanged, providing clarity and certainty for staff, assurance to the Board regarding its accountability for the oversight of the quality of care, and ensuring regulatory compliance, e.g. Regulation 17 (good governance).

• From a governance framework perspective, how key issues will be mitigated, relating to the delivery of services under CWICP, are transparent, thus mitigating the likelihood of issues becoming risks, or where they do, there is clarity regarding how the potential consequential impact of them will be treated.

• The CWP Board meeting in public is asked to approve the integration agreement, schedule an annual review as part of the CWP Board's business cycle, and to note the system leadership commitment and contribution to developing the CWICP governance handbook (including the CWICP Board terms of reference) via a governance workshop. The governance handbook will be shared with CWICP partners for agreement, it is anticipated that this will be early on in quarter 1 of 2019/20. As this is developed further, the focus will be on outcomes across pathways of care and will not describe any other such accountabilities that are reserved for the CWP Board. It will, however, enable alignment to ensure that the decisions taken by the partners to the agreement complement each other and thus facilitate a cohesive, partnership-wide approach to designing and delivering services.

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

The Board of Directors is asked to note this report, the attached CWICP briefing, and attached integration agreement. It is recommended that the Board of Directors endorses that CWP becomes a signatory to the integration agreement, and is signed by the CWP Chief Executive, as Accountable Officer, on behalf of CWP.

Who has approved this report for receipt at the above meeting?	Sheena Cumiskey, Chief Executive
Contributing authors:	David Wood, Associate Director of Safe Services

Distribution to other people/ groups/ meetings:

Version	Name/ group/ meeting	Date issued
1	Board of Directors (meeting in public)	20/03/2019

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

Appendix No.	Appendix title
1	CWICP integration agreement briefing
2	Governance Framework Integration Agreement - CWICP Final (version 1)

Cheshire West Integrated Care Partnership

Cheshire West and Chester Council and the NHS working together

NHS Cheshire West and Chester

CWP Board of Directors (meeting in public)

1.	**Date of Meeting:**	27 March 2019
2.	**Title of Report:**	**Integration Agreement – Cheshire West Integrated Care Partnership**
3.	**Key Messages:**	• The purpose of the Integration Agreement is to align the work of the partners as much as possible, with a view to making better use of their collective resources and providing better care to those who live within the ICP's footprint or receive care from its constituent organisations. • This overarching purpose is supported by the creation of a new collaborative governance model. • Aligned decision making is central to the work of the Cheshire West ICP.
4.	**Recommendations**	a) That the Board agrees the Cheshire West Integrated Care Partnership Integration Agreement and authority for the Chief Executive/Accountable Officer/Deputy Chief Executive to sign this agreement on behalf of the organisation.
5.	**Report Prepared By:**	Cheshire West ICP Governance Programme/ Debbie Bryce, Governance Programme Lead.

Cheshire West Integrated Care Partnership

Integration Agreement – Cheshire West Integrated Care Partnership

PURPOSE

1. The purpose of this report is to provide a short narrative on the purpose and basis of the Cheshire West Integrated Care Partnership (ICP) Integration Agreement.

BACKGROUND

2. An Integrated Care Partnership is an alliance of providers collaborating to meet needs of a defined population. Integrated care will bring together the different organisations and services that look after people in Cheshire West to better co-ordinate care, to make sure patient and carer experiences are as joined-up as possible and to support more people to stay healthy and well.

PURPOSE OF THE INTEGRATION AGREEMENT

3. The purpose of the Agreement is to align the work of the parties as much as possible, with a view to making better use of their collective resources and providing better care to those who live within the ICP's footprint or receive care from its constituent organisations.

4. This overarching purpose is supported by the creation of a new collaborative governance model.

5. The Integration Agreement sets out the vision and integration principles of the Cheshire West ICP, which support the overall aims of the ICP as stated below:

    - We will focus on identifying and proactively targeting people who may be rising or high risk;
    - We will focus on optimising outcomes by supporting people to tailor, direct and deliver their own care;
    - We will work together in a true collaborative and integrated way across health and social care;
    - We will design and deploy our workforce in a way and in environments that will support our new vision.

6. The integration agreement is not intended to be legally binding between the partners, however, the partners agree to act in good faith, to honour their

respective obligations and to be held to account for delivery of their commitments.

7. It is intended that the arrangements put in place by the Integration Agreement will "go live" from 1st April, 2019, or such other date as the partners agree.

8. It is recognised that the ICP and its governance arrangements will evolve and the Integration Agreement will be reviewed at least annually to make sure it remains fit for purpose and reflects the way in which the ICP operates.

PARTNERS TO THE INTEGRATION AGREEMENT

9. The partners and signatories to the Integration Agreement are:

- Cheshire West and Chester Council (statutory role and service provider)
- Cheshire and Wirral Partnership NHS Foundation Trust (service provider)
- Countess of Chester Hospital NHS Foundation Trust (host and service provider)
- Primary Care Cheshire (representing GP practices as providers in West Cheshire)
- South Cheshire and Vale Royal GP Alliance (representing GP practices as providers in Vale Royal)
- Central Cheshire Integrated Care Partnership

10. The Countess of Chester Hospital NHS Foundation Trust is recognised as the host of the ICP. Its role is that of coordinator.

BASIS FOR ICP DECISION MAKING WITHIN THE AGREEMENT

11. Aligned decision making is central to the work of the Cheshire West ICP; alignment means that the organisations within the ICP retain their own decision-making authority, but have agreed to make their decisions taking into account a vision that is common to all of them, along with common aims and principles.

12. Alignment should help to ensure that the decisions taken by the parties within the ICP mirror each other, or complement each other so as to add up to a cohesive partnership-wide approach to designing and delivering services.

13. Neither the ICP or the ICP Board has legal status. Any decisions of a legally binding nature would still sit with individual partner organisations.

GOVERNANCE

14. The governance arrangements for the ICP will be supported by a Governance Handbook which is currently under development. This Handbook will include the terms of reference for the ICP Board which will be shared with ICP partners for agreement.

RECOMMENDATIONS

15. a) That the Board agrees the Cheshire West Integrated Care Partnership Integration Agreement and authority for the Chief Executive/Accountable Officer/Deputy Chief Executive to sign this agreement on behalf of the organisation.

Cheshire West Integrated Care Partnership

Cheshire West and Chester Council and the NHS working together

NHS Cheshire West and Chester

Governance Framework Integration Agreement

Cheshire West Integrated Care Partnership

FINAL (Version 1)

VERSION CONTROL

Version	Date	Author
1	6th March, 2019	Cheshire West ICP Governance Programme

CONTENTS

Go Live date: 1st April, 2019

This Governance Framework Agreement (the **Agreement**) is made between:

1. **COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST** of Countess of Chester Health Park, Liverpool Road, Chester CH2 1UL **("COCH");**
2. **CHESHIRE WEST AND CHESTER COUNCIL of** 58 Nicholas Street, Chester CH1 2NP **("CW&C");**
3. **CHESHIRE AND WIRRAL PARTNERSHIP NHS FOUNDATION TRUST of** Chester Health Park, Liverpool Rd, Chester CH2 1BQ **("CWP");**
4. **CENTRAL CHESHIRE INTEGRATED CARE PARTNERSHIP of** Leighton Hospital, Crewe, Cheshire CW1 4QJ **("CCICP");**
5. **SOUTH CHESHIRE & VALE ROYAL GP ALLIANCE of** Ashfields Primary Care Centre, 19 Middlewich Road, Sandbach, Cheshire CW11 1EQ (**"SCVRGPA")**
6. **PRIMARY CARE CHESHIRE of** The Helsby and Elton Practice, Lower Robin Hood Lane, Helsby, Frodsham, Cheshire WA6 0BW **("PCC")**

Each a "Partner" and together the "Partners".

The Cheshire West health and care system have set out their vision in their blueprint document titled 'Design *Blueprint for the West Cheshire Integrated Care Partnership, A Sustainable Future for Health and Wellbeing in Cheshire West'* strategy.

COCH, CWP, CCICP, SCVRGPA, PCC and CW&C (where acting as a provider of services) are together referred to in this Agreement as the "Providers".

1. BACKGROUND

1.1 This Agreement has been developed by the Partners to strengthen their collaborative working arrangements as the Cheshire West Integrated Care Partnership **("CWICP").**

1.2 The Agreement sets out how the Partners will work together in a collaborative and integrated way to achieve the CWICP Vision, Aims and Priorities, in accordance with the CWICP Integration Principles.

An Integrated Care Partnership (ICP) is:

- An alliance of providers collaborating to meet needs of a defined population responsible for:
- A budget to be allocated by Commissioners within the NHS to deliver services under a long-term outcome based contract
- achieving the triple aim of improved health and wellbeing, better quality and sustainable finances.
- Focusing on prevention and proactive care to reduce unwarranted escalation and use of bed-based care.

- actively managing health and wellbeing, improving key risk factors and delivering care tailored to the individual.

1.3 This Agreement does not serve to replace or override in any way the legal and regulatory frameworks applying to, or the statutory functions of, each of the Partners as separate organisations. Rather this Agreement sits alongside and complements such frameworks and functions to set out how the Partners will come together to develop the CWICP through the delivery of system-wide plans to achieve the CWICP Vision, Aims and Priorities thereby improving the health and wellbeing of people living in Cheshire West.

1.4 This Agreement refers to the CWICP and does not include how governance within individual Partner organisations will be delivered. As these arrangements are developing all Partners to this agreement will be updated as to any amendments which may be required to this Agreement.

1.5 It is agreed that with effect from the Go Live Date CoCh will be the Host of the ICP and act on behalf of the ICP in a coordinating role. This coordinating role could include negotiating or preparing proposals on behalf of and with the prior agreement of the other parties and employing staff to undertake work on behalf of the ICP, however, decisions about the work of the ICP that are legally binding will be reserved to decision-makers within each of the individual partners.

1.6 The Host shall arrange that individuals and organisations on the ICP Board have all necessary licences and consents to perform their roles. Where such licence or consent is required from one of the Partners, the respective Partner agrees that it will endeavour to grant such licence or consent;

1.7 It is agreed that where, from the Go Live Date it is proposed that the Host enters into an agreement with a third party on behalf of the ICP the Partners shall discuss, agree and document the basis on which the Host will be indemnified for any Losses incurred by the Host;

1.8 The Host agrees to appoint:

(a) the Chair of the ICP Board as a non-executive director of the Host; and

(b) the Managing Director of the ICP Board as an executive director of the Host.

(c) the Chair and Managing Director of the ICP Board as a committee of the Host's board. The Chair and the Managing Director will have delegated authority to exercise the powers of the Host relating to the operational management of the ICP and as set out in the Host's scheme of reservation and delegation;

1.9 The organisational form of the ICP will be capable of adaptation as the scope of services is agreed over time. Any changes to the organisational form of the ICP will

be agreed by the Partners through unanimous vote;

2. DEFINITIONS AND INTERPRETATION OF THIS AGREEMENT

This Agreement is to be interpreted in accordance with the Definitions and Interpretation set out in Schedule 1, unless the context requires otherwise.

3. PARTNERS TO THIS AGREEMENT

3.1. Additional partners may become parties to this Agreement on execution of a memorandum of adherence to its terms and such other terms as the Partners shall jointly agree at the Integrated Care Partnership Board **("ICPB")**. Any disagreement between the current Partners to this Agreement over the admission of a new Partner will be referred to the Dispute Resolution Procedure for resolution.

3.2. It is acknowledged that there is no statutory framework to determine formal membership of the ICP and therefore signatories of the Agreement, however the following factors have been taken into account to determine membership:

(1) Organisations whose in-scope services will be directly provided by or within the ICP
(2) The organisation agreed as host of the ICP
(3) General Practice because of their registered patient lists and their role in referring, admitting, consulting with and treating patients
(4) The Local Authority because of their statutory role in improving the health and wellbeing of residents and whose services may be directly provided by the ICP in future phases.

