Cheshire and Wirral Partnership NHS
NHS Foundation Trust

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

Item no.	Title of item	Objectives/desired outcome	Process	Item presenter	Time allocated to item
17/18/64	Apologies for absence	Receive apologies	Verbal	Chair	1 min (1330)
17/18/65	Declarations of Interest	Identify and avoid conflicts of interest	Verbal	Chair	2 min (1331)
17/18/66	Minutes of the previous meeting held 27 September 2017	Confirm as an accurate record the minutes of the previous meetings	Written minutes	Chair	2 mins (1333)
17/18/67	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)
17/18/68	Board Meeting 2017/18 business cycle	Confirm that agenda items provide assurance that the Board is undertaking its duties	Written	Chair	3 mins (1337)
17/18/69	Chair's announcements	Announce items of significance not elsewhere on the agenda	Verbal	Chair	10 mins (1340)
17/18/70	Chief Executive's announcements *(including overview of items discussed in closed meeting)*	Announce items of significance not elsewhere on the agenda	Verbal	Chief Executive	10 mins (1350)

Item no.	Title of item	Objectives/desired outcome	Process	Item presenter	Time allocated to item
MATTERS FOR APPROVAL/ DECISION					
Operational Performance/ Finance & Use of Resources					
17/18/71	Operational Plan and Performance dashboard: October 2017 data	To note performance	Written Report	Director of Finance	10 mins (1400)
Strategic Change					
17/18/72	Board Assurance Framework and Risk Register	To review new/ existing risks and assurances	Written Report	Medical Director	10 mins (1410)
17/18/73	Central and East Cheshire redesign • a. Pre consultation business case • b. Resilience update	To approve pre consultation business case and note update	Written Report	Director of Operations/ Medical Director	30 mins (1420)
Quality of Care					
17/18/74	CQC Mental Health Survey results	To note survey findings	Presentation	Director of Nursing, Therapies and Patient Partnership	25 mins (1450)
17/18/75	Freedom to Speak Up Guardian: six monthly report	To review and note report	Written Report	Freedom to Speak out Guardian	10 mins (1515)

Item no.	Title of item	Objectives/desired outcome	Process	Item presenter	Time allocated to item
17/18/76	Quality Improvement Strategy	To review post consultation and approve	Written Report	Medical Director	10 mins (1525)
17/18/77	Safer Staffing: Daily ward staffing figures: September and October 2017	To note the ward staffing reports	Written Report	Director of Nursing, Therapies and Patient Partnership	5 mins (1535)
Governance					
17/18/78	a. Well led inspection reports: • CQC well-led pilot inspection: final report and improvement themes • AQUA/ MIAA External well led review improvement themes: six monthly review b. Workforce Race Equality Scheme (WRES) assurance update	To note reports and progress	Written Report	Medical Director Director of People and OD	10 mins (1540)
17/18/79	Corporate Governance Manual: annual review	To review and approve	Written Report	Director of Finance	5 mins (1550)

Item no.	Title of item	Objectives/desired outcome	Process	Item presenter	Time allocated to item
17/18/80	Annual Reports 2016/17: • a. Research and Development • b. Health, Safety and Fire	To review and note report	Written Report	Medical Director Director of Nursing, Therapies and Patient Partnership	10 mins (1555)
17/18/81	Q2 2017/18 reports: • a. Infection, Prevention and Control • b. Safeguarding Reports (Q1&Q2)	To note reports	Written Report	Deputy Director of Nursing/ Director of IPC	5 mins (1605)
17/18/82	Audit Committee reporting: • Chair's report of meeting held November 2017 • Approval of NED membership	Review Chair's Report and terms of reference and any matters for note/ escalation	Written Report	Chair of Audit Committee	3 mins (1610)
17/18/83	Quality Committee reporting : • Chair's report of meeting held 1 November 2017	Review Chair's Report and any matters for note/ escalation	Written Report	Chair of Quality Committee	3 mins (1613)
17/18/84	Review of risk impacts of items discussed	Identify any new risk impacts	Verbal	Chair/ All	5 mins (1616)
17/18/85	Any other business	Consider any urgent items of other business	Verbal or written	Chair	2 mins (1621)

Item no.	Title of item	Objectives/desired outcome	Process	Item presenter	Time allocated to item
17/18/86	Review of meeting	Review the effectiveness of the meeting (achievement of objectives/desired outcomes and management of time)	Verbal	Chair/All	2 mins (1623)
17/18/87	Date, time and place of next meeting: **Wednesday 31 January 2018, 9.30 Boardroom, Redesmere**	Confirm arrangements for next meeting	Verbal	Chair	1624

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

Minutes of the Board of Directors Meeting
Wednesday 27 September 2017
Room 2, Ancora House, Countess of Chester Health Park
1.30pm

PRESENT	Mike Maier, Chair Andrea Campbell, Non-Executive Director Dr Jim O'Connor, Non-Executive Director Lucy Crumplin, Non-Executive Director Sheena Cumiskey, Chief Executive Avril Devaney, Director of Nursing, Therapies and Patient Partnership David Harris, Director of People and Organisational Development Edward Jenner, Non-Executive Director Andy Styring, Director of Operations Rebecca Burke-Sharples, Non-Executive Director Dr Anushta Sivananthan, Medical Director, Quality, Compliance and Assurance Tim Welch, Director of Finance
IN ATTENDANCE	Louise Brereton, Head of Corporate Affairs Katherine Wright, Associate Director Communications and Engagement Andrea Hughes, Deputy Director of Nursing (for item 17/18/56) Tim Jenkins, Emergency Planning Manager (17/18/57)
APOLOGIES	Dr Faouzi Alam, Medical Director

	MINUTES	ACTION
17/18/43	**Apologies for absence** Mike Maier welcomed all to the meeting and advised that the meeting was a meeting held in public.	
17/18/44	**Declarations of Interest** None was declared.	
17/18/45	**Minutes of the previous meeting held 26 July 2017** The minutes of the last meeting held 26 July 2017 were reviewed. It was agreed that the reference to CQC assurance line on page 4 should be removed. The minutes of the meeting held 26 July 2017 were **approved** as a correct record.	
17/18/46	**Matters arising and action points** All actions were completed.	
17/18/47	**Board Meeting 2017/18 business cycle**	

	It was noted that some Annual Reports had been deferred to the November 2017 meeting to allow further time for them to report within the governance structure. The intervals for reporting on the Risk Register and the Board Assurance Framework had slightly changed meaning this would report in November 2017 and January 2018.	
17/18/48	**Chair's announcements** Mike Maier announced the following: **Electro-convulsive Therapy Services** The first phase of our planned changes to Electro-convulsive therapy (ECT) service is now complete, with staff receiving positive feedback from some service users about the transition. Patients from Wirral and West Cheshire are now receiving treatment at Bowmere Hospital, with Porters offering regular transport from Springview Hospital for existing Wirral outpatients. This change will not affect ECT services at the Millbrook Unit Lucy Cumplin queried that only some service users had positively feedback and a broader overview of the full feedback picture would be useful. **Action**: A more comprehensive ECT update to report to the November 2017 Board meeting to include full overview of feedback. **East Cheshire Redesign** East Cheshire and South Cheshire CCGs are holding bi-weekly meetings as part of a wider review of mental health services within their footprints. CWP and local authority representatives are also attending these meetings. CWP has also set up an internal working group for this project, as well as a Clinical Advisory Group with representatives from all disciplines including nursing, allied health professionals and therapists who will ensure the project has a solid clinical grounding, helping us to improve outcomes for patients. An update on the work to date will be reported to the Cheshire East Overview and Scrutiny Committee (OSC) in October including the outcome of two adult mental health pre-consultation workshops which are taking place next week. It is important to hear views on current services from service users and carers and to ask what could be done differently and better. Views will help us to shape a new proposed service model and inform options that form part of public consultation. At this time, it is anticipated that public consultation to take place at the end of this year/ early next year for a three month period during which time there will be further opportunities to express your views. **Speak up App** CWP now has a 'Freedom to Speak Up' app where staff can raise any concerns they may have in the workplace. All entries to the app are escalated to the Trust's Freedom to Speak Up Guardian, who will respond accordingly.	**ASt**

	AMM A final reminder that our Big Book of Best Practice event and our Annual Members' Meeting will take place at Macclesfield Town Hall on Thursday 5 October. The Big Book of Best Practice event will take place from 9.30am – 12.45pm; our Annual Members Meeting from 1.00pm – 3.30pm. **Recognition event** On Thursday 26 October we'll be *'Celebrating our Workforce'* at our new recognition awards honouring the best and brightest of CWP Staff, Volunteers and Involvement Reps. The CWP Recognition Awards: *Celebrating our Workforce* will take place at Ellesmere Port Civic Hall from 3.30pm – 7.30pm. **Urgent Treatment Centre** A new Urgent Treatment Centre (UTC) is set to open at the Countess of Chester Hospital next week supported by the CWP GP Out of Hours and Urgent Care Team. The new centre will support patients to be seen in the right place by the right person and help to ease the pressure on A&E. The UTC has been funded by NHS England and will bring the Countess Emergency Department and CWP's Out of Hours service colleagues together under one roof to deliver primary care for patients. Our existing GP Out of Hours service will move to the new Centre which is located to the right of the main hospital entrance Sheena Cumiskey advised that assurance had been provided to the September Operational Board on the MoU for this service and also concerning the assessment of clinical risks. Specialist GP support is also now in place for additional assurance. It was noted that the co-location of these services will assist with the reduction of risks. This was also discussed with CQC at the recent relationship meeting and they also gave advice on registered locations.	
17/18/49	**Chief Executive's announcements** *(including overview of items discussed in closed meeting)* Sheena Cumiskey provided an overview of the items discussed during the Closed Board of Directors meeting held earlier. These included: • West Cheshire ACO and the development of an Integrated Care Organisation, approving the new model of care for integrated work, the Target Operating Model and the Compendium. Agreement to progress the production of an outline business case was also reached. • An update on Central and East redesign including current provision and risks based on commissioner issues and funding. • The Wirral All Age Partnership which is currently in development with Wirral Council. • Trust Financial and operational performance. The Trust is currently performing in line with the forecast plan.	

17/18/50	**Operational Plan and Performance dashboard: August 2017** Tim Welch presented the report. It was noted that work on redefining strategic priorities undertaken by the Executive team recently will need to inform future versions of this report. It was noted that some names also need updating on the framework **Action**: Review framework in light of strategic priorities recently updated and to update lead names etc. There were no exceptions to note. The Board **noted** the report.	**TW**
17/18/51	**Involvement Review and Framework** Avril Devaney presented the report. The Involvement Review was requested by the Quality Committee in November 2016. The current approach had been in place since 2002 and much has changed since this time. There have been a number of more recent developments such as stronger systems for involvement at the design stage of projects and the development of locality participation roles which have grown locally to inform local services rather than corporate systems. The review has been supported by colleagues from MerseyCare who facilitated the process in a highly skilled way. Consultation workshops were held concluding with the consensus that the involvement resource should focus on developing people. The review has concluded that there will be three ways to get involved: • Volunteering (including Peer Support, PLACE visits and Lived Connector roles). Volunteers can access support that involvement representatives would not have had access to previously, in addition to a more personalised review of their needs and aspirations for the future. • Employment – including bank opportunities, for specific pieces of work. Requirements will be set out in a project plan, identifying the specific skills needed. • Procurement – when a 'package' is purchased, this will have a more strategic input and would potentially include input from independent consultations and social enterprises with a lived experienced focus. The next step for the review is to develop an implementation plan and to decide which roles fall into each category. This will be driven by an implementation group. The proposals have been agreed by the Patient and Carer Experience sub-committee, the Operational Board and the Quality Committee. It was noted that there are fewer involvement representatives from physical health services and there is a need to target this group under the new plans. It was noted that community hubs will assist with this and through the Starting Well programme, the Trust will welcome 200 new volunteers through the breast feeding programme, so there is great	

	potential to build on this. Thanks were extended to all involved in taking this review forward. Avril Devaney provided assurance that the involvement representatives who have expressed concern about the new arrangements, will be supported through the transition. The Board of Directors **approved** the new Involvement Framework.	
17/18/52	**Learning from Experience Report** Avril Devaney presented the report and highlighted the following areas: • The Learning from Deaths policy has been approved and will be published by 30 September 2017 in line with National Quality Board (NQB) requirements. • Improvements have been achieved in supporting challenging behaviour. The Quality Committee have requested a further focus on this issue instigating a 90 day quality improvement cycle which will work towards achieving 0% prone restraints over a determined period. • There has been an increase in the reports of incidents where patients had access to an ignition sources. This demonstrates better management and higher reporting of the sources and has been of interest to Governors recently. • Pressure sore incidents appear to be increasing with a trend appearing in community teams. Actions have been identified to address this. It was noted that in system working, definitions of avoidable/ unavoidable pressure sores are less helpful as all partners should be working together on this issue. The Board of Directors **approved** the report and **endorsed** the recommendations contained within.	
17/18/53	**Quality Improvement Report** Dr Anushta Sivananthan presented the report and highlighted the following points: • Improving the effectiveness of pre-admission assessments has reduced lengths of stay by an average of 2 days. • Falls prevention programme is reducing the risk of harm from falls on inpatient wards. • Progress with implementing the Quality Account priorities of prescribing high dose antipsychotics, reducing bed occupancy, increasing friends and family test inputs. • Despite the pressures, significant redesign work has been undertaken locally, without resource, in East Cheshire. Thanks to the staff involved who are driving clinical redesign at local team level. The Board of Directors **noted** the report.	

17/18/54	**Safer Staffing: Daily ward staffing figures: July & August 2017** Avril Devaney presented the report covering ward staffing for July/ August 2017. The Board of Directors noted that the six monthly staffing report had been discussed by the Governors Scrutiny sub-committee, who welcomed the opportunity to review the report. Dr Jim O'Connor reiterated his request for further detail on community staffing levels. Avril Devaney advised that this will be available in October/ November 2017. Avril Devaney commented that the report in its current form maybe being discontinued by the NQB. **Action:** AD to check with NQB on continuing requirements for Boards to receive the ward staffing report in its current guise. The Board of Directors **noted** the report.	**AD**
17/18/55	**Annual Report 2016/17: Equality and Diversity** Avril Devaney presented the report which provided the Board with an overview of the Trust compliance with its Equality and Diversity obligations. The following points were highlighted: • Workforce issues have been highlighted by WRES action plan. There is evidence that more BME staff proportionally are entering the disciplinary process and there are also issues with the numbers of BME candidates being shortlisted for interviews. This concerns small numbers of people but it is being explored to understand if there are any underlying issues. • The Trust continues to connect with many community groups. Governors have also recently suggested connecting with the local mental health forums which the Equality and Diversity officer will seek to do. Sheena Cumiskey commented that the BME disciplinary action issue needs more understanding. David Harris advised that this concerns six individuals over a two year period. The issues and outcomes are being examined to see how this compares to other staff groups to understand if any disparity exists. A review of each individual case has also commenced. The timescale for the conclusion of this work was requested for confirmation. It was noted that this will report to the People and OD sub-committee but to ensure that the assurance from this work should report up to the Board of Directors in due course. **Action:** David Harris to confirm timescales for review and ensure assurance is received by the Board following reporting to the appropriate subcommittees/ committees. A discussion followed regarding the need to have more information with regards to the number of BME data people who access our services. Access should be the same for all groups however efforts should be taken to engage hard to reach groups, based on those we know live in certain areas. An example was given of the large Vietnamese communities in	**DH**

	certain areas of the Trust geography but do not access services. **Action:** Avril Devaney to explore the BME and hard to reach population groups issue with Andrea Hughes and Bob Davies. Sheena Cumiskey requested assurance that the recruitment and shortlisting of BME candidates was also under review. David Harris confirmed this was the case and this work would also review whether Trust recruitment processes exclude people or make applying difficult for certain groups. The Board of Directors **noted**: • The Trust is compliant with the requirements of the Equality Act and the CCGs Equality and Diversity Quality Requirements. • The progress made in embedding the Equality and Diversity Framework across Trust. • CWP's commitment to delivering personal, fair and diverse healthcare services 2016 - 2020. • The governance arrangements in place to monitor progress of the Trust Equality and Diversity 4 year 2016-2020 objective action plan. (Andrea Hughes joined the meeting)	**AD**
17/18/56	**Q1 2017/18 report: Infection, Prevention and Control** The Chair welcomed Andrea Hughes to the meeting. Andrea presented the report and highlighted the following key points: • No avoidable infections had been contracted in the last quarter. • There was one ward closure to admissions due to diarrhoea and vomiting which affected four patients and one member of staff in May. No causative organism was identified. A review of signage regarding the notification of ward closure and to educate visitors on IPC measures will be undertaken. • Audits have been undertaken on 18 wards or clinics and 13 of these have passed their audits with scores of over 95%. Two areas scored less than 90% and action plans have been agreed and re audit dates booked to assess improvements. • IPC training rates were 83% compliant in Q1. The team are looking at eLearning to allow more flexibility for staff to complete their training. • Antimicrobial resistance work continues, with close working with the pharmacy team, particularly around compliance to formulary. • The 'Stay Well This Winter' campaign has commenced across the organisation. • The Sepsis Care Improvement Programme continues to raise awareness through education to patient facing staff and aims to reduce mortality & morbidity for our service users and reduce delay to acute care for patients with identified sepsis triggers The Board of Directors **noted** the report. (Andrea Hughes left the meeting, Tim Jenkins joined the meeting)	

17/18/57	**Emergency Planning Core Standards Assurance** Tim Jenkins presented the report. The Trust is required to be assessed against 50 NHS England, Emergency Planning Core Standards. The Trust has received full compliance. CWP was assessed against 50 core Emergency Planning standards and has achieved full compliance A discussion followed regarding how our emergency planning work compares to other trusts. It was noted that the CWP team are emergency planning leaders and support many other teams in the local system. Thanks were extended to Tim Jenkins and the team for their work and their proactive approach to anticipating issues with other partners. The team are also supporting with other pieces of work in the Trust, such as the East Cheshire resilience work. The Board of Directors **approved** the report and submission to NHS England.	
17/18/58	**Audit Committee reporting:** • Chair's report of meeting held 5 September 2017 Edward Jenner provided an overview of the discussions at the September 2017 Audit Committee. There were no items for escalation. The Board of Directors **received** the minutes.	
17/18/59	**Quality Committee reporting :** • Chair's report of meeting held 6 September 2017 Dr Jim O'Connor provided an overview of the items discussed at the September 2017 Quality Committee. There were no items for escalation. The Board of Directors **received** the minutes.	
17/18/60	**Review of risk impacts of items discussed** All matters had been adequate covered and risks already contained within the risk register.	
17/18/61	**Any other business** Lucy Crumplin commented on the recent national press coverage regarding the prescribing of valproate to pregnant women and whether this posed any risk to CWP. Dr Sivananthan commented that there will always be some risks; however the new NICE quality standard on this seeks to ensure that pregnant women are made aware of the risks of any prescribed medication. Andy Styring advised that the Starting Well contract will go live from 1 January 2018 however some staff will move over to CWP from 1 October 2017. Some risks have been identified around consistency of DBS processes for the transferring staff. This is not significant risk to the process, however all DBS checks will be undertaken in line with CWP policies once the transfer of staff has been undertaken.	

	The Board were advised that CWP was successful in its tender submission to provide services from Willaston surgery. This will go live from 1 November 2017.	
17/18/62	**Review of meeting** All agreed the meeting had been effective.	
17/18/63	**Date, time and place of next meeting:** Wednesday 29 November 2017, 9.30am, Boardroom Redesmere	

Signed

Mike Maier, Chair

Date:

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

Action points from Board of Directors Meetings
September 2017

Date of Meeting	Minute Number	Action	By when	By who	Progress Update	Status
27/09/17	17/18/48	**Chair's Announcements** A more comprehensive ECT update to report to the November 2017 Board meeting to include full overview of feedback.	Oct/ Nov 2017	ASt	Verbal update due at meeting	Open
27/09/17	17/18/50	**Operational Plan and Performance dashboard** Review framework in light of strategic priorities recently updated and to update lead names etc.	Oct 2017	TW	Performance and Information team advised of changes requested.	Closed
27/09/17	17/18/54	**Safer Staffing** AD to check with NQB on continuing requirements for Boards to receive the ward staffing report in its current guise.	Oct 2017	AD	Awaiting clarification from NQB	Open
27/09/17	17/18/55	**Annual Report 2016/17: Equality and Diversity** David Harris to confirm timescales for review and ensure assurance is received by the Board following reporting to the appropriate subcommittees/ committees.	Nov 2017	DH	On November 2017 agenda under well-led reporting.	Closed

27/09/17	17/18/55	**Annual Report 2016/17: Equality and Diversity** Avril Devaney to explore the BME and hard to reach population groups issue with Andrea Hughes and Bob Davies.	Nov 2017	AD	Verbal update will be provided at the meeting.	Open

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

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

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

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

26	**Register of Sealings**	Director of Finance	Audit Committee				✓							
27	**Provider Licence compliance review and Approval of Licence Declarations**	Director of Finance	Audit Committee		✓									
28	**Statutory Registers: Directors and Governors**	Chair	Audit Committee		✓									
29	**CEO /Chair Division of Responsibilities**	Chair	N/A		✓									
30	**Integrated Governance Framework**	Medical Director Compliance Quality and Regulation	Quality Committee							✓				
31	**Minutes and/or Chair's Report of the Quality Committee**	Non Executive Director	N/A		✓		✓	✓		✓		✓		✓
32	**Minutes and/or Chair's Report of the Audit Committee**	Non Executive Director	N/A		✓		✓	✓		✓		✓		✓
33	**Audit Committee annual effectivenes review**	Non Executive Director			✓									
34	**BOD Business Cycle 2017/18**	Chair	N/A		✓		✓	✓		✓		✓		✓
35	**Approve BOD Business Cycle 2018/19**	Chair	N/A											✓
36	**Review Risk impacts of items**	Chair/All	N/A		✓		✓	✓		✓		✓		✓

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

STANDARDISED REPORT COMMUNICATION

REPORT DETAILS

Report subject:	Operational Plan 2017/18- delivery indicators dashboard [October data]
Agenda ref. no:	17-18-71
Report to (meeting):	Board of Directors
Action required:	Discussion and Approval
Date of meeting:	25/10/2017
Presented by:	Tim Welch, Director of Finance/Deputy Chief Executive

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

REPORT BRIEFING

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

The Operational Plan 2017/18 sets out the Trust's approach to activity, quality, workforce planning and financial planning.

The dashboard attached in **appendix 1** reflects the key performance indicators (KPIs) defined to enable the Board to monitor the delivery of the Operational Plan and the Trust's strategic objectives and any risks to achievement. This report relates to October 2017 Performance.

The dashboard has been updated to reflect the changes to Executive and Operational Leads following review by the executive team, further amendments will be made to reflect Care Group mapping there are two new enabling projects: people; and information/ business intelligence.

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

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

Assessment – *analysis and considerations of options and risks*

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

The dashboard reflects month 7 there are no indicators off track, however it is important to note the following

- Priority been reviewed and now reflect the 8 trust priority projects. *Please note: following Executive review, it was agreed that there would not be a PSO status report for November, that instead some time should be taken to reflect how the overall Programme of activity is reported, scrutinised and monitored and ensure arrangements are robust enough going forward.*
- KPI SO3.3.2 Both metrics are amber rated at the latest reportable position
- KPI SO3: 3.1 The trust reported last month that the CPA 12 month review target had not been met. I am pleased to report that all 14 NHSI targets were met this month, with CPA 12 month review achieving 95.07% compliance, against a target of 95%.

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

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

The Board are recommended to **note** the October 2017 Board Operational Plan dashboard.

Who/ which group has approved this report for receipt at the above meeting?	Tim Welch, Director of Finance
Contributing authors:	35T

Distribution to other people/ groups/ meetings:

Version	Name/ group/ meeting	Date issued
1	Tim Welch	17/11/17
2	Tim Welch	20/11/17
3	Tim Welch	20/11/17
4		21/11/17

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

Appendix no.	Appendix title
1	October 2017 Board Operational Plan Dashboard.
2	Operational Plan 2017/18 – Delivery Indicators/ Board KPIs
3	Key Name - CWP Forward view – Care Group

Appendix 1: Trust Dashboard

	Indicator	Outturn 2016/17	Target or Thresholds for escalation	Target	Q1	Sep-17	Q2	Oct-17	Nov-17	Dec-17	Q3	Jan-18	Feb-18	Mar-18	Q4	Year End	General Comment
Strategic Objective 1 – Quality																	
SO1: 1.1	Patient safety: The target for improvement is a 10% increase in the number of D&E incidents reported, based on numbers reported at the start of Trimester 1 of this year. The indicator is shown as a rate per 1,000 episodes of care.	58.6 per 1,000 episodes	Red: Below 2016/17 outturn Amber: better than 2016/17 outturn Green: above 2016/17 target(64.5)	75.6	65.4	62.8	72.7	71.1									Please note outturn position has been updated to reflect position as at the end of 2016/17.
SO1: 1.2	Patient experience: Demonstrable increase in the uptake of the Friends and Family Test (FFT) each quarter	Average 216 (per month)	237 per month	324.5	785	233	817	400									
SO1: 1.3	Clinical Effectiveness: Demonstrable improvement in the Trustwide average bed occupancy rate, excluding leave, for working age adult wards	93.19%	Improvement to 85% by KH03's month 12 (December 2017)		91.83%	87.52%	87.50%	87.52%									
Strategic Objective 2: People and OD/ Approach to workforce																	
SO3: 2.1	Capacity: % of staff vacancies (Contracted)	5.31%	equal to or below baseline 4.15%		4.05%	4.90%	4.49%	5.04%									
SO3: 2.2	Competence: % of staff receiving annual appraisal (via new proposed framework)	97.6%	100.0%		95.72%		89.78%										
SO3: 2.3	% staff absence due to sickness	5.04%	Above annual plan projection for 3 months		5.46%	5.31%	5.37%	5.10%									Performance measurement against Annual Plan Trajectory. Please note
Operational Performance / Priority areas																	
SO3: 3.1	100% of the 13 NHSI operational performance targets achieved (including waiting times)	100%	100%	100%	100%	93.00%	98.00%	100%									Please note CPA 12 month review target was met by the trust this month.
SO3: 3.2	100% Contractual targets met	324 (98.1%)	100%	100%		98.5%											**Wirral CCG** - 8 indicators that have been red for 3 consecutive months – (1 due to over performance) **West CCG** Physical Health - 4 indicators that have been red for 3 – both due to under performance and Mental Health Services has 1 indicator that has been red for 3 consecutive Please note this indicator reports 2 months behind.
	CQUIN performance quarterly review	TBC	100%														Processes have been implemented to improve data capture and reporting for the Risky Behaviourss CQUIN. From October 2017.
	This sectionhas been updated to refect the trust priorities agreed in October 2017																
SO3: 3.3	Priority project 1: Children and Young Families Prevention/ Early interventions:	N/A	Delivery of Key Milestones														The Executive team agreed the new 8 Priority Projects list in October 2017 Following this, it was agreed that there would not be a PSO status report for November, that instead some time should be taken to reflect how the overall Programme of activity is reported, scrutinised and monitored and ensure arrangements are robust enough going forward. This section of the report has been updated to reflect the trust priority projects and will be updated following the agreement of the new reporting processes. In light of this review all prior reporting has been removed from this dashboard.
SO3: 3.6	Priority project 2:Transforming Care LD	N/A	Delivery of Key Milestones														
SO3: 3.7	Priority project 3: Improved Place Based Care	N/A	Delivery of Key Milestones														
	Priority project 4: redesign Adult & Older peoples MH services	N/A	Delivery of Key Milestones														
	Priority 5: EI Review & Delivery	N/A	Delivery of Key Milestones														
SO3: 3.10	Priority 6: Wirral All Age Disability																
SO3: 3.11	Priority 7: Enabler: People																
SO3: 3.12	Priority 8: Enabler: Information/ Busi	N/A	Delivery of Key Milestones														
Strategic Objective 6: Financial Planning																	
SO6: 1	Use of resources		Use of Resources [UoR]		3	2	2	2									Further detail is available in Finance Report

Appendix 2: Trust Dashboard Reporting Framework

Op Plan ref	Indicator	Target or Thresholds for escalation	Base line	Reporting and Frequency	Reporting Months	01/04/2017	01/05/2017	Director	Project Lead	Risk Register/ CAF ref
Strategic Objective 1 – Quality										
SO1: 1.1	Patient safety: The target for improvement is a 10% increase in the number of D&E incidents reported, based on numbers reported at the start of Trimester 1 of this year. The indicator is shown as a rate per 1,000 episodes of care.	10% improvement in reporting of low and no harm incidents **Escalation Thresholds** Red: Below 2016/17 outturn Amber: better than 2016/17 outturn (58.6) Green: above 2016/17 target (64.5)	Red: Below 2016/17 outturn Amber: better than 2016/17 outturn Green: above 2016/17	Learning from Experience report Every 4 months	May August January April	Quality Committee	Trend line	Anushta Sivananthan/ Avril Devaney/ Jim O'Connor	David Wood	Risk 6 – learning from incidents (red 16)
SO1: 1.2	Patient experience: Demonstrable increase in the uptake of the Friends and Family Test (FFT) each quarter	10% improvement in Trustwide uptake of FFT	300 per month	Quality Improvement Report Quarterly	July October February April	Patient and Carer Experience Sub Committee	? Trajectory for improvement	Avril Devaney/ Fiona Clark/ Jim O'Connor	Liz Matthews	Risk 5 – feedback from learning (red 16)
SO1: 1.3	Clinical Effectiveness: Demonstrable improvement in the Trustwide average bed occupancy rate, excluding leave, for working age adult wards	Improvement to 85% by KH03's month 12 (December 2017)	93.19%	Continuous Improvement Report Monthly	May-March	Quality Committee	TBA	Faouzi Alam/Anushta Sivananthan/ Jim O'Connor/ Lucy Crumplin	Claire James	
SO3: 2.1	Capacity: % of staff vacancies	4.15%	5.31%	Any quarter in which each of the three months the staff vacancy rate is above the base line position	By exception	People and OD subcommittee	Chairs escalation	David Harris	Viv Williamson	Risk 11 – staffing (rated red 20)
SO3: 2.2	Competence: % of staff receiving annual appraisal (via new proposed framework)	100% of available eligible cohort	98%	Any quarter in which each of the three months the appraisal rate is below the baseline position	Quarterly	People and OD subcommittee	Performance against plan chart or variance from plan	David Harris	Hayley Rigby	Risk 11 – staffing (rated red 20)

SO3: 2.3	% staff absence due to sickness	5.30%	5.04%	Any quarter in which each of the three months the sick absence rate was % above the profile set out in the annual plan.	By exception	People and OD sub committee	Variance from target trend line	David Harris	Chris Sheldon	Risk 11 – staffing (rated red 20)
Operational Performance / Priority areas										
SO3: 3.1	100% of the 13 NHSI operational performance targets achieved (including waiting times)	100%	87%	Any occasion where the compliance with any monitor target is missed for 3 consecutive months	By exception	Operational Board	Achievement trend line	Andy Styring/ Tim Welch	Service Directors	Risk in scope re. IAPT delivery
ject the tru	100% Contractual targets met	100%	Avg 97.04%	Any occasion where the same target for any contractual KPI is missed for 3 consecutive months	By exception	Operational Board	Achievement trend line	Andy Styring/ Tim Welch	Service Directors	Risk in scope re. IAPT delivery
This section has been upadted to reflect the trust priorities as at November 2017										
SO3: 3.3	Priority project 1: Children and Young Families Prevention/ Early interventions:	Delivery of Key Milestones		Project Status report monthly and at key decision/ milestone points along the project	April - March	Operational Board	Delivery of Key Milestones	Avril Devaney and Dave Harris	Val Sturgess	Risk 13 – tendering of services (rated amber 12)
SO3: 3.4	Priority project 2:Transforming Care - LD	Delivery of Key Milestones		Project Status report monthly and at key decision/ milestone points along the project	April - March	Operational Board	Delivery of Key Milestones	Andy Styring	Mahesh Odiyoor	
SO3: 3.5	Priority project 3: Improved Place Based Care	Delivery of Key Milestones		Project Status report monthly and at key decision/ milestone points along the project	April - March	Operational Board	Delivery of Key Milestones	Dave Harris	Jonathan Gregson & Karen Moore	
SO3: 3.7	Priority project 4: redesign Adult & Older peoples MH services	Delivery of Key Milestones		Project Status report monthly and at key decision/ milestone points along the project	April - March	Operational Board	Delivery of Key Milestones	Nush Sivananthan & Faouzi Alam and Dve Harris	Sally Sanderson John Loughlin	
SO3: 3.8	Priority 5: EI Review & Delivery	Delivery of Key Milestones		Project Status report monthly and at key decision/ milestone points along the project	April - March	Operational Board	Delivery of Key Milestones	Nush Sivananthan & Faouzi Alam and Dve Harris	Sally Sanderson John Loughlin	

SO3: 3.10	Priority 6: Wirral All Age Disabilities	N/A	Delivery of Key Milestones					Andy Styring	Sarah Quinn	
SO3: 3.11	Priority 7: Enabler: People	N/A	Delivery of Key Milestones					Dave Harris/ Faouzi alam	Jane Woods	
SO3: 3.12	Priority 8: Enabler: Information/ Business Intelligence	N/A	Delivery of Key Milestones					Tim Welcch	Mandy Skelding-Jones	
Strategic Objective 6: Financial Planning										
SO6: 1	Use of resources	Use of Resources [UoR] score of 3 or 4	Plan	Monthly	April - March	Trust Board		Tim Welch/ Mike Maier/ Rebecca Burke Sharples	Andy Harland	

Appendix 3: Trust Dashboard 2017 Reporting month August

Annual Plan Trust Board Key Performance Indicators Trajectory 17/18

Please enter your key performance indicators that are reported internally. Enter in a short description of the KPI and the threshold which that KPI is measured against.			Target		Plan M1 Month Ending 30-Apr-16	Plan M2 Month Ending 31-May-16	Plan M3 Month Ending 30-Jun-16	Plan M4 Month Ending 31-Jul-16	Plan M4 Month Ending 31-Jul-16	Plan M6 Month Ending 30-Sep-16	Plan M7 Month Ending 31-Oct-16	Plan M8 Month Ending 30-Nov-16	Plan M9 Month Ending 31-Dec-16	Plan M10 Month Ending 31-Jan-17	Plan M11 Month Ending 28-Feb-17	Plan M12 Month Ending 31-Mar-17	Plan Year Ending 31-Mar-17
Patient experience: Demonstrable increase in the uptake of the Friends and Family Test (FFT) each quarter			85.00		88.00	88.00	88.00	88.00	851.00	88.00	88.00	88.00	88.00	88.00	88.00	88.00	88.00
Supervisions			85.00		54.00	57.00	60.00	63.00	67.00	70.00	73.00	77.00	80.00	82.00	84.00	85.00	85.00
Sickness			4.50		5.8%	5.7%	5.6%	5.6%	5.6%	5.5%	5.5%	5.4%	5.4%	5.4%	5.3%	5.3%	5.3%
Safeguarding training			80.00		83.00	83.00	83.00	83.00	83.00	83.00	83.00	83.00	83.00	83.00	83.00	83.00	83.00
Bed Occupancy [including leave]	98%	100%	85.00		89.00	89.00	89.00	89.00	89.00	89.00	89.00	89.00	89.00	89.00	89.00	89.00	89.00
Friends and Family Test			0.00	###	0.05	90.00	90.00	90.00	90.00	90.00	90.00	90.00	90.00	90.00	90.00	90.00	90.00

Operational Plan

Indicator	Target	Plan M1 Month Ending 30-Apr-17	Plan M2 Month Ending 31-May-17	Plan M3 Month Ending 30-Jun-17	Plan M4 Month Ending 31-Jul-17	Plan M5 Month Ending 31-Aug-17	Plan M6 Month Ending 30-Sep-17	Plan M7 Month Ending 31-Oct-17	Plan M8 Month Ending 30-Nov-17	Plan M9 Month Ending 31-Dec-17	Plan M10 Month Ending 31-Jan-18	Plan M11 Month Ending 28-Feb-18	Plan M12 Month Ending 31-Mar-18	Plan Year Ending 31-Mar-18

SO1: 1.1	Patient safety: Demonstrable improvement in the alignment of the Trust-wide incident reporting profile in line with the Heinrich ratio each trimester		75.6 per 1,000 episodes	75.6	75.6	75.6	75.6	75.6	75.6	75.6	75.6	75.6	75.6	75.6	75.6
SO1: 1.2	Patient experience: Demonstrable increase in the uptake of the Friends and Family Test (FFT) each quarter		237	237	237	237	237	237	237	237	237	237	237	237	237
SO1: 1.3	Clinical Effectiveness: Demonstrable improvement in service level health related outcome ratings each quarter		TBC	TBC	TBC	TBC	TBC	TBC	TBC	TBC	TBC	TBC	TBC	TBC	TBC
SO3: 2.1	Capacity: % of staff vacancies (Contracted)		equal to or below baseline	4.15%	4.15%	4.15%	4.15%	4.15%	4.15%	4.15%	4.15%	4.15%	4.15%	4.15%	4.15%	4.15%
SO3: 2.2	Competence: % of staff receiving annual appraisal (via new proposed framework)		100%	70%	80%	90%	80%	80%	90%	80%	90%	100%	100%	100%	100%	100%
SO3: 2.3	% staff absence due to sickness		5.30%	5.8%	5.7%	5.6%	5.6%	5.6%	5.5%	5.5%	5.4%	5.4%	5.4%	5.3%	5.3%	5.3%
SO3: 3.1	100% of the 13 Monitor operational performance targets achieved (including waiting times)		100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
SO3: 3.2	100% Contractual targets met	-73	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
	Capital expenditure position		100%					100%			100%			100%		100%
SO3: 3.3	Strategy priority 1: CAMHS T4	-829	Delivery of Key Milestones					✓								
SO3: 3.4	Strategy priority 2: West Cheshire 0-19 services		Delivery of Key Milestones							✓					✓	
SO3: 3.5	Strategy priority 3: Local implementation of the transforming Learning Disability services strategy		Delivery of Key Milestones								✓					
SO3: 3.6	Strategy priority 4: Further development of integrated community health services		Delivery of Key Milestones				✓			✓					✓	
SO3: 3.7	Strategic priority 5: Developing potential options for enhancing inpatient provision		Delivery of Key Milestones			✓					✓	✓				
SO3: 3.8	Strategic priority 6: Transformation, of trust wide IAPT services		Delivery of Key Milestones						✓	✓						
SO6: 4.1	Cash position Variance ('000)		10% adverse variance against plan	5182	4060	3294	2507	2089	2017	1769	1986	2097	1775	1687	960	960
SO6: 4.2	Income and Expenditure position ('000)		10% cumulative adverse variance YTD	-256	-359	-547	-647	-744	-879	-907	-902	-879	-874	-881	-890	-890
SO6: 4.3	Capital expenditure position (accruals) ('000)		15% variance of capex plan	1225	2475	3590	4590	5465	6340	7115	7215	7440	7565	7715	8020	8020
SO6: 4.4	Achievement of CIP plan ('000)		10% adverse variance from plan	22	43	66	191	304	417	1245	2073	2901	3742	4583	5424	5424

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

STANDARDISED REPORT COMMUNICATION

REPORT DETAILS

Report subject:	Corporate assurance framework and strategic risk register – update report
Agenda ref. no:	17-18-72
Report to (meeting):	Board of Directors – meeting in public
Action required:	Discussion and Approval
Date of meeting:	29/11/2017
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 update the Board of Directors of the current status of the corporate assurance framework to inform discussion of the current risks to the delivery of the organisational strategic objectives, and as per the requirements outlined within the Trust's integrated governance strategy. The report indicates progress against the mitigating actions identified against the Trust's strategic risks and the controls and assurances in place that act as mitigations against each strategic risk. **As at November 2017, the Trust has 6 red and 4 amber rated strategic risks. 3 strategic risks are currently in scope. 1 strategic risk is recommended for archive.**

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

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

Assessment – *analysis and considerations of options and risks*

New risks/ risks in-scope

Three risks are in-scope:

- *Risk of potential loss of Trust income and delivery of improved quality outcomes arising from failure to reach agreed targets within the CQUIN programme*. Identified at the November 2017 Quality Committee, a risk treatment plan is currently in development.
- *Risks associated with the transition to the Trust's clinician-led operational (Care Group) structure as part of the CWP Forward View strategy*. Identified formally at the November 2017 Quality Committee and also on previous occasions by the Audit Committee for consideration. It is a broad ranging risk, requiring greater specificity in its description, which will be taken forward by the CWP Forward View transitional group.
- *Risks associated with decreased capacity within the Performance & Redesign team, resulting in a reduced ability to support/ develop current work and new commissions.* This risk was identified at the November 2017 Operational Board meeting and is currently under review.

The previous in-scope *risk of harm and/ or liability associated with the management of challenging behaviour in community settings due to training and policy deficits* has been explored with the organisational lead and a quality improvement approach has been agreed to take this forward.

Amended risk scores or re-modelled risks

- Risk 2 (*Risk of ability to sustain safe and effective services within Central and Eastern Cheshire*) has been re-scored by the risk owner and lead, with the likelihood score increasing from 3 to 4 in light of the escalation of relevant issues – however subsequent resilience work and action have been taken as described in the assurance framework. This has increased the residual score to 16.
- Risk 8 (*Risk of deficiencies in IT infrastructure that are unable to support the design and delivery of new models of care thereby impacting on sustainability of services*) has been subject to further modelling since the Quality Committee's review in November 2017. This has been amended by the risk owner and lead to the *risk of deficiencies in ICT infrastructure and end of life of ICT equipment, that are unable to support the delivery of existing models of care and the design of new models of care, thereby impacting on sustainability of services* which is felt better reflects the nature of the risk. A risk treatment plan has now been developed to mitigate this risk.

Archived risks `

Risk 5 (*Lack of training in respect of mandatory Autism training requirements as per the Autism Act and related guidance including MHA Code of Practice and the Care Act*) is proposed for archive. Education CWP has confirmed that this particular risk treatment plan has been completed and the Trust is on target to achieve a compliance rate of 85% for autism training by March 2018. Should this not transpire, or should any other risks in relation to CWP work on the Transforming Care Programme be escalated through the associated workstreams, then these will be re-escalated to the strategic risk register. The Quality Committee approved the archiving of this risk and this is therefore recommended to the Board.

Exceptions – overdue risk treatment action points

There is one overdue action within the risk treatment plan for Risk 2 (*Risk of reducing ability to sustain safe and effective services within Central and Eastern Cheshire*). This concerns the action for the Community Mental Health Team review and pathway redesign project due to a gap in project management support (as reported in the October 2017 Programme Support Office report to Operational Board). This is being explored between the risk lead and the Programme Support Office.

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 made to the corporate assurance framework.

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

Distribution to other people/ groups/ meetings:

Version	Name/ group/ meeting	Date issued
1	Board of Directors	22/11/2017

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

Appendix no.	Appendix title
(attachment to agenda email)	Corporate assurance framework and risk register (click here)

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

STANDARDISED REPORT COMMUNICATION

REPORT DETAILS

Report subject:	Adult and Older People's Specialist Mental Health Redesign
Agenda ref. no:	17-18-73
Report to (meeting):	Board of Directors
Action required:	Approval
Date of meeting:	29/11/2017
Presented by:	Andy Styring, Director of Operations and Anushta Sivananthan, Medical Director

Which strategic objectives this report provides information about:	
Deliver high quality, integrated and innovative services that improve outcomes	Yes
Ensure meaningful involvement of service users, carers, staff and the wider community	Yes
Be a model employer and have a caring, competent and motivated workforce	Yes
Maintain and develop robust partnerships with existing and potential new stakeholders	Yes
Improve quality of information to improve service delivery, evaluation and planning	Yes
Sustain financial viability and deliver value for money	Yes
Be recognised as an open, progressive organisation that is about care, well-being and partnership	Yes
Which CQC quality of service domains this report reflects:	
Safe services	Yes
Effective services	Yes
Caring services	Yes
Well-led services	Yes
Services that are responsive to people's needs	Yes
Which Monitor quality governance framework/ well-led domains this report reflects:	
Strategy	Yes
Capability and culture	Yes
Process and structures	Yes
Measurement	Yes
Does this report provide any information to update any current strategic risks? If so, which?	
See current risk register in the agenda of the public meeting of the Board of Directors at http://www.cwp.nhs.uk/about-us/board-members/our-board-meetings	Risk 2
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 sets out the proposed redesign of adult and older people's mental health services in South and East Cheshire, and Vale Royal. It provides a summary of the main features of the draft Pre-Consultation Business Case (PCBC) produced by Eastern Cheshire CCG, South Cheshire CCG, Vale Royal CCG and CWP - and seeks Board approval. This PCBC will be presented to the respective Governing Bodies, and is currently with NHS England as part of the assurance process for best practice regarding public consultations.

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

The Five Year Forward View for Mental Health is a national framework for improvement. It recognises the need to address capacity in the community and reduce the over reliance on hospital services. Locally in Eastern Cheshire, South Cheshire and Vale Royal there is rising demand for care and support. Since 2010 there has been an increase in activity across the three CCGs of 35% in functional services and 60% in dementia services. CWP supports circa 5,000 people in the community for secondary mental health needs across this geography. Lack of capacity in the home treatment teams (who offer step up care) and community mental health teams (who offer ongoing support for stable patients) leads to an over-reliance on inpatient services of up to 16%, which equates to approximately 10 beds. Inpatient services are currently provided at a number of sites across Cheshire and Wirral including Millbrook in Macclesfield. The facilities at Millbrook are in need of significant refurbishment to comply with CQC standards and, due to the layout of the unit, require a disproportionately higher staffing model to maintain clinical safety. The local health and social care system is showing a deteriorating financial position. The cost of the current adult and older people's mental health service model exceeds the funding available and change is required for the local NHS to operate within

Assessment – *analysis and considerations of options and risks*

Service user, carer and staff feedback has informed the proposed new model of care and options appraisal process. In summary, users and carers state there is limited choice and access to care for patients who are experiencing crisis, with only A&E department's offering consistent 24/7 support. The proposed new model of care will cater for different levels of need and provide improved access to services, including:

Access to an enhanced multi professional community mental health service: that will support people to remain in the community, in the least restrictive environment. Care plans will be developed and delivered according to care needs for as long as they are clinically required. Community teams will also support timely discharge from hospital or transfer from crisis placement.

Timely response to crisis support: overseen by an enhanced home treatment team, who will provide support to a wider range of services including locally provided crisis beds, dementia out-reach services, and enabling people to be supported in their own home, in crisis café's and drop in centres as an alternative to hospital admission and A&E attendance.

Improved inpatient/bed-based experience: we recognise that some people will still need inpatient or bed-based care and that care will be provided in a range of facilities which offer appropriate therapeutic interventions, including new crisis beds and more traditional inpatient beds. Inpatients beds will be in an environment which is modern and supports privacy and dignity (through the provision of single ensuite accommodation), staffed appropriately, and the length of stay determined by patient need rather than what is available in the community on return to home.

Public consultation - proposals presented in the attached business case are underpinned by a needs analysis against which capacity has been modelled and workforce plans built. Eight options were developed at long list. All the options were considered based on safety, affordability and sustainability, cost, quality and strategic plans. To support carers visiting patients in inpatient settings away from home, the project team are currently developing a support plan which includes working with the voluntary sector to support carers travel, flexible visiting times and use of technology to maintain contact. Three proposals will be brought forward to public consultation for the public to consider:

Option 1 Do nothing: No enhancement of community care and no crisis care placements provided. No enhancement in Home treatment teams or dementia outreach developed. Retain all inpatient care (58 beds) on the Millbrook unit. (Whilst this is technically defined as do nothing; in accordance with the case for change the consequence of this option being selected would be the need to redirect funding from other current care services, in order to maintain, in the longer term, safe services).

Option 4a (preferred option) Enhance community and home treatment (crisis) teams: Provide the inpatient and bed-based care currently available at Millbrook within new crisis care services established locally, including up to 6 local short stay beds, as well as a new older peoples service at Lime Walk House in Macclesfield, and an adult functional service within the current provider footprint at Bowmere in Chester. In total these services provide 53 beds.

Option 4b Enhance community and home treatment (crisis) teams. Provide the inpatient and bed-based care currently available at Millbrook within new crisis care services established locally, including up to 6 local short stay beds, as well as a new adults functional service at Lime Walk House in Macclesfield, and an older

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

The Board of Directors are recommended to **approve** the Pre-Consultation Business Case.

Who/ which group has approved this report for receipt at the above meeting?		
Contributing authors:		Suzanne Edwards/Katherine Wright
Distribution to other people/ groups/ meetings:		
Version	Name/ group/ meeting	Date issued
1	Andy Styring	22.11.17
Appendices provided for reference and to give supporting/ contextual information: *Provide only necessary detail, do not embed appendices, provide as separate reports*		
Appendix no.	Appendix title	
1	Adult and Older People's Specialist Mental Health Redesign Pre-Consultation Business Case	

Adult and Older Peoples Specialist Mental Health Services Redesign

Pre-Consultation Business Case

Contents

1.0 Executive Summary

The Five Year Forward View for Mental Health[1] is a national framework for improvement. It recognises the need to address capacity in the community and reduce the over reliance on hospital services. It is a mandate to improve and modernise mental health services to reflect a proactive, timely response to the needs of people requiring mental health support in the community and provide care in the least restrictive environment

The purpose of this pre-consultation business case is to outline a compelling case for change and present options which will deliver improved mental health outcomes for the registered population of Vale Royal, South and Eastern Cheshire within the financial resources available. Specifically:

- There is rising demand for care and support. Since 2010 there has been an increase in activity across the three CCGs of 35% in functional services for people with moderate to severe mental health needs and 60% in Dementia services. The majority of people can be effectively managed in community setting with the right level of support.

- Local evidence shows up to 50% of adults and 30% of older people in hospital services could have been supported in the community as an alternative to hospital admission. In addition over 40% of adults and 69% of older people were fit for discharge from hospital but awaiting community support or long term placement

- Users and carers state there is limited choice and access to care for patients who are experiencing crisis, with only A&E department's offering consistent 24/7 support. Lack of capacity in the home treatment teams, who offer step up care, and community mental health teams, who offer ongoing support for patients with complex needs, leads to an over reliance on inpatient services of up to 16% which equates to approximately 10 additional beds[2].

- The current model of care and ways of working are not consistent with either national policy and best practice or local transformation plans leaving room to improve patient experience and outcomes of care.

- In patient services are currently provided at a number of sites across Cheshire and Wirral including the Millbrook unit in Macclesfield which is part of the East Cheshire NHS Trust estate. The facilities at Millbrook are in need of significant refurbishment to comply with CQC standards and due to the layout of the unit, require a disproportionately higher staffing model to maintain clinical safety.

- The local health and social care system is showing a deteriorating financial position. The cost of the current adult and older people's mental health service configuration

1 https://www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf
https://www.england.nhs.uk/wp-content/uploads/2016/07/fyfv-mh.pdf

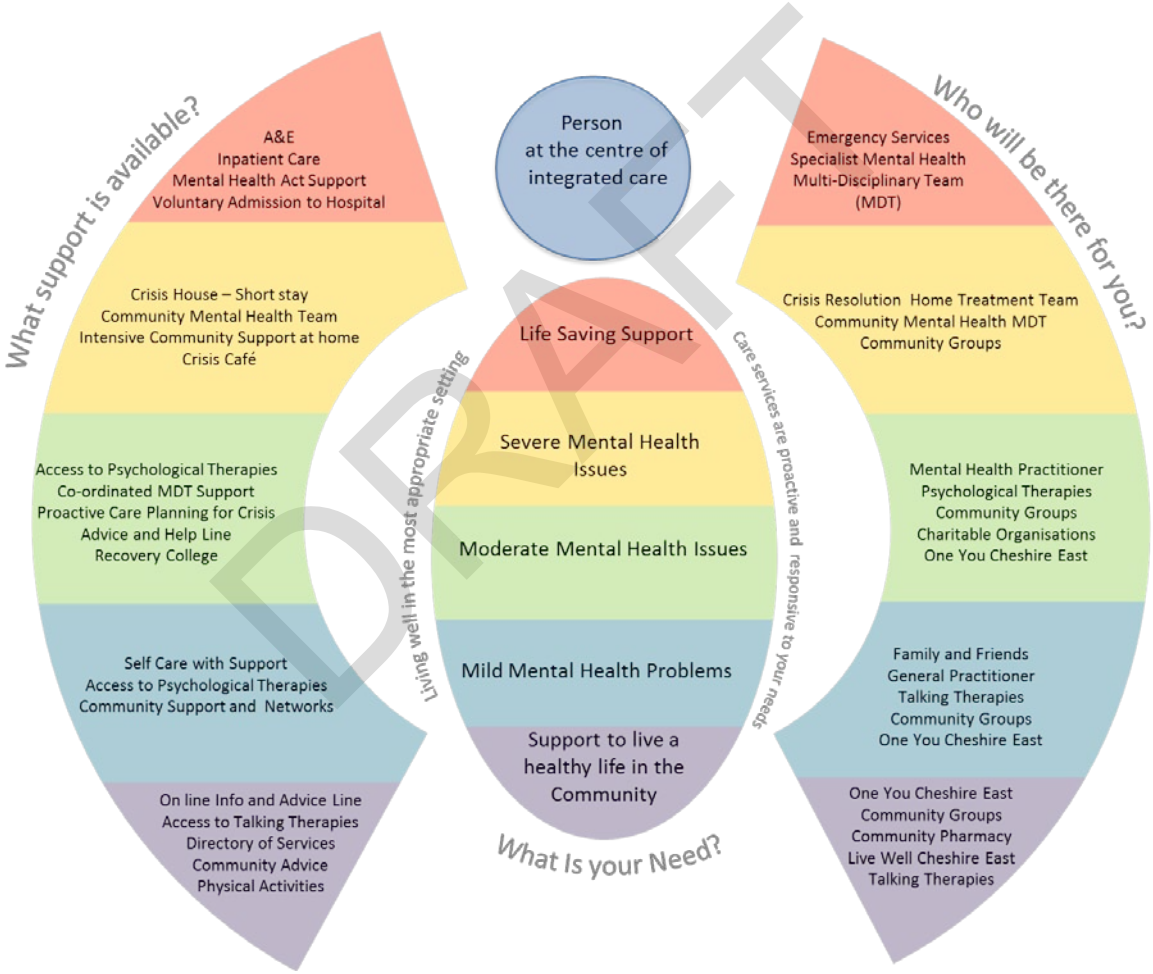
2 https://docs.wixstatic.com/ugd/0e662e_a93c62b2ba4449f48695ed36b3cb24ab.pdf

exceeds the funding available and change is required for the local NHS to operate within mandated financial controls.

In order to address the issues described above, a programme of redesign was agreed to explore opportunities and options which would deliver improved outcomes for the local population within the operating costs available.

Clinicians from secondary and primary care have developed a new model of secondary mental health care, based on national best practice and consistent with local plans for transformation and are visually represented below within the wider mental health services framework.

Diagram 1**: **A model of care for mental health



Components of the secondary care service model will <u>improve patient outcomes</u> through:

- **Access to an enhanced multi professional community mental health service:** that will support people to remain in the community, in the least restrictive environment. Care plans will be developed and delivered according to care needs for as long as they are clinically required. Community teams will also support timely discharge from hospital or transfer from crisis placement.

- **Timely response to crisis support:** overseen by an enhanced home treatment team, who will provide support to a wider range of services including locally provided crisis beds, dementia out-reach services, and enabling people to be supported in their own home, in crisis café's and drop in centres as an alternative to hospital admission and A&E attendance.

- **Improved inpatient experience:** where care will be provided in facilities which offer a range of therapeutic interventions in an environment which is modern and supports privacy and dignity through the provision of single ensuite accommodation. The unit will be staffed appropriately and the length of stay determined by patient need rather than what is available in the community on return to home.

In the current configuration of services there are potentially 58 beds on the Millbrook site in Macclesfield whereas national evidence, supported by local audit data, shows that for our population only 48 beds would be required if community services and rapid response were enhanced.

The local health and social care system is working within a capped expenditure programme due to the deteriorating financial position. There is an opportunity however, through service redesign to shift resources into the community away from the over reliance on inpatient care, to both improve outcomes for adult and older people with severe mental health needs ***and*** significantly reduce the system cost pressure resulting from services operating in excess of funds available.

Proposals presented are underpinned by a robust and innovative approach to needs analysis against which capacity has been modelled and workforce plans built. The needs analysis looks at both numbers of people but also at the level of care required; recognising that within any diagnostic group there will be people with low level needs and some with very complex needs. Capacity planning has taken account of the individual and used evidence based care pathways to determine the care the person will need.

A number of options were developed at long list which included the use of alternative providers closer to people's homes. For many of these options the cost quoted significantly exceeded the cost envelope available and worsened the financial situation for the health economy. There were also concerns in relation to patient safety, continuity of care and the ability to guarantee a level of quality which matched the current provider.

All the options were considered and following a panel decision based on safety, affordability and sustainability, cost, quality and strategic plans the below three proposals will be brought forward for the public to consider:

- **Option 1:** Do nothing: No enhancement of community care and no crisis care placements provided. No enhancement in Home treatment teams or dementia outreach developed. Retain all inpatient care (58 beds) on the Millbrook unit. ***(Whilst this is technically defined as do nothing; in accordance with the case for change the consequence of this option being selected would be the need to redirect funding from other current care services, in order to maintain, in the longer term, safe services).***

- **Option 4a:** (preferred option) Enhance community and home treatment (crisis) teams. Provide the inpatient and bed-based care currently available at Millbrook within new crisis care services established locally, including up to 6 local short stay beds, as well as a new older peoples service at Lime Walk House in Macclesfield, and an adult functional service within the current provider footprint at Bowmere in Chester. In total these services provide 53 beds.

