Cheshire and Wirral Partnership NHS
NHS Foundation Trust

Meeting of the Foundation Trust Board of Directors

Wednesday 27th May 2015 at 1430

Boardroom, Redesmere

Item no.	Title of item	Objectives/desired outcome	Process	Item presenter	Time allocated to item
15/16/01	Apologies for absence	Receive apologies	Verbal	Deputy Chair	1 min (1430)
15/16/02	Declarations of Interest	Identify and avoid conflicts of interest	Verbal	Deputy Chair	2 min (1431)
15/16/03	Minutes of the previous meetings held 25th March 2015	Confirm as an accurate record the minutes of the previous meetings	Written minutes	Deputy Chair	2 mins (1433)
15/16/04	Matters arising and action points	Provide an update in respect of ongoing and outstanding items to ensure progress	Written action schedule and verbal update	Deputy Chair	2 mins (1435)
15/16/05	Board Business Cycle 2015/16	Confirm that agenda items provide assurance that the Board is undertaking its duties	Written	Deputy Chair	3 mins (1437)
15/16/06	Chair's announcements	Announce items of significance not elsewhere on the agenda	Verbal	Deputy Chair	10 mins (1440)

Item no.	Title of item	Objectives/desired outcome	Process	Item presenter	Time allocated to item
15/16/07	Chief Executive's announcements	Announce items of significance not elsewhere on the agenda	Verbal	Chief Executive	10 mins (1450)
MATTERS FOR APPROVAL/ DECISION					
Strategy					
15/16/08	CAMHS – Future in Mind	To receive an overview of the CAMHS strategy	Verbal	Clinical Director and Young Advisers	20 mins (1500)
15/16/10	Podiatry Consultation outcome	To note the outcomes from the Podiatry consultation	Written Report	Director of Operations	10 mins (1520)
15/16/11	Q4 Quality Report	To note the Q4 Quality Report	Written Report	Medical Director	10 mins (1530)
15/16/12	Corporate Assurance Framework and Risk Register	To approve current Corporate Assurance Framework and Risk Register	Written Report	Medical Director	10 mins (1540)
Measurement					
15/16/13	Board Dashboard – April 2015	To review Trust performance	Written Report	Deputy Director of Finance	10 mins (1550)
15/16/14	Trust Provider Licence: • 2014/15 self-assessment • Declarations required by General Condition 6 of the Licence	To review self-assessment and confirm declarations required by Monitor	Written	Head of Corporate Affairs	5 mins (1600)

Item no.	Title of item	Objectives/desired outcome	Process	Item presenter	Time allocated to item
15/16/15	Mental Health Act – Activity submission to the Department of Health	To note the submission of the MHA KP90 report	Written Report	Medical Director	5 mins (1605)
15/16/16	CQC Intelligent Monitoring report	To note Trust performance against national indicators	Written Report	Medical Director	10 mins (1610)
Process and Structures					
15/16/17	Learning from Experience Executive Summary report	To approve findings of the Learning from Experience report	Written Report	Director of Nursing, Therapies and Patient Partnership	10 mins (1620)
15/16/18	Daily Ward Staffing figures (April 2015)	To note the Daily Ward Staffing Figures	Written Report	Director of Nursing, Therapies and Patient Partnership	10 mins (1630)
15/16/19	Quality Governance 2014/15 assessment	To approve 2014/15 Quality Governance assessment	Written Report	Medical Director	5 mins (1640)
15/16/20	Register of Interests 2014/15: • Directors • Governors	To note the Registers of Interests	Written Report	Head of Corporate Affairs	5 mins (1645)

Item no.	Title of item	Objectives/desired outcome	Process	Item presenter	Time allocated to item
15/16/21	Q4 Infection, Prevention and Control Report	To note the Q4 report	Written Report	Director of Infection, Prevention and Control	10 mins (1650)
Capability and Culture					
15/16/22	Recommendations from Saville Inquiry	To approve progress against recommendations prior to submission to Monitor	Written	Director of Nursing, Therapies and Patient Partnership	10 mins (1700)
Governance					
15/16/23	CQC Statement of Purpose	To approve the CWP statement of purpose	Written	Medical Director	5 mins (1710)
15/16/24	Review of risk impacts of items discussed	Identify any new risk impacts	Verbal	Deputy Chair/ All	5 mins (1705)
15/16/25	Any other business	Consider any urgent items of other business	Verbal or written	Deputy Chair	2 mins (1710)
15/16/26	Review of meeting https://www.surveymonkey.com/s/XN5ZLNC	Review the effectiveness of the meeting (achievement of objectives/desired outcomes and management of time)	Verbal	Deputy Chair/All	2 mins (1712)

Item no.	Title of item	Objectives/desired outcome	Process	Item presenter	Time allocated to item
15/16/27	Date, time and place of next closed meeting: **Wednesday 29th July, 13.00, Boardroom Redesmere.**	Confirm arrangements for next meeting	Verbal	Deputy Chair	1 min (1714)

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

Minutes of the Board of Directors Meeting
Wednesday 28th March 2015
Boardroom, Romero Centre, Macclesfield, commencing at 1.00pm

PRESENT	David Eva, Chair Sheena Cumiskey, Chief Executive Dr Faouzi Alam, Medical Director Fiona Clark, Non-Executive Director Julie Critchley, Acting Director of Operations Dr Jim O'Connor, Non-Executive Director Lucy Crumplin, Non-Executive Director Avril Devaney, Director of Nursing Ron Howarth, Non-Executive Director Mike Maier, Non-Executive Director Rebecca Burke Sharples, Non-Executive Director Andy Styring, Director of Operations (Designate) Dr Anushta Sivananthan - Medical Director Tim Welch, Director of Finance
IN ATTENDANCE	Louise Brereton, Head of Corporate Affairs David Harris, Director of HR and Organisational Development Derek Bosomworth, Member of the public Alison Harrison, Member of the public Phil Jarrold, Service User/ Carer Governor Brian Crouch, Service User/ Carer Governor
APOLOGIES	None

	MINUTES	**ACTION**
14/15/109	**WELCOME AND APOLOGIES FOR ABSENCE** David Eva, Chair welcomed all to the meeting. There were no apologies to note.	
14/15/110	**DECLARATIONS OF INTEREST** There were no declarations of interest noted.	
14/15/111	**MINUTES OF THE PREVIOUS MEETING HELD 28TH JANUARY 2015** The minutes of the meeting held 28th January 2015 were **approved** as a correct record.	
14/15/112	**MATTERS ARISING AND ACTION POINTS** Both actions listed had been completed.	
14/15/113	**BOARD BUSINESS CYCLES** The Board noted the business cycle 2014/15. The draft business cycle for 2015/16 was approved.	

14/15/114	**CHAIR'S ANNOUCEMENTS** The Chair announced: **IAPT Services - Sefton** CWP have been selected to provide a new service providing improved access to mental health services throughout Sefton and its surrounding areas. This will launch on 1 April 2015 and will be delivered in partnership by CWP and Insight Healthcare. This service is being led by Neal Fenna. Clinical Services Manager. **Free fitness sessions improve mental health and well-being** A pilot scheme in East Cheshire encouraging people with a mental health condition to get active has been hailed a success, with more than twenty people taking part in the first 8 weeks and hopes to extend the scheme. Staff from CWP are supporting the 12 week project of tailored sessions, delivered by CW1 CrossFit, after securing funding from Active Cheshire. The sessions sought to improve physical and mental well-being by offering individuals a personalised fitness plan. **CWP support smokers to take the first steps to a smokefree life** CWP is supporting people who access their services, carers and staff with a nicotine dependency to give up smoking for good. Last year, CWP took the step to become a smoke free Trust with smoking in all premises and grounds no longer permitted. This No Smoking Day (11 March), CWP is informing people who use our services, their carers and families that tobacco products and lighters will no longer be allowed into inpatient areas and if any are found in clinical areas, they will be disposed of following removal. The Trust is the first health organisation in the UK to have introduced this measure and is sharing its experience of becoming a smoke free Trust with other hospitals and local authorities. **Over £5million invested in local learning disability services** The Trust has invested over £5 million to open a new inpatient unit for people with learning disabilities in East Cheshire. Using best practice guidance, a new low secure 15 bedded unit has been built on the Soss Moss Hospital site, near Nether Alderley, to replace existing facilities on site for people with mild to moderate learning disabilities. **Mental Health Network Conference** The Chair had recently attended the conference which had received presentations from private sector organisations that are in joint venture arrangements with mental health trusts. There had also been discussions on the number of providers who were seeing actual uplift in their contracts with CCGs in line with national directives. It was noted that this was happening in very few cases.	
14/15/115	**CHIEF EXECUTIVE'S ANNOUCEMENTS** Sheena Cumiskey announced the following: **Local Area Vanguards** Sheena Cumiskey announced that two local areas (Wirral and West Cheshire) had been selected to take forward the PACS and MSCPs models of care as set out in the 5 Year Forward View. The Trust will be a key partner in taking these forward.	

	Director of Operations Sheena Cumiskey thanked Julie Critchley and Andy Styring for their joint work in the period covering Andy's planned sickness leave. **Quality Committee and Operational Board.** Sheena Cumiskey advised that she and Dr Anushta Sivananthan had met with Fiona Clark and Dr Jim O'Connor as the new Chair of the Quality Committee to look at improving the interface between the two committees particularly regarding items that are pertinent to both committees such as monitoring the Saddlebridge action plan. It has been agreed that the Operational Board are responsible for overseeing and monitoring implementation of actions and Quality Committee will receive the outcomes and assurance that these has been undertaken.	
14/15/116	**CORPORATE ASSURANCE FRAMEWORK** Dr Anushta Sivananthan introduced the report drawing attention to the key issues: • The ligature risk has been remodelled to better align the risk to the locality risk descriptions. • The ward staffing risk description is currently under review by the ward staffing Programme Board. This is to ensure the risk takes account of the findings of the recent comprehensive review of ward staffing. • There have been no archived risks or new risks added. • The Corporate Assurance Framework has been refined to allow better focus on risk treatment plan taking account of good practice in dynamic assurance frameworks. The Board resolved to **approve** the amendments to the risk register and the corporate assurance framework as recommended by the Quality Committee.	
14/15/117	**DAILY WARD STAFFING LEVELS (FEBRUARY 2015)** Avril Devaney presented the report and highlighted that the Trust continues to meet the requirements for correct levels of staffing to ensure patient safety. Issues around recruitment were noted and the impact of the turnover of staff which is resulting in the continuing gap in staff numbers. Plans are in place to mitigate this such as the rolling recruitment programme and working with universities to promote CWP as a potential employer. Localities are also implementing the 'over recruitment' of staff to ensure opportunities are maximised around recruitment. A discussed ensued regarding the cancellation of indirect care activities and minimising the impact of this on patients. The Board resolved to **note** the report.	

14/15/118	**ZERO HARM IMPLEMENATION PLAN UPDATE** Dr Anushta Sivananthan introduced the report highlighting the current position in the implementation of the zero harm strategy and the drive towards continuous improvement. The Board were reminded that the Quality Committee is overseeing the delivery of the strategy. Dr Anushta Sivananthan highlighted that the majority of actions were on track. One action regarding the collection of outcomes from the measurement of care pathways was off track due to the slow pace of the development of clinical networks. Dr Faouzi Alam commented that the clinical networks are now progressing this was discussed at the recent CELF session which focussed on zero harm. The lack of engagement with BMJ quality licence projects was queried. It was felt that this was due to capacity issues; however support from Safe Services will assist with moving this forward. It was noted that the clinical audit action was rated as amber. Rebecca Burke Sharples commented that the Audit Committee will be looking at the 2015/16 audit plan and the 2014/15 outcomes at the May meeting. It is also noted in the Audit Committee business cycle for the Committee to receive an annual update on the clinical audit programme to enable a greater alignment between audit processes in the Trust. A discussion ensued regarding the actions rated as green on track and how the Board can be assured that once actions are noted as green continue to be monitored. It was noted that the actions rated as green have been principally achieved but ongoing monitoring is undertaken as part of the overall monitoring of the strategy therefore a rating of green does not mean the action is closed. Dr Jim O'Connor commented that the locality data-packs which have recently been presented to the Quality Committee will be useful in closely monitoring assurances at locality level. The Board were reminded that a full overview of the implementation of the first year of the zero harm strategy will be presented at the May 2015 Board meeting. The Board resolved to **note** the report.	
14/15/119	**TRUST RESPONSE TO THE FRANCIS REPORT 'FREEDOM TO SPEAK UP'** Avril Devaney introduced the report setting out the Trust's response to the recently published Francis report. Highlighting the key points, Avril Devaney reported that the Trust is well placed in respect of the recommendations with the range of existing policies that the Trust has in place, however it was noted that further work is required to ensure that the Trust is fully meeting all the requirements and can fully demonstrate this. To progress this further, Avril Devaney advised that the Deputy Director of Nursing will be undertaking a gap analysis to consider the further action that the Trust needs to take to be fully compliant with the recommendations of the review. This will be received by the Operational Board. The Board resolved to **note** the report.	

14/15/120	**LEARNING FROM THE MORECAMBE BAY INQUIRY** Dr Anushta Sivananthan introduced the report highlighting the recent findings of the inquiry of Morecambe Bay Foundation Trust maternity services. It was noted that although the nature of the services delivered by this Trust are different to that of CWP, some of the learning from this inquiry is applicable to CWP. Dr Anushta Sivananthan advised Board members that several of the findings highlighted in the inquiry are addressed by the continuous improvement culture driven by the zero harm strategy. Further learning that the Trust can take from the review is around developing pathways for new mothers focusing on mental health and well-being and improving integrated working between hospital based services and community services. Further work is needed around embedding learning from incidents and using learning from complaints and incidents to improve quality. The zero harm strategy will respond to this agenda. Board members welcomed the Trust's approach to this, particularly in light of the different nature of the services provided and agreed that there is learning for the Trust to take from the inquiry. The Board resolved to **note** the report and endorsed the approach to include the themes from the inquiry into existing operational and strategic plan (via the zero harm strategy principals). (Dr Anushta Sivananthan left the meeting)	
14/15/121	**BOARD DASHBOARD/ CORPORATE PERFORMANCE REPORT - FEBRUARY 2015** Tim Welch introduced the report and advised that due to an error the dashboard for the previous month had been included in the board pack. Tim Welch briefed the Board on the key issues. These were: • Sickness -there has been a slight improvement in sickness levels in January and February 2015. The Operational Board will be receiving an update on the recent work to understand the recording and data issues. • 12 month CPA target is slightly below Monitor target but plans are in place to improve this and the quarterly regulatory targets are not at risk. • The financial plan 2014/15 is on target. • The purchase of the Springview was completed earlier this month. A discussion ensued regarding the potential to hold an event to mark the fact that Springview is now in the Trust ownership which is very positive given the investment made in the unit over the years. The Board resolved to **approve** the report.	
14/15/122	**UPDATE ON OPERATIONAL PLAN 2015/16 AND CLINICAL STRATEGIES** Tim Welch updated on the current progress with developing the	

	Operational Plan and the Clinical Strategies. Tim Welch advised that the clinical strategies had been refreshed and were focusing on a number of ley areas for development in the localities. This underpins the Trust Operational Plan 2015/16 which the Trust are required to submit to Monitor. Tim Welch briefed on the recent changes to the process which have altered the timescales for submissions. A discussion ensued regarding the contract negotiation process and the issue of the lack of local commitment from CCGs to investment in mental health services to the level of growth in contracts this year as per the Government national commitment to this. The Trust has been holding robust discussions with Commissioners on this issue highlighting that if services are not being fully commissioned, then the Trust cannot provide them. The Trust has been clear that contracts cannot be signed until levels of growth as set out in recent national announcements are locally defined and agreed. Tim Welch advised that the Trust recognises that CWP are not the only provider of mental health services locally; however we are taking a lead role in advocating the need for mental health services to be appropriately funded in line with Government directives. A discussion ensued regarding ensuring this message is reiterated in wider forums and it was agreed that Governors have a key role to play in this in terms of representing the Trust and lobbying on the Trust's behalf on these issues. **Action:** Work to be undertaken with Governors to take forward this agenda. Tim Welch advised that in line revised timescales, the Board would be formally signing off the Operational Plan 2015/16 in April 2015. The Board resolved to **note** the report.	**TW/ DE/LH**
14/15/123	**RESEARCH STRATEGY 2015/18** Dr Faouzi Alam introduced the CWP Research Strategy. This is the first time the Trust has had a strategy in place to drive the research agenda and it has been well received. Dr Faouzi Alam drew attention to the strategy priorities which are to raise the profile of CWP research internally and externally, to strengthen links with external partners and to secure external funding from academia and/or industry. Research currently sits within the Effectiveness Team and structures currently under review to ensure that the right structure is in place. A discussion ensued and Non-Executive Directors welcomed and commended the strategy. It was noted that a key driver for the strategy is making and embedding relationships with partners however it was queried that the partners noted in the strategy were more local partners and in time the strategy would want to reflect developments with partners from further afield. The Board resolved to **approve** the report and the Research Strategy 2015/18.	

14/15/124	**PEOPLE AND ORGANISATIONAL DEVELOPMENT STRATEGY** David Harris introduced the report and the new People and Organisational Development Strategy. The strategy is a key enabler for the CWP Strategic and Operational Plans and the vision is about enabling staff to be the best they can be. The strategy has four strategic themes - our people, our leaders and managers, our environment and our people services and each has a number of focus areas. These will be set out in an annual delivery plan. This will be monitored by the recently reconfigured People and Organisational Development subcommittee (formally the Workforce and Organisational Development subcommittee) which reports into the Operational Board. Board members welcomed the strategy and the strategic focus on developing the workforce. The Board resolved to **approve** the report and the People and Organisational Development Strategy 2015/20.	
14/15/125	**AMENDMENT TO THE STANDING FINANCIAL INSTRUCTIONS (SFIs)** Tim Welch introduced the report which highlighted some changes to the Standing Financial Instructions (SFIs) around e-tendering and tender waiving. The changes allow the Trust to only use electronic tendering, known as e-procurement to conduct future tendering exercises. The changes will also mean a reduction in the number of tender waivers. The changes had been presented to the Audit Committee by the Head of Procurement and these had been approved. The Board resolved to **approve** the changes to the Standing Financial Instructions.	
14/15/126	**MENTAL HEALTH ACT - UPDATED CODE OF PRACTICE** Dr Faouzi Alam introduced the report on behalf of Dr Anushta Sivananthan. The report highlights the changes resulting from the update to the Mental Health Act Code of Practice. The report also highlighted the findings of recently issues annual reports from the CQC on monitoring the mental health act and the deprivation of liberty safeguards. The Mental Health Act code of practice changes are effective from 1st April 2015 and the Compliance, Assurance and Learning subcommittee are monitoring the implementation. There is a trust-wide action plan in development to drive these changes forward. The Trust Mental Health Act policies will also be reviewed in light of the updated code. It was noted that some Non-Executive Directors have attended training on the updated code of practice which had been useful. Ron Howarth commented that the training on the updated code should be extended to include the Associate Hospital Managers. **Action:** AS to check that the code training programme extends to the Associate Hospital Managers.	**AS**

	It was noted that one of the issues raised in the report was that some Board members and Non-Executive Directors of some Trusts were unfamiliar with CQC MHA reports, themes and quality and safety issues. The Board business cycle now includes an annual report to the Board on the mental health act which will cover quality, safety and any other arising issues. Non-Executive Directors continue to chair hospital manager review hearings. The Board resolved to **note** the report and endorsed the approval of the Mental Health Act, Code of Practice implementation plan.	
14/15/127	**INFORMATION GOVERNANCE ANNUAL REPORT 2014/15** Dr Faouzi Alam introduced the Information Governance Annual Report 2014/15 and highlighted that all areas of the toolkit are compliant at level 2/3 with the exception of clinical coding which is at level 1. The Trust is looking at the options available to improve on this position moving forward. The assessment confirms that the toolkit is compliant and that appropriate information governance arrangements are in place for the Trust. The Board of Directors resolved to: • **approve** the statement that current information governance arrangements are fit for purpose, • **approve** the submission of the 2014/15 information governance toolkit on 31/03/2015; and • **note** the information governance work plan for 2015/16.	
14/15/128	**DIVISION OF RESPONSIBILITIES - CHAIR AND CHIEF EXECUTIVE** Louise Brereton introduced the report and reminded Board members that there it is a code of governance requirement to ensure that the duties for both the Chair and the Chief Executive are clearly defined and approved. It is set out in the corporate governance manual that this must be reviewed and approved annually. It was noted that there had been no changes suggested. Ron Howarth commented that in the Chair's duties, there is a reference to an external review of the Board to be undertaken at least three yearly. Louise Brereton advised that this now ties into the Monitor guidance on well-led reviews which require a three yearly external governance review to be undertaken in all foundation trusts. Originally, CWP planned to undertake this review in summer 2015, however since the notification of the CQC visit which will cover significant elements of the well-led review in the CQC framework well led domain, it was felt that the Trust would await the outcome of the CQC inspection to progress the well-led review. However this is tentatively planned for the end of quarter 3 2015/16. The Board resolved to **approve** the report.	