3.3. Based on these factors, the following organisations are formal members of the ICP and signatories to this Agreement:

- Cheshire West and Chester Council (statutory role and service provider)
- Cheshire and Wirral Partnership NHS Foundation Trust (service provider)
- Countess of Chester Hospital NHS Foundation Trust (host and service provider)
- Primary Care Cheshire (representing GP practices as providers in West Cheshire)
- South Cheshire and Vale Royal GP Alliance (representing GP practices as providers in Vale Royal)
- Central Cheshire Integrated Care Partnership

3.4. Other providers (no matter how big or small the contract) will in effect be sub-contractors in that services will not be directly provided by the ICP. Relationship/account management with these providers will be a crucial part of the ICP's work.

4. TERM

This Agreement shall commence on the Commencement Date and, unless terminated in accordance with its terms, will continue for an initial term of 3 years and thereafter subject to an annual review of the arrangements under this Agreement by the ICPB.

5. STATUS AND PURPOSE OF THIS AGREEMENT

5.1 The purpose of this Agreement is to set out how the Partners will work together to improve outcomes for the people they collectively serve. This includes raising standards of care and ensuring value for money.

5.2 This Agreement is intended to:

5.2.1 provide clarity on how the Partners will collectively plan, decide and deliver the improvements in health and care which are required now and in future years; and

5.2.2 allow the Partners to build on working together to take strategic decisions together across the whole of Cheshire West to improve the standard of care no matter where people live or the organisation charged with planning or delivering care; and

5.3 This Agreement will be reviewed at least annually by the Partners and updated by agreement of the Partners to reflect any changes to national policy and learning from emerging Integrated Care Systems and Integrated Care Partnerships nationally.

5.4 The Partners acknowledge that the Agreement is not intended to give rise to legally binding commitments between the partners. Despite the general lack of legal obligation, subject to clause 5.5, the Partners have given proper consideration to the terms set out in the Agreement and notwithstanding the good faith consideration that each Partner has afforded the terms set out in this Agreement, the Partners each enter into this Agreement intending to honour all of their respective obligations.

5.5 Clauses 13 (Conflicts of Interest); 14 (Information Sharing and Transparency); 15 (Confidentiality); 18 (Charges and Liabilities); 20 (Counterparts); and Clause 23 (Governing Law and Jurisdiction) will come into force from the Commencement Date and will give rise to lawful commitments under the auspices of the stated legal frameworks set out in these clauses as part of the Partners' engagement with each other and third parties.

6. VISION & AIMS OF THE CWICP

Vision

6.1 The Partners have developed a shared CWICP vision, ambition and purpose for health and care services across Cheshire West and will work together in good faith in accordance with this Agreement to achieve them. The vision is set out in Section 6.2 below.

6.2 The people of Cheshire West will live longer, healthier lives at home, or in a homely setting. People will be at the centre of all decisions, and receive support to the highest standards of quality and safety. We will achieve this by joining up delivery of our health and social care and focusing on prevention, early identification and supported self-management, where hospital based care is minimised.

Our vision was agreed to reflect the ambition of the CWICP, which is based on achieving ten outcomes, designed to improve the care provided to the people of Cheshire West.

- people experience improved well being
- our people receive care in a way which increases safety by using effective approaches that mitigate unwarranted risks
- a reduction in avoidable mortality
- an increase in people empowerment and self-care
- an increase in the provision of care closer to home
- a reduction in avoidable admissions and readmissions to hospital
- care is delivered in a fully integrated way, using efficient and effective processes
- people only have to tell their story once
- people have a great experience of care
- care and prevention is financially sustainable

Aims of the CWICP

6.3 The Partners have agreed to work together and to perform their obligations under this Agreement in order to achieve the following overall aims which have guided thinking and choices.

CWICP overall aims:

6.3.1 we will focus on identifying and proactively targeting people who may be rising or high risk

6.3.2 we will focus on optimising outcomes by supporting people to tailor, direct and deliver their own care

6.3.3 we will work together in a true collaborative and integrated way across health and social care

6.3.4 we will design and deploy our workforce in a way and in environments that will support our new vision

7. OBJECTIVES AND INTEGRATION PRINCIPLES OF THE CWICP

7.1 The overall objectives agreed by us are to deliver sustainable, effective and efficient services with significant improvements over the term of the CWICP arrangements (the Integration Objectives). We will agree detailed Integration Objectives after the development of this Agreement.

7.2 In consideration of the mutual benefits and obligations under the Agreement, We will work together to perform the obligations to be set out in the Agreement and, in particular, achieve the Integration Objectives.

7.3 Subject to and in accordance with provisions set out in the Agreement, we will work to the following **Integration Principles**:

- commit to delivery of system outcomes in terms of clinical and adult social care matters, patient / service user experience and resource allocation;
- adopt collective responsibility for identifying, managing and mitigating all risks in performing our respective obligations in this Agreement, with a commitment to using this performance information to consider how to practicably implement a fair share risk and reward scheme;
- commit to delivering the best possible care for the whole population;
- adopt an uncompromising commitment to trust, honesty, collaboration, innovation and mutual support;
- commit to work together and to make system decisions on a Best for System basis;
- establish an integrated collaborative team environment to encourage open, honest and efficient sharing of information, subject to competition law and information governance compliance;

- co-produce with others, especially service users, people with lived experience, families and carers, in designing and delivering, the Service; and
- take responsibility to make unanimous decisions on a Best for System basis.

8. GOVERNANCE AND DECISION MAKING

8.1 The Partners have established a governance model that facilitates a process of aligned decision making to support the delivery of the Cheshire West integrated health and care system.

8.2.1 The CWICP governance structure does not replace or override the authority and accountability of each Partner's board or governing body or cabinet (as

relevant), and each of the Partners remains sovereign and accountable in respect of its statutory duties and functions (as applicable).

8.2.3. The ICPB is not a joint committee of the Partners and is not itself a single committee of any of the Partners. The ICPB is not a separate legal entity in its own right and cannot take decisions as a separate entity. A committee, or any nominated representative of a Partner participating in the ICPB, cannot take a decision which binds any other partner organisation or committee.

8.2.4 All Partners will participate in discussion and debate at the ICPB as part of being a key partner within the CWICP and signing up to the principles set out in this framework. However, decisions will only be taken by a Partner in accordance with its statutory governance procedures and delegated decisions given to officers.

8.2.5 Each Partner must ensure that it's appointed members of the board and its committees attend the meetings of the relevant Governance structure and participate fully and exercise their rights on a best for system basis to achieve the CWICP Vision in accordance with the CWICP Integration Principles.

8.3 CW&C has established a People Overview and Scrutiny Committee responsible for holding to account those who deliver services based on individual need to children and adults. The committee may review and make recommendations for improvement across a number of areas including services relating to health services and the integration of services. CWICP will participate in discussion or debate where requested to do so by the Committee on relevant matters.

8.4 The CWICP Governance structure (Appendix 1) illustrates the CWICP governance framework and the terms of reference for each of the Governance structures are included within the Governance Handbook.

8.5 Clinical Governance and Practice Requirements

8.5.1 The Partners agree that the objectives of the Partnership are for the Partners to work together at all times as a single, integrated, group of providers, and to deliver the Services in accordance with good clinical practice and good industry practice (as applicable) and all applicable laws and regulations.

8.5.2 The Partners will continue to implement their respective organisations professional practice requirements including risk assessment and management policies in accordance with their respective governance frameworks and statutory duties including the statutory responsibilities of the Director of Adult Social Care. This is to assure that the management of clinical/ practice risk is not compromised at service delivery level and that the sensitivity of clinical/ practice escalation processes at local and organisational level remain effective. This is to ensure compliance with Partners'

regulatory requirement, e.g. Regulation 17 "Good Governance" – Health and Social Care Act 2008 (Regulated Activities) Regulations 2014".

8.6 Key Boards & Groups within the System

[The terms of reference for key boards and groups will be detailed within the ICP Governance Handbook.]

Cheshire West and Chester Health & Wellbeing Board

8.6.1 The Cheshire West and Chester Health & Wellbeing Board is a statutory committee of CW&C established under the provisions of the Health and Social Care Act 2012 and the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013.

8.6.2 The Health and Wellbeing Board is accountable to CW&C for the delivery of the Board's Joint Health and Wellbeing Strategy (2015-2020). This Strategy has been approved by all members of the Board, and contains the overarching vision for health and wellbeing in the Borough

8.6.3 The Board is also accountable to a number of national bodies and organisations for the provisions of information and mandated returns (for example: quarterly Better Care Fund (BCF) performance report).

8.6.4 The primary focus of the Health and Wellbeing Board is the improvement and co-ordination of services related to NHS, social care and related children's and public health. However, this will be within the context that the Board is a lever to improve the Health and Wellbeing of the citizens of Cheshire West.

8.6.5 The CWICP will support, guide and influence the priority programmes of work linked to the delivery of the Board's Joint Health and Wellbeing Strategy (2015-2020). This includes ensuring alignment of system transformational plans and strategies within health and social care.

The specific duties of the Cheshire West and Chester Health and Wellbeing Board ("HWB") can be found in the following link https://www.cheshirewestandchester.gov.uk/your-council/how-we-work/constitution/documents/b2-committees.pdf

Integrated Care Partnership Board

8.6.6 The Integrated Care Partnership Board has been established to develop and implement the system-wide vision for the CWICP.

8.6.7 The ICPB will set strategic direction, agree priorities and delivery plan for Cheshire West's health, social care and wellbeing. The ICPB will have oversight of the development of an Integrated Care Partnership in Cheshire West and the delivery of outcomes by local leadership.

8.6.8 The ICPB will provide strategic leadership and oversight to support achievement of our shared vision and objectives through delivery of the programmes of work required to:

- Transform local health and social care services
- Integrate Services
- Collective system resilience and risk approach
- Apply system leadership to Cheshire West challenges

8.6.9 The specific remit of the ICPB is to:

(i) Take a collective, proactive role in delivering the vision for the Integrated Health and Care System across Cheshire West.

(ii) Develop, oversee the mechanics/approaches and lead on the performance requirements of the Integrated Health and Care System across Cheshire West.

(iii) Develop integrated and joint commissioning aspects of the Integrated Health and Care System in accordance with strategic and local commissioning plans.

(iv) Oversee the development of building a population health management system in order to segment, risk stratify and prioritise future need & demand for care.

(v) Identify collective ICP/local health system risks for aligned approaches to mitigation and/or review, including co-dependencies on proposed service changes across the system.

(vi) Have collective oversight of the development and implementation of sustainable system strategies and transformational plans (including HCP) by the Partners.

(vii) Together have regard to the outputs of public and patient engagement and identify future services which require system wide reviews to improve local population health outcomes.

CWICP Executive Team

8.6.10 The ICP Executive team will advise and be accountable to the ICPB on strategic direction and priorities, develop a transformation plan and be accountable to the ICPB for the delivery of the operational plan for Cheshire West's health, social care and wellbeing.

Its remit includes:

8.6.11 Oversight of the production and delivery of key business plans and cases for investment.

8.6.12 Delivery of the key milestones associated with implementation of strategic plans.

8.6.13 Monthly oversight of the system performance dashboard.

Stakeholder Partnership Forum

8.6.14 The purpose of the Stakeholder Partnership Forum is to ensure that the Partners understand the views of key Stakeholders and provide a clear mechanism within which Stakeholders can help set the future direction and delivery of plans and strategies.

The Stakeholder Partnership Forum will:

8.6.15 Articulate effectively the views and experiences of the population of Cheshire West to the Partners

8.6.16 Provide advice and guidance on the high level design for implementation of service developments, including the effectiveness of mechanisms for engaging with people who use the services of CWICP

8.6.17 Support the Partners to deliver the transformational plans and strategies, including a focus on benefits realisation for local people

8.6.18 Act as a 'critical friend' to challenge any performance issues and improvement plans

8.6.19 Provide an environment to consider and develop thinking about future service development

8.6.20 Seek assurances on the active implementation of co-production across Cheshire West.

Joint Commissioning Committee

8.6.21 The Joint Commissioning Committee is a committee of NHS West Cheshire Clinical Commissioning Group (CCG), NHS Eastern Cheshire CCG, NHS South Cheshire CCG and NHS Vale Royal CCG. It is set up to manage to the extent permitted the activities of the four CCGs as within it delegated responsibilities.