- **Option 4b:** Enhance community and home treatment (crisis) teams. Provide the inpatient and bed-based care currently available at Millbrook within new crisis care services established locally, including up to 6 local short stay beds, as well as a new adults functional service at Lime Walk House in Macclesfield, and an older peoples service within the current provider footprint at Bowmere in Chester. In total these services provide 53 beds.

During the pre-consultation engagement events there was a consistent concern raised in relation to the travel implications for carers should inpatient care be re-provided at Bowmere in Chester. In addition to a detailed analysis into the logistics of travelling the project team are currently developing a support plan which includes working with the voluntary sector to support carers travel, flexible visiting times and use of technology to maintain contact

This Pre Consultation Business Case (PCBC) will be presented to the Cheshire East Overview and Scrutiny Committee in December 2017 to seek support to commence public consultation for a 12-week period. Analysis of consultation results and reporting will be in June 2017 following which a full business case will be produced for consideration and implementation.

2.0 Introduction and background

Commissioners in Vale Royal, South and Eastern Cheshire are working with local mental health provider; Cheshire and Wirral Partnership NHS Trust, users of the service and Cheshire East Council to review and redesign secondary care adult and older peoples mental health services for those people with severe mental illness (SMI). Secondary care is the term used to differentiate services from those provided in primary mental health such as GP only care and universal psychological therapies (IAPT) Secondary care services includes specialised community support, crisis response and inpatient care.

There are 479,000 people living in Vale Royal, South Cheshire and Eastern Cheshire. Based on national prevalence data we would expect to see around 119,750 people locally with a diagnosable mental health problem, but of these people only 10,778 will have SMI and require care and support from specialist mental health services, rather than primary mental health services such as GP care and IAPT.

Current services are organised around; functional mental health needs, which relates to the type of illness which has a predominantly psychological cause. It may include conditions such as depression, schizophrenia, mood disorders or anxiety and organic such as dementia.

There are currently in excess of 7,127 people receiving CCG commissioned care and support from the main local provider of specialist mental health Cheshire and Wirral Partnership via the community mental health teams. Others are accessing care via other commissioners such as NHS England and Cheshire East Council and through third sector and other mental health providers.

2.1 The case for change

- There is rising demand for care and support. Since 2010 there has been an increase in activity across the three CCGs of 35% in functional services for people with moderate to severe mental health needs and 60% in Dementia services. The majority of people can be effectively managed in community setting with the right level of support.

- Local evidence shows up to 50% of adults and 30% of older people in hospital services could have been supported in the community as an alternative to hospital admission. In addition over 40% of adults and 69% of older people were fit for discharge from hospital but awaiting community support or long term placement

- Users and carers state there is limited choice and access to care for patients who are experiencing crisis, with only A&E department's offering consistent 24/7 support. Lack of capacity in the home treatment teams, who offer step up care, and community mental health teams, who offer ongoing support for patients with complex needs, leads to an over reliance on inpatient services of up to 16% which equates to approximately 10 additional beds[3].

- The current model of care and ways of working are not consistent with either national policy and best practice or local transformation plans leaving room to improve patient experience and outcomes of care.

- In patient services are currently provided at a number of sites across Cheshire and Wirral including the Millbrook unit in Macclesfield which is part of the East Cheshire NHS Trust estate. The facilities at Millbrook are in need of significant refurbishment to comply with CQC standards and due to the layout of the unit, require a disproportionately higher staffing model to maintain clinical safety.

- The local health and social care system is showing a deteriorating financial position. The cost of the current adult and older people's mental health service configuration exceeds the funding available and change is required for the local NHS to operate within mandated financial controls.

[3] https://docs.wixstatic.com/ugd/0e662e_a93c62b2ba4449f48695ed36b3cb24ab.pdf

In order to address the issues described above a programme of redesign was agreed to explore opportunities and options, which would deliver improved outcomes for the local population within the operating costs available.

2.2 Project scope and process

The scope of this PCBC is Adult and Older people with severe mental illness who are in contact with secondary care specialist services. The table below shows the scope in more detail and outlines where future pathway development will need to establish links to other services in order to response to user and clinician feedback.

Table 1: Detailed project scope

In scope services	Linked services	Out of scope
Adult functional	Health and wellbeing: IAPT step 1	Children's services
Older peoples functional	Talking therapies IAPT step 2 & 4	Complex secure services
Dementia	Specialist IAPT step 4	Specialist Mental Health Pre and Post Natal Care
Crisis response: Home Treatment Teams	Liaison psychiatry	
Crisis support:- third sector collaborative	Mental health reablement	
Dementia outreach	Rehabilitation services	
Electro convulsive Therapy (ECT)	GP led Primary mental health	

A joint commissioner/provider project group was established in June 2017. Patient representation and social care partners are key members of the project team. The mandate for the team was to undertake a clinically led, systematic approach to the identification of need and then determine options for care delivery to best meet those needs within the resources available. The project membership can be found at appendix 1.

The approach taken to the management of this programme of work is consistent with NHSE guidance[4] and provides assurance in relation to the four tests for service redesign which are:

1. strong public and patient engagement;
2. consistency with current and prospective need for patient choice;
3. clear, clinical evidence base; and
4. support for proposals from commissioners.

2.3 Ensuring strong clinical and user engagement

[4] https://www.england.nhs.uk/wp-content/uploads/2015/10/plan-ass-deliv-serv-chge.pdf

This work has been strongly influenced by the involvement and leadership of a variety of clinical professionals including public health, consultant psychiatrists, therapy staff and GPs. A multi-disciplinary clinical advisory group led the care model development and the identification of options for delivery. (See appendix 1 for a complete list of members). The scoring of options created an opportunity to extend the clinical input into the development process, as did workshops which enabled GPs to identify across the three CCGs how plans could be shaped to align with local transformation plans.

During development of these proposals we have demonstrated a commitment to be proactive to seek the views and experiences of our local populations and be accessible and convenient. We have met with various interest groups, undertaken site visits with experts by experience and invited users to share experiences and views in a range of meetings from CCG Annual Fairs and listening events to individual case studies. Partners have used this information alongside carer and staff views and experiences in the development of the Pre-Consultation Business Case; including the options appraisal process.

Patient and carers workshops were held at the Millbrook Unit and the Recovery Colleges, as well as a series of briefings and drop-in sessions for frontline staff towards the end of 2016. At this time there was engagement with Cheshire East Healthwatch, Eastern Cheshire Health Voice and Cheshire East Council's Adult Health and Social Care Overview and Scrutiny Committee. This included providing a site-visit for scrutiny committee members to CWP services.

More recently listening events were held in September 2017 at Crewe Alexandra FC and Macclesfield Town FC. Over 50 people attended the events, the majority of whom were service users and carers. Table-based discussions gave participants an opportunity to describe what had worked well for them, what had not worked well and how secondary care services might be improved. In addition an online survey was also made available to those who couldn't attend the sessions.

The views and experiences of users and carers have informed the development of plans so far and will be referenced throughout. In addition stated priorities have directly informed the development of the long list of options, and appraisal process – specifically informing the public acceptability criteria.

A detailed engagement and communications strategy has been developed to ensure that service users, health care professionals and other key stakeholders have a wide range of opportunities to shape developments as they emerge. This can be seen at appendix 2.

2.4 Needs analysis

Prior to identifying the model of care and the options for service delivery it is important to first understand the needs of the population in relation to mental health. A number of planning assumptions were agreed in relation to the needs analysis:

- It relates to registered population rather than resident.

- A number of information sources were used such as projected population statistics and actual activity data as we found limited national benchmarking data was available to check assumptions relating to prevalence vs incidence.
- Professional judgement and local benchmarking was used to 'check assumptions'.
- Activity data reviewed was by primary diagnostic codes but it is possible that there are overlaps with secondary diagnosis numbers.

The starting point was public health prevalence and the categories of health need related to dementia, depression, psychosis, bipolar disorder, personality disorder, and anxiety. We then compared this data to current activity using caseload data. The prevalence codes were different to the activity codes requiring professional input to 'map' them accurately across.

Once the core numbers had been signed off by the clinical and information group we used the data to understand the actual needs of patients within each diagnostic code. Previous 'PbR clustering' categories have been used. Diagnostic conditions were grouped into Super Clusters which describe the severity of need rather than condition specific symptoms. Super clusters link to evidence based care pathways which describe the care required from low to highly complex needs which enabled the project team to model the capacity required and the skill mix within the new workforce model. The completed needs analysis can be found at appendix 3.

3.0 Improving Quality and Outcomes

The Five Year Forward View for Mental Health is a national framework for improvement. It recognises the need to address capacity in the community and reduce the over reliance on hospital services. It is a mandate to improve and modernise mental health services to reflect a proactive, timely response to the needs of people requiring mental health support in the community and provide care in the least restrictive environment.

In the table below is a summary of the key standards to be achieved by 2021 for the services within scope of this programme.

Table 2: Five Year Forward View (5YFV) standards to be achieved by 2021
Adult community mental health services will provide timely access to evidence-based, person-centred care, which is focused on recovery and integrated with primary and social care and other sectors.
A reduction in premature mortality of people living with severe mental illness (SMI); and 280,000 more people having their physical health needs met by increasing early detection and expanding access to evidence-based physical care assessment and intervention each year.
Increased access to psychological therapies for people with psychosis, bipolar disorder and personality disorder.

All areas will provide crisis resolution and home treatment teams (CRHTTs) that are resourced to operate in line with recognised best practice – delivering a 24/7 community-based crisis response and intensive home treatment as an alternative to acute in-patient admissions.

The FYFV describes a new model of clinical care, based on needs and built around the person. It outlines the importance of aligning mental health and physical health and the importance of early intervention and prevention. The principles within the national framework are entirely consistent with locally developed transformation plans which provide the vehicle through which change can be achieved.

Learning from other areas show that facilities like crisis café's and places of safety with 24/7 access to crisis support are highly valued by carers and people who use the service. These are now common place in other parts of the country. During the listening events there was strong support for an alternative model for crisis care which should range from overnight placements to day centres and cafes.

A café in a North East Hampshire has helped reduce mental health hospital admissions by a third in seven months by providing an alternative solution for service users[5]. Other examples are evident across the country.

During the planning phase members of the project team alongside experts by experience and carers undertook site visits to existing local facilities and other areas within the current provider footprint. These included inpatient facilities and community and crisis centres.

Initial feedback would suggest crisis beds located in the community and run through a collaboration of third sector organisations and specialist clinical services offer a timely, cost effective and highly valued service to people and carers. Evidence both locally and nationally show that these facilities are well used, length of stay is around 6 days and onward admission to hospital is low.

Underpinning the proposals presented here is a collective ambition for improved user outcomes of mental health services which is to:

- improve clinical outcomes for people with SMI;
- meet people's health and well-being needs;
- ensure people live longer healthier lives;
- support people as close to home as possible in the least restrictive environment; and
- empower users and their carers through choice and co – production.

Success will be measured by looking at:

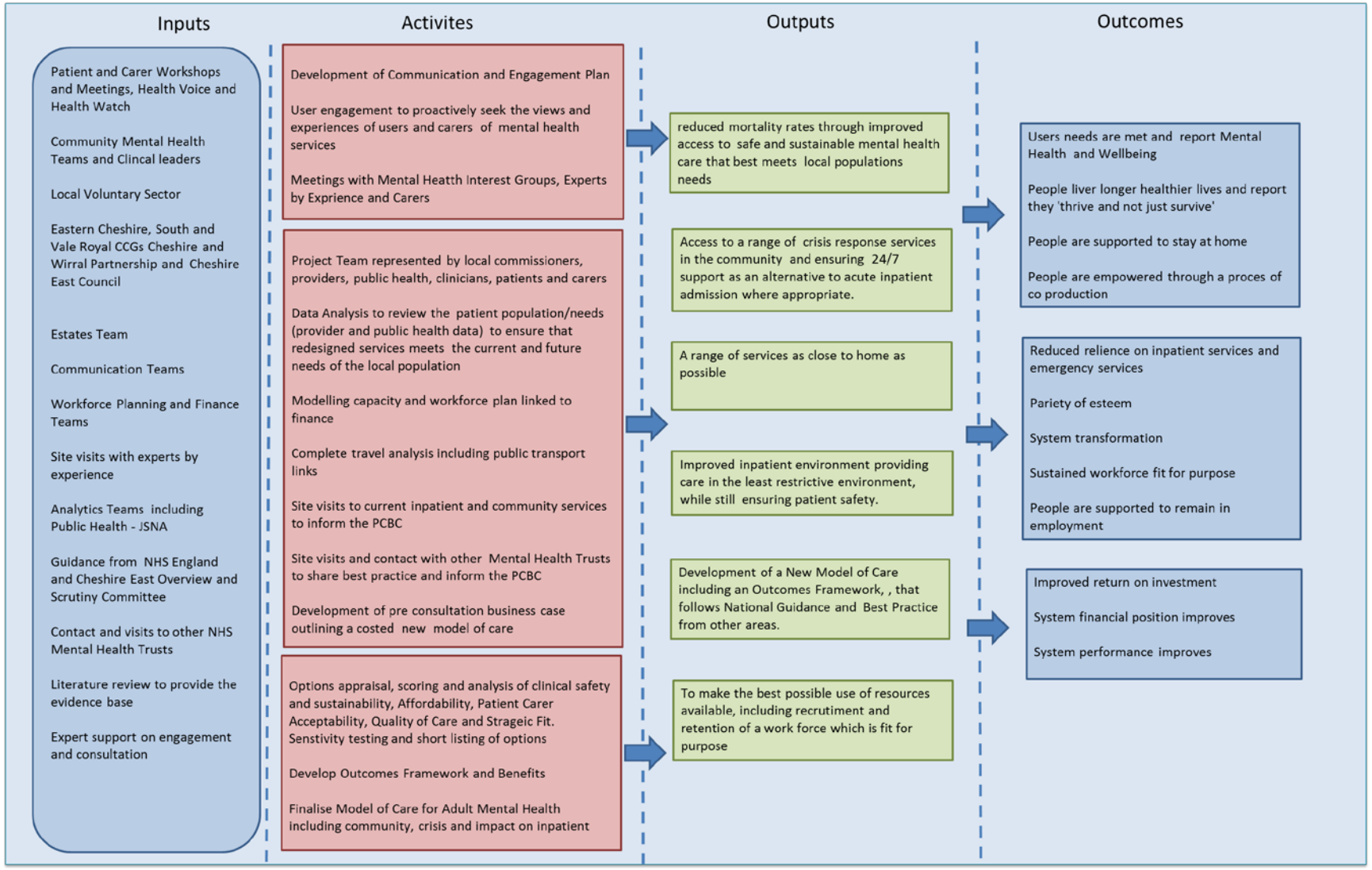
- patient reported outcomes;

5 www.england.nhs.uk/mental-health/casestudies/aldershot

- mortality/morbidity data;
- patient experience and satisfaction;
- access and waiting times; and
- referral data and activity.

In diagram 2 (below) we describe the development journey taken to deliver plans which, once implemented will achieve and outcomes for service users.

Diagram 2: Achieving improved outcomes for people through service redesign



4.0 Options for delivery of adult and older peoples mental health services

Locally developed transformation plans describe a programme of co-design across the health and social care economy where commissioners and providers respond to patient needs and work together to redesign care services. They represent a system wide commitment to implementing the changes required to deliver a care system that is fit for the 21st century's population needs and is entirely consistent with the national vision for future mental health services described in the 5YFV.

The aim is to develop a new model of care to achieve a responsive, community focussed, personalised care system that is wrapped around the empowered individual. It enables professionals to fully utilise their skills in working together to target the support and care to people most in need.

Components of the new model of care will improve patient outcomes through:

- access to an enhanced multi professional community mental health services;
- timely response to crisis support; and
- improved inpatient experience.

Feedback from both users and professionals is that there needs to be better links with primary mental health services to ensure the wider determinants of health are addressed and there is a recognition of the importance of managing physical and mental health together in the application of person centred care.

4.1 Enhanced Community Mental Health Teams

People will be supported in their own homes as far as possible by a multi professional team who support the GP as the lead professional where appropriate and deliver integrated care through care communities. Care management plans will be co-produced and people will know what to expect in relation to care, review and medicines management. Patients who have required hospital care should be able to return home as soon as possible and may include a period of increased 'step down' support by community and home treatment teams. The community teams will provide the following key functions:

- a person- centred approach to treatment that supports people to live full and meaningful lives. Treatment approaches will be in line with NICE Clinical Guidelines and encourage personal independence and self-management approaches to maintaining physical and mental wellbeing where appropriate
- a single point of referral. This will be for assessment of need and ongoing management e.g. to crisis support secondary care mental health services where clinically appropriate. Additional community support or an alternate package of care in line with NICE Clinical Guidelines.

4.2 Crisis Support

A range of options will be available to people both in and out of hours. Home treatment teams will provide additional support in the home but will also have access to crisis placements for short stay care and day time community support through crisis cafes. They will provide 'in reach services' for crisis placements to provide alternatives to hospital admission and A&E attendance. The crisis service will be a collaboration between CWP and third sector partners.

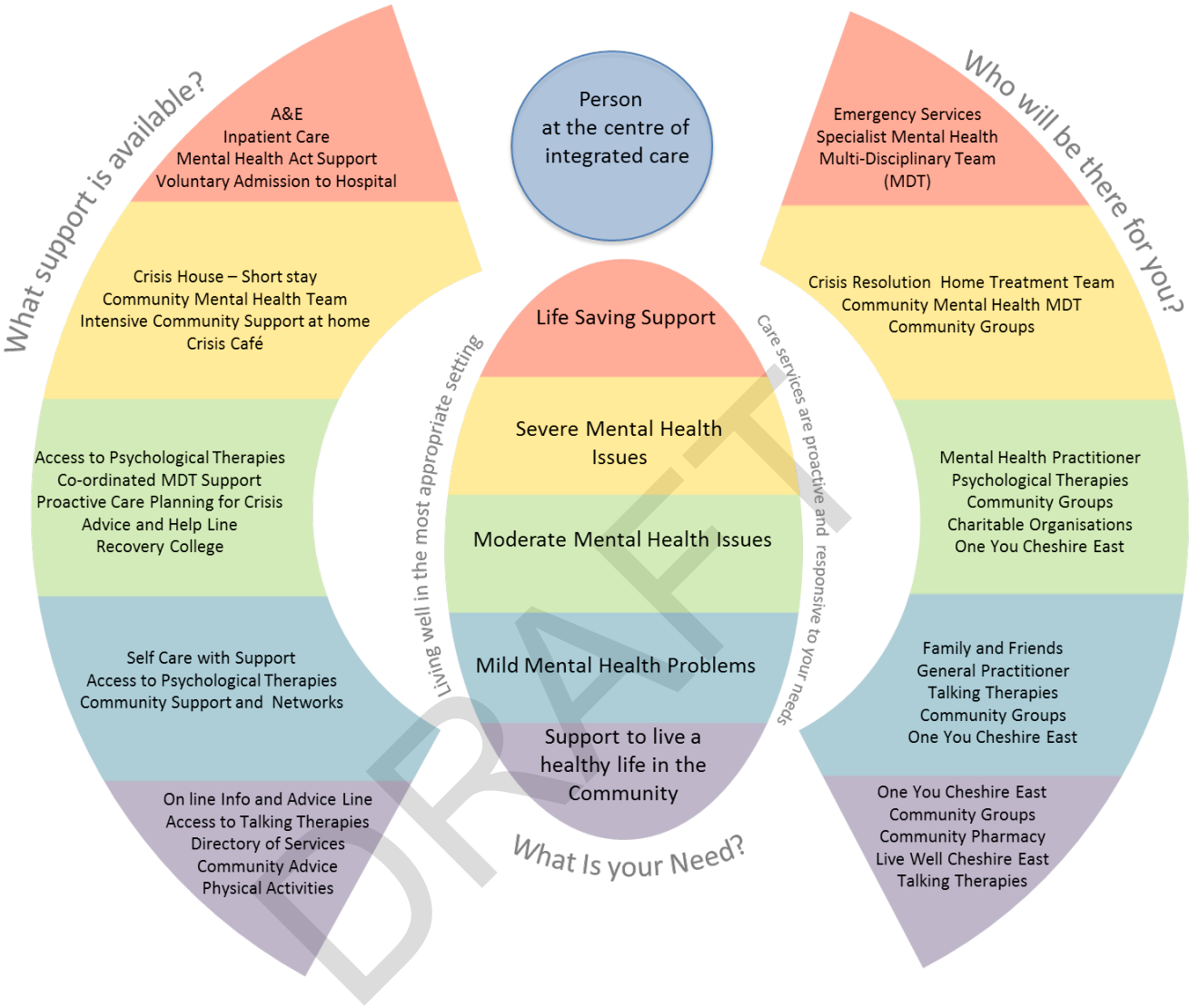
For older people with dementia an outreach service will support people in crisis in their own homes to avoid unnecessary admissions to hospital or allow time for a long term placement to be identified.

4.3 Inpatient provision

When a period of very specialised care is needed and there is no appropriate alternative to care, people will be admitted to hospital, where care will be provided in facilities which offer a range of therapeutic interventions options in an environment which is modern and supports privacy and dignity through the provision of single ensuite accommodation. The unit will be staffed appropriately and the length of stay determined by patient need rather than what is available in the community on return to home.

In the care model below we show how mental health secondary care services will be delivered within a wider, holistic model of care where patients can access services that meet their needs. The development of the 'navigator role' will ensure people can move easily between levels of support combining low level interventions and complex care packages where required.

Diagram 3: A model of care for mental health



In the scenarios below we show how the new model of care will bring benefits to people and demonstrate how professionals, working in partnership with a wider range of options can deliver care closer to home

5 *Case Study 1: A model of care for mental health*

Crisis support

Carol is a 34 year old lady who has suffered from Bipolar Affective Disorder since she had her first child. She has 3 children aged 12, 7, and 3 years old. She lives with them and her partner. When younger she had episodes where she felt elated and hyperactive but these days her illness means that she feels depressed most of the time. She struggles to motivate herself to get out of the house. She is on a lot of medication and worries about the effect this is having on her body. Sometimes her moods become so bad that she feels like killing herself and she has had to be admitted to hospital. However this in infrequent and she had only had two admissions in the last 10 years. Carol is very reliant on the support she gets from the Community Mental Health Team. She has noticed that her community nurse, Peter, and her Consultant psychiatrist both seem much busier these days and she is not able to see them as often as she would like.
In the past few weeks Carol has been feeling very low and has started to think it might be better if she wasn't here

Current -Carol has told Peter how she feels and he has increased his visits to see her. He has asked the Community Home Treatment Team to be involved. Carol feels supported throughout the day but things are much worse at night. She can't sleep and feels she has no-one to turn to when she wakes in the night. She calls the emergency contact number and talks to a nurse on the ward. The nurse listens and is supportive. However carol feels she has to tell her story all over again and she is worried the nurse has other work she should be doing so she hangs up. Things are so bad that she takes an overdose and ends up admitted to hospital

After redesign – As well as support throughout the day there is now a 24 hour Community Home Treatment Team. They give Carol a number to call if she becomes afraid in the night and when she calls the nurse knows about her case and what has been happening recently. She is able to calm Carol and arrange to see her first thing in the morning. Carol feels at the end of her tether and to have a break "from life" she ends up at the local crisis house for a couple of nights. After 2 days she feels well enough to return home and resume her parenting role and continue to be supported by her CMHT.

Carol is given the number for a Talking Therapies, Crisis Café and Recovery College that she can visit for additional group support.

Case Study 2: A model of care for mental health

Dementia outreach service

Mr Joseph is a 75 years old elderly gentleman with a diagnosis of an Alzheimer's Dementia of moderate severity (known to Memory Clinic). He has deteriorated rapidly in his mental state and has become agitated and aggressive towards others (family) especially on intervention. His wife contacts the GP stressing that she requires extra support but desperately wishes to keep him at home for as long as possible.

Currently: Due to the degree of his acute presentation he is admitted to an inpatient ward. He becomes more distressed due to the change in environment and change in people who he is not familiar with. We establish that his abdomen is heavily distended and he is acutely constipated. He is treated successfully and has a good bowel movement in the next 24-48 hours. His presentation settles. No further agitation / aggression is reported, however he ends up developing Pneumonia and spends some time on the medical ward. He has a fall and sustains a fracture to his wrist. He is eventually discharged home with a care package 3 months later.

After redesign: With the development of the Dementia Outreach Service – professionals will be able to visit him in his own home and complete a thorough assessment. They can liaise with the GP and work with the multi-disciplinary team in managing his relapse. They treat his underlying constipation and he settles. The above medical complications can be avoided by simply having this service – where staff from the dementia outreach service are going out to see him in his own familiar surroundings.

4.4 Options for service delivery

A long list of options for future service delivery was drawn up for consideration. In addition to the mandated 'do nothing' and 'do minimum options we considered:

- the range of services required in response to the needs analysis
- new models of care in place elsewhere demonstrating improved outcomes
- existing service providers to maintain quality and continuity of care
- new service providers including the private sector to increase capacity locally
- travelling time for patients in response to user feedback

In total eight options were developed as outlined below:

Option 1: Do nothing: No enhancement of community care and no crisis care placements provided. No enhancement in Home treatment teams or dementia outreach developed. Retain all inpatient care (58 beds) on the Millbrook unit

Option 2: Do minimum: No enhancement of community care and no crisis care placements provided. No enhancement in Home treatment teams or dementia outreach developed. Retain reduced inpatient care on Millbrook Unit and upgrade the facility. (52 beds)

Option 3: Enhanced community and home treatment teams. Crisis care services established including up to 6 local short stay beds. Retain all inpatient care on the Millbrook unit (58 + circa 6 beds)

Option 4a: (preferred option) Enhance community and home treatment (crisis) teams. Provide the inpatient and bed-based care currently available at Millbrook within new crisis care services established locally, including up to 6 local short stay beds, as well as a new older peoples service at Lime Walk House in Macclesfield, and an adult functional service within the current provider footprint at Bowmere in Chester. In total these services provide 53 beds.

Option 4b: Enhance community and home treatment (crisis) teams. Provide the inpatient and bed-based care currently available at Millbrook within new crisis care services established locally, including up to 6 local short stay beds, as well as a new adults functional service at Lime Walk House in Macclesfield, and an older peoples service within the current provider footprint at Bowmere in Chester. In total these services provide 53 beds.

Option 5: Enhanced community and crisis care services (circa 6 local beds) Re-provide adult inpatient care (25 beds) from Millbrook to other facilities within current provider footprint. Procure older peoples dementia services (10 beds) from the private sector Older peoples functional re (12 beds) at Lime Walk. Total 53 beds

Option 6: Enhance community and crisis care services (circa 6 local beds). Re-provide older peoples services to Lime Walk site in Macclesfield (22 beds) and utilise multiple NHS providers for adult inpatient (25 beds). Total 53 beds

Option 7: Transfer some community, crisis care (circa 6 local beds) and inpatient services (45 beds) to alternative providers closer to the users home. Re-provide older peoples dementia services (10 beds) at Lime Walk site in Macclesfield. Total 55 + 6 beds

In Options 4a, 4b, 5, 6 and 7 the Millbrook unit would close and in patient services re -provided elsewhere

Once complete, a stakeholder panel undertook an options appraisal exercise to identify the pros and con of each long listed option. In doing this we considered the:

- need to deliver clinically safe and sustainable services;
- need to offer services that are acceptable to users;
- ambition to improve clinical outcomes;
- need to reduce the system cost pressure whilst enhancing services available;
- potential to utilise existing provider estates;
- use of alternative providers to reduce travelling for patients and carers; and
- need to increase choice through a range of service and treatment options.

In order to assess each option a set of criteria were developed against which people could score against the set benefit with 1 being the lowest and 5 the highest. The patient acceptability criteria was developed using feedback from the patient engagement events whereas clinicians determined the quality, sustainability and safety criteria.

The full pack (scoring sheet and long list of options) can be seen at appendix 4. 47 scoring packs were sent out to clinicians, managers and the project team and 26 completed sets were returned. Of the 26 returned there was an even split between clinical and non- clinical responses. The results of the scoring can be seen in the table below

Table 3: Results of the non- financial scoring of options

Option	Non-Financial Criteria Scores
Option 1	493
Option 2	516
Option 3	964
Option 4a	1,074
Option 4b	979
Option 5	832
Option 6	860
Option 7	824

4.5 Financial gateway

Each option was then assessed against a defined affordability gateway set on the current cost of the 'do nothing' option. Therefore where the cost of an option exceeded the current cost of service provision it was excluded.

The results of this assessment was that only options 1, 4a and 4b passed the financial gateway.

Therefore the project group determined that the options to take forward to consultation are as follows

Option 1: Do nothing: No enhancement of community care and no crisis care placements provided. No enhancement in Home treatment teams or dementia outreach developed. Retain all inpatient care (58 beds) on the Millbrook unit

Option 4a: (preferred option) Enhance community and home treatment (crisis) teams. Provide the inpatient and bed-based care currently available at Millbrook within new crisis care services established locally, including up to 6 local short stay beds, as well as a new older peoples service at Lime Walk House in Macclesfield, and an adult functional service within the current provider footprint at Bowmere in Chester. In total these services provide 53 beds.

Option 4b: Enhance community and home treatment (crisis) teams. Provide the inpatient and bed-based care currently available at Millbrook within new crisis care services established locally, including up to 6 local short stay beds, as well as a new adults functional service at Lime Walk House in Macclesfield, and an older peoples service within the current provider footprint at Bowmere in Chester. In total these services provide 53 beds.

However it is recognised that whilst option 1 is technically defined as do nothing; in accordance with the case for change the consequence of this option being selected would be the need to redirect funding from other current care services, in order to maintain, in the longer term, safe services.

4.6 Sensitivity test

While both the weighting applied to each benefit and the scores attributed were determined by stakeholders, it is recognised that the concerns of stakeholders vary significantly. It was agreed that sensitivity testing should be undertaken. This is a means of scrutinising what the effect would be of applying different weights to the benefits and will determine the level of confidence the project team has in the ranking of options.

It was agreed that the sensitivity test should include;

- **Sensitivity Test 1:** Applying an equal weight to all options. This removes any possibility that weighting favoured particular benefit disproportionately. Thus each weight is given an equal score of 2.

- **Sensitivity Test 2:** Lowering the weight applied to weighting applied to affordability by one point from 3 to 2, and increasing the weighting applied to patient acceptability from 2 to 3. This is to demonstrate that the exercise is not finance led and that the views of patients have been taken into consideration.

The sensitivity test does not alter the overall outcome of the evaluation of options. Both sensitivity test 1 and 2 both result in Option 4a scoring the highest followed by Option 4b.

4.7 Impact of options 4a and 4b on Travel for patients and carers

With the development of highly specialised services such as stroke, cardiac and trauma, the development of networked services aims to provide access at a population level with the growing expectation that for some people this will incur additional travel. Whilst this is similar for mental health services, the enhancement of community services will reduce the need for hospital care by 16% and some crisis bed based care will be locally available.

During the last year there have already been 12 people from Eastern Cheshire and 57 from South Cheshire and Vale Royal who have received treatment and travelled to Bowmere, and there have been no problems with travel reported.

There are currently approximately 305 patients who would need to travel further to get to Bowmere than if travelling to Macclesfield shown below by CCG:

Table 4: Table showing number of patients travelling further	
Name of CCG	**Number of People**
NHS EASTERN CHESHIRE CCG	176
NHS SOUTH CHESHIRE CCG	118
NHS VALE ROYAL CCG	11
Grand Total	305

For these patients and their carers this will mean additional travel as outlined below

Table 5: Table showing the additional miles if services move to Bowmere			
Town	**Distance (miles) to Macclesfield**	**Distance (miles) to Chester**	**Additional miles**
Macclesfield	1	41.9	40.90
Crewe	20.7	26.5	5.80

The project team undertook further work in response to patient and public concerns looking at the logistics of traveling to Bowmere particularly in relation to public transport and is summarised in the table below.

Table 6: Table showing the available modes of transport if services move to Bowmere			
From and To	**Mode of Transport**	**Time (one way)**	**Approx cost return**
Macclesfield to Chester	Bus	3.30 minutes	£5.50
Crewe to Chester	Bus	1.30	£5.50
Macclesfield to Chester	Train	1.30	£12 – 21

Crewe to Chester	Train	23 minutes	£7 – 12
Macclesfield to Chester	Car	51 minutes	£12 - 20
Crewe to Chester	Car	36 minutes	£8 - 12

In the majority of cases if travelling from towns in Cheshire East it isn't possible to do the whole journey by bus in the same day if existing visiting hours remain later in the day.

Plans are being developed to minimise impact for patients and carers include:

- Working with third sector organisations to provide short term support for travel
- Agreeing flexible visiting times to enable people to visit earlier in the day
- Use of technology to support contact e.g. skype, face time. In accordance with CWPs enabling technology strategy

A more detailed travel analysis is available in appendix 5

4.8 NHS System Impact

In the options 4a and 4b the existing inpatient facility 'Millbrook' on the Macclesfield Hospital site would be left vacant following the re provision of inpatient care to other facilities with a consequential shift in financial deficit from one system partner to another. To prevent this scenario a number of options are being considered as part of a strategic approach to estates management and includes:

- using the site to support the accommodation of new and additional NHS services
- offer the vacant site for land sale, with proceeds being reinvested into local NHS services.

The system partners across Vale Royal, South and Eastern Cheshire will be tasked with undertaking a high level feasibility study on the potential options for the Millbrook site pending a final decision post consultation.

4.9 Patient transport and place of safety

NWAS state when services are provided out of Cheshire to busy towns, cities and hospitals, this reduces the number of vehicles able to respond to 999 calls within the Cheshire footprint

People who have mental health problems, who need a place of safety within the meaning of the Mental Health Act are transported via 'blue light' emergency ambulance, with Cheshire Police accompanying the person. NWAS also provide Urgent Care Services for planned work between hospitals. Patient Transfer Services are commissioned through West Midland Ambulance Service.

Cheshire Police Mental Health Liaison outlined the importance of adequate provision of 'places of safety' within Cheshire, to enable Police to complete a section within the Mental Health Act, with Approved Mental Health Practitioner (AMP) or Psychiatrist in the interest of the person's mental health and wellbeing.

The project team will continue to partner with NWAS, Cheshire Police Mental Health Liaison and the Pan Cheshire Crisis Care Concordat Board, to develop the model of care for the preferred options, that will ensure adequate provision of 'places of safety' supported by competent and timely assessment and treatment.

5.0 Capacity and Workforce plan

The national shortage of candidates with the right knowledge, skills and behaviours in some NHS professions has created a very competitive market providing a challenge to building capacity to take plans forward. Nationally there are professions and roles where the vacancy rates are high and recruitment is difficult. This includes qualified nurses across all specialties, medical staff including Doctors in Training and GPs and specialised roles such as IT and Finance. In a recent NHS Confederation report (July 2017) it highlighted a 12.6% decline of mental health nurses over the last 7 years.

It is necessary therefore to extend our thinking beyond the traditional roles within mental health and capitalise on some of the new and exciting developments that are occurring within the workforce as a whole.

It is essential that we attract and employ individuals with key skills and experience, along with the right attitudes, behaviours and values to deliver person centred care. However as a system we recognise that this is influenced by factors which include an ageing workforce; increasingly attractive career opportunities outside the NHS; the effect on staff of changes in the healthcare economy as a whole that impact on workloads, work place stress and perception of job security. For CWP this has been more so in the past twelve months where the future of Millbrook has been under review.

We believe that the plans outlined in this pre consultation business case will improve staff retention and attract new people by:

- introducing new roles;
- training and education opportunities to improve skills and deliver NICE; recommended interventions;
- creating opportunities for career progression and succession planning;
- extending the practice of existing roles and professions;
- providing opportunities for flexible working;
- linking in with educational Establishments to improve recruitment to training and educational programmes; and
- capitalising on the apprenticeship levy.

The changes described in the new model of care will also provide existing staff with an opportunity to move into different roles by providing other roles in both inpatient and community services. This would be managed through existing HR processes and procedures.

5.1 Modelling capacity and workforce plan linked to finance

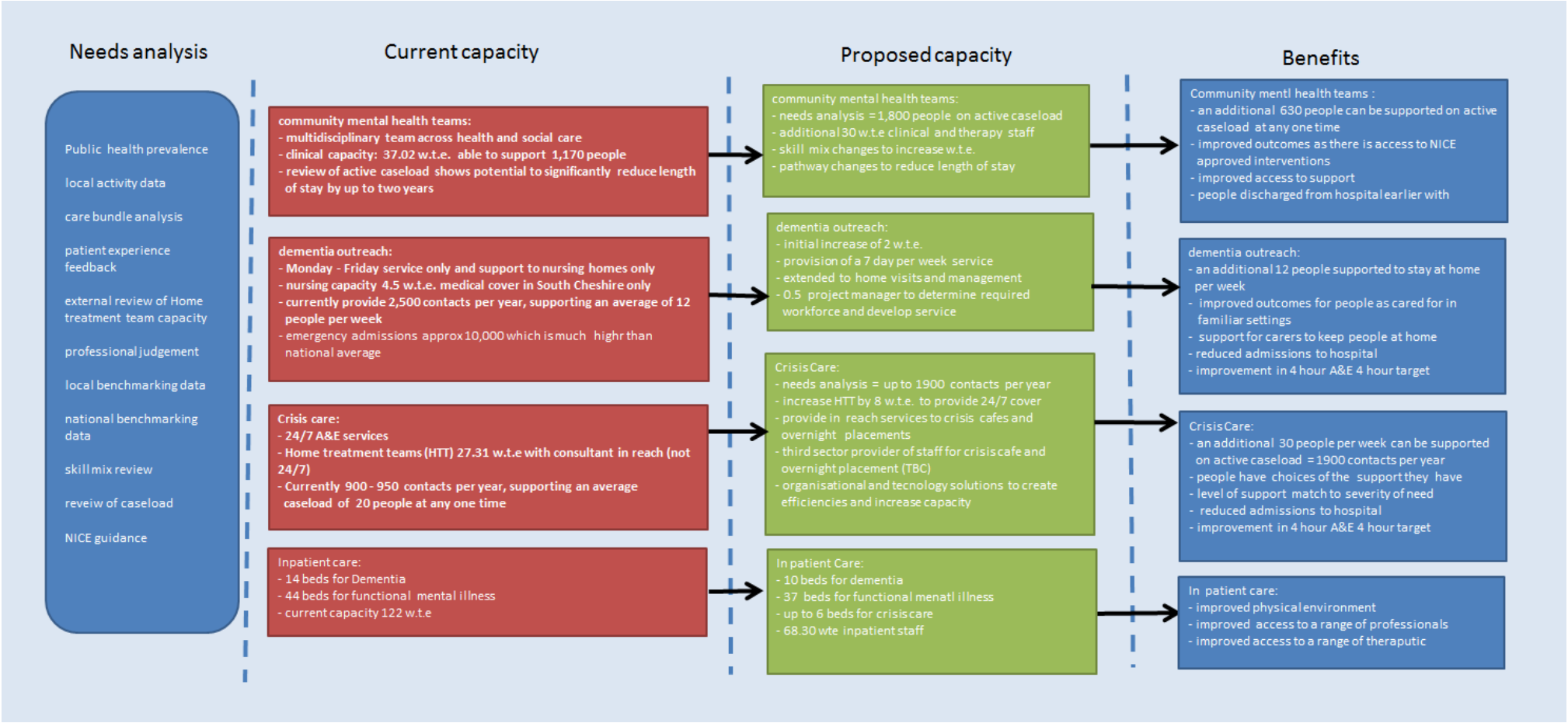
Using the needs analysis as a baseline in relation to numbers and evidenced based pathways of care to determine what people needed in relation to care and support, capacity requirements were modelled. The skill mix of staff was determined by patient needs for a safe and effective service. The cost modelling work was undertaken in parallel and determined by the skill mix and numbers required. The workforce plan is presented in summary in Diagram 4 below and in detail at appendix 6

The results represent a starting position against which future developments can be delivered. It describes the community and crisis response which will deliver improved outcomes for patients and reduce the over reliance on inpatient services.

According to national guidelines care coordinators should be carrying a caseload of 35, and there should be 1 consultant per 50,000. The current caseload for coordinators is in excess of this however a review of working practices shows that people can stay on active caseload for up to two years longer than required and should be discharged back into the care of the GP.

Diagram 4 shows the link to demand and the difference in capacity generated by new ways of working and enhancement. It describes how changes will deliver improved outcomes for patients and carers.

Diagram 4: Capacity and workforce plan



6.0 Finance

The local health and social care system is showing a deteriorating financial position. The cost of the current adult and older peoples mental health service configuration exceeds the funding available and change is required for the local NHS to operate within mandated financial controls.

As a consequence of the limited community resources the level of service in Vale Royal South and Eastern Cheshire has more of a focus on inpatient services when compared with CWP's model on the Wirral and in Western Cheshire. Additionally the Millbrook facility is CWP's least good inpatient environment and results in additional costs being incurred to ensure safe services.

Both the current service model in Vale Royal, South and Eastern Cheshire, and the financial position, are unsustainable.

In the current financial environment it is not expected that new funding will be identified to meet the shortfall identified or provide funding for community services. The aim of this redesign programme is to both enhance the community and crisis care provision and help close the financial gap through a redirection of existing funding

Without the proposed redirected investment in community services the dependency on the current bed configuration will continue and the service delivery and financial risks associated with these services will continue to grow.

From a financial perspective, the optimal option, whilst reducing the deficit in this area does not completely eliminate the financial challenge facing these services and is still some way short of the level of investment required for the Five Year Forward View and the surplus expected by regulators. A detailed cost analysis on long listed options is available at appendix 7

7.0 Risks and mitigation plan

Table 7: Risk mitigation plan			
	Risks	**Impact**	**Mitigation**
Consultation	There is a risk that the Pre Consultation Business case won't be approved.	• Impact the ability to deliver the strategic changes required as set out by the Mental Health 5 year forward view.	• Engagement with OSC and organisational Boards/Governing Bodies throughout the process. • Pre consultation engagement events to inform preferred options • Follow NHSE process for service redesign • CWP to evoke business continuity plans pending decisions on next steps •
Patient Acceptability	Lack of public support for options	• Options 4a and 4b would result in some people having to travel further should a period of inpatient care be necessary	• Work with third sector organisations to provide short term support for travel • Agree flexible visiting times to enable people to visit during the day • Use of technology to support contact e.g. skype, face time • Minimise length of stay in hospital through enhanced community services
Delay in Consultation	There is a risk that the consultation process may be delayed if the Pre Consultation Business case is not approved	• Impact on staffing numbers. • Clinical risks not addressed • Recruitment continues to be difficult during period of uncertainty • Sustainability of services •	• CWP to evoke business continuity plans. • Regular communication with staff • Clinical leadership across system to identify measures to maintain quality of care • Monitoring of key safety indicators to highlight increasing risks • Continue active recruitment to all vacant posts

Clinical Risks	There is a risk to service sustainability during the planning and consultation phase	• Unable to recruit and retain staff due to uncertainty • Increase in un-planned staff absences • Increase in caseloads in community teams • Longer response and waiting times in the community • Occurrence of out of area admissions to other Trusts • Increase in avoidable harm incidents	• CWP to evoke business continuity plans. • Regular communication with staff • Clinical leadership across system to identify measures to maintain quality of care. • Monitoring of key safety indicators to highlight increasing risks
Reputational and Organisational	There is a risk to the project from Negative media coverage.	• Public consultation outcome influenced by negative coverage	• Development of a communications and engagement strategy • Fully engage public in pre consultation and consultation events • Engagement with media to establish relationship

8.0 Next Steps

8.1 Public consultation strategy

The public consultation will be for a 12-week period and will be a comprehensive process involving six public meetings across the major towns in Eastern Cheshire, South Cheshire and Vale Royal.

In addition offers will be made to attend local community meetings such as mental health forums, Age UK, Alzheimer's Society etc.

A comprehensive Equality Impact Assessment has been conducted that will guide our approach to formal consultation, ensuring that we target groups that will be directly and indirectly affected by the proposals – and that we produce information in different formats and made available in different places that are convenient and accessible for different people, including those with protected characteristics.

To enable people to understand the rationale for change and give full consideration to the options, information will be shared via a number of channels, these include:

- A public consultation booklet in plain language that clearly sets out the reasons for change and the options the public are being asked to comment on, including details of public meetings and ways to find out more information and feedback views. It will feature a freepost survey to complete and return;
- An online version of this booklet will also enable people to share their views via a simple online survey;
- Further hard copy information including posters and flyers signposting people to the public meetings and website, distributed widely in:
    - CWP services, including the Millbrook Unit where volunteers will support an information hub throughout the 12-week consultation period;
    - GP surgeries;
    - Macclesfield and Leighton general hospitals;
    - Other NHS and public sector premises, including libraries; and
    - Voluntary sector premises
- Where possible the use of messages on information screens in hospital and GP surgeries will also be utilised;
- There will be a dedicated website page to act as a hub of online information;
- We will seek to engage with local media outlets (local newspapers and radio) as well sharing information via NHS and local authority websites and social media channels;
- Dedicated staff events and drop-in sessions in Eastern Cheshire, South Cheshire and Vale Royal will continue during the formal consultation period;
- All CWP members and staff in Eastern Cheshire, South Cheshire and Vale Royal will be invited to give their views;
- A dedicated phone number will be available throughout the 12 week period for people with any queries about public meetings or getting copies of the consultation document; and

- In addition, the Patient Advice and Liaison Service at commissioners and CWP will support service users and carers with specific concerns raised as a result of the consultation during this time.

We will engage an independent organisation to receive feedback and conduct analysis of findings in order for the partnership to fully consider views put forward, before making a decision on next steps.

Any personal details provided will be treated in accordance with the Data Protection Act and will not be used for any other purpose. We will also establish robust methods of recording stakeholder comment directed at partners during this period, to ensure we can channel all feedback into the final report.

8.2 Reporting and decision-making

The independent analysis of feedback on the consultation will be reviewed by a range of organisations before any decisions are made on the way forwards:

- CWP's Trust Board;
- Eastern Cheshire CCG's Governing Body;
- South Cheshire and Vale Royal CCG's Governing Body;
- Cheshire East Council's Adult Health and Social Care Overview and Scrutiny Committee; and
- NHS England's Assurance Process.

The partners are committed to communicating the outcome of the consultation and what will happen next and ensure the continued involvement of service users, carers, staff and partners during implementation of any changes.

Appendix 1

Membership Groups

Adult Mental Health Project Team	
Ian Hulme	GP Mental Health Clinical Lead
Jacki Wilkes	Sponsor
Suzanne Edwards	Service Director CWP
Sadia Ahmed	Consultant CWP
Sally Sanderson	Service lead CWP
Marie Ward	Transformation Project Manager
Elizabeth Insley	Finance Lead
Robert Walker	Expert by Experience
Jamaila Tausif	South Cheshire Lead
Nicola Glover Edge	Director, Cheshire East Council
John Loughlin	Project Manager CWP
Katherine Wright	Comms and Engagement CWP
Scott Maull	Finance Lead CWP
Charles Malkin	Comms and Engagement ECCCG
Amanda Graham	ECCCG PMO
Clinical Advisory Group	
Kate Chapman	Matron CWP
Jane Tyrer	Therapy Lead CWP
Sabu Oomman	Consultant CWP
Sadia Ahmed	Consultant CWP
Anushta Sivananthan	Medical Director CWP
Teresa Strefford	GP Mental Health Clinical Lead
Philip Goodwin	GP Mental Health Clinical Lead
Ian Hulme	GP Mental Health Clinical Team
Zoe Ball	Clinical pychologist
Options Appraisal Scoring - additional support	
Andrew Smith	Cheshire Police Mental Health Liason
Carol Robertson	NWAS - East Cheshire
Julia Cottier	Service Director CWP
Tracy Parker Priest	Director Vale Royal and South CCG
Julia Huddart	GP
James Milligan	GP
Mike Clark	GP
Julie Sin	PH consultant
Site Visits	
Phil Jarrold	Expert by Experience
Mike Heald	Expert by Experience
Robert Walker	Expert by Experience
Marie Ward	Transformation Project Manager
John Loughlin	CWP Estates

Appendix 2

Communication and Engagement Strategy

Eastern Cheshire, South Cheshire and Vale Royal Adult Mental Health Services

Communications & Engagement Strategy to Support Pre-Consultation and Consultation

Dated 17th November 2017

Version 1.9

Version	Comments	Date
1.0	First draft of document shared with NHS Eastern Cheshire CCG and Cheshire & Wirral Partnership Foundation Trust (CWP) for comments and amends.	10/10/2017
1.1	Amends and comments received from Eastern Cheshire CCG and CWP, further draft updated and shared within CSU teams for further work and development.	11/10/2017
1.2	Further draft updated and shared within CSU teams for further work and development.	12/10/2017
1.3	Amends completed and shared with NHS Eastern Cheshire CCG, CWP, NHS South Cheshire CCG and Vale Royal CCG for comments and amends.	23/10/2017
1.4	Amends completed and shared with NHS Eastern Cheshire CCG, CWP, NHS South Cheshire CCG and Vale Royal CCG for comments and amends.	31/10/2017
1.5	Amends completed and shared with NHS Eastern Cheshire CCG, CWP, NHS South Cheshire CCG and Vale Royal CCG for comments and further amends.	9/11/2017
1.6	Amends completed and shared with NHS Eastern Cheshire CCG, CWP and NHS South Cheshire and Vale Royal CCGs for comments and amends.	10/11/2017
1.7	Amends completed and shared with NHS Eastern Cheshire CCG, CWP, NHS South Cheshire CCG and Vale Royal CCG	13/11/2017
1.8	Amends completed and shared with NHS Eastern Cheshire CCG, CWP, NHS South Cheshire CCG and Vale Royal CCG	14/11/2017
1.9	Amends completed and shared with NHS Eastern Cheshire CCG, CWP, NHS South Cheshire CCG and Vale Royal CCG	17.11.17

Contributing partners include; Cheshire and Wirral Partnership NHS Foundation Trust, NHS Eastern Cheshire Clinical Commissioning Group, NHS South Cheshire Clinical Commissioning Group and NHS Vale Royal Clinical Commissioning Group

Contents

1.0 Introduction

This document sets out the approach to the communications and engagement supporting the Adult Mental Health Services Consultation for Eastern Cheshire, South Cheshire and Vale Royal. The partners involved in the re-configuration are:

- Cheshire and Wirral Partnership NHS Foundation Trust (CWP)
- NHS Eastern Cheshire Clinical Commissioning Group
- NHS South Cheshire Clinical Commissioning Group
- NHS Vale Royal Clinical Commissioning Group

It is recognised that the population served by the Adult Mental Health Services falls within the two Council footprints of Cheshire East and Cheshire West and Chester and that they are a key stakeholder to be addressed in the development of this work.

2.0 Background

Thousands of people of all ages with acute or long term chronic mental health conditions are supported each year in Cheshire within hospitals and outpatient clinics, as well as in people's homes.

Most people access mental health services in the community, either via primary mental health services e.g. Improving Access to Psychological Therapies services (IAPT) or specialist community mental health services.

Specialist community mental health services include:

- Adult community mental health services
- Older adult community services
- Early intervention team
- A home treatment team which operates daily between 8am and 9pm
- Street triage
- Recovery colleges
- Liaison Psychiatry within local hospital NHS trusts
- Mental health rehabilitation services

CWP is the main NHS mental health provider in Cheshire. In the most recent inspection by the Care Quality Commission (CQC), CWP was rated as an organisation as 'good' overall and 'outstanding' for caring. CWP provides inpatient mental health services for adults and older people in three locations in Cheshire and Wirral – Bowmere Hospital, Chester; Springview Hospital, Wirral; and the Millbrook Unit, Macclesfield, as well as the range of community services described above (with the exception of IAPT services in Eastern Cheshire, which are provided by another service provider).

Inpatient services for residents in Eastern Cheshire, South Cheshire are currently delivered at the Millbrook Unit which provides 44 inpatient beds for people with mental illness and 14 beds for people living with dementia. Inpatient recovery and assessment services are delivered from nearby Limewalk House, Macclesfield. For residents who live in the Vale Royal area, inpatient services are delivered at Bowmere Hospital.

2.1 The Challenge

The NHS is committed to improving services for people with mental ill-health in Eastern Cheshire, South Cheshire and Vale Royal.

In order to do this we face two main challenges:

- to improve outcomes in the face of increasing demand for mental health services; *and*
- to achieve this within available financial resources.

In order to improve overall outcomes for people we aim to improve four key areas in line with the Mental Health Five-Year Forward View and local best practice:

- Community mental health services.
- The inpatient environment.
- Access to psychiatric intensive care.
- Physical health outcomes.

3.0 Communications, Engagement and Consultation

Section 14 (Z2) and 13 (Q) of the Health and Social Care Act require the involvement and engagement of the public and stakeholders in the formulation and planning of service change proposals. Section 244 of the NHS Act 2006 also includes the duty to consult the relevant local authority in its health scrutiny capacity.

NHS England provide guidance on how to fulfill the statutory requirements surrounding service change in their publication: “Planning and delivering service changes for patients – a good practice guide for commisioners on the development of proposals for major service changes and reconfigurations”. They also provide further guidance on ensuring appropriate involvement of patients and the public in service change: ‘Transforming Participation in Health and Care’ and the recent ‘Engaging Local People in Sustainability and Transformation Plans’.

Our approach to pre-consultation and planning for full public consulation has been based on this guidance. Central to an effective strategy is to ensure that service change communications are appropriate and accessible to meet the needs of diverse communities; and that patients and the public are involved throughout the development, planning and decision making of proposals. This includes early involvement with local Healthwatch organisations and the local voluntary sector.

Involvement activity around developing and presenting our proposals aims to:

- Be proactive to local populations
- Be accessible and convenient
- Take into account different information and communication needs;

and

- Be clinically led, to ensure that clinicians are driving any changes for the benefit of service users and carers.

3.1 How we will communicate and engage

Our guiding principles are to ensure that the communications and engagement relating to potential service change, is both within statutory requirements and allows the public to understand the changes being proposed, are to:

- Provide honest, simple and accessible information at appropriate stages of the process to enable people to influence plans;
- Establish clear messages on why change is needed, what the process for change is, and what that change will involve at each significant milestone;

- Deliver messages consistently and tackle mis-information quickly and effectively;
- Ensure that relevant stakeholders are engaged and reach out to groups with protected characteristics to ensure they have equal opportunity to influence change and are informed about any change to services and how to access them.

3.2 Communication Aims and Objectives

We will deliver a consultation based on best practice principles, which is founded on the commitment to inform and listen. We will work with our stakeholders to deliver key consultation work and to analyse the results to ensure an objective outcome. We will use a mix of qualitative and quantitative methodologies to allow for both volume and richness of response.

To help us achieve this, we have the following three high-level objectives:

- To ensure that the consultation process is transparent and that it meets its statutory requirements through sufficient inclusiveness, breadth and depth.
- To provide sufficient opportunity for existing and former service users, and their carers, to have their say in shaping options for consultation by delivering pre-consultation events in an open and honest manner.
- To create a significant and meaningful amount of engagement with local stakeholders, and to provide evidence of this.

3.3 Stakeholders

The following provides a list of key stakeholders from which the communications and engagement can be planned. This list will be continuously reviewed and added to, as and when new stakeholders are identified.

Type	Stakeholders
Clinical Commissioning Group (CCG)	NHS Eastern Cheshire CCG NHS South Cheshire CCG NHS Vale Royal CCG
Clinical	GP Practices GP Alliances and Federations Secondary care clinicians Mental health clinicians
Councillors	Cheshire East Council
Health and wellbeing board	Cheshire East Health & Wellbeing Board
Local Authority	Cheshire East Cheshire West and Chester (for information purposes re Vale Royal) Social services Police Fire & Rescue Service
Media	Local and regional media outlets – please see Appendix E for full details
MPs	Cheshire East MP for Vale Royal area
OSC	Cheshire East OSC
PALS, Complaints and FOIs	NHS Eastern Cheshire CCG NHS South Cheshire CCG Vale Royal CCG

	CWP East Cheshire NHS Trust Mid Cheshire Hospitals NHS Foundation Trust
Staff	CCGs CWP
Trusts	CWP East Cheshire NHS Trust Mid Cheshire Hospitals NHS Foundation Trust
Voluntary and third sector	For example Healthwatch, Eastern Cheshire HealthVoice, local charity groups, community groups etc. For full list of stakeholders, please see Appendix D

4.0 The Approach

4.1 Pre-consultation Engagement

Service user, carers and staff views have been integral to development of the Pre-Consultation Business Case; including the options appraisal process.

Engagement has taken place from 2016 up until October 2017 as outlined below.

4.1.1 CWP Initial engagement (2016)

CWP held patient and carers workshops at the Millbrook Unit and the Macclesfield Recovery College, as well as a series of briefings and drop-in sessions for frontline staff towards the end of 2016. At this time CWP also engaged with Healthwatch Cheshire East, Cheshire East Health Voice and Cheshire East Council's Adult Health and Social Care Overview and Scrutiny Committee. This included providing a site-visit for scrutiny committee members to CWP services.

The main themes from CWP's pre-consultation engagement were:

- Ensuring that community services were sufficiently resourced to support people earlier on to enable early intervention, prevention and thereby preventing unnecessary inpatient admissions
- Concerns about the travel implications of any potential relocation of inpatient services for people who access services and their carers - particularly the older population
- An awareness of the challenging financial conditions
- Queries regarding why a new inpatient facility could not be built
- Acknowledgement among people accessing services that the Millbrook Unit does not meet the environmental standards required for modern mental health practice
- Recognition for the care provided by the mental health teams at the Millbrook Unit despite the building limitations
- More support is needed with rehabilitation, housing and finding a job.

4.1.2 NHS South Cheshire CCG and NHS Vale Royal CCG Engagement (2016)

NHS South Cheshire CCG and NHS Vale Royal CCG have engaged over the last 12 months with their population in regard to the 5 Year Forward View as well as the future of mental health services.