14/15/129	**REVIEW OF RISK IMPACTS OF ITEMS DISCUSSED** There were no further items of risk identified.	
14/15/130	**ANY OTHER BUSINESS** There were no further items of business raised for discussion. David Eva invited comments from the members of the public gallery.	
14/15/131	**REVIEW OF MEETING** Board members felt that the meeting had been effective.	
14/15/132	**DATE, TIME AND PLACE OF NEXT MEETING** Wednesday 27th May 2015, 1.00pm at Redesmere Boardroom.	

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

Action points from Board of Directors Meetings
27th May 2015

Date of Meeting	Minute Number	Action	By when	By who	Progress Update	Status
25.03.15	14/15/122	**UPDATE ON OPERATIONAL PLAN 2015/16 AND CLINICAL STRATEGIES** it was agreed that Governors have a key role to play in terms of representing the Trust and lobbying on the Trust's behalf on these issued. **Action:** Work to be undertaken with Governors to take forward this agenda.	July 2015	TW/DE/ LB	This will be taken forward following the general election	Ongoing
25.03.15	14/15/126	**MENTAL HEALTH ACT - UPDATED CODE OF PRACTICE** **Action**: AS to check that the code training programme extends to the Associate Hospital Managers.	May 2015	AS/FC	Confirmed with MHA Manager that Associate Mangers will be receiving a briefing on the new Code as part programme of training	Closed

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

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

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

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

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

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

STANDARDISED REPORT COMMUNICATION

REPORT DETAILS

Report subject:	REDESIGNING PODIATRY SERVICES IN WEST CHESHIRE
Agenda ref. no:	15/16/10
Report to (meeting):	Board of Directors
Action required:	Approval to implement redesign
Date of meeting:	27/05/2015
Presented by:	Andy Styring, Director of Operations

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

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

To provide the Board of Directors with:

-a report on the outcome of the public consultation on service redesign proposals for the Podiatry Service for consideration and agreement on the way forward.

- assurance to the board on full consideration on the public consultation process to inform the transitional implementation plans if the model is adopted.

-recommendations on the way forward.

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

In September 2014, Directors received a report with information regarding the review and proposed redesign of Podiatry Services, following which directors approved progressing to formal public consultation.

The September paper explained the rationale for developing a new model for podiatry service and gave details of the proposed options for redesign which included three options for service delivery.

A public consultation process run jointly with West Cheshire CCG was held between 8th December 2014 and 15th March 2015 and the paper provides a report on the outcome of the consultation process

Assessment – *analysis and considerations of options and risks*

Option 1 – Continue with the current NHS Service and keep the same eligibility criteria to acces NHS Podiatry Services
Risks – Service unable to meet demand; some patients waiting 40-60 weeks for routine appointments.

Option 2 – Improve the currentNHS Service for people with high level medical and/or podiatric needs by changing the eligibility criteria to access NHS Podiatry Services. People who are assessed as having low level needs would be discharged.
Risks – 3,000 patients are likely to be discharged from the service.

Option 3 – As option 2. Current patients with podiatric needs would continue to receive appointments based on their level of need.
Risks – It would take 5-10 years for the demand to reduce to a manageable level

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

- To note the completion of a formal consultation and broad support for Option 2.
- To approve implementation of Option 2, subject to appropriate approval at CCG meetings and a robust implementation plan monitored by CWP West Senior Management Team.

Who/ which group has approved this report for receipt at the above meeting?		Podiatry Project Team
Contributing authors:		Katherine Wright/ Jennie Atkins
Distribution to other people/ groups/ meetings:		
Version	Name/ group/ meeting	Date issued
V1 5.5.15	Julie Critchley (CWP/Karen Moore (CWP)/Helen Ashcroft (CCG)	5.5.15

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

Appendix no.	Appendix title
	Appendix 1: Podiatry Service Redesign Report Ops Board May 15 Appendix 2: Podiatry Communications and Engagement Consultation Report May 15 Appendix 3: Podiatry Service Redesign Impact Assessment Nov 14 Appendix 4: Liverpool University Podiatry Redesign Report

Appendix 1 Podiatry Service Redesign Report May 15

1. Background and consultation process

In September 2014 Directors received a report entitled Podiatry Redesign with information regarding the review and proposed redesign of Podiatry Services following which directors approved progressing to formal public consultation.

The September paper explained the rationale for adopting a new model of delivering podiatry services. Traditionally, the service has been provided to patients who have a low level podiatric need but the service is unable to meet the current demand.

As a result of Board approval to progress to consultation on a new model of care for podiatry services, a project governance structure was put in place led by Karen Moore, General Manager.

Public consultation
A report of the communications and involvement process for consultation is attached as appendix 2 to this report, key elements include:

- prior pre-consultation engagement with key stakeholder including; staff, Healthwatch, Health and Well-being Board and 2 GP Network meetings from March 2014 which informed the proposed service change;
- sharing our plans for engagement with the local Health and Well-being Board, Healthwatch, commissioners and NHS England to ensure that we were within the best practice guidelines for consultation as set out by the Home Office and the principles for engagement on service change in the Section 14 (Z2) and 13 (Q) of the Health and Social Care Act;
- development of a written consultation document, fact sheets and web based information;
- holding 7 public meetings across West Cheshire and attendance by lead clinicians and managers at a number of local stakeholder meetings;
- 'testing' the effectiveness of the signposting systems and self-care advice, which are integral to the model of service delivery agreed with the CCG as being desirable, i.e. prioritising high risk patients and discharging low risk.
- proactive use of media through press notices and social media to raise awareness of the consultation with the wider public;
- engagement of Liverpool University to provide independent analysis of the returned questionnaires included in the consultation document.

Staff consultation
Informal discussions and meetings were held with staff members. This enabled staff to engage with and contribute to the redesign and consultation proposals. It also enabled information to be shared at an early stage to ensure staff would be prepared to respond to questions by patients and members of the public once the consultation process commenced.

GP consultation
Presentations were made to the 3 GP Network Groups across West Cheshire; 2 as part of the pre-consultation stakeholder engagement and the third as part of the wider public consultation.

2. Consultation outcome

Public consultation

176 responses were received by the University (41 online and 135 paper copies). Not all respondents answered every question, so the percentages below represent a percentage of those who **did** answer the relevant question. For more detail see section 3 of this report.

Key statistics:

- **63% of people who answered the question supported the preferred option 2, 22% favoured no change (option 1) and 10% chose to support option 3.**

- **86% of people who answered the question strongly agreed or agreed that it's important to redesign the service to ensure patients with high/moderate level needs get seen quicker and more frequently.**

- **78% of people who answered the question supported plans to increase awareness of how to take care of their own foot-health. 14% were neutral, 9% were against it.**

- **64% of people who answered the question supported the idea of a course for people with low-level medial and/or podiatric needs following their assessment. 21% were neutral and 15% were against it.**

Respondents had the opportunity to complete a comments section having given their answer to the survey questions. Of those who gave positive responses the following opinions were expressed:

- Seems most 'fair' and 'most sensible' option
- 'Appreciate' need to change 'only option with money available'
- 'It gives priority to patients with high needs'
- 'As long as each patient is assessed according to their requirements. It seems fairer'

Of those who commented on concerns about the proposals, a number of key themes emerged. CWP also provided a variety of alternative ways in which local people could provide their thoughts and opinions which added to these themes. They can be summarised as follows:

- **Prevention:** a key concern expressed included the need for good information for patients. The existing service was commended for providing general health and wellbeing advice and for preventing more serious conditions. People were concerned that their health may deteriorate if they do not have regular support. Some people also expressed concern about poor co-ordination between podiatry and other health services which they may require.

- **Level of care:** respondents appear to value the service and are worried that they would not meet revised criteria and would lose regular podiatric support. Frequency and timeliness of appointments was a key theme.

- **Living well:** many respondents were older people with physical disabilities, some expressed a concern that they will not be physically able to care for themselves and this could lead to loss of independence and issues such as chronic pain. Written responses certainly raised issues of concern to service users, such as loss of access to free, qualified podiatrists and podiatry services on the basis of need. There also appeared to be particular concern expressed about reaching and physically accessing services among older/disabled responders. In addition, a broader unwillingness to accept funding changes, or a lack of funding increase to podiatry services, was also featured in detailed responses.

- **Funding/commissioning:** comments were received regarding the need to meet and fund local need - if demand for podiatry is there, 'this money must be found'. There was suggestion that the changes were about cost-cutting, not the provision of better services. There were some concerns about people's ability to pay for basic nail cutting services.

- **Consultation process**: comments were received expressing some dissatisfaction with the consultation process itself – some respondents stated that they felt the options that were presented for consideration were too limited and others queried the cost of the consultation process .

Further analysis can be found in appendix 2

3. Summary of feedback themes and proposed evaluation process

We draw to the Board's attention the broad support from the headline outcomes of the public consultation process outlined above. As part of listening to the views expressed during the consultation, which have been independently analysed by Liverpool University, we seek to provide the Board with the following assurances regarding the transitional/implementation plans, (if the model is to be adopted).

- **Service users/carers feedback:**

Issue	CWP response (mitigation)
Prevention of foot health deterioration and development of more serious conditions	All patients on the current caseload will receive an appointment for a review with a podiatrist to have their podiatric needs assessed against the new eligibility criteria. This will ensure that any patients are discharged appropriately and according to their level of needs. Patients who are discharged will receive: • Signposting to alternative foot care providers for basic toenail cutting. These services provide a variety of clinics and home visits • A list of podiatrists who are registered with the Health and Care Professions Council (HCPC) • Information leaflets about footwear and self- care • Information and education about recognising the signs and symptoms of deteriorating foot health and when to seek re-referral • Training in basic foot health and nail cutting will be offered to those caring for patients. This will include carers working in residential settings and agency staff commissioned by Cheshire West and Chester Council to provide nail cutting and basic foot care • Support from volunteers (where available) who will explain information given to patients at discharge.
Level of care	• Patients who are discharged will be signposted to alternative foot care providers and podiatrists registered with the HCPC. • There will be a re-referral mechanism available to the providers of toenail cutting basic foot care • Patients with a new medical condition which may

	place them at risk of developing an ulcer may be re-referred back into the service by their GP should their foot health deteriorate • The Podiatry Service will engage with practice nurses at GP Surgeries to inform them of the re-referral pathway for patients with diabetes who have low level podiatric needs • Patients with diabetes who have low level podiatry needs and who have been discharged can self-refer into the service, should they develop a podiatric need • Emergency drop-in clinics will continue to be available for patients with diabetes and low level podiatric needs • Information will be provided to all patients with diabetes on discharge regarding the Diabetes Essential
Living well	• The Podiatry Service will continue to visit patients in their own homes, providing they meet the new eligibility criteria • Patients who are discharged will be provided with the contact number for Cheshire West and Chester Council Adult Social Care Gateway Team who provide older people with assessments of holistic care needs for older people with physical disabilities. Care packages resulting from this assessment may include basic foot care. • Podiatrists are able to utilise referral pathways to services such as pain clinics, rheumatology, orthotists and the falls prevention service. Referrals to such services may be made for patients with painful debilitating conditions which do not directly impact on their foot health. • The Podiatry Service will work with other providers to ensure patients are signposted well and appropriately to ensure their low level needs are met.
Finances/commissioning	• The consultation public presentation contextualised the need for service redesign. • Commissioners were explicit that this was not a "cost cutting exercise" and the budget for podiatry was not being reduced. • The needs to improve access, frequency of appointments and outcomes for patients in line with NICE Guidance are the drivers for change. • Costs of toenail cutting services were identified as £20 for the first consultation (which includes purchasing nail cutters). Subsequent appointments cost £10 per session. • Patients were advised to discuss fees with non-NHS podiatrists before committing to appointments as prices range from £25-35 per

	session. • The contact number for Cheshire West and Chester Council's Benefits Centre will be provided to patients who are being discharged. • Age UK will assist in completing application forms for benefit claims.
Utilisation of resource	Outcomes for patients with high level podiatric needs will be improved as a result of service redesign: • Patients who are treated in a timely way are less likely to develop serious complications which may lead to ulceration and amputation. • Improved prevention - deterioration in circulation and nerve supply will be detected earlier which will prevent the need for more invasive, complex interventions.

GP Feedback

Issue	CWP response (mitigation)
Concerns about increasing requests for referral back into the Podiatry Service from patients who have been discharged	• GPs expressed concern about a potential increase in workload if patients are required to be referred back into the Podiatry Service by a GP. • Patients with diabetes who have been discharged will have access to the Emergency Drop-In clinics. • Staff providing toenail cutting and basic foot care services will be given a direct referral route • The Podiatry Service will engage with practice nurses to discuss the new eligibility criteria and how and when to make referrals into the Podiatry Service • GPs to be issued with the new eligibility criteria and referral pathway

Consultation process

Issue	CWP response (mitigation)
Some dissatisfaction was expressed with the consultation process in that the options that were presented for consultation were too limited. The cost of the consultation process was questioned.	• It was explained at all public meetings that the purpose of the consultation was to encourage people to express their views relating to the 3 options contained within the consultation document, or any additional ideas they had on how the service could be redesigned • The challenges facing the NHS in respect of rising demand without a corresponding increase in funding were explained. • Suggestions were sought about future service provision and a freepost envelope was provided with the consultation document for the return of questionnaires. • The cost of the consultation was rationalised by explaining the benefits of redesign in terms of improving frequency and access of appointments for those at higher risk and achieving improved

	patient outcomes The costs of producing the consultation document and room hire were identified as the main costs of the consultation process • We have received positive feedback from Health Watch regarding the way we have engaged with them in pre-consultation and during the consultation process. NHS England also completed an assurance process for the consultation.

Risk assessment

Issue	CWP response (mitigation)
Have any risk assessments been undertaken to determine likely impact on service users.	An impact assessment was completed before the consultation commenced and will be revisited within the transitional plans (if the model is adopted). (See Appendix 3)

Ends.

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

STANDARDISED REPORT COMMUNICATION

REPORT DETAILS

Report subject:	Quality Report – Quarter 4, 2014/15
Agenda ref. no:	15/16/11
Report to (meeting):	Board of Directors – meeting in public
Action required:	Endorse approval by other group
Date of meeting:	27/05/2015
Presented by:	Dr Anushta Sivananthan – Medical Director/ Executive Lead for Quality

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

REPORT BRIEFING

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

To provide an update on progress in improving quality across CWP's services during Quarter 4 of 2014/15.

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

Regular, transparent reporting on the quality of CWP's services strengthens the Trust's approach to listening and involving staff, people who access the Trust's services, carers, the public, commissioners, internal groups, and external scrutiny groups in improving quality across CWP's services.

The Trust's Quality Reports provide a highlight of what CWP is doing to continuously improve the quality of care and treatment that its services provide. The quarter 4 report describes progress in delivering against CWP's Trustwide quality priorities for 2014/15, as well as work to improve outcomes by supporting recovery, and also a number of quality success stories.

Assessment – *analysis and considerations of options and risks*

The Quality Report for Quarter 4 2014/15 details:

- Successful delivering against the Trustwide quality priorities.
- How Community Mental Health Services in East Cheshire have supported a 12 week project of tailored gym session delivered by CW1 Crossfit, after securing funding from Active Cheshire. The sessions sought to improve physical and mental well-being by offering individuals a personalised fitness plan.
- That the College of Social Work and the Royal College of General Practitioners have produced a report in which the West locality "Altogether Better" programme was used as a case study to demonstrate how to deliver health and social care integration together.
- The creation of an Innovation Register, to capture innovative ideas from across the Trust.
- How CWP's Mental Health Act team successfully secured funding from NHS England to provide training on the Mental Capacity Act and Deprivation of Liberty Safeguards to 90 delegates from across the Trust footprint.
- CWP's investment of over £5 million to open the new Alderley Unit for people with learning disabilities in East Cheshire to provide a better experience to people accessing services there.
- That a paper written by Paula Lonsdale, Mental Health Lead Nurse for the Integrated Discharge Team, has been published by Health Education North West. It describes work to reduce length of stay and return people to their preferred discharge destination.

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

The Board of Directors is asked to **endorse** the Quality Committee's approval of the quarter 4 Quality Report.

Who/ which group has approved this report for receipt at the above meeting?	Quality Committee
Contributing authors:	Hayley Mannin, Quality Support Manager David Wood, Associate Director of Safe Services

Distribution to other people/ groups/ meetings:

Version	Name/ group/ meeting	Date issued
1	Board of Directors	20/05/2015

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

Appendix no.	Appendix title
1	Quality Report – Quarter 4, 2014/15

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

Quality Report

Quarter 4
January – March 2015

Vision:
Leading in partnership
to improve health and well-being by providing
high quality care

Community Mental Health Services in East Cheshire are supporting a 12 week project of tailored gym sessions, delivered by CW1 CrossFit, after securing funding from Active Cheshire.
The sessions sought to improve physical and mental well-being by offering individuals a personalised fitness plan.

Service users from Cheshire East Community Mental Health Services
and trainers from the gym pictured with staff – See page 6

Care • Well-being • Partnership

CONTENTS

An explanation of terms used throughout this report is available on the Trust's internet:
http://www.cwp.nhs.uk/reports/1628-quality-reporting-glossar

Welcome to CWP's fourth *Quality Report* of 2014/15

These reports are produced every quarter to update staff, people who access the Trust's services, carers, the public, commissioners, internal groups, and external scrutiny groups on progress in improving quality across CWP's services, which CWP is required to formally report on in its annual *Quality Account*.

CWP's *Quality Account* 2013/14 and the previous *Quality Reports* of 2013/14 and 2014/15 are available on the Trust's internet site:

http://www.cwp.nhs.uk/our-publications/reports/categories/431

Reporting on the quality of the Trust's services in this way enhances involvement of people by strengthening the Trust's approach to listening and involving the public, partner agencies and, most importantly, acting on the feedback the Trust receives.

Quality in the NHS is split into three parts.
It can mean different things to different people, for example:

QUALITY

Patient safety	Clinical effectiveness	Patient experience
Being protected from harm and injury	*Receiving care and treatment that will make me better*	*Having a positive experience*
Being treated in a safe environment	*Having an improved quality of life after treatment*	*Being treated with compassion, dignity and respect*

This report is just one of many reviewed by the Trust's Board of Directors. Other reports include:

- the three times a year *Learning from Experience* report –
  reviews learning from incidents, complaints, concerns, claims and compliments, including Patient Advice and Liaison Service [PALS] contacts;
- the quarterly Infection Prevention and Control report –
  reviews the management and clinical governance systems in place to ensure that people experience care in a clean environment, and are protected from acquiring infections;
- the monthly Performance dashboard –
  reviews the Trust's quality and safety performance by reporting on compliance in achieving key local and national priorities;
- the Medicines Management Group newsletter –
  contains clinical information for practitioners, articles of interest and general pharmacy information for ward staff and teams.

Together, these reports give a detailed view of CWP's overall performance.
This *Quality Report* provides a highlight of what CWP is doing to continuously improve the quality of care and treatment that its services provide.

EXECUTIVE SUMMARY – QUALITY HEADLINES THIS QUARTER

CWP has made good progress in delivering against its trustwide **quality priorities** for 2014/15 in quarter 4

➲ see page 5

Community Mental Health Services in East Cheshire have supported a 12 week project of tailored gym session delivered by CW1 Crossfit, after securing funding from Active Cheshire. The sessions sought to **improve physical and mental well-being** by offering individuals a personalised fitness plan.

➲ see page 6

The *College of Social Work* and the *Royal College of General Practitioners* produced a report in which the West locality "Altogether Better" programme was used as a case study to demonstrate how to **deliver health and social care integration** together

➲ see page 7

The Effective Services Department has created an Innovation Register, to capture **innovative ideas** from across the Trust

➲ see page 8

CWP's Mental Health Act team secured funding from *NHS England* to provide training on the Mental Capacity Act and Deprivation of Liberty Safeguards to 90 delegates from across the Trust footprint

➲ see page 9

CWP has invested over £5 million to open the new Alderley Unit for people with learning disabilities in East Cheshire to provide a **better experience** to people accessing services there

➲ see page 10

A paper written by Paula Lonsdale, Mental Health Lead Nurse for the Integrated Discharge Team, has been published by *Health Education North West*. It describes work to **reduce length of stay** and **return people to their preferred discharge destination**.

➲ see page 11

QUALITY PRIORITIES 2014/15

CWP has set three **Trustwide quality priorities** for 2014/15, which reflect the Trust's vision of "**leading in partnership to improve health and well-being by providing high quality care**". They are linked to the Trust's strategic objectives, and reflect an emphasis on **patient safety**, **clinical effectiveness** and **patient experience**.

The Trust has made a commitment in its *Quality Account* to monitor and report on these in its quarterly *Quality Report*s. This year, the common focus across all the priorities is **reducing unnecessary avoidable harm** to help reduce avoidable variations in the quality of care and to improve outcomes.

Patient Safety priority for 2014/15 – Achieve a continuous reduction in unnecessary avoidable harm and make measurable progress to embed a culture of patient safety in CWP, including through improved reporting of incidents

CWP has worked towards achieving this quality priority, as detailed below:

- Human Factors and cognitive task analysis has been introduced into a reflective review template that has been designed to specifically review learning from incidents involving restraint. The results of this will inform how to implement Human Factors into routine incident reporting and will be factored into incident investigation processes and policy post April 2015 once the NHS England framework for serious investigation has been developed.
- Locality Data Packs (LDPs) have been issued to 9 wards/ teams in February 2015, feedback from the team/ ward managers is currently being collated for further developments to the LDPs prior to their Trustwide roll out by May 2015. The Locality Data Pack has been developed as part of CWP's zero harm strategy to report quality and safety indicators in line with the CQC's 5 domains. The aims are:
  - to bring existing data together into one place so it can be used as information;
  - to apply data visualisation principles – a fancy way of saying we'll use a better mix of tables and charts to make sure the key messages stand out and monitor trends over time;
  - to set team data against local and national benchmarks so that data are set in context i.e. benchmark internally and will national and international evidence;
  - to make a pack which is both easy for managers to share, and easy for staff to understand how they are doing.