8.6.22 The Joint Commissioning Committee has the primary purpose of enabling the CCG members to work effectively together to collaborate and take joint decisions in the areas of work they agree.

8.6.23 The principles of joint commissioning across Cheshire include:

(i) Commissioning at scale to help lead to better outcomes
(ii) Meeting the needs of people not organisations
(iii) Reducing unwarranted variation
(iv) Be an enabler for the development of accountable/integrated care systems
(v) Ensuring the local NHS commissions services within its available resources.

Cheshire West and Cheshire People Overview and Scrutiny Committee

8.6.24 Cheshire West and Cheshire People Overview and Scrutiny Committee is responsible for holding to account those who deliver services based on individual need to children and adults, including health and wellbeing and education services. The Committee comprises nine elected members constituted on a politically proportionate basis in line with the political composition of CW&C.

8.6.25 Its functions include reviewing and making recommendations for improvement in relation to any matter that has an impact on the health and wellbeing of people in Cheshire West and Chester, including statutory scrutiny responsibilities relating to health services, public health and health inequalities.

8.6.26 Further information on the People Overview and Scrutiny Committee can be found in the following link: https://www.cheshirewestandchester.gov.uk/your-council/how-we-work/constitution/documents/e1-scrutiny.pdf

9 INTEGRATING HOW WE WORK

9.1 The Partners have agreed clear priorities as to how they will mobilise working together in more integrated ways across the CWICP. The priorities will be signed off by the ICPB each year.

9.2 The Cheshire West ICP has identified long terms outcomes to support CWICP to achieve its overall aims. The draft Outcomes Framework is attached as Appendix 2. It is recognised that the Outcomes Framework is an evolving document which will require ratification by the Commissioners and CW&C.

9.3 The Partners understand that no decision shall be made to make changes to services in Cheshire West or the way in which they are delivered without appropriate public and patient engagement where appropriate, in accordance with the Partners' respective statutory duties.

10 EXCLUSION AND TERMINATION

10.1 Any Partner may exit this Agreement on giving not less than 6 months' written notice to each of the other Partners' representatives on the ICPB or the ICPB may determine the Agreement if there is a dispute which is not capable of resolution in accordance with Clause 15 (*Dispute Resolution Procedure*).

10.2 Where a Partner exits this Agreement, the Partners agree to work together in good faith to agree the necessary changes so that the CWICP continues to be developed for the benefit of people of Cheshire West. The exiting Partner shall procure that all data and other material belonging to any other Partner in respect of the Services shall be delivered to the relevant Partner or deleted or destroyed (as instructed by the relevant Partner) as soon as reasonably practicable.

11 INTELLECTUAL PROPERTY

11.1 In order to meet the CWICP Integration Principles each Partner grants to each of the other Partners a fully paid up non-exclusive licence to use its existing Intellectual Property insofar as is reasonably required for the sole purpose of the fulfilment of that Partner's obligations under this Agreement.

11.2 If any Partner creates any new Intellectual Property through the development of the CWICP, the Partner which creates the new Intellectual Property will grant to the other Partners a fully paid up non-exclusive licence to use the new Intellectual Property for the sole purpose of the fulfilment of that Partner's obligations for the CWICP under this Agreement.

12 CONFLICTS OF INTEREST

The Partners will:

12.1 disclose to each other the full particulars of any real or apparent conflict of interest which arises or may arise in connection with this Agreement, the development of the CWICP or operation of the ICPB or any other Governance structure, immediately upon becoming aware of the conflict of interest, or at the latest within 28 days of becoming aware, whether that conflict concerns the Partner or any person employed or retained by them for or in connection with the development and operation of the CWICP;

12.2 not participate in any decision-making in respect of any aspect of the ICPB that could allow themselves to be placed in a position of conflict of interest in regard to any of their rights or obligations under this Agreement, without the prior consent of the other Partners to participate in that decision-making;

12.3 when appropriate ensure members of the different Governance structures make declarations of interest which are placed in a register and are updated annually or promptly as they acquire new interests or relinquish existing interests; and

12.4 use best endeavours to ensure that their representatives on the ICPB and the other Governance structures comply with the requirements of this Clause 12 when acting in connection with this Agreement or the development and/or operation of the CWICP.

13 INFORMATION SHARING AND TRANSPARENCY

13.1 The Partners will provide to each other all information that is reasonably required in order to achieve the vision, aims and objectives of the CWICP.

13.2 The Partners have responsibilities to comply with Law (including Competition Law). The Partners will make sure that they share information, and in particular Competition Sensitive Information, in such a way that is compliant with Competition Law and, accordingly, each Governance structure will ensure that the exchange of Competition Sensitive Information will be restricted to circumstances where:

13.2.1 it is essential;

13.2.2 it is not exchanged more widely than necessary;

13.2.3 it is subject to suitable non-disclosure or confidentiality agreements which include a requirement for the recipient to destroy or return it on request or on termination or expiry of this Agreement; and

13.2.4 it may not be used other than to achieve the aims of this Agreement in accordance with the CWICP Integration Principles.

13.3 Subject to compliance with Clauses 13.1 and 13.2 above, the Partners will ensure that they provide the ICPB and other Governance structures with all financial cost resourcing, activity or other information as may be reasonably required so that the ICPB and/or other relevant Governance structure can be satisfied that the ICPB vision, aims and objectives are being satisfied.

13.4 The Commissioners will make sure that each Governance structure procures the establishment of appropriate information barriers between and within the Providers so as to ensure that Competition Sensitive Information and Confidential Information are only available to those Providers who need to see it to achieve the ICPB vision, aims and objectives and for no other purpose whatsoever so that the Partners do not breach Competition Law.

13.5 It is accepted by the Partners that the involvement of the Providers in the ICPB and other Governance structures is likely to give rise to situations where information will be generated and made available to the Providers, which could give the Providers an unfair advantage in competitions or which may be capable of distorting such competitions (for example, disclosure of pricing information or approach to risk may provide one Provider with a commercial advantage over a separate Provider). Any Provider will have the opportunity to demonstrate to the reasonable satisfaction of the relevant Commissioner in relation to any competitive procurements that the information it has acquired as a result of its participation in the CWICP, other than as a result of a breach of this Agreement, does not preclude the Commissioners from running a fair competitive procurement in accordance with their legal obligations.

13.6 Notwithstanding Clause 13.5 above, the Commissioners may take such measures as they consider necessary in relation to such competitive procurements in order to comply with their obligations under Law (for example, the Public Contracts Regulations 2015 and the National Health Service (Procurement, Patient Choice and Competition) (No 2) Regulations 2013) including excluding any potential bidder from the competitive procurement in accordance with the Law governing that competitive procurement.

13.7 The Partners understand that in certain circumstances collaboration or joint working could trigger the merger rules and as such be notifiable to the Competition and Markets Authority and NHS Improvement and will keep this position under review accordingly.

13.8 The partners will agree to process any personal identifiable data in ways that are consistent with the Caldicott Principles, the General Data Protection Regulation and the Data Protection Act 2018.

13.9 The Partners understand that the ICP Board may meet in public at a future date and as such the papers, agenda and minutes of the meetings will be made available to the public via the partners' website.

14 CONFIDENTIALITY

14.1 Each Partner shall keep in strict confidence all Confidential Information it receives from another Partner except to the extent that such Confidential Information is required by Law to be disclosed or is already in the public domain or comes into the public domain otherwise than through an unauthorised disclosure by a Partner. Each Partner shall use Confidential Information received from another Partner solely for the purpose of complying with its obligations under this Agreement and for no other purpose.

14.2 To the extent that any Confidential Information is covered or protected by legal privilege, then disclosing such Confidential Information to any Partner or otherwise permitting disclosure of such Confidential Information does not constitute a waiver of privilege or of any other rights which a Partner may have in respect of such Confidential Information.

14.3 Each CWICP Partner acknowledges that the others are or may be subject to the Freedom of Information Act 2000 (the "**FOIA**") and may be required to disclose information about this Agreement to ensure their compliance with the FOIA. Each CWICP Partner notes and acknowledges the FOIA and both the respective Codes of Practice on the Discharge of Public Authorities' Functions and on the Management of Records (which are issued under section 45 and 46 of the FOIA respectively) as may be amended, updated or replaced from time to time. The CWICP Partners will act in accordance with the FOIA and these Codes of Practice (and any other applicable codes of practice or guidance applicable from time to time) to the extent that they apply to the work of the CWICP

14.4 The ICP Partners agree that where a Partner receives a FOIA request (the "**Receiving Party**"), the subject of which in its opinion relates to the CWICP, the Receiving Party will provide a copy of the request and its draft response to the other Partners. The Receiving Party will notify the other Partners of a date by which they may make representations as to the contents of the draft response. The Receiving Party shall have regard to any representations received when finalising its response.

14.5 Notwithstanding the provisions of Clause 14.4, the CWICP Partners agree that the decision on whether any exemption applies to a request for disclosure of recorded information is a decision solely for the Receiving Party.

14.6 Nothing in this Clause 14 will affect any of the Partners' regulatory or statutory obligations, including but not limited to competition law of any applicable jurisdiction.

15 DISPUTE RESOLUTION PROCEDURE

15.1 The Partners commit to working cooperatively to identify and resolve issues to the Partners' mutual satisfaction so as to avoid all forms of dispute or conflict in performing their obligations under this Agreement. Accordingly the Partners will look to collaborate and resolve differences in respect of this Agreement prior to commencing this procedure.

15.2 The Partners believe that by focusing on their agreed CWICP vision, aims, objectives and CWICP Integration Principles they are reinforcing their commitment to avoiding disputes and conflicts arising out of or in connection with the CWICP arrangements set out in this Agreement.

15.3 The Partners shall promptly notify each other of any dispute or claim or any potential dispute or claim in relation to this Agreement or the operation of the CWICP (each a "Dispute") when it arises.

15.4 In the first instance the CWICP Executive Team shall seek to resolve any Dispute to the mutual satisfaction of the Partners. If the Dispute cannot be resolved by the CWICP Executive Team within 10 Operational Days of the Dispute being referred to it, the Dispute shall be referred to the Chair for resolution.

15.5 The Chair shall deal proactively with any Dispute on a Best for System basis in accordance with this Agreement so as to seek to reach a unanimous decision. If the [ICPB] reaches a consensus that resolves, or otherwise concludes a Dispute, it will advise the Partners of its decision by written notice.

15.6 If the Chair cannot proactively deal with any dispute in accordance with Clause 15.5, the Partners agree that the Chair, on a Best for System basis, may determine whatever action he / she believes is necessary including the following:

15.6.1 If the Chair cannot resolve a Dispute, he / she may select an independent facilitator to assist with resolving the Dispute; and

15.6.2 The independent facilitator shall:

15.6.2.1 be provided with any information he or she requests about the Dispute;

15.6.2.2 assist the parties to work towards a consensus decision in respect of the Dispute;

15.6.2.3 regulate his or her own procedure subject to prior agreement with the Chair;

15.6.2.4 determine the number of facilitated discussions, provided that there will be not less than three and not more than six facilitated discussions, which must take place within 20 Operational Days of the independent facilitator being appointed; and

15.6.2.5 have its costs and disbursements met by the Partners in Dispute equally.

15.7 If the independent facilitator cannot resolve the Dispute, the Dispute must be considered afresh in accordance with this Clause 15 and only after such further consideration again fails to resolve the Dispute, the ICPB may resolve to:

15.7.1 terminate this Agreement in accordance with Clause 10; or

15.7.2 agree that the Dispute need not be resolved.