Jointly with CWP from Jan-June they held a number of workshops around early intervention models through a newly developed Mental Health gateway service.
They also have patient feedback from the provider through contract meetings, and, through

their clinical commissioning executive and GP membership meeting they gained further feedback from GPs.

Over the past 12 months, engagement work saw over 100 service users and carers, CWP staff, and providers from across the local health and social economy including third sector agencies, involved with events and surveys, with the majority of responses focused largely on secondary care services.

The process of engagement included the following;

- Information about proposals for the mental health gateway, discussions around access to services, choice and the process of assessment
- a mental health focused questionnaire included in the 'Cheshire Chat' event and
- A focus on mental health crisis services.

From this engagement, the following themes were identified under the headings – what works well, what could be improved and how does crisis care work;

- Concerns around communication i.e between providers and patients, friends and family etc
- Concerns around access to services i.e wanting services and support closer to home, meeting thresholds, access to appointments out of office hours
- Concerns around attitudes and knowledge i.e a stigma and lack of awareness in primary care
- The following were listed as some of the top 3 priorities for crisis care;
    - Support for carers and family, especially providing support for people at home
    - Access to treatment quickly and
    - Consistent follow up appointments after a crisis event.

This feedback has helped inform the Pre-Consultation Business Case. For full report on this activity, please see Appendix F.

4.1.3 Engagement by the Joint Project Team: Second Phase Pre-engagement (2017)

Having accepted CWP's case for change, commissioners have led the partnership project to produce a pre-consultation business case since the Spring of 2017. As a partnership, commissioners and CWP held listening events in September 2017 at Crewe Alexandra FC and Macclesfield Town FC. Approximately 50 people attended the events, the majority of whom were service users and carers. A full summary of the event workshop is outlined in Appendix A and further information is provided below

4.1.4 Event Aim & Objectives

Aim

To gather feedback from service users, carers and other stakeholders which can be used to inform the development of a new service model and the options appraisal process.

Objectives

- To understand users' and carers' experiences of adult mental health services across the Eastern Cheshire, South Cheshire and Vale Royal areas. What has worked well, what has not worked well; what we can do differently and better.

- To understand the perception and experiences of key stakeholders who are familiar and/or work with adult mental health services across the Eastern Cheshire, South Cheshire and Vale Royal areas.
- To gauge understanding of and appreciation for the case for change
- To explore views and opinions to shape the development of a new service model (Community Care, Crisis Care and Inpatient Care). Specifically what should it look like? What is missing? How can it be improved?

To understand what is important to service users and carers (in the broadest sense of the term including wider stakeholders) when producing a shortlist of proposals.

Table-based discussions gave participants an opportunity to describe what had worked well for them, what had not worked well and how services might be improved.

The event was structured and feedback was provided on the following areas:

- Experiences of using mental health services.
- Understanding of the importance of the reasons for change
- Views on the future of mental health services around the specific areas of: crisis care, inpatient care and community care.
- Rating the criteria which will inform the possible scenarios for mental health services.

Feedback was provided within each of these areas through a mix of both qualitative and quantitative feedback.

4.1.5 Analysis of Findings: Summary

The main themes from the events were as follows (a full analysis of the event is available in appendix B):

- Support for the case to change
- Calling for more 'personalised' care
- Calling for more support in community
- Local services were important to people
- Travel times for carers were important
- Calling for more support when in crisis – specifically:
    - One point of contact for services / clear access points
    - Care available quickly e.g. 24/7 care which is not A&E
    - Support available at different places: home setting/ safe houses/ day centre.

Views expressed have directly informed the development of the long list of options, and the options appraisal process – specifically informing the public acceptability criteria and also feeding into further thinking on options development and appraisal.

4.2 Public Consultation Strategy

The public consultation will be for a 12-week period and will be a comprehensive process involving six public meetings across the major towns in Eastern Cheshire, South Cheshire and Vale Royal, held at different and accessible times for the local community.

In addition offers will be made to attend local community meetings such as mental health forums, Age UK, Alzheimer's Society etc.

A comprehensive Equality Impact Assessment has been conducted that will guide our approach to formal consultation, ensuring that we target groups that will be directly and indirectly affected by the proposals – and that we produce information in different formats and made available in different places that are convenient and accessible for different people, including those with protected characteristics.

To enable people to understand the rationale for change and give full consideration to the options, information will be shared via a number of channels, these include:

- A public consultation booklet in plain language that clearly sets out the reasons for change and the options the public are being asked to comment on, including details of public meetings and ways to find out more information and feedback views. It will feature a freepost survey to complete and return;
- An online version of this booklet will also enable people to share their views via a simple online survey;
- Further hard copy information including posters and flyers signposting people to the public meetings and website, distributed widely in:
    - CWP services, including the Millbrook Unit where volunteers will support an information hub throughout the 12-week consultation period;
    - GP surgeries;
    - Macclesfield and Leighton general hospitals;
    - Other NHS and public sector premises, including libraries;
    - Voluntary sector premises.
- Where possible the use of messages on information screens in hospital and GP surgeries will also be utilised;
- There will be a dedicated website page to act as a hub of online information;
- We will seek to engage with local media outlets (local newspapers and radio) as well sharing information via NHS and local authority websites and social media channels;
- Dedicated staff events and drop-in sessions in Eastern Cheshire, South Cheshire and Vale Royal will continue during the formal consultation period;
- All CWP members and staff in Eastern Cheshire, South Cheshire and Vale Royal will be invited to give their views;
- A dedicated phone number will be available throughout the 12 week period for people with any queries about public meetings or getting copies of the consultation document;
- In addition, the Patient Advice and Liaison Service at commissioners and CWP will support service users and carers with specific concerns raised as a result of the consultation during this time;
- Communication to GP Practices will take place within the CCG areas via bulletins and newsletters.

We will engage an independent organisation to receive feedback and conduct analysis of findings in order for the partnership to fully consider views put forward, before making a decision on next steps.

Any personal details provided will be treated in accordance with the Data Protection Act and will not be used for any other purpose. We will also establish robust methods of recording stakeholder comments directed at partners during this period, to ensure we can channel all feedback into the final report.

4.2.1 Stakeholder Communication

We will engage with stakeholders in advance of the consultation go live date; to inform them of the rationale and options to be presented to patients and public audiences, and the channels that will be used.

Communication will take place via the following methods:

Clinical Communications

- Briefing note to GP Alliance leads
- Briefing via GP newsletters to GP Practices
- Letter to all GP practices from the Lead Commissioner
- Briefing to secondary care clinicians, including regular briefings for CWP staff both face-to-face and written briefings.

Acute Care

Letter from the Lead Commissioner to Chief Executives outlining the consultation background and approach and commencement date.

Health Overview & Scrutiny Committees

Engagement will take place via face to face briefings and presentation at OSC meetings.

Councillors

Briefings will be provided to councillors across the Cheshire footprint, in advance of the consultation commencing.

Health & Wellbeing Boards

The Lead Commissioner and appropriate CCG will brief the H&WB Boards at a face to face meeting.

PALS and Complaints Teams

A briefing will be provided to CCG and Acute Trust PALS and Complaints / FOI teams to enable them to effectively respond to queries or to direct queries to the Lead Commissioner.

Neighbouring CCGs

A briefing will be provided to neighbouring CCGs to inform them of the consultation process and the appraoch to be taken, with timelines and channels to be used.

Voluntary & Third Sector

Briefings will be provided to relevant voluntary and third sector organisations in advance of the consultation start date.

A local campaign group ‘Do You Mind’ is running an online petition which has gathered the support of 2,805 people calling for a number of actions around mental health, including retaining inpatient services in Macclesfield and increased funding for mental health.

The project team has met with the group during pre-consultation and has a constructive ongoing dialogue with them. A key objective during the public consultation will be to ensure that service users, carers and the wider public are fully aware of the case for change and the proposed future service model.

4.3 Reporting and decision-making

The independent analysis of feedback on the consultation will be reviewed by a range of organisations before any decisions are made on the way forwards:

- CWP's Trust Board
- NHS Eastern Cheshire CCG's Governing Body
- NHS South Cheshire CCG's Governing Body
- NHS Vale Royal CCG's Governing Body
- Cheshire East Council's Adult Health and Social Care Overview and Scrutiny Committee
- NHS England's Assurance Process

The partners are committed to communicating the outcome of the consultation and what will happen next and ensure the continued involvement of service users, carers, staff and partners during implementation of any changes.

5.0 Media

Local media interest is high with the result that some inaccurate articles have been printed. Media lines to take are agreed (see Appendix C) and will be revised throughout the process. All partners will take a proactive approach to working with the local media to inform and engage on the stages of the consultation process and will operate within a joint protocol adhering to SMART principles.

It is recognised that the media are a key communications channel for the local population and that the messages need to be correct in order to reduce incorrect articles which lead to confusion and inaccuracy. With that in mind, a media planner will be implemented to support the consultation process

5.1 Proactive communications

The proposed consultation survey and public events will be promoted across partners' external communications channels at the earliest opportunity and again at periodic intervals, as appropriate, throughout the consultation process.

Consultation findings and consequent actions will also be communicated proactively. Channels will include print and broadcast media, websites and social media. News releases will be complemented by paid-for advertising and by posters, flyers and an animation. Partners will use media monitoring software to measure advertising value equivalency, audience reach and sentiment and all coverage will be collated within a joint report.

5.2 Reactive communications

It is probable that the media, members of the public and key stakeholders including MPs and councilors will request information at various stages of the consultation process and during the period following consultation and preceding implementation of decisions. Every effort will be made to provide information to meet information request deadlines.

Any such requests will be responded to adhering to the joint media protocol. Requests for information under the Freedom of Information Act 2000 will be met by the relevant team of the partner receiving the request. Responses will be drafted in collaboration with the communications team of the recipient partner. Responses will be published in compliance with legislation.

5.3 Values

All communications, both proactive and reactive, will demonstrate transparency, openness, honesty and integrity.

5.4 Joint protocol

All communications will be authored by the communications and engagement teams of NHS Eastern Cheshire CCG, Cheshire and Wirral Partnership NHS Foundation Trust, NHS South Cheshire CCG and NHS Vale Royal CCGs, and quality assured by Midlands and Lancashire Commissioning Support Unit. A joint protocol is in place to guide approval of documents.

Appendices

Appendix A: Pre-Consultation Workshops

The workshops were designed to encourage interaction and engagement with the audience. An initial ice breaker 'quiz' which is based on mental health services acts as a warm up and also provides information on the services. The project lead then provided a presentation outlining the purpose of the event and then led into the interactive workshops, as follows:

Presentation from senior CCG lead and lead facilitator covering the following.

- What is a CCG and what are its responsibilities
- What the CCG is trying to achieve around adult mental health
- Where this event sits within the consultation process
- How the event is going to run/structure/governance

Workshop 1 – Your experiences

- Introductions at the table, who participants are sat with and the role of the facilitator
- Participant demographic profiling questionnaire.
- First activity explores their experiences of mental health services – specifically what's been good/strengths and what's been bad/weaknesses and challenges.

Workshop 2 – the case for change

- Conduct a case for change quiz. For each reason outlined in the case for change a simple multiple choice question was designed. Each question had 4 possible answers (A, B, C and D).
- Each table was asked to guess the correct answer and the lead facilitator then provided the correct answer
- At the end of this round a clinical expert from the CCG described the case for change in more detail.
- Each participant completed a questionnaire where they were asked 'to what extent do you understand the 'insert reason' from the case for change between 1 and 4 where 1 is understand and 4 is do not understand'.

Workshop 3 – the model for change

- Senior clinician/CCG member presented the model for change
- Each table discussed the model and each element of the model in turn. Their feedback will be used to feed into the options list.
- They were asked to think about how the model can be implemented. What should this look like, what is missing, how can it be improved.
- Each part of the model was the focus of a separate flipchart sheet (Community Care, Crisis Care and Inpatient Care).

Workshop 4 – how do we evaluate the options that we put together to implement the model

- Participants were given a list of the factors used to evaluate the options.
- They were discussed and explained.
- Participants were asked to rank them in terms of importance, both individually and as a table

Workshop 5 – Q&A

- Throughout the session participants were invited to post-it note questions on a large piece of flipchart paper.
- At the end of the session the clinical lead/CCG lead fielded the common questions.

Appendix B: Analysis of findings from Pre-Consultation Workshops

Please click below for PDF of findings

Appendix C: Media – key messages during pre-consultation

1. **Why is the NHS reviewing local adult mental health services?**
   NHS England has published a Mental Health Five-Year Forward View that challenges commissioners and providers of services to work together to redesign services so that people get high-quality, responsive care that allows them to get better quickly. There is evidence that timely support reduces the number of people experiencing crisis and requiring hospital care. By designing services in line with existing and projected demand, the aim is to provide affordable care that meets people's needs. The project involves NHS Eastern Cheshire Clinical Commissioning Group (CCG) NHS South Cheshire CCG, NHS Vale Royal CCG, Cheshire East Council and Cheshire and Wirral Partnership (CWP) NHS Foundation Trust, as main provider of the area's mental health services.

2. **Is it true that the Millbrook Unit is closing?**
   At this time, there are no proposals for the Millbrook Unit or any other element of adult mental healthcare in the area. Options for consultation will be informed by the needs of service users and carers as expressed during pre-consultation, and by clinical evidence, data on use of current services and financial information. A three-month public consultation is expected to start early in 2018 and will include an online survey and public events that give people plenty of chance to have their say. No decisions will be made until after the consultation has ended.

3. **What was the purpose of the pre-consultation events?**
   The listening events in Crewe and Macclesfield gave current and former service users, and their carers, an opportunity to express their needs and wishes. Interactive discussions encouraged participants to say what worked well, what did not work well, and how services might be improved. The events were attended by more than 40 service users and carers in total.

4. **Is this process all about saving money?**
   No. The aim is to ensure high quality and sustainable care that meets demand in a way that enables service users to get well quickly and then stay well.

5. **What happens next?**
   Workshop findings are informing the development of consultation options which will require approval by NHS England; Cheshire East Council's Health, Adult Social Care and Communities Overview and Scrutiny Committee; the Governing Bodies of NHS Eastern Cheshire CCG, NHS South Cheshire CCG and NHS Vale Royal CCG; and the CWP Board. A public consultation will then commence in the New Year for a three-month period. The findings of the consultation will be presented back to the above groups before any changes are implemented.
   ENDS

Appendix D – Third and Voluntary sector stakeholder list

Type	Name
Sport Groups	A variety of sports and community groups in the local area
Older people	Age UK Cheshire East
Voluntary	Always There Homecare
Condition Specific Group	Alzheimer Society
Community & Voluntary	Big Life Group
Condition Specific Group	British red cross
Misc	Buddies women's group
Misc	CAB - Congleton, Crewe, Knutsford, Macclesfield, Nantwich (mental health advocate)
Carers	Carers Trust
Carers	Carers Trust 4 all
Misc	CEC Parent Partnership
CEC Public Health	CEC Public Health
CEC	CEC Youth Service
Condition Specific Group	Central Cheshire Alcohol Services
Misc	ChAPS
Carers	Cheshire Carers Centre
Condition Specific Group	Cheshire Disability Federation
Carers	Cheshire East Parent Carer Forum
Condition Specific Group	Cheshire West Eating Support Team
SC & VR GP Alliances	Chief Executive of East Cheshire Hospice/ and managers Alliance
Misc	Crewe Women's Aid
Community & Voluntary	CVS Cheshire East
CWaC Parent Partnership	CWaC Parent Partnership
CWaC Public Health	CWaC Public Health
Forum	Do You Mind
Social Care	Director of Adult Social Care and Independent Living
Misc	East Cheshire Advocacy Service
SC & VR GP Alliances	GP - Ashfields Primary Care Centre - Sandbach
Voluntary organisation	Healthwatch
Forum	Eastern Cheshire Mental Health forum
Voluntary organisation	Eastern Cheshire HealthVoice
Misc	Homestart West Cheshire-Northwich
Condition Specific Group	Knutford GROW
Condition Specific Group	MENCAP Mid Cheshire
Condition Specific Group	Mental Health Re-ablement South
Condition Specific Group	MIND - Macclesfield, Winsford
Forum	Open Minds Forum
Community & Voluntary	Richmond Fellowship
Voluntary organisation	Samaritans Macclesfield
Community & Voluntary	SMILE
Misc	The Rossendale Trust
Misc	The Wishing Well Project

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Community & Voluntary	Travellers Voice
LBGT	UTOPIA @ The Hub Youth Support Service Crewe
Young people	Visyon
Misc	YMCA

Appendix E – Media list

Type	Outlet
Print	Cheshire Independent Chester Chronicle Congleton Chronicle (also Alsager and Sandbach titles) Crewe Chronicle Knutsford Guardian Macclesfield Express Norwich Guardian Wilmslow Guardian
Online	Alderley Edge and Wilmslow community websites So Cheshire Community website
Radio	BBC Radio Manchester BB Radio Stoke Canalside Radio Imagine FM Signal Radio Silk FM
TV	North West News

Appendix F –South Cheshire/Vale Royal Mental Health Gateway Engagement Report

Joint Report Template - MH Gatev

Appendix 3

Needs Analysis

Process applied:

1. Data upload of all people registered as being in contact with a CMHT in South, East and Vale in mid-May 2017
2. 2. Data sorted into:
   a) CCG
   b) Diagnostic code by PbR cluster
   c) Each care cluster shown as a percentage of the entire diagnostic group

3. Diagnostic groups clumped into 'Super Clusters' - Dementia, Depression, Psychosis, Bipolar, Personality Disorder, Anxiety
4. Data sense checked by clinicians. Some specific issues clarified:
   a) absence of people with personality disorder within older adult services - clinical advice suggests that symptoms tend to become less problematic with age and other MH issues tend to come to the forefront - dementia, depression, etc that then become the primary diagnostic code
   b) Care Cluster breakdowns for Cognitive Impairment (Clusters 18 - 21) showed an unexpected spread with significant numbers of people with a low level of need being in service compared to very low number of people in cluster 19-21 where there was a greater level of need. Teams explained that this had been a pragmatic decision to manage the administrative burden associated with keeping the clusters live due to the need to recluster on a 12-month basis rather than three-monthly. In addition changes to NICE Guidance and 'best practice' pathways was only just starting to be adopted meaning that the breakdown for clusters 18-21 will change. This will mean that a different approach requiring clinical judgement will be required to provide a costed model for these pathways.
   c) secondary diagnostic codes reviewed: a number of people identified with a secondary code of personality disorder. This identified a further 75 people with a diagnosis of personality disorder who also had a primary diagnosis of a different mental health condition. The numbers are broken down by CCG as below but not included within the overall data

Table showing the number of people identified with a secondary code of personality disorder	
CCG	**Number of people**
EC CCG	22
SC CCG	36
VR CCG	17
Total	**75**

   d) secondary diagnostic codes were reviewed for the subsections .5 and .7 which indicate the presence of psychotic symptoms but is NOT included within Public Health Prevalence Data. A further 36 people were identified with either a primary or secondary diagnostic code from the secondary care community mental health team caseloads

CCG	Primary Code	Secondary Code	Older Adults	Total

EC CCG	8	8	0	16
SC CCG	9	5	0	14
VR CCG	2	4	1	7
Total	**19**	**17**	**1**	**37**

5. Application of PH Prevalence data - Data for South, East and Vale Royal (with the exception of dementia) provided by Rory and Dementia and Wirral prevalence data obtained from POPPI and PANSI sites
6. Dementia prevalence rates only available on LA footprint, therefore divided into CCG on a pro-rata basis. Population figures used:
    a) Western Cheshire 260,000
    b) Vale Royal 109,000
    c) Eastern Cheshire 201,000
    d) South Cheshire 173,000
    e) Wirral 320,000

7. Percentage of people in contact with CWP within each of the super clusters calculated against the PH prevalence data for the corresponding disorder – sense check of data completed where there were significant numbers of people clustered but not diagnosed against specific clusters, e.g. clusters 18-21 for cognitive deficits and where appropriate this was added to the current activity numbers - current admin issue meant that diagnosis was included on clinic letter but hadn't been added to the service user's clinical record within the electronic record it so had therefore not been reported within the data download
8. Attempted to understand whether the proportion of people within CWP services was appropriate or whether there was information to suggest the recommended proportion (taking account of hidden need) in order to build/ cost a service with appropriate levels of capacity based upon Nice compliant pathways using a PbR Care Cluster approach. Methods used to understand appropriate proportions included:
    a) comparison with other areas within CWP where different services were commissioned to review differences in caseload composition eg Wirral where there is a mature Personality Disorder treatment team, however caseload analysis revealed little difference in the number of people with a personality disorder in contact with services across the areas. What will however be different is the service offer.
    b) review of Rightcare, JSNA and National Benchmarking data together with NICE Guidelines and Care Pathways from leading MH Providers (SLAM). None of these data sources provided suggestions on the recommended proportion of people with given disorders who should be in contact with services in any given year. NHSE provides some data re: incidence rates and for dementia and IAPT suggests the proportion of people that should have a diagnosis of dementia and the gap in diagnosis and the number of people with mild - moderate mental health conditions that should access IAPT treatments. It also suggests the prevalence for First Episode Psychosis.

What rapidly became evident was the lack of information regarding the proportion of suggested prevalence that would require service input in any one year. As a result it was necessary to survey clinical opinion.
Additional information provided by:
Projecting Adult Needs and Service Information System
National Benchmarking data


Mental Health Benchmarking.pdf

Dementia Diagnostic Rate Workbook
https://www.england.nhs.uk/publication/dementia-diagnosis-rate-workbook/
Public Health Data
Public Health Profiles

Table to show Public health prevalence data analysis mapped to current activity

Dementia Prevalence	**Incidence**	**Prevalence**		**Predicted need**
Eastern Cheshire	1249 + 204 = 1,453	3,301	44.02%	
South Cheshire	1042 + 316 = 1,358	2,812	48.23%	
Vale Royal	379 + 208 = 586	1,466	39.97%	
Western Cheshire		3,406		
Wirral	604 + 600 + 55 = 655	4,834	26.04%	
Psychosis Prevalence	**Incidence**	**Prevalence**		**Predicted need**
Eastern Cheshire	372	924	40.26%	
South Cheshire	331	797	41.53%	
Vale Royal	211	455	46.37%	
Wirral	458	1,478	30.99%	
Bipolar Prevalence	**Incidence**	**Prevalence**		**Predicted need**
Eastern Cheshire	208	3,357	6.20%	
South Cheshire	171	2,898	5.90%	
Vale Royal	75	1,656	4.53%	
Wirral		5,375		
Borderline Personality Disorder Prevalence	**Incidence**	**Prevalence**		**Predicted need**
Eastern Cheshire	55	4,086	1.35%	
South Cheshire	116	3,528	3.29%	
Vale Royal	29	2,016	1.44%	

Wirral	221	6,544	3.38%	
Generalised Anxiety Prevalence	**Incidence**	**Prevalence**		**Predicted need**
Eastern Cheshire	98	10,096	0.97%	
South Cheshire	141	8,717	1.62%	
Vale Royal	41	4,981	0.82%	
Wirral		16,167	0.00%	
Depressive Disorders Prevalence	**Incidence**	**Prevalence**		**Predicted need**
Eastern Cheshire	279	5,647	4.94%	
South Cheshire	296	4,875	6.07%	
Vale Royal	90	2,786	3.23%	
Wirral		9,042	0.00%	

Table to show Public health prevalence data analysis mapped to current activity

Disorder	CCG	Current Secondary Care Activity	Public Health Prevalence Data	%age
Dementia Prevalence data collected from POPPI	Eastern Cheshire CCG	1,453	3,301	44.02%
	South Cheshire CCG	1,358	2,812	48.23%
	Vale Royal CCG	586	1,466	39.97%
Psychosis	Eastern Cheshire CCG	372	924	40.26%
	South Cheshire CCG	331	797	41.53%
	Vale Royal CCG	211	455	46.37%
Bipolar Disorder	Eastern Cheshire CCG	208	3,357	6.20%
	South Cheshire CCG	171	2,898	5.90%
	Vale Royal CCG	75	1,656	4.53%
Personality Disorder	Eastern Cheshire CCG	55	4,086	1.35%
	South Cheshire CCG	116	3,528	3.29%
	Vale Royal CCG	29	2,016	1.44%
Anxiety Disorder secondary care activity only	Eastern Cheshire CCG	98	10,096	0.97%
	South Cheshire CCG	141	8,717	1.62%
	Vale Royal CCG	41	4,981	0.82%
Depressive	Eastern Cheshire	279	5,647	4.94%

Disorder secondary care activity only	CCG			
	South Cheshire CCG	296	4,875	6.07%
	Vale Royal CCG	90	2,786	3.23%

The 21 cluster groups enable care to be categorised in relation to patients' needs which can range from low level to complex. Professional judgement was used to estimate within each of the diagnostic groups what proportion of people would be in each category:

- **Cluster 1:** Common Mental Health Problems – low severity
- **Cluster 2:** Common Mental Health Problems – low severity with greater need
- **Cluster 3:** Non psychotic – moderate severity
- **Cluster 4:** Non psychotic - severe
- **Cluster 5:** Non psychotic - very severe
- **Cluster 6:** Non psychotic disorder of over-valued idea
- **Cluster 7:** Enduring non psychotic disorder – high disability
- **Cluster 8:** Non psychotic, chaotic and challenging disorders
- **Cluster 10:** First episode psychosis
- **Cluster 11:** Ongoing recurrent psychosis – low symptoms
- **Cluster 12:** Ongoing recurrent psychosis – high disability
- **Cluster 13:** Ongoing recurrent psychosis – high symptoms and disability
- **Cluster 14:** Psychotic crisis
- **Cluster 15:** Severe psychotic depression
- **Cluster 16:** Dual diagnosis
- **Cluster 17:** Psychosis and affective disorder – difficult to engage
- **Cluster 18:** Cognitive Impairment – Low need
- **Cluster 19:** Cognitive Impairment or Dementia Complicated -Moderate need
- **Cluster 20:** Cognitive Impairment or Dementia Complicated - High need
- **Cluster 21:** Cognitive Impairment or Dementia – High physical or engagement

Table to show needs analysis data mapped to level of care need									
	Dementia	**Psychosis**	**Bipolar Disorder**	**Personality Disorder**	**Anxiety Disorder**	**Depressive Disorder**	**Other**	**Total Number**	**Total %**
Cluster 1	2	0	1	2	8	7	13	33	0.5
Cluster 2	1	2	3	8	11	21	15	61	0.9
Cluster 3	5	4	11	29	70	112	69	300	4.2
Cluster 4	1	4	3	19	17	37	36	117	1.6
Cluster 5	1	0	2	4	6	12	8	33	0.5
Cluster 6	2	0	0	2	12	1	3	20	0.3
Cluster 7	1	4	5	55	69	176	95	405	5.7
Cluster 8	0	9	0	38	6	14	14	81	1.1
Cluster 10	3	187	11	2	4	27	39	273	3.8
Cluster 11	14	378	187	6	10	79	42	716	10.1
Cluster 12	10	355	78	5	9	49	33	539	7.6
Cluster 13	6	125	17	2	2	14	12	178	2.5
Cluster 14	0	15	7	0	0	0	2	24	0.3

Cluster 15	0	1	0	0	2	4	2	9	0.1
Cluster 16	0	5	0	1	0	1	7	14	0.2
Cluster 17	0	20	6	1	0	2	2	31	0.4
Cluster 18	1,693+520	9	2	1	10	22	10	2,267	31.8
Cluster 19	794+197	3	1	0	1	10	7	1,013	14.2
Cluster 20	32 + 4	2	2	0	1	0	3	44	0.6
Cluster 21	50 + 7	0	0	0	0	0	1	58	0.8
Null cluster	100	20	17	25	40	78	622	1,002	14.1
Total no.	3,443	1,143	353	200	278	666	1,035	7,118	100

Appendix 4

Final Scoring Options

1) Scoring Options Template (example)

2) Scoring Options Overview

Option 1: Do nothing: No enhancement of community care and no crisis care placements provided. No enhancement in Home treatment teams or dementia outreach developed. Retain all inpatient care (58 beds) on the Millbrook		
Description: In this option 58 beds are retained on the Millbrook Unit 44 for adults and 14 for older people. There would be no upgrading of the current facility and no enhancement of the community services or crisis care. ECT inpatient and day case would continue on the Millbrook site		
Benefit	**Pros**	**Cons**
Clinical safety and sustainability	Adequate inpatient capacity	Community teams unable to meet the needs of the local population with existing capacity and current service model Unable to provide a 24/7 response in the community for people experiencing crisis. Limited community response for people with complex needs. No onsite access to PICU resulting in service users not having timely access to the least restrictive environment.
Affordability		The cost of providing services from the Millbrook unit have been assessed by the provider as being £2,000,000 higher than that being recovered from the commissioners. Higher spend on inpatient compared to community with fewer people benefiting from inpatient care compared to community services. Higher levels of staff are required at a greater cost compared to other more fit for purpose mental health inpatient facilities. Net impact is system cost pressure of £2,000,000
Patient acceptability	No additional travelling for patients and carers	Lack of community support leads to unnecessary admissions and extended length of stay of up to 50% (local clinical snapshot audit). Shared bedrooms in Millbrook would continue to impact on individuals privacy and dignity. Users and carers have limited choice to the type of response to support them in a crisis.

Quality of care		Increased risk of breaching CQC requirements for mixed sex and single bedroom accommodation NICE guidance cannot be fully implemented within existing staff skill mix.
Strategic fit		The existing model of care is historical and not consistent with either national policy (five year forward view) or local integration plans as described in Connecting Care and Caring Together There is a lack of choice for crisis intervention and inadequate community capacity to support care closer to home

Option 2: Do minimum: No enhancement of community care and no crisis care placements provided. No enhancement in Home treatment teams or dementia outreach developed. Retain reduced inpatient care on Millbrook Unit and upgrade the facility. (52 beds)		
Description: In this option 58 beds are retained on the Millbrook Unit 44 for adults and 14 for older people. The unit would be upgraded to comply with CQC standards. There would be no enhancement of community or crisis services. ECT inpatient and day case would continue on the Millbrook site		
Benefit	**Pros**	**Cons**
Clinical safety and sustainability	Adequate inpatient capacity	Community teams unable to meet the needs of the local population with existing capacity and current service model Unable to provide a 24/7 response in the community for people experiencing crisis. Limited community response for people with complex needs. No onsite access to PICU resulting in service users not having timely access to the least restrictive environment. Refurbishment would result in a reduction in bed numbers without the enhancement of community services to offset the loss.
Affordability		The cost of providing services from the

		Millbrook unit have been assessed by the provider as being £2,000,000 higher than that being recovered from the commissioners. The capital cost of refurbishment is £14,000,000 paid at £560,800 per annum. Higher levels of staff are required at a greater cost compared to other more fit for purpose mental health inpatient facilities. Net impact would be system cost pressure of £2,500,000
Patient acceptability	No additional travelling for patients and carers Improved environment for service users	Lack of community support leads to unnecessary admissions and extended length of stay of up to 50% (local clinical snapshot audit) Users and carers have limited choice to the type of response to support them in a crisis.
Quality of care	Facility does comply with building guidance and the provision of single sex rooms with en-suite facilities	NICE guidance cannot be fully implemented within existing staff skill mix.
Strategic fit		The existing model of care is historical and not consistent with either national policy (five year forward view) or local integration plans as described in Connecting Care and Caring Together There is a lack of choice for crisis intervention and inadequate community capacity to support care closer to home

Option 3: Enhanced community and home treatment teams. Crisis care services established including up to 6 local short stay beds. Retain all inpatient care on the Millbrook unit (58 + circa 6 beds)

Description: In this option 58 beds are retained on the Millbrook Unit. This would mean 44 for adults and 14 for older people. Community mental health teams would deliver interventions to enable safe care and have the appropriate skill mix to do so community teams would be able to provide a timely response to the current level of demand. A new model of crisis care introduced which would see the home treatment team providing 24/7 care in conjunction with overnight placement support and day time crisis cafe.

Benefit	Pros	Cons
Clinical safety and sustainability	Adequate inpatient capacity Increased community support	No onsite access to PICU resulting in service users not having timely access to the least restrictive environment.

	leads to reduced admissions and length of stay of up to 50% (local clinical snapshot audit). Staffing levels within community services mapped to meet the current level of demand Able to provide a range of responses in the community for people experiencing crisis. Community response for people with complex needs.	
Affordability		The cost of providing services from the Millbrook unit have been assessed by the provider as being £2,000,000 higher than that being recovered from the commissioners. The predicted reduction in admissions is likely to lead to under use of bedstock by a minimum of 17%. The estimated cost of enhancing Community/Crisis services is £1,170,000 The Net Impact would be system cost pressure of £3,170,000
Patient acceptability	No additional travelling for patients and carers Users and carers will have access to a range of crisis responses.	
Quality of care		Increased risk of breaching CQC requirements for mixed sex and single bedroom accommodation
Strategic fit	The new model of care is partially consistent with both national policy (five year forward view) and local integration plans. There is increased choice for crisis intervention and community capacity to support care closer to home.	

Option 4a: Enhanced community and home treatment teams. Crisis care services established including up to 6 local short stay beds. Re-provide inpatient care from Millbrook to other facilities within current provider footprint with older people services at Lime Walk House Macclesfield, and adults functional services at Bowmere , Chester (47 + circa 6 beds)		
Description: In this option 22 beds would be provided at Lime Walk; 10 for older people with dementia and 12 for older or more physically vulnerable adults with functional illness. 22 beds would be provided at Bowmere and 3 at Wirral for adults. Central and East patients would be admitted to Bowmere. Rehabilitation services currently delivered at Lime Walk would be re-provided at the Soss Moss site in Nether Alderley. In patient ECT would be delivered at the specialist ward in Bowmere. Community mental health teams would deliver interventions to allow safe care and have the appropriate skill mix to do so. A new model of crisis care introduced which would see the home treatment team providing 24/7 care in conjunction with an increase in home treatment team, overnight placement support and day time crisis café.		
Benefit	**Pros**	**Cons**
Clinical safety and sustainability	Adequate inpatient capacity. Staffing levels within community services mapped to meet the current level of demand. Increased community support leads to reduced admissions and length of stay of up to 50% (local clinical snapshot audit) Able to provide a range of responses in the community for people experiencing crisis. Community response for people with complex needs.	
Affordability	Shift of resources to the community, with more people benefiting from community care compared to inpatient services The cost of expanding the community resource is offset by cash release from unnecessary inpatient costs	Ability to deliver interventions in line with NICE guidance will not be achievable for all mental health conditions, however services will be safe and effective. Re-provision of inpatient services would result in net financial impact of £670,000 remaining cost pressure to the system.
Patient acceptability	Improved environment for service users Timely alternatives to hospital	Additional travelling for some patients and carers.

	admission are available Length of stay are reduced with additional support offered in the community Users and carers will have access to appropriate crisis support 24/7	
Quality of care	Improved environment for service users within facilities that comply with HBN and CQC requirements.	
Strategic fit	The new model of care is consistent with both national policy (five year forward view) and local integration plans. There is increased choice for crisis intervention and community capacity to support care closer to home	

Option 4b: Enhanced community and home treatment teams. Crisis care services established including up to 6 local short stay beds. Re-provide inpatient care from Millbrook to other facilities within current provider footprint with older people services at Bowmere, Chester and adults functional services at Lime Walk House Macclesfield, (47 + circa 6 beds)		
Description: In this option 22 beds would be provided at Lime Walk for adults. 22 beds would be provided at Bowmere, 10 for older people with dementia and 12 for older or more physically vulnerable adults with functional illness. There will be 3 beds at Wirral for adults. Central and East patients would be admitted to Bowmere. Rehabilitation services currently delivered at Lime Walk would be re-provided at the Soss Moss site in Nether Alderley. In patient ECT would be delivered at the specialist ward in Bowmere. Community mental health teams would deliver interventions to allow safe care and have the appropriate skill mix to do so. A new model of crisis care introduced which would see the home treatment team providing 24/7 care in conjunction with an increase in home treatment team, overnight placement support and day time crisis café.		
Benefit	**Pros**	**Cons**
Clinical safety and sustainability	Adequate inpatient capacity. Staffing levels within community services mapped to meet the current level of demand.	

	Increased community support leads to reduced admissions and length of stay of up to 50% (local clinical snapshot audit) Able to provide a range of responses in the community for people experiencing crisis. Community response for people with complex needs.	
Affordability	Shift of resources to the community, with more people benefiting from community care compared to inpatient services The cost of expanding the community resource is offset by cash release from unnecessary inpatient costs	Ability to deliver interventions in line with NICE guidance will not be achievable for all mental health conditions, however services will be safe and effective. Net impact is as for Option 4a (£670,000 remaining system cost pressure).
Patient acceptability	Improved environment for service users Timely alternatives to hospital admission are available Length of stay are reduced with additional support offered in the community Users and carers will have access to appropriate crisis support 24/7	Additional travelling for some patients and carers. Previous engagement feedback indicated this would be more problematic for an older population.
Quality of care	Improved environment for service users within facilities that comply with HBN and CQC requirements.	
Strategic fit	The new model of care is consistent with both national policy (five year forward view) and local integration plans. There is increased choice for crisis intervention and community capacity to support care closer to home.	

Option 5: Enhanced community and crisis care services (circa 6 local beds) Re-provide adult inpatient care (25 beds) from Millbrook to other facilities within current provider footprint. Procure older peoples dementia services (10 beds) from the private sector Older peoples functional re (12 beds) at Lime Walk. Total 53 beds

Description: In this option 12 beds would be provided at Lime Walk for older adults and adults with functional mental health problems. 22 beds would be provided at Bowmere. 10 beds for older people with functional problems would be procured from the private sector and 3 beds at Wirral. Community mental health teams would deliver interventions to allow safe care and have the appropriate skill mix to do so. A new model of crisis care introduced which would see the home treatment team providing 24/7 care in conjunction with an increase in home treatment team, overnight placement support and day time crisis café. ECT services will be provided at the specialist unit in Bowmere.

Benefit	Pros	Cons
Clinical safety and sustainability	Increased community support and crisis services leads to reduced admissions and length of stay of up to 50% (local clinical snapshot audit) Staffing levels within community services mapped to meet the current level of demand. Able to provide a range of responses in the community for people experiencing crisis. Community response for people with complex needs.	Lack of capacity and capability within the care home market to support the model. High risk of increased acute hospital DTOC due to lack of capacity
Affordability	The cost of expanding the community resource is partially offset by cash release from unnecessary inpatient costs	Ability to deliver interventions in line with NICE guidance will not be achievable for all mental health conditions, however services will be safe and effective. Increased cost of private sector provision will negate value for money benefits when compared to other inpatient facilities. Net impact would be remaining system cost pressure of £1,450,000.
Patient acceptability	Improved environment for service users Timely alternatives to hospital admission are available Length of stay are reduced with additional support offered in the community	Additional travelling for patients and carers using adult services Unpredictable travel times for patients and carers of older peoples services

	Users and carers will have access to appropriate crisis support 24/7	
Quality of care	Improved environment for service users within facilities that comply with HBN and CQC requirements	Reduced continuity of care Risk of extended lengths of acute hospital stay due to none availability of private sector placement. Varied quality across the care home provider sector evidenced by CQC.
Strategic fit	The new model of care is consistent with both national policy (five year forward view) and local integration plans. There is increased choice for crisis intervention and community capacity to support care closer to home.	

Option 6: Enhance community and crisis care services (circa 6 local beds). Re-provide older peoples services to Lime Walk site in Macclesfield (22 beds) and utilise multiple NHS providers for adult inpatient (25 beds). Total 53 beds

Description: In this option12 beds would be provided at Lime Walk for older adults with functional problems and 10 for older people's services. In Patient services would be delivered by alternate providers in North Staffordshire and Stockport approx 25 beds. There is no additional capacity available in South Manchester. Community mental health teams would deliver interventions to allow safe care and have the appropriate skill mix to do so. A new model of crisis care introduced which would see the home treatment team providing 24/7 care in conjunction with an increase in home treatment team, overnight placement support and day time crisis café. ECT services will be provided at the specialist units in multiple providers.

Benefit	**Pros**	**Cons**
Clinical safety and sustainability	Inpatient capacity matched to predicted demand Increased community support and crisis services leads to reduced admissions and length of stay of up to 50% (local clinical snapshot audit). Staffing levels within community services mapped to meet the current level of demand.	Fragmented care and potential delays due to repatriation processes. Higher risk of avoidable harm occurring when multiple providers are involved in complex care packages and discharge planning. Level of complexity due to cross boundary working required with the local authority. Variable CQC rating across alternative providers.

	Able to provide a range of responses in the community for people experiencing crisis. Community response for people with complex needs.	
Affordability	The cost of expanding the community resource is partially offset by cash release from unnecessary inpatient costs	Ability to deliver interventions in line with NICE guidance will not be achievable for all mental health conditions, however services will be safe and effective. The cost of multiple contracts with other providers will result in increased costs for inpatient services. Loss of income to existing provider requiring further efficiencies to be made. Initial quotes from alternative providers demonstrate 50% increase on bed day rates. Net impact would be system cost pressure of £2,870,000.
Patient acceptability	Less travelling for some patients and carers. Timely alternatives to hospital admission are available Length of stay are reduced with additional support offered in the community Users and carers will have access to appropriate crisis support 24/7	Capacity constraints in alternative providers may render this option non-viable. (Please score option 6 and 7 as if they are viable) Patients in the catchment area for South Manchester are unable to access services in South Manchester.
Quality of care		Unable to guarantee improved environment for service users within facilities that comply with HBN and CQC requirements. Potential impact on continuity of care
Strategic fit	The new model of care is consistent with both national policy (five year forward view) and local integration plans. There is increased choice for crisis intervention and community capacity to support	

	care closer to home	

Option 7: Transfer some community, crisis care (6 local beds) and inpatient services (45 beds) to alternative providers closer to the users home. Re-provide older peoples services at Lime Walk site in Macclesfield. Total 53 beds.		
Description: In this option the entire care for patients would transfer to alternative providers including North Staffordshire and Stockport. In this option 12 beds would be provided at Lime Walk for older adults with dementia and 10 for older people's services.		
Benefit	**Pros**	**Cons**
Clinical safety and sustainability	For some patients: Inpatient capacity matched to predicted demand. For some patients: Increased community support and crisis services leads to reduced admissions and length of stay of up to 50% (local clinical snapshot audit). For some patients: Staffing levels within community services mapped to meet the current level of demand. For some patients: Able to provide a range of responses in the community for people experiencing crisis. For some patients: Community response for people with complex needs.	Variable CQC rating across alternative providers. Local service provisions for the remaining population may become non-viable due economies of scale.
Affordability		The cost of multiple contracts with other providers will result in increased costs for inpatient services. Loss of income to existing provider requiring further efficiencies to be made. Initial quotes from alternative providers demonstrate 50% increase on bed day rates. Net impact would be in the region of

		£1,700,000 without including consequences of unpicking services currently shared between commissioners which may increase costs further.
Patient acceptability	Improved environment for service users Timely alternatives to hospital admission are available Length of stay are reduced with additional support offered in the community Less travelling for some patients and carers Users and carers will have access to appropriate crisis support 24/7	Capacity constraints in alternative providers may render this option non-viable. (Please score option 6 and 7 as if they are viable) Patients in the catchment area for South Manchester are unable to access services in South Manchester.
Quality of care		Unable to guarantee improved environment for service users within facilities that comply with HBN and CQC requirements. Potential impact on continuity of care
Strategic fit	The new model of care is consistent with both national policy (five year forward view) and local integration plans. There is increased choice for crisis intervention and community capacity to support care closer to home	

Scoring Options for Adult Mental Health Redesign

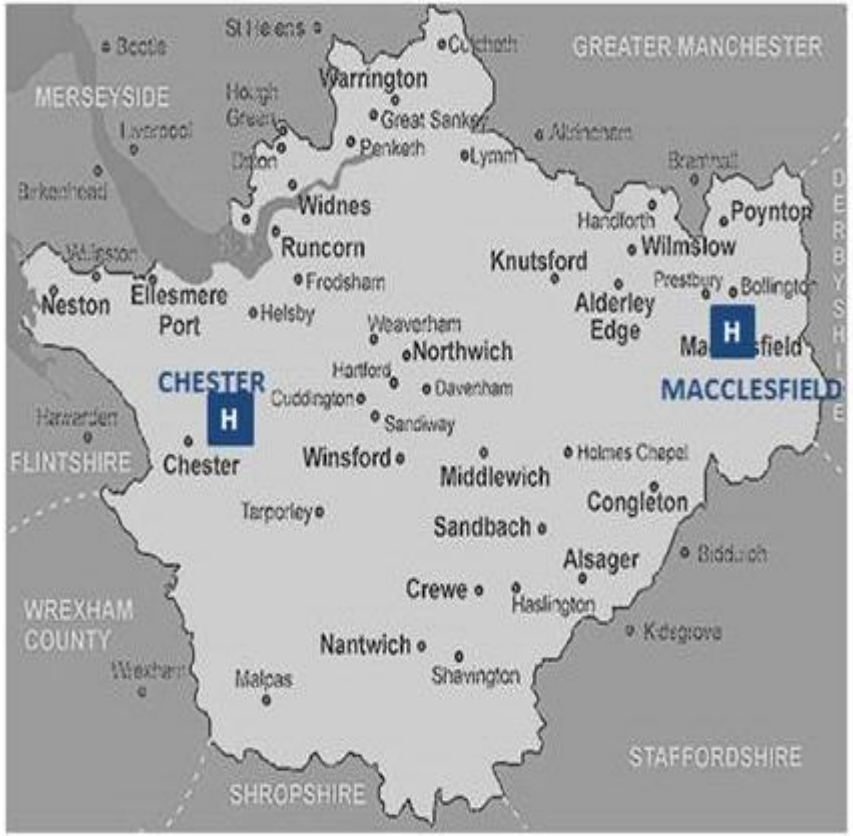
Option 1: Do nothing: No enhancement of community care and no crisis care placements provided. No enhancement in Home treatment teams or dementia outreach developed. Retain all inpatient care (58 beds) on the Millbrook

Grouping	Factor	Score					Your Score (user input) 1-5
		1	2	3	4	5	
Clinical safety and sustainability section							
Clinical safety and sustainability	Adequate staffing across community, crisis and inpatient relative to care needs (ratio).	Provides inadequate staffing across community, crisis and inpatient relative to care needs	Provides limited staffing needs across community, crisis and inpatient relative to care needs	Provides some of the staffing needs across community, crisis and inpatient relative to care needs	Provides majority of the staffing needs across community, crisis and inpatient relative to care needs	Provides adequate staffing across community, crisis and inpatient relative to care needs	
Clinical safety and sustainability	PICU provision within appropriate inpatient service	There is no PICU provision				PICU provision available	
Clinical safety and sustainability	Right staff skill mix	Provides inadequate staffing skill mix	Provides limited staffing skill mix	Provides some of the staffing skills mix	Provides majority of the staffing skills mix	Provides adequate staffing skills mix	
						Subtotal	**0**
Affordability							
Affordability	Value for money - what gives us the best return on investment	Cost more than 10% above CCG funding	Costs between 0.1% and 10% above CCG funding	Cost matches CCG funding	Cost between 0.1% and 5% less than CCG funding	Cost more than 5% less than CCG funding	1
						Subtotal	**1**
Patient/carer acceptability							
Patient/carer acceptability	To be completed as part of pre consultation engagement process	Little choice of services locally which are not personalised. Not 24/7 access	Limited choice of services locally, some personalised not 24/7 access	Some increase in range of services locally, some personalisation and cover extended hours	Provides a range of services locally which is mainly personalised and accessible 24/7	Provides a full range of services locally which is personalised and easily accessed 24/7	
						Subtotal	**0**
Quality of care							
Quality of care	Provides the right care in the right place at the right time	Care needs not met with inadequate access to services across limited facilities	Care needs often unmet with limited access to services across limited facilities	Care needs sometimes met with reasonable access to services in a small range of facilities	Care needs often met with with good access to services in a wide range of facilities	Care needs always met with with good access to services in a wide range of facilities	
						Subtotal	**0**
Strategic fit							
Strategic fit	National - Implementing Five Year Forward View for Mental Health	Major adverse contribution to national strategic plans	Some adverse contribution to national strategic plans	Moderate contribution to national strategic plans	Significant positive contribution to national strategic plans	Major positive contribution to national strategic plans	
Strategic fit	Local - CCG 5 Year Plan, CWP Strategic Plan 5 Year Plan	Major adverse contribution to local strategic plans	Some adverse contribution to local strategic plans	Moderate contribution to local strategic plans	Significant positive contribution to local strategic plans	Major positive contribution to local strategic plans	
						Subtotal	0
						GRAND TOTAL	**1**

Appendix 5

Travel Map and Analysis

Distance to Chester and Patient Numbers



Area	Town	Macclesfield	Chester	Difference in miles between Macc & Chester	Patients Admitted (-16%)
Eastern Cheshire	Bollington	5	46	-41	<10
Eastern Cheshire	Macclesfield	1	42	-41	66
Eastern Cheshire	Disley	11	49	-38	<10
Eastern Cheshire	Congleton	8	46	-38	22
Eastern Cheshire	Poynton	8	43	-35	<10
Eastern Cheshire	Alderley	6	40	-34	<10
Eastern Cheshire	Wilmslow	8	38	-30	13
Eastern Cheshire	Handforth	9	39	-30	<10
Eastern Cheshire	Chelford	7	37	-30	<10
Eastern Cheshire	Holmes Chapel	12	37	-25	<10
South Cheshire	Scholar Green	13	36	-23	<10
South Cheshire	Alsager	15	33	-18	<10
Eastern Cheshire	Knutsford	11	27	-16	13
South Cheshire	Sandbach	15	27	-12	19
Vale Royal	Northwich	18	27	-9	11
South Cheshire	Crewe	21	26	-5	60
South Cheshire	Middlewich	15	21	-6	<10
South Cheshire	Shavington	23	25	-2	<10
South Cheshire	Wistaston	23	23	0	<10
Vale Royal	Winsford	19	19	0	<10
South Cheshire	Audlem	31	31	0	<10
South Cheshire	Nantwich	26	22	4	<10
Vale Royal	Weaverham	23	17	6	<10
South Cheshire	Marbury	34	22	12	<10

<10 denotes between 0 – 9 patients admitted

Appendix 6

Workforce and Capacity Table

Community Mental Health Team

Community mental health services are embarking upon a wholescale transformative process. This will result in:

- A revised patient journey based upon new ways of working that will increase the time that staff spend providing direct patient care, through the introduction of new technologies such as digital dictation and through new job roles, skill-mix and team structures, enabling evidence-based clinical pathways to be implemented.
- The Care Programme Approach (CPA) will continue to be the framework in which mental health services are delivered. CPA is a national model of assessing, planning, implementing / delivering care and then evaluating that care or intervention
- New evidence-based treatment pathways will be available for service users to ensure that they benefit as quickly as possible and outcomes are maximised
- Services will provide a recovery-focused culture.
- Decisions around care and treatment will be made collaboratively with service users and their carers.
- Service users will be educated and supported where possible to self-manage their condition with clear plans for staying well, including at discharge.

Current Workforce	Current Capacity	Current Demand	Proposed Workforce	Proposed Capacity	Proposed Benefits
The Community Mental Health Teams currently operate on a Clinical Commissioning Group footprint The Community Mental Health Teams are multi-disciplinary and are comprised of a mix of medical staff, nurses, occupational therapists, psychological practitioners and support workers and work in partnership with social care staff. The clinical workforce currently represents **37.02 w.t.e**. Medical support and senior clinical leadership is provided by the Consultant Psychiatrists that cover inpatient care and community care.	Based upon the CMHT Policy Implementation Guide (PIG) suggests that the teams currently have the capacity to support **1,170** people with functional mental health difficulties at any time based upon: - Care Coordinators carrying an individual caseload of 35 people under enhanced care of the CPA; and - Consultant psychiatrists capacity should be based on 1 consultant per 50,000 adult population	Referrals to community mental health services have grown by **35%** since 2010. The teams collectively hold a caseload of 2,652 people. Some of these individuals no longer need the support of specialist mental health team Consultant Psychiatrists carry individual caseloads in excess of 300 people Teams lack the capacity to respond to more urgent pieces of work without cancelling other routine pieces of work. The current operational model, its systems and processes are not wholly	The proposed workforce is based upon a new way of working underpinned by a transformative approach to ensure a more recovery-focused and person-centred approach to treatment and support by the community mental health team. This process will require a fundamental change in the way that services currently operate and that staff have the right skills to support service users to recovery. This would include: - Releasing senior clinical staff [including medics] from routine tasks to ensure a more responsive and proactive and early intervention approach.	Capacity within the enhanced community mental health service for people with functional mental health difficulties would be positively affected as a result of: Teams aligning to the developing care communities reducing travel requirements Improved IT to support agile working Enhanced staffing levels. As a result of the proposed investment, it is envisaged that the team's capacity should result in the ability to support **1,800** people in line with CPA. Increasing the capacity by an additional 630 (current capacity 1,170)	Increased recovery focus resulting in people remaining within services for as long as is necessary Increased ability to achieve NICE recommended interventions through the delivery of clear treatment pathways Improved availability of senior clinical and medical support enabling a proactive/ early intervention approach. Investment would allow a service redesign that would: A central point of referral to and triage for community-based specialist mental health services allowing for improves response and better access Nominated care coordinators for

		recovery focused and as a result many people stay within services for lengthy periods of time despite them not requiring input from a specialist mental health team/service – the current average length of stay in service is in excess of two years.	- Increase the number of therapy staff that are available to plan and deliver specific elements of the treatment plan. With an additional investment of £700k across the three locality teams there would be a potential increase in staffing of up to of 30 wte clinical staff of B3 – B6 to include increased therapy staff. These figures are indicative based upon demand and capacity modelling and further refinements and developments will occur as we progress to a full business case	Whilst this may be a reduction in the current caseload figures, this reflects a move to actively managing caseloads, bring the capacity in line with demand, by moving to a recovery-focused and goal orientated treatment packages of treatment and support This will enable a focus on people with severe mental illness who require active treatment from a specialist mental health team	both standard and enhanced care in accordance with CPA, to assess and coproduce a treatment plan that reflects NICE recommended interventions. The introduction of wellbeing hubs that would provide increased support people's physical health monitoring in addition to delivering specific pharmacological interventions resulting in improved capacity and capability to monitor the physical health and wellbeing of people with severe mental health needs

Dementia Outreach

Development of a dementia outreach service will support:

- A more joined up approach to the care and treatment of people with dementia by primary care, social care and community mental health services.
- Assessment, diagnosis and initiation of treatment where clinically indicated for people with memory difficulties will be quicker
- A joined up approach to monitoring the impact of memory drugs would see this undertaken as part of the annual physical health review completed by Primary Care services for people who have mild cognitive impairment and low level needs.
- Reduce the need for hospital admissions
- Reduce inappropriate admissions
- Reduce the number of emergency readmissions

As a result, people with more complex and challenging presentations will be seen more quickly with increased support and advice available to the individual, their family and/ or carers over an extended week. Consequently more people will be supported to remain within the usual place of residence – whether that is their own home or a residential/ nursing care placement

Current Workforce	Current Capacity	Current Demand	Proposed Workforce	Proposed Capacity	Proposed Benefits

The Older Peoples Community Mental Health Team currently supports individuals with complex and challenging presentations. However this service is limited in its ability to respond to crisis situations, provide intensive home based support and is limited to Monday to Friday cover. Currently there is a limited resource specifically aligned to support people in nursing homes who present with challenging behaviours. This currently equates to **4.5 w.t.e**. B6 nurses across Central and East footprint and dedicated medical input in only the South Cheshire CCG footprint	The current care home service links with all nursing and residential care homes across South Cheshire, Vale Royal and Eastern Cheshire resulting in them completing over **2,500 contacts** in the last 12 months, with each practitioner seeing an average of 12 service users a week. As this service will be a new development baseline data is not currently available	There is currently no available data regarding the number of requests made to specifically support people reaching a crisis as a result of dementia however benchmarking data reflects that emergency admissions to hospital for people with a diagnosis of dementia are higher than the national average with admission rates in excess of 2,500 per 100,000 population. We also know that current demand outstrips the available capacity due to anecdotal evidence suggesting that a number of requests for support are currently being managed via the wider older peoples'/ memory team,	The proposed service would see the development of a 7-day, extended hours, multi-disciplinary/ multi-agency team that crosses between primary and secondary care services. Bringing together geriatricians, physiotherapy and 'falls' advisors as well mental health staff experienced in managing challenging presentations associated with dementia. The initial phase would see an increase in workforce of 2 wte Although reflective of work that is currently underway as part of the 'frailty' work, 'Home First' and 'Primary Care Home' developments that form part of the wider health and social care system transformations of '*Caring Together*' and '*Connecting Care*', this development seeks to consolidate these various schemes with mental health as an intrinsic factor. Consequently further work outside of the remit of this redesign will need to be undertaken with health and social care partners to develop the overall scope and	The resource initially identified would support the development of '*proof of concept*' for the service, whilst allowing for flexibility to adapt to emerging models based upon demand Up to an additional 12 people could be supported to stay at home per week	Increased ability for people to maintain their usual care arrangements and to remain in their usual place of residence. Increased confidence in the ability of carers [both formal and informal] to support people with dementia. Enhanced hours of support. Reduction in the number of attendances at A+E and admissions to hospital. Greater integration with primary care services to ensure seamless support.

			vision for the service It is proposed that the initial phase would be to redesign the current older adult/ memory workforce to focus upon more complex rather than routine work would maximise the resource available within the older people's teams and then aligning with the *Primary Care Home* models to focus upon supporting people with dementia whose usual care package is at risk. In addition, a project manager (0.5wt) for a twelve-month period would enable the identification of all projects currently underway together with opportunities for these to be integrated to maximise their impact whilst identifying gaps requiring future investment.		