Clinical Effectiveness priority for 2014/15 – Achieve a continuous improvement in health outcomes for people using the Trust's services by engaging staff to improve and innovate

CWP has worked towards achieving this quality priority, as detailed below:

- The implementation of a virtual "Healthcare Quality Improvement team" from March 2015 will support localities to drive continuous improvements from the outputs of audits.
- The internal promotion of CWP's Zero Harm presentation at the national NHS Quality: Improving Patient Care conference.
- An Innovation Register has been developed to capture and assist with the implementation of ideas that could improve quality, make process and provision more effective or improve patient experience

Patient Experience priority for 2014/15 – Achieve a continuous improvement in people's experience of healthcare by promoting the highest standards of caring through implementation of the Trust's values

CWP has worked towards achieving this quality priority, as detailed below:

- The Communications and Engagement Team supported the Trust's presence at the Mental Health: Better, Faster and Earlier Help Conference in March 2015 where the Trust promoted continuous improvement and Zero Harm.
- There has been a significant increase in the number of FFT responses received during March 2015. From the 812 responses since implementation in October 2014, 93% of people said they were 'extremely likely' or 'likely' to recommend CWP services. Reporting mechanisms are being developed to bring together results from the FFT app, survey monkey and paper based solutions more easily.

STOP THINK LISTEN
#CWPZeroHarm

IMPROVING OUTCOMES BY SUPPORTING RECOVERY

CWP is committed to **improving outcomes** for the people who access its services, so that the care and treatment that the Trust provides improves their **quality of life**, **social functioning** and **social inclusion**, self-reported **health status** and supports them in reaching their best level of **recovery**. Recovery is CWP's approach to **helping people to be the best they can and want to be**. In each *Quality Report*, CWP reports on how its services are improving outcomes for people who use its services by supporting recovery.

A pilot scheme in East Cheshire encouraging people with a mental health condition to get active has been hailed a success, with more than twenty people taking part in the first 8 weeks.

What they did

Staff from Community Mental Health Services in East Cheshire supported the 12 week project of tailored sessions, delivered by CW1 CrossFit, after securing funding from Active Cheshire. The sessions sought to improve physical and mental well-being by offering individuals a personalised fitness plan.

Donna Davies, health facilitator from CWP said: *"The success of the project has exceeded our expectations, and we are continuing to see new people attend each week. Initially we set out to get more people, more active, more often, but what we have also achieved is to create an atmosphere that is safe, supportive, fun and sociable. The sessions have given people a great insight into the importance of balancing physical and mental health. The partnership between CWP, Active Cheshire and CW1 CrossFit is one we hope to continue."*

Mat Blake, physical health instructor from CWP said, *"We would love to open the sessions up to anyone with a mental health issues, focusing on people supported in primary care by their GP as well as those known to CWP. We are also looking into the possibility of a dedicated session for people with learning disabilities."*

Impact

People who participated in the pilot said: *"The social aspect makes me smile and laugh, and that doesn't happen too often for me. It delivers a fantastic full body work out, and I'm knackered – but in a good way! I come every week to get fit but it makes me think more positively too."*

Jane Critchley, clinical service manager at CWP, attended a session and said: *"The people I've met today are testament to our collaborative working with local partners. We know good physical health makes a difference to our general well-being and speaking to the people here today demonstrates how important it is to take time to look after ourselves."*

Conclusion & Next Steps

Improving physical health care for people with mental health problems is a key recommendation from 'A Manifesto for Better Mental Health', a paper produced by several mental health organisations advising the next Government on how to improve the lives of those with mental health problems. Carl Bennett, deputy chief executive of Active Cheshire said: *"Active Cheshire are really pleased to see the positive impact our investment is having and I look forward to hearing about the continued positive behaviour change participants are achieving. It is crucial that interventions such as the CrossFit sessions attract and continue to inspire and motivate those engaged to become and remain active so they achieve measurable and lasting benefits."*

Adella Williamson, director of CW1 CrossFit said, *"We are overwhelmed with the success of the programme so far and are extremely proud of those who have been attending. The sessions are really challenging and making a difference to how people feel - it makes it all worthwhile and the reason we wanted to be part of the project. We look forward to many more future sessions."*

QUALITY SUCCESS STORIES

In addition to earlier success stories featured in the report, below is a summary of some of CWP's other success stories over the past quarter in **promoting quality** within the communities that the Trust serves, and in **improving the quality of the Trust's services**.

Patient Safety News

The College of Social Work and the **Royal College of General Practitioners** produced a report in which the CWP West locality "Altogether Better" programme was used as a case study to demonstrate how to deliver health and social care integration together.

The integrated community care teams are drawn from a broad range of professionals from the statutory and independent sectors: GPs, social workers, pharmacists, practice nurses, district nurses, community matrons, and community therapy, community mental health and reablement staff, among others. The teams are responsible for identifying older people at high risk of an unnecessary admission to hospital or long-term care and finding alternatives which enable people to live independently and healthily at home wherever possible. They offer a variety of interventions: care management, intermediate care, reablement, urgent response and end of life care. Each team covers a practice population of 30,000 to 50,000 and provides urgent response "step up" care to prevent unnecessary hospital admissions and "step down" care to speed up discharge and promote rehabilitation and reablement.

Impact

A real-life example illustrates how integrated working has benefitted people who access services and the public purse at the same time.

A 90 year old man was the main carer for his 89-year-old wife who had dementia. He required an eye operation as a day case at the local hospital but this was complicated by the fact that he had to bring his wife with him. The hospital was unable to look after his wife and the operation had to be cancelled twice. Faced with the husband's deteriorating eye condition, the integrated team co-ordinated a conversation with the acute trust, arranging for the operation to be rescheduled and giving the social worker time to build up a trusting relationship with the wife. On the day of the surgery, the social worker took both husband and wife to the hospital and sat with the wife throughout. Arrangements like these would not have been possible prior to the integrated team. Care and support could now be coordinated across the system as a whole. As a consequence, the husband was able to have his operation and return home to resume his caring duties.

Wirral Memory Assessment Service has been ranked third in the country for reaching MSNAP accreditation standards. The **Memory Services National Accreditation Programme** (MSNAP) was launched in 2009 by the *Royal College of Psychiatrists*' Centre for Quality Improvement. It helps memory services and memory clinics to improve the quality of their service and supports them to achieve accreditation. People with dementia and carers are involved in the programme alongside professionals and clinicians to ensure that the focus remains on high quality care for people accessing services and those that care for them. Teams are reviewed against a set of standards which are created from published documents, guidelines and expert opinion and are revised regularly. The MSNAP standards cover assessment, diagnosis, drug treatment and psychological and social therapies for people with dementia.

Mental Capacity Act and Deprivation of Liberty Safeguards

What they did

The Mental Health Act Team successfully secured funding of £8,000 from *NHS England* to provide a full day's training session on the Mental Capacity Act and Deprivation of Liberty Safeguards. The training held at the Holiday Inn, Ellesmere Port was attended by 90 delegates who were a combination of non-executive directors, associate hospital managers, Trust doctors, community and ward staff and GPs from across the Trust footprint.

The training was facilitated by AFTAThought who are a group of actors who specialise in training through drama, bringing to life the experiences of people who access services, relatives, and staff involved in any decision making process. Good drama has the power to change hearts and minds. It can challenge perceptions, improve understanding and create recognition and empathy in a 'safe', positive learning environment.

The morning training session focused on the Mental Capacity Act and in the afternoon focused on Deprivation of Liberty Safeguards. Laura Nazar from Hill Dickinson LLP co-facilitated the training and was able to provide the legal aspect of this complex piece of legislation.

Impact

Feedback received from staff clearly indicates the positive impact that the training had achieved. Here are a few comments from feedback:

"Excellent way to present difficult topics."

"One of the best study days I have attended."

"The actors were brilliant, great impression on my learning – brilliant, wonderful."

"Excellent, unique and very inspiring. The actors and facilitators made it so remarkable."

Next steps

The next step is for staff to apply their learning into practice to meet the Trust values. Staff were asked to consider how they would do this, the feedback was as follows:

- More consideration of the values and principles in hospital managers' hearings
- Utilise information and put knowledge into practice on the ward
- Mental Capacity Act is a huge aspect of my role so will help improve standards
- Ensure all interventions involve the patient and have courage and commitment to ensure people who lack capacity receive care in their best interests
- Part of my role is to consider the least restrictive options for people's care pathways – the training session has refreshed my knowledge
- Will consider Mental Capacity Act in all aspects of care whilst delivering the 6Cs

Clinical Effectiveness News

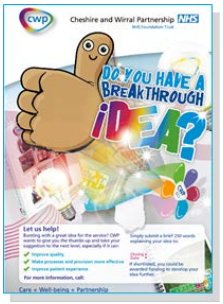
Wirral-based GP **Dr Stefan Janikiewicz** has been awarded an **MBE** for services to reducing drug misuse in the **New Year's Honours** 2015. **Dr Janikiewicz**, GP at **Moreton Health Centre**, is a former **CWP clinical director**, and recently retired after holding the position for 23 years.

Following the news of his MBE, **Dr Janikiewicz** said: *"I think I've been a challenging person to work with throughout the years, but because I always spoke from the heart I got away with it! During my time at CWP I worked with so many caring drug and alcohol workers, good managers and admin staff, and although the award is in my name, it really is a massive team effort. I've had such great support from the Trust during my years as clinical director. Being a person who doesn't really like a fuss, I'm surprised by just how much this means to me."*

During his time at CWP **Dr Janikiewicz** was instrumental in shaping drug and alcohol services across the Wirral and beyond. Particular achievements include developing an award winning shared care service with 100% of Wirral GP practices being involved. He also made a significant contribution to Wirral's Alcohol Harm Reduction Strategy and had a leading role in developing a pioneering Hepatitis C pathway into treatment for drug users.

David Eva, CWP Chairman, said: *"We are delighted for Stefan. He has made a fantastic contribution to the development of our leading edge drug and alcohol services on the Wirral and has made a positive difference to thousands of people over the years. Having followed his work for the last 25 years I can bear witness to this being thoroughly deserved recognition of someone who can go the extra mile on many occasions."*

Innovation in CWP is about making a real and tangible difference to the lives of people accessing its services. New medicines, medical technologies and informatics can **transform people's outcomes**. Innovation can help improve quality at the same time as driving productivity and efficiency. In order to capture innovative ideas within the Trust the Effective Services Department launched the **'Innovation Competition'**. In 2014 they asked staff to submit ideas that could:



- Improve quality
- Make processes and provision more effective
- Improve patient experience

In Quarter 4 the department convened the Innovation Panel which was made up of Executives and Senior Management who reviewed all of the entries. In total 15 ideas were submitted from across the Trust for consideration and all were recommended for further development or approved! All staff who submitted ideas have been assigned a colleague who can help them progress their ideas further; this is usually one of the Effective Service Managers who can support with the development of business cases. The ideas are recorded on the **'Innovation Register'** which is currently being developed in order to share these ideas across the Trust. The department will be launching the 2015/16 Innovation competition in April in order to develop the register further.

CWP's **chief executive**, **Sheena Cumiskey**, has been recognised for the second time as an outstanding leader of NHS organisations by the **Health Service Journal** (HSJ). The HSJ Top Chief Executives 2015 list, regarded Sheena as *"a wonderful advocate for the NHS"*, praising her ability to see *"the bigger picture in the interests of the wider NHS and that of the patient"*. **Alastair McLellan**, **editor of HSJ**, wrote that the judging panel *"were full of admiration for the many chief executives who have held things together in this most difficult of years"*. The independent judging panel included **Sir Bruce Keogh**, *NHS England* **medical director** and **Stephen Dalton chief executive**, Mental Health Network *NHS Confederation*, amongst other key figures in the NHS.

Patient Experience News and *patient feedback*

The Trust has invested over £5 million to open a new inpatient unit for people with learning disabilities in East Cheshire. Using best practice guidance, the new low secure 15 bedded unit has been built on the Soss Moss Hospital site, near Nether Alderley, to replace existing facilities on site for people with mild to moderate learning disabilities.

The new facilities in the Alderley Unit have large spacious therapeutic areas, private bedrooms, dedicated family visiting areas, an art therapy room, activity room and gym as well as a light and airy lounge area that looks out on to the countryside. The décor is themed 'outdoors' with lots of colourful artwork of nature and gardens throughout.

Dave Jones, CWP Clinical Services Manager, says: *"Around 1.5 million people in the UK have a learning disability which can be mild, moderate or severe depending on the individual. A learning disability affects the way a person understands information and how they communicate – it affects everyday life for the person and their family. People with learning disabilities mustn't be confused with having a learning difficulty or mental illness – although some people can have multiple conditions. Around 30% of people with epilepsy have a learning disability, cerebral palsy; autism and Down's syndrome are also commonly linked with learning disabilities".*

Julia Cottier, CWP Service Director, says: *"This new unit will enable us to support people in our community who have most profound and/ or multiple learning disabilities. It will help us to further enhance our service by providing an environment that people feel safe and supported in – our priority is to care for people with compassion and respect and to support people to live living fulfilling lives."*

Cheshire East Substance Misuse Service welcomed over 40 members of the local community to publicly launch this new service. Cheshire East Council appointed CWP as lead provider of the all-age service in November 2014. The new and integrated service is designed for people whose lives are affected by drug or alcohol issues. The open day was held at one of the Trust's sites, Catherine House in Crewe, to show local people the types of support available and how people can access it. Service partners also provided interactive demonstrations to show people how to take better care of themselves as part of holistic recovery and wider health and well-being.

A spokesperson at the event, spoke about her addiction to drugs: "*Without the support of this service, I wouldn't be here today. I began using cannabis, but then moved on to harder stuff. I didn't realise I had a problem, I just thought I was doing a bit too much at the time, until I hit rock bottom and was close to losing everything. The team helped build me back up, they didn't judge me or question me, just accepted that I needed help and support. I would encourage anyone to get help as early as you can. I am living proof that there is hope and you can recover."*

Dr Heather Grimbaldeston, *Cheshire East*'s Director of Public Health, said: *"Doctors and nurses tell us they are incredibly worried about the amount of alcohol people are drinking. The new service will help us do more to help people avoid the physical, mental and social damage so often seen as a result of misuse of alcohol or drugs."*

Councillor Janet Clowes, *Cheshire East*'s Cabinet Member in charge of Care and Health in the community, said: *"We are delighted to have CWP deliver the new service. The change in the service design means there will be a greater focus on prevention and early help support. We want the best for our young people. Families and adults and this service will help empower people to develop skills and confidence to build stronger and safer communities."*

Andy Styring, CWP Director of Operations, says: *"Substance misuse affects all members of our communities; from those who have issues themselves to those around them such as their family and friends. We are committed to seeing the 'whole person' and not just the condition. By working with people and their families, we want to reduce avoidable harms and continue to deliver the best care possible, as safely as possible in collaboration with our service partners."*

The substance misuse service is open to people of all ages whose lives are affected by drug or alcohol issues. Referral is accepted from any source including self-referral and via a GP.

Paula Lonsdale, Mental Health Lead Nurse for the Integrated Discharge Team, recently had a paper published by *Health Education North West* via the eWIN Workforce Information Network Portal. The paper clearly demonstrates the good work that has been done by her team, and will be instrumental in helping others address similar challenges.

What they did

It is estimated that 8.9% of older people occupying NHS acute beds have been declared fit to leave hospital but have not yet done so for a variety of reasons. This equates to more than 4,100 older people on any given day. Delays in discharge can undermine a patient's quality of life and increase their dependence upon institutional care. To address this, the Trust, our neighbouring acute trust (the *Countess of Chester Hospital NHS Foundation Trust*), and our social service providers (*Cheshire West and Chester Council*), developed a proposal for a 6 month pilot post of a Specialist Practitioner in mental health to:

- Reduce the length of stay of the target group through the intervention of the Specialist Practitioner in mental health.
- Show that this group, having received intervention from the Specialist Practitioner in mental health, returned to their original place of residence following discharge from hospital.
- Demonstrate whether intervention from the Specialist Practitioner in mental health had an impact upon reducing readmission rates of the target group.

Impact

The intervention from the Specialist Practitioner in mental health had a positive impact upon the length of stay and discharge destination for patients over 65 with dementia, delirium or other mental health issues. An initial audit demonstrated that patients who received intervention from the Specialist Practitioner in mental health had a combined stay in hospital of 2,925 hours less than those who had no intervention. The second phase of the audit demonstrated that 86% of the patients who received intervention from the Specialist Practitioner in mental health were able to return to their admission address in comparison to 71% of the non-intervention group.

It could be suggested that comprehensive discharge planning during an inpatient stay, coupled with a timely home review and robust co-ordination of community services, is important to ensure positive health outcomes for the elderly population in acute hospitals.

The personal growth of the practitioner was immense in the initial phase of the post and has continued as the post evolves. The practitioner has established enhanced skills in developing productive relationships, learnt to be more patient and understanding of the roles and pressures of other professionals, and developed strong working relationships with outside agencies such as homecare providers, care homes and voluntary agencies. This has taken perseverance and a consistent presence/ approach – a method that has been replicated in all aspects of the post, which has helped with the acceptance and reliance upon it within the acute hospital setting.

Next steps

A further audit of length of stay, discharge destinations and readmission rates to compare initial findings is planned. There have been inpatient developments in the *Countess of Chester Hospital NHS Foundation Trust* in the care of the elderly, such as dementia specialist nurses. The next audit will be an opportunity to review the impact their intervention has had upon the work of the Specialist Practitioner in Mental Health.

A more detailed satisfaction questionnaire is planned to gain more depth of information from patients, carers and professionals experience of using the service. This will inform the future development of the service.

In quarter 4, CWP formally received 672 ***compliments*** from people accessing the Trust's services, and others, about their experience of the Trust's services. Below is a selection of the comments and compliments received for the services across the Trust:

Adult mental health services – CWP West

"I wish to put on record my gratitude for the excellent care I received as in inpatient at Bowmere Hospital. Without exception I found the staff to be dedicated, caring, compassionate and highly professional, always totally focused on monitoring patients and their needs, and at all times showing great respect and maintaining patient dignity."

Physical health services

"I just wanted to express how impressed I was with the service from the Out of Hours service based on the Countess of Chester Health Park. My comments are from my visit on Saturday 7th February 2015. I rang the Out of Hours number at 11.45am as my 23month old son had a barking cough, extremely high temperature and generally unwell. The lady I spoke to was very helpful, reassuring and informative. Within 5minutes I had a call back from a nurse who suspected my son had croup. Again she was very helpful, reassuring and talked me through my son's symptoms. She offered me an appointment at 12.30pm. As this was only half an hour later I was very impressed. We were seen on time at the Out of Hours service and the nurse practitioner was very thorough, explaining to me what she was doing and talking through what she had found. Again she was very helpful and reassuring. She informed me that she would like my son to be seen by a pediatrician at the hospital and we were given a direct referral. By 1pm my son was on the Children's Assessment Unit and by 1.15pm he had been given his first lot of medication. This was only an hour and a half after I had made my phone call. Overall I was extremely impressed by the level of service, care and treatment my son received and believe this is an excellent example of the Out of Hours service working at its best."

Adult mental health services – CWP Wirral

"I was truly moved by the wonderful care my mother received from you. It makes me well up to think about how you looked after her and loved her. When she came to you she was angry and confused and had a difficult time settling but over the months, with your compassion and patience, I think she really knew how lucky she was and was much more at peace. Throughout her illness I felt that you looked after me as well. You were always so kind on the phone and to me in person when I visited. I know that my sister feels exactly the same and we both feel blessed that she spent her final months with you."

Drug and alcohol services

"A big thank you for all your help and support, I couldn't have done it without you. I am now looking forward to a brighter, sober future thanks to you!"

Adult mental health services – CWP East

"(Staff member) has enabled me to realign myself. I can honestly say she's amazing and has shown me how I'm able to take control and to be able to live again. I'm amazed at how quickly her suggestions have guided me to take back control, gain empathy, compassion and I feel a need to pass this on. (Staff member) has changed my attitude to my life!"

Share your stories

We welcome feedback about any of the Trust's services; please share your stories via email at hayley.mannin@cwp.nhs.uk

Look out for more quality stories in the quarter 1 *Quality Report*

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

STANDARDISED REPORT COMMUNICATION

REPORT DETAILS

Report subject:	Corporate assurance framework – update report
Agenda ref. no:	15/16/12
Report to (meeting):	Board of Directors – meeting in public
Action required:	Discussion and Approval
Date of meeting:	27/05/2015
Presented by:	Dr Anushta Sivananthan, Medical Director – Executive Lead for Quality

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

REPORT BRIEFING

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

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

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

The Board of Directors monitors and reviews the corporate assurance framework and receives assurances on risk via the Quality Committee. This is a key component of the Trust's integrated governance strategy which provides assurance regarding the quality and safety of the services that the Trust provides. The Quality Committee is the designated committee for risk management operationally and last reviewed the strategic risk register at its meeting on 6 May 2015.