16 VARIATIONS

This Agreement may only be varied by written agreement of all of the Partners.

17 CHARGES AND LIABILITIES

17.1 Except as otherwise provided in this Agreement, the Partners shall each bear their own costs and expenses incurred in complying with their obligations under this Agreement.

17.2 The Partners shall remain liable for any losses or liabilities incurred due to their own or their employees' actions.

18 NO PARTNERSHIP

Nothing in this Agreement is intended to, or shall be deemed to, establish any partnership between any of the Partners, constitute any Partner the agent of another Partner, nor authorise any Partner to make or enter into any commitments for or on behalf of any other Partner except as expressly provided in this Agreement.

19 COUNTERPARTS

This Agreement may be executed in any number of counterparts, each of which when executed and delivered shall constitute an original of this Agreement, but all the counterparts shall together constitute the same agreement. The expression "counterpart" shall include any executed copy of this Agreement scanned into printable PDF, JPEG, or other agreed digital format and transmitted as an e-mail attachment. No counterpart shall be effective until each Partner has executed at least one counterpart.

20 NOTICES

20.1 Any notice or other communication given to a Partner under or in connection with this Agreement shall be in writing, addressed to that Partner at its principal place of business or such other address as that Partner may have specified to the other Partner in writing in accordance with this Clause, and shall be delivered personally, or sent by pre-paid first class post, recorded delivery or commercial courier.

20.2 A notice or other communication shall be deemed to have been received: if delivered personally, when left at the address referred to in Clause 20.1; if sent by pre-paid first class post or recorded delivery, at 9.00 am on the second Operational Day after

posting; if delivered by commercial courier, on the date and at the time that the courier's delivery receipt is signed.

21 THIRD PARTY RIGHTS

A person who is not a party to this Agreement shall not have any rights under or in connection with it.

22 GOVERNING LAW AND JURISDICTION

This Agreement, and any dispute or claim arising out of or in connection with it or its subject matter or formation (including non-contractual disputes or claims), shall be governed by, and construed in accordance with, English law, and subject to Clause 15 (Dispute Resolution Procedure) the Partners irrevocably submit to the exclusive jurisdiction of the courts of England and Wales.

This Agreement has been entered into on the date stated at the beginning of it.

Signature	Name & Delegation	For and on behalf of	Date
		The Countess of Chester Hospital NHS Foundation Trust	
		Cheshire West & Chester Council	
		Cheshire and Wirral Partnership NHS Foundation Trust	
		Central Cheshire Integrated Care Partnership	
		South Cheshire & Vale Royal GP Alliance	
		Primary Care Cheshire	

SCHEDULE 1

DEFINITIONS AND INTERPRETATION

Interpretation

1. In this Agreement, unless the context requires otherwise, the following rules of construction shall apply:

   1.1 a "person" includes a natural person, corporate or unincorporated body (whether or not having separate legal personality);

   1.2 unless the context otherwise requires, words in the singular shall include the plural and in the plural shall include the singular;

   1.3 a reference to a "Clause" or a "Schedule" or an "Appendix" is to a Clause, Schedule or Appendix to this Agreement;

   1.4 a reference to a "Provider" the "Council" or "Commissioners" includes its representatives, successors or permitted assigns;

   1.5 a reference to a statute or statutory provision is a reference to such statute or provision as amended or re-enacted. A reference to a statute or statutory provision includes any subordinate legislation made under that statute or statutory provision, as amended or re-enacted;

   1.6 any phrase introduced by the terms "including", "include", "in particular" or any similar expression shall be construed as illustrative and shall not limit the sense of the words preceding those terms;

   1.7 documents in "agreed form" are documents in the form agreed by the Partners and initialled by them for identification and attached to this Agreement; and

Definitions

2. The following words and phrases have the following meanings:

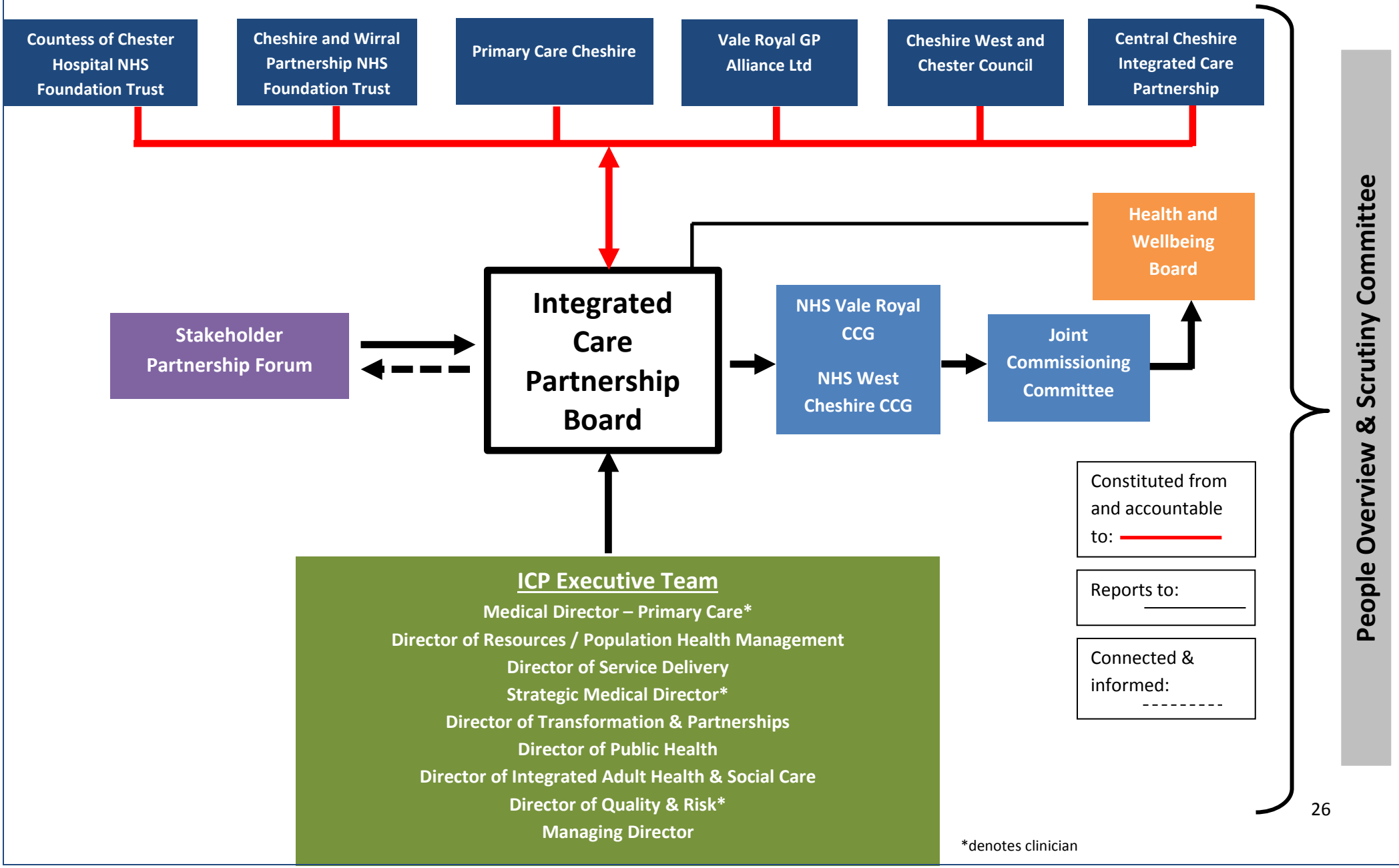
Agreement	this agreement incorporating the Schedules and Appendices
Aligned decision making	this is central to the work of the ICP and means that the partner organisations within the ICP retain their own decision making authority but have agreed to make their decisions taking into account a vision that is common to all of them
Best for System	means best for the achievement of the CWICP vision and aims for the Cheshire West population on the basis of the CWICP Integration Principles
Commencement Date	means the date of this Agreement, 'go-live date'
Competition Law	means the Competition Act 1998 and the Enterprise Act 2002, as amended by the Enterprise and Regulatory Reform Act 2013 and as applied to the healthcare sector by Monitor in accordance with the Health and Social Care Act 2012
Competition Sensitive Information	means Confidential Information which is owned, produced and marked as Competition Sensitive Information including information on costs by one of the Providers and which that Provider properly considers is of such a nature that it cannot be exchanged with the other Providers without a breach or potential breach of Competition Law
Commissioners	means NHS Vale Royal CCG, NHS West Cheshire CCG and Cheshire West & Chester Council
Confidential Information	means all information which is secret or otherwise not publicly available (in both cases in its entirety or in part) including commercial, financial, marketing or technical information, know-how, trade secrets or business methods, in all cases whether disclosed orally or in writing before or after the date of this Agreement
CWICP	Cheshire West Integrated Care Partnership
Dispute	any dispute arising between two or more of the Partners in connection with this Agreement or their respective rights and obligations under it
Dispute Resolution Procedure	the procedure set out in Clause 15.

FOIA	means the Freedom of Information Act 2000 and any subordinate legislation (as defined in section 84 of the Freedom of Information Act 2000) from time to time together with any guidance and/or codes of practice issued by the Information Commissioner or relevant Government department in relation to such Act
Governance structure(s)	As outlined within the Cheshire West ICP governance structure in Appendix 1
Go-Live Date	**1st April, 2019**, or such other date as the partners agree
Guidance	any applicable health or social care guidance, guidelines, direction or determination, framework, code of practice, standard or requirement to which a Partner has a duty to have regard (whether specifically mentioned in this Agreement or not)
Host	Countess of Chester Hospital NHS Foundation Trust is the host of the ICP and will have a coordinating role for the ICP under collaborative governance arrangements and aligned decision making.
ICPB	Integrated Care Partnership Board
Intellectual Property	patents, rights to inventions, copyright and related rights, trade marks, business names and domain names, goodwill, rights in designs, rights in computer software, database rights, rights to use, and protect the confidentiality of, Confidential Information and all other intellectual property rights, in each case whether registered or unregistered and including all applications and rights to apply for and be granted, renewals or extensions of, and rights to claim priority from, such rights and all similar or equivalent rights or forms of protection which subsist or will subsist now or in the future in any part of the world
Law	(i) any applicable statute or proclamation or any delegated or subordinate legislation or regulation; (ii) any enforceable EU right within the meaning of section 2(1) European Communities Act 1972; (iii) any applicable judgment of a relevant court of law which is a binding precedent in England and Wales; (iv) Guidance;

	(v) National Standards; and (vi) any applicable code.
National Standards	those standards applicable to the Partners under the Law and/or Guidance as amended from time to time
Operational Day	a day other than a Saturday, Sunday or bank holiday in England
Population	the population we serve
Stakeholders	Partners to Cheshire West ICP within the local health system

Appendix 1

Cheshire West Integrated Care Partnership – Governance Framework



Appendix 2– CWICP Outcomes Framework

CWICP Outcomes Framework
1. Improve quality of life for users and carers
2. Reduce the number of admissions to hospital following a fall
2i. Emergency hospital admissions due to falls in people aged 65 and over (rate per 100,000 pop)
3.Reducing the gap in health inequalities/life expectancy by highest and lowest wards
3i. The gap in life expectancy at birth (most to least deprived) Male
3i. The gap in life expectancy at birth (most to least deprived) Female
4. Increased proportion of people who use services who have control over their daily life
5. Increase the proportion of people who feel supported to manage their own condition
6. Reduce the number of older people who have a permanent admission to residential and nursing care home
7. Increased proportion of older people (65+) who were still at home 91 days after discharge from hospital into re-ablement or rehabilitation services
8. & 10. Employment of people with long term conditions or mental illness
8i. Employment of people with long term conditions
10i. Employment of people with mental illness
11. Reduction in delayed transfers of care from hospital per 100,000 population
12. Reduction in the number of A&E attendances (for low acuity conditions)
13. Reduce mental health patients presenting in crisis out of hours
14. Services users and carers who find it easy to find information about services

N.B. The priority outcomes are being developed with oversight by CWICP Delivery Group members. These outcomes (in Appendix 2) are currently being tested with ongoing review and development.