Home Treatment Team

An enhanced home treatment team would provide a range of offers to people who are experiencing a mental health crisis that include:

- Enhanced resource within the Home Treatment Team will ensure their ability to support people at home 24/7
- A single phone number will be available 24/7 for people who are experiencing a crisis in their mental health.
- The provision of crisis beds and a crisis café will provide an appropriate alternative for those people who require a period of increased support away from home but do not need to be admitted to an acute mental health unit.

As a result there will be greater choice about the range of support available when experiencing a mental health crisis and fewer people will require admission to a specialist acute mental health bed for support and treatment.

Current Workforce	Current Capacity	Current Demand	Proposed Workforce	Proposed Capacity	Proposed Benefits

The Home Treatment Teams currently operate on a Local Authority footprint with the service for Vale Royal based alongside that for Western Cheshire and is based at Chester. The team covering South and Eastern Cheshire operates from a central base in Congleton. The Home Treatment Team is currently comprised of a limited multi-disciplinary team. The team is primarily made up of mental health nurses at B5 and B6 together with some community support workers at B3. The clinical workforce [excluding medical staff] currently represents **27.31 w.t.e**. Medical support and senior leadership is provided by the Consultant Psychiatrists that sit within the acute care pathway and work intro the inpatient unit.	The team's capacity is impacted upon by a number of variables – the distance from base, the number of people required to visit, the number of assessments required, etc. as such it is difficult to establish a clear capacity for the team The Mental Health Policy Implementation Guide (PIG) suggests that a Home Treatment Team covering the population of South Cheshire, Vale Royal and Eastern Cheshire should have a caseload of approximately 50-60 service users at any one time, allowing for the geography. The current capacity meets **900-950** episodes of care per year which on average is a caseload of 20.	The Home Treatment team receives in excess of **900** referrals a year for people resident in South Cheshire, Vale Royal and Eastern Cheshire. Referrals are for a number of reasons including: All admissions to the inpatient unit must go via the Home Treatment Team Gatekeeping requests to assess whether admission to hospital admission is required or whether care could be provided safely at home A period of home treatment to avoid the need for hospital admission; or To facilitate early discharge due to the degree of risk reducing to a level that can be safely managed within the community. As such these episodes of care ranged from a single contact to contact over several weeks	Through a redesign of Home Treatment services, it is proposed to bring together the resources for South Cheshire, It is proposed that approximately £500,000 will be allocated to crisis support following the redesign, this would support the following: Enhance current Home Treatment Team by 8 additional staff to offer a 24/7 service, this will include nursing, support staff and therapy staff Crisis Café supported by the Voluntary and Third Sector with support from the Home Treatment and Community Mental Health teams Up to 6 Crisis / Emergency Respite Beds supported by the Third Sector with around the clock support from the Home Treatment Team on an in-reach basis. These figures are indicative based upon demand and capacity modelling and further refinements and developments will occur as we progress to a	Capacity within the enhanced service would be positively affected as a result of: Locality based teams reducing travel Improved IT to support agile working Enhanced staffing levels. As a result it is envisaged that the team's capacity should double resulting in up to 1,900 contacts per year Based on the increased number of staff and national workforce recommendations the team would have a caseload of up to 50 people	Creation of additional 'crisis/ emergency respite' beds as an alternative to hospital admission following a crisis in their mental health. Creation of a crisis café for people who require additional support due to a mental health crisis. Reduced time spent travelling due to creation of small locality based teams that are centrally coordinated resulting in increased clinical contact time/ capacity. Creation of a 24 hour service with the capacity to visit people at home outside of current hours (09:00 – 21:00). Creation of an 'out of hours' telephone line for people who experience a mental health crisis. Increased choice regarding appropriate alternatives to hospital admission. Reduced admission to mental health unit and reduced attendance at A+E. Increased ability to achieve NICE recommended treatment for disorders. A service that provides the

			full business case		same level of response 365 days a year. Meets the requirements of the Crisis Care Concordat and move to achieving the requirements of the 5 Year Forward View for Mental Health

Inpatient services

Improvements to inpatient services would result in:

- Increased space available and greater attention to privacy and dignity, for example, the elimination of shared bedrooms and the introduction of en-suite facilities.
- Adopting new roles including Advanced Practitioners to enhance senior clinical leadership
- Introducing nurse associates to support the qualified nurse role
- Introduction of psychological therapists to ensure the delivery of NICE recommended interventions

Current Workforce	Current Capacity	Current Demand	Proposed Workforce	Proposed Capacity	Proposed Benefits
Inpatient services for adults and older people are provided in three inpatient units which are based in Macclesfield, Chester and Wirral. The quality of physical provision within each of these units varies due to the differing amounts of space available resulting in the requirement for higher levels of staff within Millbrook than within the other units to ensure patient privacy, dignity and safety is maintained. The current workforce model for inpatient care is based upon traditional roles and pay structures. The current resource does not allow for the recruitment of psychological therapists	There are currently a total of **167** beds across the three units (Bowmere, Spingview and Millbrook): **36** beds for dementia **131** beds for functional mental illness. Millbrook currently has **58** beds: **14** beds for dementia **44** beds for functional mental illness. With a current workforce of 122.08 w.t.e including clinical and clerical staff	Whilst demand is high, benchmarking data shows that both admission rates are below the national average and that bed occupancy and lengths of stay are in line with the national average.	Whilst the final workforce profile will depend upon the options developed within the Consultation paper, however using the National Safe Staffing levels under option 4a and 4b there would be the following staff: 4a Older People = 36.52 w.t.e. comprised of clinical and clerical staff between B3 and B7 4b Adults = 31.75 w.t.e. comprised of clinical and clerical staff between B3 and	Whilst the final capacity will depend upon the options developed within the Consultation paper, the models developed may result in an overall reduction of 5 beds with: **22** beds being provided in Macclesfield; **22** additional beds being provided in Bowmere, Chester; **3** additional beds being provided in Springview, Wirral; and **6** newly commissioned crisis beds	Improved physical environment resulting in: - Improved patient and carer experience and satisfaction - Improved compliance with CQC standards regarding privacy and dignity Enhanced senior clinical leadership due to the introduction of new, enhanced roles and new ways of working. Introduction of psychological therapist resulting in increased ability to deliver NICE recommended interventions. Improved flow with shorter periods of admission as a larger range of community services would be on offer Reduced reliance on inpatient

<table>
<tr>
<td>leaving gaps in the ability to deliver NICE compliant interventions.
Inpatient care is led by Consultant Psychiatrists who traditionally would have been supported by junior doctors. This is becoming increasingly difficult as a result of the national decline in doctors filling these posts.
In order to providing the staffing for the Millbrook unit in its current format that meets the 2015 National Safer Staffing requirements there is currently a cost pressure of £800,000.</td>
<td>between B3 and B7<table><tr><td>B7</td><td>4.4</td></tr><tr><td>B6</td><td>11.96</td></tr><tr><td>B5</td><td>49.51</td></tr><tr><td>B4</td><td>3</td></tr><tr><td>B3</td><td>53.21</td></tr></table></td>
<td></td>
<td>B8a

Bowmere = 31.75 w.t.e. comprised of clinical and clerical staff between B3 and B8a

Springview – an increase of 3.0 wte clnical staff between B3 and B5</td>
<td></td>
<td>provision as access to a larger range of community services will be available</td>
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Appendix 7

Finance Table

Table XX: Financial Impact of Each Option								
	Option 1	**Option 2**	**Option 3**	**Option 4a**	**Option 4b**	**Option 5**	**Option 6**	**Option 7**
Brief Description	Do Nothing	Do minimum: upgrade Millbrook, no enhanced community/crisis offer	Enhance Community/Crisis Offer. Maintain Inpatients "as is".	Enhanced community and crisis care service and re-provide inpatient care from Millbrook to other facilities within current provider footprint (older people Macclesfield site, adults Bowmere)	Expand community and crisis care services and relocate all inpatient care from Millbrook to other facilities within current provider footprint (Adults Macclesfield site, Older people Bowmere	Enhance Community/Crisis Offer. relocate inpatients. 12 beds move to Lime Walk. 22 beds move to Bowmere and 3 on the Wirral and 10 from Private Sector	Enhance Community/Crisis Offer. Older People move to Lime Walk 10 beds and 12 for Adults with other 25 provided by other NHS Providers	Older People move to Lime Walk, other inpatients across alternative NHS beds, re-contract Community/Crisis offer with neighbouring NHS Trusts.
Revenue Costs £000								
Baseline Cost - Inpatient Care	6,134	6,134	6,134	6,134	6,134	6,134	6,134	6,134
Baseline Cost - Community and Crisis Care	10,714	10,714	10,714	10,714	10,714	10,714	10,714	10,714
Annual charge for Millbrook improvements	0	560	0	0		0	0	0
Additional Cost of Enhanced Community and Crisis Care	0	0	1,170	1,170	1,170	1,170	1,170	1,170
Change in Cost for revised inpatient provision	0	0	0	(2,500)	(2,500)	(446)	2,072	2,072
Total Revenue Cost In-scope Services	**16,848**	**17,408**	**18,018**	**15,518**	**15,518**	**17,572**	**20,090**	**20,090**
Commissioner Income for Adult MH	14,848	14,848	14,848	14,848	14,848	14,848	14,848	14,848
Cost Pressure Adult MH	**(2,000)**	**(2,560)**	**(3,170)**	**(670)**	**(670)**	**(2,724)**	**(5,242)**	**(5,242)**
Total Revenue Cost All CWP Services	**39,806**	**40,366**	**40,976**	**38,476**	**38,476**	**40,530**	**43,048**	**43,048**
Total Contract Income from Commissioners	37,306	37,306	37,306	37,306	37,306	37,306	37,306	37,306
System Cost Pressure (Total Contract)	**(2,500)**	**(3,060)**	**(3,670)**	**(1,170)**	**(1,170)**	**(3,224)**	**(5,742)**	**(5,742)**
Capital Costs								
Cost of Millbrook Improvements	0	14,000	0	0	0	0	0	0
Total Capital Cost	**0**	**14,000**	**0**	**0**	**0**	**0**	**0**	**0**

Supporting Documents;

1. Equality Impact Assessment 4a
2. Equality Impact Assessment 4b
3. Quality Impact Assessment 4a
4. Quality Impact Assessment 4b
5. Privacy Impact Assessment.

MIDLANDS AND LANCASHIRE COMMISSIONING SUPPORT UNIT

Equality Impact and Risk Assessment Stage 2

Equality Impact and Risk Assessment

Title

Equality & Inclusion Team, Corporate Affairs
For enquiries, support or further information contact
Email: equality.inclusion@nhs.net

EQUALITY IMPACT AND RISK ASSESSMENT TOOL

STAGE 2

ALL SECTIONS – MUST BE COMPLETED

SECTION 1 - DETAILS OF PROJECT

Organisation: Eastern Cheshire CCG

Assessment Lead: Mandie Graham / Marie Ward

Directorate/Team responsible for the assessment: Option 4a: Adult and Older Peoples Mental Health Redesign Project Team

Responsible Director/CCG Board Member for the assessment : Jacki Wilkes

Who else will be involved in undertaking the assessment? Marie Ward, Suzanne Edwards, Jamaila Tausif

Date of commencing the assessment: 13/10/17

Date for completing the assessment: 09/11/17

SECTION 2 - EQUALITY IMPACT ASSESSMENT

Please tick which group(s) this project will or may impact upon?	Yes	No	Indirectly
Patients, service users	☑		
Carers or family	☑		
General Public		☑	
Staff	☑		
Partner organisations	☑		

Background of the project being assessed:

The NHS in Eastern and Central Cheshire are working with users of the service, local mental health provider Cheshire and Wirral Partnership and the local council to review and redesign secondary care adult and older peoples mental health services for people with a severe and enduring mental health need. Secondary care services is the term used to differentiate them from primary mental health services such as GP only care and universal psychological therapies (IAPT) Secondary services includes specialised community support, crisis response and inpatient care which is provided mainly on The Millbrook unit in Macclesfield. The project aims to improve clinical and health and well-being outcomes for service users through a new model of care and redesigned service delivery arrangements to support early intervention and prevention and reduce overall reliance on hospital services

What are the aims and objectives of the project being assessed?

Option 4a: Enhanced community and crisis care service and re-provide inpatient care from Millbrook to other facilities within current provider footprint (older people Macclesfield site, adults Bowmere)

Description: In this option 22 beds would be provided at Lime Walk; 10 for older people with dementia and 12 for older or more physically vulnerable adults with functional illness. 22 beds would be provided at Bowmere and 3 at Wirral for adults. Central and East patients would be admitted to Bowmere. 6 beds will be available locally

to support short stay care for people in crisis. . Rehabilitation services currently delivered at Lime Walk would be re-provided at the Soss Moss site in Nether Alderley. In patient ECT would be delivered at the specialist ward in Bowmere. Community mental health teams would deliver interventions to allow safe care and have the appropriate skill mix to do so. A new model of crisis care introduced which would see the home treatment team providing 24/7 care in conjunction with an increase in home treatment team, overnight placement support and day time crisis café

Services currently provided in relation to the project:

Community care is provided by Community Mental health Teams (CMHTs) based in Macclesfield for Eastern Cheshire residents and Crewe for Vale Royal and South Cheshire residents. Home Treatment Teams provide access to crisis care and are the gatekeepers to inpatient services. They will also provide in reach services for crisis care. In this option the service would be extended to cover 24/7. In addition a dementia outreach service would provide intensive support to people at home, thereby preventing unnecessary admissions to hospital

Community mental health teams are comprised of a mix of community psychiatric nurses, allied professionals and medical staff provided by CWP whilst Local Authorities provide social work input to these teams: Cheshire East Council for Eastern Cheshire and South Cheshire teams and Cheshire West and Chester to the Vale Royal teams. In patient facilities are provided at both Millbrook in Macclesfield and Bowmere in Chester.

Which equality protected groups (age, disability, sex, sexual orientation, gender reassignment, race, religion and belief, pregnancy and maternity, marriage and civil partnership) and other employees/staff networks do you intend to involve in the equality impact assessment?

Please bring forward any issues highlighted in the Stage 1 screening

In this option it is proposed that 22 beds would be provided at Lime Walk; 10 for older people with dementia and 12 for older or more physically vulnerable adults with functional illness. 22 beds would be provided at Bowmere and 3 at Wirral for adults. Central and East patients would be admitted to Bowmere. Rehabilitation services currently delivered at Lime Walk would be re-provided at the Soss Moss site in Nether Alderley. In patient ECT would continue to be delivered at the specialist ward in Bowmere. Community mental health teams would deliver interventions to allow safe care and have the appropriate skill mix to do so. A new model of crisis care introduced which would see the home treatment team providing 24/7 care in conjunction with an increase in home treatment team, overnight placement support and day time crisis café

In response to the growing body of evidence that demonstrates improved outcomes for people where there are adequate community services and rapid response to support people in crisis. (Kings Fund 2017, FYFV 2016) we are planning to make changes to the way in which services are commissioned and delivered for our population.

Locally developed transformation plans describe a programme of co-design across the health and social care economy where health and care commissioners and providers respond to patient needs and work together to redesign care services. They represent a system wide commitment to implementing the changes required to deliver a care system that is fit for the 21st century's population needs and is entirely consistent with the national vision for future mental health services described in the 5YFV and is the framework we have used for our needs analysis and workforce planning

In early stages of implementation, the aim is to achieve a responsive, community focussed, personalised care system that is wrapped around the empowered individual. It enables professionals to fully utilise their skills in working together to target the support and care to people most in need.

In taking transformation plans forward for people with SMI an improved approach to care has been created by local clinicians and patients. We have segmented the population into groups according to their risk of needing care so that we can develop services to meet their needs and better target services where they have the most impact. We believe that we will be able to dramatically shift the over reliance on reactive, acute hospital care to proactive care closer to home with improved patient experience and outcomes.

Based on the above following sections will consider the impact of this option against the Protected Characteristics.

1. **Gender**

The 2011 census data shows that in East Cheshire approximately 51% of the population are female and 49% are male.

Nationally, when looking at the sex distribution for people who have a severe mental illness, overall rates do not differ significantly between male and female. This is for conditions such as psychotic disorders, bipolar effective disorder and personality disorder.

The table below highlights the admissions to Millbrook, broken down by gender. Slightly more females were admitted between 1st April 2016 to 31st March 2017.

	Female	% Female	Male	% Male	Total Patients
Adelphi Ward - open age inpatient mental health ward caring for older people in East Cheshire.	222	69.16%	99	30.84%	321
Bollin Ward - open age inpatient mental health ward caring for young adults in East Cheshire	217	48.33%	232	51.67%	449
Croft Ward - 14 bed inpatient ward providing specialist treatment for people with dementia in East Cheshire	39	57.35%	29	42.65%	68
Overall	**478**	**57.04%**	**360**	**42.96%**	**838**

It is considered that all genders will be impacted upon as a result of the changes.

Impact of service reconfiguration on Gender as a Protected Characteristics.

Option 4a

All genders will be adversely impacted by this option. All genders will receive their care in the main in Bowmere, Chester. All genders over the age of 64 and/or with greater physical health needs will in the main receive their care in Lime Walk House. Both male and female within this option will be cared for in single, ensuite rooms in buildings that meet the national standards.

Enhanced community services will be provided closer to home and support will be offered 24/7 for those experiencing a crisis. For those who are unable to attend community based clinics, practitioners will be able to

visit at home or venue of choice to provide the appropriate support, therefore negating the need for additional travel. Community provision will remain in Central and East Cheshire. This option is expected to improve service user experience, and provide improved quality of care through improved access to community based services.

Potential Mitigations for option 4a

The relocation of some inpatient services to Bowmere may have an adverse impact on all genders. For all service users requiring an admission to Bowmere CWP will ***continue*** to support their transfer via a mental health practitioner or ambulance.

CWP, CCG and Local Authority would need to ensure that travel options are well published, which would include travelling with NHS patient transport services. Individual difficulties would be reviewed on a case by case basis and every attempt made to support family and carers and patients to remain connected through in patient stay, through flexible visiting, use of technology and local in patient crisis beds.

2. Pregnancy and maternity

In 2009 the general fertility rates for England and Wales was 63.6 (per live 1,000 births), in East Cheshire this rate is 59.8, and therefore slightly lower than the national rate, but is more or less equal to the birth rate in the North West.

Perinatal services are specialist mental health services that support women and their families during pregnancy and following birth.

Impact of service reconfiguration on Pregnancy and Maternity as a Protected Characteristics

Option 4a

There is no proposed change in the provision of Specialist community perinatal services and these are provided via CWP and are across Cheshire and Merseyside. Women in the perinatal period who require admission to a specialist mother and baby unit will continue to access regional units. This is not provided at Millbrook or any of the other inpatient units within CWP.

Women in the perinatal period who wish to remain at home during periods of crisis will be able to receive enhanced community support via the crisis service, therefore increasing the likelihood of the mother being able to stay at home. Access to mother and baby units can take a number of days to secure due to the limited numbers, and therefore at times of need they will require admission to an acute inpatient unit. Bowmere has single on suite rooms, family visiting areas that can be utilised to support mother and baby during periods of visiting. The community specialist perinatal team will ensure that the service user maintains contact with their local midwifery services and arrangements will be put in place for this to continue if admitted to Bowmere. It is believed that this option will improve service user experience and supports person centred care.

Potential Mitigations to option 4a

The relocation of some inpatient services to Bowmere will have no adverse impact on women during the perinatal period. For all service users requiring an admission to Bowmere CWP will continue to support their transfer via a mental health practitioner, ambulance or other means based on individual choice.

CWP, CCG and Local Authority would need to ensure that travel options are well published, which would include travelling with NHS patient transport services. The use of technology and flexible visiting hours to

maintain contact with family and friends will be explored.

3. Impact of service reconfiguration on Age as a Protected Characteristic

Since the 2001 census there has been a 26% increase in the number of residents 65 and older, which is a larger increase than in the North West (15%) and England and Wales (20%). There has been a 35% increase in the number of residents 85 years and older, which again is a larger increase than the North West (205) and England and Wales (24%). There has been a decrease in the number of children by 4% and those of approximate working age have increased by 4% in line with trends in the North West and England and Wales. There are fewer people in all age groups under 40 than England and Wales, and the median age of residents in 2001 was 40.6 years and by 2011 this has increased to 43.6 years.

Population of East Cheshire by Age

Age All categories: Age - 370,127	Number	% of population
Under 16	65,753	17.9%
16-29	55,282	14.90%
29-64	177,720	48%
65+	71,372	19.30%

Admissions to Millbrook by age (2016/2017)

	Aged 16-29	% 16-29	Aged 30-64	% 30-64	Aged 65 +	% 65+	Total Patients
Adelphi Ward	37	11.53%	163	50.78%	121	37.69 %	321
Bollin Ward	116	25.84%	322	71.71%	11	2.45%	449
Croft Ward	Less than 10	0.00%	Less than 10	10.29%	61	89.71 %	68
Overall	**153**	**18.26%**	**492**	**58.71%**	**193**	**23.03 %**	**838**

Option 4a

Enhanced community services will be provided closer to home and support will be offered 24/7 for those experiencing a crisis. For those who are unable to attend community based clinics, practitioners will be able to visit at home or venue of choice to provide the appropriate support, therefore negating the need for additional travel. Community provision will remain in Central and East Cheshire, and will be enhanced. This option is expected to improve service user experience, and provide improved quality of care through improved access to community based services.

For older adults age 65+ requiring inpatient care, they will experience a positive impact as a result of this option as most service users in this group will receive their care at Limewalk House. Those who require PICU, ECT or specialist intervention for complex presentations will receive their care at Bowmere.

Adults of working age will receive the same enhanced community provision however this group will be admitted to Bowmere if they require inpatient care, and therefore maybe adversely impacted on as a result of this option, as a result of extra travel, but would have a positive impact from the enhanced community care. This cohort during 2016/17 accounted for 0.016% of the total population of Central and Eastern Cheshire.

Potential Mitigations to option 4a

Access to community based crisis services 24/7 will reduce the need for admission to an inpatient unit, and will reduce length of stay by facilitating early discharge

The relocation of some inpatient services to Bowmere may have an adverse impact on adults of working age. For all service users requiring an admission to Bowmere CWP will continue to support their transfer via a mental health practitioner or ambulance.

4. **Impact of service reconfiguration on Disability as a Protected Characteristic**

Disability All households - 159,441	Number	% of population
One person in household with a long-term health problem or disability: With dependent children	6,045	3.8%
One person in household with a long-term health problem or disability: No dependent children	33,628	21.1%

Option 4a

Enhanced community services will be provided closer to home and support will be offered 24/7 for those experiencing a crisis. For those who are unable to attend community based clinics, practitioners will be able to visit at home or venue of choice to provide the appropriate support, therefore negating the need for additional travel. Community provision will remain in Central and East Cheshire. This option is expected to improve service user experience, and provide better quality of care through improved access to community based services.

For all service users requiring an admission to Bowmere CWP will continue to support their transfer via a mental health practitioner or ambulance.

Potential Mitigations for Option 4a

Ensure that services and locations where community services will be offered from are EQUALITY ACT 2010 compliant

Improve data quality of services for users with a disability to inform further mitigations and equality impact assessments.

Ensure that reasonable adjustments are made, and facilities are suitable.

Ensure that information on the service reconfiguration specially targets disabled groups

Provide clear information in alternative formats and with alterative content targeted at people with different

abilities for wide dissemination (Accessible Information Standard)

Ensuring compliance with safeguarding regulations

Provide staff training on how to actively support members of this community

CWP, CCG and Local Authority would need to ensure that travel options are well published, which would include travelling with NHS patient transport services.

5. Impact of service reconfiguration on Race as a Protected Characteristic

Breakdown from 2011 Census

Ethnicity All categories: Ethnic group - 370,127	Number	% of population
White	357,627	96.7%
Black/African/Caribbean/Black British	1,402	0.4%
Asian/Asian British:Chinese	2,553	0.7%
Asian/Asian British:Bangledeshi/Indian,Pakistani	3,507	0.9%
Mixed/Multiple Ethnic Groups	3,873	1.0%
Gypsy/Traveller/Irish Traveller	313	0.1%
Other Ethnic Group	852	0.2%

Breakdown of Ethnicity for Individuals accessing all services in Central and East Cheshire

Ethnicity	Total
Asian Or Asian British, Bangladeshi	Less than 10
Asian Or Asian British, Indian	15
Asian Or Asian British, Other	28
Asian Or Asian British, Pakistani	10
Black Or Black British, African	18
Black Or Black British, British Caribbean	27
Black Or Black British, Other	Less than 10
Mixed, Other	20
Mixed, White & Asian	13
Mixed, White & Black African	Less than 10
Mixed, White & Black Caribbean	16
Not Stated	41
Other Ethnic Groups, Chinese	Less than 10

Other Ethnic Groups, Other	18
Unknown	929
White, British	9359
White, Irish	55
White, Other	133
Total	**10704**

Option 4a

Enhanced community services will be provided closer to home and support will be offered 24/7 for those experiencing a crisis. For those who are unable to attend community based clinics, practitioners will be able to visit at home or venue of choice to provide the appropriate support, therefore negating the need for additional travel. Community provision will remain in Central and East Cheshire. This option is expected to improve service user experience, and provide better quality of care through improved access to community based services and crisis beds.

For all service users requiring an admission to Bowmere CWP will continue to support their transfer via a mental health practitioner or ambulance.

Potential mitigations for option 4a

The mitigations would be:

- Providing information in alternative languages;
- Ensuring all staff have appropriate training in cultural diversity
- Ensuring effective and timely interpretation services are made available and staff understand the requirements and system for providing this
- All CWP staff work within the Equality, Diversity and Human Rights policy, and regardless of the outcome of the consultation everyone will be offered a person centred approach.
- All CWP inpatient units provide access to multi-faith rooms, facilitate support from faith leaders and promote and support individuals to continue to access faith based community support whilst receiving inpatient care.

6. Impact of service reconfiguration on Gender reassignment as a Protected Characteristic

Currently CWP do not hold any information on the number of people who have undergone gender reassignment.

At present there is no official estimate of the transgender population. The England/Wales and Scottish Census have not asked if people identify as trans and did not ask the question in the 2011 census. In a Home Office funded study estimated numbers of transgender people in the UK was documented to be between 300,000 – 500,000. This was however described as including anybody who experienced some degree of gender variance.

The absence of public data raises concerns for the completeness of this pre-consultation equality impact assessment.

Despite the lack of data we know that transgender individuals may require services typically associated with a defined gender that they do not identify with, or are accessing services that are seen to promote traditional "family" orientated services. It is acknowledged that individuals may experience anxiety and discomfort when

receiving inpatient care where signage and labels are male and female and they may still be undergoing gender reassignment. CWP will facilitate the gender assignment that the person identifies with, and will provide the appropriate support and adjustments. This issue could be addressed by the provision of single ensuite rooms.

Mitigations

- Single ensuite rooms
- The provision of non-gender bathrooms in community resources.
- Providing staff training and awareness sessions, on how to actively support individuals in the different care settings.
- Work with 3rd sector organisations via the EDS2 framework including Body Positive (LGBT) and a Unique Transgender organisation. Both organisations have provided training and information sessions to CWP staff, with Body Positive sitting on the assessment panel.
- Data collection methodology should be explored on how best this information can be captured.

7. Impact of service reconfiguration on Marriage and civil partnerships as a Protected Characteristic

Marital & civil partnership All categories: Marital and civil partnership status - 304,374	Number	% of population
Single (never married or never registered a same-sex civil partnership)	86,618	28.5%
Married	158,540	52.1%
In a registered same-sex civil partnership	563	0.2%
Separated (but still legally married or still legally in a same-sex civil partnership)	6,708	2.2%
Divorced or formerly in a same-sex civil partnership which is now legally dissolved	28,426	9.3%
Widowed or surviving partner from a same-sex civil partnership	23,519	7.7%

Breakdown of marital status for individuals receiving CWP services

Marital Status	Total
Cohabiting	186
Divorced	438
Married	2916
Not Disclosed	14
Not Known	1084
Separated	139

It is acknowledged the role that partners play in caring for their loved ones. A separate section of this EIA will address the impact that the proposed option will have on carers.

It is however not anticipated that individuals who are married or in a civil partnership will be disproportionally affected on either of the options described in this pre-consultation business case.

8. Impact of service reconfiguration on Religion and belief as a Protected Characteristic

Access to and the provision of services is not provided on the grounds of religion. All CWP inpatient units

provide access to multi-faith rooms, facilitate support from faith leaders and promote and support individuals to continue to access faith based community support whilst receiving inpatient care. The EDS2 stakeholder assessment will monitor the actions in relation to this protected group and ensure that there are no unintended consequences as a result of the agreed option following consultation. Both options put forward will be expected to impact all religious beliefs equally.

Religion All categories: Religion - 370,127	Number	% of population
Christian	254,940	68.9%
Buddhist	882	0.2%
Hindu	1328	0.4%
Jewish	581	0.2%
Muslim	2438	0.7%
Sikh	279	0.1%
Other religion	1065	0.3%
No religion	83,973	22.7%
Religion not stated	24,641	6.7%

Baptist	Less than 10
Buddhist	16
Christian	2515
Christian Science	11
Church Of England	1586
Church Of Scotland	Less than 10
Church Of Wales	Less than 10
Declined To Disclose	15
Hindu	14
Jehovah's Witness	32
Jewish	Less than 10
Lutheran	Less than 10
Methodist	69
Muslim	29
None	383
Not Specified	3368
Orthodox	Less than 10
Other	581
Pagan	Less than 10
Pentecostal	Less than 10
Roman Catholic	258
Salvation Army	Less than 10

Seventh Day Adv'Tist	Less than 10
Sikh	Less than 10
United Reform Church	Less than 10
Unknown	1780
Total	**10704**

9. Impact of service reconfiguration on sexual orientation as a Protected Characteristic

Currently there is no local data that provides a breakdown of sexual orientation by authority. In 2009, there were approximately 430,000 lesbian and gay people living in the North West.Ref: Ecotec (2009), Improving the Region's knowledge base on LGBT population in the North West.

Breakdown of sexual orientation of individuals in receipt of CWP services

Sexual Orientation	Total
BI-SEXUAL	23
GAY OR LESBIAN	Less than 10
GAY/LESBIAN	33
HETEROSEXUAL	4376
Not Known	6067
NOT STATED	132
OTHER	Less than 10
PERSON ASKED AND DOES NOT KNOW OR IS NOT SURE	Less than 10
PREFER NOT TO ANSWER	63
Total	**10704**

Data collection and the quality of the data will require enhancement to ensure that this can then inform the consultation and this equality impact assessment.

Research suggests that LGBT communities experience considerable health inequalities compared to the population on average which impact on their experience in the healthcare system and health outcomes (Stonewall 2008 Prescription for Change)

In 2014 the JSNA in Cheshire East undertook a consultation with the Third Sector Provider on mental health. One of the findings of this work was that gay farmers are a particularly vulnerable group in rural Cheshire East and they recommended that future service-design should take into account the increased risk of suicide amongst gay farmers. They report on evidence that farmers and farm managers are the occupational group with the fourth highest risk of suicide in England and Wales, and say that there is evidence to suggest this figure is much higher. Added to this is the statistic that one in four gay men will attempt suicide at some stage in their lives. This highlights gay farmers to be a particularly vulnerable group.

A further finding of this group concluded that LGBT people confirmed that Isolation and loneliness around

sexual orientation is an issue, and can lead to depression and the use of substances.

Neither of the options described in the pre-consultation business care are expected to discriminate against LGBT individuals.

Carers

Based on this option, carers may be impacted as follows

Option 4a

Adults of working age who require an acute inpatient bed, ECT or PICU provision will be admitted to Bowmere. It is acknowledged that carers will have to travel to visit their loved ones, and this may be a greater distance than they would if their loved one was admitted to Millbrook. This is dependent on where the carer lives in relation to the various inpatient units, and we cannot assume that all carers reside with the individual whom they are caring for and/or related to. Older people will in the main be admitted to Lime Walk House, unless they require PICU or ECT. Based on admission in the previous year, this would equate to circa 370 individuals (admissions that would be admitted to Bowmere if we progressed option 4a). To put this into context there are around 5,300 service users being supported in the community. By making this change we would anticipate that the number of in patient admissions to be reduced due to the enhanced community care provision.

Inpatient mental health care is considered as specialist, and not comparable to physical health care from district general hospitals. It is common for individuals to travel for specialist care, such as cancer, cardiac, paediatrics or neurology. Individuals requiring specialist inpatient mental health care should not be seen any differently from those requiring specialist physical health care. However it is acknowledged that under this option some carers may be disadvantaged compared to the current arrangements.

Mitigations for option 4a

- use of technology to support carers and family to maintain contact
- Flexible visiting hours
- where the family or carers have concerns around in patient placement every attempt will be made to support the patients, carers and family to remain connected.
- Enhanced community provision will reduce the need for hospital admission and facilitate early discharge therefore reducing the number of carers impacted by the changes
- consultation will have a focus on carer engagement and feedback

Summary of the pre-consultation equalities impact assessment

The following provides an overview of whether the proposed options are expected to have a disproportionate effect on any of the 9 protected characteristics.

Protected Group	Options	Expected Impact	Risk	Mitigations
Gender	4a	Neutral	Low	Staff support and training Provision of single ensuite rooms

Disability	4a	Neutral	Low	Ensure that services are compliant with the Equality Act 2010 Ensure reasonable adjustments Staff support and training Support engagement with identified groups via the EDS2
Gender Reassignment	4a	Neutral	Low	Staff support and training Support engagement with identified groups via the EDS2
Marriage and Civil Partnership	4a	Neutral	Low	No specific mitigations identified
Pregnancy and maternity	4a	Neutral	Low	No specific mitigations identified
Race	4a	Neutral	Low	Access to information in a range of languages and formats Staff training and support Access to translation services Single ensuite rooms
Religion and belief	4a	Neutral	Low	Provide adequate faith facilities Facilitate community engagement with faith groups via EDS2 Training and staff support
Sexual orientation	4a	Neutral	Low	Work closely with LGBT groups Support engagement with LGBT community via EDS2 Training and staff support
Age	4a	Neutral for Older People	Medium	Enhanced community provision

How will you involve people from equality/protected groups in the decision making related to the project?

During development of these proposals we have demonstrated a commitment to be proactive to seek the views and experiences of our local populations and be accessible and convenient. We have met with various interest groups, undertaken site visits with experts by experience and invited users to share experiences and views in a range of meetings from CCG Annual Fairs to individual case studies

We have used this information alongside carer and staff views and experiences in the development of the Pre-Consultation Business Case; including the options appraisal process.

Patient and carers workshops were held at the Millbrook Unit and the Recovery Colleges, as well as a series of briefings and drop-in sessions for frontline staff towards the end of 2016. At this time there was engagement with Cheshire East Healthwatch, Cheshire East Health Voice and Cheshire East Council's Adult Health and Social Care Overview and Scrutiny Committee. This included providing a site-visit for scrutiny committee members to CWP services.

More recently listening events were held in September 2017 at Crewe Alexandra FC and Macclesfield Town FC. Over 60 people attended the events, the majority of whom were service users and carers.

Table-based discussions gave participants an opportunity to describe what had worked well for them, what had not worked well and how services might be improved. In addition an online survey was also made available to those who couldn't attend the sessions.

Further engagement with people from the different protected characteristic groups, will take place throughout the consultation period.

EVIDENCE USED FOR ASSESSMENT

What evidence have you considered as part of the Equality Impact Assessment?

- **All research evidence base references including NICE guidance and publication – please give full reference**

The table below shows the 5 year forward view mental health standards to be achieved by 2021. This option will help towards meeting these standards. A copy of the full Adult mental health policy is attached.

Adult community mental health services will provide timely access to evidence-based, person-centred care, which is focused on recovery and integrated with primary and social care and other sectors.
A reduction in premature mortality of people living with severe mental illness (SMI); and

280,000 more people having their physical health needs met by increasing early detection and expanding access to evidence-based physical care assessment and intervention each year.
Increased access to psychological therapies for people with psychosis, bipolar disorder and personality disorder
All areas will provide crisis resolution and home treatment teams (CRHTTs) that are resourced to operate in line with recognised best practice – delivering a 24/7 community-based crisis response and intensive home treatment as an alternative to acute in-patient admissions.

People recover better in the home environment – find quote

- **Bring over comments from Stage 1 and prior learning (please embed any documents to support this)**

Mitigating actions

The Five Year Forward View recognises the need to address capacity in the community and is a national mandate to improve and modernise mental health services to reflect a proactive, timely response to need. (FYFV)

Underpinned by an appropriately trained workforce, there is a requirement to improve access for Crisis Resolution and Home Treatment Teams (CRHTTs) to ensure that a 24/7 community-based mental health crisis response is available in all areas. These teams must be adequately resourced to offer intensive home treatment as an alternative to an acute inpatient admission, in the least restrictive manner and as close to home as possible. There must be evidence of investment to increase access to psychological therapies for people with psychosis, bipolar disorder and personality disorder and 'navigators' who are available to people who need specialist care from diagnosis onwards, to guide them through options for their care and ensure they receive appropriate information and support

In this option we will Enhance community services through:

- 24/7 crisis house
- Crisis café
- 22 beds for older people at Soss Moss (10 people aged 65+) 12 beds for adults between aged 18-64
- Increased capacity of mental health teams to enhance home treatment.

ENSURING LEGAL COMPLIANCE		
Think about what you are planning to change; and what impact that will have upon 'your' compliance with the Public Sector Equality Duty (refer to the Guidance Sheet complete with examples where necessary)		
In what way does your current service delivery help to:	How might your proposal affect your capacity to:	How will your mitigate any adverse effects? (You will need to review how effective these measures have been)
End Unlawful Discrimination?	**End Unlawful Discrimination?**	**End Unlawful Discrimination?**
Enhances provision for all protected characteristics	Enhances provision for all protected characteristics	Enhanced community services to all groups
Promote Equality of Opportunity?	**Promote Equality of Opportunity?**	**Promote Equality of Opportunity?**
This change facilitates all members of the community to access information, services, help and support by providing access to all the local community services 24/7.	This change facilitates all members of the community to access information, services, help and support by providing access to all the local community services 24/7.	Enhanced community services to all groups
Foster Good Relations Between People	**Foster Good Relations Between People**	**Foster Good Relations Between People**
The various types of support available through this service help to engage and enable people from different backgrounds to participate in public life	The various types of support available through this service help to engage and enable people from different backgrounds to participate in public life	Investigate use of technology i.e. facetime, skype. Flexible visiting hours

WHAT OUTCOMES ARE EXPECTED/DESIRED FROM THIS PROJECT?

What are the benefits to patients and staff?

Care in community

Evidence shows from other areas that facilities like crisis café's and places of safety with 24/7 access to crisis support are highly valued by carers and people who use the service. These are now common place in other parts of the country.

A café in a North East Hampshire has helped reduce mental health hospital admissions by a third in seven months by providing an alternative solution for service users (NHS England case study) Other

examples are evident across the country including Greater Manchester, Wirral. We want these types of services to be available to our communities too

Enhancing our community support

Benefits will include:

- Consistent access to services
- PICU provision within appropriate inpatient facility
- Enhanced community services
- Responsive, community focussed, personalised care system providing wrap around care.
- Access to specialist services as close to home as possible
- Support for individuals to effectively manage their wellbeing with a focus on empowerment, prevention and resilience
- More patients supported in their own homes
- Access to out of hours support for those in a crisis

How will any outcomes of the project be monitored, reviewed, evaluated and promoted where necessary?

The project will be monitored using the Outcomes framework, IAF framework measures to ensure no adverse impact on care, and also through contractual obligations with CWP

"think about how you can evaluate equality of access to, outcomes of and satisfaction with services by different groups"

- Feedback from users of the service will be captured through the use of the following:
- Friends and family test
- Patient satisfactions survey
- Patient reported outcomes measures
- Patient reported experience measures

EQUALITY IMPACT AND RISK ASSESSMENT

Does the 'project' have the potential to:

- Have a ***positive*** **impact (benefit)** on any of the equality groups?
- Have a ***negative impact / exclude /*** **discriminate** against any person or equality group?
- **Explain** how this was **identified? Evidence/Consultation?**
- Who is most likely to be **affected** by the proposal and **how** (think about barriers, access, effects, outcomes etc.)

- Please include all evidence you have considered as part of your assessment e.g. Population statistics, service user data broken down by equality group/protected group

Please request guidance on Equality Groups/Protected Groups and their issues, this document may help and support your thinking around barriers for the equality groups

Equality Group / Protected Group	Positive effect	Negative effect	Neutral effect	Please explain - MUST BE COMPLETED
Age	☑	☑		Positive impact - With the changes proposed in this model the Services users will have the opportunity to access a 24/7 crisis service, which should ensure access to help at the point at which it is most needed, therefore preventing the need for hospitalisation. Enables earlier supported discharge. Adults in the age category 65+ would continue to have their care provided locally. Potential negative impact – Adults of working age who require an acute inpatient bed, ECT or PICU provision will be admitted to Bowmere. This may be a greater distance than if they were admitted to Millbrook. In some cases the in-patient facility may be closer to the patients home than the one based in Macclesfield. With regards to visiting we will work with family and carers to find solutions to any transport problems on a case by case basis.
Disability	☑	☑		Positive impact - With the changes proposed in this model the Services users will have the opportunity to access a 24/7 crisis service, which should ensure access to help at the point at which it is most needed, therefore preventing the need for hospitalisation. Enables earlier supported discharge Potential negative impact – Adults of working age who require an acute inpatient bed, ECT or PICU provision will be admitted to Bowmere. This may be a greater distance than if they were admitted to Millbrook. In some cases the in-patient facility may be closer to the patients home than the one based in Macclesfield. With regards to visiting we will work with family and carers to find solutions to any transport problems on a case by case basis.

Gender Reassignment	☑	☑		Positive impact - With the changes proposed in this model the Services users will have the opportunity to access a 24/7 crisis service, which should ensure access to help at the point at which it is most needed, therefore preventing the need for hospitalisation. Enables earlier supported discharge. Potential negative impact – Adults of working age who require an acute inpatient bed, ECT or PICU provision will be admitted to Bowmere. This may be a greater distance than if they were admitted to Millbrook. In some cases the in-patient facility may be closer to the patients home than the one based in Macclesfield. With regards to visiting we will work with family and carers to find solutions to any transport problems on a case by case basis Mitigation • Taking into regard the persons chosen gender identity, patients would be appropriately placed.
Pregnancy and Maternity	☑			Patients already travel out of area for maternal mental health.
Race	☑	☑		Positive impact - With the changes proposed in this model the Services users will have the opportunity to access a 24/7 crisis service, which should ensure access to help at the point at which it is most needed, therefore preventing the need for hospitalisation. Enables earlier supported discharge. Potential negative impact – Adults of working age who require an acute inpatient bed, ECT or PICU provision will be admitted to Bowmere. This may be a greater distance than if they were admitted to Millbrook. In some cases the in-patient facility may be closer to the patients home than the one based in Macclesfield. With regards to visiting we will work with family and carers to find solutions to any transport problems on a case by case basis Mitigation • Providing information in alternative languages; • Ensuring all staff have appropriate training

				in cultural diversity • Ensuring effective and timely interpretation services are made available and staff understand the requirements and system for providing this • All CWP staff work within the Equality, Diversity and Human Rights policy, and regardless of the outcome of the consultation everyone will be offered a person centred approach.
Religion or Belief	☑	☑		Positive impact - With the changes proposed in this model the Services users will have the opportunity to access a 24/7 crisis service, which should ensure access to help at the point at which it is most needed, therefore preventing the need for hospitalisation. Enables earlier supported discharge. Potential negative impact – Adults of working age who require an acute inpatient bed, ECT or PICU provision will be admitted to Bowmere. This may be a greater distance than if they were admitted to Millbrook. In some cases the in-patient facility may be closer to the patients home than the one based in Macclesfield. With regards to visiting we will work with family and carers to find solutions to any transport problems on a case by case basis. Mitigation • Providing information in alternative languages; • Ensuring all staff have appropriate training in cultural diversity • Ensuring effective and timely interpretation services are made available and staff understand the requirements and system for providing this • All CWP staff work within the Equality, Diversity and Human Rights policy, and regardless of the outcome of the consultation everyone will be offered a person centred approach. • All CWP inpatient units provide access to

				multi-faith rooms, facilitate support from faith leaders and promote and support individuals to continue to access faith based community support whilst receiving inpatient care.
Sex (Gender)	☑	☑		Positive impact - With the changes proposed in this model the Services users will have the opportunity to access a 24/7 crisis service, which should ensure access to help at the point at which it is most needed, therefore preventing the need for hospitalisation. Enables earlier supported discharge. Potential negative impact – Adults of working age who require an acute inpatient bed, ECT or PICU provision will be admitted to Bowmere. This may be a greater distance than if they were admitted to Millbrook. In some cases the in-patient facility may be closer to the patients home than the one based in Macclesfield. With regards to visiting we will work with family and carers to find solutions to any transport problems on a case by case basis Mitigation • Staff support and training • Provision of single ensuite rooms
Sexual Orientation	☑	☑		Positive impact - With the changes proposed in this model the Services users will have the opportunity to access a 24/7 crisis service, which should ensure access to help at the point at which it is most needed, therefore preventing the need for hospitalisation. Enables earlier supported discharge. Potential negative impact – Adults of working age who require an acute inpatient bed, ECT or PICU provision will be admitted to Bowmere. This may be a greater distance than if they were admitted to Millbrook. In some cases the in-patient facility may be closer to the patients home than the one based in Macclesfield. With regards to visiting we will work with family and carers to find solutions to any transport problems on a case by case basis.

				Mitigation • Work closely with LGBT groups • Support engagement with LGBT community via EDS2 • Training and staff support
Marriage and Civil Partnership N.B. Marriage & Civil Partnership is only a protected characteristic in terms of work-related activities and NOT service provision	☑	☑		Positive impact - With the changes proposed in this model the Services users will have the opportunity to access a 24/7 crisis service, which should ensure access to help at the point at which it is most needed, therefore preventing the need for hospitalisation. Enables earlier supported discharge. Potential negative impact – Adults of working age who require an acute inpatient bed, ECT or PICU provision will be admitted to Bowmere. This may be a greater distance than if they were admitted to Millbrook. In some cases the in-patient facility may be closer to the patients home than the one based in Macclesfield. With regards to visiting we will work with family and carers to find solutions to any transport problems on a case by case basis.
Carers	☑	☑		Positive impact - With the changes proposed in this model the Services users will have the opportunity to access a 24/7 crisis service, which should ensure access to help at the point at which it is most needed, therefore preventing the need for hospitalisation. Enables earlier supported discharge. Potential negative impact – Adults of working age who require an acute inpatient bed, ECT or PICU provision will be admitted to Bowmere. It is acknowledged that carers will have to travel to visit their loved ones, and in some cases this may be a greater distance than they would if their loved one was admitted to Millbrook. This is dependent on where the carer lives in relation to the various inpatient units, and we cannot assume that all carers reside with the individual whom they are caring for and/or related to. With regards to visiting we will work with family and carers to find solutions to any transport problems on a case by case basis. Mitigation

				• Flexible visiting hours • Explore the use of technology for Virtual visiting i.e. Skype, Facetime etc
Deprived Communities	☑	☑		Positive impact - With the changes proposed in this model the Services users will have the opportunity to access a 24/7 crisis service, which should ensure access to help at the point at which it is most needed, therefore preventing the need for hospitalisation. Enables earlier supported discharge. Potential negative impact – Adults of working age who require an acute inpatient bed, ECT or PICU provision will be admitted to Bowmere. This may be a greater distance than if they were admitted to Millbrook. In some cases the in-patient facility may be closer to the patients home than the one based in Macclesfield. With regards to visiting we will work with family and carers to find solutions to any transport problems on a case by case basis Mitigation • Flexible visiting hours • Virtual visiting. I.e. Skype, Facetime etc. • Prioritise local beds based on patient and carer need • Appropriate package of care on discharge from hospital.
Vulnerable Groups e.g. Homeless, Sex Workers, Military Veterans	☑	☑		Positive impact - With the changes proposed in this model the Services users will have the opportunity to access a 24/7 crisis service, which should ensure access to help at the point at which it is most needed, therefore preventing the need for hospitalisation. Enables earlier supported discharge. Potential negative impact – Adults of working age who require an acute inpatient bed, ECT or PICU provision will be admitted to Bowmere. This may be a greater distance than if they were admitted to Millbrook. In some cases the in-patient facility may be closer to the patients home than the one based in Macclesfield. With regards to visiting we will work with family and carers to find solutions to any transport problems on a case by case basis. Mitigation

				• Flexible visiting hours • Virtual visiting. I.e. Skype, Facetime etc. • Prioritise local beds based on patient and carer need • Appropriate package of care on discharge from hospital.

SECTION 3 - COMMUNITY COHESION & FUNDING IMPLICATIONS

Does the 'project' raise any issues for Community Cohesion?

N/A

What effect will this have on the relationship between these groups? Please state how will you manage this relationship?

N/A

What is the overall cost of implementing the 'project'?

Potential additional cost of providing free transport for those admitted to Bowmere for those in the protected characteristics.

Please state: Cost & Source(s) of funding:

This is the end of the Equality Impact section, please use the embedded checklist to ensure and reflect that you have included all the relevant information

EI&RA checklist_V1.0_11091

SECTION 4 - HUMAN RIGHTS ASSESSMENT

If the Stage 1 Equality Impact and Risk Assessment highlighted that you are required to complete a Stage 2 Human Rights assessment (please request a stage 2 Human Rights Assessment from the Equality and Inclusion Team), please bring the issues over from the screening into this section and expand further using the Human Rights full assessment toolkit then embed into this section.

SECTION 5 - PRIVACY IMPACT ASSESSMENT

If the Stage 1 Equality Impact and Risk Assessment highlighted that you are required to complete a Stage 2 Privacy Impact Assessment, please request a stage 2 Privacy Impact Assessment either from the Equality and Inclusion Team or the Information Governance Team, email your completed stage 2 to your Information Governance Support Officer either at the CCG or CSU.

SECTION 6 – RISK ASSESSMENT

Please identity any possible risk for patients and / or the Clinical Commissioning Group if the project is implemented without amendment. All risks will be monitored for trends and provided to the project author when the project is due to be reviewed

IMPLEMENTATION RISK: CONSEQUENCE SCORE

DOMAIN	INSIGNIFICANT	MINOR	MODERATE	MAJOR	CATASTROPHIC
Impact on the safety of patients, staff or public (physical / psychological harm	Minimal injury requiring no / minimal intervention or treatment	Minor injury or illness, requiring minor intervention	Moderate injury requiring professional intervention RIDDOR / agency reportable incident, an event which impacts on a small number of patients	Major injury leading to long-term incapacity / disability. Mismanagement of patient care with long-term effects	Incident leading to death. An event which impacts on a large number of patients
Complaints / Audit	Informal complaint / inquiry	Formal complaint (Stage 1) Local resolution Single failure to meet internal standards Reduced performance rating if unresolved	Formal complaint (Stage 2) complaint Local resolution (with potential to go to independent review) Repeated failure to meet internal standards	Multiple complaints / independent review Low performance rating Critical report	Inquest / Ombudsman inquiry Gross failure to meet national standards Severely critical report
Statutory Duty / Inspections	No or minimal impact or breech of guidance / statutory duty For example: Unsatisfactory patient experience which is not directly related to patient care. No action required	Breech of statutory legislation. Reduced performance rating if unresolved. For example: a minor impact on people with a protected characteristic has been identified that was agreed to be accepted within the scope of the project. No action required.	Single breech in statutory duty. Challenging external recommendations / improvement notice. For example: a moderate impact on people with a protected characteristic has been identified. This can be resolved by making amendments to the project or providing an objective justification for not amending the project (This must be published with the EIA)	Multiple breeches in statutory duty. Enforcement action Low performance rating report For example: a major impact on people with a protected characteristic has been identified. Consideration	Multiple breeches in statutory duty. Prosecution Zero performance rating Severely critical report. For example: a catastrophic impact on people with a protected characteristic has been identified that may lead to litigation or impact on patient safety. The project should be stopped immediately

				should be given to and review the project immediately. Q. Can we make amendments to the project or provide objective justifications? If yes, this must be published the EIA.	
Adverse Publicity / Reputation	Rumours Potential for public concern	Local media coverage short-term reduction in public confidence. Elements of public expectation not being met	Local media coverage. Long-term reduction in public confidence	National media coverage <3 days service well below reasonable public expectation	National media coverage > 3 days MP concerned (questions in the House) Total loss of public confidence
Business Objectives / Projects	Insignificant cost increase No impact on objectives	<5 per cent over project budget Minor impact on delivery of objectives	5 – 10 per cent over project budget	Non-compliance with national 10 – 25 per cent over budget Major impact on delivery of strategic objectives	Incident leading > 25 per cent over project budget Failure of strategic objectives impacting on delivery of business plan
Finance Including Claims	Small loss risk of claim remote	Loss of 0.1 – 0.25 per cent of budget Claim less than £10,000	Loss of 0.25 – 0.5 per cent of budget Claims (s) between £10,000 and £100,000	Loss of 0.5 – 1.0 per cent of budget Claim(s) between £100,000 and £1	Loss of >1 per cent of budget Claim(s) > £1 million

				million	
IMPLEMENTATION RISK: LIKELIHOOD SCORE					
Frequency: How often might it / does it happen?	Not expected to occur for years	Expected to occur annually	Expected to occur monthly	Expected to occur weekly	Expected to occur daily
Probability	<1%	1.5%	6-20%	21-50%	>50%
	Will only occur in exceptional circumstances	Unlikely to occur	Reasonable chance of occurring	Likely to occur	More likely to occur than not occur

RISK MATRIX					
	RARE	**UNLIKELY**	**POSSIBLE**	**LIKELY**	**ALMOST CERTAIN**
Insignificant	**1**	**2**	**3**	**4**	**5**
Minor	**2**	**4**	**6**	**8**	**10**
Moderate	**3**	**6**	**9**	**12**	**15**
Major	**4**	**8**	**12**	**16**	**20**
Catastrophic	**5**	**10**	**15**	**20**	**25**

RISK SCORE ON DRAFT PROJECT	**RISK SCORE ON FINALISED PROJECT**
5	**5**

WHAT ARE THE KEY REASONS FOR THE CHANGE IN THE RISK SCORE?
N/A

EQUALITY IMPACT AND RISK ASSESSMENT AND ACTION PLAN

Risk identified	Actions required to reduce / eliminate the negative impact	Resources required* (see guidance below)	Who will lead on the action?	Target completion date
Negative media coverage has a detrimental impact on public consultation outcome	Communication and Engagement Plan to support proactive approach to local media. Consistent message from partners in communicating case for change. Joint approach to communication to wider statutory bodies. Clear governance process to obtain sign off from all partners for communication plan. Fully engage public in pre consultation process and consultation process (health voice, health watch, general public, 3rd sector organisations)	**Comms and Enagagement team**	**Katherine Wright, Charles Malkin**	**Ongoing throughout life of project**
Service sustainability during the planning and consultation phase	CWP to evoke Business Continuity plans. Regular communication with staff. Clinical	**CWP**	**Suzanne Edward**	**Post Consultation**

	Leadership across system to identify measures to maintain quality of care.		**s**	
Potential delays in delivering the programme within the timescales	Develop project plan with clear time lines to deliver the work plan and navigate governance process including NHSE sign off. Project Meetings bi weekly to monitor delivery against plan. Escalate project slippage to SRO.	**Project Sponsor**	**Jacqui Wilkes**	**Throughout the life of the project**
The decision making process following consultation period is challenged	Project process to follow NHS England best practice guidance recruit consultation expert to support pre-consultation engagement and the consultation itself. Ensure project documentation fully up to date and take clear and transparent approach to process and decision making. Take legal advice on consultation documentation. Independent review by Chester University within consultation timeline	**Project Sponsor**	**Jacqui Wilkes**	**Throughout the life of the project**
The new care model may exceed the financial envelope available and cannot be fully implemented.	To ensure clinical engagement in the redesign process. Highlighting efficiency measures that deliver savings whilst not compromising patient safety.			

'Resources required' is asking for a summary of the costs that are needed to implement the changes to mitigate the negative impacts identified

SECTION 7 – ONGOING MONITORING AND REVIEW OF EQUALITY IMPACT ASSESSMENTS AND ACTION PLANS

Please describe briefly, how the equality action plans will be monitored through internal CCG governance processes?

Using the IAF framework, and project highlight reports to Programme executive and organisational boards.

Date of the next review of the Equality Impact Assessment section and action plan? (Please note: if this is a project or pilot reviews need to be built in to the project/pilot plan)

Date: End of consultation
Which CCG Committee will be responsible for monitoring the action plan progress? Caring Together Board, Connecting Care
Who will be the responsible person in the organisation to ensure the action plan is monitored? Jacki Wilkes and Jamaila Tausif
FINAL SECTION **SECTION 8**
Date sent to Equality & Inclusion (E&I) Team for quality check: **09-11-2017**
Date quality checked by Equality and Inclusion Business Partner: **09-11-2017**
Date of final sign off by Equality and Inclusion Business Partner: **09-11-2017**
Signature Equality and Inclusion Business Partner: *Q Hussain*
CCG Committee Name and sign off date:

This is the end of the Equality Impact and Risk Assessment process: By now you should be able to clearly demonstrate and evidence your thinking and decision(s).
To meet publishing requirements this document SHOULD NOW BE PUBLISHED ON YOUR ORGANISATIONS WEBSITE.