The Audit Committee undertakes in-depth reviews of strategic risks as part of its remit to review the effectiveness of integrated governance and internal control Trustwide. At its May 2015 meeting, the Audit Committee undertook an in-depth review of the potential risk of cyber security. The action agreed was to further assess this risk for consideration at the next Quality Committee. At its next meeting, it will request assurances of the effectiveness of the risk treatment plans for the risks in relation to the management of physical health conditions and the ligature points/ environment risk.

Assessment – *analysis and considerations of options and risks*

New risks – none.

Amended risk scores, re-modelled risks, updates to current risks

- No risks have been re-scored.
- The risk description of the current 'Risk of harm to patients and staff due to staffing levels across inpatient services in the three localities' is currently under review. The Inpatient Bed/ Ward Review Programme Board has referred this to the Operational Board and the outcome of this review will be reported to the next meeting of the Board of Directors.
- The Quality Committee has welcomed the positive results achieved for the national mental health CQUIN developed to improve physical healthcare to reduce premature mortality in people with severe mental illness, whilst recognising the effort has not translated into full implementation in line with NHS England guidance (difficulties with compliance, nationally, have formally been recognised by NHS England). The Quality Committee has requested that effort be placed on the national CQUIN for 2015/16 and also the skills of mental health staff in managing physical healthcare and that this is reflected in a more comprehensive assurance framework/ risk treatment plan for the delivery of further actions to help achieve the target risk, to be developed by the physical healthcare clinical network.
- Informed by its annual review of effectiveness, the Quality Committee has requested further assurance from the Trustwide Safeguarding Group regarding its assurance framework/ risk treatment plan for the delivery of further actions that would help achieve the target risk.

Archived risks – none.

Corporate assurance framework – outlines controls and assurances and is available at appendix 1/ T drive. As reported to the January 2015 meeting of the Board of Directors, the presentation has been refined with more focused and contemporaneous content in response to Monitor's (2014) Well-led framework for governance reviews. The presentation responds to a number of recommendations that foundation trusts should include in a dynamic corporate assurance framework. Work is continuing with risk leads to ensure the achievement of more comprehensive strategic risk treatment plans.

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

The Board of Directors is asked to **review**, **discuss** and **approve** the amendments that have been made to the strategic risk register and corporate assurance framework as recommended by the Quality Committee, as presented in this report.

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

Distribution to other people/ groups/ meetings:

Version	Name/ group/ meeting	Date issued
1	D Wood to L Brereton for Board of Directors	19/05/2015

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

Appendix no.	Appendix title
1	Risk Register and Corporate assurance framework-

Document Reference (2014/15)	May-15

Date of Meeting: 27th May 2015

Title of Report: CWP Performance Dashboard

Trust Board

Action sought: **DISCUSSION & APPROVAL**

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

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

The Board are asked to:

Note:

1. The Continuity of Services Risk Rating forecast for the end of 2014-15 is a an overall 3 but is forecast to be 4 for Quarter 1 2015-16. Current performance for April 2015 is a risk rating of 3. As of the end of April 2015, the Trust's overall income and expenditure position is a deficit of £68k from continued operations and this is in line with our plan submitted to Monitor. In line with guidance and reporting in 2014/15 CWP continues to have an element of discontinued operations and exceptional items which are excluded from Monitor's continuity of services risk ratings.

2. Trustwide CIP savings to date are £9k behind plan of £83k in month 1.

3. All current Monitor indicators are above target, however the performance against the new IAPT waiting times indicator (which are to be reported to Monitor from Q3 2015-16) is below target for both 6 weeks (59.0% against a target of 75%) and 18 weeks (87.1% against a target of 95%) from referral to treatment. Please see waiting times section of this report for a full breakdown of performance by locality. The exception report provides details of the reasons why performance is below target and work being undertaken to improve performance.

4. Sections of this new-format dashboard remain in development and work is ongoing to provide all data. Items remaining in development (estimated dates of availability in parenthesis):

- Customer Satisfaction *(Q2 2015-16; delayed due to electronic survey not yet having gone live)*
- Friends and Family Test *(Q2 2015-16; delayed due to data only becoming available in March, development under way)*
- Staff Experience *(Q2 2015-16; delayed due to electronic survey not yet having gone live)*
- Timely reporting for ESR data *(Late May 2015 - see item 5)*

5. Live data feeds are now available from ESR, however the Trust is not yet in a position to use this data for reporting purposes. It has become apparent that assurances provided previously around live reporting were inaccurate; however, the situation is under review and the timescales for live reporting from ESR will be provided to the next Ops Board.

6. Waiting times reporting has now been expanded, to include the access targets for IAPT and Early Intervention detailed in the 2015-16 Monitor Risk Assessment Framework. Trending will be included once sufficient data is available.

7. Overall compliance with new Essential 1 training has again improved, to 86.5% for March (from 85.9% in February), and remains above the 85% compliance target. Non-renewal is performing above target, however three-yearly training and annually-renewed training are below target, at 73.4% and 82.8% respectively . Please see workforce section of this report for a full breakdown of performance. The exception report provides details of actions being taken to improve compliance with the trust standards. Compliance with the mandatory training, appraisal and staff supervision are in important for the trust to ensure its workforce is well-led and supported.

Discuss:

8. The year to date cumulate sickness absence rate is 5.76 per cent. This is the second month in a row with absence below the recent high levels, and below 6%, making it more in line with absence rates in early Summer 2014. It is too early to say if this reduction is due to normal variance or is indicative of a clear downward trend. Please see workforce section of this report for a full breakdown of performance. The exception report provides details of actions being taken to improve the management of sickness absence performance.

9. The Trust's clozaril clinics have not been audited since 2012. Following an initial audit of each clinic, 8 out of 9 were found to be non-compliant, with an average audit rating of 84% (the Trust's minimum acceptable rating is 93%). Each location is now on the IPCSC risk register and on the Estates and Facilities work programmes.

Strategic Objective(s) that this report covers:

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

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

Executive Director

Tim Welch, Director of Finance/Deputy Chief Executive

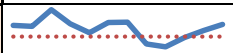
CWP Board Dashboard

Reporting Month: April 2015

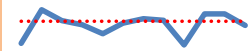
Exception Reports

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

	Previous month	Current month	Trend
Monitor Targets - 7	↓	↑	
Finance			
Income & Expenditure	↑	↓	
CoSRR (Monitor Target)	→	↓	
Cashflow	↓	↓	
Cost Improvement	↓	↑	Plan £83k Actual £74k Gap £9k

Inpatient Metrics	Bed occupancy rate	Ward staffing levels
Previous Month	**86.54%**	Planned Shifts **7,232** Actual **6,792 (93.91%)**
Current Month	**88.16%**	Planned Shifts **7,499** Actual **7,005 (95.96%)**
Trend		

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

	Target	Previous month	Current month	Trend
Workforce				
Essentials 1	85%	↑	↑	
Appraisals (including medical staff)	85%	↑	↑	
Safeguarding	80%	→	↓	
Supervisions	85%	↑	→	
Sickness	< 4.5%	↑	↑	
Disciplinary	TBC	↓	↑	
Patient Experience				
Complaints per 1000 episodes	< 2.17	↓	↑	
Staff Concerns	TBC	↑	→	
Customer Satisfaction	80%	Process for data collection in development. Reporting expected to be in place Q2 2015/16		
Family & Friends Test	Process for data collection is developed, and recording has commenced. Reporting to be in place by end of Q1 2015/16			

Waiting Times Indicators	Target	Previous month	Current month	Trend
Early Intervention (2 weeks)	50%	**74.42%**	**65.00%**	Insufficient data for trending; available September 2015
IAPT (6 weeks)	75%	**64.02%**	**59.08%**	
IAPT (18 weeks)	95%	**88.23%**	**87.30%**	
Allied Health Prof'ls (18 weeks)	95%	**99.61%**	**98.61%**	

CWP Board Dashboard

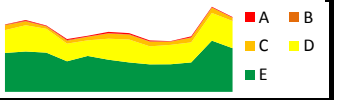
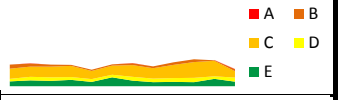
Reporting Month: April 2015

Exception Reports

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

Risks	Number of risks						Number of new risks added to register	Number of risks archived from register
	Red		Amber		Green			
	Current	Trend	Current	Trend	Current	Trend		
Strategic	10	→	4	→	1	→	0	0
Clinical Services	17	↑	33	↓	2	↓	5	15
Corporate Support	In development - being piloted by Performance and Redesign							

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

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

Quality	Previous month	Current month	Trend
Patient Safety Composite Score	→	→	
Staff Experience	Process for data collection in development. Expected to be in place Q2 2015/16		

Infection Prevention and Control	Previous audit compliance	Current audit compliance	Trend
Infection Control	2/7 passed 84% compliance	1/10 passed 84% compliance	↓

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

Board Dashboard - Glossary

Back to top

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

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

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

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

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

CWP Objectives

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

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

STANDARDISED REPORT COMMUNICATION

REPORT DETAILS

Report subject:	Provider Licence – 2014/15 self-assessment and Declarations required by General Condition 6
Agenda ref. no:	15/16/14
Report to (meeting):	Board of Directors
Action required:	Discussion and Approval
Date of meeting:	27/05/2015
Presented by:	Louise Brereton, Head of Corporate Affairs

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

REPORT BRIEFING

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

This report provides an update to the Board of Directors on the self assessment of the Trust's compliance with the Provider Licence at the end of 2014/15.

The report also sets out the declarations required by General Condition 6 of the Licence which are required by Monitor by 29 May 2015.

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

The Health and Social Care Act introduced the requirement for provdiers of NHS services to hold a licence. NHS Foundation Trusts had licences issued and these were enforced by Monitor from April 2013. The licence sets out various conditions for providers of NHS services and specific obligations for NHS foundation trusts. The licence is one of Monitor's main monitoring tools and the conditions give powers for regulating providers.

On an annual basis, the Board of Directors is required to confirm the Declarations required by General Condition 6 of the Licence. This is declaration to confirm that the Trust has systems in place to ensure compliance with the Licence conditions.

Assessment – *analysis and considerations of options and risks*

An assessment of compliance against the Trust Licence criteria is undertaken on a six monthly basis. The self assessment has been completed for year ending 2014/15 and finds that the Trust continues to be compliant with the Licence conditions.

As part of the Internal Audit plan 2013/14, MIAA has recently completed an internal audit on Trust compliance with the Licence. Having reviewed the arrangements to maintain compliance with the Licence conditions, the Trust received significant assurance regarding the systems in place.

To further enhance the process for maintaining oversight of compliance with the Licence, from 2015/16, the Audit Committee will receive a quarterly assurance report setting out the key conditions and any exceptions. The Board will continue to receive a six monthly self assessment of compliance.

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

The Board of Directors is requested to:

- **Note** the 2014/15 self assessment of Provider Licence compliance.
- **Approve** the Declaration required by General Condition 6 of the Provider Licence.

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

Distribution to other people/ groups/ meetings:

Version	Name/ group/ meeting	Date issued
1	D Wood	20/05/2015

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

Appendix no.	Appendix title
1	Summary of key Licence conditions and actions
2	Declarations required by General Condition 6
3	Full Licence Conditions Document (T Drive)

Appendix 2.1: Self assessment evidence against *Monitor* NHS provider licence criteria as at Q4 2014/15

RAG	Definition
GREEN	Meets or exceeds expectations. Many elements of good practice. No major omissions.
AMBER/ GREEN	Partially meets expectations but confident in management's capacity to deliver green performance within reasonable timeframe.
AMBER/ RED	Partially meets expectations but some concerns on capacity to deliver within a reasonable timeframe.
RED	Does not meet expectations.

Licence reference	Licence provision	Self assessment	Q4 response	Further actions for completion by end Q1 2015/16
1. General provisions				
G2	Has Monitor given any direction regarding setting or limiting conditions within the Provider Licence?	**GREEN**	No.	No further actions.
G4(1)	Is the Trust aware of any reason why a newly appointed Governor or an appointed Governor is unfit to be a Governor?	**GREEN**	No.	No further actions.
G4(2)	Is the Trust aware of any reason why a newly appointed Director or a Director in post is unfit to be a Director?	**GREEN**	No.	No further actions.
G5	Has Monitor issued new guidance relating to the provider licence in the quarter?	**GREEN**	No.	No further actions.
G6	Executive to consider any new licencing risks identified in the quarter – update of Board	**GREEN**	The current corporate assurance framework includes a strategic risk in relation to "Risk of breach of Trust Licence as a result of external scrutiny"	This risk is still current on the strategic risk register. Recent MIAA audit of provider licence compliance received significant assurance. Risk is on track to be archived

Licence reference	Licence provision	Self assessment	Q4 response	Further actions for completion by end Q1 2015/16
	Assurance Framework for Board approval?			pending the outcome of the CQC inspection in June 2015.
G6(3)	Publication of Annual Governance Statement (AGS)?	**GREEN**		The AGS is published as part of the Annual Report and Accounts 2014/15 in July 2015.
G7	Consider CQC registration status in quarter – note cancellations and registrations (G7(2))?	**GREEN**	No.	No further actions.
G9	Consider whether Commissioner Requested Services have not been amended?	**GREEN**	No.	No further actions.
G9(12)	Have the contractual requirements to activities or any mandatory services been amended?	**GREEN**	No.	No further actions.
2. Pricing				
P1(4)	Have any services been sub contracted?	**GREEN**	Yes	The Trust is developing a number of sub-contracts with third party providers in relation to the East Cheshire Substance Misuse Services Contract (Cheshire East Council), 5 – 19 Health and Wellbeing Services Contract (Cheshire West and Chester Council) and IAPT Services Contract (Sefton CCG). These arrangements will be reported in due course in line with licence requirements.
3. Choice and competition				
C1(3)	Are clear systems in place for notifying individual patients about choice re	**GREEN**	N/A.	

Licence reference	Licence provision	Self assessment	Q4 response	Further actions for completion by end Q1 2015/16
	'18 week' breaching when arranging alternative care?			
4. Integrated care				
IC1	Are there any service changes that require staff/ public consultation (need to be cognisant of Public Interest)?	**GREEN**	Podiatry public consultation process concluded in Q4 2014/15.	No further action.
5. Continuity of services				
CoS1	Have any contract variations been completed to service specifications [if Yes action required CoS1(4)]?	**GREEN**	As part of the 2015/16 contract negotiations which take place during quarter 4, all service specifications should be reviewed and any changes agreed with the commissioners will have been included as part of the 2015/16 contract at sign off. Service specifications have been reviewed as part of contract negotiations for Wirral CCG, South and Vale Royal CCGs and are being reviewed as part of the ongoing contract negotiations for the smaller contracts we have with Trafford and Bolton CCGs. It has been agreed with East Cheshire CCG that the current service specifications will be rewritten based on an agreed priority list to encompass the commissioning agenda and current CWP structure. It has also been agreed that the service specifications for West Cheshire CCG contracts will continue to be reviewed during the life of the contract in line with	To complete contract specification work as per Q4 response.

Licence reference	Licence provision	Self assessment	Q4 response	Further actions for completion by end Q1 2015/16
			work in developing care pathways.	
CoS2	Have any assets been disposed of that would impact on the ability to provide 'Commissioner Requested Services'?	**GREEN**	No.	No further action.
6. NHS Foundation Trust conditions				
FT1	Has the Constitution been amended? Publication of the Annual Report and Accounts in accordance with Monitor requirements – once published requires submission to Monitor with 28 days.	**GREEN**	No.	No further action.
FT4(8)	Submit to Monitor audited Corporate Governance Statement following Board approval in Q1 by 30 June 2015.	**GREEN**	N/A.	Due for sign off at June 2015 Board meeting.

15_16_14_Appendix 2

Declarations required by General condition 6 of the NHS provider licence

The board are required to respond "Confirmed" or "Not confirmed" to the following statements (please select 'not confirmed' if confirming another option). Explanatory information should be provided where required.

1 & 2 General condition 6 - Systems for compliance with license conditions

1	Following a review for the purpose of paragraph 2(b) of licence condition G6, the Directors of the Licensee are satisfied, as the case may be that, in the Financial Year most recently ended, the Licensee took all such precautions as were necessary in order to comply with the conditions of the licence, any requirements imposed on it under the NHS Acts and have had regard to the NHS	Confirmed
	AND	
2	The board declares that the Licensee continues to meet the criteria for holding a licence.	Confirmed

Signed on behalf of the board of directors, and having regard to the views of the governors

Signature	Signature
Name	**Name**
Capacity [job title here]	**Capacity** [job title here]
Date	**Date**

Further explanatory information should be provided below where the Board has been unable to confirm declarations 1 or 2 above.

A

B

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

STANDARDISED REPORT COMMUNICATION

REPORT DETAILS

Report subject:	Click here to enter text.
Agenda ref. no:	15/16/15
Report to (meeting):	Board of Directors – meeting in public
Action required:	Information and noting
Date of meeting:	27/05/2015
Presented by:	Dr Anushta Sivananthan, Medical Director/ Executive Lead for Quality

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

REPORT BRIEFING

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

The purpose of this report is to inform the Board of Directors of the annual Mental Health Act activity figures for submission by the Trust to the Health and Social Care Information Centre, known as the KP90. The Care Quality Commission expects that Boards have line of sight of Mental Health Act activity and usage. They use this information as part of their Intelligent Monitoring Tool (see next paper on the agenda). Nationally, the KP90 informs policy development in relation to the Act. It also provides input to the process of needs assessment on hospital accommodation requirements. CWP will also use this information to inform its own policies and its own/ joint strategic needs assessments.

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

The data returned through this collection is the source data for annual national statistics on uses of the Mental Health Act 1983 (as amended by the Mental Health Act 2007). This is essential for monitoring uses of the Mental Health Act.

The KP90 collection is approved by the Burden Advice and Assessment Service (BAAS) formerly Review of Central Returns – ROCR. This approval is for an annual mandatory collection from all providers who are registered to provide services under the Mental Health Act 1983.

Data is submitted annually, upon request, by the Mental Health Act Team Manager.

Assessment – *analysis and considerations of options and risks*

Key points from analysis of the Mental Health Act activity (Appendix 1):

1. *Detention under section 136 has seen a significant reduction in numbers this year*:
   2012/13 = 426, 2013/14 = 427, 2014/15 = 271
   This is in line with overall national activity reported to-date. In relation to CWP's particular decrease, the commended Mental Health Act Team training programme for the police, together with delivering Street Triage with our police forces, are likely to have had an impact. This is supported by the attached triage figures from Cheshire Police covering the period 17/11/2014 to 28/02/2015 (Appendix 2). This is also reflected in the decrease of regrades from one section to another. This new approach to policing incidents involving people with mental ill-health helps to reduce the number of people being arrested under section 136 and reduces unnecessary hospital admissions, therefore bringing about better outcomes as per the Trust's Zero Harm aspirations.
2. *Admissions to hospital on a section have seen a minor annual increase over the past three years*.
   This is in line with overall national activity reported to-date.
3. *This year has seen an increase in Community Treatment Order numbers*.
   This is not significant but will be benchmarked with other Trusts' performance once available.

Information on the KP90 return is published in a statistical bulletin, published later in the year (date to be confirmed) which will allow the Trust to consider its benchmarked position – findings of this analysis will be reported to a future meeting of the Board for discussion regarding incorporation into strategic needs assessments, for example in relation to hospital accommodation requirements.

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

The Board of Directors is asked to **note** the Mental Health Act activity for the Trust for 2014/15.

Who/ which group has approved this report for receipt at the above meeting?	David Wood, Associate Director of Safe Services
Contributing authors:	Jan Devine, Mental Health Act Team Manager

Distribution to other people/ groups/ meetings:

Version	Name/ group/ meeting	Date issued
1	J Devine to D Wood and A Sivananthan	20/05/15

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

Appendix no.	Appendix title
1	KP90 return 2014/15
2	Cheshire Police Street Triage statistics 17/11/2014 – 28/02/2015

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

STANDARDISED REPORT COMMUNICATION

REPORT DETAILS

Report subject:	Care Quality Commission: Intelligent Monitoring Report – (Draft) April 2015
Agenda ref. no:	15/16/16
Report to (meeting):	Board of Directors – meeting in public
Action required:	Information and noting
Date of meeting:	27/05/2015
Presented by:	Dr Anushta Sivananthan – Medical Director/ Executive Lead for Quality

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

REPORT BRIEFING

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

To provide an update on the Care Quality Commission (CQC) draft Intelligent Monitoring Report – April 2015. This is the second publication of the Intelligent Monitoring Report which will be published by the CQC on or around 11 June 2015. The report details CWP performance across a number of indicators across varying time ranges between 1 April 2013 to 31 March 2015 and identifies the possible risk of such indicators. The data source relating to the Central Alerting System has identified a risk in the April 2015 version of the tool, this report describes how this is being taken forward. However overall, Trust performance against the indicators used by the CQC indicates CWP as a low risk organisation and these will continue to feed into the ward and team Locality Data Packs to flag early warnings of emerging risk issues.

