Cheshire and Wirral Partnership NHS
NHS Foundation Trust

Meeting of the Foundation Trust Board of Directors
Wednesday 25th November 2015
Boardroom, Redesmere, Countess of Chester Health Park
1.30pm

Item no.	Title of item	Objectives/desired outcome	Process	Item presenter	Time allocated to item
15/16/79	Apologies for absence	Receive apologies	Verbal	Chair	1 min (1330)
15/16/80	Declarations of Interest	Identify and avoid conflicts of interest	Verbal	Chair	2 min (1331)
15/16/81	Minutes of the previous meeting held 30th September 2015	Confirm as an accurate record the minutes of the previous meetings	Written minutes	Chair	2 mins (1333)
15/16/82	Matters arising and action points	Provide an update in respect of ongoing and outstanding items to ensure progress	Written action schedule and verbal update	Chair	2 mins (1335)
15/16/83	Board Meeting business cycle 2015/16	Confirm that agenda items provide assurance that the Board is undertaking its duties	Written	Chair	3 mins (1337)
15/16/84	Chair's announcements	Announce items of significance not elsewhere on the agenda	Verbal	Chair	10 mins (1340)
15/16/85	Chief Executive's announcements	Announce items of significance not elsewhere on the agenda	Verbal	Chief Executive	10 mins (1350)

Item no.	Title of item	Objectives/desired outcome	Process	Item presenter	Time allocated to item
MATTERS FOR APPROVAL/ DECISION					
Strategy					
15/16/86	Corporate Assurance Framework, Risk Register and Integrated Governance Framework	To approve current Corporate Assurance Framework, Risk Register and amended Integrated Governance Framework	Written Report	Medical Director	15 mins (1400)
15/16/87	Q2 15/16 Quality Report	To note Q2 position	Written Report	Medical Director	10 mins (1415)
Measurement					
15/16/88	Board Performance Dashboard – October 2015 data	To review Trust performance	Written Report	Director of Finance	15 mins (1425)
15/16/89	Mental Health Benchmarking	To review Trust position/ performance	Presentation	Medical Director	20 mins (1440)
15/16/90	Monitor Well-Led Framework- update	To update on Trust plans for Well-led review	Written Report	Head of Corporate Affairs	10 mins (1500)
Capability and Culture					
15/16/91	Community Mental Health Survey Results	To note recent results	Written Report	Director of Nursing, Therapies and Patient Partnership	10 mins (1510)

Item no.	Title of item	Objectives/desired outcome	Process	Item presenter	Time allocated to item
15/16/92	Healthy Wirral (Vanguard) Information Sharing Agreement	To approve information sharing agreement	Written Report	Medical Director	15 mins (1520)
Process and Structures					
15/16/93	Daily Ward Staffing figures October 2015	To note the Daily Ward Staffing Figures	Written Report	Director of Nursing, Therapies and Patient Partnership	10 mins (1535)
15/16/94	Q2 2015/16Infection, Prevention and Control report	To note the Q2 2015/16 report	Written Report	Director of infection, Prevention and Control	10 mins (1545)
15/16/95	Monitor Provider Licence – six monthly compliance	To note the 6 month/ Q2 compliance report	Written Report	Director of Finance	10 mins (1555)
15/16/96	Q2 2015/16 Quality Governance assessment	To note the Q2 2015/16 position	Written Report	Medical Director	10 mins (1605)
15/16/97	Mental Health Act compliance update	To note the annual update report	Written Report	Medical Director	10 mins (1615)
Governance					
15/16/98	Audit Committee reporting: • Chair's Report of meeting held 27th October 2015 • Approval of NED membership	Review Chair's Report and any matters for note/ escalation	Written	Chair of Audit Committee	5 mins (1625)

Item no.	Title of item	Objectives/desired outcome	Process	Item presenter	Time allocated to item
15/16/99	Quality Committee reporting : • Chair's Report of meeting held 4th November 2015	Review Chair's Report and any matters for note/ escalation	Written	Chair of Quality Committee	5 mins (1630)
15/16/100	Review of risk impacts of items discussed	Identify any new risk impacts	Verbal	Chair/ All	5 mins (1635)
15/16/101	Any other business	Consider any urgent items of other business	Verbal or written	Chair	2 mins (1640)
15/16/102	Review of meeting https://www.surveymonkey.com/s/XN5ZLNC	Review the effectiveness of the meeting (achievement of objectives/desired outcomes and management of time)	Verbal	Chair/All	2 mins (1642)
15/16/103	Date, time and place of next closed meeting: **Wednesday 27th January 2016, 1.30pm, Boardroom, Redesmere.**	Confirm arrangements for next meeting	Verbal	Chair	1644

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

Minutes of the Board of Directors Meeting
Wednesday 30th September 2015
Boardroom, Redesmere commencing at 1.00pm

PRESENT	David Eva, Chair Sheena Cumiskey, Chief Executive Dr Jim O'Connor, Non-Executive Director Ron Howarth, Non-Executive Director Mike Maier, Deputy Chair and Non-Executive Director Dr Anushta Sivananthan, Medical Director Andy Styring, Director of Operations Rebecca Burke – Sharples, Non-Executive Director Dr Faouzi Alam, Medical Director Fiona Clark, Non-Executive Director Lucy Crumplin, Non-Executive Director Tim Welch, Director of Finance Stephen Scorer, Interim Director of Nursing, Therapies and Patient Partnership
IN ATTENDANCE	David Harris, Director of HR and Organisational Development Louise Brereton, Head of Corporate Affairs Maria Nelligan Director of Infection, Prevention and Control (for item 15/16/70) Phil Jarrold, Service User/ Carer Governor Brian Crouch, Service User/ Carer Governor Derek Bosomworth, Member of the public
APOLOGIES	Ron Howarth, Non-Executive Director

	MINUTES	**ACTION**
15/16/55	**WELCOME AND APOLOGIES FOR ABSENCE** The Chair welcomed all to the meeting.	
15/16/56	**DECLARATIONS OF INTEREST** No declarations of interest were raised by any members of the Board.	
15/16/57	**MINUTES OF THE PREVIOUS MEETING HELD 29th JULY 2015** The minutes of the meeting held 29th July 2015 were **approved** as a correct record.	
15/16/58	**MATTERS ARISING AND ACTION POINTS** All actions were noted as in progress or completed.	
15/16/59	**BOARD BUSINESS CYCLE 2015/16** The Board noted the business cycle for 2015/16.	
15/16/60	**CHAIR'S ANNOUCEMENTS** The Chair announced:	

	CWP Chief Executive shortlisted for top CEO award Sheena Cumiskey has been shortlisted in the Chief Executive of the Year category at the 2015 Health Service Journal (HSJ) Awards. The awards will be held on 18 November at the Grosvenor House Hotel, London. Sheena's entry was endorsed by a wide range of people working in mental health and the wider NHS, and included her many and varied roles including her work with the NHS Leadership Academy. **CWP wins prestigious HSJ Value in Healthcare Award** CWP has won the Value and Improvement in Communication category at the 2015 Health Service Journal (HSJ) Value in Healthcare Awards. The Trust was presented the accolade for its pioneering Child and Adolescent Mental Health (CAMHS) website, Mymind.org.uk. **Crewe celebrates recovery with open day** Patients, families and carers gathered to celebrate the work of CWP's recovery college in Crewe. In the spirit of co-production, the day was organised in collaboration between patients, carers and staff from Cheshire and Wirral Partnership NHS Foundation Trust (CWP). **Cheshire's first at-scale telehealth programme aims to improve patient self-management** CWP, NHS West Cheshire Clinical Commissioning Group and Royal Philips have today announced the launch of the Supported Self Care Champion Project in Cheshire. This partnership between the three organisations is designed to provide state-of-the-art telehealth support programmes and equipment to the region. **Latest visit to Uganda leaves NHS staff inspired** Staff from CWP are supporting the development of mental health services in Uganda. CWP's Dr Maureen Wilkinson and Dr Andy Cotgrove visited Kisiizi Hospital in south western Uganda to help the development of mental health services within the only mental health inpatient facility serving the large rural area. The service currently treats 4000 people a year. Together with two Ugandan friends, the team travelled 415 miles and have so far raised £3000.	
15/16/61	**CHIEF EXECUTIVE'S ANNOUCEMENTS** The Chief Executive announced the following: **CQC** The final draft CQC inspection report is due w/c 5th October 2015, which is later than originally planned. The Trust will have 10 days for factual accuracy checks before the publication of the final report. This will be two days prior to the Quality summit meeting which is provisionally arranged for 5th November 2015. The Trust is awaiting further details about the plans for the Quality summit and who will be required to attend. **Interim Director of Nursing, Therapies and Patient Partnership** A formal welcome was extended to Stephen Scorer who has recently taken up post with CWP as Interim Director of Nursing, Therapies and Patient Partnership covering Avril Devaney's adoption leave. **Big Book of Best Practice and Annual Members Meeting** The Trust will hold its Annual Members' meeting on Thursday 1ST October	

	2015 alongside the Big Book of Best Practice event offering an opportunity to showcase examples of clinical quality and, service redesign by CWP. **Key items discussed at the Closed Board meeting** An overview of the key items discussed at the closed meeting were provided including the CQC inspection and the learning about leadership arising from the inspection of Saddlebridge, discussions on the strategy for Learning Disability services and moving services to be more community focused and responsive to national directives and the progress with the implementation of the financial recovery plan.	
15/16/62	**CORPORATE ASSURANCE FRAMEWORK AND RISK REGISTER** Dr. Anushta Sivananthan updated the Board on the current position with the Trust strategic risk register and the corporate assurance framework and highlighted the following issues: • The Audit Committee have recently received assurances on the physical health risks as part of the review of individual risk. The Committee continue to be interested in the cyber risk issue and have requested further assurances on the Trust's approach to mitigating this risk. • One new risk has been added to the register regarding reduced clinical pharmacy support. The implementation of the business continuity plan is currently mitigating the impact of the risk while the full risk treatment plan is in development. • The CIP risk has been broadened to include the impact of the current financial position and has been re-scored to a red 16 as a result. A discussion followed regarding the impact of the newly added pharmacy risk and it was noted that the lack of pharmacy representation is apparent at compliance visits. Assurance was requested on how the risks are being managed operationally. Dr Anushta Sivananthan acknowledged that there is a gap at the moment but work has been done to review some of the broader responsibilities of the pharmacy team and some operational tasks will be taken on by ward managers and modern matrons. It was noted that Operational Board are due to receive the outcome of the pharmacy review at the October 2015 meeting which will be reflected in the assurance framework. David Eva commented on the tendering risk and whether this is truly reflective of the current environment. It was agreed that this should be remodelled. **Action:** LB to discuss re-modelling of the tendering risk with the risk lead Claire James. The Board of Directors resolved to **approve** the amendments to the strategic risk register and corporate assurance framework, including the changes to the integrated governance framework.	**LB**

15/16/63	**QUALITY REPORT Q1 2015/16** Dr Anushta Sivananthan introduced the report and highlighted the following key issues: • Street triage services have resulted in a significant decrease in s136s enabling savings for the Trust and local police forces. There is a significant issue regarding the further funding for these services across the localities as the current funding is time limited. Commissioners have been presented with the evidence of the outcomes the service is producing but nothing further has been agreed and existing funding is due to cease at the end of October 2015. • CWP have attained the workplace charter mark indicating the Trust's commitment to the health and well-being of staff. • Lloyds pharmacy have move into their new base in Bowmere hospital providing a purpose built pharmacy service. A discussion followed regarding the situation with funding street triage services. Andy Styring commented that this being taken forward with CCG and NHS England and indications are that CCGs are likely to fund this for another year. It was queried how this is being taken forward with the police particularly in light of the cost savings to them. There are differing views amongst the police forces across the Trusts geographies and some forces see that this service should be funded by mental health services not the police. It was queried how long the Trust would continue to fund the service should there is no forthcoming decision on the CCG position. It was acknowledged that the Trust are not in a position to fund the service without being commissioned to do so and if they did, this would impact on other services that the Trust is commissioned to provide. The Board agreed that clarification on the funding position was required urgently from the CCGs. **Action:** DE and SC to write to CCGs and other bodies on behalf of the Board of Directors requesting clarity on the future funding of these services. Dr Jim O'Connor commended the Quality Report and the promotion of the innovative best practice that is happening in services. It was queried how the report could be used more widely to externally promote the work that CWP are doing. **Action:** Communications team to be asked to consider other ways of communicating the Quality Report and promoting Trust good news stories out in to the public arena. The Board resolved to **note** the report.	**DE/ SC** **SS/LB**
15/16/64	**BOARD PERFORMANCE DASHBOARD: AUGUST 2015** Tim Welch updated that CPA 12 month target has been challenging in early part of the quarter. Work is being undertaken to manage this better and the Trust has achieved the target for Q2.	

	Reporting on financial performance, the forecast is showing an improvement with a reduction in the deficit from £1.5m to £650k. The implementation of the Financial Recovery Plan (FRP) is gathering pace and work is progressing around the two key areas of risk – income generating beds (IGB) and agency staffing. An improvement in the performance of these two areas is expecting moving into Q3. Tim Welch informed that as part of the new risk assessment framework, the financial substantiality risk rating will be reported as a 3 at the end of Q2. With regard to annual planning and the planning cycle for 16/17, the key focus in identifying new recurrent saving plans. A discussion followed regarding IAPT performance. Dr Jim O'Connor queried whether there is any risk of financial penalties for non-achievement. Tim Welch confirmed that this would be the case from the end of 2015/16 which is a change to the original position which was due to be in year. The most challenging area is east Cheshire however work is progressing to apply the learning from the well performing service in Sefton. The Trust is working jointly with the CCG on the silvercloud software trial. This has been well received to date and will help to drive up performance on the targets. It was noted that the east Cheshire performance has seen a recent improvement. The Board resolved to **note** the report.	
15/16/65	**RISK ASSESSMENT FRAMEWORK** Tim Welch introduced the report and informed the Board of the recently announced changes to the Monitor risk assessment framework. The changes are symptomatic of the national picture and the number of foundation trusts in serious financial distress. The changes will mean more scrutiny of targets set out in operational and strategic plans and income and expenditure positions. This is a move from the previous framework which focused more on the cash position. The impact of the changes is such that there is now greater potential for more trusts to trigger investigations. All foundation trusts are required to report the financial position on a monthly basis in addition to the usual quarterly report. The monthly submissions are subject to executive approval. . There is a additional requirement regarding governance to maintain value for money. This gives rise to the potential for investigations even where Trusts are performing adequately financially. Potential triggers to this aspect of the framework are agency spend, consultant spend and potentially other triggers such as absence levels. Tim Welch confirmed that achievement of the FRP will mean that the Trust meets the requirements of the financial sustainability risk ratings but the Board should be cognisant of the potential impact of new measures. In other developments, Tim Welch reported that Monitor and the Trust Development Agency (TDA) are coming together as a new organisation to be known as NHS Improvement.	

	The Board resolved to **note** the report.	
15/16/66	**EQUALITY ACT COMPLIANCE** Stephen Scorer updated the Board of the Trust's compliance with the Equality Act. A key area of risk of the Trust is around data quality and actions are in place to address these areas. The circulation of the report was queried as it was noted in the report that it had been received by a third sector group. **Action**: SS to clarify third sector distribution of the report. The Board resolved to **note** the report.	**SS**
15/16/67	**CALDICOTT 2 AND INFORMATION GOVERNANCE PROGRESS REPORT** Dr Faouzi Alam presented the report. The Board were informed that following the first Caldicott review, an additional review was undertaken in 2013 which resulted in further requirements for organisations to provide information as well as safeguard it. The challenge is to implement these requirements when working closely with partners. Information sharing agreements are now progressing with partners but there is also a need for a strategy to embed this within our clinical systems. Dr Alam informed that the Trust is currently compliant with obligations around this but need to be cognisant of the requirements for data sharing particularly in the local health economy context where information sharing amongst partners to progress integrated working and vanguard developments is important. The Board resolved to **note** the report and the timescales for the implementation of actions to maintain compliance.	
15/16/68	**DAILY WARD STAFFING FIGURES (JULY AND AUGUST 2015)** Stephen Scorer presented the report. This report included the ward staffing data for June, July and August 2015 as it had been identified that the data provided to the July Board meeting was incorrect. The Board noted that the return to Unify was correctly submitted. Stephen Scorer informed that recruitment work is progressing. In January 2014, there was a gap of 37 nurses and 34 Clinical Support Workers. This gap has been reduced to 18 nurses and the position with Clinical Support Workers is that over-recruitment has taken place and a further 7 individuals have been recruited. Further work continues including the preceptorship programme as many of those appointed are newly qualified nurses. The improved position is anticipated to lead towards an increase in the fill rate due to be evident in September data. The process for the next six monthly review will be starting in October 2015 and will again review establishments.	