- Save this document for your own records
- Send this document and copies of your completed Privacy Impact Assessment and Human Rights Screening to equality.inclusion@nhs.net

MIDLANDS AND LANCASHIRE COMMISSIONING SUPPORT UNIT

Equality Impact and Risk Assessment Stage 2

Equality Impact and Risk Assessment

Title

Equality & Inclusion Team, Corporate Affairs
For enquiries, support or further information contact
Email: equality.inclusion@nhs.net

EQUALITY IMPACT AND RISK ASSESSMENT TOOL STAGE 2 ALL SECTIONS – MUST BE COMPLETED
SECTION 1 - DETAILS OF PROJECT
Organisation: Eastern Cheshire CCG
Assessment Lead: Mandie Graham / Marie Ward
Directorate/Team responsible for the assessment: Option 4b: Adult Mental Health Redesign Project Team
Responsible Director/CCG Board Member for the assessment: Jacki Wilkes
Who else will be involved in undertaking the assessment? Marie Ward, Suzanne Edwards, Jamaila Tausif
Date of commencing the assessment: 13/10/17
Date for completing the assessment: 03/11/17

SECTION 2 - EQUALITY IMPACT ASSESSMENT			
Please tick which group(s) this project will or may impact upon?	**Yes**	**No**	**Indirectly**
Patients, service users	☑		
Carers or family	☑		
General Public		☑	
Staff	☑		
Partner organisations	☑		

Background of the project being assessed:

The NHS in Eastern and Central Cheshire are working with local mental health provider Cheshire and Wirral Partnership and the local council to review and redesign secondary care adult and older peoples mental health services for those residents with a severe and enduring mental health need. Secondary care services is the term used to differentiate them from primary mental health services such as GP only care and universal psychological therapies (IAPT) Secondary services includes specialised community support, crisis response and inpatient care which is provided mainly on The Millbrook unit in Macclesfield. The project aims to improve clinical and health and well-being outcomes for service users through a new model of care and redesigned service delivery arrangements to support early intervention and prevention and reduce overall reliance on hospital services.

What are the aims and objectives of the project being assessed?

The purpose of this project is to deliver improved mental services for the registered population of Vale Royal South and Eastern Cheshire.

Option 4b: Expand community and crisis care services and relocate all inpatient care from Millbrook to other facilities within current provider footprint (Adults Macclesfield site, Older people Bowmere)

Description: In this option 22 beds would be provided at Lime Walk for adults. 22 beds would be provided at Bowmere, 10 for older people with dementia and 12 for older or more physically vulnerable adults with functional illness. There will be 3 beds at Wirral for adults. Central and East patients would be admitted to Bowmere. Rehabilitation services currently delivered at Lime Walk would be re-provided at the Soss Moss site in Nether Alderley. In patient ECT would be delivered at the specialist ward in Bowmere. 6 beds will be available locally to support short stay care for people in crisis. Community mental health teams would deliver interventions to allow safe care and have the appropriate skill mix to do so. A new model of crisis care introduced which would see the home treatment team providing 24/7 care in conjunction with an increase in home treatment team, overnight placement support and day time crisis café.

Services currently provided in relation to the project:

Community care is provided by Community Mental health Teams (CMHTs) based in Macclesfield for Eastern Cheshire residents and Crewe for Vale Royal and South Cheshire residents. Home Treatment Teams provide access to crisis care and are the gatekeepers to inpatient services. They will also provide in reach services for crisis care. In this option the service would be extended to cover 24/7. In addition a dementia outreach service would provide intensive support to people at home, thereby preventing unnecessary admissions to hospital.

Community mental health teams are comprised of a mix of community psychiatric nurses, allied professionals and medical staff provided by CWP whilst Local Authorities provide social work input to these teams: Cheshire East Council for Eastern Cheshire and South Cheshire teams and Cheshire West and Chester to the Vale Royal teams. In patient facilities are provided at Millbrook in Macclesfield and Bowmere in Chester.

Which equality protected groups (age, disability, sex, sexual orientation, gender reassignment, race, religion and belief, pregnancy and maternity, marriage and civil partnership) and other employees/staff networks do you intend to involve in the equality impact assessment?

Please bring forward any issues highlighted in the Stage 1 screening

In this option 22 beds would be provided at Lime Walk for adults. 22 beds would be provided at Bowmere, 10 for older people with dementia and 12 for older or more physically vulnerable adults with functional illness. There will be 3 beds at Wirral for adults. Central and East patients would be admitted to Bowmere. Rehabilitation services currently delivered at Lime Walk would be re-provided at the Soss Moss site in Nether Alderley. In patient ECT would be delivered at the specialist ward in Bowmere. Community mental health teams would deliver interventions to allow safe care and have the appropriate skill mix to do so. A new model of crisis care introduced which would see the home treatment team providing 24/7 care in conjunction with an increase in home treatment team, overnight placement support and day time crisis café.

In response to the growing body of evidence that demonstrates improved outcomes for people where there are adequate community services and rapid response to support people in crisis. (Kings Fund 2017, FYFV 2016) we are planning to make changes to the way in which services are commissioned and delivered for our population.

Locally developed transformation plans describe a programme of co-design across the health and social care

economy where health and care commissioners and providers respond to patient needs and work together to redesign care services. They represent a system wide commitment to implementing the changes required to deliver a care system that is fit for the 21st century's population needs and is entirely consistent with the national vision for future mental health services described in the 5YFV and is the framework we have used for our needs analysis and workforce planning

In early stages of implementation, the aim is to achieve a responsive, community focussed, personalised care system that is wrapped around the empowered individual. It enables professionals to fully utilise their skills in working together to target the support and care to people most in need.

In taking transformation plans forward for people with SMI an improved approach to care has been created by local clinicians and patients. We have segmented the population into groups according to their risk of needing care so that we can develop services to meet their needs and better target services where they have the most impact. We believe that we will be able to dramatically shift the over reliance on reactive, acute hospital care to proactive care closer to home with improved patient experience and outcomes.

Based on the above options the following sections will consider the impact of each of the options against the Protected Characteristics.

1. Gender

The 2011 census data shows that in East Cheshire approximately 51% of the population are female and 49% are male.

Nationally, when looking at the sex distribution for people who have a severe mental illness, overall rates do not differ significantly between male and female. This is for conditions such as psychotic disorders, bipolar effective disorder and personality disorder.

The table below highlights the admissions to Millbrook, broken down by gender. Slightly more females were admitted between 1st April 2016 to 31st March 2017.

	Female	% Female	Male	% Male	Total Patients
Adelphi Ward - open age inpatient mental health ward caring for older people in East Cheshire.	222	69.16%	99	30.84%	321
Bollin Ward - open age inpatient mental health ward caring for young adults in East Cheshire	217	48.33%	232	51.67%	449
Croft Ward - 14 bed inpatient ward providing specialist	39	57.35%	29	42.65%	68

treatment for people with dementia in East Cheshire					
Overall	**478**	**57.04%**	**360**	**42.96%**	**838**

It is considered that all genders will be impacted upon as a result of the changes.

Impact of service reconfiguration on Gender as a Protected Characteristics.

All genders will be adversely impacted by this option. All genders will receive their care in the main in Bowmere, Chester. All genders over the age of 65 and/or with greater physical health needs will in the main receive their care in Bowmere. Both male and female within this option will be cared for in single, en-suite rooms in buildings that meet the national standards.

Enhanced community services will be provided closer to home and support will be offered 24/7 for those experiencing a crisis. For those who are unable to attend community based clinics, practitioners will be able to visit at home or venue of choice to provide the appropriate support, therefore negating the need for additional travel. Community provision will remain in Central and East Cheshire. This option is expected to improve service user experience, and provide improved quality of care through improved access to community based services.

Potential Mitigations for Option 4b

The relocation of some inpatient services to Bowmere may have an adverse impact on all genders. For all service users requiring an admission to Bowmere CWP will ***continue*** to support their transfer via a mental health practitioner or ambulance.

CWP, CCG and Local Authority would need to ensure that travel options are well published, which would include travelling with NHS patient transport services. Individual difficulties would be reviewed on a case by case basis and every attempt made to support family and carers and patients to remain connected through in patient stay, through flexible visiting, use of technology and local in patient crisis beds.

2. Pregnancy and maternity

In 2009 the general fertility rates for England and Wales was 63.6 (per live 1,000 births), in East Cheshire this rate is 59.8, and therefore slightly lower than the national rate, but is more or less equal to the birth rate in the North West.

Perinatal services are specialist mental health services that support women and their families during pregnancy and following birth.

Impact of service reconfiguration on Pregnancy and Maternity as a Protected Characteristics

There is no proposed change in the provision of Specialist community perinatal services and these are provided via CWP and are across Cheshire and Merseyside. Women in the perinatal period who require admission to a specialist mother and baby unit will continue to access regional units. This is not provided at Millbrook or any of the other inpatient units within CWP.

Women in the perinatal period who wish to remain at home during periods of crisis will be able to receive

enhanced community support via the crisis service, therefore increasing the likelihood of the mother being able to stay at home. Access to mother and baby units can take a number of days to secure due to the limited numbers, and therefore at times of need they will require admission to an acute inpatient unit. Bowmere has single ensuite rooms, family visiting areas that can be utilised to support mother and baby during periods of visiting. The community specialist perinatal team will ensure that the service user maintains contact with their local midwifery services and arrangements will be put in place for this to continue if admitted to Bowmere. It is believed that this option will improve service user experience and supports person centred care.

Potential Mitigations

The relocation of some inpatient services to Limewalk will have no adverse impact on women during the perinatal period. For all service users requiring an admission to Bowmere CWP will continue to support their transfer via a mental health practitioner, ambulance or other means based on individual choice.

CWP, CCG and Local Authority would need to ensure that travel options are well published, which would include travelling with NHS patient transport services. The use of technology and flexible visiting hours to maintain contact with family and friends will be explored.

3. Impact of service reconfiguration on Age as a Protected Characteristic

Since the 2001 census there has been a 26% increase in the number of residents 65 and older, which is a larger increase than in the North West (15%) and England and Wales (20%). There has been a 35% increase in the number of residents 85 years and older, which again is a larger increase than the North West (205) and England and Wales (24%). There has been a decrease in the number of children by 4% and those of approximate working age have increased by 4% in line with trends in the North West and England and Wales. There are fewer people in all age groups under 40 than England and Wales, and the median age of residents in 2001 was 40.6 years and by 2011 this has increased to 43.6 years.

Population of East Cheshire by Age

Age All categories: Age - 370,127	Number	% of population
Under 16	65,753	17.9%
16-29	55,282	14.90%
29-64	177,720	48%
65+	71,372	19.30%

Admissions to Millbrook by age (2016/2017)

	Aged 16-29	% 16-29	Aged 30-64	% 30-64	Aged 65 +	% 65+	Total Patients
Adelphi Ward	37	11.53%	163	50.78%	121	37.69 %	321
Bollin Ward	116	25.84%	322	71.71%	11	2.45%	449
Croft Ward	Less than 10	0.00%	Less than 10	10.29%	61	89.71 %	68

Overall	**153**	**18.26%**	**492**	**58.71%**	**193**	**23.03 %**	**838**

Option 4b

Enhanced community services will be provided closer to home and support will be offered 24/7 for those experiencing a crisis. For those who are unable to attend community based clinics, practitioners will be able to visit at home or venue of choice to provide the appropriate support, therefore negating the need for additional travel. Community provision will remain in Central and East Cheshire and will be enhanced. This option is expected to improve service user experience, and provide improved quality of care through improved access to community based services.

For older adults age 65+ requiring inpatient care, they will receive their care at Bowmere, balancing additional travel and quality of specialist care. Those who require PICU, ECT or specialist intervention for complex presentations will also receive their care at Bowmere.

Adults of working age will receive the same enhanced community provision, this group will be admitted to Limewalk if they require inpatient care, and therefore are not adversely impacted on as a result of this option. This cohort during 2016/17 accounted for 0.016% of the total population of Central and Eastern Cheshire.

Potential Mitigations

Access to community based crisis services 24/7 will reduce the need for admission to an inpatient unit, and will reduce length of stay by facilitating early discharge

For all service users requiring an admission to Bowmere CWP will continue to support their transfer via a mental health practitioner or ambulance.

4. Impact of service reconfiguration on Disability as a Protected Characteristic

Disability All households - 159,441	Number	% of population
One person in household with a long-term health problem or disability: With dependent children	6,045	3.8%
One person in household with a long-term health problem or disability: No dependent children	33,628	21.1%

Option 4b

Enhanced community services will be provided closer to home and support will be offered 24/7 for those experiencing a crisis. For those who are unable to attend community based clinics, practitioners will be able to visit at home or venue of choice to provide the appropriate support, therefore negating the need for additional travel. Community provision will remain in Central and East Cheshire. This option is expected to improve service user experience, and provide better quality of care through improved access to community based services.

For all service users requiring an admission to Bowmere CWP will continue to support their transfer via a mental health practitioner or ambulance.

Potential Mitigations for Option 4b

Ensure that services and locations where community services will be offered from are EQUALITY ACT 2010 compliant

Improve data quality of services users with a disability to inform further mitigations and equality impact assessments.

Ensure that reasonable adjustments are made, and facilities are suitable.

Ensure that information on the service reconfiguration specially targets disabled groups

Provide clear information in alternative formats and with alterative content targeted at people with different abilities for wide dissemination (Accessible Information Standard)

Ensuring compliance with safeguarding regulations

Provide staff training on how to actively support members of this community

CWP, CCG and Local Authority would need to ensure that travel options are well published, which would include travelling with NHS patient transport services.

5. **Impact of service reconfiguration on Race as a Protected Characteristic**

Breakdown from 2011 Census

Ethnicity All categories: Ethnic group - 370,127	Number	% of population
White	357,627	96.7%
Black/African/Caribbean/Black British	1,402	0.4%
Asian/Asian British:Chinese	2,553	0.7%
Asian/Asian British:Bangledeshi/Indian,Pakistani	3,507	0.9%
Mixed/Multiple Ethnic Groups	3,873	1.0%
Gypsy/Traveller/Irish Traveller	313	0.1%
Other Ethnic Group	852	0.2%

Breakdown of Ethnicity for Individuals accessing all services in Central and East Cheshire

Ethnicity	Total
Asian Or Asian British, Bangladeshi	Less than 10
Asian Or Asian British, Indian	15
Asian Or Asian British, Other	28

Asian Or Asian British, Pakistani	10
Black Or Black British, African	18
Black Or Black British, British Caribbean	27
Black Or Black British, Other	Less than 10
Mixed, Other	20
Mixed, White & Asian	13
Mixed, White & Black African	Less than 10
Mixed, White & Black Caribbean	16
Not Stated	41
Other Ethnic Groups, Chinese	Less than 10
Other Ethnic Groups, Other	18
Unknown	929
White, British	9359
White, Irish	55
White, Other	133
Total	**10704**

Option 4b

Enhanced community services will be provided closer to home and support will be offered 24/7 for those experiencing a crisis. For those who are unable to attend community based clinics, practitioners will be able to visit at home or venue of choice to provide the appropriate support, therefore negating the need for additional travel. Community provision will remain in Central and East Cheshire. This option is expected to improve service user experience, and provide better quality of care through improved access to community based services and crisis beds.

For all service users requiring an admission to Bowmere CWP will continue to support their transfer via a mental health practitioner or ambulance.

Potential mitigations for Option 4b

The mitigations would be:

- Providing information in alternative languages;
- Ensuring all staff have appropriate training in cultural diversity
- Ensuring effective and timely interpretation services are made available and staff understand the requirements and system for providing this
- All CWP staff work within the Equality, Diversity and Human Rights policy, and regardless of the outcome of the consultation everyone will be offered a person centred approach.
- All CWP inpatient units provide access to multi-faith rooms, facilitate support from faith leaders and promote and support individuals to continue to access faith based community support whilst receiving inpatient care.

6. Impact of service reconfiguration on Gender reassignment as a Protected Characteristic

Currently CWP do not hold any information on the number of people who have undergone gender reassignment.

At present there is no official estimate of the transgender population. The England/Wales and Scottish Census have not asked if people identify as transgender and did not ask the question in the 2011 census. In a Home Office funded study estimated numbers of trans people in the UK was documented to be between 300,000 – 500,000. This was however described as including anybody who experienced some degree of gender variance.

The absence of public data raises concerns for the completeness of this pre-consultation equality impact assessment.

Despite the lack of data we know that transgender individuals may require services typically associated with a defined gender that they do not identify with, or are accessing services that are seen to promote traditional "family" orientated services. It is acknowledged that individuals may experience anxiety and discomfort when receiving inpatient care where signage and labels are male and female and they may still be undergoing gender reassignment. CWP will facilitate the gender assignment that the person identifies with, and will provide the appropriate support and adjustments. This issue could be addressed by the provision of single en-suite rooms.

Mitigations

- Single en-suite rooms
- The provision of non-gender bathrooms in community resources.
- Providing staff training and awareness sessions, on how to actively support individuals in the different care settings.
- Work with 3rd sector organisations via the EDS2 framework including Body Positive (LGBT) and a Unique Transgender organisation. Both organisations have provided training and information sessions to CWP staff, with Body Positive sitting on the assessment panel.
- Data collection methodology should be explored on how best this information can be captured.

7. Impact of service reconfiguration on Marriage and civil partnerships as a Protected Characteristic

Marital & civil partnership All categories: Marital and civil partnership status - 304,374	Number	% of population
Single (never married or never registered a same-sex civil partnership)	86,618	28.5%
Married	158,540	52.1%
In a registered same-sex civil partnership	563	0.2%
Separated (but still legally married or still legally in a same-sex civil partnership)	6,708	2.2%
Divorced or formerly in a same-sex civil partnership which is now legally dissolved	28,426	9.3%
Widowed or surviving partner from a same-sex civil partnership	23,519	7.7%

Breakdown of marital status for individuals receiving CWP services

Marital Status	Total

Cohabiting	186
Divorced	438
Married	2916
Not Disclosed	14
Not Known	1084
Separated	139

It is acknowledged the role that partners play in caring for their loved ones. A separate section of the EIA will address the impact that the proposed options will have on carers.

It is however not anticipated that individuals who are married or in a civil partnership will be disproportionally affected on either of the options described in this pre-consultation business case.

8. Impact of service reconfiguration on Religion and belief as a Protected Characteristic

Access to and the provision of services is not provided on the grounds of religion. All CWP inpatient units provide access to multi-faith rooms, facilitate support from faith leaders and promote and support individuals to continue to access faith based community support whilst receiving inpatient care. The EDS2 stakeholder assessment will monitor the actions in relation to this protected group and ensure that there are no unintended consequences as a result of the agreed option following consultation. Both options put forward will be expected to impact all religious beliefs equally.

Religion All categories: Religion - 370,127	Number	% of population
Christian	254,940	68.9%
Buddhist	882	0.2%
Hindu	1328	0.4%
Jewish	581	0.2%
Muslim	2438	0.7%
Sikh	279	0.1%
Other religion	1065	0.3%
No religion	83,973	22.7%
Religion not stated	24,641	6.7%

Baptist	Less than 10
Buddhist	16
Christian	2515
Christian Science	11
Church Of England	1586

Church Of Scotland	Less than 10
Church Of Wales	Less than 10
Declined To Disclose	15
Hindu	14
Jehovah's Witness	32
Jewish	Less than 10
Lutheran	Less than 10
Methodist	69
Muslim	29
None	383
Not Specified	3368
Orthodox	Less than 10
Other	581
Pagan	Less than 10
Pentecostal	Less than 10
Roman Catholic	258
Salvation Army	Less than 10
Seventh Day Adv'Tist	Less than 10
Sikh	Less than 10
United Reform Church	Less than 10
Unknown	1780
Total	**10704**

9. Impact of service reconfiguration on sexual orientation as a Protected Characteristic

Currently there is not local data that provides a breakdown of sexual orientation by authority. In 2009, there were approximately 430,000 lesbian and gay people living in the North West.Ref: Ecotec (2009), Improving the Region's knowledge base on LGBT population in the North West.

Breakdown of sexual orientation of individuals in receipt of CWP services

Sexual Orientation	Total
BI-SEXUAL	23
GAY OR LESBIAN	Less than 10
GAY/LESBIAN	33
HETEROSEXUAL	4376
Not Known	6067
NOT STATED	132
OTHER	Less than 10
PERSON ASKED AND DOES NOT KNOW OR IS NOT SURE	Less than 10

PREFER NOT TO ANSWER	63
Total	**10704**

Data collection and the quality of the data will require enhancement to ensure that this can then inform the consultation and this equality impact assessment.

Research suggests that LGBT communities experience considerable health inequalities compared to the population on average which impact on their experience in the healthcare system and health outcomes (Stonewall 2008 Prescription for Change)

In 2014 the JSNA in Cheshire East undertook a consultation with the Third Sector Provider on mental health. One of the findings of this work was that gay farmers are a particularly vulnerable group in rural Cheshire East and they recommended that future service-design should take into account the increased risk of suicide amongst gay farmers. They report on evidence that farmers and farm managers are the occupational group with the fourth highest risk of suicide in England and Wales, and say that there is evidence to suggest this figure is much higher. Added to this is the statistic that one in four gay men will attempt suicide at some stage in their lives. This highlights gay farmers to be a particularly vulnerable group.

A further finding of this group concluded that LGBT people confirmed that Isolation and loneliness around sexual orientation is an issue, and can lead to depression and the use of substances.

Neither of the options described in the pre-consultation business care are expected to discriminate against LGBT individuals.

Carers

Based on this option, carers may be impacted as follows

Option 4b

Older people, age 65+ who require an acute inpatient bed, ECT or PICU provision will be admitted to Bowmere. It is acknowledged that carers will have to travel to visit their loved ones, and this may be a greater distance than they would if their loved one was admitted to Millbrook. This is dependent on where the carer lives in relation to the various inpatient units, and we cannot assume that all carers reside with the individual whom they are caring for and/or related to. Based on admission in the previous year, this would equate to circa 41 individuals (that would be potentially be admitted to Bowmere if we progressed option 4b). To put this into context there are around 5,300 service users being supported in the community. By making this change we would anticipate that the number of in patient admissions to be reduced due to the enhanced community care provision.

Adults of a working age will in the main be admitted to Lime Walk House, unless they require PICU, ECT or have complex needs. Inpatient mental health care is considered as specialist, and not comparable to physical health care from district general hospitals. It is common for individuals to travel for specialist care, such as cancer, cardiac, paediatrics or neurology. Individuals requiring specialist inpatient mental health care should not be seen any differently from those requiring specialist physical health care. However it is acknowledged that under this option some carers may be disadvantaged compared to the current

arrangements

Mitigations for option 4b

- use of technology to support carers and family to maintain contact
- Flexible visiting hours
- where the family or carers have concerns around in patient placement every attempt will be made to support the patients, carers and family to remain connected.
- Enhanced community provision will reduce the need for hospital admission and facilitate early discharge therefore reducing the number of carers impacted by the changes
- consultation will have a focus on carer engagement and feedback

Summary of the pre-consultation equalities impact assessment

The following provides an overview of whether the proposed options are expected to have a disproportionate effect on any of the 9 protected characteristics.

Protected Group	Expected Impact	Risk	Mitigations
Gender	Neutral	Low	Staff support and training Provision of single ensuite rooms
Disability	Neutral	Low	Ensure that services are compliant with the Equality Act 2010 Ensure reasonable adjustments Staff support and training Support engagement with identified groups via the EDS2
Gender Reassignment	Neutral	Low	Staff support and training Support engagement with identified groups via the EDS2
Marriage and Civil Partnership	Neutral	Low	No specific mitigations identified
Pregnancy and maternity	Neutral	Low	No specific mitigations identified
Race	Neutral	Low	Access to information in a range of languages and formats Staff training and support Access to translation services

			Single ensuite rooms
Religion and belief	Neutral	Low	Provide adequate faith facilities Facilitate community engagement with faith groups via EDS2 Training and staff support
Sexual orientation	Neutral	Low	Work closely with LGBT groups Support engagement with LGBT community via EDS2 Training and staff support
Age	Neutral for Adults	Medium	Enhanced community provision

How will you involve people from equality/protected groups in the decision making related to the project?

During development of these proposals we have demonstrated a commitment to be proactive to seek the views and experiences of our local populations and be accessible and convenient. We have met with various interest groups, undertaken site visits with experts by experience and invited users to share experiences and views in a range of meetings from CCG Annual Fairs to individual case studies

We have used this information alongside carer and staff views and experiences in the development of the Pre-Consultation Business Case; including the options appraisal process.

Patient and carers workshops were held at the Millbrook Unit and the Recovery Colleges, as well as a series of briefings and drop-in sessions for frontline staff towards the end of 2016. At this time there was engagement with Cheshire East Healthwatch, Cheshire East Health Voice and Cheshire East Council's Adult Health and Social Care Overview and Scrutiny Committee. This included providing a site-visit for scrutiny committee members to CWP services.

More recently listening events were held in September 2017 at Crewe Alexandra FC and Macclesfield Town FC. Over 60 people attended the events, the majority of whom were service users and carers.

Table-based discussions gave participants an opportunity to describe what had worked well for them, what had not worked well and how services might be improved. In addition an online survey was also made available to those who couldn't attend the sessions.

Further engagement with people from the different protected characteristic groups, will take place throughout the consultation period.

EVIDENCE USED FOR ASSESSMENT

What evidence have you considered as part of the Equality Impact Assessment?

- **All research evidence base references including NICE guidance and publication – please give full reference**

The table below shows the 5 year forward view mental health standards to be achieved by 2021. This option will help towards meeting these standards. A copy of the full Adult mental health policy is attached.

Adult community mental health services will provide timely access to evidence-based, person-centred care, which is focused on recovery and integrated with primary and social care and other sectors.
A reduction in premature mortality of people living with severe mental illness (SMI); and 280,000 more people having their physical health needs met by increasing early detection and expanding access to evidence-based physical care assessment and intervention each year.
Increased access to psychological therapies for people with psychosis, bipolar disorder and personality disorder
All areas will provide crisis resolution and home treatment teams (CRHTTs) that are resourced to operate in line with recognised best practice – delivering a 24/7 community-based crisis response and intensive home treatment as an alternative to acute in-patient admissions.

- **Bring over comments from Stage 1 and prior learning (please embed any documents to support this)**

Mitigating actions

The Five Year Forward View recognises the need to address capacity in the community and is a national mandate to improve and modernise mental health services to reflect a proactive, timely response to need. (FYFV)

Underpinned by an appropriately trained workforce, there is a requirement to improve access for Crisis Resolution and Home Treatment Teams (CRHTTs) to ensure that a 24/7 community-based mental health crisis response is available in all areas. These teams must be adequately resourced to offer intensive home treatment as an alternative to an acute inpatient admission, in the least restrictive manner and as close to home as possible. There must be evidence of investment to increase access to psychological therapies for people with psychosis, bipolar disorder and personality disorder and 'navigators' who are available to people who need specialist care from diagnosis onwards, to guide them through options for their care and ensure they receive appropriate information and support

In this option we will Enhance community services through:

- 24/7 crisis house
- Crisis café
- 22 beds would be provided at Lime Walk for adults. 22 beds would be provided at Bowmere, 10 for older people with dementia and 12 for older or more physically vulnerable adults with functional illness. There will be 3 beds at Wirral for adults.
- Increased capacity of mental health teams to enhance home treatment.

ENSURING LEGAL COMPLIANCE		
Think about what you are planning to change; and what impact that will have upon 'your' compliance with the Public Sector Equality Duty (refer to the Guidance Sheet complete with examples where necessary)		
In what way does your current service delivery help to:	How might your proposal affect your capacity to:	How will your mitigate any adverse effects? (You will need to review how effective these measures have been)
End Unlawful Discrimination?	**End Unlawful Discrimination?**	**End Unlawful Discrimination?**
Enhances provision for all protected characteristics	Enhances provision for all protected characteristics	Enhanced community services to all groups
Promote Equality of Opportunity?	**Promote Equality of Opportunity?**	**Promote Equality of Opportunity?**
This change facilitates all members of the community to access information, services, help and support by providing access to all the local community services 24/7.	This change facilitates all members of the community to access information, services, help and support by providing access to all the local community services 24/7.	Enhanced community services to all groups

Foster Good Relations Between People	Foster Good Relations Between People	Foster Good Relations Between People
The various types of support available through this service help to engage and enable people from different backgrounds to participate in public life	The various types of support available through this service help to engage and enable people from different backgrounds to participate in public life	Investigate use of technology i.e. facetime, skype. Flexible visiting hours

WHAT OUTCOMES ARE EXPECTED/DESIRED FROM THIS PROJECT?

What are the benefits to patients and staff?

Care in community

Evidence shows from other areas that facilities like crisis café's and places of safety with 24/7 access to crisis support are highly valued by carers and people who use the service. These are now common place in other parts of the country.

A café in a North East Hampshire has helped reduce mental health hospital admissions by a third in seven months by providing an alternative solution for service users (NHS England case study) Other examples are evident across the country including Greater Manchester, Wirral. We want these types of services to be available to our communities too

Enhancing our community support

Benefits will include:

- Consistent access to services
- PICU provision within appropriate inpatient facility
- Enhanced community services
- Responsive, community focussed, personalised care system providing wrap around care.
- Access to specialist services as close to home as possible
- Support for individuals to effectively manage their wellbeing with a focus on empowerment, prevention and resilience
- More patients supported in their own homes
- Access to out of hours support for those in a crisis

How will any outcomes of the project be monitored, reviewed, evaluated and promoted where necessary?

The project will be monitored using the Outcomes framework, IAF framework measures to ensure no adverse impact on care, and also through contractual obligations with CWP

"think about how you can evaluate equality of access to, outcomes of and satisfaction with services by different groups"

- Feedback from users of the service will be captured through the use of the following:
- Friends and family test
- Patient satisfactions survey

- Patient reported outcomes measures
- Patient reported experience measures

EQUALITY IMPACT AND RISK ASSESSMENT

Does the 'project' have the potential to:

- Have a ***positive* impact (benefit)** on any of the equality groups?
- Have a ***negative impact / exclude /* discriminate** against any person or equality group?
- **Explain** how this was **identified? Evidence/Consultation?**
- Who is most likely to be **affected** by the proposal and **how** (think about barriers, access, effects, outcomes etc.)
- Please include all evidence you have considered as part of your assessment e.g. Population statistics, service user data broken down by equality group/protected group

Please request guidance on Equality Groups/Protected Groups and their issues, this document may help and support your thinking around barriers for the equality groups

Equality Group / Protected Group	Positive effect	Negative effect	Neutral effect	Please explain - MUST BE COMPLETED
Age	☑	☑		Positive impact - With the changes proposed in this model the Services users will have the opportunity to access a 24/7 crisis service, which should ensure access to help at the point at which it is most needed, therefore preventing the need for hospitalisation. Enables earlier supported discharge. Adults in the age category 18-64 would continue to have their care provided locally. Potential negative impact – Adults age 65+ who require an acute inpatient bed, ECT or PICU provision will be admitted to Bowmere. This may be a greater distance than if they were admitted to Millbrook. In some cases the in-patient facility may be closer to the patients home than the one based in Macclesfield. With regards to visiting we will work with family and carers to find solutions to any transport problems on a case by case basis..
Disability	☑	☑		Positive impact - With the changes proposed in this model the Services users

				will have the opportunity to access a 24/7 crisis service, which should ensure access to help at the point at which it is most needed, therefore preventing the need for hospitalisation. Enables earlier supported discharge Potential negative impact – Adults age 65+ who require an acute inpatient bed, ECT or PICU provision will be admitted to Bowmere. This may be a greater distance than if they were admitted to Millbrook. In some cases the in-patient facility may be closer to the patients home than the one based in Macclesfield. With regards to visiting we will work with family and carers to find solutions to any transport problems on a case by case basis.
Gender Reassignment	☑	☑		Positive impact - With the changes proposed in this model the Services users will have the opportunity to access a 24/7 crisis service, which should ensure access to help at the point at which it is most needed, therefore preventing the need for hospitalisation. Enables earlier supported discharge. Potential negative impact – Adults age 65+ who require an acute inpatient bed, ECT or PICU provision will be admitted to Bowmere. This may be a greater distance than if they were admitted to Millbrook. In some cases the in-patient facility may be closer to the patients home than the one based in Macclesfield. With regards to visiting we will work with family and carers to find solutions to any transport problems on a case by case basis. Mitigation • Taking into regard the persons chosen gender identity, patients would be appropriately placed.
Pregnancy and Maternity	☑			Patients already travel out of area for maternal mental health.
Race	☑	☑		Positive impact - With the changes proposed in this model the Services users will have the opportunity to access a 24/7 crisis service, which should ensure access to help at the point at which it is most needed,

				therefore preventing the need for hospitalisation. Enables earlier supported discharge. Potential negative impact – Adults age 65+ who require an acute inpatient bed, ECT or PICU provision will be admitted to Bowmere. This may be a greater distance than if they were admitted to Millbrook. In some cases the in-patient facility may be closer to the patients home than the one based in Macclesfield. With regards to visiting we will work with family and carers to find solutions to any transport problems on a case by case basis. Mitigation • Providing information in alternative languages. • Ensuring all staff have appropriate training in cultural diversity. • Ensuring effective and timely interpretation services are made available and staff understand the requirements and system for providing this. • All CWP staff work within the Equality, Diversity and Human Rights policy, and regardless of the outcome of the consultation everyone will be offered a person centred approach.
Religion or Belief	☑	☑		Positive impact - With the changes proposed in this model the Services users will have the opportunity to access a 24/7 crisis service, which should ensure access to help at the point at which it is most needed, therefore preventing the need for hospitalisation. Enables earlier supported discharge. Potential negative impact –Adults age 65+ who require an acute inpatient bed, ECT or PICU provision will be admitted to Bowmere. This may be a greater distance than if they were admitted to Millbrook. In some cases the in-patient facility may be closer to the patients home than the one based in Macclesfield. With regards to visiting we will work with family and carers to find solutions to any transport problems on a case by case

				basis. Mitigation • Providing information in alternative languages; • Ensuring all staff have appropriate training in cultural diversity • Ensuring effective and timely interpretation services are made available and staff understand the requirements and system for providing this • All CWP staff work within the Equality, Diversity and Human Rights policy, and regardless of the outcome of the consultation everyone will be offered a person centred approach. • All CWP inpatient units provide access to multi-faith rooms, facilitate support from faith leaders and promote and support individuals to continue to access faith based community support whilst receiving inpatient care.
Sex (Gender)	☑	☑		Positive impact - With the changes proposed in this model the Services users will have the opportunity to access a 24/7 crisis service, which should ensure access to help at the point at which it is most needed, therefore preventing the need for hospitalisation. Enables earlier supported discharge. Potential negative impact – Adults age 65+ who require an acute inpatient bed, ECT or PICU provision will be admitted to Bowmere. This may be a greater distance than if they were admitted to Millbrook. In some cases the in-patient facility may be closer to the patients home than the one based in Macclesfield. With regards to visiting we will work with family and carers to find solutions to any transport problems on a case by case basis. Mitigation • Staff support and training

				• Provision of single ensuite rooms
Sexual Orientation	☑	☑		Positive impact - With the changes proposed in this model the Services users will have the opportunity to access a 24/7 crisis service, which should ensure access to help at the point at which it is most needed, therefore preventing the need for hospitalisation. Enables earlier supported discharge. Potential negative impact – Adults age 65+ who require an acute inpatient bed, ECT or PICU provision will be admitted to Bowmere. This may be a greater distance than if they were admitted to Millbrook. In some cases the in-patient facility may be closer to the patients home than the one based in Macclesfield. With regards to visiting we will work with family and carers to find solutions to any transport problems on a case by case basis. Mitigation • Work closely with LGBT groups • Support engagement with LGBT community via EDS2 • Training and staff support
Marriage and Civil Partnership N.B. Marriage & Civil Partnership is only a protected characteristic in terms of work-related activities and NOT service provision	☑	☑		Positive impact - With the changes proposed in this model the Services users will have the opportunity to access a 24/7 crisis service, which should ensure access to help at the point at which it is most needed, therefore preventing the need for hospitalisation. Enables earlier supported discharge. Potential negative impact – Adults age 65+ who require an acute inpatient bed, ECT or PICU provision will be admitted to Bowmere. This may be a greater distance than if they were admitted to Millbrook. In some cases the in-patient facility may be closer to the patients home than the one based in Macclesfield. With regards to visiting we will work with family and carers to find solutions to any transport problems on a case by case basis.
Carers	☑	☑		Positive impact - With the changes proposed in this model the Services users will have the opportunity to access a 24/7

				crisis service, which should ensure access to help at the point at which it is most needed, therefore preventing the need for hospitalisation. Enables earlier supported discharge. Potential negative impact – Adults age 65+ who require an acute inpatient bed, ECT or PICU provision will be admitted to Bowmere. It is acknowledged that carers will have to travel to visit their loved ones, and this may be a greater distance than they would if their loved one was admitted to Millbrook. This is dependent on where the carer lives in relation to the various inpatient units, and we cannot assume that all carers reside with the individual whom they are caring for and/or related to. With regards to visiting we will work with family and carers to find solutions to any transport problems on a case by case basis. Mitigation • Flexible visiting hours • Virtual visiting. I.e. Skype, Facetime etc.
Deprived Communities	☑	☑		Positive impact - With the changes proposed in this model the Services users will have the opportunity to access a 24/7 crisis service, which should ensure access to help at the point at which it is most needed, therefore preventing the need for hospitalisation. Enables earlier supported discharge. Potential negative impact – Adults age 65+ who require an acute inpatient bed, ECT or PICU provision will be admitted to Bowmere. This may be a greater distance than if they were admitted to Millbrook. In some cases the in-patient facility may be closer to the patients home than the one based in Macclesfield. With regards to visiting we will work with family and carers to find solutions to any transport problems on a case by case basis. Mitigation • Flexible visiting hours • Virtual visiting. I.e. Skype, Facetime etc. • Prioritise local beds based on patient and carer need • Appropriate package of care on

				discharge from hospital.
Vulnerable Groups e.g. Homeless, Sex Workers, Military Veterans	☑	☑		Positive impact - With the changes proposed in this model the Services users will have the opportunity to access a 24/7 crisis service, which should ensure access to help at the point at which it is most needed, therefore preventing the need for hospitalisation. Enables earlier supported discharge. Potential negative impact – Adults age 65+ who require an acute inpatient bed, ECT or PICU provision will be admitted to Bowmere. This may be a greater distance than if they were admitted to Millbrook. In some cases the in-patient facility may be closer to the patients home than the one based in Macclesfield. With regards to visiting we will work with family and carers to find solutions to any transport problems on a case by case basis. Mitigation • Flexible visiting hours • Virtual visiting. I.e. Skype, Facetime etc. • Prioritise local beds based on patient and carer need • Appropriate package of care on discharge from hospital.

SECTION 3 - COMMUNITY COHESION & FUNDING IMPLICATIONS

Does the 'project' raise any issues for Community Cohesion?

N/A

What effect will this have on the relationship between these groups? Please state how will you manage this relationship?

N/A

What is the overall cost of implementing the 'project'?

Please state: Cost & Source(s) of funding:

This is the end of the Equality Impact section, please use the embedded checklist to ensure and reflect that you have included all the relevant information

EI&RA checklist_V1.0_11091

SECTION 4 - HUMAN RIGHTS ASSESSMENT

If the Stage 1 Equality Impact and Risk Assessment highlighted that you are required to complete a Stage 2 Human Rights assessment (please request a stage 2 Human Rights Assessment from the Equality and Inclusion Team), please bring the issues over from the screening into this section and expand further using the Human Rights full assessment toolkit then embed into this section.

SECTION 5 - PRIVACY IMPACT ASSESSMENT

If the Stage 1 Equality Impact and Risk Assessment highlighted that you are required to complete a Stage 2 Privacy Impact Assessment, please request a stage 2 Privacy Impact Assessment either from the Equality and Inclusion Team or the Information Governance Team, email your completed stage 2 to your Information Governance Support Officer either at the CCG or CSU.

A separate document has been completed for the Privacy Impact Assessment.

SECTION 6 – RISK ASSESSMENT

Please identity any possible risk for patients and / or the Clinical Commissioning Group if the project is implemented without amendment. All risks will be monitored for trends and provided to the project author when the project is due to be reviewed

IMPLEMENTATION RISK: CONSEQUENCE SCORE

DOMAIN	INSIGNIFICANT	MINOR	MODERATE	MAJOR	CATASTROPHIC
Impact on the safety of patients, staff or public (physical / psychological harm	Minimal injury requiring no / minimal intervention or treatment	Minor injury or illness, requiring minor intervention	Moderate injury requiring professional intervention RIDDOR / agency reportable incident, an event which impacts on a small number of patients	Major injury leading to long-term incapacity / disability. Mismanagement of patient care with long-term effects	Incident leading to death. An event which impacts on a large number of patients
Complaints / Audit	Informal complaint / inquiry	Formal complaint (Stage 1) Local resolution Single failure to meet internal standards Reduced performance rating if unresolved	Formal complaint (Stage 2) complaint Local resolution (with potential to go to independent review) Repeated failure to meet internal standards	Multiple complaints / independent review Low performance rating Critical report	Inquest / Ombudsman inquiry Gross failure to meet national standards Severely critical report
Statutory Duty / Inspections	No or minimal impact or breech of guidance / statutory duty For example: Unsatisfactory	Breech of statutory legislation. Reduced performance rating if unresolved. For	Single breech in statutory duty. Challenging external recommendations / improvement notice.	Multiple breeches in statutory duty. Prosecution Zero performance rating Severely critical report.	Multiple breeches in statutory duty. Prosecution Zero performance rating Severely critical report.

	patient experience which is not directly related to patient care. No action required	example: a minor impact on people with a protected characteristic has been identified that was agreed to be accepted within the scope of the project. No action required.	For example: a moderate impact on people with a protected characteristic has been identified. This can be resolved by making amendments to the project or providing an objective justification for not amending the project (This must be published with the EIA)	performance rating report For example: a major impact on people with a protected characteristi c has been identified. Consideratio n should be given to and review the project immediately. Q. Can we make amendment s to the project or provide objective justifications ? If yes, this must be published the EIA.	For example: a catastrophic impact on people with a protected characteristic has been identified that may lead to litigation or impact on patient safety. The project should be stopped immediately
Adverse Publicity / Reputation	Rumours Potential for public concern	Local media coverage short-term reduction in public confidence. Elements of public expectation not being met	Local media coverage. Long-term reduction in public confidence	National media coverage <3 days service well below reasonable public expectation	National media coverage > 3 days MP concerned (questions in the House) Total loss of public confidence
Business Objectives / Projects	Insignificant cost increase No impact on objectives	<5 per cent over project budget Minor impact on delivery of objectives	5 – 10 per cent over project budget	Non-compliance with national 10 – 25 per cent over budget Major impact on delivery of strategic objectives	Incident leading > 25 per cent over project budget Failure of strategic objectives impacting on delivery of business plan
Finance Including Claims	Small loss risk of claim remote	Loss of 0.1 – 0.25 per cent of budget Claim less than £10,000	Loss of 0.25 – 0.5 per cent of budget Claims (s) between £10,000 and £100,000	Loss of 0.5 – 1.0 per cent of budget Claim(s) between £100,000 and £1 million	Loss of >1 per cent of budget Claim(s) > £1 million
IMPLEMENTATION RISK: LIKELIHOOD SCORE					
Frequency: How often	Not expected to occur for years	Expected to occur annually	Expected to occur monthly	Expected to occur weekly	Expected to occur daily

might it / does it happen?					
Probability	<1%	1.5%	6-20%	21-50%	>50%
	Will only occur in exceptional circumstances	Unlikely to occur	Reasonable chance of occurring	Likely to occur	More likely to occur than not occur

RISK MATRIX					
	RARE	UNLIKELY	POSSIBLE	LIKELY	ALMOST CERTAIN
Insignificant	1	2	3	4	5
Minor	2	4	6	8	10
Moderate	3	6	9	12	15
Major	4	8	12	16	20
Catastrophic	5	10	15	20	25

RISK SCORE ON DRAFT PROJECT	RISK SCORE ON FINALISED PROJECT
5	5

WHAT ARE THE KEY REASONS FOR THE CHANGE IN THE RISK SCORE?

EQUALITY IMPACT AND RISK ASSESSMENT AND ACTION PLAN

Risk identified	Actions required to reduce / eliminate the negative impact	Resources required* (see guidance below)	Who will lead on the action?	Target completion date
Negative media coverage has a detrimental impact on public consultation outcome	Communication and Engagement Plan to support proactive approach to local media. Consistent message from partners in communicating case for change. Joint approach to communication to wider statutory bodies. Clear governance process to obtain sign off from all partners for communication plan. Fully engage public in pre consultation process and consultation process (health voice, health watch, general public, 3rd sector organisations)	**Comms and Enagagement team**	**Katherine Wright, Charles Malkin**	**Ongoing throughout life of project**
Service sustainability during the planning and consultation phase	CWP to evoke Business Continuity plans. Regular communication with staff. Clinical Leadership across system to identify measures to maintain quality of care.	**CWP**	**Suzanne Edwards**	**Post Consultation**

Potential delays in delivering the programme within the timescales	Develop project plan with clear time lines to deliver the work plan and navigate governance process including NHSE sign off. Project Meetings bi weekly to monitor delivery against plan. Escalate project slippage to SRO.	**Project Sponsor**	**Jacqui Wilkes**	**Throughout the life of the project**
The decision making process following consultation period is challenged	Project process to follow NHS England best practice guidance recruit consultation expert to support pre-consultation engagement and the consultation itself. Ensure project documentation fully up to date and take clear and transparent approach to process and decision making. Take legal advice on consultation documentation. Independent review by Chester University within consultation timeline	**Project Sponsor**	**Jacqui Wilkes**	**Throughout the life of the project**
The new care model may exceed the financial envelope available and cannot be fully implemented.	To ensure clinical engagement in the redesign process. Highlighting efficiency measures that deliver savings whilst not compromising patient safety.	**Project Sponsor, Finance Rep**	**Jacki Wilkes, Scott Maull, Elizabeth Insley**	

'Resources required' is asking for a summary of the costs that are needed to implement the changes to mitigate the negative impacts identified

SECTION 7 – ONGOING MONITORING AND REVIEW OF EQUALITY IMPACT ASSESSMENTS AND ACTION PLANS

Please describe briefly, how the equality action plans will be monitored through internal CCG governance processes?

Using the IAF framework, and project highlight reports to Programme executive and organisational boards.

Date of the next review of the Equality Impact Assessment section and action plan? (Please note: if this is a project or pilot reviews need to be built in to the project/pilot plan)

Date: End of the consultation

Which CCG Committee will be responsible for monitoring the action plan progress?
Caring Together Board, Connecting Care

Who will be the responsible person in the organisation to ensure the action plan is monitored? Jacki Wilkes and Jamaila Tausif
FINAL SECTION **SECTION 8**
Date sent to Equality & Inclusion (E&I) Team for quality check: **09-11-2017**
Date quality checked by Equality and Inclusion Business Partner: **09-11-2017**
Date of final sign off by Equality and Inclusion Business Partner: **09-11-2017**
Signature Equality and Inclusion Business Partner: Q Hussain
CCG Committee Name and sign off date:

This is the end of the Equality Impact and Risk Assessment process: By now you should be able to clearly demonstrate and evidence your thinking and decision(s).
To meet publishing requirements this document SHOULD NOW BE PUBLISHED ON YOUR ORGANISATIONS WEBSITE.

- Save this document for your own records
- Send this document and copies of your completed Privacy Impact Assessment and Human Rights Screening to equality.inclusion@nhs.net

NHS
Eastern Cheshire
Clinical Commissioning Group

Eastern Cheshire Clinical Commissioning Group: Quality Impact Assessment Tool

This tool involves an initial assessment (stage 1) to quantify potential impacts (positive or negative) on quality from any proposal to change the way services are commissioned and/or delivered. Where potential negative impacts are identified they should be risk assessed using the risk scoring matrix to reach a total risk score. A total score is achieved by assessing the level of impact and the likelihood of this occurring and assigning a score to each. These scores are multiplied to reach a total score.

Quality is described in 7 areas, each of which must be assessed at stage 1. Where a potentially negative risk score is identified and is greater than a score of 8 this indicates that a more detailed assessment is required in this area, to be completed within stage 2.

Please take care with this assessment. A carefully completed assessment should safeguard against challenge at a later date.

Definitions for grading

Risk Assessment Matrix								
Risk Assessment		Circle consequence, likelihood and total score e.g. 2 x 3 = 6			SCORE			
		LIKELIHOOD/PROBABILITY OF REPEAT						
INCIDENT CONSEQUENCES or POTENTIAL CONSEQUENCES		Rare	Unlikely	Possible	Highly Likely	Almost Certain		
		1	*2*	*3*	*4*	*5*		
1	Negligible	1	2	3	4	5		
2	Minor	2	4	6	8	10		
3	Moderate	3	6	9	12	15		
4	Major	4	8	12	16	20		
5	Extreme	5	10	15	20	25		

Green	(score 5 or less)	Low risk	Low priority	Manage situation by routine procedures
Amber	(score 6 to 15)	Medium risk	Medium priority	Management responsibility and action must be specified
Red	(score 16 to 25) Or any incident recorded as extreme regardless of the likelihood/probability of repeat	High risk	High Priority	Immediate action – Senior Management attention required. 16+ Senior Management to consider informing the Board.

Measures of Likelihood

LEVEL	DESCRIPTOR	PROBABILITY
1	Rare	The event may only happen in exceptional circumstances
2	Unlikely	The event could occur (recur) at some time
3	Possible	The event may well occur (recur) at some time
4	Highly likely	The event will occur (recur) in most circumstances
5	Almost Certain	The event is expected to occur (recur) in most circumstances

Stage 1 – Initial Risk Assessment 6th Month Review Date – 12-June-2017

Title: Adult Mental Health Redesign Option 4a

Lead for scheme: Jacki Wilkes Associate Director of Commissioning

Brief description of scheme:
Commissioners in Vale Royal, South and Eastern Cheshire are working with local mental health provider; Cheshire and Wirral Partnership, users of the service and Cheshire East Council to review and redesign secondary care adult and older peoples mental health services for those people with severe mental illness (SMI).

A Pre Consultation Business Case (PCBC) will outline a compelling case for change and present options which will deliver redesigned services for improved outcomes for the registered population of Vale Royal, South and Eastern Cheshire in line with national Five Year Forward View (FYFV) for Mental Health.

The FYFV for mental health sets out an ambitious programme of improvement to be achieved by 2021 setting standards for access and guidelines for care including 24/7 access to care, early intervention (proactive care) and prevention. The proposals presented are done so within a context of rising demands for services, increasing financial constraints across the health and social care system and national drivers to improve access to a

range of services not currently commissioned.