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

The CQC Intelligent Monitoring Report replaced the previous Quality and Risk Profile (QRP) in October 2014. The second draft version of the intelligent monitoring tool has been provided to the Trust for review for factual accuracy and reports Trust performance against a number of indicators based on source data available to the CQC.

The data sources utilised by the CQC are as follows:

- National Reporting & Learning System (NRLS)
- Mental Health & Learning Disability Data Set (MHLDDS)
- Mental Health Act database (MHAdb)
- KP90 report (Mental Health Act activity)
- NHS Staff Survey
- National Patient Survey (community mental health)
- Central Alerting System (CAS)
- Patient Led Assessment of the Care Environment (PLACE)

Assessment – *analysis and considerations of options and risks*

CWP was consistently reviewed as a low risk organisation based on the data sources reported through the previous Quality & Risk Profile. This continues to be evident in the revised Intelligent Monitoring Report (Appendix 1). The data source relating to the Central Alerting System has identified a risk in the April 2015 version of the tool, which includes the following items:

- An alert relating to handover of care, which has now been addressed by policy review and approval by the Patient Safety & Effectiveness Sub Committee in April 2015.
- Two alerts currently open which relate to:
  1. Window blinds with looped cords or chains: Response to this has passed the deadline date, this is currently on the Estates work programme and is expected to be completed within the next 6 weeks.
  2. Reminder for the testing of fire and smoke dampers and ensuring the integrity of fire stopping: This alert requires a significant amount of work to complete it.

It is important to note that currently the Trust does not close CAS alerts unless assurance is received of the full completion/ implementation of action plans, it is understood that some other organisations do (and can as a self-declaration) close CAS alerts once an action plan has been developed and agreed, despite actions for completion remaining outstanding at the time of reporting to CAS.

The Patient Safety & Effectiveness Sub Committee discussed this matter at its meeting in April 2015. It has requested that the Trust's current CAS framework be subject to an options appraisal for review at the next meeting in June 2015. This will clarify response to and monitoring of CAS alerts and will improve communication of expectations described within the alerts.
The Compliance, Assurance & Learning Sub Committee will continue to monitor CAS alerts compliance and assurance.

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

The Board of Directors is asked to **note** the information held within the intelligent monitoring tool and note the action being taken to review the governance around CAS alerts.

Who/ which group has approved this report for receipt at the above meeting?	Anushta Sivananthan, Medical Director/ Executive Lead for Quality
Contributing authors:	Jo Watts, Head of Compliance David Wood, Associate Director of Safe Services

Distribution to other people/ groups/ meetings:

Version	Name/ group/ meeting	Date issued
1	Board of Directors	20/05/2015

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

Appendix no.	Appendix title
1	Intelligent Monitoring Report – (Draft) April 2015

Intelligent Monitoring Report

Report on

Cheshire and Wirral Partnership NHS Foundation Trust

To view the most recent inspection report please visit the link below.

http://www.cqc.org.uk/Provider/RXA

Draft IM version 2

CQC has developed a new model for monitoring a range of key indicators about Trusts that provide Mental Health services. These indicators relate to the five key questions we will ask of all services – are they safe, effective, caring, responsive and well-led? The indicators will be used to raise questions about the quality of care. They will not be used on their own to make judgements. **Our judgements will always be based on the result of an inspection, which will take into account our Intelligent Monitoring analysis alongside local information from the public, the trust and other organisations.**

To view the most recent inspection report please visit the link below.
http://www.cqc.org.uk/Provider/RXA

What does this report contain?

This report presents CQC's analysis of the key indicators (which we call 'tier one indicators') for Cheshire and Wirral Partnership NHS Foundation Trust. We have analysed each indicator to identify two possible levels of risk.

We have used a number of statistical tests to determine where the thresholds of "risk" and "elevated risk" sit for each indicator, based on our judgement of which statistical tests are most appropriate. These tests include Poisson and z scoring techniques. Where an indicator has 'no evidence of risk' this refers to where our statistical analysis has not deemed there to be a risk or elevated risk. For some data sources we have applied a set of rules to the data as the basis for these thresholds - for example concerns raised by staff to CQC (and validated by CQC) are always flagged in the model.

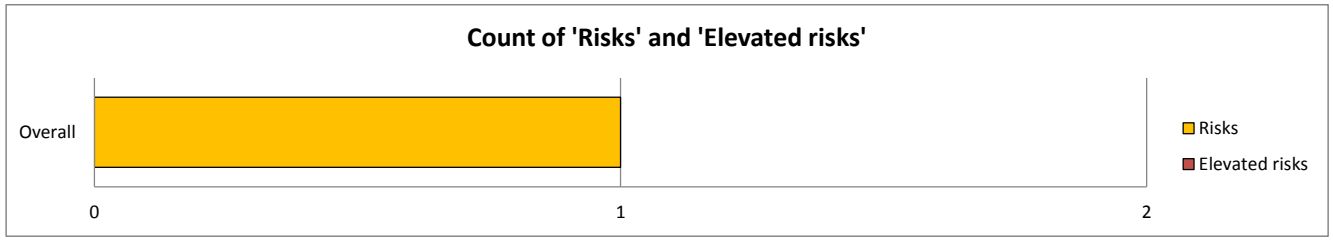
Further details of the analysis applied are explained in the accompanying guidance document.

What guidance is available?

We have published a document setting out the definition and full methodology for each indicator. If you have any queries or need more information, please email enquiries@cqc.org.uk or use the contact details at www.cqc.org.uk/contact-us

Cheshire and Wirral Partnership NHS Foundation Trust

Trust Summary



Band	4
Number of 'Risks'	1
Number of 'Elevated risks'	0
Overall Risk Score	1
Number without "Evidence of risk"	63
Number of Applicable Indicators	64
Proportional Score	0.79%
Maximum Possible Risk Score	127

Risk Composite of Central Alerting System (CAS): Dealing with (CAS) safety alerts in a timely way - CAS

Domain	ID	Indicators - Source	From	To	Observed	Expected	Risk?
Safety	MHSAF07C	Potential under-reporting of patient safety incidents - **NRLS/MHLDDS-HES Bridged**	01/12/2013	30/11/2014	0.07	0.10	No evidence of risk
	MHSAFE06	Proportion of reported patient safety incidents that are harmful - **NRLS**	01/12/2013	30/11/2014	0.53	0.40	No evidence of risk
	MHSAFE63	Patients that die following injury or self-harm within 3 days of being admitted to acute hospital beds - **MHLDDS-HES Bridged**	01/10/2013	30/09/2014	0.00	n/a	No evidence of risk
	MHSAFE64	People that take their own lives within 3 days of discharge from hospital - **MHLDDS-HES Bridged**	01/12/2013	30/11/2014	0.00	0.11	No evidence of risk
	COM_MORT01	Composite indicator showing trusts flagging for risk in relation to the number of deaths of patients detained under the Mental Health Act - **MHLDDS/MHAdb**	01/01/2014	31/12/2014	n/a	n/a	No evidence of risk
	MHMORT01	*Trusts flagging for risk in the number of suicides of patients detained under the Mental Health Act (all ages) - **MHLDDS/MHAdb***	*01/01/2014*	*31/12/2014*	*0.00*	*n/a*	*No evidence of risk*
	MHMORT03	*Trusts flagging for risk in relation to the number of deaths due to natural causes of patients detained under the Mental Health Act (people aged under 75) - **MHA db/HSCIC KP90***	*01/01/2014*	*31/12/2014*	*	*n/a*	*No evidence of risk*
	NHSSTAFF11	Fairness and effectiveness of incident reporting procedures - **NHS Staff Survey**	01/09/2014	31/12/2014	0.64	0.63	No evidence of risk
	NRLSL08	Consistency of reporting to the National Reporting and Learning System - **NRLS**	01/04/2014	30/09/2014	6 months of reporting	n/a	No evidence of risk
	COM_CASMH	Composite of Central Alerting System (CAS): Dealing with (CAS) safety alerts in a timely way - **CAS**	01/04/2004	31/01/2015	n/a	n/a	Risk
	CASMH01A	*The number of alerts which CAS stipulated should have been closed by trusts during the preceding 12 months, but which were still open on the date CQC extracted data from the CAS system - **CAS***	*01/02/2014*	*31/01/2015*	*1-4 alerts still open*	*n/a*	*Risk*
	CASMH01B	*The number of alerts which CAS stipulated should have been closed by trusts more than 12 months before, but which were still open on the date CQC extracted data from the CAS system - **CAS***	*01/04/2004*	*31/01/2014*	*0 alerts still open*	*n/a*	*No evidence of risk*
	CASMH01C	*Percentage of CAS alerts with closing dates during the preceding 12 months which the trust has closed late - **CAS***	*01/02/2014*	*31/01/2015*	*>=25% & <50% alerts closed late*	*n/a*	*Risk*
	MHRES20	Proportion of discharges from hospital followed up within 7 days - **MHLDDS**	01/12/2013	30/11/2014	0.79	0.72	No evidence of risk
	NHSSTAFF07	Proportion of staff receiving health and safety training in last 12 months - **NHS Staff Survey**	01/09/2014	31/12/2014	0.75	0.73	No evidence of risk
	PLACE01	PLACE (patient-led assessments of the care environment) score for cleanliness of environment - **PLACE**	29/01/2014	17/06/2014	0.93	0.98	No evidence of risk
	SAFEGUAR01	CQC's National Customer Service Centre (NCSC) safeguarding concerns - **CQC**	25/02/2014	24/02/2015	12.00	23.79	No evidence of risk
	MHWEL129	Proportion of registered nursing staff - **ESR**	31/12/2014	31/12/2014	0.56	0.52	No evidence of risk
	MHWEL132	Ratio of occupied beds to all nursing staff - **ESR**	31/12/2014	31/12/2014	2.25	2.85	No evidence of risk
Effective	CMHSURA06	Being informed: for having been told who is in charge of organising their care and services - **CMH Survey**	01/09/2013	30/11/2013	8.82	n/a	No evidence of risk
	CMHSURA38	Help finding support for physical health needs: for those with physical health needs receiving help or advice with finding support for this, if they needed this - **CMH Survey**	01/09/2013	30/11/2013	6.14	n/a	No evidence of risk
	MHCAR201	Proportion of patients who have been in hospital less than a year who received a physical health check on admission - **MHA Database**	01/12/2013	30/11/2014	1.00	0.97	No evidence of risk
	MHCAR202	Proportion of wards where there were difficulties in arranging GP services - **MHA Database**	01/12/2013	30/11/2014	0.00	0.13	No evidence of risk
	MHEFF107	Proportion of records checked that show evidence of discharge planning - **MHA Database**	01/12/2013	30/11/2014	0.90	0.72	No evidence of risk
	NAS_PH02	Service users who had five individual cardiometabolic health risk factors monitored in the past 12 months - **NAS2**	01/08/2013	30/11/2013	0.38	0.33	No evidence of risk
	NAS_PH03	Monitoring of alcohol intake in the past 12 months - **NAS2**	01/08/2013	30/11/2013	0.88	0.71	No evidence of risk
	NAS_PT01	Has cognitive behavioural therapy ever been offered to the service user? - **NAS2**	01/08/2013	30/11/2013	0.62	0.41	No evidence of risk
	NAS_PT02	Has family intervention ever been offered to the service user? - **NAS2**	01/08/2013	30/11/2013	0.25	0.20	No evidence of risk
	PLACE02	PLACE (patient-led assessments of the care environment) score for food - **PLACE**	29/01/2014	17/06/2014	0.86	0.90	No evidence of risk
	GMC_MH01	General Medical Council enhanced monitoring - **GMC**	31/03/2015	31/03/2015	No concerns	n/a	No evidence of risk
	NHSSTAFF04	Proportion of staff appraised in last 12 months - **NHS Staff Survey**	01/09/2014	31/12/2014	0.86	0.87	No evidence of risk
	NHSSTAFF05	Proportion of staff having well-structured appraisals in last 12 months - **NHS Staff Survey**	01/09/2014	31/12/2014	0.46	0.41	No evidence of risk
	NHSSTAFF06	Proportion of staff receiving support from immediate managers - **NHS Staff Survey**	01/09/2014	31/12/2014	0.71	0.70	No evidence of risk
	MHSAFE51	The proportion of times that the Responsible Clinician has recorded their assessment of a patients' capacity to consent at first treatment - **MHA Database**	01/12/2013	30/11/2014	0.32	0.65	No evidence of risk
	MHCAR19	Is there a current independent Mental Health Advocate (IMHA) service? - **MHA Database**	01/12/2013	30/11/2014	1.00	0.99	No evidence of risk
	MHCAR20	Do detained patients have direct access to the Independent Mental Health Advocate (IMHA) service? - **MHA Database**	01/12/2013	30/11/2014	1.00	0.94	No evidence of risk
	MHEFF106	Proportion of Approved Mental Health Practitioner (AMHP) reports available - **MHA Database**	01/12/2013	30/11/2014	0.71	0.77	No evidence of risk
	MHSAFE52	Proportion of patients who have their rights on detention explained to them - **MHA Database**	01/12/2013	30/11/2014	0.92	0.90	No evidence of risk

Domain	ID	Indicators - Source	From	To	Observed	Expected	Risk?
Caring	CMHSURA18	Respect and dignity: for feeling that they were treated with respect and dignity by NHS mental health services - **CMH Survey**	01/09/2013	30/11/2013	8.62	n/a	No evidence of risk
	CMHSURA31	Time: for being given enough time to discuss their needs and treatment - **CMH Survey**	01/09/2013	30/11/2013	8.22	n/a	No evidence of risk
	PLACE03	PLACE (patient-led assessments of the care environment) score for privacy, dignity and well being - **PLACE**	29/01/2014	17/06/2014	0.86	0.89	No evidence of risk
	CMHSURA10	Involvement in planning care: for those who have agreed what care and services they will receive, being involved as much as they would like in agreeing this - **CMH Survey**	01/09/2013	30/11/2013	7.94	n/a	No evidence of risk
	CMHSURA12	Involvement in care review: for those who had had a formal meeting to discuss how their care is working, being involved as much as they wanted to be in this discussion - **CMH Survey**	01/09/2013	30/11/2013	7.90	n/a	No evidence of risk
	CMHSURA35	Involvement in decisions: for those receiving medicines, being involved as much as they wanted in decisions about medicines received - **CMH Survey**	01/09/2013	30/11/2013	7.37	n/a	No evidence of risk
	CMHSURA42	Involving family or friends: for NHS mental health services involving family or someone else close to them as much as they would like - **CMH Survey**	01/09/2013	30/11/2013	7.20	n/a	No evidence of risk
	NAS_SD01	Was the patient provided with written information (or an appropriate alternative) about the most recent antipsychotic prescribed? - **NAS2**	01/08/2013	30/11/2013	0.26	0.36	No evidence of risk
	CMHSURA16	Support: for the people seen through NHS mental health services helping them achieve what is important to them - **CMH Survey**	01/09/2013	30/11/2013	6.61	n/a	No evidence of risk
Responsive	COM_BEDS	Composite indicator to assess bed occupancy - **MHA Database/NHS England**	01/12/2013	31/12/2014	n/a	n/a	No evidence of risk
	MHSAF65a	*Occupancy ratio, looking at the number of patients allocated to a location, compared with the number of available beds - **MHA Database***	*01/12/2013*	*30/11/2014*	*0.86*	*n/a*	*No evidence of risk*
	MHSAF65c	*Occupancy ratio, looking at the average daily number of available and occupied beds open overnight - **NHS England***	*01/01/2014*	*31/12/2014*	*0.84*	*n/a*	*No evidence of risk*
	PLACE04	PLACE (patient-led Assessments of the care environment) score for facilities - **PLACE**	29/01/2014	17/06/2014	0.94	0.92	No evidence of risk
	CMHSURA23	Contact: for knowing who to contact out of office hours if they have a crisis - **CMH Survey**	01/09/2013	30/11/2013	7.95	n/a	No evidence of risk
	DTC46	The ratio of the number of patients whose transfer of care is delayed to the average daily number of occupied beds open overnight in the quarter, where the delay is attributable to the NHS and both the NHS and social care - **NHS England**	01/10/2014	31/12/2014	0.01	0.03	No evidence of risk
	MHRES12	Proportion of new IAPT referral requests received where people have waited more than 28 days for first assessment - **IAPT**	01/07/2014	30/09/2014	0.38	0.28	No evidence of risk
	MHRES13	Proportion of new IAPT referral requests received where people have waited more than 28 days for first treatment - **IAPT**	01/07/2014	30/09/2014	0.42	0.36	No evidence of risk
	CQC_COM01	Concerns and complaints received by CQC - **CQC**	25/02/2014	24/02/2015	18.00	29.76	No evidence of risk
	PHSOMH01	Fully and partially upheld investigations into complaints - **PHSO**	01/04/2013	31/03/2014	Less than 3	n/a	No evidence of risk
	PROV_COM01	NHS written complaints - **HSCIC**	01/04/2013	31/03/2014	161.00	229.52	No evidence of risk
Well Led	MONITOR01	Monitor: risk rating for governance - **Monitor**	02/03/2015	02/03/2015	Monitor risk rating: No evident concerns	n/a	No evidence of risk
	TDA03	NHS Trust Development Authority escalation score - **TDA**	Not included	Not included	Not included	Not included	Not included
	FLUVACMH01	Proportion of Health Care Workers with direct patient care that have been vaccinated against seasonal influenza - **Department of Health**	01/09/2013	31/01/2014	0.42	0.41	No evidence of risk
	MHWEL137	Proportion of days sick in the last 12 months for medical and dental staff - **ESR**	01/01/2014	31/12/2014	0.03	0.02	No evidence of risk
	MHWEL138	Proportion of days sick in the last 12 months for nursing and midwifery staff - **ESR**	01/01/2014	31/12/2014	0.06	0.05	No evidence of risk
	MHWEL139	Proportion of days sick in the last 12 months for other clinical staff - **ESR**	01/01/2014	31/12/2014	0.07	0.05	No evidence of risk
	MHWEL140	Proportion of days sick in the last 12 months for non-clinical staff - **ESR**	01/01/2014	31/12/2014	0.04	0.04	No evidence of risk
	NHSSTAFF16	Proportion of staff reporting good communication between senior management and staff - **NHS Staff Survey**	01/09/2014	31/12/2014	0.28	0.31	No evidence of risk
	NHSSTAFF20	Proportion of staff feeling pressure to attend work when feeling unwell in the last 3 months - **NHS Staff Survey**	01/09/2014	31/12/2014	0.19	0.21	No evidence of risk
	NTS12	General Medical Council national training survey – trainee's overall satisfaction - **GMC**	26/03/2014	08/05/2014	Within the middle quartile (Q2/IQR)	n/a	No evidence of risk
	STASURBG01	Proportion of staff who would recommend the trust as a place to work or receive treatment - **NHS Staff Survey**	01/09/2014	31/12/2014	0.67	0.63	No evidence of risk
	MHRES17	Proportion of wards that have community meetings - **MHA Database**	01/12/2013	30/11/2014	1.00	0.92	No evidence of risk
	WBLOW_MH01	Snapshot of whistleblowing alerts received by CQC - **CQC**	04/03/2015	04/03/2015	0.00	n/a	No evidence of risk
	MONITOR02	Monitor: continuity of service rating - **Monitor**	02/03/2015	02/03/2015	4: no evident concerns	n/a	No evidence of risk

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

STANDARDISED REPORT COMMUNICATION

REPORT DETAILS

Report subject:	Learning from Experience report – trimester 3 2014/15
Agenda ref. no:	15/16/17
Report to (meeting):	Board of Directors – meeting in public
Action required:	Discussion and approval
Date of meeting:	27/05/2015
Presented by:	Avril Devaney, Director of Nursing, Therapies & Patient Partnership

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

REPORT BRIEFING

1. Situation

This report compares current performance across a 4 trimester time series to mitigate seasonal variations, whilst also facilitating the identification of potential triggers to detect and prevent incidents by comparing current performance with the previous trimester.

2. Background – Key performance indicators

Performance indicator		**2013/14**	**2014/15**			**Change from T2**
		T3	**T1**	**T2**	**T3**	
Number of patient safety incidents reported		2514	2673	2368	2598	↑
Severity	Category A	11	26	33	23	↓
	Category B	33	18	37	45	↑
	Category C	409	313	306	419	↑
	Category D	786	847	734	817	↑
	Category E	1220	1469	1258	1294	↑

Performance indicator			2013/14	2014/15			Change from T2
			T3	T1	T2	T3	
	Reporting of Injuries, Diseases and Dangerous Occurrences Regulations		10	9	1	7	↑
	NHS Litigation Authority – NHSLA	Non clinical claims	2	2	9	11	↑
		Clinical claims	0	0	1	1	=
	National Reporting and Learning System		1055	809	685	540	↓
Number of complaints			85	70	69	83	↑
Acknowledgement of complaints within 3 days			95%	99%	100%	99%	↓
Number of compliments			864	927	825	847	↑

All incident associated and compliment numbers represent a snapshot at the time of publication of the report 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.