	A discussion ensued regarding the cancellation of non-patient activity for staff and it was queried whether this included cancellation of staff appraisal and supervision. Incidents of cancelled patient activity were also noted and it was requested that future reports highlight this where this is becoming a trend. It was noted that work on understanding sickness absence data will help inform whether issues are systematic or isolated occurrences. Commenting on the improved position regarding recruitment, Mike Maier queried whether there had been reductions in those leaving the Trust or retiring. It was noted that CWP staff turnover is not high but here is a need to look more closely at retirement and different ways to retain knowledge and experience. The impact of nurse revalidation could impact on staffing levels if some nurses decide not to do it. If large numbers did not renew, then this could be a risk. Dr Jim O'Connor commented for the need for continuing assurance on safety and quality of care in the areas with staffing gaps and ensuring sufficient staff support is in place while we continue to work toward achieving our desired recruitment levels. Sheena Cumiskey informed that the report only comments on ward staffing and does not take into account the community or multiagency staffing support. It was also noted that community teams also need that added support themselves as they are often operating at over capacity and this can then potentially risk impacting on quality of care. Stephen Scorer advised that the next report on ward staffing would also include an update on NMC registration and other projects. The Board resolve to **note** the report.	
15/16/69	**LEARNING FROM EXPERIENCE EXECUTIVE SUMMARY REPORT** Dr Anushta Sivananthan introduced the report and reminded Board members that the full Learning from Experience report is received at the Quality Committee. Dr Anushta Sivananthan highlighted the following issues: • Numbers of incidents are higher than the same time last year and there has been an increase since the last trimester. • Good progress is being made in reducing the incidents involving restraint. Benchmarking information was provided in August to formally report on this. A discussion followed regarding the increasing number of incidents which was pleasing in terms of reporting levels, however the expectation had been that category A and B incidents would fall and category C, D and E incidences would rise as part of the zero harm strategy. The increasing number of claims was also noted in this context. It was noted that the Quality Committee are analysing this further and there is a need to consider the differences between mental health and physical health services which can impact on the numbers. The reporting of staff concerns was queried and where the Board can expect to see information on this. It was noted that the Learning from Experience would report these and that there were no reports in this	

	trimester. It was requested that future reports note a NIL return in future. **Action:** LFE to reflect NIL return on staff concerns where there are none to report. The Board of Directors resolved to **approve** the report and **endorse** the recommendations contained within. (Maria Nelligan joined the meeting)	**SS**
15/16/70	**INFECTION, PREVENTION AND CONTROL Q1 REPORT 2015/16** Maria Nelligan was welcomed to the meeting. Maria informed the Board that Infection, Prevention and Control Team will be managed by Andrea Hughes from 12th October 2015 following Maria's departure from the Trust. Highlighting some key issues from the report, Maria Nelligan informed that Amanda Miskell is speaking at the national conference for IPC. The contract with Cheshire West and Chester is also progressing well with no exceptions to report. David Eva congratulated Maria on her new post at North Staffordshire NHS Foundation Trust and extended thanks on behalf of the Board to Maria for her long service to the Trust. The Board of Directors resolved to **note** the report. (Maria Nelligan left the meeting)	
15/16/71	**EMERGENCY PLANNING ANNUAL REPORT 2014/15** Andy Styring introduced the Emergency Planning Annual Report 2014/15 and highlighted the following key issues: • CWP continues to be a part of the local resilience partnership and part of the Merseyside partnership. • The most significant event in 2014/15 was the Saddlebridge incident. This was well managed from an emergency planning perspective and post incident review work has led to joint emergency planning between northwest providers and NHS England, and the development of three local incident rooms. • An extensive review of on call processes has been undertaken. • CWP have responded to recent incidents impacting on people within the Trust's geography including the recent Tunisia shootings and the mill fire in east Cheshire. • There will shortly be changes to the Emergency Planning team. Neil Furness is leaving to take up post at another Trust and Tim Jenkins has been appointed to this post. Sheena Cumiskey commended the work of the Emergency Planning team particularly following incidents where plans have been tested such as the Saddlebridge incident. The Board resolved to **note** the report.	

15/16/72	**CQC STATEMENT OF PURPOSE – AMENDED POSITION** Dr Anushta Sivananthan presented the reviewed CQC statement of purpose. This has been updated to include the services at the Westminster practice. The Board resolved to **note** the information held within the Statement of Purpose and **approve** the submission to the CQC registration team	
15/16/73	**AUDIT COMMITTEE REPORTING – MEETING OF 1ST SEPTEMBER 2015** Mike Maier, Chair of Audit Committee highlighted the following issues discussed at the last meeting. These included: • The cyber risk report had some shortcomings. Further work will be undertaken including the gathering of more specialist knowledge required for a fuller assessment of the risk which will be brought to the October audit committee. • A final report on the procurement strategy was received. The Committee commented on the pace and quantity of savings but received assurance that these will be expedited. The Board resolved to receive the minutes of the Audit Committee.	
15/16/74	**QUALITY COMMITTEE REPORTING – MEETING OF 2ND SEPTEMBER 2015** Lucy Crumplin, Deputy Chair of the Quality Committee highlighted the following issues discussed at the last meeting. • A new risk has been added to the risk register regarding pharmacy and staffing. • Continuing impetus of the zero harm strategy and the need to ensure close consideration and monitoring to ensure impacts of financial savings do not affect quality of care. • Locality data pack work is progressing well and these are being well received by clinicians and services. • Seclusion – this was a theme arising from the CQC inspection. There is some confusion around what defines seclusion. Further work is needed on these definitions and ensuring a consistent approach to these and the recording of these incidences. It was noted the task and finish group is taking this work forward. The Board resolved to receive the minutes of the Quality Committee.	
15/16/75	**REVIEW OF RISK IMPACTS OF ITEMS DISCUSSED** It was noted that a risk review of the tendering risk is required to ensure this is fully reflective of the current commissioning position.	
15/16/76	**ANY OTHER BUSINESS** David offered the governors and members of the public in attendance the opportunity to comment or to ask a question regarding the items discussed.	

15/16/77	**REVIEW OF MEETING** All agreed that the meeting had been purposeful and effective.	
15/16/78	**DATE, TIME AND PLACE OF NEXT MEETING** Wednesday 25th November, 2pm, Boardroom, Redesmere. .	

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

Action points from Board of Directors Meetings
25th November 2015

Date of Meeting	Minute Number	Action	By when	By who	Progress Update	Status
29.7.15	15/16/34	**CHIEF EXECUTIVE'S ANNOUCEMENTS** Issue of underfunding CWP (have been ongoing) for significant period of time and now need benchmarking to clearly show the impact of this and then make a public statement on the Trust position. **Action:** Produce this information and SC and DE to then write to all key commissioners to request a Board to Board with each Commissioner to take this forward.	October 2015	DE/ SC/ TW		In progress
30/09/15	15/16/62	**CORPORATE ASSURANCE FRAMEWORK AND RISK REGISTER** David Eva commented on the tendering risk and whether this is truly reflective of the current environment. It was agreed that this should be remodelled. **Action:** LB to discuss re-modelling	November 2015	LB	Work in progress to re-model risk	In progress

		of the tendering risk with the risk lead Claire James.				
30/09/15	15/16/63	**QUALITY REPORT Q1 2015/16** DE and SC to write to CCGs and other bodies on behalf of the Board of Directors requesting clarity on the future funding of street triage services.	October 2015	SC/DE	ASt wrote to CCGs on this issue and response received from CCGs that monies would be available.	In progress
30/09/15	15/16/63	**QUALITY REPORT Q1 2015/16** Communications team to be asked to consider other ways of communicating the Quality Report and promoting Trust good news stories out in to the public arena.	October 2015	SS/LB	Approach to internal and strategic comms currently under review. Enhanced leadership arrangements in place with Comms and Engagement team	Closed
30/09/15	15/16/66	**EQUALITY ACT COMPLIANCE** SS to clarify third sector distribution of the report.	October 2015	SS	Third sector distribution in line with groups providing services and is representative of the various members of the local communities.	Closed
30/09/15	15/16/69	**LEARNING FROM EXPERIENCE EXECUTIVE SUMMARY REPORT** LFE to reflect NIL return on staff concerns where there are none to report.	December 2015	SS	This will be reflected in next LFE report	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 (via board dashboard)**	Director of Operations	Operational Board				✓			✓		✓		✓
4	**Approve Integrated Governance Framework**	Medical Director Compliance Quality and Regulation	Quality Committee					✓						
5	**Receive Quarterly Quality Reports**	Medical Director Compliance Quality and Regulation	Quality Committee		✓			✓		✓		✓		
6	**Strategic Risk Register and Corporate Assurance Framework**	Medical Director Compliance Quality and Regulation	Quality Committee		✓		✓	✓		✓		✓		✓
7	**Strategic Plan 2014-2019 monitoring**	Director of Finance	Operational Board					✓						
Well Led Domain 2: Capability and Culture														
8	**CQC Community Patient Survey Report 2014/15 and Action Plan**	Director of Nursing, Therapies and Patient	Operational Board					✓						
9	**Single Equality Scheme and Equality Act Compliance**	Director of Nursing, Therapies and Patient	Operational Board					✓						
10	**Avoidable Harm / Zero Harm strategy reporting**	Medical Director Compliance Quality and Regulation	Quality Committee				✓							✓
11	**Staff survey 2014/15**	Director of HR and OD	People and OD subcommittee (Operational Board)											✓
12	**Six monthly staffing review**	Director of Nursing, Therapies and Patient	Quality Committee/ Operational Board				✓					✓		
Monitor Well Led Domain 3: Process and Structures														
13	**Receive and Approve Quarterly Monitor returns**	Director of Finance	N/A	✓			✓		✓			✓		
14	**Receive Learning from Experience Report executive summary**	Director of Nursing, Therapies and Patient	Quality Committee		✓			✓				✓		
15	**Assessment of Quality Governance**	Medical Director Compliance Quality and	Quality Committee		✓		✓		✓			✓		

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

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

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

STANDARDISED REPORT COMMUNICATION

REPORT DETAILS

Report subject:	Corporate assurance framework and risk register – update report
Agenda ref. no:	15/16/86
Report to (meeting):	Board of Directors – meeting in public
Action required:	Discussion and Approval
Date of meeting:	25/11/2015
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. As reported to the September Board meeting, Quality Committee will now undertake individual in-depth reviews of risks, with the Audit Committee undertaking periodic reviews of risk treatment processes for individual risks on an escalation/ enquiry basis.

Assessment – *analysis and considerations of options and risks*

New risks

No new risks have been added to the register since the last update report. However, the Audit Committee agreed at its October 2015 meeting to now formally model the cyber threat risk for the Quality Committee to consider its inclusion in January 2016. Work is underway with the Head of ICT Services to model and score this risk appropriately.

Amended risk scores or re-modelled risks

Risk 12 (data quality having an adverse impact on contractual monitoring) has been increased to 20 in light of recent gaps in data/ information provided for contract monitoring processes in relation to a number of contracts. The increase represents the potential adverse impact (likelihood) of contract query performance notices and now represents the highest rated non direct care risk posed to the Trust. A remedial plan has been sought in relation to this risk for review at the Executive Directors meeting. The Board should be aware that whilst for quarter 2, the measurement domain of the Monitor quality governance framework will remain as Amber-Green, there is an increased likelihood of this being rated as Amber-Red for quarter 3, dependent on the robustness and demonstration of the effectiveness of the remedial plan to the end of December.

As at November 2015, despite remodelling risk 12, the Trust continues to have 12 red rated risks on the strategic risk register; this represents no change since the last report to Board in September 2015.

The October 2015 Audit Committee meeting asked that the Quality Committee schedule an in-depth review of risk 9 (Risk of adverse clinical incident due to quality of record keeping and dual record keeping systems) given the pace in working towards the target risk score. There should also be consideration that the risk description is reviewed to ensure that it captures the current nature of the risk.

Archived risks – none.

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

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

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

Distribution to other people/ groups/ meetings:

Version	Name/ group/ meeting	Date issued
1	E Fergusson to L Brereton	17/11/2015
2	D Wood to L Brereton for Board of Directors	17/11/2015

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

Appendix no.	Appendix title
1	Risk register and corporate assurance framework - November 2015 (full document)

Corporate Assurance Framework

Updated:
17 November 2015

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

Risk no.	Current risk description	Origin/ source	Date initial risk added	Target risk score review date
	and effective services due to inadequate attendance on mandatory training. This may result in harm to patients, litigation claims and breach of legislation.	registers		2015
11	Failure to maintain (and predict the need for) the right number of staff with the right skills/ attitudes in the right place at the right time could impact on the Trust's ability to deliver a safe and effective service against changing needs	Strategic plan 2014/19	05/11/2014	March 2016
12	Data quality may have an adverse impact on external (regulatory, contractual) monitoring and governance ratings and on effective internal decision making regarding service planning and development	External/ independent recommendation	11/05/2010	February 2016
13	Loss of current services due to risks associated with the market environment and the potential for commissioners to seek further competitive tendering for clinical services	Strategic plan 2014/19	05/11/2014	December 2015
14	Risk of not being able to deliver planned financial risk rating due to weaker than planned financial performance and incomplete CIP plans, resulting in potential breach of terms of licence	Locality risk registers and Trust-wide reporting	11/05/2010	March 2016
15	Risk of breach of Trust Licence as a result of external scrutiny	External recommendations	07/12/2011	December 2015

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

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

Risk appetite: 3

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

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

Controls (what we are currently doing about the risk)	Assurances (how do we know we are making an impact)	Gaps in Controls	Further actions that would help achieve the target risk (who and when by)
▪ Physical healthcare network looking at areas such as physical health in mental health and pressure ulcers ▪ Physical health zero harm group in CWP West (which includes review of pressure ulcer care) ▪ Physical health pathway and policy ▪ Essential learning ▪ Patient safety metrics ▪ Falls policy and pathway; falls risk assessment tool (cross reference with risk 3)	▪ Training reports to Patient Safety & Effectiveness Sub Committee (PSESC) ▪ Safety metrics reporting ▪ Learning from Experience reporting ▪ Participation in mental health physical healthcare CQUIN ▪ Assurance Framework completed including triangulation of complaints, incidents and concerns in relation to pressure ulcers, falls and other physical health risks ▪ Healthcare quality improvement programme 2015/16 ▪ Training in Physical Health ▪ Benchmarking CWP performance against NICE Guidelines, Safety	▪ Gaps in relation to new policy and pathway implementation in relation to healthcare monitoring ▪ Commissioners supported the archive of the pressure ulcer specific strategic risk (05/11/2014), however ongoing assurance is required via review at physical healthcare network to ensure care being delivered is evidence based and that standards are continuously improving	Audit via a three month trial across three wards of the proposed CWP physical health early warnings chart against the national chart to compare the number of false positives and gain an understanding of its points of use and practice Clinical Training Manager – Physical Health and Resuscitation January 2016 Undertake quality improvement projects on physical healthcare risks, e.g. falls, pressure ulcers Physical healthcare network 2015/16 healthcare quality improvement programme

	Thermometer etc ▪ Localities have scoped resources, training, support and equipment needed to implement the national CQUIN 2015/2016 – this was reported to PSESC in February 2015 ▪ Improvements are being demonstrated in stage 3 and stage 4 pressure ulcer reporting (trimester 1 2015/16 to-date)		

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

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

Risk appetite: 2

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

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

Controls (what we are currently doing about the risk)	Assurances (how do we know we are making an impact)	Gaps in Controls	Further actions that would help achieve the target risk (who and when by)
▪ Safeguarding policies: ▪ Adult safeguarding policy ▪ Children's safeguarding policy ▪ Mandatory Essential Learning policy ▪ Policy for management of investigations ▪ Policy for management of complaints/ concerns ▪ How to raise and escalate concerns policy including whistleblowing ▪ Health records policy ▪ Incident reporting and management policy ▪ Supervision policy ▪ Visiting of patients by children on adult wards ▪ Prevent assurance framework ▪ Audit programme 2015/16	▪ Learning from experience and incident reporting ▪ Safeguarding exception reporting to Quality Committee ▪ Contractual requirements within NHS standard contract regarding 100% access to supervision and 80% compliance with statutory and mandatory training ▪ Inspection report from CQC safeguarding and looked after children January 2014 – completion of action plan approved by designated nurse ▪ Trustwide Safeguarding Sub Committee minutes, business cycle and terms of reference ▪ Training needs analysis of compliance with intercollegiate guidance	▪ CWP current benchmarked position indicates that a review of current controls in relation to e.g. seclusion/ segregation, restraint, DoLS requires review and/ or improvement to be assured that improper/ incorrect applications are not safeguarding concerns ▪ Current red complaints in CWP East require investigation by the Trust (in parallel to local authority investigation) ▪ Clinical audit plan requires close monitoring to ensure remains on track ▪ Training compliance with Prevent below requirement ▪ New guidance for Prevent required to be implemented ▪ Full impact of Care Act not known	Ensure links between Trustwide Safeguarding Sub Committee and Patient Safety and Effectiveness Sub Committee (for Mental Capacity Act) are effective Associate Director of Nursing & Therapies [Physical Health] End March 2016 Ensure compliance reaches 85% across all levels of safeguarding training Service Directors End March 2016 Scope adequate DoLS and MCA training via needs analysis Education CWP End January 2016

▪ MHA visits ▪ MIAA programme ▪ Link to LSABs and LSCBs ▪ Safeguarding flow chart displayed on all wards and community teams ▪ Locality safeguarding groups ▪ Essential learning ▪ Patient safety metrics ▪ Healthcare quality improvement programme ▪ Compliance visits ▪ Practice audits ▪ CQC visits ▪ Monitoring of safeguarding performance	▪ Monthly tracker of safeguarding training ▪ CCG Self Assessment for Safeguarding Adults and Children ▪ Completion of Section 11 audit and feedback and action plan ▪ Monitoring of Prevent implementation – quarterly reporting to NHS England ▪ Compliance/inspection reports internal ▪ Quarterly performance reports to LSABs and LSCBs ▪ MIAA reports and action plans ▪ Benchmarking reports to Operational Board ▪ Improvements to restraint reduction and seclusion via quality improvement projects ▪ Medical Director Quality/ ▪ Associate Director of Safe Services ▪ End September 2015	▪ Capability and capacity within workforce in relation to front line safeguarding practice requires strengthening within localities	Continue to work closely with LSABs and sub groups to monitor impact of Care Act Members of LSABs and sub groups End October 2015 and ongoing – update end December 2015 Develop the Safeguarding Practitioner Links programme across all localities Named Nurses Safeguarding End September 2015 and ongoing – update end December 2015