This QIA is for Option 4a outlined below:

Option 4a: Enhanced community and crisis care service and re-provide inpatient care from Millbrook to other facilities within current provider footprint (older people Lime Walk House, Macclesfield and adults Bowmere in Chester)

Description: In this option 22 beds would be provided at Lime Walk House; 10 for older people with dementia and 12 for older or more physically vulnerable adults with functional illness. 22 beds would be provided at Bowmere and 3 at Wirral for adults. Central and Eastern Cheshire patients would be given priority admission to Bowmere. Rehabilitation services currently delivered at Lime Walk House would be re-provided at the Soss Moss site in Nether Alderley. In patient ECT would be delivered at the specialist ward in Bowmere. Community mental health teams would deliver evidenced based interventions to support people in their own homes and have the appropriate skills to do so. A new model of crisis care will be introduced which would see the home treatment team providing 24/7 care in conjunction with, overnight placement support and day time crisis café

Answer positive/negative (+ / -) in each area. If N; score the impact, likelihood and total in the appropriate box. If score > 8 insert Y for full assessment

Area of Quality	Impact question	+ / -	Impact	Likely-hood	Score	Full Assessment required?
Duty of Quality	Could the proposal impact positively or negatively on any of the following - compliance with the NHS Constitution, partnerships, safeguarding children or adults and the duty to promote equality?	positive	**2**	**2**	**4**	**N**
Patient Experience	Could the proposal impact positively or negatively on any of the following - positive survey results from patients, patient choice, personalised & compassionate care?	Neutral	**2**	**3**	**6**	**N**
Patient Safety	Could the proposal impact positively or negatively on any of the following – safety, systems in place to safeguard patients to prevent harm, including infections?	Positive	**2**	**2**	**4**	**N**
Clinical Effectiveness	Could the proposal impact positively or negatively on evidence based practice, clinical leadership, clinical engagement and/or high quality standards?	Positive	**2**	**2**	**4**	**N**
Prevention	Could the proposal impact positively or negatively on promotion of self-care and health inequality?	Positive	**2**	**2**	**4**	**N**
Productivity and Innovation	Could the proposal impact positively or negatively on - the best setting to deliver best clinical and cost effective care; eliminating any resource inefficiencies; low carbon pathway; improved care pathway?	Positive	**2**	**2**	**4**	**N**
Resource Impact	Could this proposal impact positively or negatively with regard to estates, IT resource, community equipment service or other agencies or providers e.g. Social care/voluntary sector/District nursing*	Positive	**2**	**2**	**4**	**N**

Completed by:	Designation:	Date:
Marie Ward	Transformation Project Manager	07.11.17

Stage 2 – Full Assessment for identified areas of risk

Area of quality	Indicators	Description of impact (Positive or negative)	Risk (5 x5 risk matrix)			Mitigation strategy and monitoring arrangements
			Impact	Likelihood	Overall Score	
DUTY OF QUALITY	What is the impact on the organisation's duty to secure continuous improvement in the quality of the healthcare that it provides and commissions?	Continuous improvement in the quality of healthcare will be monitored as part of Mental Health Outcomes Framework, Friends and Family Test and self-reported Experience and Outcomes Assessments.	2	2	4	Monitor and Review
	Does it impact on the organisation's commitment to the public to continuously drive quality improvement as reflected in the rights and pledges of the NHS Constitution?	The projects aim is to support the delivery of the Five Year Forward View for Mental Health. To improve quality of care, patient experience and mental health outcomes, whilst ensuring the services are clinically and financially sustainable. The views and experiences of users and carer have informed the development of Pre Consultation Business Case (PCBC)	2	2	4	Monitor and Review
	Does it impact on the organisation's commitment to high quality workplaces, with commissioners and providers aiming to be employers of choice as reflected in the rights and pledges of the NHS Constitution?	Engagement and communication with Clinical Mental health Specialist including; NHS Mental Health Trust and Community Services and General Practice includes; front line staff drop-in sessions, Clinical Leaderships Meetings, GP Locality	2	2	4	Monitor and Review

Area of quality	Indicators	Description of impact (Positive or negative)	Risk (5 x5 risk matrix)			Mitigation strategy and monitoring arrangements
			Impact	Likelihood	Overall Score	
		and membership meetings to engage views and inform the PCBC and design of new model of care for Adult Mental Health.				
	What is the impact on strategic partnerships and shared risk?	Positive Impact Providers and Commissioners across Eastern Cheshire, South and Vale Royal CCG, Cheshire East Council and Cheshire and Wirral Partnership NHS Foundation Trust, working in partnership to develop the PCBC, North West Ambulances Service and Cheshire Police have been involved in discussion and scoring the options. The project team includes; clinical specialists, patients and carers, commissioners from health and social care and providers of mental health services.	**2**	**2**	**4**	Mitigating Actions Joint /Shared risk log jointly owned across partner organisations
	What is the equality impact on race, gender, age, disability, sexual orientation, religion and belief, gender reassignment, pregnancy and maternity for individual and community health, access to services and experience of using the NHS (Refer to CCG Equality Impact Assessment Tool)?	Stage 1 and Stage 2 equality impact and risk assessment have been completed and an action plan has been developed.	**2**	**2**	**4**	Monitor and Review

Area of quality	Indicators	Description of impact (Positive or negative)	Risk (5 x5 risk matrix)			Mitigation strategy and monitoring arrangements
			Impact	Likelihood	Overall Score	
DUTY OF QUALITY	Are core clinical quality indicators and metrics in place to review impact on quality improvements?	A set of standardised key performance indicator measures aligned to National and Local Outcomes Frameworks have been identified to support completion of a final business case and future commissioning of Adult Mental Health Services.	2	2	4	Monitor and Review
	Will this impact on the organisation's duty to protect children, young people and adults?	There is no perceived negative impact on organisation's duty to protect adults	2	2	4	Monitor and Review
PATIENT EXPERIENCE	What impact is it likely to have on self-reported experience of patients and service users? (Response to national/local surveys/complaints/PALS/incidents)	**In option 4a there** is a change in how inpatient beds are provided across Cheshire with 22 beds being provided locally for older people with dementia and more physically vulnerable adults with functional illness, Rehabilitation services would continue to be provided locally. Up to 25 beds would be re provided in Chester and the Wirral. A new model of crisis care introduced which would see the home treatment team providing 24/7 care in conjunction with an increase in home treatment team, overnight placement support and day time crisis café.	2	3	6	Mitigating Actions Continued engagement with service, users, families and carers to understand solutions for a small proportion of people who will need to travel further for in-patient care and visiting such as flexible visiting times and use of technology e.g. facetime To support for patients, families and carers who will need to travel further. It may be possible to access short term support for families and carers to visit Bowmere, which would be on a case by

Area of quality	Indicators	Description of impact (Positive or negative)	Risk (5 x5 risk matrix)			Mitigation strategy and monitoring arrangements
			Impact	Likelihood	Overall Score	
						case basis and dependent on individual circumstances Monitoring through Friends and Family Test, Patient Reported Outcomes Measures (PROMS), Patient Experience Measures (PREMS)
	How will it impact on choice?	In line with the 5YFV for MH the PCBC is aligned to providing specialist care, at the right time, in the right place. Providing high quality, CQC compliant inpatient care and improving community and crisis resolution home treatment 24/7. Option 4a provides older peoples inpatient care in Macclesfield, Rehabilitation and Crisis Beds. Adult inpatient care will move to Bowmere in Chester which impacts on patients, families and carers travel times.	**2**	**3**	**6**	Mitigating Actions Continued engagement with service, users, families and carers to understand solutions for a small proportion of people who will need to travel further for in-patient care and visiting. With regards to visiting we will work with family and carers to find solutions to any transport problems on a case by case basis. Travel bursaries may be available for low income families Monitoring through Friends and Family Test, Patient Reported Outcomes Measures (PROMS), Patient Experience Measures (PREMS)

Area of quality	Indicators	Description of impact (Positive or negative)	Risk (5 x5 risk matrix)			Mitigation strategy and monitoring arrangements
			Impact	Likelihood	Overall Score	
	Does it support the compassionate and personalised care agenda?	Positive Impact additional support will be provided in Community services and crisis resolution home treatment team including Crisis House (short inpatient stay) and Crisis Café. This will achieve the standard of care in the most unrestricted environment. The newly provided Dementia Outreach service will support people to stay safely at home in familiar surroundings	2	2	4	Monitor and Review
PATIENT SAFETY	How will it impact on patient safety?	There is no perceived negative impact to patient safety.	2	2	4	Mitigating Actions Datix Risk Management CQC Reports Audit Outcomes Complaints Reviews Mortality Data
	How will it impact on preventable harm?	There is no perceived negative impact on preventable harm	2	2	4	Mitigating Actions Datix Risk Management CQC Reports Audit Outcomes Complaints Reviews Mortality Data
	Will it maximise reliability of safety systems?	There is no perceived negative impact on safety systems	2	2	4	Mitigating Actions Datix Risk Management CQC Reports Audit Outcomes Complaints Reviews

Area of quality	Indicators	Description of impact (Positive or negative)	Risk (5 x5 risk matrix)			Mitigation strategy and monitoring arrangements
			Impact	Likelihood	Overall Score	
						Mortality Data
	How will it impact on systems and processes for ensuring that the risk of healthcare acquired infections is reduced?	There shall be no additional impact on safety systems. As part of STP Prevention Programme additional Antimicrobial Resistance support is being planned, which will impact positively to reduce infection rates. Caring for people in the home where possible will have an impact on hospital acquired infection rates.	**2**	**2**	**4**	Mitigating Actions Datix Risk Management CQC Reports Audit Outcomes Complaints Reviews Mortality Data
	What is the impact on clinical workforce capability care and skills?	A workforce plan will ensure that community and inpatient teams have the right skill mix and capabilities on a rota 24/7 where appropriate to provide high quality patient care and outcomes. The workforce plan has been modelled against patients care needs and will include training on physical and mental health clinical knowledge to support parity of esteem.	**2**	**2**	**4**	Mitigating Actions Mapping existing and future workforce requirements including associated financial implications Development of Work Force Plan
CLINICAL EFFECTIVENESS	How does it impact on implementation of evidence based practice?	The Pre Consultation Business Case has been developed and based on evidence based best practice, national policy and includes a literature review on achieving	**2**	**2**	**4**	Mitigating Actions Site visits to other Mental Health Units delivering Integrated Community Care and Crisis Models of Care

Area of quality	Indicators	Description of impact (Positive or negative)	Risk (5 x5 risk matrix)			Mitigation strategy and monitoring arrangements
			Impact	Likelihood	Overall Score	
		improved outcomes and parity of esteem. Site visits to other Mental Health Trusts have been undertaken with clinicians and experts by experience to look at best practice.				Review of literature
	How will it impact on clinical leadership?	There is no perceived negative impact on clinical leadership	**2**	**2**	**4**	Monitor and Review
	Does it support the full adoption of Better care, Better Value metrics?	The project team has adopted Better Value principles and aligned to Better Care metrics which will be aligned to mental health outcomes framework and future provider contract management	**2**	**2**	**4**	Monitor and Review

Area of quality	Indicators	Description of impact (Positive or negative)	Risk (5 x5 risk matrix)			Mitigation strategy and monitoring arrangements
			Impact	Likelihood	Overall Score	
	Does it reduce/impact on variations in care?	There is a neutral impact on variations in care. Enhanced community and crisis care 24/7 will deliver a proactive approach to community mental health care, with staff being trained to provide intensive home treatment. The new model of care will over time deliver approximately 16% reduction in hospital based activity (Crisp Report) . In patient care will be delivered locally for older people and people requiring short term inpatient care in a crisis. Specialist Mental Health inpatient care for adults and day case Electro Convulsive Therapy will be provided at Bowmere in Chester	2	3	6	Mitigating Actions Where travel is a problem CWP will work with family and carers to find solutions to any transport problems on a case by case basis. Travel bursaries may be available for low income families
	Are systems for monitoring clinical quality supported by good information?	A set of standardised key performance indicator measures aligned to a Mental Health Outcomes Framework will be agreed as part of future provider contract management and monitored via contract and quality assurance	2	2	4	Monitor and Review
	Does it impact on clinical engagement?	As part of the communication and engagement plan, staff are being	2	2	4	Monitor and Review

Area of quality	Indicators	Description of impact (Positive or negative)	Risk (5 x5 risk matrix)			Mitigation strategy and monitoring arrangements
			Impact	Likelihood	Overall Score	
		engaged with through drop-in sessions. The project team include clinical specialists from primary and secondary care. General Practitioners have been engaged with at locality and clinical leadership group meetings.				
PREVENTION	Does it support people to stay well?	The project will encourage people to stay well through supported self-care sign posting to care services though Directory of Services and Single Point of Access. On line information and tools to support people to manage their own health and wellbeing	2	2	4	Monitor and Review
	Does it promote self-care for people with long term conditions?	A key outcome of Mental Health outcomes Framework is Parity of Esteem, which is also a National CQUIN.	2	2	4	Monitor and Review
	Does it tackle health inequalities, focusing resources where they are needed most?	Stage 1 and Stage 2 equality impact and risk assessment have been completed and an action plan has been developed.	2	2	4	Monitor and Review
IVITY & IN	Does it ensure care is delivered in the most clinically and cost effective way?	The proposed service change would cost less overall than current	2	3	6	Mitigating Actions

Area of quality	Indicators	Description of impact (Positive or negative)	Risk (5 x5 risk matrix)			Mitigation strategy and monitoring arrangements
			Impact	Likelihood	Overall Score	
		services and contribute to reducing the deficit in NHS mental health services for Central and Eastern Cheshire. Finding an affordable solution is necessary for long-term clinical sustainability and this moves services in the right direction, within the context of severe financial challenge across the Health and Care Economy.				Develop accurate costing model for new model of care to minimise over spend on agreed budget through implementation of new services. Underlying sustainability of the whole economy supported by on-going QIPP/CIP programmes and support from NHSE/I through CEP process Partnership approach to driving out costs Ensure any external contracts procured with value for money at forefront.
	Does it eliminate inefficiency and waste?	The project aim is to reduce inefficiency and waste in the system to enable high quality care, patient experience and improved patient outcomes. Improved access to community teams and crisis resolution home treatment team, which are adequately resourced to	**2**	**2**	**4**	Monitor and Review

Area of quality	Indicators	Description of impact (Positive or negative)	Risk (5 x5 risk matrix)			Mitigation strategy and monitoring arrangements
			Impact	Likelihood	Overall Score	
		offer intensive home treatment as an alternative to acute inpatient admission. Increased access to psychological therapies and access to navigators who are available to people who require specialist care from diagnosis onwards, to guide them through the options for their care and ensure they receive appropriate information and support. Analysis of data highlights that there are currently 58 beds however national and locally modelled data shows that for our population only 45 beds would be required if community services and rapid response was enhanced.				
	Does it support low carbon pathways?	A Travel Assessment has been completed looking at current and future travel to inpatient care and public transport links. There is a neutral impact which will be realised as the service is implemented and benefits are realised in reduced inpatient activity and length of stay.	**2**	**2**	**4**	Monitor and Review
	Will the service innovation achieve large gains in performance?	The new care model design is innovative in supporting people in	**2**	**2**	**4**	Monitor and Review

Area of quality	Indicators	Description of impact (Positive or negative)	Risk (5 x5 risk matrix)			Mitigation strategy and monitoring arrangements
			Impact	Likelihood	Overall Score	
		their own homes or close to home in delivering enhanced Community Care, Crisis Resolution, short stay in-patient care in Crisis House and day time support in Crisis Café with access to Recovery College. Technology will support integrated working across health and social care. A significant gain will be reduction in hospital activity by approximately 16%				
	Does it lead to improvements in care pathway(s)?	The new care model design provides seamless care across the care model, to support people in their own homes or close to home through the delivery of older people inpatient care, increased provision of community care, crisis resolution home treatment and short stay in patient care in Crisis House and day time support in Crisis Cafes	**2**	**2**	**4**	Monitor and Review

Completed by:	Designation:	Date:
Marie Ward Jacki Wilkes	Transformation Project Manager Associate Director of Commissioning Eastern Cheshire	07.11.17

	CCG	

Reviewed and signed off by: Sally Rogers Julia Curtis Pending sign off by CQ&P 13.12.17	Designation: Lead Nurse, Community and Safeguarding Registered Eastern Cheshire CCG Nurse, Governing Body Member Eastern Cheshire CCG Head of Clinical Quality	Date: 09.11.17

NHS
Eastern Cheshire
Clinical Commissioning Group

Eastern Cheshire Clinical Commissioning Group: Quality Impact Assessment Tool

This tool involves an initial assessment (stage 1) to quantify potential impacts (positive or negative) on quality from any proposal to change the way services are commissioned and/or delivered. Where potential negative impacts are identified they should be risk assessed using the risk scoring matrix to reach a total risk score. A total score is achieved by assessing the level of impact and the likelihood of this occurring and assigning a score to each. These scores are multiplied to reach a total score.

Quality is described in 7 areas, each of which must be assessed at stage 1. Where a potentially negative risk score is identified and is greater than a score of 8 this indicates that a more detailed assessment is required in this area, to be completed within stage 2.

Please take care with this assessment. A carefully completed assessment should safeguard against challenge at a later date.

Definitions for grading

Risk Assessment Matrix								
Risk Assessment		Circle consequence, likelihood and total score e.g. 2 x 3 = 6			SCORE			
		LIKELIHOOD/PROBABILITY OF REPEAT						
INCIDENT CONSEQUENCES or POTENTIAL CONSEQUENCES		Rare	Unlikely	Possible	Highly Likely	Almost Certain		
		1	*2*	*3*	*4*	*5*		
1	Negligible	1	2	3	4	5		
2	Minor	2	4	6	8	10		
3	Moderate	3	6	9	12	15		
4	Major	4	8	12	16	20		
5	Extreme	5	10	15	20	25		

Green	(score 5 or less)	Low risk	Low priority	Manage situation by routine procedures
Amber	(score 6 to 15)	Medium risk	Medium priority	Management responsibility and action must be specified
Red	(score 16 to 25) Or any incident recorded as extreme regardless of the likelihood/probability of repeat	High risk	High Priority	Immediate action – Senior Management attention required. 16+ Senior Management to consider informing the Board.

Measures of Likelihood

LEVEL	DESCRIPTOR	PROBABILITY
1	Rare	The event may only happen in exceptional circumstances
2	Unlikely	The event could occur (recur) at some time
3	Possible	The event may well occur (recur) at some time
4	Highly likely	The event will occur (recur) in most circumstances
5	Almost Certain	The event is expected to occur (recur) in most circumstances

Stage 1 – Initial Risk Assessment 6th Month Review Date – 12-June-2017

Title: Adult Mental Health Redesign Option 4b

Lead for scheme: Jacki Wilkes Associate Director of Commissioning

Brief description of scheme:
Commissioners in Vale Royal, South and Eastern Cheshire are working with local mental health provider; Cheshire and Wirral Partnership, users of the service and Cheshire East Council to review and redesign secondary care adult and older peoples mental health services for those people with severe mental illness (SMI).

A Pre Consultation Business Case (PCBC) will outline a compelling case for change and present options which will deliver redesigned services for improved outcomes for the registered population of Vale Royal, South and Eastern Cheshire in line with national Five Year Forward View (FYFV) for Mental Health.

The FYFV for mental health sets out an ambitious programme of improvement to be achieved by 2021 setting standards for access and guidelines for care including 24/7 access to care, early intervention (proactive care) and prevention. The proposals presented are done so within a context of rising demands for services, increasing financial constraints across the health and social care system and national drivers to improve access to a

range of services not currently commissioned.

This QIA is for Option 4b outlined below:

Option 4b: Expand community and crisis care services and relocate all inpatient care from Millbrook to other facilities within the current provider footprint (Adults Macclesfield site, Older people Bowmere)

Description: In this option 22 beds would be provided at Lime Walk House for adults. 22 beds would be provided at Bowmere and 3 at Wirral for adults. Central and Eastern Cheshire patients would be given priority admission to Bowmere, 10 for older people with dementia and 12 for older or more physically vulnerable adults with functional illness. There will be 3 beds at Wirral for adults. Rehabilitation services currently delivered at Lime Walk House would be re-provided at the Soss Moss site in Nether Alderley. In patient Electro Convulsive Therapy would be delivered at the specialist ward in Bowmere. Community mental health teams would deliver evidenced based interventions to support people in their own homes and have the appropriate skills to do so. A new model of crisis care will be introduced which would see the home treatment team providing 24/7 care in conjunction with, overnight placement support and day time crisis café

Answer positive/negative (+ / -) in each area. If N; score the impact, likelihood and total in the appropriate box. If score > 8 insert Y for full assessment

Area of Quality	Impact question	+ / -	Impact	Likely-hood	Score	Full Assessment required?
Duty of Quality	Could the proposal impact positively or negatively on any of the following - compliance with the NHS Constitution, partnerships, safeguarding children or adults and the duty to promote equality?	positive	**2**	**2**	**4**	**N**
Patient Experience	Could the proposal impact positively or negatively on any of the following - positive survey results from patients, patient choice, personalised & compassionate care?	Neutral	**2**	**3**	**6**	**N**
Patient Safety	Could the proposal impact positively or negatively on any of the following – safety, systems in place to safeguard patients to prevent harm, including infections?	Positive	**2**	**2**	**4**	**N**
Clinical Effectiveness	Could the proposal impact positively or negatively on evidence based practice, clinical leadership, clinical engagement and/or high quality standards?	Positive	**2**	**2**	**4**	**N**
Prevention	Could the proposal impact positively or negatively on promotion of self-care and health inequality?	Positive	**2**	**2**	**4**	**N**
Productivity and Innovation	Could the proposal impact positively or negatively on - the best setting to deliver best clinical and cost effective care; eliminating any resource inefficiencies; low carbon pathway; improved care pathway?	Positive	**2**	**2**	**4**	**N**
Resource Impact	Could this proposal impact positively or negatively with regard to estates, IT resource, community equipment service or other agencies or providers e.g. Social care/voluntary sector/District nursing*	Positive	**2**	**2**	**4**	**N**

Completed by:	Designation:	Date:
Marie Ward	Transformation Project Manager	07.11.17

Stage 2 – Full Assessment for identified areas of risk

Area of quality	Indicators	Description of impact (Positive or negative)	Risk (5 x5 risk matrix)			Mitigation strategy and monitoring arrangements
			Impact	Likelihood	Overall Score	
DUTY OF QUALITY	What is the impact on the organisation's duty to secure continuous improvement in the quality of the healthcare that it provides and commissions?	Continuous improvement in the quality of healthcare will be monitored as part of Mental Health Outcomes Framework, Friends and Family Test and self-reported Experience and Outcomes Assessments.	2	2	4	Monitor and Review
	Does it impact on the organisation's commitment to the public to continuously drive quality improvement as reflected in the rights and pledges of the NHS Constitution?	The projects aim is to support the delivery of the Five Year Forward View for Mental Health. To improve quality of care, patient experience and mental health outcomes, whilst ensuring the services are clinically and financially sustainable. The views and experiences of users and carer have informed the development of Pre Consultation Business Case (PCBC)	2	2	4	Monitor and Review
	Does it impact on the organisation's commitment to high quality workplaces, with commissioners and providers aiming to be employers of choice as reflected in the rights and pledges of the NHS Constitution?	Engagement and communication with Clinical Mental health Specialist including; NHS Mental Health Trust and Community Services and General Practice includes; front line staff drop-in sessions, Clinical Leaderships Meetings, GP Locality	2	2	4	Monitor and Review

Area of quality	Indicators	Description of impact (Positive or negative)	Risk (5 x5 risk matrix)			Mitigation strategy and monitoring arrangements
			Impact	Likelihood	Overall Score	
		and membership meetings to engage views and inform the PCBC and design of new model of care for Adult Mental Health.				
	What is the impact on strategic partnerships and shared risk?	Positive Impact Providers and Commissioners across Eastern Cheshire, South and Vale Royal CCG, Cheshire East Council and Cheshire and Wirral Partnership NHS Foundation Trust, working in partnership to develop the PCBC, North West Ambulances Service and Cheshire Police have been involved in discussion and scoring the options. The project team includes; clinical specialists, patients and carers, commissioners from health and social care and providers of mental health services.	**2**	**2**	**4**	Mitigating Actions Joint /Shared risk log jointly owned across partner organisations
	What is the equality impact on race, gender, age, disability, sexual orientation, religion and belief, gender reassignment, pregnancy and maternity for individual and community health, access to services and experience of using the NHS (Refer to CCG Equality Impact Assessment Tool)?	Stage 1 and Stage 2 equality impact and risk assessment have been completed and an action plan has been developed.	**2**	**2**	**4**	Monitor and Review

Area of quality	Indicators	Description of impact (Positive or negative)	Risk (5 x5 risk matrix)			Mitigation strategy and monitoring arrangements
			Impact	Likelihood	Overall Score	
DUTY OF QUALITY	Are core clinical quality indicators and metrics in place to review impact on quality improvements?	A set of standardised key performance indicator measures aligned to National and Local Outcomes Frameworks have been identified to support completion of a final business case and future commissioning of Adult Mental Health Services.	2	2	4	Monitor and Review
	Will this impact on the organisation's duty to protect children, young people and adults?	There is no perceived negative impact on organisation's duty to protect adults	2	2	4	Monitor and Review
PATIENT EXPERIENCE	What impact is it likely to have on self-reported experience of patients and service users? (Response to national/local surveys/complaints/PALS/incidents)	**In option 4b** there is a change in how inpatient beds are provided across Cheshire with 22 beds being provided locally for adults, Rehabilitation services would continue to be provided locally. Up to 25 beds would be re provided in Chester for older people with dementia and more physically vulnerable adults with functional illness. A new model of crisis care introduced which would see the home treatment team providing 24/7 care in conjunction with an increase in home treatment team providing specialist intensive home treatment,	2	3	6	Mitigating Actions Continued engagement with service, users, families and carers to understand solutions for a small proportion of people who will need to travel further for in-patient care and visiting such as flexible visiting times and use of technology e.g. facetime To support for patients, families and carers who will need to travel further. It may be possible to access short term support for families and carers to visit Bowmere, which would be on a case by

Area of quality	Indicators	Description of impact (Positive or negative)	Risk (5 x5 risk matrix)			Mitigation strategy and monitoring arrangements
			Impact	Likelihood	Overall Score	
		overnight placement support and day time crisis café.				case basis and dependent on individual circumstances Monitoring through Friends and Family Test, Patient Reported Outcomes Measures (PROMS), Patient Experience Measures (PREMS)
	How will it impact on choice?	In line with the 5YFV for MH the PCBC is aligned to providing specialist care, at the right time, in the right place. Providing high quality, CQC compliant inpatient care and improving community and crisis resolution home treatment 24/7. Option 4b provides adult inpatient care in Macclesfield, Rehabilitation and Crisis Beds. Older people mental health care will move to Bowmere in Chester which impacts on patients, families and carers travel times.	**2**	**3**	**6**	Mitigating Actions Continued engagement with service, users, families and carers to understand solutions for a small proportion of people who will need to travel further for in-patient care and visiting. With regards to visiting we will work with family and carers to find solutions to any transport problems on a case by case basis. Travel bursaries may be available for low income families Monitoring through Friends and Family Test, Patient Reported Outcomes Measures (PROMS), Patient Experience Measures (PREMS)

Area of quality	Indicators	Description of impact (Positive or negative)	Risk (5 x5 risk matrix)			Mitigation strategy and monitoring arrangements
			Impact	Likelihood	Overall Score	
	Does it support the compassionate and personalised care agenda?	Positive Impact - additional support will be provided in Community services and crisis resolution home treatment team including Crisis House (short inpatient stay) and Crisis Café. This will achieve the standard of care in the most unrestricted environment. The newly provided Dementia Outreach service will support people to stay safely at home in familiar surroundings	**2**	**2**	**4**	Monitor and Review
PATIENT SAFETY	How will it impact on patient safety?	There is no perceived negative impact to patient safety.	**2**	**2**	**4**	Mitigating Actions Datix Risk Management CQC reports Audit Outcomes Complaints Reviews Mortality Data
	How will it impact on preventable harm?	There is no perceived negative impact on preventable harm	**2**	**2**	**4**	Mitigating Actions Datix Risk Management CQC reports Audit Outcomes Complaints Reviews Mortality Data
	Will it maximise reliability of safety systems?	There is no perceived negative impact on safety systems	**2**	**2**	**4**	Mitigating Actions Datix Risk Management CQC reports Audit Outcomes Complaints Reviews

Area of quality	Indicators	Description of impact (Positive or negative)	Risk (5 x5 risk matrix)			Mitigation strategy and monitoring arrangements
			Impact	Likelihood	Overall Score	
						Mortality Data
	How will it impact on systems and processes for ensuring that the risk of healthcare acquired infections is reduced?	There shall be no additional impact on safety systems. As part of STP Prevention Programme additional Antimicrobial Resistance support is being planned, which will impact positively to reduce infection rates. Caring for people in the home where possible will have an impact on hospital acquired infection rates.	**2**	**2**	**4**	Mitigating Actions Datix Risk Management CQC Reports Audit Outcomes Complaints Reviews Mortality Data
	What is the impact on clinical workforce capability care and skills?	A workforce plan will ensure that community and inpatient teams have the right skill mix and capabilities on a rota 24/7 where appropriate to provide high quality patient care and outcomes. The workforce plan has been modelled against patients care needs and will include training on physical and mental health clinical knowledge to support parity of esteem.	**2**	**2**	**4**	Mitigating Actions Mapping existing and future workforce requirements including associated financial implications Development of Work Force Plan
CLINICAL EFFECTIVENESS	How does it impact on implementation of evidence based practice?	The Pre Consultation Business Case has been developed and based on evidence based best practice, national policy and includes a literature review on achieving	**2**	**2**	**4**	Mitigating Actions Site visits to other Mental Health Units delivering Integrated Community Care and Crisis Models of Care

Area of quality	Indicators	Description of impact (Positive or negative)	Risk (5 x5 risk matrix)			Mitigation strategy and monitoring arrangements
			Impact	Likelihood	Overall Score	
		improved outcomes and parity of esteem. Site visits to other Mental Health Trusts have been undertaken with clinicians and experts by experience to look at best practice.				Review of literature
	How will it impact on clinical leadership?	There is no perceived negative impact on clinical leadership	**2**	**2**	**4**	Monitor and Review
	Does it support the full adoption of Better care, Better Value metrics?	The project team has adopted Better Value principles and aligned to Better Care metrics which will be aligned to mental health outcomes framework and future provider contract management	**2**	**2**	**4**	Monitor and Review

Area of quality	Indicators	Description of impact (Positive or negative)	Risk (5 x5 risk matrix)			Mitigation strategy and monitoring arrangements
			Impact	Likelihood	Overall Score	
	Does it reduce/impact on variations in care?	There is a neutral impact on variations in care. Enhanced community and crisis care 24/7 will deliver a proactive approach to community mental health care, with staff being trained to provide intensive home treatment. The new model of care will over time deliver approx 16% reduction in hospital based activity. In patient care will be delivered locally for adults and people requiring short term inpatient care in a crisis. Specialist Mental Health inpatient care for older people and day case Electro Convulsive Therapy will be provided at Bowmere in Chester	2	3	6	Mitigating Actions Where travel is a problem CWP will work with family and carers to find solutions to any transport problems on a case by case basis. Travel bursaries may be available for low income families
	Are systems for monitoring clinical quality supported by good information?	A set of standardised key performance indicator measures aligned to a Mental Health Outcomes Framework will be agreed as part of future provider contract management and monitored via contract and quality assurance	2	2	4	Monitor and Review
	Does it impact on clinical engagement?	As part of the communication and engagement plan, staff are being engaged with through drop-in	2	2	4	Monitor and Review

Area of quality	Indicators	Description of impact (Positive or negative)	Risk (5 x5 risk matrix)			Mitigation strategy and monitoring arrangements
			Impact	Likelihood	Overall Score	
		sessions. The project team include clinical specialists from primary and secondary care. General Practitioners have been engaged with at locality and clinical leadership group meetings.				
PREVENTION	Does it support people to stay well?	The project will encourage people to stay well through supported self-care sign posting to care services though Directory of Services and Single Point of Access. On line information and tools to support people to manage their own health and wellbeing	**2**	**2**	**4**	Monitor and Review
	Does it promote self-care for people with long term conditions?	A key outcome of Mental Health outcomes Framework is Parity of Esteem, which is also a National CQUIN.	**2**	**2**	**4**	Monitor and Review
	Does it tackle health inequalities, focusing resources where they are needed most?	Stage 1 and Stage 2 equality impact and risk assessment have been completed and an action plan has been developed.	**2**	**2**	**4**	Monitor and Review
TIVIT Y & INNO	Does it ensure care is delivered in the most clinically and cost effective way?	The proposed service change would cost less overall than current services and contribute to reducing	**2**	**3**	**6**	Mitigating Actions

Area of quality	Indicators	Description of impact (Positive or negative)	Risk (5 x5 risk matrix)			Mitigation strategy and monitoring arrangements
			Impact	Likelihood	Overall Score	
		the deficit in NHS mental health services for Central and Eastern Cheshire. Finding an affordable solution is necessary for long-term clinical sustainability and this moves services in the right direction, within the context of severe financial challenge across the Health and Care Economy.				Develop accurate costing model for new model of care to minimise over spend on agreed budget through implementation of new services. Underlying sustainability of the whole economy supported by on-going QIPP/CIP programmes and support from NHSE/I through CEP process Partnership approach to driving out costs Ensure any external contracts procured with value for money at forefront.
	Does it eliminate inefficiency and waste?	The project aim is to reduce inefficiency and waste in the system to enable high quality care, patient experience and improved patient outcomes. Improved access to community teams and crisis resolution home treatment team, which are adequately resourced to offer intensive home treatment as an	**2**	**2**	**4**	Monitor and Review

Area of quality	Indicators	Description of impact (Positive or negative)	Risk (5 x5 risk matrix)			Mitigation strategy and monitoring arrangements
			Impact	Likelihood	Overall Score	
		alternative to acute inpatient admission. Increased access to psychological therapies and access to navigators who are available to people who require specialist care from diagnosis onwards, to guide them through the options for their care and ensure they receive appropriate information and support. Analysis of data highlights that there are currently 58 beds however national and locally modelled data shows that for our population only 45 beds would be required if community services and rapid response was enhanced.				
	Does it support low carbon pathways?	A Travel Assessment has been completed looking at current and future travel to inpatient care and public transport links. There is a neutral impact which will be realised as the service is implemented and benefits are realised in reduced inpatient activity and length of stay.	**2**	**2**	**4**	Monitor and Review
	Will the service innovation achieve large gains in performance?	The new care model design is innovative in supporting people in their own homes or close to home in	**2**	**2**	**4**	Monitor and Review

Area of quality	Indicators	Description of impact (Positive or negative)	Risk (5 x5 risk matrix)			Mitigation strategy and monitoring arrangements
			Impact	Likelihood	Overall Score	
		delivering enhanced Community Care, Crisis Resolution, short stay in-patient care in Crisis House and day time support in Crisis Café with access to Recovery College. Technology will support integrated working across health and social care. A significant gain will be reduction in hospital activity by approximately 16%				
	Does it lead to improvements in care pathway(s)?	The new care model design provides seamless care across the care model, to support people in their own homes or close to home through the delivery enhanced provision of community care, crisis resolution home treatment including intensive treatment at home, short stay crisis in patient care at Crisis Houses and day time support in Crisis Cafes, and Specialist Mental Health Inpatient Care.	**2**	**2**	**4**	Monitor and Review

Completed by:	Designation:	Date:
Marie Ward	Transformation Project Manager	07.11.17

Jacki Wilkes	Associate Director of Commissioning Eastern Cheshire CCG	

Reviewed and signed off by: Sally Rogers Julia Curtis Pending sign off by CQ&P 13.12.17	Designation: Lead Nurse, Community and Safeguarding Registered Eastern Cheshire CCG Nurse, Governing Body Member Eastern Cheshire CCG Head of Clinical Quality	Date: 09.11.17

Privacy Impact Assessment – Screening Questions

Key Information – please be as comprehensive as possible.	
Project Name:	Adult and Older peoples Mental Health Redesign Project
Description of project:	*Explain what the project aims to achieve, what the benefits will be to the organisation, to individuals and to other parties.* *You may find it helpful to link to other relevant documents related to the project, for example a project proposal.* The NHS in Eastern and Central Cheshire are working with local mental health provider Cheshire and Wirral Partnership and the local council to review and redesign secondary care adult and older peoples mental health services for those residents with a severe and enduring mental health need. Secondary care services is the term used to differentiate them from primary mental health services such as GP only care and universal psychological therapies (IAPT) Secondary services includes specialised community support, crisis response and inpatient care which is provided mainly on The Millbrook unit in Macclesfield. For this project there are several options being considered for the redesign. Data will be used to help inform these options and enable the Project Team to score the options and make decisions about those to be taken forward to the Pre Consultation business case.

Will the project involve any data from which individuals could be identified (including pseudonymised data)? **(Yes/No)**	Yes – Admission data and patient numbers for Millbrook and Bowmere will be used to inform where their nearest mental health facility is

IF NO THEN YOU DO NOT NEED TO ANSWER ANY FURTHER QUESTIONS AND A PIA IS NOT REQUIRED.

Privacy Impact Assessment – Screening Questions

Key Contacts	
Project Manager Name & Job Title:	**Jacki Wilkes**
Project Manager Email:	jackiwilkes@nhs.com
Project Manager Phone:	01625 663350
Key Stakeholder Names & Roles:	Suzanne Edwards – CWP, Jamaila Tausif – South and Vale Royal CCG

Screening Questions	YES or NO
Will the project involve the collection of **new** information about individuals?	NO – As admission data is already collected by CWP on Millbrook and Bowmere.
Will the project compel individuals to provide information about themselves?	YES – During pre consultation and consultation events service users, carers and the general public will be asked to provide input into the proposed redesign, during which time patient experiences of using services may be shared
Will information about individuals be disclosed to organisations or people who have not previously had routine access to the information?	YES – To help inform the options available - High level admission data / patient numbers will be shared with Staffordshire, Pennine and Wythenshawe
Are you using information about individuals for a new purpose or in a new way that is different from any existing use?	YES – The admission data and patient numbers will be used to inform the options that are taken forward to consultation for the redesign of the

Privacy Impact Assessment – Screening Questions

	services
Does the project involve you using new technology which might be perceived as being privacy intrusive? For example, the use of biometrics or facial recognition.	NO
Will the project result in you making decisions about individuals in ways which may have a significant impact on them? e.g. service planning, commissioning of new services	YES – The project will evaluate several options on how to redesign the services, admission data and patient numbers will potentially help to inform these options so they can be assessed and scored against acceptability criteria
Is the information to be used about individuals' health and/or social wellbeing?	YES – Both data provided by CWP and patient experience info shared at the consultation events will be used to inform the options, score these options against acceptability criteria and shortlist options for the pre consultation business case and consultation.
Will the project require you to contact individuals in ways which they may find intrusive?	YES – During the project patient representatives and carers may be contacted regarding the option to visit mental health facilities elsewhere in the North West, along with members of the project team to help inform the range services available, and how they may fit into the redesign of the services.

If any of the screening questions have been answered "YES", then please continue with the Privacy Impact Assessment Questionnaire (below).

If all questions are "NO", please return the document to the Information Governance Team and **do not** complete a Privacy Impact Assessment. Please email the completed screening to mlcsu.ig@nhs.net

Privacy Impact Assessment – Screening Questions

Use of personal information	
Description of data:	*e.g. name, address, date of birth, NHS number, gender, clinical or other health information, ethnicity.* In this project the following data will be requested for Bowmere and Millbrook admissions, all the data requested will be pseudonymised. The fields requested will be: • Speciality description • Admission ward • Admission date • Trust id • Admission type • MHA status • Practice code • CCG • CCG code • Postcode –Outer • Electoral ward • Discharge date time • Gender • Time on ward • Primary diagnosis code • Primary diagnosis • Secondary diagnosis code • Secondary diagnosis • CSU • Year • Month • PICU admission data This data, specifically, admission data for Millbrook (Macclesfield) and Bowmere (Chester) and patient numbers will be used to create tables of data showing information such as : • number of patients/admissions • split between older people and adult admissions/patient numbers

Privacy Impact Assessment – Screening Questions

	• towns where they live, • number of patients / admissions from towns • Postcodes and number of patients • travel distance and times • nearest alternative mental health facility to the town in which they live • Average Length of stay of admissions This data will help to inform the options put forward as part of the pre consultation business case, and the options that will be scored against criteria for patient acceptability, safety, financial and strategic criteria. This data will be shared with other CCGs to enable the costing of different options to establish if they are financially viable. Data/information will also be collated at the pre consultation and consultation events based on feedback from service users and carers. The data will not be identifiable to CCG staff. The flat tables of data will show patient numbers / admissions as listed above.
What is the justification for the inclusion of identifiable data rather than using de-identified/anonymised data?	This data will be used to generate the financial costings for services being provided by alternative providers. The number of admissions/patient numbers will be shared with other providers so they have an idea of potentially how many potential patients may be directed to their services. In order to cost this information they will need to know details of numbers of patients, broken down by type of admission. The data will be non identifiable where ever possible, in some cases this may mean only 1 patient from a town. When sharing this data outside the CCG it will be grouped together with other towns but due to low numbers these may still be under five patients.

Privacy Impact Assessment – Screening Questions

Will the information be new information as opposed to using existing information in different ways?	The data used for the admission and patient numbers is existing information gathered by CWP. This data will be used to work up options for the pre consultation business case. The patient data gathered from the pre consultation and consultation events will be used to inform the options for the redesign of the services. This will be new information.
What is the legal basis for the processing of identifiable data? **If consent, when and how will this be obtained and recorded?**	*e.g. explicit data subject consent, s251 support, statutory power.* The basis for processing this data is to establish the number of patients who had in-patient treatment during a specific period of time, in order to ensure the appropriate size service is in place when redesigning. When liaising with other CCGs high level data will be shared to enable financial costings to be gathered.
Who will be able to access identifiable data?	*This should include details of any data processors / contractors and sub-contractors and any proposed overseas transfers.* The initial data spreadsheet will be provided by CWP and accessible to the Information team. The spreadsheet of data will be shared with the ECCCG PMO to generate the numbers of patients/admissions per town. This will be pseudonymised data, identifiable only by the trust ID. This data will be analysed by the PMO and shared with key members of the project team to inform the options. A subset of this data may be consolidated and shared with other CCGs (Staffordshire, Pennine and Wythenshawe) to allow costings of potential new services to be carried out. Some high level data may be used in the business case. The pre-consultation and consultation feedback will be consolidated by the communications team and anonymised, sharing only the numbers of people who attended the events

Privacy Impact Assessment – Screening Questions

	and high level themes.
Will the data be linked with any other data collections?	*Please specify and provide business reason / information requirement.* There will be no other links into patient identifiable information.
How will this linkage be achieved?	*Who will undertake the linkage and using what identifiers?* N/A
Is there a legal basis for these linkages?	*i.e. is it within the terms of any prior consent? Is it within the scope of any statutory justification?* N/A
What security measures will be used to transfer the data?	The spreadsheet data will be shared with the PMO via NHS email. Only high level tables of data will be shared with Other CCGS. Avoiding any instances where the patient numbers are 1.

Privacy Impact Assessment – Screening Questions

What confidentiality and security measures will be used to store the data?	*i.e. contractual arrangements with data processors, contractual arrangements with their staff as well as physical and technical security measures.* Pseudonymised data will be stored in the Adult mental health Project team area of the CCG drive, this drive is only accessible by East Cheshire CCG staff.
How long will the data be retained in identifiable form? And how will it be de-identified? Or destroyed?	*e.g. Data retention, redaction and disposal policy. Include arrangements if the project is withdrawn/ stopped.* The data will be retained for the life of the project.
What governance measures are in place to oversee the confidentiality, security and appropriate use of the data and manage disclosures of data extracts to third parties to ensure identifiable data is not disclosed or is only disclosed with consent or another legal basis?	*e.g. oversight body / committee, security audit and risk review procedures.* *This should also include contingency planning against accidental loss, destruction or damage to personal data.* Pseudonymised data will be stored in the Adult mental health Project team area of the CCG drive, this drive is only accessible by CCG staff.
If holding personal i.e. identifiable data, are procedures in place to provide access to records under the subject access provisions of the DPA? **Is there functionality to respect objections/ withdrawals of consent?**	*This should include how personal data is located and procedures for explaining the information in the record e.g. coded data, to the individual.* *How third party and seriously harmful information will be handled and how grounds for withholding information will be managed.* IT systems and security infrastructure is already in place to support and hold personal identifiable personal information in

Privacy Impact Assessment – Screening Questions

	compliance with information governance guidelines.
Are there any plans to allow the information to be used elsewhere either in the CCG, wider NHS or by a third party?	The high level data generated will be shared in a 'flat format' with other CCGs (Staffordshire, Pennine and Wythenshawe) in order for costings to be provided.

Privacy Impact Assessment – Screening Questions

Describe the information flows The collection, use and deletion of personal data should be described here and it may also be useful to refer to a flow diagram or another way of explaining data flows.	
Does any data flow in identifiable form? If so, from where, and to where?	Between the service provider CWP and the Project team. High level data between Eastern Cheshire and South CCG and the providers Staffordshire, Pennine and Wythenshawe.
Media used for data flow? **(e.g. email, fax, post, courier, other – please specify all that will be used)**	Email
Consultation requirements Part of any project is consultation with stakeholders and other parties. In addition to those indicated "Key information, above", please list other groups or individuals with whom consultation should take place in relation to the use of person identifiable information. It is the project's responsibility to ensure consultations take place, but IG will advise and guide on any outcomes from such consultations.	
Pre consultation engagement will take place, followed by consultation events once the chosen option has been selected.	

Privacy Impact Assessment – Screening Questions

Privacy Risks List any identified risks to privacy and personal information of which the project is currently aware. Risks should also be included on the project risk register.			
Risk Description **(to individuals, to the CCG or to wider compliance)**	**Proposed Risk solution (Mitigation)**	**Is the risk reduced, transferred, or accepted? Please specify.**	**Further detail if required**

Further information Please provide any further information that will help in determining privacy impact.

Privacy Impact Assessment – Screening Questions

Following acceptance of this PIA by Information Governance, a determination will be made regarding the privacy impact and how the impact will be handled. This will fall into three categories:

1. **No action is required by IG excepting the logging of the Screening Questions for recording purposes.**
2. **The questionnaire shows use of personal information but in ways that do not need direct IG involvement – IG may ask to be kept updated at key project milestones.**
3. **The questionnaire shows significant use of personal information requiring IG involvement via a report and/or involvement in the project to ensure compliance.**

It is the intention that IG will advise and guide those projects that require it but at all time will endeavour to ensure that the project moves forward and that IG is not a barrier unless significant risks come to light which cannot be addressed as part of the project development.

Please email entire completed document to mlcsu.ig@nhs.net

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

STANDARDISED REPORT COMMUNICATION

REPORT DETAILS

Report subject:	Central and East Resilience Update
Agenda ref. no:	17-18-73b
Report to (meeting):	Board of Directors
Action required:	Noting
Date of meeting:	29/11/2017
Presented by:	Andy Styring, Director of Operations

Which strategic objectives this report provides information about:	
Deliver high quality, integrated and innovative services that improve outcomes	Yes
Ensure meaningful involvement of service users, carers, staff and the wider community	Yes
Be a model employer and have a caring, competent and motivated workforce	Yes
Maintain and develop robust partnerships with existing and potential new stakeholders	Yes
Improve quality of information to improve service delivery, evaluation and planning	Yes
Sustain financial viability and deliver value for money	Yes
Be recognised as an open, progressive organisation that is about care, well-being and partnership	Yes
Which CQC quality of service domains this report reflects:	
Safe services	Yes
Effective services	Yes
Caring services	Yes
Well-led services	Yes
Services that are responsive to people's needs	Yes
Which Monitor quality governance framework/ well-led domains this report reflects:	
Strategy	Yes
Capability and culture	Yes
Process and structures	Yes
Measurement	Yes
Does this report provide any information to update any current strategic risks? If so, which?	
See current risk register in the agenda of the public meeting of the Board of Directors at http://www.cwp.nhs.uk/about-us/board-members/our-board-meetings	Risk 2
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*

This report provides an update in relation to the current resilience position of Central and East Cheshire locality.

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

Central and East operational delivery is being impeded by a number of factors. These include;

- Acuities and level of observations
- Vacancies
- Sickness including maternity
- Restrictions on staff
- Minimum staffing levels (in hours / out of hours)
- Medical staffing

The combination of these factors collectively, have led to the implementation of a CWP response and the formation of a Central and East Pressures Management Group. This group has trust-wide representation and its objectives are to;

- Provide assurance that Central and East Cheshire can continue to deliver safe and effective care.
- Identify risks in Central and East Cheshire to the continued delivery of safe and effective care.
- Identify, recommend, implement and oversee mitigating actions including contingencies for Central and East Cheshire
- Consider trust wide impacts and develop a communication strategy.

Assessment – *analysis and considerations of options and risks*

The continued delivery of safe and effective care is the priority of the Central and East Cheshire Pressures Management Group. Any analysis and mitigating action is undertaken from a trust-wide viewpoint with due cognisance to the NHS and CWP Forward View. The strategy of the group is to implement short term mitigating activities whilst identifying and analysing options for the medium to long term.

A number of early risks were identified that had the potential for a detrimental impact on the delivery of safe and effective care. These predominantly focus on acuity and clinical / medical staffing levels. The Pressures Management Group has implemented a framework for identifying the risks, developing and delivering remedial actions whilst maintaining governance and oversight. Members of the group have the authority to enable positive outcomes whilst the Chair provides regular reporting to the Executive team.

An initial decision was made to reduce the number of beds available in the system by 8. This has now been in place for a number of weeks, and the system continues to manage the level of demand within existing resources available. To date there have been no service users that have been placed outside of the Trust due to the lack of available beds.

The pressures management group continue to meet, and link to the central bed management hub and Trust wide acute care meeting. The group continues to receive and manage escalated issues, meets and reviews activities regularly and is committed to ensuring continued delivery of safe and effective care across CWP.

The locality continues to actively recruit to the vacant posts, and this is supported by temporary staffing. Medical staffing arrangements are in place and locum cover was secured. The Pressures Management Group alongside locality management will continue to review the temporary reduction on beds and make recommendations on when these beds can be reopened.

Alongside this there is on-going monitoring of key clinical risk indicators, to ensure that early warning signs continue to be picked up and responded to.

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

The Board of Directors is recommended to **note** the report and the onging actions to continue to provide safe acute care in Central and East Cheshire .

Who/ which group has approved this report for receipt at the above meeting?	Andy Styring
Contributing authors:	Sarah Quinn Tim Jenkins

Distribution to other people/ groups/ meetings:

Version	Name/ group/ meeting	Date issued
n/a	n/a	n/a

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

Appendix no.	Appendix title
N/A	N/A

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

STANDARDISED REPORT COMMUNICATION

REPORT DETAILS

Report subject:	Freedom to Speak up six monthly update
Agenda ref. no:	17-18-75
Report to (meeting):	Board of Directors
Action required:	Discussion and Approval
Date of meeting:	29/11/2017
Presented by:	CWP Freedom to Speak up 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	No
Improve quality of information to improve service delivery, evaluation and planning	Yes
Sustain financial viability and deliver value for money	Yes
Be recognised as an open, progressive organisation that is about care, well-being and partnership	Yes
Which CQC quality of service domains this report reflects:	
Safe services	Yes
Effective services	Yes
Caring services	Yes
Well-led services	Yes
Services that are responsive to people's needs	Yes
Which Monitor quality governance framework/ well-led domains this report reflects:	
Strategy	Yes
Capability and culture	Yes
Process and structures	Yes
Measurement	Yes
Does this report provide any information to update any current strategic risks? If so, which?	
See current risk register in the agenda of the public meeting of the Board of Directors at http://www.cwp.nhs.uk/about-us/board-members/our-board-meetings	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	No
Click here to enter text.	

REPORT BRIEFING

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

This report is to provide the Board with a six monthly update on progress and activity in relation to Raising Concerns.

This is in response to Freedom to Speak up Guardian guidance that a report should be taken to Board at least every six months. This report coers the period April – September 2017

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

Following the Mid Staffordshire Public enquiry recommendations were made to make the culture of the NHS more patient focused, open and transparent. The Freedom to speak up(F2SU) report (2015) arising from the review identified five overarching themes; culture change, improved handling of cases, measures to support good practice, particular measures for vulnerable groups and extending the legal protection.

Guidance was received from the Office of the National Gurardian (ONG) in 2016 which set out the expectations of the role of the Freedom to speak up Guardian which set out an expectation that a six monthly report be provided to Trust Boards. This report forms part of that compliance.

Assessment – *analysis and considerations of options and risks*

The attached update outlines the progress made during the last six months in response to the objectives identified for 17/18; Improving process and progress, building confidence and capability, measuring progress and an overview of the activities undertaken by the F2SU Guardian in support of the continuous building of a culture within the organisation where people are confident to speak up and raise concerns. The update also provides the Board with an a brief synopsis of the documents and guidance published by the ONG and an overview of concerns raised to the F2SU Guardian and the actions taken in response during this period. The F2SU group reporting to the People, Organisational Development sub Committee (PODSC) continues to support the governance arrangements in ensuring changes are embedded across the organisation. These include reporting of trimester themes and trends to PODSC, contributing to the Learning from Experience report and inclusion into the Trusts' Annual Quality Report.

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

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

Who/ which group has approved this report for receipt at the above meeting?	Director of Nursing, Therapies and Patient Participation
Contributing authors:	Click here to enter text.

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	Freedom to Speak Out: six monthly report

Mid-year report April 2017 – September 2017

Contents

1. Background and Context

1.1 The Freedom to Speak Up (F2SU) Review was an independent review, led by Sir Robert Francis QC, into creating an open and honest reporting culture in the NHS following concerns raised by NHS staff and the treatment of some who had spoken up. The review produced a comprehensive report providing details good practice which is taking place and to address the gap and variation, the report covers how organisations can create the right culture, how concerns should be handled and what is needed to ensure the system works. The overall purpose of the report is to make the NHS a 'better place to work and a safer place for patients'.

In 2016 The Office of the National Guardian (ONG) published a guide for NHS Trusts on establishing the Freedom to Speak Up (FTSU) Guardian role. The guidelines also set out the expectations of the role including providing a six monthly report to Boards. This report forms part of that compliance.

2. National Guardian Office

The National Guardian Office (NGO) provides leadership and advice for Freedom to Speak Up Guardians based in NHS trusts and NHS foundation trusts on best practice to enable staff to speak up safely. Dr Henrietta Hughes was appointed as the National Guardian for the NHS in October 2016.

The NGO has published several documents of guidance and information for F2SU guardians and NHS Trusts;

2.2 Recording Issues

This guidance has been drawn up to assist Freedom to Speak Up Guardians (FTSUG) record issues raised by people speaking up in a way that will be helpful to them, and that will promote consistency across Trusts. The NGO routinely requests iinformation so that it can oversee the work done by the FTSUG network

This guidance has been reviewed and implemented in CWP from April 2017 this has impacted on how numbers of concerns are recorded. For example previously a concern raised by a group of staff was recorded as one concern, from April 2017 this is recorded as a concern by each of the members of staff. The guidance has also suggested ten categories of concern which have now been adopted and will be reported against further in this update. In addition processes are in place to record the demographics and other characteristics of people who are speaking up.

2.3 Case Review Process for NHS Trusts and Foundation Trusts

The NGO has put in place a case review process for NHS Trusts and Foundation Trusts. The Francis Freedom to Speak Up review summarised the need for an independent case review system as 'a mechanism for external review of how concerns have been handled at local level and the impact on the individual where there is legitimate cause for concern'.

The draft summary sets down how the National Guardian's Office (NGO) will undertake such a review of individual cases referred to it. It summarises how this process will operate, including the triaging of cases referred to the NGO, evidence gathering and report writing, and how some specific challenges could be addressed.

A case review process will look at four main areas, relating to how a NHS service supported its workers to speak up in a particular case and whether or not this met best practice. Where there is evidence that best practice was absent recommendations will be made as to how a trust can deliver this. These four areas are taken from the sub headings in the FTSU review related to each of the 20 principles, namely; staff culture, handling safety concerns , good practice and support for vulnerable groups

2.4 How the National Guardian's Office will deal with issues raised about Freedom to Speak Up Guardians.

This guidance applies to concerns that are raised about the suitability and conduct of individuals appointed to the FTSUG role, and acknowledges that these should initially be dealt with through local processes, but that anyone may speak up and raise concerns about a FTSUG to the NGO.

The NGO will raise the issue with the trust Chief Executive, providing as much relevant information as possible to enable the trust to respond fully to the issue being raised, whilst preserving the confidentiality of the person speaking up. The NGO will ask for assurance that the FTSUG role is being implemented in a way meets the needs of workers in the organisation and the expectations of the role set out by the NGO. The Trust will be asked to respond to any particular areas of concern that the issue raised highlights within a 2-week timeframe.

2.5 CQC inspections Information for Freedom to Speak Up Guardians.
This document provides an overview of the inspection process in relation to speaking up. How trusts support speaking up will potentially affect the overall rating inspectors give for Well Led. The National Guardian's Office (NGO) has worked with the CQC to ensure that an assessment of speaking up is at the heart of inspecting the Well Led domain

3. Progress on Priorities identified for 2017 – 2018

3.1 Improving process and progress.
3.1.1 The FTSU Guardian is integral to ensuring all staff within the Trust feel able to raise any issues or concerns, or challenge any wrongdoing – safe in the knowledge that they will be addressed confidentially, promptly, and in line with best practice. Within the six month reporting period the Trust Guardian has;

- attended national training / networking event facilitated by NHS Employers to enable benchmarking and sharing of best practice.
- Continued to be a member of the North West Freedom to Speak up Guardian Network The purpose of which is to provide regional support for FTSU Guardians, where learning and best practice is shared, enabling the recommendations of the Francis FTSU Review to be implemented consistently and effectively. In addition the Trust Guardian is a member of the Community and Mental Health NHS Trusts Network which has a focus on the geographical challenges faced in supporting staff working remotely.
- Participated in two video / audio conferences with the NGO to participate in the development of guidance.
- Attended internal CWP staff meetings as part of the on-going awareness raising of the role and function of the Guardian.

3.1.2 Board Champion. Rebecca Burke-Sharples is the Non - Executive Director Freedom to Speak Up Champion and acts in support to the Guardian in the promotion of the role and continuous development of and open culture across the organisation.

3.1.3 The Trust Freedom to Speak Up mini site is in the process of being refreshed; the site will be a repository of information, guidance, examples of bestpractice and links to the National Guardians Office which contains details of that role and links to other resources. The mini site will also have links to an educational film which has been developed by health education England which informs healthcare professionals at all levels –. The films look at three scenarios that highlight broad lessons to be applied elsewhere. The site will also provide contact details for the F2SU guardian and the App.

3.1.4 Freedom to Speak Up App.
One of the challenges for the Trust is reaching all grades of staff with the same information and opportunity of access and information regarding freedom to speak up. Many staff have limited access to email and do not have mobile devices supplied by the organisation, but do have their own mobile phones. Executives agreed to the investment in a Freedom to Speak Up App in early 2017 and this has now been developed and went live on 1st September 2017. 27 devices have downloaded the app as at 30th September.

The main purpose of the App is to educate, encourage and facilitate the raising of concerns by staff members in a simple, convenient and innovative way. Additional benefits of the app are; staff can report concerns from anywhere at any time, reports are secure and will only be seen by the guardian, the app provides another line of communication, allows the trust to communicate directly with staff via push notifications and news articles and informs staff members of the protection they will receive

should they report a concern. This has been promoted initially via CWP Essentials, and by word of mouth from F2SU ambassadors and at meetings attended by the F2SU guardian; a programme to raise awareness of the app is in development.

3.2 Building Confidence and Capability

3.2.1 The Trust continues the recruitment of Speak up Ambassadors. These are self nominated staff who provides immediate support and signposting for colleagues in raising concerns, determining the best course of action and advising the staff member of their options. The two monthly rolling recruitment process was interrupted during this reporting period however six additional Ambassadors are now in place.

3.2.2 The Trust has adopted the Health Education England e-learning awareness raising training which went live 1st September, as of 30 September 2017 there have been 522 staff who have completed this competence.

3.3 Measuring Progress. Success should not be measured in the number concerns and issues being raised. The majority of concerns will be addressed at Step 1 or Step 2 (as outlined in the How to raise and escalate concerns within work, incorporating whistleblowing policy) No central record of these concerns is maintained.

Learning from concerns is shared within the team/service and locality as appropriate, and across the organisation via the Learning from Experience report which is reviewed at Quality Committee. Learning is also highlighted in the Trusts Annual Quality Report.

The Speak up guardian will continue to provide confidential support to staff raising concerns, however in order to continue to improve the culture regarding raising concerns staff will be encouraged to be open and only use the anonymous route when absolutely necessary.

The Speak up guardian continues to support the work of organisational development to understand the matters which contribute to related areas highlighted in the staff survey.

4. Concerns Raised

4.1 As shown in table 1 below; Wirral continues to be the locality of origin with the least concerns raised to the Trust Guardian. This locality also has the least number of Raising Concerns Ambassadors. This may indicate that the locality is successfully resolving issues locally; further work is in place to encourage more Ambassadors from the locality, and to raise the profile of the Guardian. The apparent increase in the number of concerns raised is due to the changes in recording as described earlier, therefore numbers are slightly skewed.

No concerns have been raised anonymously during this period; two concerns were raised as part of exit interviews. Capturing and utilising information gained during exit interview forms part of work currently being undertaken and is due to be refreshed and re-launched with regular data review and actions established and monitored at the People and Organisation Sub-Committee.

Table 1. Total numbers of concerns raised by locality

Locality	**2015 – 2016**				**2016 - 2017**				**2017 - 2018**			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
East	4			2	2		3		1	8		
Wirral	1	2		1		1	1			1		
West	4	1	2	1	1		2	1	2	2		
Trust wide		1		1		1						
Sub Total	9	4	2	5	3	2	6	1	3	11		
IN year	20				12				24 (ytd)			

4.1 Analysis of Themes

Theme	2017 – 2018			
	Q1	Q2	Q3	Q4
Patient Safety/Quality	2			
Staff Safety				
Behavioural/Relationship	1			
Bully/Harassment				
System/Process				
Infrastructure/Environmental				
Cultural/Attitude	1	10		
Leadership		1		
Management Issue		10		
Fraud				
Sub Total	4	21		
IN year				

Concerns which have identified more than one issue are now recorded under the each of the categories contained within the guidance from NGO, this will assist in the identification of emerging themes or trends but may not indicate an increase in the overall number of concerns raised.

Caution should be noted when considering the analysis due to the small numbers involved, and changes to recording, as discussed earlier. Further understanding of the themes/ trends will be required as our information and data becomes more robust over time. However with the limited information available culture and attitude of staff and management issues would appear to be the most common. The definition of Management issues in the Guidance is not described however within CWP we have taken the following definition “Poor attitude, communication or management, inappropriate targets and poor accountability mechanisms’. Culture is also open to interpretation, CWP has taken the definition as where there is poor support to develop or implement a strong organisational approach to raising concerns which promotes the value of openness, transparency and candour.

The majority of the concerns (10) raised within this reporting period were in regard to communication of change management.

4.2 What have we done in response?

All the concerns raised have been investigated and responded to in a proportionate way by a variety of methods, examples include;, a focused programme of education and support concentrating on specific professional working issues including client relationships, using scenario based learning to support staff in speaking up, challenging practice and outcomes, piloting cultural values assessments and improving communication with service user families and supporting staff to consider using mediation services in response to difficult working relationships.

5. Recommendations

The Board of Directors is asked to note the contents and progress to date against the priorities identified for 2017/18.

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

STANDARDISED REPORT COMMUNICATION

REPORT DETAILS

Report subject:	CWP Quality Improvement Ambition: Phase 1 Strategy (2018 – 2021)
Agenda ref. no:	17-18-76
Report to (meeting):	Board of Directors – meeting in public
Action required:	Discussion and Approval
Date of meeting:	29/11/2017
Presented by:	Dr Anushta Sivananthan – Medical Director (Executive Lead for Quality)

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

REPORT BRIEFING

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

Appendix 1a presents CWP's Quality Improvement (QI) strategy, for Board approval, following an extensive consultation period. Appendix 1b outlines the associated delivery and implementation plan, which will now be taken forward to the Quality Committee to agree timeframes and positioning into its business cycle for 2018/19. This plan will be supported by dedicated, long term investment in a QI faculty, whose aim it is to continuously enable QI within the Trust, as well as short-medium term investment in an external strategic partner. The latter is to help guide CWP in applying its QI methodology robustly and consistently, and to help identify measurable goals for the 2019/20 and 2020/21 years of phase one of the strategy. The aim is to be self sufficient as the Trust moves into phase 2 of its QI strategy from 2021. The Board is asked to approve the strategy and endorse a long term commitment to a QI ambition.

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

An externally facilitated Board seminar in June 2017 explored the Board appetite for developing an explicit and long-term commitment to an ambition where QI becomes the operating principle of the Trust, including in its systems working. As a result, the Board commissioned the development of a QI strategy. The requirement for a QI strategy was also fed back to CWP as an outcome of the well-led pilot undertaken by the CQC (also in June 2017). The strategy appended to this report describes how CWP will deliver this commitment.

Assessment – *analysis and considerations of options and risks*

The QI strategy is clear in describing what is needed to build a sustainable infrastructure that will enable QI to be applied, delivered and implemented, through a combination of re-alignment of existing resources and investment in dedicated resources. This investment was agreed by the Board of Directors, to go forward as part of the upcoming 2018/19 budget setting process.