3. Assessment

3.1 Incident reporting

All incidents involving patient safety are reported to the *National Reporting and Learning System* [*NRLS*]. CWP's incident team has met with Patient Safety Reporting Lead, NHS England to improve the data quality uploaded onto the *NRLS*. CWP completed an action plan which has resulted an increase in the number of incidents uploaded onto *NRLS* in the last trimester. Increases in incident reporting are encouraged, in line with best practice. The number of incidents reported this trimester is 8% more than the overall average number of incidents reported in the last trimester. Category A incident reports have decreased, whilst category B incident reports have increased, though not significantly. The lower harm categories of incidents continue to be the highest number of reported incidents and are showing increases, which is a positive indicator in relation to patient safety. Further analysis of category A and B incident data continues to be analysed by locality Quality Surveillance Support Managers.

3.2 Falls incidents

There has been a minor increase in falls incidents since the last trimester, from 145 to 151. Longitudinally, the number of falls incidents has increased by 4% since trimester 2 in 2013/14. This is in part as a consequence of the risk treatment plan in place as part of management of this risk through the corporate assurance framework process. Most frequently reported severity of falls has been category E [near miss/ prevented] patient safety incidents. There was 1 grade B fall reported, a patient fell and fractured their hip. The patient has recovered from the fracture and a root cause analysis investigation is currently underway. There were 3 category C incidents reported as in the last trimester. There were no category A incidents for falls in 2014/15. Work is ongoing on the inpatient units to promote the identification of those patients who are at risk of falls and further to ensure suitable interventions have been undertaken. Work is planned in quarter 2 of 2015/16 to pilot new documentation to assess risk and to help to develop care plans. Work is planned to start in May 2015 to focus on those patients in the community who may be at risk of falls, ensuring that they are identified and referred to appropriate services.

3.3 Medicines incidents

The total number of medicines incidents this trimester is 117; this is a 12% decrease from last trimester 2. Continuing the trend noted in the previous report, each service reported a decrease in the number of medicines-related incidents in trimester 3 when compared with the four trimester average. The exceptions to this were *Physical Health West* (same number of incidents as the average) and *Learning Disability Services* (two additional incidents compared to the average number). There has been a decrease in the number of incidents related to the Drug & Alcohol services. The likely cause of this is that the number of contracts the Trust operates has reduced from three to one.

3.4 Complaints, PALS, compliments

83 complaints were received under the NHS complaints procedure during the trimester. Of these, they were received per locality as follows: *CWP East* 25 complaints, *CWP West* 34 complaints, *CWP Wirral* 23 complaints, *CWP Clinical/ Corporate Support* 1 complaint. This trimester there has been a slight increase of PALS contacts to 174 contacts handled this trimester and 172 in trimester 2. The PALS officer continues to work with services to ensure that concerns are dealt with quickly and try to resolve locally if possible.

3.5 Management of challenging behaviour

Restraint features strongly in the ward Locality Data Packs, which were issued for the first time at the end of April. The Locality Data Packs have been developed as part of CWP's zero harm strategy, to report quality and safety indicators under the CQC 5 domains to enable ward and team managers to celebrate best practice areas and focus on any areas for improvement. A minimum data set for reporting against this area of safety has been agreed and will be included in the packs – over time the Learning from Experience report will build up longitudinal trend analysis data for review and assurance. All staff are educated to use a graduated approach to the management of safe environments which can then be evidenced and supported through service user led management plans.

4. Recommendation

4.1 Recommendations from trimester 3 analysis

	Recommendation	Action	By Whom	When
1	As part of the review of the Trust's incident reporting and management policy, the CWP incidents team should draft supporting documentation and should pilot human factors questions as part of reflective review/ investigatory learning documentation.	Policy is being updated in line with the new NHS England framework. Tools for investigation will be developed to include questions which relate to safe clinical human factors practices.	Head of Clinical Governance/ Associate Director of safe Services	This is currently being tested and piloted. The policy will be uploaded to the policy discussion board by 30 May 2015.
2	Trustwide, new learning from incidents to be demonstrated, underpinned by Human Factors. Recurrent themes to be mitigated through appropriate identification of actions, mitigation of confirmation bias, enabling and supporting staff to mitigate contributory factors to incidents to ensure that the right learning is identified in relation to index cases and this is shared effectively (contextual learning) across localities.	A thematic surveillance system should be identified and implemented collectively between the Safe Services Department, Educations CWP and localities to track improvement actions from incident investigation.	Locality Quality Surveillance Managers/ Head of Clinical Governance/ CWP Education	Commence May 2015
3	To review the benefits of actions that were agreed to improve investigation management processes during trimester 1.	To meet with commissioners at the end of trimester 2 to review the benefits of the actions agreed	Director of Nursing, Therapies & Patient Partnership/ Medical Director/ Associate Director of Safe Services	November 2015

4	To scope and cost options for providing more support to staff through access to a clinical expert champion and bank investigatory staff.	An options appraisal to be considered by the executive team regarding introducing capacity for investigation management. .	Head of Clinical Governance	June 2015
5	To address the reasons for failure to administer medicines. This should promote that staff employ approaches that ensure frequency of 'failure to administer' is minimised. This action plan should to come to the Medicines Management Group every two months to assess improvement through a reduction in reported incidents in this sub-category.	Each locality to formulate a robust improvement plan to minimise 'failure to administer' incidents.	Pharmacy Team/ localities	June 2015
6	Antibiotics should be prescribed in line with the antibiotic formulary and only if clinically appropriate.	Pharmacy Team to alert prescribers of this, continue to monitor and escalate as necessary.	Pharmacy Team	May 2015
7	Junior Doctors need to be more aware of the medicines reconciliation process.	The Pharmacy Team to put more emphasis on the medicines reconciliation process at junior doctor induction.	Pharmacy Team	The next induction (August 2015)
8	For Band 5 staff and above to receive training on themes from complaints, incidents in workshops using case based scenarios.	For complaints feedback themes to be referenced in the upcoming schedule of case based scenario care planning workshops for all Band 5 and above clinical staff Trustwide.	Effective Care PlanningLead	To commence May 2015
9	For staff to receive further targeted training in relation to the management of challenging behaviour.	Awareness training for the management of challenging behaviour to be introduced through Education CWP courses and also through the scheduled clinical trainers inpatient drop in sessions.	CWP Education/ Clinical Trainers	June 2015

4.2 Updates and assurances received against trimester 2 recommendations

Recommendation:
The Director of Nursing, Medical Director and Associate Director of Safe Services to meet with commissioners to discuss potential new ways of working within current capacity to bring about better outcomes rather than addressing the current issue of requesting extensions to investigations by adding process focussed capacity.

Update: The above meeting took place where a strategy was agreed between CWP and the commissioners where investigations should be proportionate to the incident. It has been agreed that incidents categorised A will still require a full Root Cause Analysis. Incidents categorised B will be investigated using a concise review. These latter reports will not need to be submitted to the CCG, however, a report will be produced to analyse the learning themes that have evolved. If there are recurrent themes, then in agreement between CWP and the CCG a cluster analysis/ themed analysis will be undertaken using Root cause Analysis methodology.

Recommendation:
The Pharmacy Team should request that each locality formulate a robust action plan to address the reasons for failure to administer medicines. This should promote that staff employ approaches that ensure frequency of 'failure to administer' is minimised. This action plan should to come to the Medicines Management Group every two months to assess improvement through a reduction in reported incidents in this sub-category.

Update: This is under review and is overseen by the Medicines Management Group. Medicines incidents do appear to be reducing. This will continue to be reviewed during the next trimester and will be reported on again in the trimester 1 report 2015/16.

The Pharmacy Team should identify means of reminding teams of the importance of monitoring room and fridge temperatures where medication is stored and report any excursions of fried temperatures outside the recommended range promptly. This is a CQC outcome 9 requirement.

Update: This is currently being reviewed in each locality and will be reported in the trimester 1 report 2015/16.

Matrons should work with their wards to identify mechanisms for staff involved in the administration of medication being afforded more protected time in carrying out administration of medicines as per the inpatient drug chart in order to reduce the incidence of avoidable errors.

Update: This is currently underway and will be reported in the trimester 11 report 2015/16.

The Safe Services Department should:

- Implement a process of peer support for new investigating managers.
- Update the complaints policy to include a process of offering support to those people whose complaint against the Trust has been upheld.

Update: The complaints policy has been approved and it includes a process of offering support to those people whose complaint against the Trust has been upheld.

The Incidents and Complaints Manager should work together with the Safety, Security & Clinical Education Lead to develop the Datix incident reporting system to better record the details of incidents of restraint. The focus will be to ensure the reporting codes are clear and that staff are able to record why they have used the technique that has been used. This will specifically focus on prone restraint.

Update: The Incidents and Complaints Manager has worked with the Safety, Security & Clinical Education Lead to develop the Datix incident reporting system. This has led to improved reporting which is clearer regarding why someone has been restrained using the prone position. There is a post incident evaluation currently being undertaken. This is to help to get a deeper understanding of restraint incidents, the impact on patients and staff. Prone position restraints are being monitored via an accelerating restraint reduction quality improvement task and finish group. There is a current project plan in place. Each time prone position restraint is used, the Matron co-ordinates a reflective review and a questionnaire undertaken with the patient. This is discussed at the weekly meeting of harm to ensure senior oversight.

4.3 Recommendation to the Board of Directors

The Board of Directors is asked to **approve** the report and **endorse** the recommendations contained within.

Who/ which group has approved this report for receipt at the above meeting?		Director of Nursing, Therapies & Patient Partnership Associate Director of Safe Services
Contributing authors:		Audrey Jones, Head of Clinical Governance David Wood, Associate Director of Safe Services
Distribution to other people/ groups/ meetings:		
Version	Name/ group/ meeting	Date issued
1	Board of Directors	20/05/2015

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

STANDARDISED REPORT COMMUNICATION

REPORT DETAILS

Report subject:	Ward Daily Staffing Levels April 2015
Agenda ref. no:	15/16/18
Report to (meeting):	Board of Directors
Action required:	Information and noting
Date of meeting:	27/05/2015
Presented by:	Avril Devaney, Director of Nursing, Therapies and Patient Partnership

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

REPORT BRIEFING

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

This report details the ward daily staffing levels during the month of April 2015.The planned and actual hours for registered nurses (RN) and clinical support workers (CSWs) for April 2015 have been submitted to UNIFY using the template supplied by NHS England (appendix 1). The themes arising within this monthly submission continue to mirror those that have arisen previously. These themes identify how patient safety is being maintained on a shift by shift basis.

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

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

Assessment – *analysis and considerations of options and risks*

During April 2015 patient safety was maintained by nurses working additional unplanned hours, nursing staff cross covering across wards, the multi-disciplinary team and ward manager supporting nursing staff in the delivery of planned care and patient care being prioritised over non-direct care activities.

Recruitment of both registered and non-registered nursing staff has been continual over the past 18 months and continues to be a significant issue in the East and West localities. Planned over recruitment and refined recruitment practices are anticipated to improve this situation moving forward.

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

The Board of Directors are recommended to note the report.

Who/ which group has approved this report for receipt at the above meeting?	Ward Staffing Project Team
Contributing authors:	Maria Nelligan

Distribution to other people/ groups/ meetings:

Version	Name/ group/ meeting	Date issued
Click here to enter text.	Click here to enter text.	Click here to enter text.

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

Appendix no.	Appendix title
1	Ward daily staffing

	Ward	Day				Night				Fill Rate				Comment
		Registered midmives/nurses		Care Staff		Registered midmives/nurses		Care Staff		Day		Night		
		Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Average fill rate - registered nurses (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses (%)	Average fill rate - care staff (%)	
East	Adelphi	1277	1116	1642.5	1524	713	713	1161.5	1092.5	87.4%	92.8%	100.0%	94.1%	Nursing staff have worked additional hours, the ward manager has worked within the clinical team and the multidisciplinary team have supported the ward in maintaining safe staffing levels. Some non-direct care activity was cancelled.
	Alderley Unit	933.5	910	1325.25	1319.3	609.5	621	793.5	770.5	97.5%	99.6%	101.9%	97.1%	*
	Bollin	1458.5	1332.25	1528	1404.5	828	1000.5	1363	1213.5	91.3%	91.9%	120.8%	89.0%	Non-direct patient care activities cancelled. The ward also provided cross cover to other wards.
	CARS	1132.35	1078.25	1232	1205.5	713	644	690	684	95.2%	97.8%	90.3%	99.1%	Non-direct patient care activities cancelled. The ward also provided cross cover to other wards.
	Croft	1196.5	1165	1928.5	1623	717	682.5	1732	1559.5	97.4%	84.2%	95.2%	90.0%	To maintain safe staffing levels nursing staff worked additional hours and non-direct patient care activities cancelled.
	Greenways A&T	1346	1200.5	1632.1	1693	690	701.5	690	655.5	89.2%	103.7%	101.7%	95.0%	Safe staffing levels were maintained be altering skill mix.
	LimeWalk Rehab	969.75	946.7	1244.5	1175.5	690	690	702.5	648	97.6%	94.5%	100.0%	92.2%	Adhoc support was sought from other wards to maintain safe staffing levels.
	Saddlebridge	813	778.5	1396	1288	632.5	621	770.5	759	95.8%	92.3%	98.2%	98.5%	To maintain safe staffing levels nursing staff worked additional hours.
Wirral	Brackendale	978.5	758.5	1035	1039	690	655.5	690	793.5	77.5%	100.4%	95.0%	115.0%	Nursing staff have worked additional hours and the ward manager has worked in the clinical team to maintain safe staffing levels.
	Lakefield	1104.5	1102.95	1046.5	943	667	667	701.5	1023.5	99.9%	90.1%	100.0%	145.9%	To maintain safe staffing levels nursing staff worked additional hours.
	Meadowbank	1425	1065.5	1725	2228.5	690	558	1380	1503	74.8%	129.2%	80.9%	108.9%	To maintain safe staffing levels nursing staff worked additional hours and non-direct patient care activities cancelled.
	Oaktrees	1097.5	1090	1207.5	1138.5	701.5	655.5	339	350.5	99.3%	94.3%	93.4%	103.4%	Nursing staff have worked additional hours and the ward manager has worked in the clinical team to maintain safe staffing levels.
	Brooklands	1065.4	1001.4	1079	1017	644	655.5	621	771.4	94.0%	94.3%	101.8%	124.2%	Nursing staff have worked additional hours and the ward manager has worked in the clinical team to maintain safe staffing levels.
West	Beech	1404.5	1316.5	1184.5	1058	678.5	609.5	713	690	93.7%	89.3%	89.8%	96.8%	To maintain safe staffing levels nursing staff worked additional hours and non-direct patient care activities cancelled.
	Cherry	1173	1060	1127	1028.5	747.5	632.5	1012	908.5	90.4%	91.3%	84.6%	89.8%	Support was sought form other wards to maintain safe staffing levels.
	Eastway A&T	1052.5	1009.5	1474.5	1556.5	685.5	727	999	904.25	95.9%	105.6%	106.1%	90.5%	To maintain safe staffing levels nursing staff worked additional hours and non-direct patient care activities cancelled.
	Juniper	1217	1079	1046.5	1000.5	575	483	805	782	88.7%	95.6%	84.0%	97.1%	To maintain safe staffing levels nursing staff worked additional hours and non-direct patient care activities cancelled.
	Maple Ward	1158	1108.5	1279	1129.5	552	609.5	839.5	828	95.7%	88.3%	110.4%	98.6%	To maintain safe staffing levels nursing staff worked additional hours. On occasions patient activties have had to be cancelled or shortened.
	Pine Lodge (YPC)	1285.5	1195.5	920	908.5	471.4	483	805	816.5	93.0%	98.8%	102.5%	101.4%	Adhoc support was sought from other wards to maintain safe staffing levels.
	Rosewood	1291.5	1239	1472	1207.5	690	540.5	690	740.5	95.9%	82.0%	78.3%	107.3%	Safe staffing levels were maintained be altering skill mix.
	Willow PICU	912.5	952.25	885.5	816.4	690	483	667	816.5	104.4%	92.2%	70.0%	122.4%	Safe staffing levels were maintained be altering skill mix.
	Trust wide	24292	22505.8	27410.85	26304.2	14075.4	13433	18165	18310.65	92.6%	96.0%	95.4%	100.8%	

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

STANDARDISED REPORT COMMUNICATION

REPORT DETAILS

Report subject:	Monitor Quality Governance Framework self assessment – quarter 4 and year-end 2014/15
Agenda ref. no:	15/16/19
Report to (meeting):	Board of Directors – meeting in public
Action required:	Discussion and approval
Date of meeting:	27/05/2015
Presented by:	Dr Anushta Sivananthan – Medical Director/ Executive Lead for Quality

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

REPORT BRIEFING

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

To provide an update on the Trust's current quarter 4 and year-end position with respect to the *Monitor* Quality Governance Framework. Scrutiny against this framework provides the Board of Directors with assurance that the organisation is working effectively to improve patient care. The Board's self assessment of the framework is referred to in the Annual Governance Statement, for which internal audit provide an opinion, for 2014/15 no significant control issues were identified. This is, in effect, the *Monitor* equivalent of the *Care Quality Commission*'s well-led domain. This quarter 4/ year-end self-assessment concludes that there are **no concerns regarding the Trust's quality governance arrangements**, however improvements are required to return the 'Measurement' (use of data/ data quality domain) to 'green' (currently 'amber/ green). Actions to achieve this are identified within *Appendix 1* and also aligned with the strategic risk register. Ratings are reviewed each quarter and further actions identified if the said quality area has not returned to 'green'.

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

The Quality Governance Framework helps Boards to understand what is required of its internal assurance mechanisms for assuring the organisation wide processes for governing quality, with a view to improve decision making and to support Boards in discharging their responsibilities to improve care for patients. It helps Boards to consider and assess the assurance on the following quality governance systems and processes:

1. *Engagement on quality* – does the Board provide a clear steer on the strategic and operational quality outcomes it expects the organisation to achieve?
2. *Gaining insight and foresight into quality* – how is the Board assured that it is receiving the right type and level of quality information?
3. *Accountability for quality* – what are the key sources of assurance upon which the Board is reliant?
4. *Managing risks to quality* – are the corporate Assurance Framework and local risk registers effective in capturing the risks to quality with the Trust?

Assessment – *analysis and considerations of options and risks*

CWP has a sound history of rigorous challenge of this framework, by undertaking a quarterly self-assessment to provide assurance that governance arrangements are contemporary and fit for purpose. To further strengthen this rigour, and in support of the rigorous review of specific aspects of governance as described in *Monitor*'s Well-led framework for governance reviews: guidance for NHS foundation trusts, CWP applies indicative scoring against each quality area/ well-led domain. Whilst *Monitor* guidance around this scoring is primarily in relation to aspirant foundation trusts, applying this scoring methodology increases transparency of the current Trust position and acts as an early warning framework in relation to emerging risks/ gaps. This will also mitigate risks that have been identified nationally from 'well-led governance reviews' to-date in relation to minimal interrogation of 'green' key performance indicators and data quality.

Appendix 1 details that all quality areas are assessed as being 'green' this quarter and therefore at year-end, with the exception of the 'Measurement' domain whose quality areas are assessed as 'amber/ green'. This equates to the Trust's current summative score of 1.5 [a score greater than 3.5 would indicate concerns regarding a Trust's quality governance arrangements].

A number of improvement actions have been identified in *Appendix 1*, irrespective of the rating of the quality areas, demonstrating the Trust's aspiration to achieve continuous improvement.

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

The Board of Directors is invited to comment on the self-assessment attached as *Appendix 1* and, subject to any recommended changes, **approve** and adopt it as the Trust position.

Who/ which group has approved this report for receipt at the above meeting?	Board of Directors – business cycle requirement
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	20/05/2015

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

Appendix no.	Appendix title
1.1	*Monitor* Quality Governance Framework – annual self assessment 2014/15
1.2	Self assessment evidence against *Monitor* Quality Governance Framework as at Q4 2014/15 and year-end position

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

15_16_19_Appendix 1.1: *Monitor* Quality Governance Framework – annual self assessment 2014/15

Following a review of *Monitor*'s Quality Governance Framework, the following self assessment has been completed. Below is a summary of each area, with a self assessment RAG rating. A comprehensive assessment is outlined in *Appendix 1.2*, detailing information used to formulate this assessment and areas that may required further development, with suggested actions.

QUALITY AREA/ WELL-LED DOMAIN		Self assessment (RAG) rating 2013/14				
Strategy		**Q1**	**Q2**	**Q3**	**Q4/ year-end**	
1a	Does quality drive the trust's strategy?	GREEN	GREEN	GREEN	GREEN	
1b	Is the Board sufficiently aware of potential risks to quality?	GREEN	GREEN	GREEN	GREEN	
Capabilities and culture						
2a	Does the Board have the necessary leadership and skills and knowledge to ensure delivery of the quality agenda?	GREEN	GREEN	GREEN	GREEN	
2b	Does the Board promote a quality-focused culture throughout the Trust?	GREEN	GREEN	GREEN	GREEN	
Processes and structure						
3a	Are there clear roles and accountabilities in relation to quality governance?	GREEN	GREEN	GREEN	GREEN	
3b	Are there clearly defined, well understood processes for escalating and resolving issues and managing performance?	GREEN	GREEN	GREEN	GREEN	
3c	Does the Board actively engage patients, staff and other key stakeholders on quality?	GREEN	GREEN	GREEN	GREEN	
Measurement						
4a	Is appropriate quality information being analysed and challenged?	GREEN	GREEN	GREEN	AMBER/	GREEN
4b	Is the Board assured of the robustness of the quality information?	GREEN	GREEN	GREEN	AMBER/	GREEN
4c	Is quality information being used effectively?	GREEN	GREEN	GREEN	AMBER/	GREEN
SUMMATIVE SCORE		**0.0**	**0.0**	**0.0**	**1.5**	

The rating scale is explained below:

RAG		**Indicative score** [based on *Monitor*'s rating scale]	**Definition**
Individual scores			
GREEN		0.0	Meets or exceeds expectations. Many elements of good practice. No major omissions.
AMBER/	**GREEN**	0.5	Partially meets expectations but confident in management's capacity to deliver green performance within reasonable timeframe.
AMBER/	**RED**	1.0	Partially meets expectations but some concerns on capacity to deliver within a reasonable timeframe.
RED		4.0	Does not meet expectations.
Overall score			
GREEN		0.0 – 3.5	No concerns regarding quality governance arrangements.