Cheshire and Wirral Partnership NHS Foundation Trust

STANDARDISED REPORT COMMUNICATION

REPORT DETAILS

Report subject:	Operational Plan 2018/19- delivery indicators dashboard [February data]
Agenda ref. no:	18.19.148
Report to (meeting):	Board of Directors
Action required:	Discussion and Approval
Date of meeting:	27/03/2019
Presented by:	Tim Welch, Director of Finance/Deputy Chief Executive

Which strategic objectives this report provides information about:	
Deliver high quality, integrated and innovative services that improve outcomes	Yes
Ensure meaningful involvement of service users, carers, staff and the wider community	Yes
Be a model employer and have a caring, competent and motivated workforce	Yes
Maintain and develop robust partnerships with existing and potential new stakeholders	Yes
Improve quality of information to improve service delivery, evaluation and planning	Yes
Sustain financial viability and deliver value for money	Yes
Be recognised as an open, progressive organisation that is about care, well-being and partnership	Yes
Which CQC quality of service domains this report reflects:	
Safe services	Yes
Effective services	Yes
Caring services	Yes
Well-led services	Yes
Services that are responsive to people's needs	Yes
Which Monitor quality governance framework/ well-led domains this report reflects:	
Strategy	Yes
Capability and culture	Yes
Process and structures	Yes
Measurement	Yes
Does this report provide any information to update any current strategic risks? If so, which?	
See current risk register in the agenda of the public meeting of the Board of Directors at http://www.cwp.nhs.uk/about-us/board-members/our-board-meetings	Yes
36T	
Does this report indicate any new strategic risks? If so, describe and indicate risk score:	
See current integrated governance strategy: CWP policies – policy code FR1	No
36T	

REPORT BRIEFING

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

The Operational Plan 2018/19 sets out the Trust's approach to activity, quality, workforce planning and financial planning.

The dashboard attached in **appendix 1** reflects the key performance indicators (KPIs) defined to enable the Board to monitor the delivery of the Operational Plan and the Trust's strategic objectives and any risks to achievement and has been updated to reflect the priorities for 2018/19. This report relates to February 2019 Performance.

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

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

Following the Board seminar in January work continues to align reporting formats/ styles/ definitions across the Trusts committee structures, phase one of this work is focusing on the Quality Committee and Trust Board dashboard reporting, and the redevelopment of the dashboard will be delivered for the new year.

Assessment – *analysis and considerations of options and risks*

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

The dashboard reflects month 11 (February) performance and there are 13 indicators off track.
SO1: 1.3 Clinical Effectiveness
SO1:1.2 FFT uptake
SO1:1.6 Patient Safety Indicators
SO1:1.8 Patient Safety: Reduction in the severity of harm
SO3: 2.1 Capacity: % of staff vacancies (Contracted)
SO3: 2.2 Competence: % of staff receiving annual appraisal
SO3: 2.3 % staff absence due to sickness
SO3: 3.2 100% of contract targets met & CQUIN performance quarterly review
SO3: 3.6/9 Priority Projects

Following review of the operational performance dashboard, at Operational Committee on 20 February 2019 it was agreed to escalate the following issues to Trust Board for oversight and discussion:

Challenges:

- Attendance (a deep dive report is being taken to March Operational Committee)
- SMH Financial position
- Efficiency savings (please refer to finance report)

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

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

The Board are recommended to **note** the February 2019 Board Operational Plan dashboard.

Who/ which group has approved this report for receipt at the above meeting?		Tim Welch, Director of Finance
Contributing authors:		Mandy Skelding-Jones, Associate Director Performance & Redesign, Viv Williamson, Hayley Curran, Lisa Parker
Distribution to other people/ groups/ meetings:		
Version	Name/ group/ meeting	Date issued
1	Andy Styring/ Andy Harland	20/02/19

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	February 2019 Board Operational Plan Dashboard.
2	Operational Plan 2017/18 – Delivery Indicators/ Board KPIs

Appendix 1: Trust Dashboard

	Indicator	Outturn 2017/18	Target or Thresholds for escalation	Q1	Q2	Oct-18	Nov-18	Dec-18	Q3	Jan-19	Feb-19	Mar-19	Q4	Year End	General Comment
Strategic Objective 1 – Quality															
SO1: 1.8	Patient Safety: Reduction in the severity of harm (by 20%) sustained by those people accessing CWP services that cause harm to themselves	121 (10 per month)	97 (8 per month)	29	23	7	11	6	24	10	8				Long term trajectory is continuous improvement against 2017/18 outturn however progress needs to be made in the remainder of quarter 4. A driver diagram has been developed and QI work is being implemented. Note: All incident numbers represent a snapshot as at the time of publication and are subject to change over time, for example: re-categorisation of incidents following receipt of further information since the previous report, receipt of compliments retrospectively. A data quality review has been undertaken in Q3 to review the categories recorded throughout 2018/19.
SO1: 1.2	Patient experience: Demonstrable increase in the uptake of the Friends and	Average 201 (per month)	330 per month	841	711	333	312	300	945	308	287				Figures from Decemebre are inclusive of both paper and electronic surveys completed.
SO1: 1.3	Clinical Effectiveness: Demonstrable improvement in the Trustwide average bed occupancy rate, excluding leave, for working age adult wards	93.30%	Improvement to 85% by KH03's month 12 (December 2017)	93.58%	91.16%	92.97%	93.77%	87.96%	91.57%	87.61%	88.39%				The trust cntinues to experienced improvement in the bed occupancy rates this year. However this improvement continues to be at a level that is higher than the Royal Psychiatrist nationally recommended bed occupancy rate of 85%.
SO1: 1.4	Patient Safety: Total % inpatient deaths subject to a case record review	100%	100%	100%	**N/A**	N/A	N/A	N/A	**N/A**	100.00%	N/A				N/A
SO1: 1.5	Patient Safety: Total number of inpatient deaths subject to a case record review identifying that there may have been a problem in the care provided	3	2 in 2018/19 (1 in any month)	1	**N/A**	N/A	N/A	N/A	**N/A**	N/A	N/A				N/A
SO1: 1.6	Patient Safety: Total % deaths reported by and to the Trust (including inpatient deaths) subject to a case record review	18%	15%	*** 34%**	***54%**	*61%	*65%	*58%	***63%**	*88%	*82%				* Includes only CAREnotes and PCMIS data in the denominator - Amber rating reflects this position. The mortality monitoring group met in January 2019 and agreed to alter the scope of older peoples deaths where there had been minimum on a CPA or staff or families raise concerns. The inclusion of EMIS data in the denominator due to the difference to the deaths in scope for this population was also discussed. It was agreed that a sub group will identify the scope to review deaths for people receiving specialist services where there is little CWP care provision, this will be included from Q1 2019/2020.
SO1: 1.7	Patient Safety: Total number of deaths (including inpatient deaths) subject to a case record review identifying that there may have been a problem in the care provided	4	3 in 2018/19 (1 in any month)	**0**	**0**	0	0	0	0	0	N/A				N/A

Strategic Objective 2: People and OD/ Approach to workforce															
SO3: 2.1	Capacity: % of staff vacancies (Contracted)	5.00%	equal to or below baseline 5.31%	5.98%	5.57%	5.72%	5.36%	6.29%	6.29%	6.29%	6.42%				The vacancy figure from the Finance ledger of 6.42% equates to 214.14 WTE. There are 251.64 WTE in all stages of recruitment as at 20/3/19 and time to hire remains consistent at an average of 52.2 working days.
SO3: 2.2	Competence: % of staff receiving annual appraisal (via new proposed framework)	97.6%	100.0%	89.14%	82.91%	91.08%	87.04%	86.60%	86.60%	91.34%	92.84%				Appraisal compliance continues to improve with a further 1.43% increase during February reporting period. This is attributed to ongoing follow up and reporting, together with managers commitment to ensuring staff have appraisals. 2018 staff survey reflects that whilst staff are receiving an appraisal there is more work to do to ensure it s a quality experience. This will form work to review current appraisal and supervision (both clinical and management) processes. Work is underway to align both appraisal and supervision processes under one policy to ensure this is clearer for staff. This is a key action for the Trust, and update will be presented to March P&OD Committee together with recommendations to improve appraisal and supervision processes for the new year 2019/20.
SO3: 2.3	% staff absence due to sickness	5.89%	Above annual plan projection for 3 months	5.24%	5.90%	6.28%	6.29%	6.29%	6.29%	6.55%	6.36%				The issue has been discussed with Care Group leads at Operational Committee and PODSC and POD Business Partners are supporting Care Groups to ensure that absences are being addressed as effectively as possible through a more detailed analysis of the situation. A quarterly report will be presented to March PODSC and Ops Committee in April 19.
SO3: 2.4	Staff, in month, Turnover rate (as a percentage)	0.91%	3 consecutive months where the turnover rate is 25% above the planned rate	0.78%	0.67%	0.64%	0.91%	0.73%	0.73%	0.84%	0.95%				

Operational Performance / Priority areas															
SO3: 3.1	100% of the 13 NHSI operational performance targets achieved (including waiting times)	100%	100%		100.00%	93.0%	93.0%	93.0%	100.00%	95.0%	100.00%	100%				The Trust achieved compliance across all indicators in February
SO3: 3.2	100% Contractual targets met	324 (98.1%)	100%		95.5%	95.6%	96.0%	94.4%	95.2%	95.2%	95.7%					This indicator reports a month behind 11 performance targets not met out of 376 , 5 (45%) targets being off track due to over performance.
	CQUIN performance quarterly review		100%													The monthly CQUIN review process has reulted in the health & well being CQUIN being red rated due to Flu vaccination uptake and the staff survey results, not recahing the required 5% improvement metric
Trust Priority Projects															
Care Group: Neighbourhood Care															
SO3: 3.3	Single Model for Integrated Care	N/A	Delivery of Key Milestones													No Update received
Care Group: Specialist mental Health															
SO3: 3.7a	Redesign Adult & Older peoples MH services -(In patient, Community and Rehab)	N/A	Delivery of Key Milestones													The project has been integrated with Redesign Adult & Older peoples MH services - Bed based. A single PID for this project was approved at February 2019 Operational Committee for Approval. The combined project has established a clear governance structure to mange the combined priority project.
SO3: 3.10	Wirral All Age Disability	N/A	Delivery of Key Milestones													Project Closure report to be submitted to Operational Committee March 2019
Care Group: Children Young People & Families															
SO3:3.15	CYP New Model of Care	N/A	Delivery of Key Milestones													New PID Due to be submitted to April 2019 Operational Committee
Care Group: Learning Disabilities & Nuero Developmental (LD&ND)															
SO3: 3.6	Transforming Care - LD	N/A	Delivery of Key Milestones													Project end date revised to 31 March 2020, the rationale for this being the commissioners decision to delay the reprovision of short breaks schemes, therefore the reduction in inpatient beds has been delayed, the 4 uncontracted beds are operating as Income Generating Beds.
SO3: 3.9	ADHD	N/A	Delivery of Key Milestones													Project is on track and assocaited risks are on the Care Group risk register. Outcome of the QIA review was that service can not be continued as is; discussions are ongoing with commissioners regarding signing up to the new service offer , risks would reduce . Improvments to reporting and data
Enablers															
SO3: 3.11	People& OD Strategy	N/A	Delivery of Key Milestones													No update received
SO3: 3.12	Health Informatics	N/A	Delivery of Key Milestones													
SO3: 3.13	Quality Improvement Strategy	N/A	Delivery of Key Milestones													Revised delivery plan being developed and agreed
SO3: 3.14	Communications & engagement	N/A	Delivery of Key Milestones													No Update received
Strategic Objective 6: Financial Planning															
SO6: 1	Use of resources	1	Use of Resources [UoR]		**1**	**1**	1	1	1	1	1	1				Further detail is available in Finance Report