Momentum is gathering across the NHS in making the case for applying QI consistently and systematically across organisations and systems, notwithstanding the regulatory imperative. The appended QI strategy is a roadmap that describes what quality means to us and how we will achieve improvements in outcomes and the quality of care for the population we serve, with an ambition to achieve the best outcomes nationally.

Of specific relevance to the Board of Directors, the QI strategy sets out a number of leadership priorities and commitments for the Board. These are linked to The King's Fund publication 10 lessons for NHS boards and includes the following specific areas for the Board:

- The Board will be trained in Quality Improvement to enable them to be an effective sponsor of others undertaking improvement activities.
- Identification and approval of the strategic priority areas over the period of the QI strategy.
- Development of a strategic dashboard that is robust, appropriate and in near-real time, presented as 'statistical process control' run charts, to enable an understanding of variation and ability to track achievement of aims over time.

In addition to the aforementioned appointment of an external strategic partner, next steps include:

- Appointments to those QI posts that the Board agreed to invest in, with the aim to have these in place by 1 April 2018 in time for commencement of the strategy.
- A meeting will be led by the Medical Director (Quality) in January 2018 between all QI faculty senior leads, representing every executive portfolio, to ensure their state of preparedness to support delivery and implementation of the QI strategy – this will include identification of any developmental or education and training needs.

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

The Board of Directors is recommended to **approve** the QI strategy (Appendix 1a) and its delivery and implementation plan (Appendix 1b).

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

Distribution to other people/ groups/ meetings:

Version	Name/ group/ meeting	Date issued
1	D Wood to A Sivananthan	20/11/2017
2	D Wood to L Brereton for agenda	20/11/2017

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

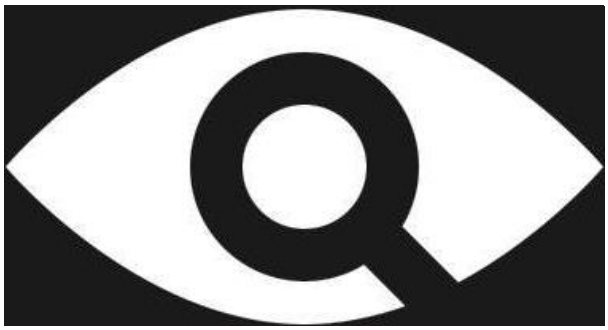
Appendix no.	Appendix title
1a & b	CWP Quality Improvement Strategy Phase 1 (2018 – 2021) & delivery plan

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

Quality Improvement Strategy

Phase 1

2018 – 2021



"Working in partnership to deliver the best outcomes nationally for the population we serve"

This strategy is a roadmap that describes what quality means to us and how we, through a series of measurable goals, will know whether we have achieved improvements in outcomes and the quality of care for the population we serve

Contents

Introduction:
Why do we need a Quality Improvement strategy?

Quality Improvement is about systematically improving care by enhancing quality – the safety, outcomes and experiences of people who access our services. It is based on a principle of organisations, staff and people who access our services working together to improve care and outcomes for the population. The purpose of Quality Improvement is to deliver person-centred health care that responds to the needs and preference of people who access our services, with a compelling ambition to deliver the very best outcomes.

We need a Quality Improvement strategy because improvements in the quality of care do not happen by chance. Quality Improvement is a continuous process and a long-term, overarching commitment that requires a change in culture (the way we do things). It will therefore rely on a shift in the way we think, lead and work. This means every member of staff will need to be empowered to be a leader and to take responsibility for their part in the quality of care and services that we provide.

This Quality Improvement strategy is a high level framework which sets out our ambition to deliver the best outcomes for the population we serve. We recognise that to do this, we need to underpin this strategy by developing systematic, organisation-wide programmes (and wherever possible, whole health care system-wide programmes) to ensure that continuous improvement happens at scale and as part of our every-day way of working. This Quality Improvement strategy should therefore not be read in isolation – we must not see this Quality Improvement strategy as the only way in which we will seek to improve quality. Each of our other supporting strategies[1] also have a strong focus on Quality Improvement.

Our strategy describes how we will deliver and implement our framework for Quality Improvement. For this framework to be effective, it is really important at the outset to accept that not everything will work – Quality Improvement is about trying, succeeding or failing, reflecting and learning from things that are successful and things that are not.

Our Quality Improvement journey:
What have we achieved so far?

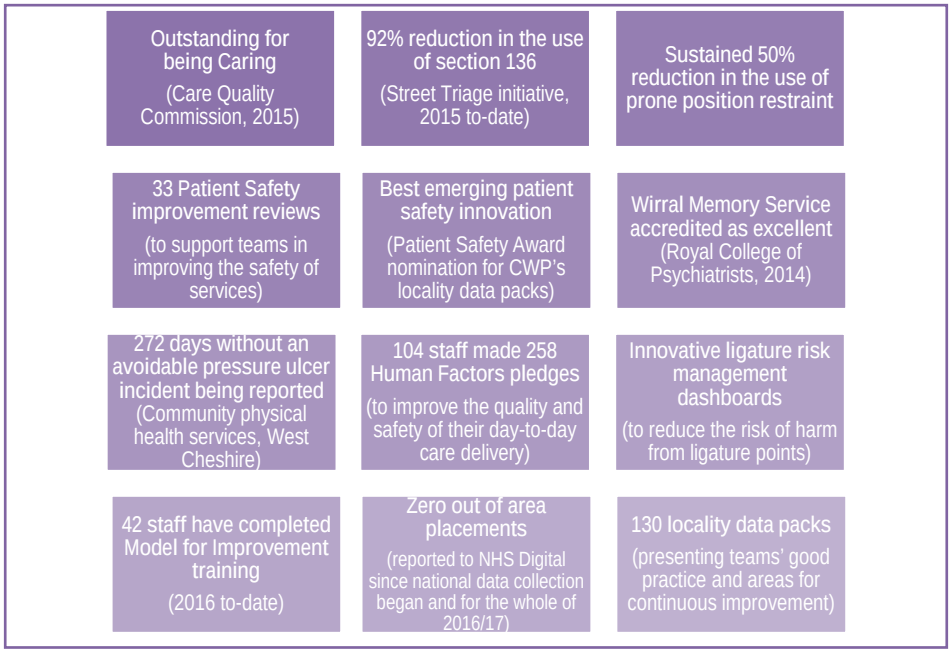
In 2014, we launched our Zero Harm quality strategy. We were determined to assess and monitor the quality of our services in ways which:

- Promote what good quality healthcare looks like.
- Celebrate success in delivering good outcomes.
- Tackle unwarranted variations in clinical care.
- Improve the effectiveness of care planning.

We have implemented this strategy over 4 years and as part of this we rolled out a wide range of patient safety initiatives to tackle issues such as pressure ulcer care in our community physical health services and the use of prone position restraint in our inpatient mental health services. *Figure 1* displays a snapshot of some of the things we are proud of achieving during the course of this strategy:

[1] CWP Forward View; Zero Harm quality strategy; People and Organisational Development strategy; Person-centred Framework; Communications and Marketing strategy; Research and Effectiveness strategy; Information strategy

Figure 1: What we have achieved through our Zero Harm quality strategy



We are proud to celebrate examples of how the support systems we have put in place have enabled best practice, every year since we launched our Zero Harm quality strategy, at our Best Practice Showcase event and in our Big Book of Best Practice. So far, the Big Book alone has showcased 146 examples of best practice. Our Quality Improvement Reports have showcased a further 129 examples, i.e. we have undertaken 275 Quality Improvement projects over 4 years.

We are proud of our staff and their unwavering commitment to quality and Quality Improvement. But we recognise that we can only deliver the best care if we enable our staff. We need to ensure that they have the capability (i.e. capacity, confidence and competence) to bring about sustainable changes and improvements in care. We also need to provide an environment that nurtures behaviours that strive for improvement. This means we will ensure that leaders at all levels of the organisation constantly enable our staff. We therefore need to join up our Quality Improvement strategy with our People and Organisational Development strategy 2015 – 2020.

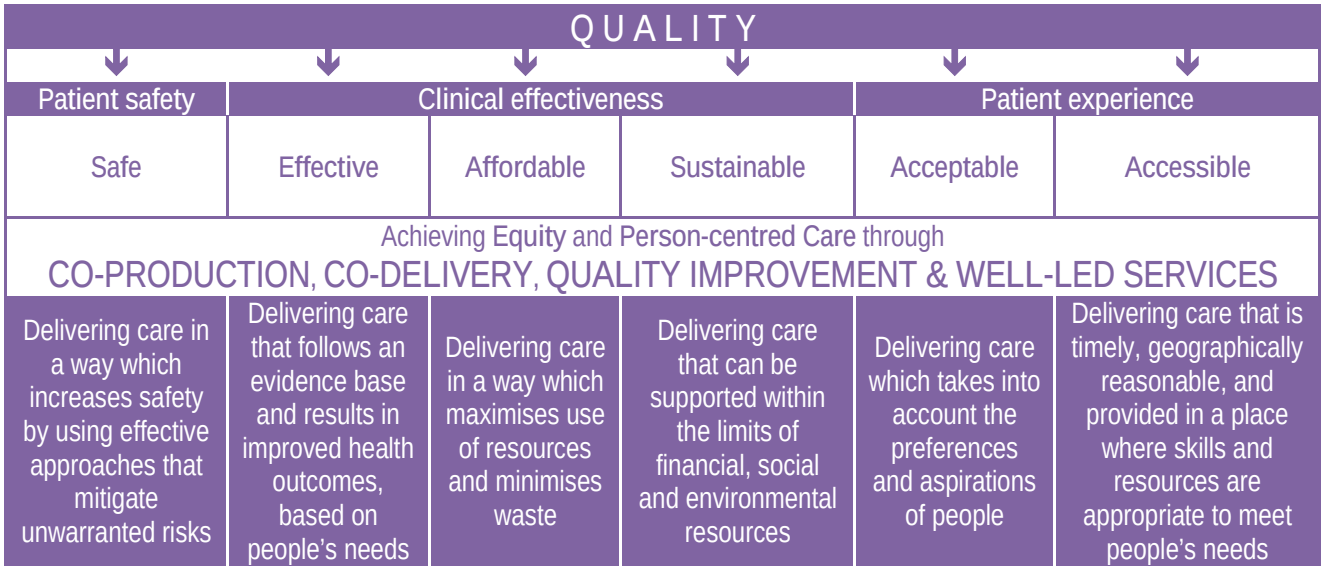
Above all we are realistic – generating capacity for continuous and sustained improvements in the quality of care requires a substantial and sustained commitment of time and resources. Improvement requires both local action and central co-ordination, and resources for both of these things. But we are optimistic – we know that high quality care often costs less. As such, this new strategy refocuses and reinvigorates our ambition to deliver the best outcomes nationally for the population we serve.

Improving how we define Quality

Institute for Healthcare Improvement guidance has encouraged us to assess and monitor quality using a broader definition than as defined in 2008 by the Department of Health. This will help us to better identify and prioritise areas for improvement. Together with World Health Organization definitions and our Person-centred Framework, we have defined quality as described in our Quality Framework in *Figure 2*.

Our Quality Framework places an emphasis on co-production, which is about our staff, people who access our services, their families and the populations we serve playing more of an active role in planning, improving and delivering services. When we apply systematic methods of Quality Improvement, we will ensure the principles of co-production are integral. We recognise that by involving people with lived experience in improvement, design, implementation and governance of our Quality Improvement strategy, it will maximise the effectiveness and impact of our services.

Figure 2: Our Quality Framework



Our Ambition

The first step in building our Quality Improvement capability is to develop an ambition that is aligned to our vision, our purpose, and our values.

Our ambition for Quality Improvement is to lead in partnership to deliver the best outcomes nationally for the population we serve. This is a demanding ambition, which requires a focused commitment from us as an organisation on **all** the components of quality. When we complete Phase 1 of this strategy by 2021, we will have a baseline of the outcomes we are achieving that we are able to benchmark nationally. Phase 2 of the strategy will raise the bar of our ambition by setting a realistic, but challenging timeframe for when we will deliver this ambition by.

Our ambition for Quality Improvement has been developed based on an assessment of changes in the external environment in which we operate, our strengths and areas for development, and to support our Trust strategy – the CWP Forward View. The CWP Forward View and Quality Improvement strategy will be closely aligned for the next three years (phase 1 of the Quality Improvement strategy). The CWP Forward View will help to set the foundation for the next 20 years (in terms of population need), therefore phase 2 (and subsequent phases) of the Quality Improvement strategy will support this.

In developing our Quality Improvement strategy and our ambition (*Figure 3*), we have sought feedback from our Board, Quality Committee, Clinical Engagement and Leadership Forum, Governors, and via focus groups with partners and stakeholders.

Figure 3: Our Quality Improvement Ambition

Ambition Our Quality Improvement challenge	**Ambition** Working in partnership to deliver the best outcomes nationally for the population we serve
Vision What we want to be *We will use Quality Improvement to deliver this vision*	**Vision** Working in partnership to improve health and well-being by providing high quality care
Purpose Why we exist	**Purpose** Being person-centred Striving to enable the population we serve to be the best they can be
Values These guide our behaviours and the way in which we work	**Values** Care Compassion Competence Communication Courage Commitment

We recognise that we will not achieve our ambition overnight. Building our strategy will take time, so preparatory work will take place during quarters 3 and 4 of 2017/18. Ultimately we want to foster a culture of finding solutions and be even more focussed on learning and improvement – i.e. we want to be a learning organisation committed to improvement.

Improving quality of care is complex and takes time to achieve and to demonstrate progress and impact – organisations which are further ahead on their Quality Improvement journey have shown this. We recognise that three years is the minimum time required to evidence wider scale results of Quality Improvement. The first year of our delivery and implementation plan is therefore realistic and mainly identifies measures of success. We will, however, start to identify improvement targets as we make small scale changes in embedding this strategy – in doing so, this will give us baseline results so that we can identify realistic improvement targets.

We recognise that we are on a journey of discovery and uncertainty, so this strategy also needs to be emergent to be effective. Annual reviews of this strategy's delivery plan will inform the next phase of our Quality Improvement ambition from 2021 and beyond.

Creating the right conditions: Actions we will take to become a successful improvement focused organisation

We want to create the conditions for Quality Improvement to flourish, to celebrate success and promote good practice so that people can see the overall approach is working and worthwhile – thereby ensuring sustainability of our approach. We already support a focus on continuous improvement by:

- Holding an annual Best Practice Showcase event and producing an annual Big Book of Best Practice.
- Giving access an intranet-based best practice portal to support frontline teams with Quality Improvement.

- Producing a Quality Improvement report and Learning from Experience report, three times a year, to share and learn from best practice and feedback.
- Service improvement support, and fora, to tackle variation and to improve outcomes.
- Developing capability through training, support and advice in relation to service improvement and quality improvement.
- Provision of simulation training to support staff to practise real life scenarios.

Despite this support system, to become a successful improvement focused organisation, we need to be open to learning from other organisations about what the right conditions are to help us realise this. These conditions are linked to the following themes:

- Leadership.
- Strategy.
- Organisational improvement.
- Leading edge, innovative performance.

Leadership

We will:

- Encourage each and every one of our people to be leaders and ensure that these leaders, at all levels, understand how to improve quality and support change effectively. (*page 10*)
- Involve our senior medical, clinical and managerial leaders, including our Board, at the outset. (*page 13*)
- Ensure our leaders will be able to adapt their behaviours, signalling their commitment to delivering our Trust vision, through a new way of working in which improvement is central. (*page 13*)

Strategy

We will:

- Be clear about our chosen method of Quality Improvement, recognising that the outcomes we achieve are unlikely to be sustained if we make it more difficult to learn about the mechanisms that lead to change and improvement. (*page 8*)
- Set realistic goals and be clear about them and how we will measure and evidence our progress. (*Appendix 1b* for 2018/19 and then in each annual delivery and operational plan)

Organisational improvement

We will:

- Take every opportunity to share learning and good practice in relation to Quality Improvement, internally and externally. (*page 12*)
- Review and build our infrastructure for Quality Improvement to enable us to be dynamic in the way we learn. (*page 12*)
- Ensure we invest in and provide the training required to our workforce to deliver Quality Improvement. (*page 13*)

Leading edge, innovative performance

We will:

- Use measurement, Quality Improvement methods, and benchmarking processes to assess how teams or systems compare to others – locally, nationally or internationally. (*page 12*)

- Tackle unwarranted variation and inefficiency within the Trust and, wherever possible, across the whole health care system, by seeking to transform and standardise clinical standards. (*page 14*)
- Work with our regulators and commissioners to ensure there is an understanding of our strategy and build a relationship with them that includes support for our Quality Improvement journey to free up capacity to focus on Quality Improvement. (*page 14*)

It is important that we get the balance right in this strategy. Improvement in healthcare is 20% technical and 80% human. We know we need to build a technical infrastructure for Quality Improvement, but not lose focus on enabling our staff – as this is how we will sustain quality and Quality Improvement. We have therefore placed a strong emphasis throughout this strategy on building capability for Quality Improvement.

Measuring Quality and Quality Improvement: How will we know we are delivering the desired outcomes?

Measuring quality (including safety and cost) against a range of agreed metrics will enable us to know how we are doing, what we do well, and, most importantly, how and where we need to do better. This will help us to be systematic and transparent in reporting our progress.

Quality Assurance

Quality Assurance is about:

"the ongoing monitoring of the quality of care against agreed standards".

Monitoring the quality of care that we provide against internal and external guidelines and standards is vital in assuring everyone that we have effective oversight of the care provided throughout the Trust.

National Institute of Health and Care Excellence (NICE) guidelines and standards

NICE guidelines and standards set out best, evidence-based clinical practice. We believe that we should pursue clinical excellence through our treatments and interventions, systematically drawing on available evidence-bases. Risks to our ability to deliver against NICE standards due to commissioning arrangements will be highlighted to commissioners. Areas of priority include:

- Treatment of schizophrenia and psychosis.
- Treatment of ADHD – all ages.
- Treatment of bipolar affective disorder.
- Diagnosis and treatment of personality disorder.
- Access to treatment for depression.

Regulatory standards – Care Quality Commission, NHS Improvement & Ofsted

We welcome strong regulation and inspection, as a means of assuring the populations we serve and are accountable to, that we are meeting fundamental standards of care. Our regulators also consider the processes we have in place to support learning, continuous improvement and innovation. We believe that delivery of our Quality Improvement strategy will support us to:

- Maintain our Trustwide rating of 'Good' overall and 'Outstanding' for Caring and achieve an 'Outstanding' well-led rating (Care Quality Commission).
- Maintain our position as a 'segment 1' organisation – i.e. we can demonstrate the highest level of performance in relation to quality of care, finance and use of resources, operational performance, strategic change and leadership and improvement capability (NHS Improvement).
- Achieve overall effectiveness ratings of 'Good' for the services we provide that care for children and young people (Ofsted).

- Meet annual quality goals, and key national quality targets set out by our regulators relating to access and outcomes, by:
  - ✓ Tracking performance against key quality targets at all levels of reporting, including an increased focus at team level, to encourage continuous improvement.
  - ✓ Setting quantified and measurable annual goals for each of the three domains of quality, as part of our Quality Account.

We recognise that there will be occasions when clinicians need to deliver care that is in exception of Trust policies and internal/ external guidelines so that they can deliver the best possible care. We are supportive of this, otherwise we may stifle positive variation, innovation and person-centred care – in these instances, improvements will be incorporated into Quality Improvement work so that we can learn how care can be strengthened.

Quality Improvement

Quality Improvement goes beyond Quality Assurance. There is no single definition, but it is about:

"systematically improving care by enhancing quality –
the safety, outcomes and experiences of people who access our services".

We recognise that to achieve our Quality Improvement ambition, we need to ensure that continuous improvement happens as part of our every-day way of working. Our current positive performance with regulatory standards not only provides Quality Assurance, but is a sound platform for empowering our staff, at all levels, to bring about further improvements from within and create the momentum by which continuous quality improvement can occur at scale.

Those directly involved in giving and receiving a service are best placed to understand where improvements can be made. As such, it is vital that all staff should have an opportunity to contribute and act on ideas, which will make Quality Improvement feel relevant and meaningful. To sustain quality and build a sustainable Quality Improvement infrastructure, we will ensure that the building blocks for this strategy support staff to bring about change locally. Our teams will be trusted and supported to make changes – they will have the flexibility and authority to work on local priority areas that matter to them and people accessing the services they provide. We will give them the capacity, confidence and competence to improve care.

Our Board and our 'Care Groups' will identify and approve strategic priority areas over the period of this strategy.

Our Framework for Quality Improvement

This Quality Improvement strategy is a high level framework and will be underpinned by the following programmes and plans of work that are enabled by our clinical support teams – see *Figure 8*:

- Healthcare quality improvement programme (which includes national and clinical audits).
- Service improvement and effectiveness work programme.
- Organisational development work programme.
- Essential and bespoke programmes of learning (which includes Human Factors).
- Person-centred framework implementation plan.

We intend to tackle identified Quality Improvement projects by using our principal methodology, identified below in *Figure 4*. The common thread to success of each project will be strong engagement and collaboration supported by training our staff, senior managers and people with lived experience of our services in these methods.

We will use the principal methodology of Model for Improvement. We will ensure that we apply this consistently and throughout the organisation. Evidence shows that ensuring fidelity in a Quality Improvement method is vital for success. We have chosen the Model for Improvement because it tests change ideas using PDSA (Plan-Do-Study-Act) cycles, which will help us to identify what does and does not work before we redesign. *Figures 4* and *5* describes our approach.

Figure 4: Our principal Quality Improvement methodology – Model for Improvement

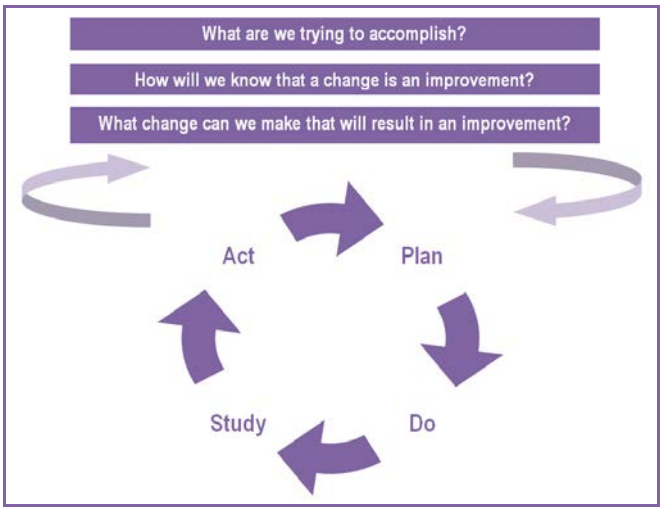
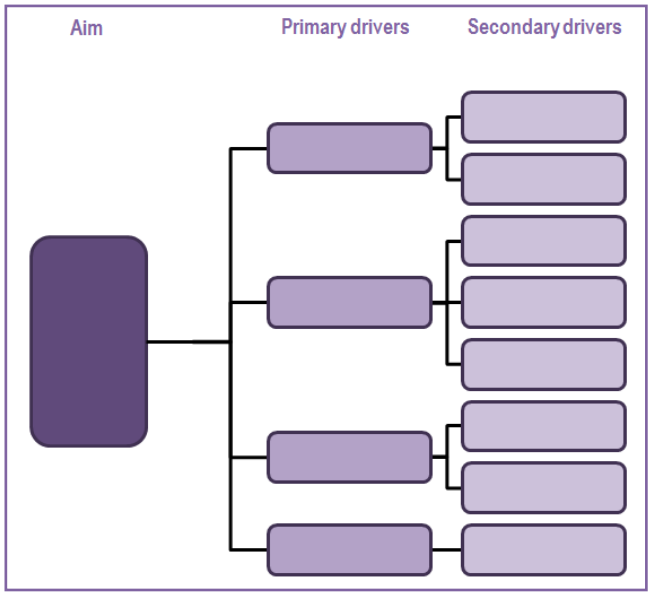


Figure 5: Driver Diagram format



Our method of describing our change ideas will be by putting them into a driver diagram, which is a visual display of what "drives" the achievement of a project aim. It usually has three levels:

- An aim – a clear goal or vision.
- Primary drivers – high level factors needed to influence in order to achieve the aim.
- Secondary drivers – specific projects and activities that would act upon the primary drivers.

This clear picture of a team's shared view of their project is a useful tool for communicating to a range of stakeholders about its change and improvement work.

We will use improvement methodologies that are about redesign where these are more appropriate, e.g. Lean, Quality Improvement Cycles and Experience based design. Subject matter experts from clinical services and clinical support services will work with our improvement experts to assess and identify the most appropriate approach.

Lean – a set of tools that assist in delivering value through the identification and steady elimination of inefficiency, mistakes and cost[2]. Techniques such as process mapping and value stream mapping are used to tackle variation in care and work towards the principle of "getting it right first time" so that we can demonstrate that we are using our assets to the best effect.

[2] Quality and finance are closely related through many opportunities that exist to deliver better outcomes at lower cost. This Quality Improvement strategy works on the operating principle of delivering better value, not 'cost-cutting'.

Quality Improvement Cycles – predominantly we will use the PDSA (Plan-Do-Study-Act) approach:

Plan: The quality problem or the change we want to test
Do: Carry out the test
Study: Observe and learn from measuring the impact of the test
Act: Determine what should happen next based on the results

Quality Improvement Cycles are a way of testing and implementing changes at the front line of care. If successful, systems will be redesigned from the bottom up using small scale tests of change.

Experience based design – approaches to support people with lived experience of our services to work in partnership with staff to apply systematic methods of Quality Improvement to maximise the effectiveness and impact of our services and pathways. These approaches gather data about the current experience of the service through in-depth interviews, observations and group discussions, and facilitated improvement exercises, which are then analysed to identify areas for improvement.

Sustaining Quality and Quality Improvement

Building an organisation-wide commitment to Quality Improvement requires courageous leadership, a sustained focus over time, and promotion of transparency, evaluation and shared learning across the organisation and beyond.

Our high level ambition for Quality Improvement will take time to see large scale impacts. We are realistic that this will take years of sustained effort, including an initial period for us to "learn" how to do Quality Improvement in practice. We are particularly motivated by the example of Jönköping County Council, Sweden, which is well known for its work on quality improvement and the sustainable benefits of their approach. Teams there are encouraged to work together to think about how they can deliver the best outcomes, using the principle that 95% of their time is spent doing their job, 5% of their time is learning how to do their job better.

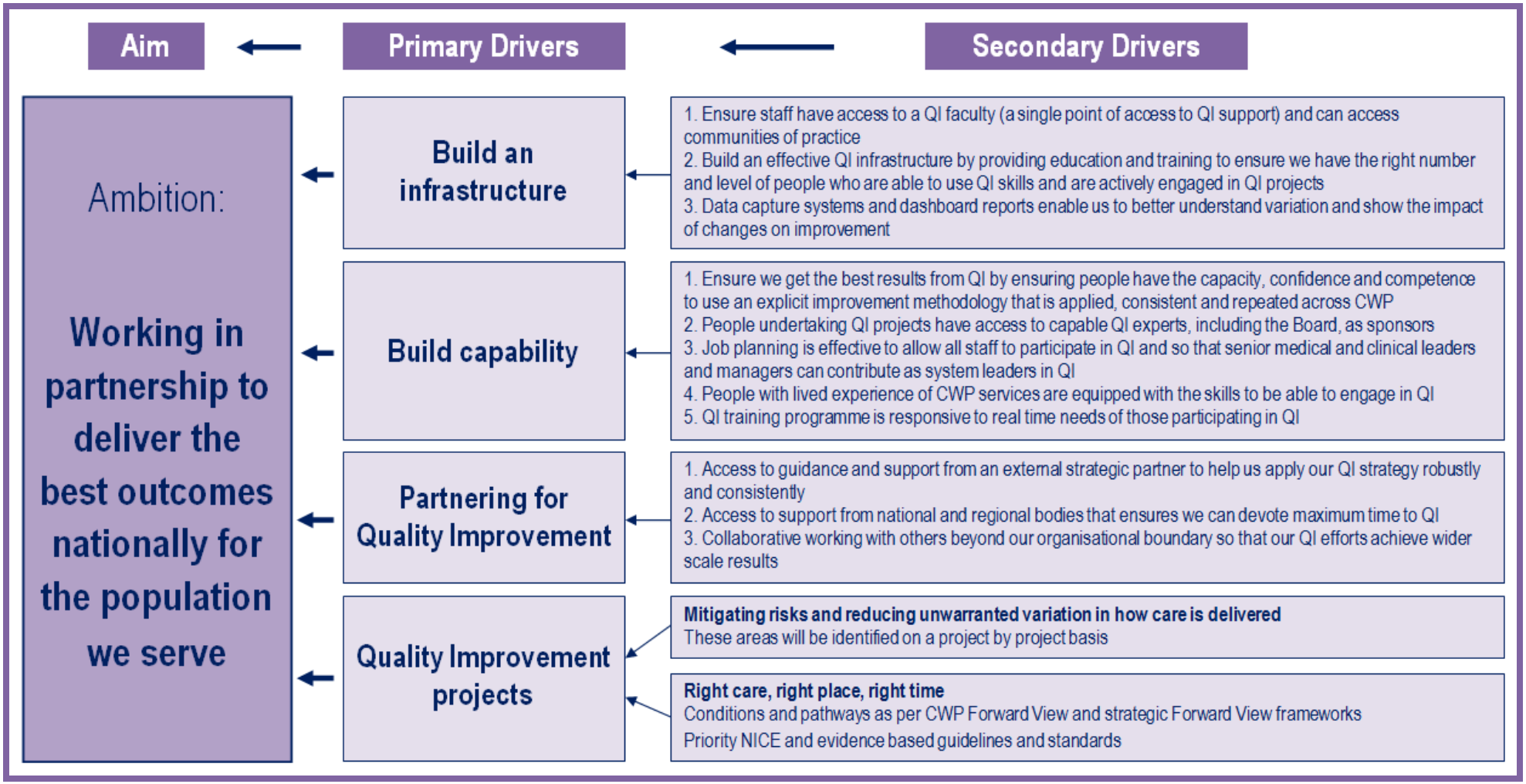
To sustain Quality Improvement, it must be part of our culture and our everyday work. There are three key building blocks which will bring a number of benefits (*Figure 6*).

Figure 6: Building blocks of our Quality Improvement system

	Building block	Benefits
1	Everyone talks a common Quality Improvement language	✓ There is widespread understanding of our approach to Quality Improvement, which becomes embedded in the way we do things. ✓ Previous barriers to addressing problems are overcome.
2	Empowerment of staff	✓ Everyone's contribution is respected. ✓ Staff morale improves (demonstrated through an increase in satisfaction and retention rates and lower sickness and absence rates) – their creativity drives improvement.
3	Quality Improvement priorities are person-centred	✓ Makes life better for people who access our services.

To sustain quality and to achieve our Quality Improvement ambition, we have identified a driver diagram to describe our change ideas. How we will deliver and implement these change ideas is detailed in *Appendix 1b* and then in each annual delivery and operational plan.

Figure 7: Phase 1 Quality Improvement Strategy Driver Diagram

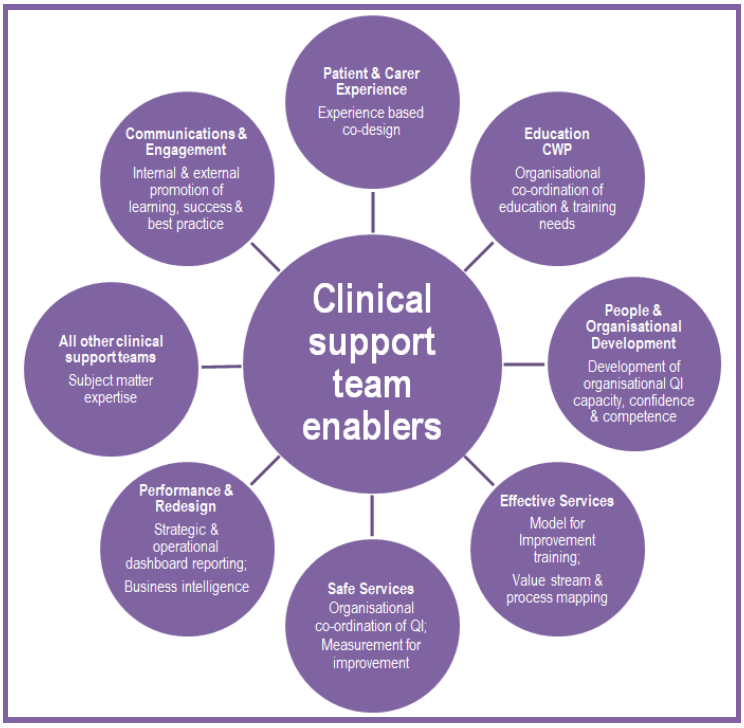


Building an infrastructure

We recognise that we need to develop the necessary infrastructure to enable Quality Improvement to thrive and spread. We have used research undertaken by The King's Fund to support our work. We will:

- Identify a central Quality Improvement faculty that brings together the Quality Improvement support offers of each clinical support team – to ensure that staff have a single point of access.
- Provide direct support for projects via this Quality Improvement faculty.
- Co-ordinate support from all teams across our clinical support infrastructure. Our collective assets (through a re-alignment of existing resources and investment in dedicated resources) will manage and promote Quality Improvement (*Figure 8*) and ensure that learning is shared between Quality Improvement efforts.
- Implement 'QI Life' – a web-based resource to make Quality Improvement as easy as possible for frontline teams (it helps manage projects, including the creation of driver diagrams and recording progress with Quality Improvement Cycles).
- Maximise our contribution to The Health Foundation's 'Q initiative', an NHS UK-wide improvement 'community of practice' that are able to connect and share their improvement ideas, enhance their skills and make tangible improvements in health care.
- Improved use of dashboards to better understand how we are doing. Board reporting (our strategic dashboard) will be robust, appropriate and will be in near-real time, presented as 'statistical process control' run charts, to enable us to understand variation and track achievement of our aims over time, complemented by a RAG (Red-Amber-Green) status to show 'current' performance. Committee, sub committee,
  service-level and team-level reporting will replicate this at increasing levels of granularity.

Figure 8: Clinical support infrastructure for Quality Improvement

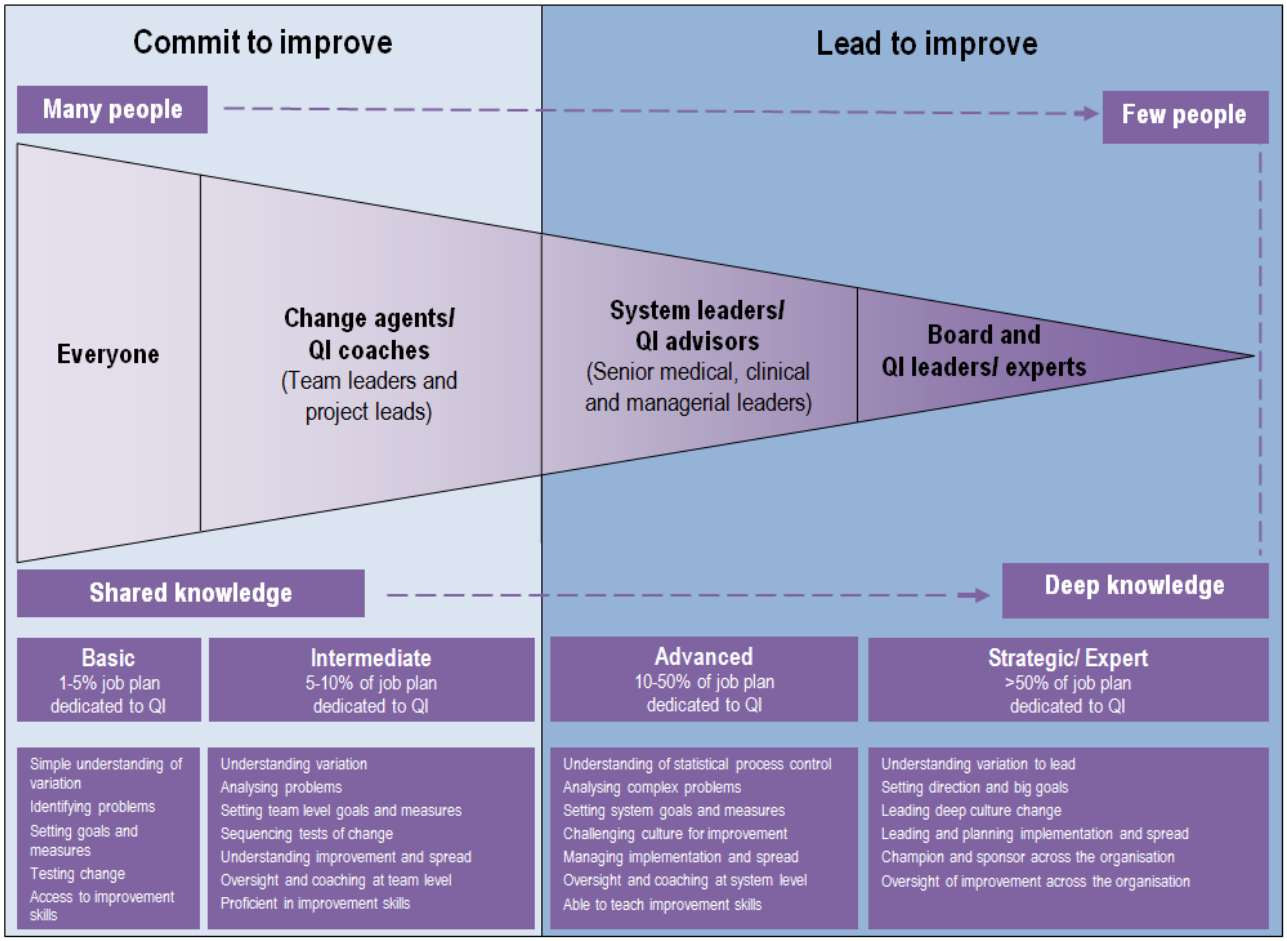


- Ensure that we have the right level of skill and knowledge to build an effective Quality Improvement infrastructure. To do this, we will use a 'dosing' model that will help us to identify the right numbers of people with the right level of skill and knowledge (see *Figure 9*).

Building capability

We recognise that for Quality Improvement to be our standard way of working across the organisation, we need to prepare the whole workforce to take on Quality Improvement alongside their routine work. Studies tell us that we will get the best results if we apply a consistent and explicit methodology for Quality Improvement across the organisation and if we ensure buy-in of key leadership and managerial roles. *Figure 9* describes what skills we need to ensure consistent commitment and leadership for Quality Improvement.

Figure 9: Building a skill set for Quality Improvement commitment and leadership



We will:

- Agree and ensure fidelity in our Quality Improvement method. Evidence shows that what matters most is the use of an explicit improvement methodology that is applied, consistent and repeated throughout the organisation.
- Ensure that the Board is trained in Quality Improvement to enable them to be an effective sponsor of others undertaking improvement activities.
- Ensure all staff have been trained in order to embed Quality Improvement into daily working.
- Give people the capacity (time) to carry out Quality Improvement work.
- Target key service-level leadership and managerial roles as part of the Quality Improvement training programme.
- Ensure that people with lived experience of our services have the opportunity to access Quality Improvement training programmes.
- Evaluate the Quality Improvement training offer regularly and adjust the programme where necessary and to meet changing needs.

If we deliver this training, it will ensure capability – that people have the capacity, confidence and competence to deliver change through Quality Improvement support being made available to all, including through:

- Introduction to Quality Improvement at induction – including how to understand measurement for improvement (run charts).
- Advice and training in improvement methods and tools.
- Access for frontline staff to improvement coaching – to help develop their insights, skills and capabilities.

Partnering for Quality Improvement

We recognise the value of having an external partner with relevant experience and expertise to help guide us in applying our Quality Improvement methodology robustly and consistently, and to objectively help us identify measurable goals for our delivery and implementation plan for 2019/20 and 2020/21. We will:

- Develop a specification of what guidance and support we require of an external partner, seek expressions of interest, and appoint the successful partner to this role.
- Scope support available from national and regional bodies and build relationships with them to ensure that their offer is aligned to the deliverables of this strategy, e.g. NHS Improvement, Care Quality Commission, commissioners, Academic Health Science Networks, Health Education England, Royal Colleges.
- Scope peer support and buddying arrangements with other organisations and NHS trusts.

Quality Improvement projects

Priority Quality Improvement projects will be approved by the Board and our Care Groups on an annual basis, with progress monitored via the strategic and operational dashboards described on *page 12*. Over the period of this strategy, we will put specific focus on conditions and pathways that are:

- Delivered with wide variation that cannot be explained by differences in people's health needs/ preferences, or those of significant risk that requires mitigation.
- Of strategic importance to us and across the whole health care system, again in order to seek out and reduce variation. In 2018/19, focus will be on the conditions and pathways associated with the CWP Forward View and strategic Forward View frameworks.
- Important for the delivery of consistent, high quality care, 7 days a week.

In focusing on the above, priority NICE/ evidence based guidelines and standards will be incorporated into our improvement work. Wherever possible, technology will support measurement and understanding variation.

Governance, Delivery and Prioritisation

The Quality Committee will oversee delivery of this strategy and will report and be accountable to the Board of Directors. As the strategy will be operational from 1 April 2018, the committee will discuss and approve a timeline for the initiation and continuation of the high level priorities associated with the strategic Forward View frameworks that are applicable to CWP as part of its business cycle.

Implementation of this Quality Improvement strategy will usually take place at a local level, taking into account local context and services, and the needs of the population. CWP's Care Groups will therefore be asked to identify priority conditions and pathways in which they aim to bring about change. To help clinical teams with this, data and intelligence will be used to identify problems and to measure progress – this includes providing teams with disaggregated data on processes and outcomes of care, as well as analysis and feedback about key indicators of quality.

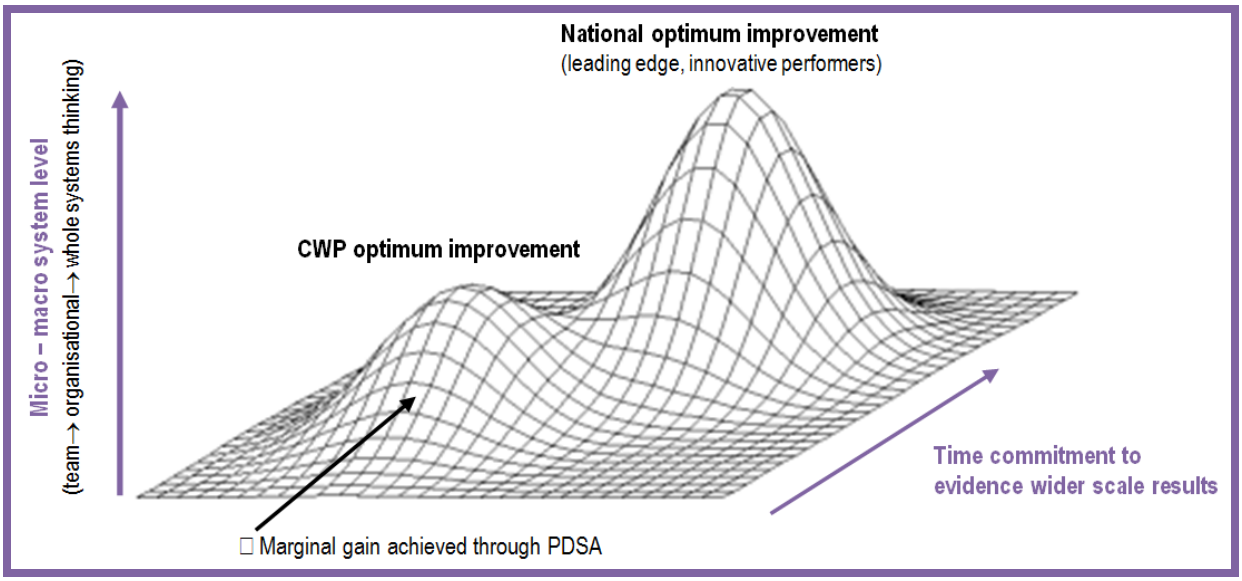
Each project will deliver a project level driver diagram, with the Quality Committee overseeing improvement trajectories and receiving exception reports.

Whole systems working:
Developing our Quality Improvement strategy to be fit for the future

We have been realistic about the years of sustained effort we need to commit to in building capability for Quality Improvement within CWP in order to achieve improvements in outcomes for the populations we serve. Whilst it is vital to learn and improve within our organisation, we are at risk of only achieving slowly accrued marginal gains. Our ambition, however, is to lead in partnership, which includes the whole health care system, to deliver the *best* outcomes, not just within CWP but *nationally* (ultimately internationally).

Quality Improvement is likely to be more effective if it is addressed at a whole systems level and approached as a long-term, sustained change effort, where we work in collaboration and pool resources across local systems of care. *Figure 10*, which is based on a recognised mathematical algorithm, demonstrates why we need to do this, i.e. we need to think differently and aspire to working at the macro (whole system) level, to achieve the best outcomes.

Figure 10: How to achieve optimum quality performance through improvement



In our approach to identifying high level priority areas, we will always explore improving population health and prioritising prevention by collaborating with and strengthening partnerships between NHS organisations, local government, housing, wider public services, and the private, voluntary and community sectors. Working as a whole system is vital at a time of constrained budgets. We will therefore take every opportunity to overcome this challenge by enabling systems to deliver the transformation that is needed by focusing on improving and sustaining high standards of care.

Our priority areas for systems working for the period of this, our first Quality Improvement strategy, will be those described in:

- The NHS Five Year Forward View
- The Five Year Forward View for Mental Health
- The General Practice Forward View
- The Cheshire and Merseyside Five Year Forward View
- The CWP Forward View – focussing on how we can improve place-based care

We understand that our priorities for the future are likely to be influenced by developments in areas like genetic data analysis and public health intelligence. Greater understanding of health conditions will inevitably lead to a change in which we identify priorities for Quality Improvement – our future delivery and implementation plans will reflect this.

Glossary of terms used throughout this strategy

Accountable	Accountability is about people taking responsibility for their actions. Organisational accountability in the NHS includes statutory responsibilities.
Care Group	Our clinician-led operational structure, responsible for developing new models of care.
Genetic data analysis	The study of a person's hereditary information (their DNA, chromosomes and genes) to look at differences that may increase their risk of developing certain health problems or the impact of their response to treatment.
Human Factors	Those factors that can influence people and their behaviour in a work context; they are the environmental, organisational and job factors, and individual characteristics which influence this behaviour.
Innovation	An idea, service or product, new to the NHS or applied in a way that is new to the NHS, which significantly improves the quality of health and care wherever it is applied.
Outcomes	The effectiveness of treatment provided to people who access our services.
Person-centred Framework	Our framework to encourage and facilitate connection with people as unique individuals with their own strengths, abilities, needs and goals.
Process mapping/ value stream mapping	A tool that uses a flow diagram to show every step of a process in order to identify ways to improve.
Public health intelligence	Health and social care data and evidence that can be used to improve the health of populations.
Quality Account	Our annual report about the quality of our services.
Regulator	In the NHS, Government funded organisations that hold NHS providers to account for the quality of care they deliver and how they are run.
Service improvement	A way of looking at how making changes to the way services currently work can help improve care by making services better.
Specification	A comprehensive description of objectives for a development project.
Stakeholders	In relation to CWP, all people who have an interest in the services we provide.
Statistical Process Control (SPC)	A time series analysis, used to identify variation beyond predictable limits.
System	The different organisations that collectively make up and support the common set of health and social care principles and values.
Variation	Differences in healthcare quality, safety, equity, outcomes, the money spent and the types of service used.
Zero Harm	Our strategy to reduce unwarranted avoidable harm and embed a culture of patient safety.

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

STANDARDISED REPORT COMMUNICATION

REPORT DETAILS

Report subject:	Ward Daily Staffing Levels September and October Data 2017
Agenda ref. no:	Click here to enter text.
Report to (meeting):	Board of Directors
Action required:	Information and noting
Date of meeting:	29/11/2017
Presented by:	Avril Devaney, Director of Nursing, Therapies and Patient Partnership

Which strategic objectives this report provides information about:	
Deliver high quality, integrated and innovative services that improve outcomes	Yes
Ensure meaningful involvement of service users, carers, staff and the wider community	No
Be a model employer and have a caring, competent and motivated workforce	Yes
Maintain and develop robust partnerships with existing and potential new stakeholders	No
Improve quality of information to improve service delivery, evaluation and planning	Yes
Sustain financial viability and deliver value for money	Yes
Be recognised as an open, progressive organisation that is about care, well-being and partnership	Yes
Which CQC quality of service domains this report reflects:	
Safe services	Yes
Effective services	Yes
Caring services	Yes
Well-led services	Yes
Services that are responsive to people's needs	Yes
Which Monitor quality governance framework/ well-led domains this report reflects:	
Strategy	No
Capability and culture	Yes
Process and structures	Yes
Measurement	Yes
Does this report provide any information to update any current strategic risks? If so, which?	
See current risk register in the agenda of the public meeting of the Board of Directors at http://www.cwp.nhs.uk/about-us/board-members/our-board-meetings	No
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 months of September and October 2017 following the submission of the planned and actual hours of both registered nurses (RN) and clinical support workers (CSWs) to UNIFY (appendix 1 and 2). The themes arising within these monthly submissions continue to mirror those that have arisen previously. These themes identify how patient safety is being maintained on a shift by shift basis.

To inform the board of the trusts participation in the NHSI Care Hours per Patient Day [CHPPD] data collection exercise.

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

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

Assessment – *analysis and considerations of options and risks*

During September 2017 the trust achieved staffing levels of 95.6% for registered nurses and 94% for clinical support workers on day shifts and 94% and 98.5% respectively on nights. During October 2017 the trust achieved staffing levels of 96.5% for registered nurses and 92.5% for clinical support workers on day shifts and 93.5% and 96.9% respectively on nights.

In the month of September and October the wards had pressures in terms of staffing in particular on the wards in Central and East locality due to staff sickness, patients on increased levels of observations and vacancies.

Where 100% fill rate was not achieved patient safety on in-patient wards was maintained by nurses working additional unplanned hours, staff cross covering across wards, the multi-disciplinary team and ward manager supporting nursing staff in the delivery of planned care and patient care being prioritised over non-direct care activities. Appendix 1 and 2 details how wards, who did not achieve overall staffing of 95%, maintained patient safety.

From the 4th September 2017 until 1st October 2017 the trust participated in a data collection exercise undertaken by NHSI. Care Hours per Patient Day [CHPPD] is a calculation derived from dividing the number of actual care hours provided by the number of inpatients in a 24 hour period. NHSI recognise that the needs of patients using these services are often quite different; the CHPPD measure provides a representation of the number of care hours available to patients and is a measure that enables wards/units of a similar size, speciality and patient group to be benchmarked.

NHSI collected 1 months' data from all mental health and community inpatient wards nationally across September 2017. The aim being to undertake further testing to tailor the data collection and metric and ensure that it is fit for purpose ahead of mandating the metric in April 2018.

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?	Gary Flockhart, Associate Director of Nursing [MH and LD]
Contributing authors:	Anne Casey

Distribution to other people/ groups/ meetings:

Version	Name/ group/ meeting	Date issued
1	Gary Flockhart, Associate Director of Nursing [MH and LD] Avril Devaney, Avril Devaney, Director of Nursing, Therapies and Patient Partnership	20/11/2017 20/11/2017

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

Appendix no.	Appendix title
1 2	Ward Daily Staffing September 2017 Ward Daily Staffing October 2017

	Ward	Day				Night				Fill Rate				Safe Staffing was maintained by:
		Registered		Care Staff		Registered		Care Staff		Day		Night		
		Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Average fill rate - registered nurses/ midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/ midwives (%)	Average fill rate - care staff (%)	
East	Adelphi	1381.25	1272.75	1107	1001.5	711.5	711.5	1301	1190	92.1%	90.5%	100.0%	91.5%	Ward Manager working in the clinical team. Nursing staff working additional unplanned hours. Cross cover arrangements.
	Alderley Unit	1028	924	1403	1338	690	642.5	690	711.5	89.9%	95.4%	93.1%	103.1%	Ward Manager working in the clinical team. Nursing staff working additional unplanned hours. Cross cover arrangements.
	Bollin	1256	1141	1372.5	1285	690	644	1346	1288.5	90.8%	93.6%	93.3%	95.7%	Nursing staff working additional unplanned hours. Cross cover arrangements. MDT supported the team.
	Croft	1192.5	1109	1779.5	1450.25	690	667	1380	1244	93.0%	81.5%	96.7%	90.1%	Ward Manager working in the clinical team. Nursing staff working additional unplanned hours. Cross cover arrangements.
	Greenways A&T	1170	1276	1734.5	1274	690	563.5	966	1024	109.1%	73.5%	81.7%	106.0%	Ward Manager working in the clinical team. Nursing staff working additional unplanned hours. Cross cover arrangements.
	LimeWalk Rehab	1044	868.5	1035	1112.5	690	609.5	690	717.5	83.2%	107.5%	88.3%	104.0%	Cross cover arrangements. Staff covered from other wards.
	Saddlebridge	1013	966.5	1318.5	1265.5	644	552	724.5	782	95.4%	96.0%	85.7%	107.9%	Ward Manager working in the clinical team. Cross cover arrangements.
Wirral	Brackendale	1050.5	1020	902	871	701.5	690	701.5	701.5	97.1%	96.6%	98.4%	100.0%	*
	Brooklands	991	941	1115.5	1073.5	597	516.5	769	882.9	95.0%	96.2%	86.5%	114.8%	Ward Manager working in the clinical team. Nursing staff working additional unplanned hours. MDT supported the team.
	Lakefield	1079.5	1033.5	954.5	977.6	690	609.5	736	701.5	95.7%	102.4%	88.3%	95.3%	Cross cover arrangements. Staff covered from other wards. Nursing staff working additional unplanned hours.
	Meadowbank	1120.5	1109	1449.5	1417.5	701.5	647.5	1104	1029.5	99.0%	97.8%	92.3%	93.3%	Nursing staff working additional unplanned hours.
	Oaktrees	1040.5	987	861.25	769.75	690	690	391	379.5	94.9%	89.4%	100.0%	97.1%	Ward Manager working in the clinical team. Nursing staff working additional unplanned hours.
	Willow PICU	1041	1017	899	832	690	614.5	793.5	751.5	97.7%	92.5%	89.1%	94.7%	Ward Manager working in the clinical team. Nursing staff working additional unplanned hours. Cross cover arrangementsx. MDT supported the team.
West	Beech	1327.15	1282.65	1012	989	693.5	693.5	717	695	96.6%	97.7%	100.0%	96.9%	*
	Cherry	1116	1077	1192.5	1167.5	704.5	693	950.5	919	96.5%	97.9%	98.4%	96.7%	*
	Eastway A&T	934.25	907.2	1146	1109	545	543.5	855	855	97.1%	96.8%	99.7%	100.0%	*
	Juniper	1199.5	1188	936.5	915	695	695	680	678.5	99.0%	97.7%	100.0%	99.8%	*
	Coral	1108.5	1051.5	1073	1035	557.5	536	954	954	94.9%	96.5%	96.1%	100.0%	*
	Indigo	918.5	899.5	1091.75	1068.75	638.5	595.5	771.5	760	97.9%	97.9%	93.3%	98.5%	Ward Manager working in the clinical team. Nursing staff working additional unplanned hours. Cross cover arrangements from other wards.
	Rosewood	1016.5	993.5	1353	1353	562.5	555.75	865	865	97.7%	100.0%	98.8%	100.0%	*
	Trustwide	22028.15	21064.6	23736.5	22305.35	13272	12470.25	17385.5	17130.4	95.6%	94.0%	94.0%	98.5%	

	Ward	Day				Night				Fill Rate				Safe Staffing was maintained by:
		Registered		Care Staff		Registered		Care Staff		Day		Night		
		Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Average fill rate - registered nurses/ midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/ midwives (%)	Average fill rate - care staff (%)	
East	Adelphi	1387.5	1337.25	966	931.5	724.5	713	1270.5	1259	96.4%	96.4%	98.4%	99.1%	*
	Alderley Unit	1066	974.5	1409	1309.5	713	678.5	713	726.5	91.4%	92.9%	95.2%	101.9%	Nursing staff working additional unplanned hours. Cross cover arrangements. Staff covered from other wards.
	Bollin	1325	1281	1394.75	1280.75	713	620	1587	1343.5	96.7%	91.8%	87.0%	84.7%	Nursing staff working additional unplanned hours. Cross cover arrangements. MDT supported the team.
	Croft	1197	1290.5	1841.5	1314.5	713	671.5	1426	1408	107.8%	71.4%	94.2%	98.7%	Ward Manager working in the clinical team. Nursing staff working additional unplanned hours. Cross cover arrangements.
	Greenways A&T	1227	1100.5	1792	1675	713	598	1069.5	1150	89.7%	93.5%	83.9%	107.5%	Ward Manager working in the clinical team. Nursing staff working additional unplanned hours. Cross cover arrangements.
	LimeWalk Rehab	1101	1042.75	1023.5	912	713	655.5	713	713	94.7%	89.1%	91.9%	100.0%	Cross cover arrangements. Staff covered from other wards. MDT supported the team. Ward Manager working in the clinical team.
	Saddlebridge	997	898.5	1414.5	1404	701.5	529	724.5	839.5	90.1%	99.3%	75.4%	115.9%	Ward Manager working in the clinical team. Cross cover arrangements.
Wirral	Brackendale	1094	1082.5	911.5	888.5	759	747.5	667	667	98.9%	97.5%	98.5%	100.0%	*
	Brooklands	1023	941.5	1352.5	1365.5	724.5	655.5	1133.5	1186	92.0%	101.0%	90.5%	104.6%	Nursing staff working additional unplanned hours. Cross cover arrangements.
	Lakefield	1176.5	1146	1052.5	1018.5	714	702.5	713	690	97.4%	96.8%	98.4%	96.8%	*
	Meadowbank	1326.5	1292	1457	1108.5	736	567	1000.5	736	97.4%	76.1%	77.0%	73.6%	Nursing staff working additional unplanned hours.
	Oaktrees	1191.4	1092	1007.75	812.25	713	736	563.5	483	91.7%	80.6%	103.2%	85.7%	Nursing staff working additional unplanned hours. Cross cover arrangements.
	Willow PICU	1050	951	926	834	713	701.5	828	733.5	90.6%	90.1%	98.4%	88.6%	Ward Manager working in the clinical team. Nursing staff working additional unplanned hours. Cross cover arrangements.
West	Beech	1360	1348.5	981.5	970	644	635	816.3	824.4	99.2%	98.8%	98.6%	101.0%	*
	Cherry	1090.25	1078.75	1162.65	1151.15	598	517.5	1058	1046.5	98.9%	99.0%	86.5%	98.9%	Cross cover arrangements. Staff covered from other wards. MDT supported the team. Ward Manager working in the clinical team.
	Eastway A&T	1092.5	1092.4	1154	1154	532.5	541	870.5	874.5	100.0%	100.0%	101.6%	100.5%	*
	Juniper	1475.5	1429.5	874	846.5	713	705	724.5	701.5	96.9%	96.9%	98.9%	96.8%	*
	Coral	1189	1179	1269.5	1235	616.5	605	1061	980.5	99.2%	97.3%	98.1%	92.4%	*
	Indigo	1051	1039.5	1129.5	1075	544	534.5	931.5	929.5	98.9%	95.2%	98.3%	99.8%	*
	Rosewood	838.25	837.25	1501	1478	587.25	587.25	963.75	952.25	99.9%	98.5%	100.0%	98.8%	*
	Trustwide	23258.4	22434.9	24620.65	22764.15	13585.75	12700.75	18834.55	18244.15	96.5%	92.5%	93.5%	96.9%	

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

STANDARDISED REPORT COMMUNICATION

REPORT DETAILS

Report subject:	Well-led updates: ▪ Themed response to pilot review recommendations ▪ Progress with recommendations from externally commissioned governance review
Agenda ref. no:	17-18-78a
Report to (meeting):	Board of Directors – meeting in public
Action required:	Information and noting
Date of meeting:	29/11/2017
Presented by:	Dr Anushta Sivananthan, Medical Director (Executive Lead for Quality)

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

REPORT BRIEFING

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

The aim of this report is to provide an update for the Board of Directors in relation to the Trust's response to the ongoing well-led agenda. The Board agreed to receive an update, six months post, on the progress with recommendations made in the externally commissioned governance review which took place during quarters 3 and 4 of 2016/17 and reported to Board in March 2017. Subsequent to this, CWP was approached by the CQC to consider participating in a pilot of its new well-led inspection framework (a partnership between the CQC and NHS Improvement). This was agreed to, and on-site visits took place 29 – 30 June 2017. The final report was received on 24 October 2017. As a pilot, the report will not be published by the CQC; it is however indicative of the current status of whether CWP's services are well-led according to the CQC's eight key lines of enquiry – CWP was rated as Good, thus maintaining the current published rating awarded following the comprehensive inspection in 2015. There are no regulatory actions identified. This report highlights the good practice findings and progress on actions identified for improvement that were the conclusion from both aforementioned well-led reviews.