RED	4.0 – 5.0	Concerns regarding quality governance arrangements.

Appendix 1.2 – Self assessment evidence against *Monitor* Quality Governance Framework as at Q4 2014/15 and year-end position

Quality area	Trust assurance mechanisms/ Response	Self assessment	Actions from Q3 with update	Further actions for completion by end Q1 2015/16
1. Strategy				
1a: Does quality drive the Trust's strategy?	• Quality is embedded in the Trust's overall strategy. ▪ Overall vision '*Leading in partnership to improve health and well-being by providing high quality care'.* ▪ The Trust's vision and strategy comprises a number of Trustwide quality goals covering patient safety, clinical effectiveness and patient experience which drive year on year improvement. ▪ Quality goals reflect local as well as national priorities, reflecting what is relevant to patients and staff – forward planning events and working with commissioners and other local scrutineers on development of quality priorities help identify priorities. ▪ Overall Trustwide quality goals link directly to goals in localities/ services [which will be tailored to the specific service] – as part of annual and strategic plans and clinical strategies. • Quality goals are communicated as part of quality accounts, regular quality reporting, via Clinical Directors at Quality Committee [via	**GREEN**	None.	No further actions.

Quality area	Trust assurance mechanisms/ Response	Self assessment	Actions from Q3 with update	Further actions for completion by end Q1 2015/16
	a quality dashboard], and as part of clinical service performance reviews. • CWP performance dashboard has quality section.			
1b: Is the Board sufficiently aware of potential risks to quality	• The Board regularly assesses and understands current and future risks to quality and is taking steps to address them. Risks are aligned to annual and strategic plans. • The Board regularly reviews quality risks in an up-to-date strategic risk register and corporate assurance framework, which has been mapped to the strategic objectives for the Trust. • The strategic risk register is supported and fed by quality issues captured in locality/ service risk registers – there is a process of escalation in place for 'red' rated risks on the clinical service risk registers to be considered for inclusion on the strategic risk register. • The risk register covers potential future external risks to quality [e.g. new techniques/ technologies, competitive landscape, demographics, policy change, funding, regulatory landscape] as well as internal risks – risks are aligned to the annual planning process, which looks at external risks.	**GREEN**	Development of a standardised report communication to explicitly correlate information within corporate and locality reports with potential risks to quality. *Standardised report communication successfully developed and implemented across corporate meetings. It is also available for locality use via the Intranet as the Trust's new report template. Each report considers "Does this report indicate any new strategic risks? If so, describe and indicate risk score".* **Associate Director of Safe Services** **COMPLETED**	No further actions.

Quality area	Trust assurance mechanisms/ Response	Self assessment	Actions from Q3 with update	Further actions for completion by end Q1 2015/16
	• There is clear evidence of action to mitigate risks to quality – actions on the risk register are monitored by the Safe Services Department. • Proposed initiatives are rated according to their potential impact on quality [e.g. clinical staff cuts would likely receive a high risk assessment] – service change/ new service developments are subject to quality impact assessments. • There is an appropriate mechanism in place for capturing frontline staff concerns.			
2. Capabilities and culture				
2a: Does the Board have the necessary leadership, skills and knowledge to ensure delivery of the quality agenda?	• The Board is assured that quality governance is subject to rigorous challenge, including full NED engagement and review – NEDs chair Quality Committee and Audit Committee. • Board development programme in place. • Board seminars in place which allow time to debate issues on quality and assurance – this has included "well-led". • Board members have attended training sessions covering the core elements of quality governance and continuous improvement.	**GREEN**	Board seminar to be scoped and delivered [February 2015] as a follow up to the new clinical and professional leadership structure implemented 2013/14 to ensure capacity and effectiveness in relation to ensuring well-led services. *Board seminar on "well-led" and "clinical leadership" delivered in February 2015 by Associate Director of Safe Services and Medical Director [Effectiveness & Medical Workforce] respectively. Attended by clinical and professional leads.*	Board seminar to be scoped and delivered [April 2015] as a follow up to the annual risk training for senior managers in 2013/14 in relation to Human Factors to ensure the underpinning principles of communication and teamwork are debated to support delivery of the quality agenda. **Medical Director [Quality]/ Associate Director of Safe Services**

Quality area	Trust assurance mechanisms/ Response	Self assessment	Actions from Q3 with update	Further actions for completion by end Q1 2015/16
			Medical Director [Effectiveness & Medical Workforce]/ Director of Nursing, Therapies & Patient Partnership/ Head of Corporate Affairs **COMPLETED**	
2b: Does the Board promote a quality focused culture throughout the Trust?	• Quality Committee chaired by NED, attendance by Executive team and other NEDs. • The Board takes a proactive approach to improving quality [e.g. it actively seeks to apply lessons learnt in other Trusts and external organisations]. • The Board regularly commits resources [time and money] to delivering quality initiatives – e.g. QIPP agenda discussions, zero harm continuous quality improvement cultural programme. • The Board is actively engaged in the delivery of quality improvement initiatives [e.g. some initiatives led personally by Board members]. CQUIN monies reinvested into QIPP and continuous quality improvement programmes. • NED involvement in compliance visit schedule. • Staff are encouraged to participate in quality/ continuous improvement training and development – the	**GREEN**	Patient safety cultural assessments to be rolled out during quarters 2 and 3 [this has been amended to July 2015 to align with Board business cycle] at ward and team levels to inform baseline in order to demonstrate shift of culture during way points of the zero harm continuous improvement cultural programme. *Organisational baselines have been scoped using the current and previous NHS staff surveys and incident reporting associated questions. Appropriate cultural assessments will be scoped and implemented as per ongoing Zero Harm implementation plan.* **Safe Services Department supported by zero harm 'culture carriers' in**	No further actions.

Quality area	Trust assurance mechanisms/ Response	Self assessment	Actions from Q3 with update	Further actions for completion by end Q1 2015/16
	Trust has reviewed its essential learning programme underpinned by patient safety following Berwick review and also the zero harm implementation plan is underpinned by a learning and development programme. • Staff feel comfortable reporting harm and errors [these are seen as the basis for learning, rather than punishment] – positive feedback from staff survey, which is reviewed at Operational Board level and National Reporting and Learning System data stating that CWP reports incidents in line with other Trusts in its benchmarked cluster. • Staff are entrusted with delivering the quality improvement initiatives they have identified [and held to account for delivery – link to annual and strategic plans]. • Internal communications [e.g. monthly newsletter, intranet, notice boards] regularly feature articles on quality – quarterly quality report, three times per year learning from experience report.		**partnership with ward and team managers** **IN PROGRESS**	
3. Structures and processes				
3a: Are there clear roles and accountabilities in relation to quality governance?	• Each and every Board member understands their ultimate accountability for quality – discussed at Board seminars and as part of the self assessment	**GREEN**	Action identified following governance workshop for localities to draw up a forward plan to include what help and support is needed to help the new clinical and professional	Review areas for improvement identified within the locality well-led assurance frameworks and deliver a programme of seminars during the

Quality area	Trust assurance mechanisms/ Response	Self assessment	Actions from Q3 with update	Further actions for completion by end Q1 2015/16
	process and signed off by Board as part of the Annual Governance Statement. • The governance structure is in place within the Trust with committees/ sub committees with clear terms of reference, outlining roles and responsibilities in relation to quality. • Quality is a core part of main Board meetings, both as a standard agenda item and as an integrated element of all major discussions and decisions. • Quality performance is discussed in more detail each month by a quality focused Board sub committee. Quality Committee meets every two months but any issues requiring discussion in relation to quality are brought to Operational Board which meets monthly.		structure deliver on their roles and accountabilities in relation to quality governance. This will inform the development of a "good governance" framework as a resource tool for localities. *This was captured as part of Board seminar on "well-led" delivered in February 2015 by Associate Director of Safe Services. Attended by clinical and professional leads. Assurance framework subsequently developed to identify areas for improvement – see further actions identified in next column.* **Clinical Directors – locality and specialty, Service Directors, General Managers supported by Safe Services Department senior managers** **COMPLETED**	2015/16 to support Clinical Directors with their roles and accountabilities in relation to quality governance. **Medical Director [Quality]/ Associate Director of Safe Services**
3b: Are there clearly defined, well understood processes for escalating and resolving issues and managing performance?	• Boards are clear about the processes for escalating quality performance issues to the Board – performance dashboard in place. • Process for escalation of risks to the Board is outlined in Integrated Governance Strategy. • Process for escalation of incidents to Board is outlined in Incident reporting and management policy –	**GREEN**	None.	No further actions.

Quality area	Trust assurance mechanisms/ Response	Self assessment	Actions from Q3 with update	Further actions for completion by end Q1 2015/16
	level 3 incidents reported to Board and actions followed up by Quality Committee. • Robust action plans are put in place to address quality performance issues [e.g. including issues arising from serious incidents and complaints] – monitored by Compliance, Assurance and Learning Sub Committee. • Lessons from quality performance issues are well-documented and shared across the Trust on a regular, timely basis - communicated via learning from experience report. • There is a proactive healthcare quality improvement programme in place aligned to national audit priorities, contractual requirements and quality priorities identified by the Trust. • There is also scope for undertaken reactive audits/ re-audits linked to risks. • There is an internal audit programme in place, which links to quality. • An error reporting process is in place.			
3c: Does the Board actively engage patients, staff and other key	• Quality outcomes are made public [and accessible] regularly, and include objective coverage of both good and poor performance –	**GREEN**	Appointment of an Associate Director of Patient & Carer Experience to strengthen engagement of patients and	No further actions.

Quality area	Trust assurance mechanisms/ Response	Self assessment	Actions from Q3 with update	Further actions for completion by end Q1 2015/16
stakeholders on quality?	quality report and learning from experience report presented to public Board. Inpatient safety metrics results presented on all inpatient wards for staff/ patients/ visitors to see. • The Board actively engages patients on quality, e.g. - Patient feedback is actively solicited, made easy to give and based on validated tools, e.g. surveys, patient stories, video diaries, PALS, real time patient experience. - Patient views are proactively sought during the design of new pathways and processes - via surveys/ focus groups, attendance at annual planning events. - All patient feedback is reviewed on an ongoing basis, with summary reports reviewed regularly by the Board – learning from experience report looks at patient feedback via PALS/ complaints. - The Board regularly reviews and interrogates complaints and serious incident data – via the learning from experience report three times per year and standing agenda items reviewing SUIs/ complaints.		other stakeholders, including carers, on quality. *Associate Director of Patient & Carer Experience in post and is identifying actions required in this area of quality, these will feature in subsequent self assessments as they emerge.* **Director of Nursing, Therapies & Patient Partnership** **COMPLETED**	

Quality area	Trust assurance mechanisms/ Response	Self assessment	Actions from Q3 with update	Further actions for completion by end Q1 2015/16
	- The Board uses a range of approaches to 'bring patients into the Board room', e.g. patient stories. • Staff are encouraged to provide feedback on an ongoing basis, as well as through specific mechanisms – staff blog, annual staff survey, training feedback. • The Board actively engages all other key stakeholders on quality, e.g. - Quality performance is clearly communicated to commissioners to enable them to make educated decisions via contract meetings, reports. - Feedback from PALS and local Healthwatch organisations is considered - Healthwatch commentary on quality accounts, feedback from annual planning events, consultations on new service developments etc., PALS talkback. - For care pathways involving GP and community care, discussions are held with all providers to identify potential issues and ensure overall quality along the pathway - Trust working with clinical commissioning groups and via clinical networks.			

Quality area	Trust assurance mechanisms/ Response	Self assessment	Actions from Q3 with update	Further actions for completion by end Q1 2015/16
	- The Board is clear about Governors' involvement in quality governance – with meetings structure in place. • Public consultation sought on service changes identified as part of annual and strategic planning priorities.			
4. Measurement				
4a: Is appropriate quality information being analysed and challenged?	• The Board reviews a monthly 'dashboard' of metrics outlined within the performance dashboard. • The Quality Committee reviews quality and safety metrics displayed in a quality dashboard. • Quality information can be analysed and challenged at the individual team level – as part of CAREnotes reporting and data quality/ control. • External assessment/ data delves take place as part of Quality Account auditing and external and internal audit programmes.	**AMBER/ GREEN**	Development of locality data packs as a maturation of the Trust's approach to continuous quality improvement and quality reporting. These will amalgamate the qualitative information from the current quality dashboard with a number of other qualitative data items such as CQC mental health intelligence information, the mental health minimum data set and service specific indicators. This will strengthen the reporting of trends in relation to quality improvement and quality assurance and strengthen challenge by the Quality Committee. *Scheduled to be implemented across all wards and teams by end quarter 1 2015/16. Quality Committee will receive a progress report at its July 2015 meeting which will also outline*	No further actions.

Quality area	Trust assurance mechanisms/ Response	Self assessment	Actions from Q3 with update	Further actions for completion by end Q1 2015/16
			a framework of how the quality information contained in these packs will be analysed and challenged. **Safe Services Department/ Performance & Redesign Team** **IN PROGRESS**	
4b: Is the Board assured of the robustness of the quality information?	• There are clearly documented, robust controls to assure ongoing information accuracy, validity and comprehensiveness: - Roles and responsibilities in relation to data quality are outlined within the Trust's Data Quality Policy. - Assurance on data quality given to Board via Information Governance Toolkit scores and independent review of Quality Account. - Clinical audit programme driven by national audits, with processes for initiating additional audits as a result of identification of local risks [e.g. incidents]. - Electronic systems are used where possible, generating reliable reports with minimal ongoing effort. - Information can be traced to source and is signed off by	**AMBER/ GREEN**	Review of assurance processes within the performance and information function to scope the extent of any residual organisational risks in relation to the robustness of quality information associated with data sources – due to manual checks of data sourced for the NHS Benchmarking Network's voluntary participation in the 2013/14 Mental Health Benchmarking exercise [adult and community mental health services]. Outcome will inform self-assessment RAG rating for quarter 2. *A data quality improvement framework [for better quality data and business intelligence] has been approved by the Operational Board, October 2014. The current corporate assurance framework identifies further assurance being sought*	Appoint to Data Quality Project Lead post to lead implementation of Data Quality Framework. **Associate Director of Performance & Redesign**

Quality area	Trust assurance mechanisms/ Response	Self assessment	Actions from Q3 with update	Further actions for completion by end Q1 2015/16
	owners – gate keeping process in place within the Trust. • There is clear evidence of action to resolve audit concerns: - Action plans are completed from audit [and subject to regular follow-up reviews] – Trustwide action plans monitored by Compliance, Assurance and Learning Sub Committee. - Re-audits are undertaken to assess performance improvement.		*of the robustness of quality information. An implementation plan to assure the Board of Directors [as part of its duties to monitor via the quarterly Monitor quality governance framework self-assessment] that the required systems, processes, competencies and gatekeeping arrangements are in place to operationalise the framework was presented to March 2015 Operational Board. Operationalisation of this is in progress and will continue to be monitored as an action through this self assessment.* **Associate Director of Performance & Redesign, Acting Head of Performance & Information and Acting Senior Information Analyst supported by Medical Director for Quality, Associate Director of Safe Services and Head of Compliance.** **IN PROGRESS**	
4c: Is quality information being used effectively?	• Information in quality reports is displayed clearly and consistently – ongoing development of CWP performance dashboard and quality dashboards. • Information is compared with target	**AMBER/ GREEN**	Development of a "document of understanding" defining the roles, responsibilities and expectations across teams in relation to data provision to support the subsequent	Review of all data extracts from the data warehouse that support contractual and mandatory reporting requirements.

Quality area	Trust assurance mechanisms/ Response	Self assessment	Actions from Q3 with update	Further actions for completion by end Q1 2015/16
	levels of performance [in conjunction with a R/A/G rating], historic own performance and external benchmarks [where available and helpful]. • Information being reviewed is the most recent available, and recent enough to be relevant, e.g. inpatient bed/ ward review, West star chamber reports with Monitor. • 'On demand' data is available/ sought for the highest priority metrics. • The Trust is able to demonstrate how reviewing information has resulted in actions which have successfully improved quality performance, e.g. inpatient safety metrics and care bundles continue to demonstrate sustained improvements.		effective use of quality information. This will be achieved by the development of a data set owned and used at ward and team level to enhance the management of their day to day business. September 2014 meeting of the Quality Committee will consider. *Quality Committee agreed the above at its January 2015 meeting. The operational roll out of locality data packs was deferred to the end of quarter 1 2015/16, see action identified for quality area 4a.* **Quality Surveillance Support Managers in partnership with service and clinical leads** **IN PROGRESS**	**Associate Director of Performance & Redesign**

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

STANDARDISED REPORT COMMUNICATION

REPORT DETAILS

Report subject:	Registers of Interests: Directors and Governors
Agenda ref. no:	15/16/20
Report to (meeting):	Board of Directors
Action required:	Information and noting
Date of meeting:	27/05/2015
Presented by:	Lousie Brereton, Head of Corporate Affairs

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

REPORT BRIEFING

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

This report provides an introduction to the updated Registers of Interests for Directors and Governors.

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

The requirements for Directors and Governors to identify and declare interests are set out in the Trust's Constitution; the Corporate Governance Manual and in the Governors' Code of Conduct.

In order to assist with the identification and declaration of interests, Directors and Governors are requested to declare their interests upon initial appointment and annually thereafter. There is also the opportunity at each Board of Directors and Council of Governors meeting for Directors and Governors respectively to declare their interests and for the declared interests to be managed appropriately. Directors and Governors are provided with guidance to inform their declarations. Where Directors and Governors have no declarations of interest, they are asked to provide NIL response.

Assessment – *analysis and considerations of options and risks*

Registers are updated in year where changes arise and are reported. Registers are also subject to an annual review of declarations.

The Directors Register of Interests and the Governors Register of Interests have been presented to the Audit Committee meeting in March 2015 and May 2015 respectively.

Both Registers are required to the noted by the Board on an annual basis. Both Registers are publically available at www.cwp.nhs.uk.

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

The Board of Directors are recommended to note the Registers of Interest for Directors and Governors 2014/15.