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

Risk Owner: Medical Director Quality
Risk Lead: Associate Director of Safe Services

Risk appetite: 3

Risk 3: The inability of staff to manage the occurrences of slips, trips, and falls of patients resulting in patient injury

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

Controls (what we are currently doing about the risk)	Assurances (how do we know we are making an impact)	Gaps in Controls	Further actions that would help achieve the target risk (who and when by)
▪ Falls policy and pathway ▪ Fall Safe care bundle is in place across all wards ▪ Falls risk assessment tool developed for older persons and service users who are known to have a risk of falls ▪ Healthcare quality improvement programme ▪ Links with PCT falls co-ordinators ▪ Patient safety metrics ▪ Falls Task and Finish group ▪ Negotiation of community falls CQUIN for 2015/16 for West and Wirral – this will also be mirrored in East ▪ Wards are currently using the FRAT as guidance, however, all patients over 65 are considered to	▪ External assurance received from acute falls nurse specialist who undertook a review of falls prevention and management. The review found that CWP has a robust system in place for falls management, however, sometimes locally these systems are not always fully implemented. ▪ Ongoing monitoring of proportion of harm/ no harm reporting via the Learning from Experience report ▪ Audit Committee has undertaken two in-depth assurance reviews of the risk during 2014 to agree target risk score of 12 ▪ University of Stirling's Dementia Services Development Centre work re dementia care	▪ Local implementation of environmental improvements and training ▪ FRAT remains incorporated currently within the falls care bundle	Falls task and finish group to meet in quarter 2 of 2015/16 to agree an implementation plan to replace the falls risk assessment tool with an holistic assessment of needs, and also requirements of a CQUIN identified for community falls pathways Head of Clinical Governance End November 2015

be a falls risk on the inpatient units	environments ▪ Prioritised capital programme		

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

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

Risk appetite: TBC

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

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

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

		full service review has been undertaken in line with NDCC workplan ▪ Inability to carry out non-core strategic work of the medicines management business cycle	

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

Risk Owner: Medical Director Quality
Risk Lead: Clinical Directors

Risk appetite: 3

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

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

Controls (what we are currently doing about the risk)	Assurances (how do we know we are making an impact)	Gaps in Controls	Further actions that would help achieve the target risk (who and when by)
▪ Clinical risk management policy ▪ Essential learning ▪ Patient safety metrics ▪ Effective Care Planning Lead in situ ▪ Zero Harm strategy implementation plan ▪ Care co-ordination policy ▪ Appointed clinical care planning lead ▪ Ward manager task and finish groups ▪ Care planning (incorporating risk assessment) meta-analysis undertaken with improvement actions	▪ Patient safety metrics reporting ▪ Data quality/ completeness reporting to wards and teams ▪ Learning from experience and incident reporting ▪ Compliance visits ▪ Critical issues escalated to Patient Safety & Effectiveness Sub Committee	▪ Services not sustaining over 99% completion rates ▪ Further assurance needed on quality of CARSO assessments prior to re-modelling ▪ Care co-ordination policy approved at April 2015 Patient Safety & Effectiveness Sub Committee, agreed a further review by end of 2015 calendar year based on feedback from training, further work around advance statements and an integrated checklist for care planning needs – to better align with standards around formulation of risk and clinical risk standards	Second/ further review of care co-ordination policy that was approved in April 2015 to be undertaken based on feedback from training, further work around advance statements and feedback provided to Effective Care Planning Lead via Matrons and Ward Managers to October meeting of the Patient Safety & Effectiveness Sub Committee – to better align with standards around formulation of risk and clinical risk standards Effective Care Planning Lead December 2015 Workshops to be held to educate staff on effective care planning, enabled through the managerial/ supervisory hierarchy Education CWP End March 2016

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

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

Risk appetite: 3

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

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

Controls (what we are currently doing about the risk)	Assurances (how do we know we are making an impact)	Gaps in Controls	Further actions that would help achieve the target risk (who and when by)
▪ Incident reporting and management policy ▪ Complaints management policy ▪ Essential learning ▪ Quality assurance group with Non Executive Director review ▪ Weekly meeting of harm with senior oversight (Director of Nursing, Therapies and Patient Partnership and Medical Director) ▪ Learning from experience report ▪ Commissioner serious incident meetings ▪ Healthcare quality improvement programme ▪ SUI Board report ▪ Investment in clinical expert champion for serious incidents	▪ Learning from experience reporting ▪ Compliance, Assurance & Learning Sub Committee review of completion of serious incident investigations ▪ Quality Committee review of Regulation 28 learning ▪ Board review of level 3 investigations ▪ Audit Committee in-depth review of current assurances March 2015 ▪ The governance of ensuring duty of candour is recorded ▪ Significant assurance received from Internal Audit regarding incident reporting and	▪ Incident reporting and management policy does not reflect standards agreed with commissioners ▪ Agreement required on formal performance management of investigations ▪ Repeated learning themes ▪ Capacity in the Trust to meet contractual timeframes (as per NHS England guidance)	2015/16 contracts to agree performance management standards Head of Clinical Governance Ongoing (based on iterative discussions with commissioners) Theme incomplete/ outstanding individual actions in response to investigations into serious incidents reported by the Trust and identifying how these thematic areas have been/ will be addressed through existing/ planned work programmes Service Directors January 2016 Develop trajectories and forecasts based on the Trust's claims portal

and bank of investigation officers	management		data – trail by forecasting quarters 3 and 4 Safe Services Department/ Finance Department

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

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

Risk appetite: 2

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

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

Controls (what we are currently doing about the risk)	Assurances (how do we know we are making an impact)	Gaps in Controls	Further actions that would help achieve the target risk (who and when by)
▪ Environmental clinical risk assessment policy ▪ Seclusion and segregation policy reviewed against new MHA Code of Practice guidance, including associated education programme ▪ Board approved capital programme in place ▪ Patient safety walkrounds ▪ Cascade of safety alerts ▪ Suicide prevention action group meeting ▪ Suicide prevention strategy/ assurance framework ▪ Zero Harm strategy ▪ Compliance visits ▪ Patient safety metrics ▪ Testing protocol for door top alarm system	▪ Works completed (October 2014) regarding en-suite door top alarm systems and clinical risk management of dressing gown cords ▪ Patient safety metrics reporting ▪ Staff trained and guidance provided on the technical aspects of the en-suite door top alarm system ▪ Reporting to Operational Board on locality risks ▪ Reporting to Patient Safety & Effectiveness Sub Committee on outputs of suicide prevention strategy work ▪ Continuous improvement of patient environment ▪ Significant investment in ligature	▪ No formal link between HoNOS score and self-harm risk and/ or sudden new or sudden emergence of known risk factors to self ▪ Alignment of clinical and environmental risk management to be further enhanced ▪ Review required of the standard of rooms which being used as an emergency contingency measure for seclusion purposes	Task and finish group to review current policy to ensure observation and environment standards are aligned and HoNOS score of 4 scoped/ operationalised as a trigger for clinical risk management plans when self-harm risk and/ or sudden new or sudden emergence of known risk factors to self. Consultant Nurse Acute Care November 2015 (deferred from April 2015 following level 3 recommendation to Board and change of meeting schedule of Patient Safety & Effectiveness Sub Committee) Capital plan to presented to Operational Board

▪ Operational risk registers monitor local controls ▪ Estates network ▪ Monthly seclusion task and finish group (from May 2015) ▪ Peer benchmarking groups: CAMHS Secure Eating Disorder Learning Disability ▪ New build – secure services and CAMHS Tier 4 unit ▪ Ligature points are risk assessed by a process involving systematic examination of identified areas including external reviews of estate re ligatures ▪ Each ward has a ligature “floor map” of all the bedrooms and bathrooms and identifies any potential ligature points – this supports staff when allocating bedrooms to facilitate clinical risk assessment and management ▪ Safeguards (flow chart setting out escalation procedures) for seclusion incidents	remedial work over the last 4 years		Associate Director Infrastructure Services November 2015

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

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

Risk appetite: 4

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

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

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

partnerships, e.g. via pathfinder model ▪ Establishing even better strategic partnerships with commissioners and providers to maximise adverse impact upon services to citizens ▪ Vanguard; provider partnerships ▪ Active partner in the Vanguards in Wirral and West Cheshire ▪ Key partner in Connecting Care and Caring Together			leaders - cascade through CWP Immediate and ongoing

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

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

Risk appetite: 4

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

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

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

			Interim audit in place, process to review alerts audit to be developed September 2015 (deferred to end November 2015 pending confirmation from supplier) In-depth review of this strategic risk, with review of the risk description to ensure that it captures the current nature of the risk Associate Director of Performance & Redesign January 2016

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

Risk Owner:	**Director of Nursing, Therapies and Patient Partnership**
Risk Lead:	**Associate Director of Nursing & Therapies (Mental Health)**

Risk appetite: 2

Risk 10: Risk of not being able to deliver safe and effective services due to inadequate attendance on mandatory training. This may result in harm to patients, litigation claims and breach of legislation.

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

Controls (what we are currently doing about the risk)	Assurances (how do we know we are making an impact)	Gaps in Controls	Further actions that would help achieve the target risk (who and when by)
▪ Essential learning and induction policy ▪ Trust training strategy in place responsive to corporate services review, planning priorities, Francis/ Berwick reports, CWP always events framework ▪ Approved essential learning programme approved by October 2013 Operational Board ▪ E-learning and rolling half days available ▪ Essentials 1 target in place: 85% to take into account turnover and other absences and longitudinal targets have been agreed (to 90% over two years) ▪ New 'Education Governance Group' to enable partnership working	▪ 2014/15 CWP performance dashboard identifying continuous improvements in essential learning compliance Trustwide ▪ Compliance data reviewed at People and Organisational Development Sub Committee and feeds into quality dashboard (Quality Committee), performance reviews and supervision/ appraisal (via 'trigger reports') ▪ Audit Committee has undertaken an in-depth assurance review of the risk during 2014 to agree target risk score of 12 by December 2015 ▪ Human Factors training events have been run throughout 2014/15. Over 100 staff have been trained to become 'culture	▪ Reported gaps in current essential learning programme content, e.g. fire, safeguarding, physical health in mental health, suicide training, psychological interventions, dementia, personality disorder, human factors, risk assessment, care planning, specifics for district nurses, clinical supervision ▪ Essential learning policy needs to reflect the Essentials framework training needs analysis that was agreed by POD Sub Committee in May 2015 ▪ Assurance around capacity of training schedule to meet demand	Delivery plan for training programme to be implemented Associate Director of Nursing and Therapies (Mental Health) Ongoing Consider outcomes of CQC inspection and following this, consider re-modelling or archiving risk. Ensure consideration of feedback at November 2015 Quality Committee – training as teams, training needs aligned to emerging clinical and organisational risk, Human Factors etc Head of Education November 2015

▪ Action plan in place re review of the essential learning programme ▪ Extended hours to support e-learning at training venues ▪ Development of 12 hour days for inpatient staff introduced to increase compliance ▪ Monthly trigger reports provided to service managers that includes current position and DNA rates	carriers' throughout CWP. During 2015, there are additional plans to extend this group and numbers so that the Human Factors message is embedded within CWP ▪ Training venue in Macclesfield introduced February 2014 to facilitate improved compliance		

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

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

Risk appetite: 4

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

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

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

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

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

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

Risk appetite: 4

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

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

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

		Recent gaps in data/ information provided for contract monitoring processes in relation to the Wirral Early Intervention, Sefton IAPT and Secure Services contracts	Redesign End November 2015

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

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

Risk appetite: 4

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

Initial Risk (inherent)			Current Risk (Residual)			Target Risk		
Likelihood	Consequence	Score	Likelihood	Consequence	Score	Likelihood	Consequence	Score
3	4	12	3	3	9	1	3	3

Controls (what we are currently doing about the risk)	Assurances (how do we know we are making an impact)	Gaps in Controls	Further actions that would help achieve the target risk (who and when by)
▪ Clinical and financial review and involvement throughout tender process ▪ Ability to influence commissioners via close working relationships ▪ History of good performance ▪ Robust Standard Operating procedures developed by Effective Services to respond to tender opportunities ▪ A non-direct care cost review is currently being undertaken and this will help to identify any gaps in current tendering processes and skills	▪ Clinical and financial review and involvement throughout the tender process ▪ Executive Director sponsor assigned to each tender ▪ 'Black hat' meeting undertaken in advance of tender submission ▪ Executive Director sign off of tender submission ▪ It is acknowledged that this risk score is likely to be volatile based on market environment	▪ Lack of business development strategy ▪ Bid writing constraints ▪ Contract management capacity constraints ▪ Costing and pricing capacity ▪ Current tendering exercises in the CWP West locality of value £25,000 - £100,000	Monitor impact of Service Improvement Framework to address the gaps in controls, to guide localities, mitigate governance issues associated with sub contracted services, and to bring about consistency to mitigate the volatility of the risk score Business Development and Innovation Sub Committee/ Effective Services Department Ongoing throughout 2015/16 Business Development Framework under development Associate Director, Effective Services March 2016

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

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

Risk appetite: 4

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

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

Controls (what we are currently doing about the risk)	Assurances (how do we know we are making an impact)	Gaps in Controls	Further actions that would help achieve the target risk (who and when by)
▪ Budget statements detail CIP ▪ Quarterly financial risk rating to Monitor ▪ Quarterly performance reviews address financial issues ▪ Associate Director of Performance and Redesign leading CIP management process/ tracking of CIP delivery ▪ Strengthened financial infrastructure via locality accountants ▪ Board approved operational plan including 2014/15 CIP plans ▪ Monthly reporting to Operational Board ▪ CIP forward planning events held in August 2014 to start the 2015/16 process ▪ Impact assessment process	▪ Impact assessment of service redesign as part of the annual planning processes ▪ CWP performance report monthly monitoring ▪ Regular monitoring via CIP steering group ▪ Internal audit programme mapped to financial strategy ▪ Audit Committee and Quality Committee overview ▪ Weekly reporting to Exec team ▪ Formal review in quarterly Performance Reviews with services ▪ Improvement in M4 and M5 positions	▪ Quality of CIP plans ▪ Plans off track ▪ Uncertainty of commissioning intentions ▪ Inability to influence the overall budget available to commissioners ▪ Fully understanding of issues driving expenditure	To continue to review quality of CIP plans and those off track (as part of 2015/16 efficiency targets) Associate Director of Performance and Redesign Ongoing 2015/16 Agree strategic service plans with commissioners based either on disinvestment from CWP or reinvestment to deliver wider systemic efficiencies Service Directors Ongoing 2015/16 Implementation of Financial Recovery Plan 2015/16 and monthly reporting to Operational Board/ Board of Directors Ongoing until return to Plan 2015/16.

▪ Associate Director of Performance & Redesign and Director of Operations meeting with Service Directors to review progress ▪ Development of Integrated Provider/ Commissioning Hubs to manage service re-design; delivery in a more strategic manner ▪ Shared planning via emerging Vanguard model ▪ Review and redesign of non-direct clinical care services to achieve greater efficiencies ▪ Financial Recovery Plan 15/16 approved by Board of Directors, July 2015 ▪ Monthly monitoring of financial recovery plan ▪ Agreement of Contracting Strategy for 2015/16			Draft Financial Plan 2016/17 to be approved Board of Directors January 2016

Strategic Objective: 7. Be recognised as an open and progressive organisation that is about care, well-being and partnership

Risk Owner: Chief Executive
Risk Lead: Associate Director of Safe Services

Risk appetite: 2

Risk 15: Risk of breach of the Trust Licence as a result of external scrutiny

Initial Risk (inherent)			Current Risk (Residual)			Target Risk		
Likelihood	Consequence	Score	Likelihood	Consequence	Score	Likelihood	Consequence	Score
4	5	20	3	4	12	2	4	8

Controls (what we are currently doing about the risk)	Assurances (how do we know we are making an impact)	Gaps in Controls	Further actions that would help achieve the target risk (who and when by)
▪ Integrated Governance Framework ▪ Internal audit plan ▪ External scrutiny by other agencies ▪ Regular patient surveys ▪ Provider licence self-assessment process in place reporting to Board ▪ Increased visibility of compliance against Provider Licence through quarterly reporting to Audit Committee	▪ Quality dashboard/ locality data pack reporting ▪ Regular meetings with commissioners to review contractual performance ▪ All registered locations are currently compliant ▪ Currently no concerns in relation to CQC compliance ▪ Monitor governance rating Green ▪ Audit Committee undertook in-depth review of this risk at May 2014 meeting (risk score 10 identified, subsequently amended to 8) ▪ Current CQC intelligence monitoring report highlights CWP as a low risk organisation ▪ April 2015 – internal audit of compliance received significant assurance	▪ CQC announced inspection scheduled w/c 22 June 2015 (assurances pending)	Await and respond to CQC draft report providing assurance to archive risk or otherwise Head of Compliance End November 2015

	▪ CELF workshop and staff survey undertaken to understand initial feedback on staff experiences ▪ MHA commissioner visits undertaken since CQC visit. ▪ MHA ward audits programme now underway		

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

Quality Report

Quarter 2
July – September 2015

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

Service users from the Sunny Café
attended this year's **Best Practice Event**
(See page 7 for further details)

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 second *Quality Report* of 2015/16

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* and the previous *Quality Report*s 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 2015/16 in quarter 2
➲ see page 5

The quality improvement project to reduce prone position restraint incidents has resulted in a significant reduction of 50%
➲ see page 6

CWP's third annual Best Practice Event launched the Big Book of Best Practice
➲ see page 7

A combined service for patients requiring alcohol detoxification has reduced the number of alcohol related hospital admissions
➲ see page 8

Physiotherapy assessment has improved service for patients with musculoskeletal problems
➲ see page 8

A CWP Nurse has been recognised for her work in national quality awards
➲ see page 10

An open day has been held to celebrate the work of Crewe Recovery College
➲ see page 11

CWP is part of a project to provide state of the art telehealth support to enable people to safely manage their health and retain at-home independence
➲ see page 13

QUALITY PRIORITIES 2015/16

CWP has set three **Trustwide quality priorities** for 2015/16, 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 2015/16 – 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:

- The locality data packs (LDPs) have been further developed, including a pilot of a CAMHS locality data pack which will inform how to roll out other specialty LDPs. These data packs will continue to act as a key line of enquiry in order to bring about **continuous improvement**.
- The Trust's suicide prevention assurance framework has been aligned with the Cheshire-Merseyside suicide prevention strategy. Work has continued on how to further ensure that education on suicide reduction/ prevention contributes to this agenda. See more detail on page 10.