0.45

Appendix 2: Trust Dashboard Reporting Framework

Op Plan ref	Indicator	Target or Thresholds for escalation	Base line	Reporting and Frequency	Reporting Months	Reporting Committee	Reporting Format	Director	Project Lead	Risk Register/ CAF ref
Strategic Objective 1 – Quality										
SO1: 1.1	Patient safety: The target for improvement is a 10% increase in the number of D&E incidents reported, based on numbers reported at the start of Trimester 1 of this year. The indicator is shown as a rate per 1,000 episodes of care.	10% improvement in reporting of low and no harm incidents **Escalation Thresholds** Red: Below 2016/17 outturn Amber: better than 2016/17 outturn (58.6) Green: above 2016/17 target (64.5)	Red: Below 2016/17 outturn Amber: better than 2016/17 outturn Green: above 2016/17 target(64.6)	Learning from Experience report Every 4 months	May August January April	Quality Committee	Trend line	Anushta Sivananthan/ Avril Devaney/ Jim O'Connor	David Wood	Risk 6 – learning from incidents (amber 6)
SO1: 1.8	reduction in the severity of harm sustained by those people accessing CWP services that cause harm to themselves	97 (per year) **Escalation Thresholds** Red: higher than outrurn Amber: = to outturn position but higher than target Green: = to or below target	121 (10 per month)	Learning from Experience report Every 4 months	May August January April	Quality Committee	Achievement trend line	Avril Devaney/ Anushta Sivananthan	David Wood	
SO1: 1.2	Patient experience: Demonstrable increase in the uptake of the Friends and Family Test (FFT) each quarter	10% improvement in Trustwide uptake of FFT based on 15/16 outurn	Average 201 per month (16/17)	Quality Improvement Report Every 4 months	May August January April	Patient and Carer Experience Sub Committee	? Trajectory for improvement	Avril Devaney/ Jim O'Connor	Cathy Walsh	Risk 5 – feedback from learning (amber 9)
SO1: 1.3	Clinical Effectiveness: Demonstrable improvement in the Trustwide average bed occupancy rate, including leave, for working age adult wards	Improvement to 85% by KH03's month 12 (December 2017)	93.30%	Continuous Improvement Report Monthly	May-March	Quality Committee	Tabular	Faouzi Alam/Anushta Sivananthan/ Jim O'Connor/	Sarah Quinn	
SO1: 1.4	Patient Safety: Total % inpatient deaths subject to a case record review	100%	100%	Learning from Experience report Every 4 months	May August January April	Quality Committee	Tabular	Avril Devaney/ Jim O'Connor	Lisa Parker	
SO1: 1.5	Patient Safety: Total number of inpatient deaths subject to a case record review identifying that there may have been a problem in the care provided	2 (improvement by year end)	3	Learning from Experience report Every 4 months	May August January April	Quality Committee	Tabular	Avril Devaney/ Jim O'Connor	Lisa Parker	

SO1: 1.6	Patient Safety: Total % deaths reported by and to the Trust (including inpatient deaths) subject to a case record review	KPI escalation via Learning from Experience report	18%	Learning from Experience report Every 4 months	May August January April	Quality Committee	Tabular	Avril Devaney/ Jim O'Connor	Lisa Parker	
SO1: 1.7	Patient Safety: Total number of deaths (including inpatient deaths) subject to a case record review identifying that there may have been a problem in the care provided	3 (improvement by year end)	4	Learning from Experience report Every 4 months	May August January April	Quality Committee	Tabular	Avril Devaney/ Jim O'Connor	Lisa Parker	
SO3: 2.1	Capacity: % of staff vacancies	5.00%	5% or below is green 5.1-5.99 is amber 6% and above being red	Any 3 consecutive months where we are amber or red rated	By exception	People and OD subcommittee	Chairs escalation	Dave Harris	Viv Williamson	Risk 11 – staffing (rated amber 6)
SO3: 2.2	Competence: % of staff receiving annual appraisal (via new proposed framework)	100% of available eligible cohort	97.6%	Any quarter in which each of the three months the appraisal rate is below the baseline position	Quarterly	People and OD subcommittee	Performance against plan chart or variance from plan	Dave Harris	Hayley Rigby	Risk 11 – staffing (rated amber 6)
SO3: 2.3	% staff absence due to sickness	5.30%	5.89%	Any 3 consecutive months where we are above the monthly baseline set out in the annual plan.	By exception	People and OD sub committe e	Variance from target trend line	Dave Harris	Chris Sheldon	Risk 11 – staffing (rated amber 6)
SO3: 2.4	Staff , in month, Turnover rate		0.91%	3 consecutive months where the turnover rate is 25% above the planned rate	By exception	People and OD sub committee	variance from plan	Dave Harris	Gill Kelly	

Operational Performance / Priority areas										
SO3: 3.1	100% of the 13 NHSI operational performance targets achieved (including waiting times)	100%	100%	Any occasion where the compliance with any monitor target is missed for 3 consecutive months	By exception	Operational Board	Achievement trend line	Andy Styring/ Tim Welch	Service Directors	Risk in scope re. IAPT delivery
SO3:3.2	100% Contractual targets met	100%	Avg 98.1%	Any occasion where the same target for any contractual KPI is missed	By exception	Operational Board	Achievement trend line	Andy Styring/ Tim Welch	Service Directors	Risk in scope re. IAPT delivery
	CQUIN Achievement of milestones	(100% of CQUIN Milestones achieved)		Report quarterly on CCG confirmed achievement against milestones	By exception	Operational Board	written report	Andy Styring/ Tim Welch	Service Directors	Risk 14 Financial performance/ CIP delivery (rated green and risk archived)
Op Plan ref	**Indicator**	**Target or Thresholds for escalation**	**Base line**	**Reporting and Frequency**	**Reporting Months**	**01/04/2017**	**01/05/2017**	**Executive Sponsor**	**Project Lead**	**Risk Register/ CAF ref**
SO3: 3.3	Priority project 1: Children and Young Families Prevention/ Early interventions:	Delivery of Key Milestones		Project Status report monthly and at key decision/ milestone points along the project	April - March	Operational Board	Delivery of Key Milestones	Avril Devaney and Dave Harris	Val Sturgess	Risk 13 – tendering of services (rated green and risk archived)
Care Group: Neighbourhoods										
SO3: 3.3	Single Model for Integrated Care (Improved Place Based Care)	Delivery of Key Milestones		Project Status report monthly and at key decision/ milestone points along the project	Monthly	Operational Board	Delivery of Key Milestones	Dave Harris	Karen Moore	
Care Group: Specialist Mental Health Services										
SO3: 3.7a	Redesign Adult & Older peoples MH services- responsive care in the community	Delivery of Key Milestones		Project Status report monthly and at key decision/ milestone points along the project	Monthly	Operational Board	Delivery of Key Milestones	Nush Sivananthan & Faouzi Alam and Dave Harris	Sally Sanderson	
SO3: 3.7b	Redesign Adult & Older peoples MH services- Bed Based	Delivery of Key Milestones		Project Status report monthly and at key decision/ milestone points along the project	Monthly	Operational Board	Delivery of Key Milestones	Nush Sivananthan & Faouzi Alam and Dave Harris	Suzanne Edwards	
SO3: 3.8	EI Review & delivery			Project Status report monthly and at key decision/ milestone points along the project	Monthly	Operational Board	Delivery of Key Milestones	Faouzi Alam	Trish McCormack	
SO3: 3.10	Wirral All Age Disabilities	Delivery of Key Milestones		Project Status report monthly and at key decision/ milestone points along the project	Monthly	Operational Board	Delivery of Key Milestones	Andy Styring	Trish McCormack	

Care Group Children & Young People										
SO3: 3.5	Children and Young Families Prevention/ Early interventions:	Delivery of Key Milestones		Project Status report monthly and at key decision/ milestone points along the project	Monthly	Operational Board	Delivery of Key Milestones	Avril Devaney	Fiona Pender	
SO3: 3.4	0-19 Starting Well Service Implementation	Delivery of Key Milestones		Project Status report monthly and at key decision/ milestone points along the project	Monthly	Operational Board	Delivery of Key Milestones	Avril Devaney	Val Sturgess	
Care Group: Learning Disabilities & Nuero Developmental										
SO3: 3.6	Transforming Care - LD Care Model	Delivery of Key Milestones		Project Status report monthly and at key decision/ milestone	Monthly	Operational Board	Delivery of Key	Andy Styring	Mahesh Odiyoor	
SO3: 3.9	ADHD	Delivery of Key Milestones		Project Status report monthly and at key decision/ milestone points along the project	Monthly	Operational Board	Delivery of Key Milestones	Andy Styring	Mahesh Odiyoor	
ENABLERS										
SO3: 3.11	People & OD Strategy	N/A	Delivery of Key Milestones		Monthly	Operational Board	Delivery of Key Milestones	Dave Harris/ Faouzi Alam	Jane Woods	
SO3: 3.12	Health Informatics	N/A	Delivery of Key Milestones		Monthly	Operational Board	Delivery of Key Milestones	Tim Welch	Jane Thomas/ Mandy Skelding-Jones	
SO3: 3.13	Quality Improvement Strategy				Monthly	Operational Board	Delivery of Key Milestones	Anushta Sivananthan	Hayley Cavanagh	
SO3: 3.14	Communication & Engagement	N/A	Delivery of Key Milestones		Monthly	Operational Board	Delivery of Key Milestones	Avril Devaney	Kathrine Wright	
Strategic Objective 6: Financial Planning										
SO6: 1	Use of resources	Use of Resources [UoR] score of 3 or 4	Plan	Monthly	April - March	Trust Board		Tim Welch/ Edward Jenner	Andy Harland	

Cheshire and Wirral Partnership NHS Foundation Trust

STANDARDISED REPORT COMMUNICATION

REPORT DETAILS

Report subject:	Corporate assurance framework and strategic risk register – update report
Agenda ref. no:	18.19.150
Report to (meeting):	Board of Directors – meeting in public
Action required:	Discussion and Approval
Date of meeting:	27/03/2019
Presented by:	Dr Anushta Sivananthan, Medical Director (Executive Lead for Quality)

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

REPORT BRIEFING

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

To apprise the Board of Directors of the current status of the strategic risk register 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 framework. 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 2019, the Trust has 9 strategic risks – 2 red and 7 amber rated. There are 3 risks currently in-scope (all amber).

The significance level of the risks (as per the corporate assurance framework heat map) has reduced in this period of reporting and is indicative that the Trust's capacity to handle risk currently remains sound.

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

The Quality Committee is the designated committee for risk management operationally and ensures the quality agenda is implemented across the Trust, including the review and oversight of the strategic risk register. It works closely with the Audit Committee in identifying in-depth reviews of strategic risks as part of ongoing reviews of the effectiveness of integrated governance and internal control systems.

The Board of Directors monitors and reviews the corporate assurance framework and receives assurances on risk via the Quality Committee. This is a key component of the Trust's integrated governance strategy which provides assurance regarding the quality and safety of the services that the Trust provides.

Assessment – *analysis and considerations of options and risks*

New risks/ Risks in-scope

Three risks are in-scope. The first remains in-scope:

Risk that patients' privacy, dignity and safety is compromised as a result of breaches in relation to the Department of Health guidance on mixed sex accommodation – rated 9 (amber). The risk treatment plan will be fully developed by 31 March 2019 (scheduled submission date to the CQC) and will include detailed assurance plans to evidence that staff on the ground are compliant with this regulation on an ongoing basis. Delivery of the identified mitigations for risk 2 will address the most significant residual concerns.