Who/ which group has approved this report for receipt at the above meeting?		Audit Committee
Contributing authors:		N/A
Distribution to other people/ groups/ meetings:		
Version	Name/ group/ meeting	Date issued
Click here to enter text.	Audit Committee	March/ May 2015

Appendices provided for reference and to give supporting/ contextual information: *Provide only necessary detail, do not embed appendices, provide as separate reports*	
Appendix no.	Appendix title
1 and 2	1. Directors Register of Interests 2014/15 2. Governors Register of Interests 2014/15

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

DIRECTOR REGISTER OF INTERESTS 2015/16
(updated May 2015)

(As per section 7.23 of the Corporate Governance Manual, an annual review of the register should detail any changes to interests declared during the preceding twelve months)

NAME, DESIGNATION/ BOARD DIRECTORSHIP	TITLE OF INTEREST	DETAILS OF RELEVANT ORGANISATION	COMMENCEMENT OF INTEREST	LENGTH OF APPOINTMENT
Fiona Clark Non-Executive Director	Tribunal Member, Social Security and Child Support Appeals Tribunals	Tribunals Service, Tribunals Judiciary	January 2003	Permanent
	Tribunal Member, Employment Tribunals	Tribunals Service, Tribunals Judiciary	November 2009	Permanent
	Tribunal Member Mental Health Tribunals	Tribunals Service, Tribunals Judiciary	July 2013	Permanent
	Advisor	Tuberous Sclerosis Association	July 2009	31st March 2014
	Chief Executive	The Jamie Devaney Memorial Fund	April 2014	1 year
Dr Faouzi Alam Executive Medical Director – Effectiveness, Medical Education & Medical Workforce	Nothing to Declare			
Dr James O'Connor Non Executive Director	Sister has company 'Catch On' operational in South England (no pecuniary interest)	Catch on	N/A	Ongoing

NAME, DESIGNATION/ BOARD DIRECTORSHIP	TITLE OF INTEREST	DETAILS OF RELEVANT ORGANISATION	COMMENCEMENT OF INTEREST	LENGTH OF APPOINTMENT
Lucy Crumplin Non-Executive Director	Director	Tiger Bright Ltd (consultancy)	August 2013	On-going
Sheena Cumiskey Chief Executive	Member	Chair of the Board of the NHS North West Leadership Academy	22 February 2010	Ongoing
	Member	Health Education England North West Board	2013	On-going
Avril Devaney Executive Director of Nursing, Therapies and Patient Partnership	Trustee Of Jamie Devaney Memorial Fund	Charity supporting mental health care in Uganda	March 2013	Ongoing
	Vice Chair	Mental Health and Learning Disabilities Nurse Directors and leads' Forum	April 2015	Ongoing
David Eva Chairman	National delivery team manager. Wife is Director	UnionLearn HHM Design Ltd	April 2006 January 2014	On-going On-going
David Harris, Non-voting Director	Nothing to declare			
Ron Howarth Non-Executive Director	Non-Executive Director	Cheshire Area Probation Trust	1 April 2010	Concluded July 2014
	Non-Executive Director and Chair of Audit - Cheshire & Greater	Organisation currently in public ownership & providing	12th May 2014	On-going

NAME, DESIGNATION/ BOARD DIRECTORSHIP	TITLE OF INTEREST	DETAILS OF RELEVANT ORGANISATION	COMMENCEMENT OF INTEREST	LENGTH OF APPOINTMENT
	Manchester Community Rehabilitation Company Ltd	community based offender management services for Cheshire and Greater Manchester		
Mike Maier Non-Executive Director (Chair of Audit Committee)	Nothing to declare			
Dr Anushta Sivananthan Executive Medical Director – Compliance, Quality & Assurance	Nothing to declare			
Andy Styring Executive Director of Operations	Nothing to declare			
Tim Welch Executive Director of Finance	Nothing to declare			
Rebecca Burke Sharples Non-Executive Director	Spouse (Alan Sharples) is a NED/ Chair of Audit Committee (currently in 2nd term of office).	Walton Centre NHS Foundation Trust	Appointed 2011	Ongoing
	Vice Chairman of the Board of Trustees	North of England Zoological Society aka Chester Zoo	Began 2009	Ongoing

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

GOVERNOR REGISTER OF INTERESTS

(2014/15) Updated April 2015

NAME	DECLARED INTEREST/S	DATE
Stanley Mayne **Public Governor – Wirral**	**Wirral Healthwatch (formerly LINk)** **Liverpool Healthwatch (formerly LINk)** **West Kirby PPG** **Liverpool Prison** **BME Mental Health** **Membership Groups:** **Social Partnership** **Hope Club - Drug & Alcohol Community Programme** **Cheshire & Wirral PPG Forum** **HASCA (Health & Social Care Ambassador) Royal & Broadgreen Hospitals**	**10/02/2015**
Brian Crouch – Service User & Carer Governor	**NIL**	**17/02/2015**
Helen Hall – Service User & Carer Governor	**Self-Employed Diet Consultant – Sell Independent Cambridge Weight Plan Meal Replacements**	**05/02/2015**
Richard Agar – Public Governor	**NIL**	**02/02/2015**

NAME	DECLARED INTEREST/S	DATE
Chris Lynch – Service User & Carer Governor	Chair – Chester Plus Group Coordinator and North West Committee Member for Rethink Mental Illness Volunteer for Cheshire Police British Psychological Society – Rep Council Member and North West Branch Chair Section of Community Psychology Committee Member	17/02/2015
Philip Mook – Staff Governor	Nil	30/01/2015
Christina Evans – Staff Governor	Sister-in-Law Nurse, CWP Community Mental Health Team (Sister-in-Law) Sister-in-Law Nurse, Cedar Ward, Bowmere Hospital Husband Nurse CoCH	02/03/2015
Phil Jarrold – Service User & Carer Governor	Attend various Third Sector groups, including: Bipolar UK Making Space Open Minds Rethink	14/02/2015
Anna Usherwood – Service User & Carer Governor	Nil	15/02/2015
Steven Buckley – Staff Governor	Nil	19/02/2015
Richard Harland – Service User & Carer Governor	Nil	04/03/2015
Brenda Dowding – Partnership Governor	Councillor with Cheshire West & Chester Council Chair of Cheshire West & Chester Health & Wellbeing Board	05/03/2015

NAME	DECLARED INTEREST/S	DATE
Ann McGrath – Service User & Carer Governor	Volunteer with Alzheimer's Society (West Cheshire Office)	31/01/2015
Ferguson McQuarrie – Service User & Carer Governor	Volunteer	07/04/2015
Janie Shaw – Staff Governor	Nil	02/02/2015
Jill Doble – Staff Governor	Nil	05/02/2015
John Wray – Partnership Governor	An Elected Member of Cheshire East Council	12/04/2015
Kathy Bullen – Staff Governor	Nil	01/08/2014
Ken Wilson – Partnership Governor	Director of CLRN	14/04/2015
Maurice Lea O'Mahoney – Staffside Governor	Nil	05/03/2015 (Verbally confirmed)
Mike Robinson – Public Governor	Nil	07/04/2015
Pam Smith – Partnership Governor	Lay Member of the West Cheshire CCG Director of Pam Smith Consultancy Director of Sutton Electrical Contractors Ltd	07/02/2015
Peter Wilkinson – Public Governor	Nil	12/03/2015
Phil Gilchrist – Partnership Governor	Councillor – Wirral Borough Council	26/02/2015

NAME	DECLARED INTEREST/S	DATE
Rob Robertson – Public Governor	**Director of Friends of Muir Housing** **Chair of Cheshire West and Chester Mental Health Alliance** **Member of CHESHIRE WEST HEALTHWATCH** **Mental Health Citizens Panel**	**15/02/2015**
Deborah Bennett – Service User & Carer Governor	**Head of Strategic Planning at East Cheshire NHS Trust**	**06/11/2013 (Awaiting Update)**
Iain Stewart – Partnership Governor	**Spouse is Head of Contracting & Bid Management at Wirral University Teaching Hospitals FT**	**11/03/2015**

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

STANDARDISED REPORT COMMUNICATION

REPORT DETAILS

Report subject:	**Director of Infection Prevention and Control (DIPC) Board Report, Quarter 4 (January – March 2015)**
Agenda ref. no:	15/16/21
Report to (meeting):	Board of Directors
Action required:	Information and noting
Date of meeting:	27/05/2015
Presented by:	Maria Nelligan, Director of Infection, Prevention and Control.

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

REPORT BRIEFING

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

Director of Infection, Prevention and Control (DIPC) report are provided on a quarterly basis to the Board to update on relevant IPC priorities and any further issues.

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

As above.

Assessment – *analysis and considerations of options and risks*

The Q4 report includes the following priorities:

- New Integrated Service, including the IPC Contract for Cheshire West and Chester
- Healthcare Associated Infections (HCAI)
- Outbreak reports
- New IPC code to be published following consultation process
- Antimicrobial stewardship, and
- IPC Audit programme

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

The Board of Directors are asked to note the Q4 Director of Infection, Prevention and Control Report.

Who/ which group has approved this report for receipt at the above meeting?	Sheena Cumiskey, Chief Executive
Contributing authors:	Amanda Miskell, Acting Head of IPC

Distribution to other people/ groups/ meetings:

Version	Name/ group/ meeting	Date issued
1	Infection, Prevention and Control subcommittee	7th May 2015

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

Appendix no.	Appendix title
1 and 2	Appendix 1 – Q4 IPC Report Appendix 2 – IPC Team Structure Appendix 3 - Consultation on the revised version of the Health & Social care Act 2008 (Regulated Activities) Regulations 2010

Appendix 1: Q4 Infection, Prevention and Control report

Contents

1. The purpose of the report

Welcome to the Quarter Four (Q4), Director of Infection Prevention and Control (DIPC) report, 2014/2015. This report will give the board an update on the most relevant IPC priorities and summarise same.

This report will include the following priorities:

- New Integrated Service, including the IPC Contract for Cheshire West and Chester
- Healthcare Associated Infections (HCAI)
- Outbreak reports
- New IPC code to be published following consultation process
- Antimicrobial stewardship, and
- IPC Audit programme

2. New Integrated IPC Service

As previously reported in Q3, the CWP IPCT was successful in securing the IPC contract for services for the health and social care services including TB, for Western Cheshire CCG & Vale Royal CCG. To address the new contract there has been some staff changes in the IPCT, and a new IPC structure was communicated to all CWP staff via the CWP home page prior to Christmas 2014 in readiness for quarter four (Appendix One). This will provide the team with varied development opportunities, including clinical professional development, and for the organisation, succession planning, and business continuity. It also gives CWP an opportunity to tender for future business, across a varied range of provider services.

3. Healthcare Associated Infections (HCAI)

There are no exceptions to report from CWP services. Performance reporting to CWaC on behalf of the CCGs monthly, is also reported to our own information team. The annual reporting of surveillance for multi resistant organisms and HCAIs will be included in the Annual Report 2014/15 due to Board next month, June 2015.

4. Outbreaks, Juniper Ward and Bollin Ward

Influenza activity was exceptional during the early part of Quarter Four, however Influenza A trends have decreased towards the end of Quarter Four, but, there has been an increase in Influenza B across the Cheshire and Merseyside footprint, and it is likely to continue over the coming weeks. Juniper Ward experienced Influenza A outbreak during this period, January 2015, which was agended at March 2015 IPCSC. The ward was closed for a prolonged period, however, all the staff worked exceptional hard in managing this outbreak, which is the first experienced in CWP inpatient areas since the IPCT have been employed, 2005. All patients and staff made a full recovery.

Bollin Ward experienced several patients with intermittent symptoms of diarrhoea and vomiting during March 2015. Although the ward was closed for a short period, this was not a confirmed viral outbreak.

5. New DH consultation document for CQC inspections

On 30th January 2015 the DH published the newly revised Code of Practice on the Prevention and Control of Infections and related guidance (The Code) for consultation till March 13th. This document is due for publication April 2015. The document is used as the format for our CWP IPC Assurance Framework, against which the CQC will assess our standards against the 10 criterions, currently known as Outcome 8. In April 2015, the new registration requirements will come under Regulation 12 on Safe Treatment and Care, but Regulation 15 on Premises and Equipment is also relevant.

Antimicrobial resistance is a government priority and good antimicrobial stewardship are key components of the national five year antimicrobial resistance strategy 2013-2018 (DH 2013). The new Code will include numerous new standards to address the key work surrounding this strategy. Water safety is a new standard, and Appendix 2 gives the board assurance that the IPCT are addressing the new standards within the consultation, in preparedness.

6. Antibiotic Stewardship

In relation to items 2. and 5. The IPCT will continue to work alongside our pharmacy colleagues; in addition, from April 2015 this will involve weekly meetings in the clinical areas, reviewing any antibiotic prescribing, treatments of multi resistant organisms, and compliance with the newly introduced Western Cheshire antimicrobial formulary.

7. Audit Programme 2015/2016

As discussed in the Quarter Three DIPC report, the audit programme completed earlier than envisaged for 2014/15. From April 2015, a new electronic audit tool, endorsed by the Infection Prevention Society will be introduced to all CWP premises. This process will be carried out and actioned were necessary with our colleagues in Estates, Facilities and with our Clinical Managers where possible. This process will support the combined work programmes approved at the IPCSC meetings.

8. Recommendations

The Board of Directors is asked to note the DIPC Quarter Four report for 2014/15.

9. Appendices

Appendix 2.
IPC Team Structure

Appendix 3.
Consultation on the revised version of the Health & Social care Act 2008 (Regulated Activities) Regulations 2010

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

STANDARDISED REPORT COMMUNICATION

REPORT DETAILS

Report subject:	Response to Monitor regarding Themes and lessons learnt from NHS investigations into matters relating to Jimmy Savile
Agenda ref. no:	15/16/22
Report to (meeting):	Trust Board
Action required:	Discussion and Approval
Date of meeting:	27/05/2015
Presented by:	Avril Devaney Director of Nursing, Therapies and Patient Partnerships

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

REPORT BRIEFING

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

This paper is to provide the Trust Board with an assessment of CWPs position, and actions identified in response to the recommendations from the "Lessons Learned" report by Kate Lampard associated with Jimmy Savile. Monitor have requested a response by 15 June 2015 with an overview of any necessary actions taken as a result of the recommendations or, where these are in progress, the date by which they will be completed.

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

Following the death of Jimmy Savile and subsequent allegations of wrong doings at NHS organisations, the Department of Heath (DH) asked Kate Lampard QC to produce a lessons learned report drawing from the findings from all published investigatons and emerging themes. This report was published in March 2015 and included 14 recommendations for the NHS, DH and wider government. The secretary of state for Health accepted 13 of the recommendations 10 of which apply to NHS Foundation Trusts.

Assessment – *analysis and considerations of options and risks*

A task and finish group was set up by the Associate Director of Nursing and Therapies (PH) to consider the report and respond to Monitor. This paper gives the Trust Board a first status of CWP compliance against the recommendations contained in the Lessons learned report. Appendix 1 gives a summarised RAG rating against each recommendation, and a plan to address any gaps in compliance or areas identified which will strengthen our assurance and governance.
The task and finish group will report progress in the action plan to the Trust wide Safeguarding sub-Committee, and escalated if required, to the Quality Committee.

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

The Board is requested to;1) discuss and review the recommendations of the Lampard report. 2) Agree the relevance of those recommendations for CWP. 3) Note the current position statement of CWP in relation to the recommendations 4) Agree the actions identified

Who/ which group has approved this report for receipt at the above meeting?	Avril Devaney
Contributing authors:	Andrea Hughes Chris Sheldon Katherine Wright Lorraine Van Sluis

Distribution to other people/ groups/ meetings:

Version	Name/ group/ meeting	Date issued
Click here to enter text.	Click here to enter text.	Click here to enter text.

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

Appendix no.	Appendix title
1	Lampard Report assessment and action plan

Appendix 1

Lampard Report
Assessment and Action Plan

	RAG				
	Red = not compliant actions to be developed				
	Amber = Partially Compliant , actions identified, evidence to be developed				
	Green = Compliant and evidence available				
	RECOMMENDATION	**CURRENT POSITION / ISSUE IDENTIFIED**	**RAG**	**Planned Action**	**DATE FOR COMPLETION**
R1	**R1** All NHS hospital trusts should develop a policy for agreeing to and managing visits by celebrities, VIPs and other official visitors. The policy should apply to all such visits without exception	The Trust's Media Policy covers this requirement. All VIP and official visitors are accompanied by a member of CWP staff at all times, All visits by dignitaries and VIPs are co-ordinated by the communications team.			
R2	R2 All NHS trusts should review their voluntary services arrangements and ensure that: • they are fit for purpose; • volunteers are properly recruited, selected and trained and are subject to appropriate management and supervision; and • all voluntary services managers have development opportunities and are properly supported.	In accordance with HR20 volunteer policy and procedures, all volunteers are recruited inline with CWP policy and NHS employer standards. All volunteers have to attend the Trust's mandatory trust induction and safeguarding training. All volunteers are allocated a designated line manager and receive regular supervision inline with the HR20 volunteer policy and procedures. The voluntary services lead receives any relevant development opportunities and is fully supported		Compliant in terms of current position but action will be needed to up date the current Volunteers Policy to reflect changes in management arrangements following the operational restructure and DBS	30-Jun-15
R4	R4 All NHS trusts should ensure that their staff and volunteers undergo formal refresher training in safeguarding at the appropriate level at least every three years.	All new volunteers attend 2 hour mandatory face-to-face safeguarding training. This is provided twice yearly. A system is in place to ensure volunteers receive refresher training at least 3 yearly. All Staff receive safeguarding taining as per the intercollegiate document (2015) compliance rates for the Trust for April 2015 is 87%		Training has been organised in June however all volunteers are up to date currently. A process is in place to monitor training to ensure that training is refreshed within the timescale	

Appendix 1

Lampard Report
Assessment and Action Plan

R5	R5 All NHS hospital trusts should undertake regular reviews of: • their safeguarding resources, structures and processes (including their training programmes); and • the behaviours and responsiveness of management and staff in relation to safeguarding issues to ensure that their arrangements are robust and operate as effectively as possible.	• Resources, structures and processes are reviewed as part of the Section 11 audit undertaken and in response to the Safeguarding commissioned standards. The annual board report includes review of resources, structures and processes and the work programme of the Safeguarding Sub-committee monitors processes and functions. The training programme is reviewed annually by Trust Wide Safeguarding Sub-committee and the Training Leads group within the organisation oversees the evaluations of training programmes in addition to the Safeguarding Team. • CWP Safeguarding team provide a responsive duty arrangement to respond to daily enquiries from staff within the organisation. This is either via telephone or email accounts which are monitored daily. Each locality has a Safeguarding group within their governance arrangements where issues, concerns and risks are discussed and escalated to the Trust Wide Safeguarding Sub-committee as required. An audit programme provides assurance and identifies areas requiring strengthening in relation to robust processes and management of safeguarding concerns. Compliance with safeguarding training is monitored by locality groups and Trust wide Sub-committee to ensure high level of staff competence.			
R7	R7 All NHS hospital trusts should undertake DBS checks (including, where applicable, enhanced DBS and barring list checks) on their staff and volunteers every three years. The implementation of this recommendation should be supported by NHS Employers.	This recommendation has not as yet been supported by NHS Employers. All staff and volunteers are DBS checked at the appropriate level on recruitment and at subsequent role change. The only exception to this are those volunteers who work soley in corporate administration.		1) HR recruitment policy requires updating to reflect restructure of organisation and changes in DBS. 2) A scoping exercise to be undertaken to idntify the potential cost in terms of finance and resource to inplement a 3 yearly check on all staff.	Sep-15
R9	R9 All NHS hospital trusts should devise a robust trust-wide policy setting out how access by patients and visitors to the internet, to social networks and other social media activities such as blogs and Twitter is managed and where necessary restricted. Such policy should be widely publicised to staff, patients and visitors and should be regularly reviewed and updated as necessary.	The Trust's Media Policy covers this requirement for staff. Where computers are provided for patient use, internet access is restricted by the Trust's IT department.		Review what measures are in place around use of personal smartphones etc and what advice is given to patients and visitors. May require prominent posters in public areas.	End June 2015
R10	R10 All NHS hospital trusts should ensure that arrangements and processes for the recruitment, checking, general employment and training of contract and agency staff are consistent with their own internal HR processes and standards and are subject to monitoring and oversight by their own HR managers.	A per centage of agency bookings are handled by Temporary Staffing and all the correct assurances are place. Medical locums are booked in the main by HR in the localities and again the appropraite checks are made. However some contractors and agency staff are booked direct by the localities and further assurance is needed that all appropriate checks are carried out		Action in the short term to raise awareness with managers to carry out appropriate checks and longer term to put a business case forawrd for Temporary Staffing to book all agency staff going forward to ensure consistency of approach	Action 1 - 31.05.15 Action - 2 within 12 months

Appendix 1

Lampard Report
Assessment and Action Plan

R11	R11 NHS hospital trusts should review their recruitment, checking, training and general employment processes to ensure they operate in a consistent and robust manner across all departments and functions and that overall responsibility for these matters rests with a single executive director.	Our processes have been reviewed within the last 12 months and the recruitment function is currently in the process of being strengthed in terms of its capacity and processes. Training is provided for recruiting mangers to ensure consistency of approach . The Director of People and OD Services is the responsible executive director		Discussions have commenced to introduce a more strategic approach to recruitment in terms of planning and anticipating recruitment needs in an annual plan. The Recruitment and Retention Policy needs to be reviewed to reflect our new processes and approach to recruitment. Our apporach to values based recrutiment needs to be considered as part of the review	31 December 2015
R12	R12 NHS hospital trusts and their associated NHS charities should consider the adequacy of their policies and procedures in relation to the assessment and management of the risks to their brand and reputation, including as a result of their associations with celebrities and major donors, and whether their risk registers adequately reflect such risks.	The Trust's Communications and Engagement Strategy sets out our approach to reputation management and the Media Policy outlines our approach to all visitors. The Trust does not have any current associations with celebrities or major donors.			
R13	Monitor, the TDA , CQC and NHS England should exercise their powers to ensure that NHS trusts comply with recommendations 1,2,4,5,7,9,and 11	As contained within this response.			

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

STANDARDISED REPORT COMMUNICATION

REPORT DETAILS

Report subject:	Care Quality Commission: Statement of Purpose
Agenda ref. no:	15/16/23
Report to (meeting):	Board of Directors – meeting in public
Action required:	Discussion and approval
Date of meeting:	27/05/2015
Presented by:	Dr Anushta Sivananthan – Medical Director/ Executive Lead for Quality

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

REPORT BRIEFING

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

To provide an update to the Statement of Purpose in response to amendments to community service team bases and in preparation for the Care Quality Commission (CQC) announced inspection in June 2015.

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

The Statement of Purpose was last approved at Board in January 2015 as part of the annual review of our registered locations in line with the registration guidance outlined by the CQC. In preparation for the announced inspection in June 2015 and recent changes to team bases for community services, the Statement of Purpose has been updated to ensure accurate and contemporaneous information is recorded.

Assessment – *analysis and considerations of options and risks*

Amendments have been made to the community services location details across both Mental Health and Physical health services and across the full Trust footprint. In addition, following consultation with the CQC registration team, both the Learning Disability Respite Units have now been recorded as separate registered locations.

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

The Board of Directors is asked to **approve** the information held within the Statement of Purpose and approve the submission to the CQC registration team

Who/ which group has approved this report for receipt at the above meeting?	Anushta Sivananthan, Medical Director/ Executive Lead for Quality
Contributing authors:	Jo Watts, Head of Compliance David Wood, Associate Director of Safe Services

Distribution to other people/ groups/ meetings:

Version	Name/ group/ meeting	Date issued
1	Board of Directors	20/05/2015

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

Appendix no.	Appendix title
1	CWP Statement of Purpose – Revised May 2015