Clinical Effectiveness priority for 2015/16 – 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:

- 40 ideas were submitted to round two of the innovation competition, which the innovation panel reviewed in quarter 2. Actions are now being followed up and all round one and round two idea generators are being kept informed and involved in developing their idea.
- The Healthcare Quality Improvement team has completed a number of **quality improvement** projects. Working as a virtual team has enabled collaboration on a number of projects on the Healthcare Quality Improvement programme and the development of improved action plans.

Patient Experience priority for 2015/16 – 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:

- An online survey is being used to gather further feedback on what the Trust's values mean to people who deliver the Trust's services. As part of the wider appraisal review which took place in quarter 2, values have been incorporated in performance reviews/ appraisals.
- Questionnaires are now being sent to all people who have raised a concern/ made a complaint to evaluate how they believe their complaints/ concerns were dealt with. Learning from this will be incorporated into training and further shared through sharelearning bulletins.

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.

Accelerating Restraint Reduction

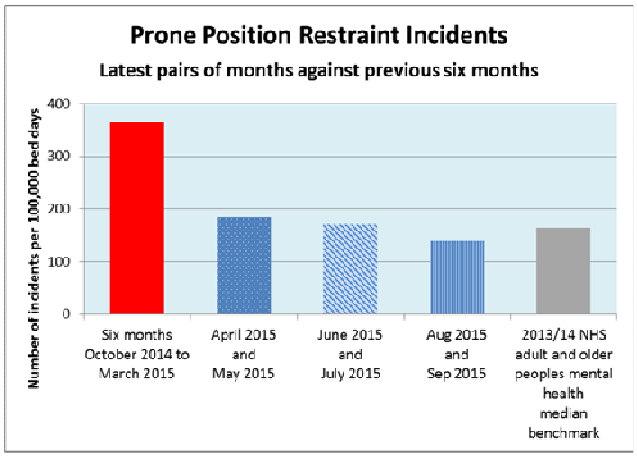
Research undertaken by the mental health charity MIND, found huge levels of variation across the country in the use of physical restraint, and highlighted the psychological and physical injuries caused as a direct result of being physically restrained. In response, CWP developed a quality improvement project to specifically understand the reasons for the variation and prevalence of the use of prone position (face down) restraint across its inpatient services, in order to identify improvement actions in response.

What we did

- Set up a task and finish group, led by the Medical Director, involving the Safe Services Department, Safety and Security lead, and Matrons.
- Trustwide communication of the quality improvement project, linked to Zero Harm messaging.
- Incidents of prone position restraint were reported monthly to the Board.
- Matrons undertook a 72 hour reflective review of each restraint incident, including patient's views.
- A staff survey was undertaken.
- Reporting of prone position restraint began at ward level through locality data packs.
- Quality Surveillance Support Managers completed a meta-analysis on the use of restraint, seclusion and rapid tranquilisation.
- As part of the Healthcare Quality Improvement programme, clinical audits and comprehensive reviews were completed on the use of restraint, the management of challenging behavior and the use of seclusion care bundles.
- An enabling meeting was held with Matrons, and representatives of the ward managers to produce an action plan to ensure sustainability of the significant improvements achieved.

Impact

To-date, the quality improvement project has resulted in a **significant reduction of 50%** in the use of prone position of restraint, as illustrated in the graph. We have attributed the improvement to a number of factors including the Matrons' reviews driving up data quality and sharing/ implementing learning as a result of reflective practice.



Data also shows that there has been a very notable reduction in seclusion incidents recorded as such, since a high point in March 2015.

A comprehensive report on the management of challenging behavior was compiled in August, which aggregated data on current clinical practice across the Trust to provide an overarching picture which will direct next steps to sustain improvement.

Next steps

A sustaining improvement plan has been developed, which details those actions needed to sustain the significant improvements seen, including through development and enabling work which focuses on behaviours. CWP hopes to publish the findings of the quality improvement project to share the hard work done by staff to improve the quality of care by reducing the use of prone position restraint and improve safety for people accessing and delivering the Trust's services.

CWP's third annual Best Practice Event

This year's Best Practice event and Annual Members' Meeting was held in Chester. The first part of the day featured the launch of the Big Book of Best Practice, with over forty staff exhibits showcasing their **innovative** work. Service users, staff and the public were welcomed to see some of the many examples of best practice happening across the Trust.

The Big Book of Best Practice is part of the Trust's #CWPZeroHarm campaign. Zero Harm's key message is Stop Think Listen – a concept that involves supporting everyone to deliver the **best care** possible, as **safely** as possible and in doing so reducing unnecessary avoidable harms.

Since the campaign's launch, CWP has invested in creating an environment that allows the maximum number of people to achieve good outcomes and positive recovery, with the smallest number of people experiencing adverse outcomes. Over the last year our commitment to Zero Harm has received national recognition, and was featured in the Health Service Journal.

You can follow what happened on the day on Twitter #CWP2015 or visit www.cwp.nhs.uk to download a copy of this year's Big Book of Best Practice.

Anushta Sivananthan, consultant psychiatrist and medical director, says:

"I was absolutely delighted to welcome our staff, members and external colleagues to our third annual Big Book of Best Practice. It is always fantastic to see how staff at CWP embrace sharing innovation, improvement and good practice to **deliver high quality care**."

Staff nominated for this year's going the extra mile award, which was part of the Annual Member's Meeting are picture left.

Wirral – Birchwood Detoxification Project

Care packages for people with complex needs requiring alcohol detoxification

In April 2015, staff from CWP's specialist drugs and alcohol team were seconded to Birchwood House Residential Detoxification Unit, in partnership with Arch Initiatives a charity in Wirral. CWP staff were asked to provide clinical expertise around pharmacological and nursing management of opiate and alcohol reduction.

What they did

The two services combined their resources, skills and knowledge to provide a unique blend of motivational care giving.

Results

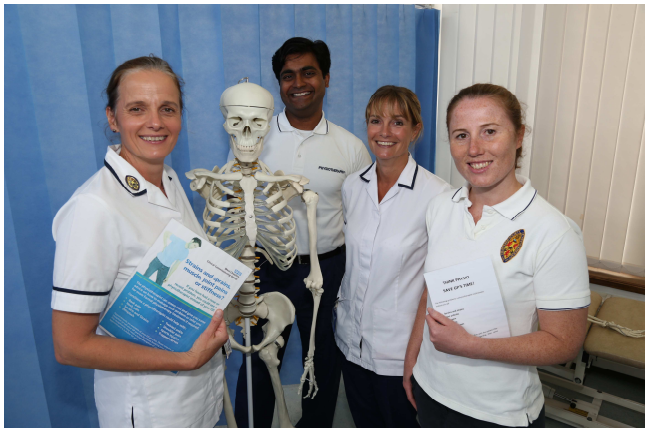
By combining resources, the project has helped reduce the number of alcohol related admissions. Service users have been able to be admitted to the detoxification unit after presenting at A&E, resulting in significant savings in hospital bed costs. Service users experience a smoother transition to becoming drug or alcohol free. The unit is able to accept admissions seven days a week.

Next steps

The team will continue to develop and expand the current service provision by learning from patient experience and developing integrated care pathways.

West Cheshire Physiotherapy Service

Direct access to support musculoskeletal patients at GP practices



What did the service want to achieve?

To improve access to assessment and advice for patients with musculoskeletal symptoms throughout West Cheshire by introducing physiotherapists into GP practices. This would free up GP appointments for other medical problems. Patients with musculoskeletal symptoms would get prompt diagnosis and self-management advice.

What they did

Physiotherapists were introduced to a number of GP practices in Cheshire West to provide musculoskeletal assessments for a three month pilot. Following the success of the pilot, the service gained more funding from the Prime Minister's Challenge Fund and the initiative has been extended to run until July 2016. Patient experience and feedback was collected by questionnaire, and the team also looked at service uptake and outcome of appointments.

Results

Over the three month pilot, 754 patients accessed the service, seeing physiotherapists rather than their GP. Uptake for the practice based appointments was better than for hospital based services. Over half the patients were discharged with advice and a third were referred for physiotherapy. A small number were referred for more specialist advice. Feedback from patients was very positive – 97% had all their issues addressed.

Next steps

The Direct Access Physiotherapy Service is working with West Cheshire CCG to roll out the programme to Neston practices from August 2015. After further recruitment there is a planned roll out to rural and Chester practices.

East – Child and Adolescent Mental Health Services

What did the service want to achieve?

To establish the first NHS Health Service group of young advisors to help improve CAMHS services and engage young people in community life and local decision making.

What they did

The CAMHS team worked closely with the national Young Advisors charity and an existing group of services users to develop a bespoke accredited training package that gave the young people involved a host of skills. These included youth 'proofing', peer mentorship and community mapping.

Results

Since November 2014 the Young Advisors have been commissioned to work on 23 projects and much of this work is ongoing. The young people are paid for their work and the programme also generates an additional sum that the team can invest in either additional training or projects in the local community.

Next steps

The team will continue to develop the Young Advisors group further creating a pathway of learning and development and supporting recovery.

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

NO MORE Zero Suicide

Trustwide suicide prevention/ reduction assurance framework

The Trust's assurance framework for the prevention/ reduction of suicide was developed in February 2014. It evolved from the Trust's action plan which had previously been in place. This framework is updated for each Patient Safety and Effectiveness Sub Committee to give oversight of the work being undertaken across the Trust and to give assurance that recent incidents and alerts have been discussed at the Environmental Suicide Prevention group. The Merseyside and Cheshire strategy for Zero Suicide 2015-2020 was developed during quarter 2. Work continues to take place with colleagues from Public Health in East, West and Wirral in relation to the joint suicide reduction assessment framework. Moving forward, this joint work will implement and operationalise the Zero Suicide strategy. The Head of Clinical Governance and the Incidents team are undertaking a thorough review of incidents in relation to self-harm, suicide attempts and suicides within CWP to inform the strategy. The Head of Clinical Governance will also approach the Trust's partner organisations to agree a way forward to benchmark CWP's work and to gain mutual support.

Clinical Effectiveness News

FOR HEALTHCARE LEADERS HSJ 2015 AWARDS In partnership with celesio

National award for CWP Nurse

CWP Community Mental Health Nurse Julie Sheen has been included in the HSJ's first ever top 50 Patient Leaders list. This award is designed to celebrate the full breadth of patients and citizens' role in healthcare – from shaping national policy and influencing the NHS nationally, to individuals making waves through being involved in their own care.

HSJ invited readers to nominate people for judges to consider and a panel of expert judges, including MP and former Health secretary Alan Johnson, selected the final 50.

Julie has been a lived experience adviser for CWP since 2009 and last year she became an employee after qualifying as a mental health nurse. In 2014, Nursing Times named her care maker of the year at their student awards and now she has been honoured by HSJ.

The HSJ judges said:

> "Julie has had a massive impact on the development of mental health provision locally, helping obtain funding from West Cheshire Clinical Commissioning Group for a programme of recovery work including tai chi, mindfulness and cookery."

When her place on the list was announced, Julie said:

> "I am overwhelmed but delighted to be listed alongside other inspirational patient leaders. The voice of the service user is paramount to me and I simply enjoy what I do because it makes a real difference to the outcomes for others."

New single point of access referral model for CWP Wirral

Following a recent review of referral methods into CWP Wirral Services, a new open referral model – providing a single front door into all Wirral services is set to launch.

This new referral model is designed to ensure that access for service users is consistent, simple and efficient and a better response to patient needs as well as less duplication for everyone.

Criminal Justice Liaison Service

CWP is to extend their existing criminal justice liaison service following a successful bid to NHS England. From 1 October, a number of CWP community mental health practitioners will be located as part of an extended team into Middlewich and Blacon police custody suites and in Chester, Crewe and Macclesfield Magistrates Courts. Mental health support will also be provided to Chester Crown Court as part of this new initiative.
The practitioners will be in place Monday to Friday to help support individuals who come into contact with local criminal justice services across Cheshire. In line with national recommendations to ensure people with suspected mental health problems are assessed more quickly when they are held by police, this proactive and innovative service will enable CWP to provide a whole range of mental health services working in partnership with the Police and courts within Cheshire.

Gordon Leonard, Specialist Forensic Lead said:

> "We are proud to have won the grant from NHS England to provide this service, which will enable us to step in and provide the right support at the right time in the right place by the right people."

Patient Experience News and patient feedback

Open Day at Crewe Recovery College

Patients, families and carers gathered on Wednesday 26 August to celebrate the work of CWP's Recovery College in Crewe.

In the spirit of co-production, the day was organised in collaboration with patients, carers and staff and was attended by many partner services. Crewe Recovery College follows an adult education model and aims to deliver a curriculum which contains responsive recovery focused workshops.

The Recovery Colleges offer free courses to enhance patients' well-being and are open to:

- Individuals who are 18 or over who use services delivered by the Community Mental Health teams.
- Families and friends of those who use services delivered by the Community Mental Health teams.
- CWP staff who work within secondary care services.

CWP has Recovery Colleges in Crewe, Macclesfield, West Cheshire and Wirral.

Each College has been created with dedicated and focussed co-produced work between our recovery team, and recovery action group members with a wide range of external partnerships to develop a truly innovative approach to increasing recovery opportunities for all. All the workshops, where possible, are co-produced and co-delivered by people who have experience of mental health conditions, together with partnerships within CWP and our local community.

Impact

A fundamental element of Recovery Colleges is helping people to become more skilled and practised in managing their own condition, and own self-care. There is good evidence to show the effectiveness of supporting self-management education in health conditions of all types.

Conclusion & Next Steps

East Recovery College offers opportunities to people with both mental and physical health conditions as part of a joined up service and stepped approach to recovery. CWP is now into its fourth year of its Recovery Strategy, providing hope, control and opportunities for all.

Improving patient experience on Croft ward

CWP re-opened Croft ward in the summer following an investment of £340,000 which has transformed the ward and vastly improved the inpatient facility for patients with dementia. Improvements have included a new open plan activity area, private bedrooms for individuals, as well as a spacious dining room with doors opening to a patio and garden area. The décor is themed 'Memory Lane' to provide a reminiscent environment in line with current thinking around improving outcomes for people with memory issues and is bright and cheerful.

People using the services, their families and representatives from the Alzheimer's Society were involved throughout the development to ensure that people's needs and care remained a priority.

The development of the Croft well-being in dementia BLOG and a newsletter for carer's have also enhanced the quality and availability of information for patient's families and carers.

Julia Cottier, CWP Service Director for CWP East, says:

> "Dementia can be a very challenging illness that 1 in 3 of us over 65 will be diagnosed with. The new facilities 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."

Telehealth Project

In partnership with NHS West Cheshire Clinical Commissioning Group and Royal Philips, CWP is part of a project to provide state of the art telehealth support and equipment to enable people to safely manage their health and retain at-home independence.

The supported Self Care Champion Project is designed to encourage greater independence for people living with multiple long-term health conditions and complex needs. The project aims to provide a customised telehealth programme to support their level of need. This pilot project aims to improve patient experience and simultaneously relieve pressure on the local health system.

Dr Lesley Appleton, clinical lead for long-term conditions, NHS West Cheshire CCG said:

> "Telehealth is a way of providing care at, or as close to, home as possible. [The idea is to address] people's problems as they arise, so their condition does not deteriorate and their need for ongoing GP or other health care consultations are reduced - as is their need for hospital admission."

Sheena Cumiskey, CEO of Cheshire and Wirral Partnership NHS Foundation Trust said:

> "We are excited to be working in partnership with West Cheshire CCG and Philips on this new project. Our hope is that this will provide us with unique insights on how best to roll out integrated care support across our area."