Two new risks are in-scope, these were agreed at the Board meeting in January 2019:

Risk of not providing effective electronic transfer of inpatient discharge summaries within 24 hours and outpatient clinic letters within 7 days, potentially impacting on the quality of clinical information and potentially increasing the likelihood of contractual and regulatory breaches – rated 12 (amber). This risk was been escalated from the Operational Committee and progress with the risk treatment plan, which is being developed by the Business Continuity team, will be reported to the Operational Committee on an ongoing basis.

Gaps in consultant staffing in both inpatient and the community setting resulting in a potential risk to patient safety, service continuity and increasing waiting times – rated 12 (amber). A risk treatment plan, with support from the Business Continuity team, is being developed and is progressing, this includes a monthly impact assessment dashboard to monitor care and quality impacts as well as the mitigating impact of risk treatment.

Amended/ Archived risks

Risk of harm due to deficits in familiarity with and staff competence in applying safety critical policies and frameworks. The Quality Committee agreed to (i) decrease the residual risk score from 16 (red) to 12 (amber), taking into consideration the separation out of specific sub-sets of this risk (following the CQC 2018 inspection feedback) and ongoing progress with the substantive risk treatment plan; and (ii) subsequently archive the current strategic risk as described in light of the residual elements of it being associated with a previously archived risk (regarding compliance with the Mental Health Act) which will now be re-escalated. The Quality Committee agreed an action for the Care Groups to develop written improvement plans and trajectories to assure of real time and ongoing compliance with all aspects of the Mental Health Act.

Quality Committee recommended archive of the further following three strategic risks, following discussion with the respective risk leads and based on evidence of progress with/ completion of the agreed risk treatment plans:

Potential for ineffective control and management of risks and inattention on business as usual associated with the transition to the Trust's clinician-led operational (Care Group) structure as part of CWP Forward View strategy. This risk has been archived due to reaching the agreed tolerable risk score, the developing risk maturity of Care Groups in accordance with the integrated governance framework; additionally the CQC 2018 inspection feedback provided positive conclusions about the operation of the Care Group structure.

Potential clinical, operational and financial risks associated with services being delivered to or by CWP for which there is no assurance of adequate documentary contractual documentation being in place. The key identified risk treatment actions, specifically the development of a Trust contract repository and the management of the risk via clinical support services' risk registers, have been completed.

Potential ligature points risk due to curtain rails that may fail to collapse for patients with low body weight. Immediate action taken assures that CWP has implemented relevant learning from external recommendations (specifically replacement of curtain rail brackets for high risk areas and inclusion of the risk on ward handover sheets for other areas to prompt mitigation via clinical risk assessment/ management processes).

Exceptions

There are 4 risk treatment actions overdue. All of these are expected to be completed by May 2019; this assurance will be provided to the Quality Committee.

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

Review, **discuss** and **approve** the amendments made to the corporate assurance framework

Who/ which group has approved this report for receipt at the above meeting?	Board of Directors – business cycle requirement
Contributing authors:	D Wood, L Brereton

Distribution to other people/ groups/ meetings:

Version	**Name/ group/ meeting**	**Date issued**
1	Board of Directors	20/03/2019

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

Appendix no.	Appendix title
1	Corporate Assurance Framework

NHS
Cheshire and Wirral Partnership
NHS Foundation Trust

STANDARDISED REPORT COMMUNICATION

REPORT DETAILS	
Report Subject:	Annual Information Governance Board Report 201819
Agenda ref. no:	18.19.151
Report to (meeting):	Board of Directors
Action required:	Discussion and Approval
Date of Meeting	27/03/2019
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 NHSI Single Oversight Framework performance themes this report reflects:		Cheshire and Wirral Partnership Quality Framework:		
Quality	Yes	Patient Safety	Safe	Yes
Finance and use of resources	Yes	Clinical Effectiveness	Effective	Yes
Operational performance	Yes		Affordable	Yes
Strategic change	Yes		Sustainable	Yes
Leadership and improvement capability	Yes	Patient Experience	Acceptable	Yes
http://www.cwp.nhs.uk/media/4142/quality-improvement-strategy-2018.pdf			Accessible	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

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

REPORT BRIEFING

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

To brief the Board of Directors on information governance resources, issues, risks and improvement plans undertaken in 2018/19, and to seek approval for the 2018/19 annual Data Security & Protection Toolkit (DSPT) submission.

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

Compliance with information governance standards is annually assessed through the completion of the Information Governance Toolkit (IGT) (replaced by the Data Security & Protection Toolkit (DSPT) in May 2018), hosted by NHS Digital. The IGT/DSPT submission is examined by the Trust's regulators, the Care Quality Commission (CQC) review the toolkit in their assessments while the foundation trust regulator, NHSI, consider the toolkit when assessing the foundation Trust's governance risk rating. The Information Governance & Data Protection Sub-Committee has devolved responsibility from the Operational Committee for monitoring overall compliance with Information Governance

Background – *(continued)*

principles, escalating risks and ensuring mitigating actions are in place.

Assessment – *analysis and considerations of the options and risks*

The new toolkit is designed for organisations to demonstrate progress in implementing the 10 National Data Security Standards. The 10 standards are broken down into 44 assertions. All NHS Trusts were required to complete an interim submission by the end of October 2018 with a final submission by the end of March 2019. The Trust completed all the assertions for the October interim submission. Completed actions against the 2018/19 work plan and the planned 2019/20 work plan may be found in appendix 1. Information governance arrangements have been reviewed during 2018/19 firstly against the latest version of the information governance toolkit (IGT)/data security & protection toolkit (DSPT), and then against guidance released throughout the year. The Information Governance & Data Protection Sub-Committee monitor the DSPT action plan through audits, spot checks and review of incidents. Risks are reported to the Operational Committee. Actions to ensure the requirement to achieve 95% staff compliance with Data Security awareness training are targeted communications with staff who are not compliant with the mandatory annual training. Mersey Internal Audit Agency have recently undertaken an audit of the current toolkit and awarded the Trust a significant/substantial assurance rating for the seventh consecutive year. This supports the case that current information governance arrangements within Cheshire & Wirral Partnership are appropriate and fit for purpose.

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

o That the Board approves the Annual Information Governance Board Report
o That the Board approves the submission of the 2018/19 Data Security & Protection Toolkit
o That the Board approves the statement that current information governance arrangements are fit for purpose

Who/ which group has approved this report for receipt at the above meeting?:	Information Governance & Data Protection Sub-Committee
Contributing authors:	Gill Monteith, Information Governance Manager & Data Protection Officer, Jane Thomas, ICT Informed Client, Tim Jenkins, Emergency Planning and Business Continuity Co-ordinator, Mandy Skelding-Jones, Head of Performance

Distribution to other people/ groups/ meetings:

Version	Name/ group/ meeting	Date issued
1	Dr Faouzi Alam, Medical Director, Effectiveness, Medical Education and Medical Workforce & Audrey Jones, Head of Clinical Governance	12/02/2019

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	IG annual board report March 2019

Annual Information Governance Board Report 2018/19

1. Purpose of the report

To brief the Board of Directors on information governance resources, issues, risks and improvement plans undertaken in 2018/19, and to seek approval for the 2018/19 annual Data Security & Protection Toolkit (DSPT) submission.

2. Summary

The Information Governance Toolkit (IGT), hosted by NHS Digital was replaced by the Data Security & Protection Toolkit (DSPT) in May 2018. The new toolkit is designed for organisations to demonstrate progress in implementing the 10 National Data Security Standards. The 10 standards are broken down into 44 assertions (questions). All NHS Trusts were required to complete an interim submission by the end of October 2018 with a final submission by the end of March 2019. The Trust completed all the assertions for the October interim submission. Mersey Internal Audit Agency have recently undertaken an audit of the current toolkit and awarded the Trust a significant/substantial assurance rating for the seventh consecutive year.

The Information Governance & Data Protection Sub-Committee monitor the DSPT action plan through audits, spot checks and review of incidents. Risks are reported to the Operational Committee. Actions to ensure the requirement to achieve 95% staff compliance with Data Security awareness training are targeted communications with staff who are not compliant with the mandatory annual training. Information governance arrangements have been reviewed during 2018/19 firstly against the latest version of the toolkits, 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.

3. Information governance briefing

Compliance with information governance standards is annually assessed through the completion of the Information Governance Toolkit (replaced by the Data Security & Protection Toolkit (DSPT) in May 2018), hosted by NHS Digital. The IGT/DSPT submission is examined by the Trust's regulators, the Care Quality Commission (CQC) review the toolkit assessment in their assessments while the foundation trust regulator, NHSI, consider the toolkit when assessing the foundation trust's governance risk rating. The Information Governance & Data Protection Sub-Committee has devolved responsibility from the Operational Committee for monitoring overall compliance with Information Governance principles, escalating risks and ensuring mitigating actions are in place.

4. Information Governance 2018/19 and 2019/20

4.1 Review of information governance work undertaken in 2018/19

The focus of the Trust's work plan for 2018/19 was:

- Implement the General Data Protection Regulation (GDPR).
- Work towards compliance with the new Data Security & Protection Toolkit.

- Replace the high number of legacy IT network switches (80% complete).
- Investigating the feasibility of migrating our primary clinical system to a hosted solution (Still ongoing and will continue in to the next financial year).
- Complete the Data Centre equipment refresh.
- Migrate to NHS Mail away from the in house provision.
- Aim to implement Patient and Public Wi-Fi subject to central funding (roll out of this has been phased to ensure that clinical areas are covered first).
- Implement MIAA recommendations contained in clinical coding audit report.
- Continue to develop the Clinical Coding Resource web page.
- Improving the content and usefulness of data quality reports provided to services.
- Focus on waiting times data cleansing exercise and setting clear guidance for the recording of referral dates and treatment start criteria.
- Improvement in the quality of data capture/ reporting for MHSMDS, by setting internal data validation processes to highlight outliers which can be checked, and corrected where appropriate, with service prior to the submission of the monthly refresh data set.

In addition to the above, actions also completed include:

- Appointment of GDPR Data Protection Officer (existing Information Governance Manager).
- Revised policies for GDPR.
- Revised fair processing notices for GDPR.
- Production of a staff fair processing notice for GDPR.
- Mapping of information flows to demonstrate the legal basis for processing information.
- Production of an information security incident response plan.
- Implementation of McAfee Advanced Threat Detection solution.
- Creation of a central repository of contracts to identify priority gaps to be resolved to ensure GDPR compliance for those supplier relationships where person identifiable information is accessed.
- ICT Services will have completed a Data Centre refresh by the end of this financial year which will give the Trust more capacity, resilience and capability to back up applications or data. Work on disaster recovery is an on-going task with a new offline backup solution being ordered, this will enable us to fulfil one of the MIAA recommendations from the IT Service Continuity Review Audit 2018.
- All internal audits required by the IGT have been completed with satisfactory results which have been monitored by the Information Governance & Data Protection Sub-Committee.

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.

- Clinical coding audit.

The above audits which are required by the IGT/DSPT have been completed with satisfactory results which have been monitored by the Information Governance & Data Protection Sub-Committee.

4.1.2 Information Governance Spot Checks

It is a requirement for the Trust to monitor staff understanding and compliance with information governance standards. A rolling programme of spot checks commenced at the beginning of 2015 and have continued during 2018/19. All ward and corporate areas were inspected and spot checks have commenced in community areas. As a result of pressures within Information Governance, spot checks have been concentrated on new services to the Trust or where concerns in relation to Information Governance have been raised.

Common themes where staff have not demonstrated sufficient knowledge were:

- Awareness of Caldicott Guardian, IG lead and SIRO role.
- Awareness of the access to health records procedure.
- Awareness of FOI procedure.
- Awareness of Caldicott 2.
- Awareness of new data protection legislation.

Staff have shown a good overall understanding of information governance requirements in terms of enquiries which may be received and information security issues. Heads of departments which have been visited have received detailed feedback and have been asked to brief all staff to address the common themes.

4.1.3 Upgrade to ICT disaster recovery facilities and backup systems

An offline backup solution has been approved and when this is installed it will enable us to completely overhaul the disaster recovery process.