In quarter 2, CWP formally received 1173 ***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:

Physical health services – CWP West
"Thanks… as usual you're a star shining brightly in our shadowed lives."

Adult mental health services – CWP West
"We are delighted to see our daughter reaching a level of well-being that they have not seen for a long time. Thank you for all your hard work."

Child and Adolescent Mental health services – CWP Wirral
"My son received a diagnosis of PTSD earlier this year after being in Hurricane Katrina when he was 7 years old as we were we stranded there after a family holiday. The service he has received from CAMHS has been excellent from the first appointment that my husband and I also attended to the ongoing sessions he has received since. He is a much more confident person now. My husband and I would like to thank the therapists involved in his treatment for their professionalism and the work they did with our son. They maintained contact throughout his treatment and enabled him to have a very mature and focused approach to his treatment and recovery."

Learning Disabilities Services – CWP East
"You have helped our daughter to get better for a happy life. Thanks for the kind and lovely way you looked after our daughter."

Older adult mental health services – CWP Wirral
"All staff helpful: Doctors, Nurses, Carers, Tea Lady and Laundry Lady. I could not speak highly enough. I don't think you can improve. Keep up the good work you do already."

Share your stories

We welcome feedback about any of the Trust's services; please share your stories via the Safe Services Department on 01244 393138

Look out for more quality stories in the quarter 3 *Quality Report*

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

STANDARDISED REPORT COMMUNICATION

REPORT DETAILS

Report subject:	Corporate Board Performance Report October 2015
Agenda ref. no:	15/16/88
Report to (meeting):	Board of Directors
Action required:	Discussion and Approval
Date of meeting:	25/11/2015
Presented by:	Tim Welch, Director of Finance/Deputy Chief Executive

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

REPORT BRIEFING

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

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

Background – *contextual and background information pertinent to the situation/ purpose of the report*
Having reviewed performance against our key KPI/priority areas, key lines of enquiry [KLOE] were identified. Operational board reviewed and discussed the KLOE. Feedback was provided by each KLOE owner. Service Directors and Clinical Support Services provided an overview of actions being taken to understand and improve performance with indicative timescales for improvement.

Assessment – *analysis and considerations of options and risks*
Following review of the CPR at Operational Board it was agreed to exception report the following areas to the Board of Directors: 1. Localities overspend and CIP underperformance; and 2. Delayed transfer of care [DTOC]

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

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

Distribution to other people/ groups/ meetings:

Version	Name/ group/ meeting	Date issued
0.1	Locality Management Teams	11 November 2015
1.0	Operational Board	18 November 2015

CWP Board Dashboard

Reporting Month: October 2015

Exception Reports

Cheshire and Wirral Partnership NHS Foundation Trust

	Previous month	Current month	Trend
Monitor Targets - 7 [SO 1 & 5]			
Finance [SO 6]			
Income & Expenditure			
CoSRR (Monitor Target)			
Cashflow			
Cost Improvement			**£261k achieved in Oct £1413k achieved YTD £335k behind plan**

	Target	Previous month	Current month	Trend
Workforce [SO 3]				
Essentials 1	85%			
Appraisals (including medical staff)	85%			
Safeguarding	80%			
Supervisions	85%			
Sickness	< 4.5%			
Disciplinary	TBC			
Patient Experience [SO 1 & 2]				
Complaints per 1000 episodes	< 2.17			
Staff Raising Concerns	TBC			
Customer Satisfaction	80%	**Process for data collection in development. Reporting expected to be in place Q3 2015/16**		
Family & Friends Test *(% would recommend)*	TBC	**91.90%** (321 respondents)	**92.29%** (363 respondents)	

Inpatient Metrics [SO 1 & 3]	**Bed occupancy rate**	**Ward staffing levels**
Previous Month	**87.58%**	Planned Shifts **7,343** Actual 6,931 **(94.39%)**
Current Month	**89.76%**	Planned Shifts **7,603** Actual 7,151 **(94.06%)**
Trend		

Waiting Times Indicators (SO 1)	**Target**	**Previous month**	**Current month**	**Trend**
Early Intervention (2 weeks)	50%	**63.79%**	**64.29%**	
IAPT (6 weeks)	75%	**71.41%**	**72.04%**	
IAPT (18 weeks)	95%	**90.55%**	**92.47%**	
Allied Health Prof'ls (18 weeks)	95%	**98.17%**	**96.58%**	

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

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

CWP Board Dashboard

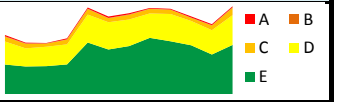
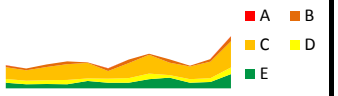
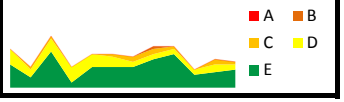
Reporting Month: October 2015

Exception Reports

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

Risks [SO 1]	Number of risks						Number of new risks added to register	Number of risks archived from register
	Red		Amber		Green			
	Current	Trend	Current	Trend	Current	Trend		
Strategic	11	→	4	→	0	→	0	0
Clinical Services	20	↑	49	→	8	→	10	2
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 [SO 1]	Category A&B (SUIs)		Category C&D (Mild / Moderate harm)		Category E (No harm)		Trend
	Previous month	Current month	Previous month	Current month	Previous month	Current month	
Mental Health Services (inc LD)	↑	↑	↑	↓	↓	↓	
West Physical Health Services	↑	↑	↓	↓	↓	↓	
Clinical Support Services	→	→	→	→	↓	↓	

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

Infection Prevention and Control [SO 1]	Previous audit compliance	Current audit compliance	Trend
Infection Control	0/2 passed 90% compliance	3/3 passed* 97% compliance	↑

Incidents of Prone Restraint [SO 1]	CWP West	CWP Wirral	CWP East	Trustwide
	5 in month 59 year to date (15/16) 2.72 per 1,000 bed days:	2 in month 13 year to date (15/16) 0.76 per 1,000 bed days	6 in month 17 year to date (15/16) 0.67 per 1,000 bed days	13 in month 89 year to date (15/16) 1.39 per 1,000 bed days

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

*1 location audited for first time in Oct 2015

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

Board Dashboard - Glossary

Back to top

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

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

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

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

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

CWP Objectives

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

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

STANDARDISED REPORT COMMUNICATION

REPORT DETAILS

Report subject:	Well-led governance review: update
Agenda ref. no:	15/16/90
Report to (meeting):	Board of Directors – meeting in public
Action required:	Information and noting
Date of meeting:	25/11/2015
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	Yes
Ensure meaningful involvement of service users, carers, staff and the wider community	Yes
Be a model employer and have a caring, competent and motivated workforce	Yes
Maintain and develop robust partnerships with existing and potential new stakeholders	Yes
Improve quality of information to improve service delivery, evaluation and planning	Yes
Sustain financial viability and deliver value for money	Yes
Be recognised as an open, progressive organisation that is about care, well-being and partnership	Yes
Which CQC quality of service domains this report reflects:	
Safe services	Yes
Effective services	Yes
Caring services	Yes
Well-led services	Yes
Services that are responsive to people's needs	Yes
Which Monitor quality governance framework/ well-led domains this report reflects:	
Strategy	Yes
Capability and culture	Yes
Process and structures	Yes
Measurement	Yes
Does this report provide any information to update any current strategic risks? If so, which?	
See current risk register in the agenda of the public meeting of the Board of Directors at http://www.cwp.nhs.uk/about-us/board-members/our-board-meetings	Yes
Risk of breach of Trust Provider Licence as a result of external scrutiny	
Does this report indicate any new strategic risks? If so, describe and indicate risk score:	
See current integrated governance strategy: CWP policies – policy code FR1	No
N/A	

REPORT BRIEFING

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

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

Specific guidance has been issued by *Monitor* to provide a framework for trusts to shape and structure their reviews. It is recommended that an external organisation be appointed to undertake reviews, excluding the organisation providing the Trust's independent/ external audit function. Costs of "well-led" governance reviews are generally between £40–£80,000, dependent on the level of specification, therefore it will require a tender process and identification of central funding.

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

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

In January 2015, the Trust was notified of its allocated date for its comprehensive CQC inspection (June 2015). Due to the alignment of the well-led elements of the CQC inspection framework and the Monitor inspection framework, the well-led governance review was paused in order that the outcome of the CQC inspection, specifically the well-led domain, could be considered. The intended consequence of this is that the review can be tailored to further test the elements of governance infrastructure that were not fully tested as part of the CQC inspection and to focus on any areas identified for improvement by CQC to inform the degree of the specification for the review.

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

Assessment – *analysis and considerations of options and risks*

At the time of writing, the final published CQC Trust reports are awaited following the conclusion of the Quality Summit. The following timeline for the well-led governance review is therefore proposed:

- January 2016 – March 2016: Finalise tender specification, tender exercise and appointment of reviewing organisation.
- April 2016 – May 2016: Review activities (Board self-assessment, determining scope of review and undertaking detailed review (including Board observations, focus groups and stakeholder discussions).
- June – July 2016: Action planning and advising Monitor of outcome and actions.

Although this is a broad timescale, this allows for sufficient time for implementation of the entire process so that the Trust acquires added value from the outcomes of the review, taking into account other significant activity which will be ongoing during this period including the production of the annual report and accounts and refreshes to operational and strategic plans.

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

The Board of Directors is asked to **note** the report.

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

Distribution to other people/ groups/ meetings:

Version	Name/ group/ meeting	Date issued
1	Board of Directors	18/11/2015

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

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

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

STANDARDISED REPORT COMMUNICATION

REPORT DETAILS

Report subject:	Community Mental Health Survey Results 2015
Agenda ref. no:	15/16/91
Report to (meeting):	Board of Directors
Action required:	Information and noting
Date of meeting:	25/11/2015
Presented by:	Stephen Scorer, 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	Yes
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Which Monitor quality governance framework/ well-led domains this report reflects:	
Strategy	
Capability and culture	
Process and structures	
Measurement	Yes
Does this report provide any information to update any current strategic risks? If so, which?	
See current risk register in the agenda of the public meeting of the Board of Directors at http://www.cwp.nhs.uk/about-us/board-members/our-board-meetings	
36T	
Does this report indicate any new strategic risks? If so, describe and indicate risk score:	
See current integrated governance strategy: CWP policies – policy code FR1	
36T	

REPORT BRIEFING

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

The Care Quality Commission conducts an annual survey which looks at the experiences of people receiving community mental health services. The national results were published in October with a presentation delivered to Operations Board by Quality Health on October 21st 2015.

CWP achieved top results from the Care Quality Commission. The report shows CWP achieving **the highest Trust score in five of the ten areas** covered in the survey. The Trust also achieved the highest number of questions with a 'better than expected' score, with a total of 13 - more than any of the other 55 Trusts who took part in the survey. In addition, the Trust's score in the **'overall experience'** of services category was the **top in the country**, with almost a quarter of people rating CWP 10 out of 10.

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

A sample of 850 was taken from circ 15,000 community mental health service users in February 2015. We had a basic response rate of 32% (average 29%). 58% of respondents had been in contact with our services for over 10 years (compared to 30% average) and 69% had been seen in the last month (compared to 51% average).

The most notable feature of the results is the degree of consistency with last year's results. For many of the questions, there were only slight differences between locality results. Where there is some divergence, there tends to be a similar pattern each time, with East's results being close to national average, and West and Wirral's results better than national average – please see the attached document for more detail.

Assessment – *analysis and considerations of options and risks*

Quality Health identified general areas for improvement (where we are below average and falling):

- Review range and level of support provided by the out of office hours mental health service;
- Review information and support around finding/keeping accommodation;
- Ensure service users' families and others close to them are as involved as the service user wants them to be in their care.

The key recommendations from the main report will now be taken forward, including locality trends, and allocated to existing developmental or review work streams where possible, with an overarching short action plan to keep the Trust on track with progress. Liz Matthews, Associate Director of Patient and Carer Experience, will lead the action plan and provide an update in March to Operations Board.

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

1. To note the national picture;
2. To note the locality themes / trends;
3. Liz Matthews, Associate Director of Patient and Carer Experience, to lead action plan.

Who/ which group has approved this report for receipt at the above meeting?	Stephen Scorer, Director of Nursing, Therapies and Patient Partnership
Contributing authors:	Jodie D'Enrico, Communications and Engagement Manager

Distribution to other people/ groups/ meetings:

Version	Name/ group/ meeting	Date issued
1	Operational Board	21.10.15

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	Initial analysis of locality findings

15_16_91_ Appendix 1

Initial analysis of locality findings from the 2015 Community Mental Health Survey

The following questions are those where there is the greatest divergence between localities:

Qn 1, When was the last time you saw someone from the NHS Mental Health Service?

West and Wirral had 74% and 73% reporting contact within the last month whereas East's figure was 59%. East is in line with national patterns whereas West and Wirral have reported more frequent contact.

Qn 2, Overall, how long have you been in contact with NHS Mental Health Services?

CWP has a much greater proportion than the national average reporting contact of over 10 years: 58% compared with 30%. Within localities, East reported 10% of less than a year whereas West (5%) and Wirral (3%) had fewer patients who had only relatively recently become service users.

Qn 4, Did the person or people you saw listen carefully to you?

Nationally, 7% said "no". In East, the "no" figure was 13%. In both West and Wirral it was 4%.

Qn 7, Have you been told who is in charge of organising your care and services?

Nationally, the response rate for "yes" was 76%. For East it was higher at 80%. For West and Wirral it was markedly higher still, at 95% and 90% respectively.

Qn 10, How well does this person organise the care and services you need?

The national "Not very well" and "Not at all well" response rate was 9%. For East it was 11%, for West 3%, and for Wirral 1%.

Qn 18 asks patients who have had a change in their care over the last 12 months what impact this change has had.

For the majority of people, it got better or stayed the same. Nationally, for 29% of patients, it got worse. The equivalent figure for East is 32%, for West is 16%, and for Wirral is 11%.

Qn 19 asks patients who had had a change of person in charge of organising their care whether they knew who was in charge of their care while the change was taking place.

The national figure for "yes" was 55%. By locality, the figures are 56% for East, 83% for West and 66% for Wirral.

Qn 20, Do you know who to contact out of office hours if you have a crisis?

The national figure for "no" was 31%. East had 28% for "no", West 15% and Wirral 16%.

Qn 26, The last time you had a new medicine prescribed for your mental health needs, were you given information about it in a way that you were able to understand?

"Yes, definitely" scored 52% nationally, 43% in East, 59% in West and 70% in Wirral (although these percentages are only based on 33 patients across CWP).

Qn 28, In the last 12 months, has an NHS mental health worker checked with you about how you are getting on with your medicines?

Nationally, 22% said "no". By locality the "no"s were 23% in East, 12% in West and 11% in Wirral

Qn 35, Has someone from NHS mental health services supported you in taking part in an activity locally?

East scored 44% replying "yes, definitely", West 33% and Wirral 25% compared with 29% nationally.

Qn 42, Overall in the last 12 months, did you feel that you were treated with respect and dignity by NHS mental health services?

"No" responses scored 9% in East. 1% in West and 4% in Wirral compared with 7% nationally.

Comment:

There were 268 responses altogether for CWP, comprising 81 for East, 79 for West and 108 for Wirral. It is unlikely that, for any one question, any differences in results between localities will be statistically significant, given the numbers involved.

For many of the questions, there were only slight differences between locality results. Where there is some divergence, there tends to be a similar pattern each time, with East's results being close to national average, and West and Wirral's results better than national average.

James Partington
Safe Services
12 November 2015

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

STANDARDISED REPORT COMMUNICATION

REPORT DETAILS

Report subject:	Wirral Vanguard Information Sharing Agreement
Agenda ref. no:	15/16/92
Report to (meeting):	Trust Board of Directors
Action required:	Discussion and Approval
Date of meeting:	25/11/2015
Presented by:	Dr Faouzi Alam, Medical Director & Caldicott Guardian

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

REPORT BRIEFING

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

To update provide information to the Board of Directors relating to the progress of the Wirral Vanguard Information Governance work stream and specifically the Information Sharing Agreement.

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

The Information Governance work stream for the Wirral Vanguard has been meeting on a bi-weekly basis since the end of July 2015. WUTH, contracting with CERNER, will be the provider and host of an electronic shared record – the `Wirral Care Record'. Cerner produced a privacy impact assessment and all partners have worked on the information sharing agreement, which all partner Boards are now asked to approve and sign. The privacy impact assessment is embedded in the extra governance assurance information sharing agreement document – section 7.10

Assessment – *analysis and considerations of options and risks*

WUTH is undertaking a publicity campaign for Wirral residents.
The Wirral Care Record will be limited to Wirral residents.
Information will only be used for direct care.
Clatterbridge Cancer Centre are not participating in the Wirral Care Record.
Phase 1 will enable GPs and WUTH to share information which will produce health registers.
Phase 2, scheduled for September 2016, will involve information streams from CWP and the Community Trust into the shared record.
CWP have agreed to share the same level of information which is being shared with the Cheshire Care Record which will be facilitated by the Information Team.
The Information Commissioner's office have been consulted and have endorsed the content of the information sharing agreement.

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

The Board of Directors is recommended to approve the privacy impact assessment and information sharing agreements.

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

Distribution to other people/ groups/ meetings:

Version	Name/ group/ meeting	Date issued
36T	36T	36T

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	Information sharing code of practice Wirral Care Record ISA v 1
2	Information sharing code of practice Tier 2 Wirral Care Record

15_16_91_Appendix 1

HealthyWirral

Wirral Care Record

Information Sharing Agreement

Name and designation of policy author(s)	Suzanne Crutchley Senior Governance Manager (Information Governance) North West Commissioning Support Unit (NWCSU)
Agreed by (committee, group, manager)	HealthyWirral Information Governance Task & Finish Group
Approved by (committee, group, manager)	Healthy Wirral IT & Information Governance Work Stream
Approving signatures	See Section 9
Adopted By	All organisations whose signatures appear in Section 9
Date approved	November 2015
Review date	November 2017
Review period	Every Two Years
Target audience	All Healthy Wirral Partner Organisations
Links to other strategies, policies, procedures	This Tiered Information Sharing Code of Practice is required for the Information Governance Toolkit. It is part of a three-tiered set of documents, agreed for use across Cheshire and Merseyside.
Protective Marking Classification	N/A

Version History:

Date	Version	Author name and designation	Summary of main changes
30/10/15	1.0	Suzanne Crutchley Senior Governance Manager (Information Governance) North West Commissioning Support Unit (NWCSU)	Final version

Contents

1. **Information Sharing Agreement**

HealthyWirral

Wirral Care Record

Information Sharing Agreement

N.B. This ISA should be read with its associated document *Further Information Governance Assurance*

1.1 Purpose of the data sharing initiative

All the partner *provider* organisations have agreed to share information about their patients, service users and clients (who for convenience are all referred to in this agreement as *patients*) to establish an electronic Wirral Care Record (**WCR**) for the purpose of caring for patients in common.

There are many purposes why Person Identifiable Data (PID) may be shared within and between NHS organisations, Social Services, other Local Authority Departments, and also with non-statutory organisations, for the health and wellbeing of Wirral residents. In summary, the purposes for sharing and using information, agreed by the organisations in this Agreement include:

- Delivering personal care and treatment.
- Maintaining and improving the quality of care and treatment.
- Monitoring and protecting public health.
- Managing safeguarding issues.
- Managing and planning services.

The primary benefit of the sharing is anticipated to be better access for clinicians to a patient's health and social care history at the point of care, leading to better and more well-informed care for that patient.

1.2 The organisations that will be involved in the data sharing

The following partners are involved in this ISA:

- ✓ GP Practice members of the NHS Wirral Clinical Commissioning Group
- ✓ Wirral University Teaching Hospital NHS Foundation Trust
- ✓ Wirral Community NHS Trust
- ✓ Cheshire and Wirral Partnership NHS Foundation Trust
- ✓ Wirral Borough Council

In time, and with review of the Privacy Impact Assessment and this Information Sharing Agreement, it may expand to include:

- ✓ Clatterbridge Cancer Centre NHS Foundation Trust
- ✓ Wirral Hospice – St Johns
- ✓ Pharmacists
- ✓ Dentists
- ✓ Optometrists
- ✓ Any Qualified Provider (AQP)
- ✓ Carers (LA)

The Healthy Wirral Partnership (HWP) is not a legal entity and therefore the constituent organisations will be Data Controllers in common; decisions will be taken at the Partnership Board by the members. If a member wishes to withdraw from the Partnership then their data will be removed from the WCR.

Where organisations do not comply with the Information Governance Toolkit (IGT) Requirements, at Level 2, of the current IGT as appropriate to their organisation type, they will be excluded from using the WCR.

Organisations who fail to maintain their registration with the Information Commissioner under the Data Protection Act 1998, will also be excluded from using the WCR.

1.3 Data items to be shared

The information shared, where available, will include:

- ✓ Person identifiable data
- ✓ Encounters
- ✓ Allergies
- ✓ Diagnostics
- ✓ Procedures
- ✓ Medications
- ✓ Immunisations
- ✓ Investigation Results

Each partner organisation shall provide staff with training on the principles and legal requirements for information sharing and the appropriate tools to enable them to comply with the obligations under this agreement;

As a general rule staff should only have access to personal information on a *'need to know'* basis. All partner organisations will monitor access to data and information.

1.4 Basis for sharing

It is worth setting out the related but separate types of ***legal basis*** upon which to rely, for processing data for the WCR. The partner organisations are all legally registered Data Controllers in their own right. That is the starting point.

The Data Controllers could in effect be described as a Multi-Disciplinary Team (MDT) collectively **providing health/social care** for their patients/clients/Service Users. There are no Information Governance concerns in this respect, as they all have a **legitimate relationship** with the patients/clients, in providing their care and treatment.

There are two distinct stages to this **Sharing of Personal Records** work programme for the WCR:

i. ***bringing data together*** held in each electronic system by each partner organisation into the WCR
ii. ***accessing data*** held by one or more of the partner organisations in the WCR

For ***bringing data together*** please see the table below: Data Protection Act 1998 Conditions, which are met.

For ***accessing data***, by involving the patients/clients in their care and treatment, and by **integrating this with the provision of their health/social care**, then again there are no Information Governance concerns in this respect, as you have **informed consent** from the patients/clients. Consent should be documented on the system used (a pop up box giving a choice of four options will be available on the system to record this).

Where consent cannot be given e.g. the patient is unconscious, lacks capacity, etc, there is still provision under the DPA to access the data. For ***accessing data*** in this way, please see the table below: Data Protection Act 1998 Conditions, which are met.

Data Protection Act 1998 Conditions	
For bringing data together	**For accessing data**
SCHEDULE 2 Conditions relevant for purposes of the first principle: processing of any personal data 3 The processing is necessary for compliance with any legal obligation to which the data controller is subject, other than an obligation imposed by contract. 5 The processing is necessary— (b) for the exercise of any functions conferred on any person by or under any enactment. 6 (1) The processing is necessary for the purposes of legitimate interests pursued by the data controller or by the third party or parties to whom the data are disclosed, except where the processing is unwarranted in any particular case by reason of prejudice to the rights and freedoms or legitimate interests of the data subject.	***SCHEDULE 2 Conditions relevant for purposes of the first principle: processing of any personal data*** 1 The data subject has given his consent to the processing. 3 The processing is necessary for compliance with any legal obligation to which the data controller is subject, other than an obligation imposed by contract. 5 The processing is necessary— (b) for the exercise of any functions conferred on any person by or under any enactment. 6 (1) The processing is necessary for the purposes of legitimate interests pursued by the data controller or by the third party or parties to whom the data are disclosed, except where the processing is unwarranted in any particular case by reason of prejudice to the rights and freedoms or legitimate interests of the data subject.
SCHEDULE 3 Conditions relevant for purposes of the first principle: processing of sensitive personal data 7 (1) The processing is necessary— (b) for the exercise of any functions conferred on any person by or under an enactment, or 8 (1) The processing is necessary for medical purposes and is undertaken by— (a) a health professional, or (b) a person who in the circumstances owes a duty of confidentiality which is equivalent* to that which would arise if that person were a health professional. (2) In this paragraph "medical purposes" includes the purposes of preventative medicine, medical diagnosis, medical research, the provision of care and treatment and the management of healthcare services. * this includes registered Social Workers.	***SCHEDULE 3 Conditions relevant for purposes of the first principle: processing of sensitive personal data*** 1 The data subject has given his explicit consent to the processing of the personal data. 7 (1) The processing is necessary— (b) for the exercise of any functions conferred on any person by or under an enactment, or 8 (1) The processing is necessary for medical purposes and is undertaken by— (a) a health professional, or (b) a person who in the circumstances owes a duty of confidentiality which is equivalent* to that which would arise if that person were a health professional. (2) In this paragraph "medical purposes" includes the purposes of preventative medicine, medical diagnosis, medical research, the provision of care and treatment and the management of healthcare services. * this includes registered Social Workers.

Also, further legislation engaged for patients/clients/Service Users of any age, is the
National Health Service Act 2006
Part 3 Local Authorities and the NHS
82 Co-operation between NHS bodies and local authorities
This says: *In exercising their respective functions NHS bodies (on the one hand) and local authorities (on the other) must co-operate with one another in order to secure and advance the health and welfare of the people of England and Wales.*

If a patient chooses to opt out, the GP Partner Organisation can flag their record for exclusion and the data is purged from the system. If the patient opts back in then a new bulk upload for that patient occurs and adds any data from the date that the patient was removed back into the delta feed. This provides flexibility to quickly reinstate the record if the patient should change their mind and opt back in.

N.B. if a GP has flagged a patient record for exclusion, then the GP record and any other record from a partner organisation will be excluded from the WCR.

1.5 Access and individuals' rights

Subject Access Requests

The Healthy Wirral WCR will hold copies of data downloaded from all partner organisations.

WUTH will manage any SARs in accordance with their own local procedures, for access to the WCR.

If data subjects would like access to their WCR they should make a Subject Access Request (SAR) by applying in writing to WUTH.

Each organisation should let patients know how they can gain access to their WCR.

Freedom of Information Requests

This document and the arrangements it details will be disclosable for the purposes of the Freedom of Information Act 2000 and so will be published within the signatories' Publication Schemes.

Any requests for information made under the Act that relates to the operation of this Agreement should, where applicable, be dealt with in accordance with the Code of Practices under the Freedom of Information Act 2000.

1.6 Information governance

Whilst recognising the importance of sharing information to support the care provided to individuals, the associated document to this ISA *Further Information Governance Assurance*, also identifies a series of exclusions which will not be included within the sharing model, unless explicitly stated, due to legal/statutory requirements and sensitivity concerns.

Each partner organisation shall ensure the accurate, timely, secure and confidential sharing of information where such information sharing is essential for the purposes of this agreement.

Personal data records held on the Solution will be overwritten every time a record is received (generally in an overnight batch) and matches an existing record using the NHS Number, but if activity on a record ceases and hence no new record arrives to overwrite the existing record, then the historic record will remain.

If a data controller ceases to participate in the WCR that data controller's data is removed at the next extract.

The arrangements for who will review the PID held on the WCR will be led by WUTH. The WCR will be reviewed on an annual basis.

Due to the WCR being created using shared information, the retention period must generally be the longer of the retention periods as required by the legislation governing each agency. Therefore, the WCR will, in general terms, be managed in accordance with the NHS Code of Practice on Records Management (April 2006).

The WCR will be retained for 8 years following the death of a patient or where a patient is no longer registered with a Wirral GP Practice.

N.B. were a patient dies or is no longer registered with a Wirral GP Practice, they will be removed from the Registries.

Data that is stored and generated within the WCR, including audit trails, access logs, etc, are retained in accordance with General Medical Council and British Medical Association guidance and the NHS Records Management Code of Practice. The audit log will be retained for ten years.

All partner organisations will have sufficient levels of security in place, including the following:

- Current registration with the ICO.
- Current Information Governance Toolkit compliance (high level exception will be considered if necessary).
- Physical and technical security of data and information systems.
- Monitor access to data and information.
- Provide security awareness and training to staff.
- Security management.
- Systems development.
- Organisation specific information security policies.
- Data Controller associated responsibilities to meet the requirements of the Data Protection Act 1998.

With regards to the Healthy Wirral WCR, there should be a standard approach on how each partner organisation is to handle complaints which may be made against members of the partner organisations. Each partner organisation will deal with any such complaints in accordance with their own procedures which will ensure that:

- WCR staff users are aware that they can complain and of how to go about it;
- complaints are resolved at first contact if possible;
- complaints are acknowledged promptly in writing;
- the complaint is investigated fairly and thoroughly;

- WCR staff users are given an appropriate written response;
- if appropriate the appeals procedure is explained to the WCR user.

Named contacts for general advice on making complaints by each partner organisation will already be in place.

The NHS Five Year Forward View, published in October 2014, described the need for the NHS to adapt to take advantage of the opportunities that science and technology offer and to evolve to meet new challenges as people live longer with complex health issues. The ongoing effectiveness of the WCR, and this ISA, will be assessed each year that the WCR continues to be in operation.

In its capacity as *host*, WUTH shall ensure that on the expiry or termination of this agreement, the Personal Confidential Data is destroyed, or migrated to an alternative software provider and shall ensure that no Personal Confidential Data is retained by the Software Provider.

1.7 Further Information

The associated document to this ISA *Further Information Governance Assurance,* contains other helpful sections, including:

- ✓ Legitimate Purposes for Sharing Information for the WCR
- ✓ Description of Arrangements and Security Procedures for the WCR (this also includes a copy of the Privacy Impact Assessment for the WCR)
- ✓ Legislation and Further Guidance (this also includes a glossary of key terms)

1.8 Signatories to Abide by this Agreement

A Signature Sheet is needed for each partner organisation:

- ✓ Wirral University Teaching Hospital NHS Foundation Trust
- ✓ Cheshire and Wirral Partnership NHS Foundation Trust
- ✓ Wirral Community NHS Trust
- ✓ Wirral Metropolitan Borough Council
- ✓ All Wirral GP Practices

NHS Wirral Clinical Commissioning Group will not have access to the WCR. Therefore, they are not required to sign up to this Information Sharing Agreement, even though they are the lead commissioner of the NHS provider organisations party to this Agreement.

Further details to include in the Signature Sheets can be found in the associated document to this ISA *Further Information Governance Assurance*.

The partner organisations signing this Agreement accept that the procedures laid down in this document provide a secure framework for the sharing of information between their agencies in a manner compliant with their statutory and professional responsibilities.

As such they undertake to:

- Implement and adhere to the procedures and structures set out in this Agreement.
- Ensure that where these procedures are complied with, then no restriction will be placed on the sharing of information other than those specified within this Agreement.
- Engage in a review of this Agreement with partners annually.

N.B. one signature sheet for each partner organisation.

ORGANISTION NAME:	
ADDRESS:	
Data Protection Registration	
Information Governance Toolkit Status	
Lead Signatory:	
Job Title:	
Email address:	
Signature:	
Date:	

Add other signatories as required

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

STANDARDISED REPORT COMMUNICATION

REPORT DETAILS

Report subject:	Ward Daily Staffing Levels October 2015
Agenda ref. no:	15/16/93
Report to (meeting):	Board of Directors
Action required:	Information and noting
Date of meeting:	25/11/2015
Presented by:	Stephen Scorer

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 October 2015 following the submission of the planned and actual hours of both registered nurses (RN) and clinical support workers (CSWs) to UNIFY (appendix 1). The themes arising within these monthly submissions continue to mirror those that have arisen previously, and have been raised at the Operations Board for follow up in services. These themes identify how patient safety is being maintained on a shift by shift basis.

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

The monthly reporting of daily staffing levels is a requirement of NHS England and the National Quality Board in order to appraise the Board and the public of staffing levels within in-patient units. CWP undertook a comprehensive review of ward staffing levels between Oct and Dec 2013 with 6 monthly follow up reviews, the most recent of which will be submitted to Operations Board and Board of Directors in December 2015. The Board of Directors, in line with the NQB requirements, will continue to receive monthly reports on Ward Daily Staffing Levels and also reports on the six monthly ward staffing reviews that the trust are required to undertake. A verbal update on progress with the 6 month review will be given at Board

Assessment – *analysis and considerations of options and risks*

During October 2015 the trust achieved staffing levels of 93.5% for registered nurses and 92.7% for clinical support workers on day shifts and 93.6% and 97.4% respectively on nights. These figures will be included in the trend analysis of fill rate in the 6 month report but are broadly comparable with previous months in the review timeframe

Where 100% fill rate was not achieved patient safety on in-patient wards was maintained by nurses working additional unplanned hours, cross covering across wards, the multi-disciplinary team and ward manager supporting nursing staff in the delivery of planned care and patient care being prioritised over non-direct care activities. These themes have been quantified from Feb 2015 onwards and analysed as part of the 6 monthly review report submitted to the Board of Directors in July 2015. They will be further analysed in the six monthly ward staffing review report that will be reported to Operations Board and Board of Directors in December 2015.