In 2018/19 we will be migrating to 2016 or 19 depending on which version the applications can support.

4.1.4 MIAA ICT Audits

MIAA audits have undertaken several audits including Cyber Essentials Gap Analysis Review and IT Service Continuity. Reports have been received and ICT are working through the tasks.

4.1.5 Zero Day Protection

Zero day protection has now been implemented.

4.1.6 Data Quality

The CYP care group has developed a data dictionary for its staff to support the accurate

capture and recording of key information, to improve data quality in this area.

4.1.7 Review of information governance incidents 2018/19

Data on information governance incidents (IG) and near misses was reviewed for the first 3 quarters of 2018/19 as reported on the Trust's Datix risk and incident reporting system. There has been **1 reportable security breach** within the reporting period involving letters containing information from the National Child Measurement Programme being sent to the wrong parents, affecting up to 70 people. The Information Commissioner's decision was that no further action was necessary due to the prompt mitigating actions taken by the Trust.

There were 205 IG incidents reported in the first three quarters of 2018 compared to 185 the previous year which is an **increase** of 11%.

Review of incidents

Description	**Total**
Internal mis-directed post and email/filing errors/missing paper records, verbal disclosure, lost work mobile phones and lost smart cards.	96 (47%)
Computer system issues e.g. computers freezing/working slowly/IPAD failing to synchronise.	42 (20%)
Mis-directed post (human error)	30 (15%)
Mis-directed external emails as a result of the Trust migrating to NHSmail and staff selecting the correct name but the incorrect Trust	18 (9%)
Neo-post system incident e.g. two letters for different patients in one envelope (system error)	11 (5%)
Documents attached to wrong patient's records	8 (4%)

The Head of Facilities investigates Neopost incidents and reports system issues and mitigating actions to the Information Governance & Data Protection Sub-Committee. Staff have received information governance reminders based on IG incidents throughout the year, including reminders of Trust policy and hi-lighting areas for improvement. The Information Governance & Data Protection Sub-Committee will continue to monitor trends in the coming year and take rememdial action where necessary.

The Information Governance & Data Protection Sub-Committee also monitors compliance with statutory timeframes associated with subject access requests and freedom of information requests.

4.2 Data Security & Protection Toolkit Submission 2018/19

NDG 1. Personal Confidential Data

Met (8 / 8)

Not Met (0 / 8)

100 % complete

NDG 2. Staff Responsibilities

Met (2 / 2)

Not Met (0 / 2)

100 % complete

NDG 3. Training

Met (4 / 4)

Not Met (0 / 4)

100 % complete

NDG 4. Managing Data Access

Met (3 / 3)

Not Met (0 / 3)

100 % complete

NDG 5. Process Reviews

Met (1 / 1)

Not Met (0 / 1)

100 % complete

NDG 6. Responding to Incidents

Met (4 / 4)

Not Met (0 / 4)

100 % complete

NDG 7. Continuity Planning

Met (2 / 2)

Not Met (0 / 2)

100 % complete

NDG 8. Unsupported Systems

Met (3 / 3)

Not Met (0 / 3)

100 % complete

NDG 9. IT Protection

Met (3 / 3)

Not Met (0 / 3)

100 % complete

NDG 10. Accountable Suppliers

Met (2 / 2)

Not Met (0 / 2)

100 % complete

4.3 Information governance work plan 2019/20

The focus of the Trust's work plan for 2019/20 will be to:

- Work towards cyber essentials with annual penetration testing.
- Progress with the investment of a tool which will give a view of whether versions of software are still supported by the supplier which will enable decisions to be made in relation to associated risks.
- Continue to replace the remaining 20% legacy IT network switches.
- Investigating the feasibility of migrating our primary clinical system to a hosted solution (Still ongoing and will continue in to the next financial year).
- Complete the Data Centre equipment refresh.
- Finalise Patient and Public Wi-Fi access subject to central funding (roll out of this has been phased to ensure that clinical areas are covered first).
- Implementation of Windows Server 2016 or 2019 Operating System across our server estate.
- Implementation of SQL 2016 or 2019 across our server estate.
- Replacement of our SCCM 2007 with Ivanti End Point Manager, this will give us 3rd party patching, password management tool, security patching, remote access tool, licence management, inventory, server patching and software deployment.
- Assessment of the Trust end point estate, selection of new devices which are matched with the job role and requirements.
- Implement a solution to achieve the electronic transfer of care initiative (eDischarge despatch and receipt).
- Selection and deployment of new devices which will support delivery of the redesigned clinical pathways emerging from the Care Groups, aligned to the NHS Long Term Plan.
- Migration to Windows 10.
- Vulnerability scanning.
- Focus on waiting times data cleansing exercise and setting clear guidance for the recording of referral dates and treatment start criteria.
- Improvement in the quality of data capture/ reporting for MHSMDS, by setting internal data validation processes to highlight outliers which can be checked, and corrected where appropriate, with service prior to the submission of the monthly refresh data set.
- Continue to develop the Clinical Coding Resource web page.
- Refresh all relevant policies and procedures to ensure they are clear, concise

and easily accessible to all staff.

- Require all staff to undertake the mandatory data security awareness training on an annual basis.
- Continue to undertake information governance spot checks on a risk basis where new services join CWP or information governance concerns are raised.
- Complete the production of the central repository of contracts and identify priority gaps to be resolved to ensure GDPR compliance for those supplier relationships where person identifiable information is accessed.
- Strengthen Data Security & Protection Toolkit evidence.
- The Data Security & Protection Toolkit action plan will monitored by the Information Governance & Data Protection Sub-Committee and any variances will be escalated to the Operational Committee.

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 Legislation 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/Data Security & Protection Toolkit does not necessarily imply that there are no areas of risk within the Trust, the toolkit cannot accommodate every eventuality and therefore the Trust needs to consider the level of risk in collecting, processing, disclosing and disposing of data. The Information Governance & Data Protection Sub-Committee monitors overall compliance with Information Governance principles, escalating risks and ensuring mitigating actions are in place. 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 2018/19 firstly against the latest version of the Information Governance Toolkit (IGT)/Data Security & Protection Toolkit (DSPT), and then against guidance released throughout the year. The Information Governance & Data Protection Sub-Committee monitor the DSPT action plan through audits, spot checks and review of incidents. Risks are reported to the Operational Committee. Actions to ensure the requirement to achieve 95% staff compliance with Data Security awareness training are targeted communications with staff who are not compliant with the mandatory annual training. This supports the case that current information governance arrangements within Cheshire & Wirral Partnership are appropriate and fit for purpose.

7. Recommendations to the Board of Directors

a. That the Board approves the Annual Information Governance Board Report.
b. That the Board approves the submission of the 2018/19 Data Security & Data Protection toolkit.
c. That the Board approves the statement that current information governance arrangements are fit for purpose.

NHS
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NHS Foundation Trust

STANDARDISED CHAIR'S REPORT

CHAIR'S REPORT DETAILS	
Name of meeting:	Quality Committee
Chair of meeting:	Dr J O'Connor, Non-Executive Director
Date of meeting:	06/03/2019

(ESCALATION) Quality, clinical, care, other risks identified that require escalation:

The strategic risk description for risk 9 is to be revised to capture specific risk treatment required in relation to Mental Health Act (MHA) compliance - the Care Groups have agreed to develop written improvement plans and trajectories to assure the Quality Committee of real time and ongoing compliance with all aspects of the MHA.

The incidents team and Care Groups, respectively, have been asked to identify approaches to improve the reporting and learning from low harm and no harm/ near miss incidents, which requires improvement based on current quality performance reporting. The incidents team have been asked to review the current process for reporting these incidents, with a view to simplifying the process and reducing the time taken to report, whilst the Care Groups have been asked to consider how to influence (supported through changes to the process) better feedback from managers to people who have reported these incidents.

The Care Groups and Safe Services are reviewing, with a view to identifying sustainable recommendations, thematic areas for improvement identified by a review into escalating usage of acute care beds across CWP.

(ASSURANCE) Matters discussed:

Plans were received, outlining a programme of improvement work in relation to the Green Light Toolkit (GLT) access and care standards. The plan will commence with a repeat of the current 'Basic' self-assessment, that will be undertaken in June 2019. This will be followed by a baseline assessment against the 'Better' audit in quarter 3 2019/20 to inform continuous improvement work, progressing on to the 'Best' audit standards for 2020/21. This Trustwide programme will involve every Care Group, who have been asked to identify leads.

The Quality Committee approved an action plan developed by the expert clinical panel that is meeting to identify approaches to reduce restrictive interventions. The plan details three priority areas for each of nine inter-dependent work streams, with their intention of precipitating the identification of what good care looks like in managing behaviour that challenges.

CWP's response to the Gosport Independent Panel Report was received, detailing evidence to demonstrate a high level of assurance in relation to CWP's comparative performance against the report's findings.

(IMPROVEMENT) Achievements:

The first year (2018/19) of Phase 1 (2018/21) of the Quality Improvement (QI) strategy has delivered improvements to infrastructure that will support capability for and a culture of QI, predominantly through the work of the QI Faculty. Consultation is progressing to identify 'signature' outcomes that can be benchmarked, for which we can raise the bar, with an ultimate aspiration to being the top performer in these areas. These will be approved by the Quality Committee in May 2019 as part of the developing 2019/20 and 2020/21 business cycles.

The programme of patient safety improvement reviews has achieved both quantitative and qualitative benefits, including 22 follow-up visits with the Non-Executive Team, and providing insights into the maturity of micro, meso and macro patient safety culture. A rotational, clinical lead role is being recruited to in order to strengthen the clinical focus on patient safety, whilst a community of practice for patient safety leaders is also being established.

The six monthly LEVEN update provided many examples of achievements and improvements, including improvements to volunteer processes and support to staff who work with volunteers.

Cheshire and Wirral Partnership
NHS Foundation Trust

CHAIR'S REPORT –
AUDIT COMMITTEE 12 MARCH 2019

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

- Internal Audit
  - Audit programme
    MIAA provided an update on the 2018/19 audit programme. The Committee received an updated on recently completed audits. These included financial systems &key controls (substantial assurance opinion), financial reporting and integrity (high assurance opinion) Data security and protection toolkit (substantial assurance opinion). The Committee approved a management requested change to the plan concerning the planned audit on children's access and waiting times. It was agreed that this would be deferred following a data cleanse exercise already underway. The audit plan for 18/19 was otherwise confirmed to be on track for completion by year end.

  - Assurance Framework audit
    The Committee received the assurance framework audit. The assurance framework was judged t be fit for purpose. One amber rating was received regarding detail of Board minutes regarding strategic risk and assurance framework discussions at Board level.

  - Draft Internal Audit plan 2019/20
    The draft internal audit plan for 2019/20 was presented to the Committee and elements of the plan discussed. The new plan includes the usual annual audits and a number of additional audits informed by current strategic risks. The Committee approved the draft plan.

- External Audit
  KPMG provided an update on the 2018/19 audit to date. The pre-audit programme was completed largely in February and was positive. The locally selected indicator was noted as being the children's eating disorder waiting times indicator as selected by the Governors scrutiny sub-committee. This will be recommended to the April 2019 Council of Governors for formal approval.

  A technical update detailing recent sector developments was presented. Implications of the GDPR on disclosures within annual remuneration reporting were noted.

- Anti-fraud
  The Committee was provided with an update on anti-fraud activity undertaken since the last meeting. All aspects of the programme were on track. The Committee was also provided with an overview on investigations and ongoing cases. The draft Anti-Fraud plan 2019/20 was also reviewed and approved.

- Strategic Risk Register
  The Strategic risk register was presented to the Committee for quarterly review.

- Matters of Governance
  The Committee reviewed and agreed the Terms of Reference for 2019/20. The Committee also noted the Directors Registers of Interests and Gifts and Hospitality.

Edward Jenner
Non-Executive Director/ Chair of Audit Committee