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?	Stephen Scorer
Contributing authors:	Julie Anne Murray

Distribution to other people/ groups/ meetings:

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

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

Appendix no.	Appendix title
1	Oct 2015 Ward Daily Staffing Board Report (Nov 2015 Board Report)

15_16_93_Appendix 1 Oct 2015 Daily Staffing Levels (Nov 2015 Report)

	Ward	Day				Night				Fill Rate				Safe staffing levels were maintained by:
		Registered		Care Staff		Registered		Care Staff		Day		Night		
		Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Average fill rate - registered nurses (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses (%)	Average fill rate - care staff (%)	
East	Adelphi	1463.75	1417.75	1166.5	713	724.5	678.5	1150	1081	96.9%	61.1%	93.7%	94.0%	Nursing staff working additional hours and the WM working in the clinical team.
	Alderley Unit	855.5	821.9	1472	1466	678.5	575	759	839.5	96.1%	99.6%	84.7%	110.6%	Altering skill mix , nursing staff working additional hours and cancelling non direct care activity.
	Bollin	1327	1304	1522	1408	747.5	701.5	1426	1334	98.3%	92.5%	93.8%	93.5%	Nursing staff working additional hours.
	CARS	878.5	805.5	1495.5	1406.2	667	636	759	711	91.7%	94.0%	95.4%	93.7%	Altering skill mix , nursing staff working additional hours and cancelling non direct care activity, nurses also cross covered other wards.
	Croft	1258	1227.5	2010	1736.75	724.5	701.5	2107	1761	97.6%	86.4%	96.8%	83.6%	Altering skill mix and nursing staff working additional hours.
	Greenways A&T	1254	1218.5	1529.5	1486.75	713	644	425.5	483	97.2%	97.2%	90.3%	113.5%	The WM working in the clinical team and cancelling non direct care activities.
	LimeWalk Rehab	1097.5	1081	1228.5	1184.5	659.5	623	802	768.5	98.5%	96.4%	94.5%	95.8%	Altering skill mix , nursing staff working additional hours and cancelling non direct care activity.
	Saddlebridge	961	932	1396.5	1397	690	614	908.5	964	97.0%	100.0%	89.0%	106.1%	Altering skill mix, nursing staff working additional hours and the WM working in the clinical team.
Wirral	Brackendale	1142.5	1181	939.5	859.5	713	701.5	713	713	103.4%	91.5%	98.4%	100.0%	Nursing staff working additional hours and the WM working in the clinical team.
	Lakefield	1202	1098	1138	1138	724.5	690	723.5	746.5	91.3%	100.0%	95.2%	103.2%	Altering skill mix and nursing staff working additional hours, nurses also cross covered other wards.
	Meadowbank	1106.5	1057.4	2276.45	1993.3	723	654	1867.5	1649	95.6%	87.6%	90.5%	88.3%	Altering skill mix and nursing staff working additional hours.
	Oaktrees	1323.5	1277.5	1220.5	1197.5	724.5	713	662.5	662.5	96.5%	98.1%	98.4%	100.0%	*
	Brooklands	971.5	932.8	1097.5	1097.5	679.5	661	1034.5	1023	96.0%	100.0%	97.3%	98.9%	*
West	Beech	1446.5	1249	1138.5	1100.5	713	690	713	701.5	86.3%	96.7%	96.8%	98.4%	Altering skill mix and the WM working in the clinical team, nurses also cross covered other wards.
	Cherry	1441	1211.5	1081	1143	690	609.5	1035.04	1115.5	84.1%	105.7%	88.3%	107.8%	Altering skill mix , nursing staff working additional hours and cancelling non direct care activity, nurses also cross covered other wards.
	Eastway A&T	1073.5	880	1382.5	1267.5	575	586.5	901	889.5	82.0%	91.7%	102.0%	98.7%	Nursing staff working additional hours and cancelling non direct care activity.
	Juniper	1607	1474.5	1058	943.5	805	729	701.5	724.5	91.8%	89.2%	90.6%	103.3%	Altering skill mix , nursing staff working additional hours, the WM working in the clinical team and cancelling non direct care activity, nurses also cross covered other wards.
	Maple Ward	1035	920	1426	1259.5	736	667	766.5	720.5	88.9%	88.3%	90.6%	94.0%	The WM working in the clinical team, nurses also cross covered other wards.
	Pine Lodge (YPC)	1159.5	1022.4	1158	1031.5	667	621	782	759	88.2%	89.1%	93.1%	97.1%	Nursing staff working additional hours and the WM working in the clinical team, nurses also cross covered other wards.
	Rosewood	1211.5	1093	1702	1565.5	436.85	402.5	724.5	724.5	90.2%	92.0%	92.1%	100.0%	Nurses cross covering between wards
	Willow PICU	1018	1004	1035	1012	724.5	690	770.5	851	98.6%	97.8%	95.2%	110.4%	*
Trust wide		24833.25	23209.25	28473.45	26407	14516.35	13588.5	19732.04	19222	93.5%	92.7%	93.6%	97.4%	

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

STANDARDISED REPORT COMMUNICATION

REPORT DETAILS

Report subject:	Director of Infection Prevention & Control Quarter Two Report 2015/16
Agenda ref. no:	15/16/94
Report to (meeting):	Board of Directors
Action required:	Information and noting
Date of meeting:	25/11/2015
Presented by:	Andrea Hughes, Director of Infection Prevention & 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	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*

Please find Quarter Two report for Infection Prevention and Control (IPC). This is a mandatory requirement and requires noting.

Background – *contextual and background information pertinent to the situation/ purpose of the report*
The Director of IPC or Nurse Consultant for IPC, delivers a quarterly report to appraise the Board regarding IPC activity and any assosciated risks.

Assessment – *analysis and considerations of options and risks*
Multi resistant organisms are still high on the IPC agenda as is antimicrobial prescribing. The team are working innovatively to address the potential risks within CWP provider services.

Recommendation – *what action/ recommendation is needed, what needs to happen and by when?*
The board is asked to note the IPC Quarter 2 report for 2015/2016.

Who/ which group has approved this report for receipt at the above meeting?		IPCSC - November 2015
Contributing authors:		Amanda Miskell
Distribution to other people/ groups/ meetings:		
Version	Name/ group/ meeting	Date issued
1	Chief Executive	November 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
Click here to enter text.	Click here to enter text.

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

15_16_94_ Appendix 1

Infection, Prevention and Control Q2 15/16 Report

Contents

1. The purpose of the report

Welcome to the Quarter Two, Director of Infection Prevention and Control (DIPC) report, 2015/2016. This report will inform the board of the performance during Quarter Two in relation to IPC activity, outcomes, incidents and assurances in line with the standards and requirements set out in the Department of Health's, Health and Social Care Act 2008 Code of Practice on the prevention and control of infections and regulated guidance (DH 2015).

In September 2015, all Chief Executives received a communication from NHS England regarding World Antibiotic Awareness Week (16-20 November 2015) and the Antibiotic Guardian campaign. This report will inform the Board of CWPs responsibilities and response with regard to Antimicrobial Stewardship.

The IPC integrated service, consisting of the CWP team; and the contractual Cheshire West and Chester (CWaC) team, continues to work efficiently, and is compliant with the internal and external reporting requests placed upon it.

We welcome our new DIPC, Andrea Hughes, who commenced her role on 12th October 2015.

2. Infection Prevention & Control Integrated Service

The IPC service is an integrated service which covers all CWP services across all localities and in addition the contractual elements to CWaC including the specialised Tuberculosis service.

2.1 CWP Team

Following a review of the services needs the IPC structure has been revisited, with locality based IPC nurses who are visible to all inpatient areas and community teams, including PH West.

There are no incidents, outbreaks or exceptions to report.

2.2 Cheshire West and Chester Team

The Nurse Consultant reports on a monthly basis to the performance team and to the PHE, for all those infections, not categorised as secondary care.

No exceptions have been reported in relation to CWP provider input and Health Care Acquired Infections (HCAIs).

3. Antimicrobial stewardship

From 1st April 2015 and following the publication of the new Code of Practice, the CWP IPC team have been proactive in raising awareness in prudent prescribing of all antimicrobials across inpatient settings. A patient safety alert from National Patient Safety Agency has been acknowledged and responded to, (October 2015) in collaboration with our pharmacy colleagues. See Appendix 1.

The Code of Practice states that as a registered provider with the Care Quality Commission, CWP have a responsibility to:

- Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance.
- Systems should be in place to manage and monitor the use of antimicrobials to ensure inappropriate and harmful use is minimised and patients with severe infections such as sepsis are treated promptly with the correct antibiotic
- The DIPC/appropriate other, have the authority to challenge inappropriate practice and inappropriate antimicrobial prescribing decisions
- Have a monthly review of antimicrobial prescribing decisions
- Benchmarking should be used to demonstrate progress in antimicrobial stewardship

- Providers should have access to timely microbiological diagnosis, susceptibility testing and reporting of results, preferably within 48 hours.
- Prescribers should have access at all times to suitably qualified individuals who can advise on appropriate choice of antimicrobial therapy
- Providers should ensure that all prescribers receive induction and training in prudent antimicrobial use and are familiar with the antimicrobial resistance and stewardship competencies [1]
- Materials from national or local antimicrobial awareness campaigns could be used to develop information on appropriate antimicrobial use

Since April 2015, the CWP IPCT has worked with our pharmacy colleagues following up every antimicrobial prescribing episode across the localities for inpatients (187 episodes for Quarters 1 and 2 - 2015/16). The majority (80%) of prescribing is for Urinary Tract Infections and Tissue Viability related Infections, with some requirements for Respiratory Infections and Ear/Nose and Throat conditions. In response to this, the team have worked closely with our microbiology and Clinical Commissioning Group colleagues to make an addition to the CWP formulary for dental/oral infections which will be in place once agreed at MMG.

This is in addition to the surveillance for all non-medical prescribers and community ePACT data which is reported to IPCSC. ePACT data (A service for pharmaceutical and prescribing advisors which allows real time on-line analysis of the previous sixty months prescribing data held on NHS Prescription Services' Prescribing Database) is a national requirement with emphasis on the prescribing of Cephalosporin's and Quinolones, with 3/7 Trimethoprim prescribing also recorded. Benchmarking information from Quarters 1 and 2 indicates further education is needed in relation to appropriate prescribing, however, quarter 3 information indicates compliance is improving. See table 1 below.

Table 1.

Recommendation **Audited - 185 forms April - September 2015**		**Wirral**	**West**	**East**	**Total**	**% audit compliance**
Allergies documented on medication chart	Yes	**67**	**80**	**31**	**178**	96%
	No	**1**	**2**	**4**	**7**	
Follows antimicrobial formulary/micro advice	Yes	**50**	**61**	**26**	**137**	74%
	No	**18**	**21**	**9**	**48**	
Indication documented on medication chart	Yes	**53**	**60**	**20**	**133**	71%
	No	**15**	**27**	**10**	**52**	
Indication documented on carenotes	Yes	**42**	**64**	**27**	**133**	71%
	No	**26**	**18**	**9**	**53**	
Stop Date indicated on medication chart	Yes	**55**	**72**	**26**	**153**	82%

	No	**10**	**13**	**9**	**32**	

The microbiology Service Level Agreement (SLA) for West and Wirral has been agreed and signed (October 2015) which will be in place till March 2017. An additional requirement within this is support for Patient Group Directives and access to direct Microbiology advice from our colleagues at the Countess of Chester.

The board is to be assured that our requirements in relation to the Code of Practice are being addressed by the IPCT.

4. Recommendations

The Board of Directors is asked to note the DIPC Quarter Two report for 2015/16.

5. References

1.www.gov.uk/government/publications/antimicrobial-prescribing-and-stewardship-competencies

6. Appendix 1

NPSA Alert and CWP response

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

STANDARDISED REPORT COMMUNICATION

REPORT DETAILS

Report subject:	CWP Provider Licence – six monthly self-assessment
Agenda ref. no:	15/16/95
Report to (meeting):	Board of Directors – meeting in public
Action required:	Information and noting
Date of meeting:	25/11/2015
Presented by:	Tim Welch, Director of Finance

Which strategic objectives this report provides information about:	
Deliver high quality, integrated and innovative services that improve outcomes	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	No
Effective services	Yes
Caring services	Yes
Well-led services	Yes
Services that are responsive to people's needs	Yes
Which Monitor quality governance framework/ well-led domains this report reflects:	
Strategy	Yes
Capability and culture	Yes
Process and structures	Yes
Measurement	Yes
Does this report provide any information to update any current strategic risks? If so, which?	
See current risk register in the agenda of the public meeting of the Board of Directors at http://www.cwp.nhs.uk/about-us/board-members/our-board-meetings	Yes
Risk of breach of Trust Provider Licence as a result of external scrutiny	
Does this report indicate any new strategic risks? If so, describe and indicate risk score:	
See current integrated governance strategy: CWP policies – policy code FR1	No
N/A	

REPORT BRIEFING

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

The licence requirement for health care providers came into effect from April 2013.

Key components within the licence criteria are reviewed on a quarterly basis. The Board receives assurance on licence compliance on a six monthly basis.

From 2015/16, a quarterly review of the key licence conditions was added to the Audit Committee business cycle. In quarter 1, a report was provided from the Trust's internal audit provider to the Audit Committee following an audit of the licence which received significant assurance. This report sets out the quarter 2/ six monthly position.

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

This report details the NHS provider licence criteria self-assessment for quarter 2. The licence contains obligations for the Trust and this assessment aims to help the Board members in confirming the accuracy of requirements that CWP is required to comply with as a license holder.

Assessment – *analysis and considerations of options and risks*

Appendix 1 contains the high level excerpts from the full licence document, which enabled the Audit Committee members to consider the key licence conditions and any risks to compliance. The majority of conditions are rated as 'Green'. The exceptions to these are:

- Condition/ licence provision C1 (3) rated as Red/ Amber: Additional assurance is required on the systems in place for notifying individual patients about choice. This is being taken forward by the Associate Director for Patient & Carer Experience and an updated position will be provided to the Audit Committee at the end of Q3 2015/16.

- Condition/ licence provision G6 rated as Amber/ Green: Due to residual risks in relation to the strategic risk '*Risk of breach of Trust Provider Licence as a result of external scrutiny'* described within the corporate assurance framework. The treatment plan for this risk is in progress and has recently received significant assurance following an internal audit review in Q1 2015/16. The risk is due for remodelling following the outcome of the CQC inspection due end of November 2015.

- Condition/ licence provision G8 (1) rated as Amber/ Green: Further work is required with the Communications and Engagement team to ensure all access and eligibility information is published.

- Condition/ licence FT4 (8) rated as Green: Despite being rated as 'Green' there is potential to improve the approval process prior to submission to for additional assurance. This will potentially include incorporating review of the condition requirements within the internal audit plan 2016/17 and ensuring presentation to the Audit Committee prior to Board sign off.

The Audit Committee will receive an update on the actions identified above at their next review at the end of quarter 3.

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?	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	Audit Committee	27/10/2015
2	Board of Directors	25/11/2015

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	Key Provider Licence conditions as at end Q2
2	Full Licence

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

15_16_95_Appendix 1: Self-assessment evidence against NHS provider licence key criteria as at Q2 2015/16

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	End quarter 2 2015/16 position	Comments/ Further actions for completion
1. General provisions				
G2	Has Monitor given any direction regarding setting or limiting conditions within the Provider Licence?	**GREEN**	Compliant	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**	Compliant	No issues identified – 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**	Compliant	No issues identified – processes in place in accordance with the licence and CQC Fit and Proper Persons regulations
G5	Has Monitor issued new guidance relating to the provider licence in the quarter?	**GREEN**	Compliant – new Risk Assessment Framework issued August 2015	No issues identified - Board informed of changes and impact of new Risk Assessment Framework. Q2 declarations are in accordance with the new Framework.
G6	Executive to consider any new licencing risks identified in the quarter – update of Board Assurance Framework for	**AMBER/ GREEN**	Compliant - the current corporate assurance framework continues to include a strategic risk in	Risk treatment plan in progress. Additional assurance provided by internal audit review significant assurance received Q1 15/16. **Action:** the risk is due to be re-modelled following the

Licence reference	Licence provision	Self assessment	End quarter 2 2015/16 position	Comments/ Further actions for completion
	Board approval?		relation to *'Risk of breach of Trust Provider Licence as a result of external scrutiny'* rated 15.	outcome of CQC inspection due November 2015.
G6(3)	Publication of Annual Governance Statement (AGS)?	**GREEN**	Compliant	Completed for 2015/16. Published as part of Annual Report and Accounts document - http://www.cwp.nhs.uk/reports/2817-annual-report-and-accounts-2014-15
G7	Consider CQC registration status in quarter – note cancellations and registrations (G7(2))?	**GREEN**	Compliant	CQC statement of purpose updated and approved by Board in September 2015
G8	Consider if all information on range of services and information on who can assess them is published	**AMBER/ GREEN**	Partially compliant	The A-Z of services directory on the CWP website needs some updating. **Action** - Further work to be taken forward with Communications and Engagement team to ensure all services and eligibility criteria is published. Due for completion December 2015.
G9	Consider whether Commissioner Requested Services have not been amended?	**GREEN**	Compliant	No further actions.
G9(12)	Have the contractual requirements to activities or any mandatory services been amended?	**GREEN**	Compliant	No further actions.
2. Pricing				
P1(4)	Have any services been sub contracted?	**GREEN**	Compliant - 'Sub-contracting arrangements are in place for the East Cheshire Substance	No further actions

Licence reference	Licence provision	Self assessment	End quarter 2 2015/16 position	Comments/ Further actions for completion
			Misuse Contract' with monitoring arrangements in place.	
3. Choice and competition				
C1(3)	Are clear systems in place for notifying individual patients about choice?	**RED/ AMBER**	Not compliant	The current system is limited to information on NHS Choices. Commissioners are seeking assurances via contract monitoring processes. The agenda requires identified leadership to develop a framework, infrastructure and delivery plan, which should include an organisational point of contact for this agenda. **Action**: Head of Patient Experience to continue to progress this improvements in this area. .
4. Integrated care				
IC1	Are there any service changes that require staff/ public consultation (need to be cognisant of Public Interest)?	**GREEN**	Compliant	Podiatry consultation recently completed and outcome published
5. Continuity of services				
CoS1	Have any contract variations been completed to service specifications [if Yes action required CoS1(4)]?	**GREEN**	Compliant - Any contract variations are in line with licence requirements.	No further actions.
CoS2	Have any assets been disposed of that would impact on the ability to provide 'Commissioner Requested Services'?	**GREEN**	Compliant	No further actions.
6. NHS Foundation Trust conditions				
FT1	Has the Constitution been amended?	**GREEN**	Compliant – constitution amendments	No further actions.

Licence reference	Licence provision	Self assessment	End quarter 2 2015/16 position	Comments/ Further actions for completion
	Publication of the Annual Report and Accounts in accordance with Monitor requirements – once published requires submission to Monitor with 28 days.		proposed and agreed by Council of Governors and Board of Directors and reported to Members at AMM *(amendments did not constitute any changes to the powers or duties of the Governors.* Revised Constitution submitted to Monitor Annual Report and Accounts 2014/15 submitted and published in accordance with timescales.	
FT4(8)	Submit to Monitor Corporate Governance Statement following Board approval in Q1 by 30 June 2015.	**AMBER/ GREEN**	Compliant.	This is compliant and submission to Monitor was completed in line with the deadline. There is potential to improve the sign off process to include internal audit and presentation to Audit Committee prior to presentation for Board approval moving forward. **Action** – to develop a more comprehensive audit process to test elements all of the corporate governance statement including internal auditing prior to submission – Head of Corporate Affairs

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

STANDARDISED REPORT COMMUNICATION

REPORT DETAILS

Report subject:	Monitor Quality Governance Framework self assessment – quarter 2 2015/16
Agenda ref. no:	15/16/96
Report to (meeting):	Board of Directors – meeting in public
Action required:	Discussion and approval
Date of meeting:	25/11/2015
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 2 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 quarter 2 self-assessment concludes that there are **no concerns regarding the Trust's quality governance arrangements**, however improvements are required to sufficiently mitigate the 'Measurement' domain (use of data/ data quality) self assessment, specifically 4b and 4c, being re-categorised to 'amber/ red'. 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 in order to strengthen the Trust's assurance, this includes where the quality area is currently 'green' in line with the Trust's commitment to continuous improvement.

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, 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]. Quality areas 4b and 4c are currently under review and dependent on the sufficiency of assurances received by the end of quarter 3, a view will be taken on the potential requirement to categorise these as 'amber/ red'.

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	18/11/2015

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	Self assessment evidence against *Monitor* Quality Governance Framework as at Q2 2015/16

15_16_96_Appendix 1.1: *Monitor* Quality Governance Framework – self assessment quarter 2 2015/16

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		**Q2**	
1a	Does quality drive the trust's strategy?	**GREEN**	
1b	Is the Board sufficiently aware of potential risks to quality?	**GREEN**	
Capabilities and culture			
2a	Does the Board have the necessary leadership and skills and knowledge to ensure delivery of the quality agenda?	**GREEN**	
2b	Does the Board promote a quality-focused culture throughout the Trust?	**GREEN**	
Processes and structure			
3a	Are there clear roles and accountabilities in relation to quality governance?	**GREEN**	
3b	Are there clearly defined, well understood processes for escalating and resolving issues and managing performance?	**GREEN**	
3c	Does the Board actively engage patients, staff and other key stakeholders on quality?	**GREEN**	
Measurement			
4a	Is appropriate quality information being analysed and challenged?	**AMBER/**	**GREEN**
4b	Is the Board assured of the robustness of the quality information?	**AMBER/**	**GREEN**
4c	Is quality information being used effectively?	**AMBER/**	**GREEN**
SUMMATIVE SCORE		**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 Q2 2015/16

Quality area	Trust assurance mechanisms/ Response	Self assessment	Actions from Q1 with update	Further actions for completion by end Q3 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 Q1 with update	Further actions for completion by end Q3 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**	None.	Educational session to be held with the Clinical Directors to explore strengthening current locality assurance mechanisms, including linkage between reported clinical, operational and financial risks and the locality assurance frameworks. **Safe Services Department/ Effective Services Department/ Finance Department/ Clinical Directors** *Note this action is for completion during quarter 4 2015/16 and quarter 1 2016/17 and also covers quality area 3a.*

Quality area	Trust assurance mechanisms/ Response	Self assessment	Actions from Q1 with update	Further actions for completion by end Q3 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 [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** **COMPLETED**	Board development session to be held and areas identified to further strengthen leadership, skills and knowledge of the Board to be developed by the external facilitator for implementation. **Board of Directors**
2b: Does the Board promote a quality focused culture	• Quality Committee chaired by NED, attendance by Executive team and other NEDs.	**GREEN**	Patient safety cultural assessments to be rolled out during quarters 2 and 3 [this	Investment in safety behavioural (Human Factors) development to be

Quality area	Trust assurance mechanisms/ Response	Self assessment	Actions from Q1 with update	Further actions for completion by end Q3 2015/16
throughout the Trust?	• 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 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		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 have been scoped and recommendation was presented to the Board in July 2015 to implement The Health Foundation "Measuring and monitoring safety" framework. This will be implemented through the Zero Harm implementation plan and specific actions identified in future Quality Governance Framework self assessments.* **Safe Services Department supported by zero harm 'culture carriers' in partnership with ward and team managers** **COMPLETED**	scoped to further promote a quality focused culture. A business case to be formulated setting out the investment [which might be shifting existing resource and/ or income generation plans to avoid cost] in educational and organisational development programmes. **Safe Services Department**

Quality area	Trust assurance mechanisms/ Response	Self assessment	Actions from Q1 with update	Further actions for completion by end Q3 2015/16
	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.			
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 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	**GREEN**	Review areas for improvement identified within the locality well-led assurance frameworks and deliver a programme of seminars during the 2015/16 to support Clinical Directors with their roles and accountabilities in relation to quality governance. *See 1b for future action.* **Medical Director [Quality]/ Associate Director of Safe Services** **COMPLETED**	No further actions.

Quality area	Trust assurance mechanisms/ Response	Self assessment	Actions from Q1 with update	Further actions for completion by end Q3 2015/16
	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.			
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 – 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	**GREEN**	None.	Based on the outputs of action 1b, processes for escalating and resolving issues and managing performance should be refined as necessary, aligned to service line management principles. **Associate Director of Safe Services/ Associate Director of Performance & Redesign** *Note this action is for completion during quarter 4 2015/16 and quarter 1 2016/17.*

Quality area	Trust assurance mechanisms/ Response	Self assessment	Actions from Q1 with update	Further actions for completion by end Q3 2015/16
	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 stakeholders on quality?	• Quality outcomes are made public [and accessible] regularly, and include objective coverage of both good and poor performance – 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.	**GREEN**	None.	No further actions.

Quality area	Trust assurance mechanisms/ Response	Self assessment	Actions from Q1 with update	Further actions for completion by end Q3 2015/16
	- 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. - 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			

Quality area	Trust assurance mechanisms/ Response	Self assessment	Actions from Q1 with update	Further actions for completion by end Q3 2015/16
	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. - 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 has plans to strengthen reviews quality and	**AMBER/ GREEN**	Development of locality data packs as a maturation of the Trust's approach to continuous quality improvement and quality reporting. These will	No further actions.

Quality area	Trust assurance mechanisms/ Response	Self assessment	Actions from Q1 with update	Further actions for completion by end Q3 2015/16
	safety metrics displayed via service locality data packs. • 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.		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. *Implemented across all wards and teams. Quality Committee in October 2015 endorsed a service locality data pack for analysis and challenge of granular level quality information at integrated level.* **Safe Services Department** **COMPLETED**	
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	**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	No further actions [see quality area 4c regarding emerging risk].

Quality area	Trust assurance mechanisms/ Response	Self assessment	Actions from Q1 with update	Further actions for completion by end Q3 2015/16
	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 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.		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 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**	

Quality area	Trust assurance mechanisms/ Response	Self assessment	Actions from Q1 with update	Further actions for completion by end Q3 2015/16
			Performance & Redesign/ Head of Performance & Information/ Senior Information Analyst **IN PROGRESS** Appoint to Data Quality Project Lead post to lead implementation of Data Quality Framework. *Data Quality Project Lead in post [from May 2015].* **Associate Director of Performance & Redesign** **COMPLETED**	
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 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.	**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 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.	No further actions [the action from quarter 1 has been strengthened based on emerging risk].

Quality area	Trust assurance mechanisms/ Response	Self assessment	Actions from Q1 with update	Further actions for completion by end Q3 2015/16
	• '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.		*Quality Committee agreed the above at its January 2015 meeting. The operational roll out of locality data packs completed.* **Quality Surveillance Support Managers in partnership with service and clinical leads** **COMPLETED** Review of all data extracts from the data warehouse that support contractual and mandatory reporting requirements *An emerging risk re data quality/ completeness/ provision to contract meetings has been identified – specifically Wirral Early Intervention, Sefton IAPT and Secure Services. A rapid turnaround plan to remedy this position has been requested by the Executive Team. The risk score on the corporate assurance framework has been increased to 20 in the interim due to potential adverse impact (likelihood) of contract query performance notices.*	

Quality area	Trust assurance mechanisms/ Response	Self assessment	Actions from Q1 with update	Further actions for completion by end Q3 2015/16
			Associate Director of Performance & Redesign	

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

STANDARDISED REPORT COMMUNICATION

REPORT DETAILS

Report subject:	Mental Health Act Annual Report
Agenda ref. no:	15/16/97
Report to (meeting):	Board of Directors
Action required:	Information and noting
Date of meeting:	25/11/2015
Presented by:	Dr Anushta Sivananthan, Medical Director

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

REPORT BRIEFING

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

The purpose of this report is to inform the Board of Directors of:

1) The effect of the new MHA Code of Practice
2) The key findings and trends following CQC MHA visits
3) Benchmarking of annual MHA figures
4) Mental Capacity Act/ Deprivation of Liberty Safeguards update
5) Assurance regarding the effective role of the Hospital Managers' Panels

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

The Mental Health Act can affect the lives and liberty of many people. Following extensive consultation a new Code of Practice came into effect on 1st April, 2015, and provides statutory guidance to all providers on how to administer the Act. The Care Quality Commission use the framework of the Code of Practice during their monitoring visits. Since the beginning of 2015 there have been sixteen MHA CQC visits trustwide; the action plans and themes of which are monitored by the MHA Team and reported bi-monhtly to the Compliance, Assurance & Learning Sub-committee. The Supreme Court Judgment in March 2014, regarding deprivation of liberty safeguards has resulted in considerable discussion nationally and a lack of clarity. Consequently the Trust has approached the Court of Protection on three occasions to seek relevant authorisation. A recent Law Commission consultation document proposed substantial changes to the system – the report is due to be published in late 2016.

Assessment – *analysis and considerations of options and risks*

1) The aim of the new MHA Code of Practice is to provide stronger protection for patients, and to clarify roles, rights and responsibilities. Deviation from the code may lead to legal challenge, therefore staff must ensure that all interventions are fully documented.
2) Benchmarking showed that the overall number of detentions within CWP is comparable to the national trend in 2014-2015. However, the use of Section 136 'bucks the trend' as there was a marked reduction in its use within the footprint of the Trust during this period, this could be attributed to the Street Triage initiative implemented during this period.
3) Specific recurrent themes have been identified by CQC, and some concern noted regarding the sustainability of actions. A more robust mechanism for monitoring action plans has been put into place by the MHA Team in conjunction with locality visits and ward audits and is now being reported to the Compliance Assurance and Learning Sub Committee. Further work will be undertaken as part of the Trust response to the CQC announced inspection, specifically relating to - documentation of assessment of capacity to consent, reading of patient rights, and referral to advocacy services.

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

The Board of Directors are asked to consider the attached appendices and discuss the implications for the Trust with regards to the implementation of, and compliance with, the Mental Health Act and Code of Practice 2015, and the Mental Capacity Act.

Who/ which group has approved this report for receipt at the above meeting?	35T
Contributing authors:	Jan Devine

Distribution to other people/ groups/ meetings:

Version	Name/ group/ meeting	Date issued
1	Jo Watts	16/11/15
2	Anushta Sivanathan & David Wood	17/11/15

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	The effect of the Code of Practice 2015
2	Key findings and trends following CQC MHA visits
3	Benchmarking the use of MHA
4	Mental Capacity Act/DoLS update
5	Hospital Managers' Panel process update

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

CHAIR'S REPORT
AUDIT COMMITTEE
27 October 2015

The following is a summary of issues discussed and any matters for escalation from the October 2015 meeting of the Audit Committee:

Review of individual strategic risk

The Committee received a further overview of the risk to the Trust of cyber threats in considering the risk, assurances and potential gaps in control. The Committee recommended that this risk is now fully modelled and presented to the Quality Committee in January 2016 for approval for addition to the strategic risk register.

The Audit Committee agreed that individual in-depth reviews of risks will move to the Quality Committee with the Audit Committee undertaking periodic reviews of risk treatment processes for individual risks on an escalation/enquiry basis. The Audit Committee will continue to receive the Strategic Risk Register and Corporate Assurance Framework on a quarterly basis to enable them to identify any such issues. The Committee noted risk 9 - Risk of adverse clinical incident due to quality of record keeping and dual record keeping systems (electronic and paper) and the length of time this has been on the risk register. The Committee will recommend this risk for review for the Quality Committee.

Internal Audit progress update
The Audit Committee received an update on the outcomes of recent audits including audits on charitable funds, board performance reporting and core financial systems. All audits had received significant assurance.

External Audit technical update
KPMG provided a technical briefing providing an update on regulatory and policy matters recently announced. This included a focus on Monitor consultation on the risk assessment framework, an overview of the top key risks facing public sector organisations, agency spend rules recently issued by Monitor and the TDA and future changes to the national audit office coming into force through the Local Audit and Accountability Act 2014.

Provider Licence compliance Q2
From 15/16 a quarterly review of the key licence conditions was added to the Audit Committee business cycle as an additional assurance for the Board.

At the end of Q2 it is reported that the majority of Licence provisions have been self-assessed as green. There were three exceptions for note, all had mitigating actions to support return to full compliance. The Board are due to receive an overview of licence compliance at the November 2015 meeting.

Clinical Audit update
The Audit Committee received an update on progress to date with the 15/16 clinical audit plan and received assurance on the Successful projects delivered so far which included care planning and CARSO risk assessment; seclusion; challenging behaviour; supervised community treatment audit and re-audit; accelerating restraint reduction, national audit and local audit for the CQUIN on physical healthcare; therapeutic observation; ward environment; POMH audits; MHA breaches/Code of Practice compliance; safeguarding adults and children; record keeping; implementation of learning from Croft and Adelphi ward investigation. Human factor's has been included in Audits.

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

Full approved minutes of the meeting of 1st September 2015 available here.

Cheshire and Wirral Partnership NHS
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CHAIR'S REPORT –
QUALITY COMMITTEE
4 NOVEMBER 2015

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

- **Strategic risk register**
  The Quality Committee reviewed the current status of controls, assurances and mitigating actions identified in relation to the Trust's strategic objectives. All risk treatment plans have been updated and the dynamism of the risk register is increasing significantly since greater ownership has been embraced by the respective risk owners/ leads. There is also clear evidence of scrutiny at the various relevant meetings within the governance structure.
  The data quality risk has been increased to 20 in light of recent gaps in data/ information provided for contract monitoring processes in relation to a number of contracts. The increase represents the potential adverse impact (likelihood) of contract query performance notices.
  Presentations were received on locality learning from incidents and the Trust's approach to developing its training needs analysis, as key themes arising from the Trust's comprehensive inspection from the CQC. Localities provided updates on how they are using their locality governance structures to effectively learn from experience, whilst Education CWP shared plans to enable staff to provide even better care through targeted education that is responsive to emerging safety critical areas and team training.
  The Board of Directors is asked to note that a remedial plan has been sought in relation to the data quality risk, for review at the Executive Directors meeting. It should also be aware that whilst for quarter 2, the measurement domain of the Monitor quality governance framework will remain as Amber-Green, there is an increased likelihood of this being rated as Amber-Red for quarter 3, dependent on the robustness and demonstration of the effectiveness of the remedial plan to the end of December.

- **Learning from experience and serious incidents**
  The Quality Committee received an appraisal of the robustness of each locality's assurances provided against the Regulation 28 report PFD 30.01.2015. This appraisal has been undertaken by a nominated Associated Director, using triangulation to assess continuing emergence of the index case themes. The appointment of a nominated Associated Director was made by the Quality Committee to put learning into context for all localities for discussion at the respective governance meetings, and to help the locality where the index case took place to not be distracted by co-ordinating learning cross-locality. The Quality Committee received an update on the current status of assurances provided to-date, with some outstanding gaps requiring more assurance.
  The Board of Directors will receive a further update on the status of this report at its next meeting.

- **Quality reporting**
  The Quality Committee received a presentation on a proposed integrated version, at service level, of the granular level quality data set contained in the locality data packs. This has been trialed in CAMHS and the Quality Committee approved the outputs for application to other service locality data packs. These will be rolled out across all core services for quarter 4 2015/16, in order to feed into locality thinking for their strategic plans for 2016/17.
  The Board of Directors should note that, in line with the Zero Harm strategy, continuous quality improvement will be promoted through the Locality Data Packs by indicating where teams require improvement based on expected quality 'performance' for that team, using internal and benchmarked information.

- **Accelerating restraint reduction**
  The Quality Committee received an update from the final meeting of the accelerating restraint reduction task and finish group. The agenda will now be taken through the Patient Safety & Effectiveness Sub Committee. As a result of clinical teams working together with the Safe Services Department, to-date the quality improvement project has resulted in a significant reduction of 50% in the use of prone position restraint and a notable reduction in seclusion incidents. To move this agenda into sustaining mode, corporate support teams are now identifying supportive and enabling solutions to residual barriers identified by front line staff, in order to secure continuing ownership and ongoing improvement at locality and team level.
  The Board of Directors is asked to note that a particular action identified is a letter of thanks to all staff involved on behalf of the Board, which the Board of Directors is asked to endorse.

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