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

During the pilot review, the CQC and NHS Improvement spoke with all of the Executive team, three Non Executive Directors (including the Chair and Deputy Chair of the Trust) and several other members of the Trust's senior leadership team. They also held focus groups with staff; they reviewed policies, reviewed investigation and complaints reports, staff files, and other key documents. They did not inspect any core services, which they will do as part of the formal annual well-led reviews.

CWP was one of just three trusts nationally – and the only mental health and community trust – to take part in the pilot. Involvement in the pilot provided the Trust with a privileged opportunity to work collaboratively with its Regulators to shape the way they monitor, inspect and regulate services. It was also an opportunity to receive valuable feedback on the current strength and effectiveness of the governance and leadership in the Trust in order to identify opportunities to improve and thus aspire towards an Outstanding rating in the future (as per the Trust's Quality Improvement ambition).

Assessment – *analysis and considerations of options and risks*

Amongst others, the pilot well-led report at **Appendix 1** identifies the following areas of good practice:

- Stable, experienced and effective board and leadership team who were committed to providing high-quality services.
- The Trust's vision and values were well-embedded and were supported by clear strategic objectives.
- The overall culture was good. Most staff felt valued and were confident in how to raise concerns.
- Robust governance structures in place to support the delivery of Trust strategy.
- The Trust investigates, and learns from, incidents and complaints.
- Information and data about finance and performance is mostly useful and of good quality.
- The Trust engaged effectively with staff, patients, carers and other stakeholders. Patient and carer involvement was well-embedded.
- Receipt of national awards for innovative practice.

The Trust's compliance function has reviewed the report to identify all those areas where there is scope for improvement, has sought feedback on progress, and has produced a themed response to these in **Appendix 2**. The specific detail relating to outstanding actions will be taken forward as part of meetings between the Medical Director (Quality) and Associate Director of Safe Services and the Chairs of the responsible sub committee meetings to ensure scrutiny and line of sight via the respective business cycles.

The Board of Directors has previously received the findings from the externally commissioned governance review. **Appendix 3** provides updates against and the current status of the associated action plan.

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

The Board of Directors is asked to:

- **Discuss** and **note** the updates detailed in this report.
- **Agree** to receive a further progress report (in March 2018) to receive assurance of the completion of actions that are currently in progress.

Who/ which group has approved this report for receipt at the	David Wood, Associate Director of

above meeting?	Safe Services
Contributing authors:	Elspeth Fergusson

Distribution to other people/ groups/ meetings:		
Version	Name/ group/ meeting	Date issued
1	E Fergusson to D Wood and H Cavanagh	16/11/2017
2	D Wood to L Brereton for Board of Directors agenda	20/11/2017

Appendices provided for reference and to give supporting/ contextual information:	
Appendix no.	Appendix title
1	CWP pilot well-led report
2	Themed response to pilot review recommendations
3	Progress with recommendations from externally commissioned governance review

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

STANDARDISED REPORT COMMUNICATION

REPORT DETAILS

Report subject:	Update in response to analysis of the Workforce Race Equality Standard Monitoring 2016/7 relating to the Black and Minority Ethnic Staff entering the disciplinary and recruitment processes.
Agenda ref. no:	17-18-78b
Report to (meeting):	Board of Directors
Action required:	discussion and noting
Date of meeting:	29/11/2017
Presented by:	David Harris, Director of People and OD

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

REPORT BRIEFING

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

Feedback from the recent Quality Care Commission (CQC) well-led pilot highlighted that further analysis was needed in respect of the relative number of black and minority ethnic staff (BME) entering the disciplinary process as highlighted in the 2016/17 Workforce Race Equality Standard (WRES) monitoring report as well as the potential for bias in recruitment processes. The Board requested that a review was undertaken to identify:-

1. whether there was any evidence of discrimination;
2. whether the outcomes were consistent with non BME staff.

This report is to provide the Board with the outcome of that review.

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

For the reporting period 2016/17 1% (42 of 3224) white staff and 4% (5 of 126) BME staff were reported as having entered the formal disciplinary process. This could be interpreted as meaning that people from BME backgrounds were three times more likely to enter the formal disciplinary process which was a change from the previous year when white staff were three times more likely to enter the process. A table top review of 2016/17 BME cases was undertaken by Head of HR, Equality and Diversity Lead and Associate Director of Nursing and reviewed which BME backgrounds the staff were from, staff group, type of allegation and the outcome.

The review considered whether there was any evidence that the disciplinary process had not been followed and whether the outcomes were consistent with comparable outcomes for white staff. In terms of recruitment it was not possible to carry out the same individual case analysis as that level of detailed data is no longer available for 16/17.

Assessment – *analysis and considerations of options and risks*

Of the five cases, one received a final written warning, one a first written warning, one dismissal and referral to the NMC . One case was not taken forward following investigation and one is outstanding.

The review concluded that the disciplinary process had been applied fairly and the outcomes were comparable with white staff and as such there was no evidence of discrimination. It was also felt that as the previous years' figures had in effect shown the reverse of the 2016/7, there was no trend or pattern that could be identified which was of concern. This report was presented and discussed at the Trust Equality and Diversity Group and People and OD sub committee (PODSC).

As part of the WRES 17/18 Action plan, a process for monthly monitoring and reporting has been established to enable early identification of issues. In the first week in October there were no candidates other than white British unsuccessful at interview. There were 2 BME candidates who withdrew due to being offered other jobs; in the same week 86 applicants were not shortlisted, 9 of which were BME. Recruitment E-learning is being developed to include highlighting unconscious bias in selection and the Recruitment team is engaging with local groups to review our approach to attracting a more diverse workforce.

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

The Board of Directors is recommended to **note** the actions taken in response to the Well led pilot feedback. Ongoing review of actions and associated data will be carried out by the Equality and Diversity Group.

Who/ which group has approved this report for receipt at the above meeting?	David Harris
Contributing authors:	Andrea Hughes, AD of Nursing Chris Sheldon Head of HR Robert Davies E& D Coordinator Viv Williamson Head of Resourcing

Distribution to other people/ groups/ meetings:

Version	Name/ group/ meeting	Date issued
1	35T	

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

Appendix no.	Appendix title
35T	35T

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

STANDARDISED REPORT COMMUNICATION

REPORT DETAILS

Report subject:	Corporate Governance Manual – 2017 update
Agenda ref. no:	17/18/80
Report to (meeting):	Board of Directors
Action required:	Discussion and Approval
Date of meeting:	29/11/2017
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	Yes
Effective services	Yes
Caring services	No
Well-led services	Yes
Services that are responsive to people's needs	Yes
Which Monitor quality governance framework/ well-led domains this report reflects:	
Strategy	Yes
Capability and culture	Yes
Process and structures	Yes
Measurement	Yes
Does this report provide any information to update any current strategic risks? If so, which?	
See current risk register in the agenda of the public meeting of the Board of Directors at http://www.cwp.nhs.uk/about-us/board-members/our-board-meetings	No
N/A	
Does this report indicate any new strategic risks? If so, describe and indicate risk score:	
See current integrated governance strategy: CWP policies – policy code FR1	No
N/A	

REPORT BRIEFING

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

The Trust Corporate Governance Manual outlines the processes and system by which Cheshire and Wirral Partnership NHS Foundation Trust is directed and controlled, at its most senior levels, in order to achieve its objectives and meet the necessary standards of accountability and probity. The Manual is subject to an annual review to ensure that the information contained within it remains accurate and up-to-date. This report outlines the amendments and updates which have been made as a result of this annual review.

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

The annual review has been conducted and a number of minor changes have been made in relation to the contents page, job titles, regulatory title changes, formatting, page numbering, cross referencing within the document. Review dates have also been undated within the manual.

Assessment – *analysis and considerations of options and risks*

The annual review has been undertaken in line with Audit Committee business cycle requirements, however the current work that the Trust is taking forward on implementing the CWP Five Year Forward view means that there will need be further changes to make to the manual, once structures are more defined and potential changes to delegated authorities are more clearly understood. This will also include a review by the Procurement team. Consequently this review should be seen as an interim review at this time, with a further review to be undertaken once the Forward View structures are finalised. At this time, the 'go live' date is 1st April 2018, therefore the subsequent review will need to be undertaken by this time.

An overview of the changes made during the interim review are set out below:

- Updated Committee Structure inserted
- Updated Terms of Reference inserted (Remuneration and Nominations Committees, Operational Board, Quality Committee)
- Removal of previous guidance on gifts, hospitality declarations of interest and sponsorship and previous standards of business conduct for staff. This has been replaced with the new conflicts of interest policy (incorporating standards of business conduct) which sets out the Trust policy as agreed by the Audit Committee in September 2017. This provides guidance to staff on the nine common situations which can give rise to risks of conflict of interest: Gifts, Hospitality, Outside employment, Shareholding and other ownership interests, Patents, Loyalty Interests, Donations, Sponsored events, research and posts and Clinical private practice, in line with NHS England requirements.
- Minor updates to the Standing Financial instructions including job titles, legislation updates and reference guidance updates.

Please note, there is a significant amount of reformatting to be undertaken to the manual following the review, therefore the version hyperlinked still represents a draft at this time, until this work is finalised.

In line with previous updates to the manual, a communications plan is in place to utilise CWP essential and Managers brief to ensure staff are aware of the changes, in particular the new policy around conflicts of interest. There will also be updates to the website and intranet, including a short guide to support this.

The Audit Committee reviewed and approved the changes to the Corporate Governance Manual at the November meeting.

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

The Board of Directors is recommended **approve** the updated Corporate Governance Manual.

Who/ which group has approved this report for receipt at the above meeting?	Audit Committee – 7.11.17
Contributing authors:	

Distribution to other people/ groups/ meetings:		
Version	Name/ group/ meeting	Date issued

Appendices provided for reference and to give supporting/ contextual information: *Provide only necessary detail, do not embed appendices, provide as separate reports*	
Appendix no.	Appendix title
1	Corporate Governance Manual 2017 (draft)

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

STANDARDISED REPORT COMMUNICATION

REPORT DETAILS

Report subject:	Annual Research Report 2016/17
Agenda ref. no:	17-18-80a
Report to (meeting):	Board of Directors
Action required:	Information and noting
Date of meeting:	29/11/2017
Presented by:	Dr Faouzi Alam, Medical Director

Which strategic objectives this report provides information about:	
Deliver high quality, integrated and innovative services that improve outcomes	Yes
Ensure meaningful involvement of service users, carers, staff and the wider community	Yes
Be a model employer and have a caring, competent and motivated workforce	Yes
Maintain and develop robust partnerships with existing and potential new stakeholders	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*

All Trusts are mandated to make research a priority area for growth and part of core business. The attached Annual Research Report provides an overview of research activity undertaken during 2016/17 within the Trust. The report details performance against the Comprehensive Research Network (CRN) targets for studies on the National Institute of Health Research (NIHR) portfolio, and non-portfolio, studies. It also reports on the progress made during the year in respect of the delivery of agreed priorities detailed within the trust Research Strategy for 2015-2018.

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

The CWP Research Strategy outlines three priorities to be addressed during 2015-2018:

Priority 1 Raise the profile of CWP research internally and externally

Priority 2 Strengthen links with external partners

Priority 3 Secure external funding from academia and/or industry

Progress has been made in each of these areas during the second year of the strategy period.

CWP recruits to a diverse range of studies from all around the UK. The research funding received by the Trust depends on the number of NIHR studies the Trust participates in. For 2016-2017, CWP received £231k funding. This funding covers the cost of 4.6 WTE Clinical Studies Officers (CSOs). This was an increase of £15k over 2015/16 funding.

Assessment – *analysis and considerations of options and risks*

CWP has successfully recruited recruited 1,572 participants to portfolio studies during the financial year and, as such, is the highest recruiting trust within the Local Delivery System. A list of all NIHR portfolio studies recruited to is detailed in the appendix attached to this annual report. The report includes a brief description of the studies, the numbers recruited in CWP and the timescales for publication of results, which in turn should contribute to improved outcomes for patients.

Many of the 2016/17 achievements are detailed within the attached report, but it is of particular note that CWP has over-recruited to a prestigious Phase 1b (first in man) clinical trial examining the use of a vaccine on participants with Mild to Moderate Alzheimer's Disease.

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

Trust Board is asked to note the contents of the Annual Research Report for 2016/17.

Who/ which group has approved this report for receipt at the above meeting?	Dr Faouzi Alam
Contributing authors:	Dr Pat Mottram Dr Taj Nathan Claire James

Distribution to other people/ groups/ meetings:

Version	Name/ group/ meeting	Date issued
1 - 6	Claire James & Taj Nathan	17/11/17

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

Appendix no.	Appendix title
1	Annual Research Report 2016/17
2	Annual Research Report 2016/17 appendices

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

Annual Research Report

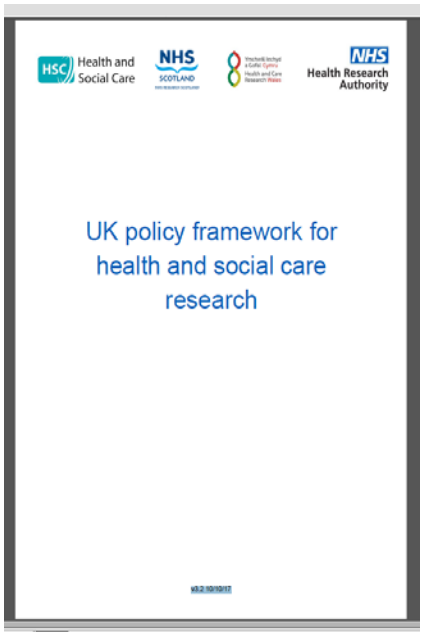
2016-2017

1. Purpose of the report

This report provides an overview of research activity undertaken within the trust during 2016-2017. The report details performance against the Comprehensive Research Network (CRN) targets for studies on the National Institute of Health Research (NIHR) portfolio, and non-portfolio, studies. It also reports on the progress made during the year in respect of the delivery of agreed priorities detailed within the trust Research Strategy for 2015-2018.

2. CWP Research

The most recent UK Policy for Health and Social Care Research states that "Evidence suggests the quality of current care may be higher in organisations that take part in research, adopt a learning culture and implement research findings". CWP embraces this evidence and aims to prioritise and grow research as part of its core business. The trust seeks every opportunity to participate in as many studies as possible to help drive improved outcomes for the population we serve.



It is important to understand both the breadth and variety of research studies undertaken by CWP and the report therefore includes a brief overview of some the trials that we have been involved in during the last year. Some of these trials are still in progress.

The research team has not reported on the nature of some of the pharmaceutical trials due to commercial sensitivities, but is able to confirm that we have just completed our Phase 1b study – a "first in humans" trial. This was a trial in Alzheimer's disease where we recruited above the agreed target and completed the trial successfully working in conjunction with the Royal Liverpool and Broadgreen University Hospital NHS FT.

The Comprehensive Research Network, North West Coast, monitors the number of trials and recruitment in real-time via the EDGE database and the National Open Data Platform Database. Reports are submitted quarterly to the Clinical Trials Performance (CTP) where performance in initiating and delivering research is monitored. Monthly updates of both Portfolio and Non-portfolio studies are undertaken to monitor performance on time and target. Updates in respect of any drug studies are reported to the Medicines Management Committee. The research team contribute quarterly to the Quality Report detailing recruitment and major trials updates.

3. Examples of completed studies

- **OCTET- OCD**

What did the study aim to find out?

Obsessive compulsive disorder (OCD) is a common problem which affects many people and rarely improves without help. Experts suggest that some patients might benefit from cognitive behavioural therapy (CBT) provided as 'self-help' through a book or computer, with assistance from a mental health professional. The OCTET study tested two different self-help treatments for OCD.

The study also looked at how effective different treatments were in the short term and if either or both are better than the usual care that people receive in the short and longer term. As well as testing the treatments, the team talked to patients and professionals about the new treatments to find out if they were likely to be acceptable, feasible and effective, and what aspects they might like to change or improve. Finally, the study team calculated the costs of each treatment to OCD sufferers, their families and the NHS. The aim of the OCTET study was to improve the way services are provided to NHS patients in the future.

How was the study designed?

The OCTET study was designed by a team headed by Manchester University and tested two different self-help treatments for OCD. Firstly, a computerised CBT (cCBT) using an internet delivered OCD treatment package called OC-Fighter, accompanied by email or telephone support from a mental health professional. The second possible intervention patients received was a self-help book which helps people to use CBT in their own home combined with face-to-face, telephone or email support, from a mental health professional. This treatment is called Guided Self Help (GSH). Both treatments were delivered over a 12-week period. Participants were either allocated to the group in which they received cCBT, a group in which they received GSH or they remained on a CBT waiting list.

When participants joined the study, they were asked about their symptoms, how much OCD was interfering with their life and which health services, or other services, they needed to use. The study team also asked clinicians to rate people's symptoms. This data was collected before treatment was started, right after treatment and one year after treatment.

The study team members also conducted interviews with staff and patients. Patients were asked about their views on the delivery of low intensity treatments for OCD and staff interviews focused on views on delivering treatments provided within the OCTET study

What was the outcome?

The CWP research team recruited 62 participants for this study. All patients completed the study. During the qualitative interviews patients informed the OCTET team that they liked the guided self-help more than the computer program. Practitioners thought that the interventions could benefit patients and provide choice and flexibility.

In the short term (3 months), the OCTET team found no worthwhile improvements in symptoms in people using the self-help book or OCD computer program. They also found no differences in symptoms in the longer term (12 months), thus suggesting that low intensity interventions did not offer any additional clinical benefit. They concluded that in the longer term, access to guided self-help and supported cCBT, prior to high-intensity CBT, did not lead to differences in outcomes compared with access to high intensity CBT alone. However, access to lower intensity interventions led to significant reductions in the uptake of CBT; this did not seem to compromise patient outcomes at 12 months. They also concluded that both the guided self-help book and the computer program were better value for money than CBT. This has now been published in PLOS (Lovell, 2017) and the NIHR has published the OCTET study findings as a SIGNAL (this is a timely summary of most important, well designed research). The summary was published in September 2017. This information was fed back to the teams who participated in the study and will be used to guide service improvement. All publications are available via the research site and the library service.

- **BENEMIN: The Benefit of Minocycline on Negative Symptoms in Psychosis: Extent and Mechanisms.**

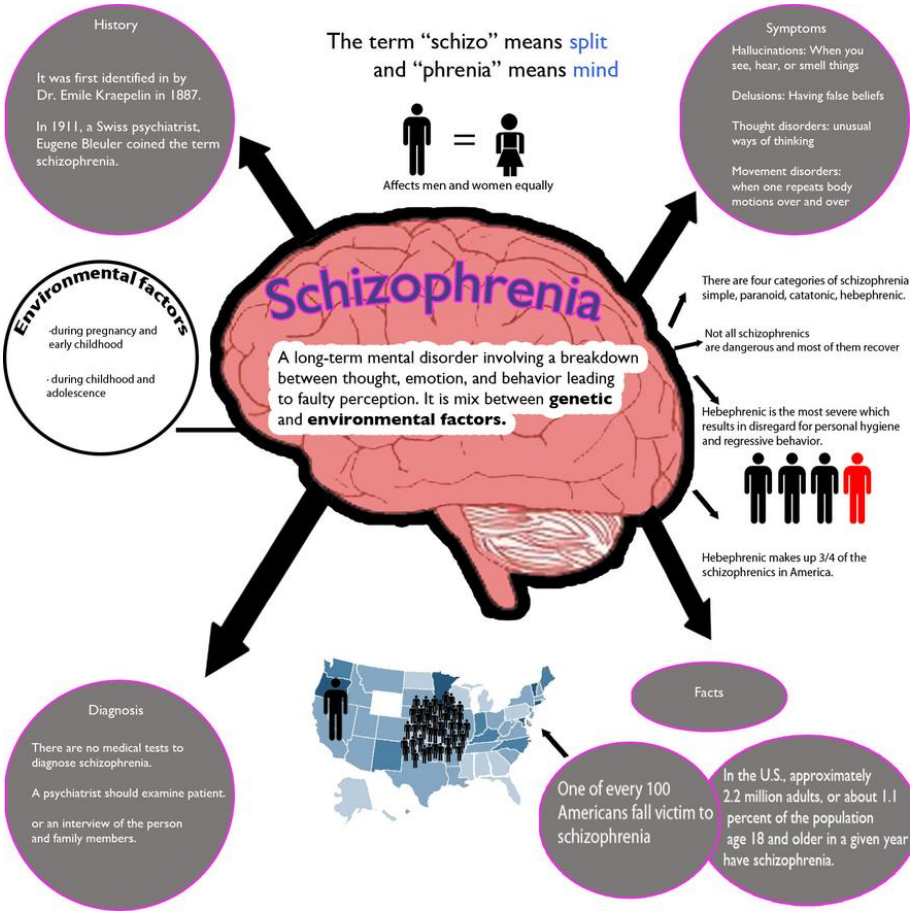
What did the study aim to find out?

This study was set up by Manchester University to confirm that minocycline benefits the negative symptoms (apathy, depression etc.) of schizophrenia when taken early in the course of the illness and aims to understand how. In addition, it looked to determine whether minocycline acts by protecting brain cells from damage, by lessening inflammation or by improving mental functions (thinking and reasoning). The study also aimed to look at whether minocycline reduces weight gain induced changes by standard antipsychotic treatments and whether improvements in negative symptoms translate into improved social and occupational functioning and quality of life.

How was the study designed?

The study compared minocycline with placebo added to each person's treatment within 3 years of starting their treatment for psychosis. The effects on positive and negative symptoms were followed over 15 months by conducting Positive and Negative Syndrome Scale (PANNS) interviews.

Minocycline might work by protecting brain cells from damage possibly caused by inflammation therefore MRI brain scans were conducted to assess changes in the grey matter of the brain. To monitor whether minocycline was working by blocking inflammation in the brain, blood samples were also taken from participants to measure cytokine levels.



What was the outcome?

The CWP research team recruited 26 participants for this study which was above target. All patients completed the study and only one participant did not meet the inclusion criteria during screening. None of the patients experienced adverse events. The study ended in spring 2016 and the study team are currently processing the data.

4. Examples of ongoing studies

- **Stopping Slips among Healthcare Workers (SSHeW): Does slip resistant footwear reduce slips among healthcare workers? A randomised controlled trial.**

What does the study aim to find out?

Slips, trips and falls are a major cause of accidents in the workplace. It is estimated that over 100,000 people are injured due to a slip, trip or fall at work each year, with 6,000 in health occupations (HSE, 2015). These represent about 40% of all injuries and 57% of major injuries reported to the Health and Safety Executive (HSE, HSE 2014). The injuries resulting from these incidents can have long-lasting effects. Furthermore, it has been estimated that one million days were taken off work in 2012/13 due to such injuries (Labour Force Survey, 2015). People working in health and social care report the highest number of non-fatal

employee slips, trips and falls. This is partly due to the nature of the flooring on health service premises which is often very smooth and may be slippery when wet due to frequent cleaning for infection control purposes or due to contaminants. The University of York in conjunction with the Health and Safety Executive have devised this study.

There is some evidence that this accident burden can be reduced through the use of appropriate footwear. There is promising evidence that slip resistant footwear can significantly reduce the burden of accidents at work. However, it is important to confirm these findings in a large pragmatic trial within a UK setting. The aim of this study is to find out if slip resistant shoes can stop NHS staff from slipping, falling or hurting themselves. If the intervention is effective it will reduce the number of work related injuries and, as a consequence of this reduction, fewer lost working days and litigation to the NHS and other industries will occur which will lead to a reduction in costs

How was the study designed?

Half of the participants received their shoes at the start of the trial, and the other half received their shoes at the end of the trial. The pilot lasted for 14 weeks. 50% of staff who participated in the study wore special anti-slip shoes (intervention group) from Shoes for Crews and 50% wore their own shoes (control group). Every week participants reported (via text) about whether or not they had a slip, and if so, how many. At the end of the 14 weeks participants were sent a questionnaire to collect data on compliance with the footwear and reasons for wearing/not wearing the shoes (directed at intervention participants only), whether participants had time off work (annual leave or sick), and to ask how many slips and how many falls they have had at work in total over the previous 14 weeks.

What is the outcome?

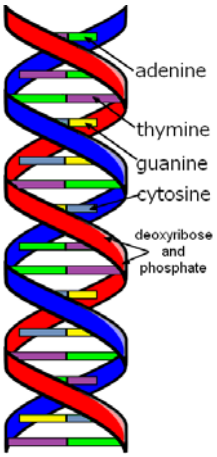
To date we have recruited 433 members of staff, mainly from inpatient settings. Half of this group received their shoes 15 weeks ago and we are currently distributing shoes to the control participants. Some staff have dropped out (we do not have the numbers for this yet) as they found the shoes uncomfortable to wear. We have also had to swap a lot of shoes for different sizes or models as some participants did not find the shoes they originally picked comfortable or they did not fit the shoes in the size they needed in a certain model. Staff members have been very helpful and generally very positive about this study. The pilot study has already helped iron out problems that became apparent so a great deal has been learned for the main study.

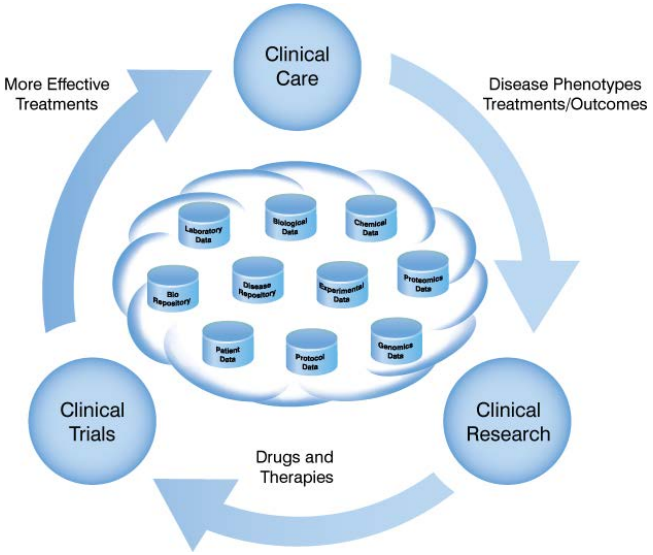
We are aiming to recruit a further 800 members of staff in the next six months and will focus on inviting community physical health teams to take part in the next cohort.

- **MGADR: Molecular Genetics of Adverse Drug Reactions: From Candidate Genes to Genome Wide Association Studies**

What does the study aim to find out?

The main aim of the project is to define the genetic and non−genetic risk factors predisposing to adverse drug reactions in patients who take Clozapine in order to develop strategies for individualisation of drug therapy to maximise benefits and minimise harms. The University of Liverpool designed this study as part of a range of studies in personalised medicine. Therefore, this research is to identify patients with different types of adverse drug reactions and using DNA obtained from blood or saliva samples from these patients, hopes to identify genetic factors which predispose to adverse reactions. The net effect of the research will be the development of genetic tests which can help in predicting individual susceptibility to adverse reactions, and thereby prevent through testing before drug intake.





How was the study designed?

Participants provided a single sample of either blood (9mls) or saliva (2ml) for DNA analysis. Information on diagnosis of adverse drug reactions, symptomatic presentation and type of drugs involved were also collected. Age, weight, height, ethnicity (in the form of a questionnaire), medical history, concomitant medication at time of reaction, current medication, and where available, clinical blood sample and investigational results conducted at time of reaction was also collected.

What was the outcome?

To date the research team has recruited 24 participants for MGADR. One participant dropped out of the study. Of the patients we recruited, one has experienced myocarditis, 10 have suffered from neutropenia and 11 patients are controls who have never experienced adverse reactions to Clozapine. This study is still ongoing and thus one of the team members still checks if patients have experienced adverse events on a regular basis. It is difficult to recruit participants to this study as patients on Clozapine are well monitored and do not often experience adverse events. We hope that as the number of samples grows they may be able to find a genetic link.

- **Wirral Child and Development Study**

What does the study aim to find out?

This longitudinal study based on a Wirral population and run by University of Liverpool aims to find out how children learn how to behave with other people as they grow up, and why some children have difficulties controlling their behaviours. To do this many aspects of their development are measured, their experiences at home and school, and the ways parents take care of them. The study team wants to find out more about the ways that early life stress influences later development as we know that for some parents and children the effects are quite long lasting, and others find ways of coping.

What will we do/ what was done?

The study team recruited first time mothers aged 18 years and above at their 20 week scan appointment, in the antenatal clinic at Arrowe Park Hospital in 2007 and 2008. A total of 1,233 first-time mothers were recruited. Mothers and children have been invited to take part approximately every two years since then and the tasks in each phase are tailored to the age and abilities of the children. For example, in the first study phase the team looked at the following measures: partner psychological abuse, maternal stroking, maternal depression, breast feeding, negative emotionality and respiratory sinus arrhythmia- vagal tone whilst infants performed several tasks. Whilst in phase 13 (age 7 and 8) the children were asked to complete a theory of mind task, a social exclusion task, questions about friendship, observing a video with stressors whilst observing vagal tone and mother and child completed a difficult task together (to observe mother-child interaction). For each study phase mothers have completed questionnaires which included questions about psychological wellbeing of mother and child, social status and economic status.

The CWP research team has helped out during several phases- either conducting interviews with mothers or running full sets of experiments with participating children.

Outcome

The team is currently running phase 14 (age 9 or 10) and are in the process of planning the following two study phases and applying for funding - hopefully to be run when the children are 11/12 and 13/14 years old.

The study team and collaborators have analysed and published several experiments. For example, Sharp et al. (2017) published the results of an experiment that was conducted in one of the first phases of the study. Sharp et al. (2017) reported that the effect of prenatal depression on the infants (looking at physiology and emotion) differed depending on post-natal exposure to maternal stroking. Though, there are still a large number of experiments from the previous phases awaiting analysis.

For a full list please see the Wirral Child Health and Development website
https://www.liverpool.ac.uk/psychology-health-and-society/research/first-steps/

A brief description of all the recent and current research and the number recruited to each study is provided in Appendix 1.

5. Research Strategy – Delivery Plan 2016/17

Research and its evidence translated into practice are vital in transforming services and improving patient outcomes across the NHS. Recognising this, the Board of Directors approved CWP's Research Strategy for 2015-2018. The strategy identifies the following three priorities:

Priority 1 Raise profile of CWP research internally and externally

Priority 2 Strengthen links with external partners

Priority 3 Secure external funding from academia and/or industry

This section provides an update on progress against each of these priorities.

- Priority 1 Raise the profile of CWP research internally and externally:

The strategy consisted of a number of points aimed at both strengthening leadership and building external relationships. CWP has been very successful in the majority of areas. Since the start of this strategy, the number of participants involved in portfolio studies has increased from 500 to 1572 representing a substantial increase during the first two years of the strategy period. In addition, CWP has maintained the number of non-Portfolio studies

and continues to provide high quality support for these projects, most of which are of an educational nature.

CWP now has an Operational Capability Statement which details the facilities and areas of research that are available in CWP. This ensures that patients, academics, other Trusts and pharmaceutical companies are aware of the types of research that we can participate in. We are developing and adding to the number of clinicians involved in delivering research across the Trust by encouraging them to complete Good Clinical Practice (GCP) training and also to attend training on becoming a Principal Investigator (PI). CWP has also been supporting trainee doctors to become actively involved in research and arranged for them to gain experience both within CWP and at a Phase 1 Clinical Trials Unit.

The research team attends all inductions of new staff to ensure awareness of the high importance we place on research and evidence based practice. We also offer training in research methods and opportunities to gain research skills by providing courses.

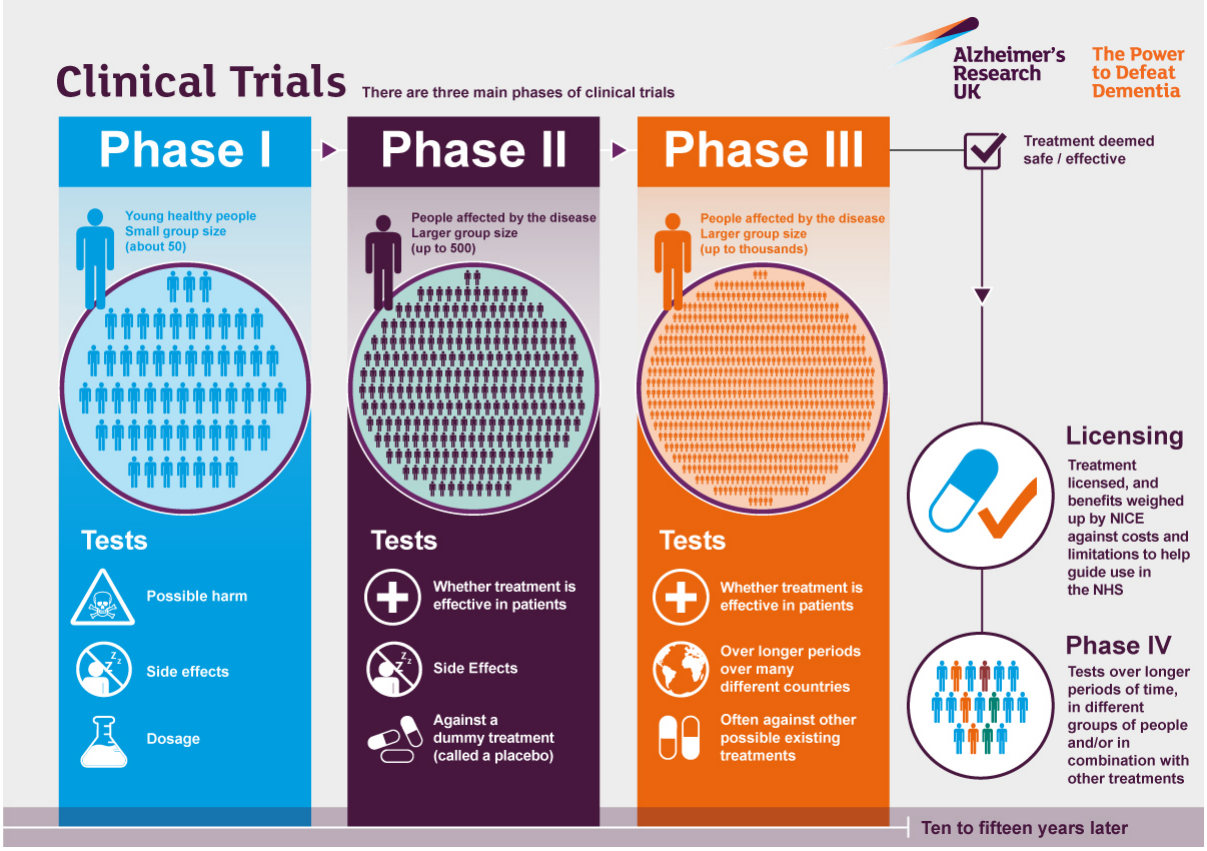
Over the year we have increase publicity and awareness of research by regularly using CWP Essential. We have enrolled nearly 500 CWP staff in a randomised controlled trial and this has given us the opportunity to discuss research on a one to one basis with high numbers of front line staff, discussing the importance and benefits that research can bring.

CWP hosted an Annual Research Conference in November 2016, which was well attended and received positive feedback. Research staff have attended a number of external events to publicise the research we are doing, most notably at Dementia Awareness Days across the footprint of the Trust as this is a particular strength in the research portfolio.

CWP run a “Consent to Contact” system whereby patients can opt to express an interest in being involved in research. The research team will contact patients if they are eligible for any studies that the Trust is involved in so that they can consider if they wish to take part.

<u>Priority 2 Strengthen the links with external partners</u>

CWP continues to build good working relationships with external organisations. We have a particularly close working relationship with the Health and Safety Executive. We are currently recruiting to a third trial with them and we are working on the development of a fourth. These trials have all been about reducing risk for both patients and staff. We have an extremely good relationship with the Phase 1 Clinical Research Unit at the Royal Liverpool and Broadgreen University Hospital Trust (RLBUHT) where we have completed one Phase 1 (small trial of drug “first in human”) study in Alzheimer’s Disease and we will be starting a further two Phase 1 studies and a Phase 3 (large efficacy study – if it works the drug is marketed) study in the next year. The diagram below provides an overview of the main phases of clinical trials.



We work closely with Manchester University and run a number of studies for them across a wide range of topics including OCD, psychosis and dementia. They are confident placing trials with CWP as we consistently recruit to time and target, and often over recruit.

CWP also work closely with a number of other universities including York, Liverpool, and Chester. The research team always endeavour to provide a good service and a good relationship with all the organisations we work with.

CWP has now started to build up its reputation with the pharmaceutical industry. We have a good working relationship with a number of pharmaceutical companies and we are now starting to see the benefits in terms of trials being placed with the Trust. We have started to successfully develop our Principal Investigators (PI) by working closely with the Phase 1 Clinical Research Unit at RLBUHT. Without having experienced staff working on trials, pharmaceutical companies will not place trials with an organisation. We now have this experience and will continue to develop staff to have a pool of experienced individuals to work with industry.

Priority 3 Secure external funding from academia and/or industry

Funding was secured from both academia and industry during the year. Setting up studies can take a year or more and over 2016-17 we have set up four studies which will be starting during 2017. These are all Alzheimer's studies; three of them will be based at RLBUHT

however, one will be running within CWP and this will potentially bring in a substantial level of funding if we are successful at recruiting.

6. CRN Funding

The Trust receives funding every year to support recruitment costs to portfolio studies. The NHS Support Funding covers the cost of staff employed to recruit to portfolio studies and related travel expenses. There is also a small amount to cover some staff time for research governance/ Health Research Authority related work. This funding is based on staff grade and incremental point for each individual member of staff employed.

CRN Funding 2016- 2017	
NHS Support Funding	£207,200
Flow-through funding for life sciences	£3,014
Contingency Funding	£21,270
Total	**£231,484**

This year we also received Flow-through funding for life sciences of £3,014. This is allocated for each study site that recruited to time and target. Funding will flow through to the relevant NHS provider organisations, routed via the LCRN Host organisation. This funding acts as an incentive for the reliable delivery of commercial contract studies and is based on rewarding past performance. This money is to be used for improving feasibility and to encourage 'green shoot' areas where more commercial research can be done.

CWP also bid, and was successful, in receiving Contingency Funds of £21,270 to cover the extra costs associated with the SSHEW study (see Appendix 1) where a large number of subjects were to be recruited to an individual study that could not be managed within the allocated staffing.

7. Other funding

A small amount of additional funding was received for work conducted with the RLBUHT on the AC Immune Trial, a Phase 1 study. Funding was to cover the costs of staff working on the study and was used employ the additional staff required. This was via a Tri-partite agreement with the RLUBHT and attracted income of £16,250.

8. Time and target

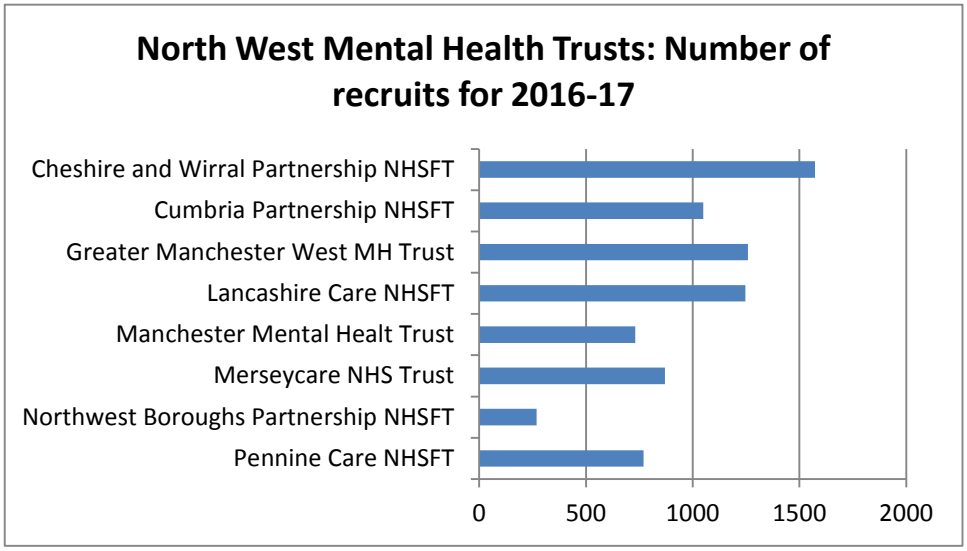
We have achieved time and target for the majority of the studies undertaken in 2016 – 2017. There have been a few exceptions but delays and problems with the sponsor have been responsible for all of these. Notably the DFEND study (see Appendix 1) which was waiting for the Green Light (go ahead) from the monitor and this delayed the start of the study.

9. Non-portfolio studies

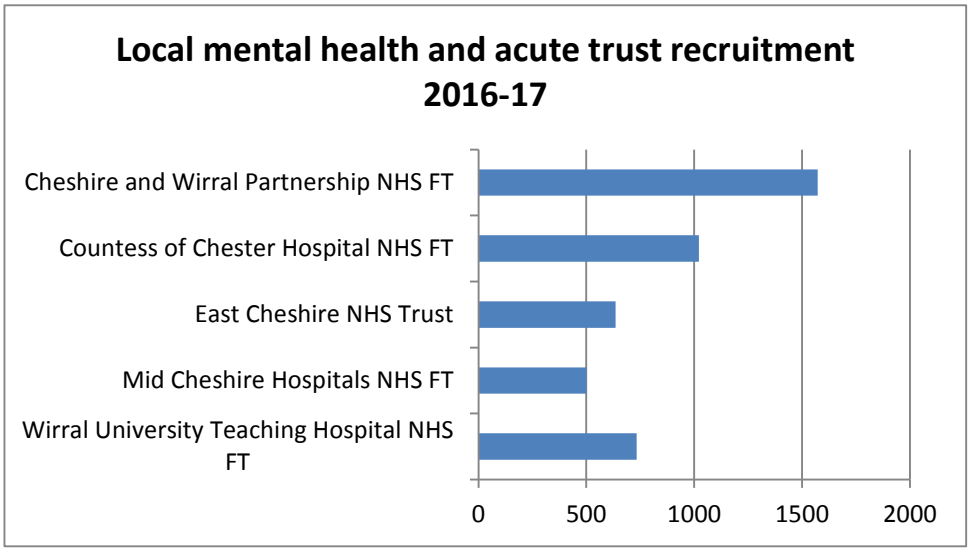
These studies are supported by a member of the research team. Most are educational in nature but we are starting to see an increase in small research/evaluation projects within the Trust addressing issues identified by clinicians. We hope that these will lead to increasing capacity to deliver research and to initiate research and apply for grants within the Trust. Appendix 2 provides an overview of non-portfolio studies.

10. Recruitment to National Portfolio Studies

CWP has been very successful over the year April 2016 to March 2017 and has recruited 1572 into studies. This is the highest number that the trust has ever recruited and we outperformed a number of other local acute and mental health trusts. The graph below shows a comparison with other North West Mental Health Trusts.



Performance has also been excellent in the context of the Cheshire and Wirral Local Delivery System, as demonstrated by the graph below for acute and mental health trusts.



The high recruitment was mainly due to two studies which both recruited very well; the Wirral Child Development Study, a cohort study, and the SSHEW study, a non-slip shoe trial in staff.

This has only been possible because of the hard work and flexibility of the research team willing to go the extra mile working early morning, nights and weekends to ensure that research studies are successful within the trust and have optimal recruitment.

11. Publications

CWP has published or contributed to 60 papers between 2014 and 2017 and these have been published in a variety of journals, some of which have a high impact. These papers are used to provide better treatment to patients internationally. A list of all the publications is available in Appendix 4, or from the CWP Library.

12. Conclusions

CWP has maintained its high standards of recruitment to NIHR portfolio studies in 2016/17, with a total of 1,572 participants recruited – higher than ever before.

Increased numbers of clinical staff are now engaged in research and work will continue to encourage staff to take part in and use research in their practice in coming years.

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

STANDARDISED REPORT COMMUNICATION

REPORT DETAILS

Report subject:	Health, Safety and Security Annual Report 2016/17
Agenda ref. no:	17/18/80b
Report to (meeting):	Board of Directors
Action required:	Information and noting
Date of meeting:	29/11/2017
Presented by:	Avril Devaney, Director of Nursing, Therapies and Patient Partnership

Which strategic objectives this report provides information about:	
Deliver high quality, integrated and innovative services that improve outcomes	Yes
Ensure meaningful involvement of service users, carers, staff and the wider community	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
35T	
Does this report indicate any new strategic risks? If so, describe and indicate risk score:	
See current integrated governance strategy: CWP policies – policy code FR1	No
35T	

REPORT BRIEFING

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

The report summarises the effectiveness of our systems for controlling risks by reviewing the activities and performance relating to health, safety and welfare within Cheshire and Wirral Partnership NHS Foundation Trust. The Health and Safety function sits within Infrastructure Services, specifically within Estates Department.

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

The attached report outlines the work completed during the year in relation to matters of health and safety, Trust compliance with alert systems and Fire safety. It also outlines future priorities.

Assessment – *analysis and considerations of options and risks*

The full report is closed at appendix 1

Recommendation – *what action/ recommendation is needed, what needs to happen and by when?*
The Board of Directors is recommended to **note** the report.

Who/ which group has approved this report for receipt at the above meeting?		35T
Contributing authors:		35T
Distribution to other people/ groups/ meetings:		
Version	Name/ group/ meeting	Date issued
35T	35T	35T

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	Health and Safety Annual Report 2016/17

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

17-18-80b Appendix 1

Health, Safety and Fire Annual Report 2016-2017

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1. Purpose of the report

The Health and Safety Executive (HSE) have recently published 'Helping Great Britain work well'. Dame Judith Hackett, Chair of the HSE stated 'We have an unprecedented opportunity to keep building a 21st-century, world class occupational health and safety system that will help Great Britain work well. If we can all come together to help achieve these things, maintain the gains made in safety and seize the opportunity to give health the same priority, it will help improve productivity, keep business costs down, help keep workers safe and well and protect members of the public'
It is recognised that Great Britain is a safe place to work and the focus is shifting onto health and keeping people well. To provide a focus for this important work, HSE has set out six new strategic themes that will bring a renewed emphasis on improving health in the workplace, as well as building on the highly successful track record on safety.
The six themes include Acting together, Tackling ill health, Managing risk well, Supporting small employers, Keeping pace with change and Sharing our success.

This annual report will set out measures in place to manage health and safety in the Trust and the effectiveness of those measures.

2. Management of Health & Safety in CWP

CWP is fully committed to developing, promoting and monitoring the highest standards of health and safety practice. CWP acknowledges its obligations to comply with statutory responsibilities laid down in the Health and Safety at Work etc. Act 1974 (HASAW). This Act provides a legislative framework to promote and encourage high standards of health and safety at work. The HASAW also requires organisations to have a signed statement of intent in relation to Health and Safety; this is reviewed and signed by the Chief Executive every 2 years. CWP also has responsibilities under numerous Regulations that govern health and safety practice at work including the Management of Health and Safety at Work Regulations 1999 and the Workplace (Health and Safety) Regulations 1992.

The Senior Health and Safety Advisor provides update reports in accordance with the Business Cycles for the Health and Safety Sub Committee (HSSC), the Patient Safety and Effectiveness Sub Committee (PSESC), the Compliance, Assurance and Learning Sub Committee (CALSC) (which has ceased operating) and has responsibility as the Chair of the Medical Devices Group, Medical Devices Liaison Officer, CAS Officer and more recently, display screen equipment and workplace assessments.

The Health and Safety function has specific responsibility to achieve compliance with the following areas of safety management within the Organisation.

- Implementation, coordination and management of the Cardinus workstation assessment and training programme Trust wide including identification of workstation corrective equipment.
- Advising managers, staff, Occupational Health, Human Resources and Safety Representatives on matters of health and safety at work.
- Completing risk assessments and workplace assessments in conjunction with managers and staff to ensure safe systems of work are followed and modifications are in place as required to maintain safety of employees and others.
- Management of and reporting on the Central Alerting System (CAS) and dissemination of relevant alerts to leads in the organisation for their action; This includes Estates and Facilities Alerts and Notifications, Medicines and Healthcare Products Regulatory Agency, NHS England Patient Safety Alerts and NHS Improvement notices.
- Preparing reports for various subcommittees assurance with input from the leads for each alert open with actions required by the Trust.
- Chair of the Medical Devices Group, joint management and co-ordination of the Medical Devices and Equipment contract including monitoring procedures for ensuring that governance requirements are met, medical device equipment is safe to use and available when required and that the contract represents value for money.

- Reporting to the Health and Safety Executive (HSE) incidents which fall within the definitions of RIDDOR (Reporting of Injuries, Diseases and Dangerous Occurrences Regulations)
- Reporting relevant adverse incidents involving medical devices and single use equipment to the Medicines and Healthcare Products Regulatory Agency (MHRA).
- In conjunction with Estates personnel, reporting adverse estates and facilities incidents to the Department of Health for national sharing and learning lessons.
- Completing Health, Safety and Security Assessments for buildings and identifying safety requirements for new services.
- Liaising with external organisations for work placements for young person's / apprentices and carrying out safety assessments prior to the placement including completion of assessment templates, provision of details of employer liability insurance.

3. Health and Safety Meetings Pilot for 2016-2017

A proposal was prepared by the Senior Health and Safety Advisor for approval at Operational Board in March 2016. This proposal outlined reduction of frequency of meetings of the Trust wide Subcommittee to ensure that when it did meet that there would be better attendance and focus on the trust wide issues and statutory responsibilities. This coincided with the developments in the People and Organisational Sub Committee where greater focus was being placed on wellbeing. The emphasis for the pilot was that local safety issues could be debated in the locality and specific issues would inform the content of the Chairs Summary reports for inclusion on the Operational Board agenda.
The proposed frequency of the Trust wide meetings was to be twice a year, piloting this for one year. The local Health and Safety meetings were to continue with a Chairs summary report (instead of all local minutes) being submitted to the Operational Board as per agreed business cycle. A generic business cycle and generic terms of reference were prepared for the West, the Wirral and Central & East Groups giving the localities the ability to include other issues pertinent to their localities

The People and Organisational Development Department launched a Workforce Wellbeing group which incorporated the wellbeing factors from the Health, Safety and Wellbeing Subcommittee. The terms of reference for this group were reviewed by Operational Board as part of the Health and Safety meetings review in March 2016.

The pilot has been effectively implemented and local groups have met discussing and resolving local issues. It was agreed during the pilot that the local health and safety group minutes would be added to the Trust wide Health and Safety Subcommittee agenda rather than the local chairs summary reports. It has also now been agreed that an exception report for the local groups will be submitted for information to the Operational Board.

There have been a total of 19 locality meetings held during 2016-2017 (table 1), six statutory standards meetings and two Trust wide subcommittee meetings. Figure 1 below identifies themes; topics and issues raised and discussed at the locality meetings.

Table 1-Local Health and Safety Group meetings 2016-2017

Health and Safety Group	West	Wirral	Central & East	Estates
Number of meetings held	4	4	6	5

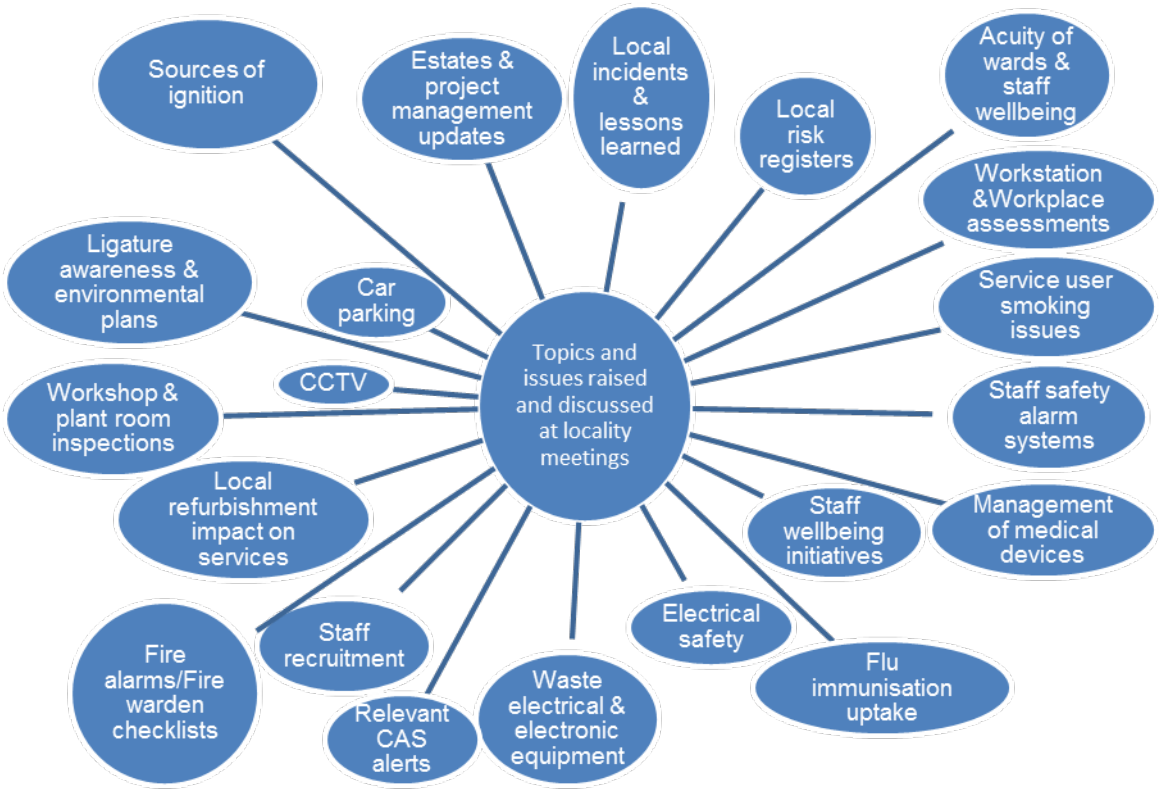

Figure 1- Topics and issues raised and discussed at the locality Health and Safety meetings

4. Cardinus Workstation Assessments and Training Programme

Since 1992 following the European Safety Directive, the Display Screen Equipment Regulations have been in force in the United Kingdom. The legislative requirement is for employees who use computers at work to carry out training and an assessment of their workstation.

Cheshire & Wirral Partnership NHS Trust has invested in Cardinus Workstation Safety Plus, a health & safety on-line training programme and self-risk assessment questionnaire for computer workstations.

All staff with an email address received an email invite to take part in the on-line training and assessment programme. The programme commenced in 2015 following a successful pilot within Infrastructure services.

The programme takes approximately 30-40 minutes to complete and includes valuable information regarding safe use of the computer and information that can help to minimise risks and improve comfortable working. There are also video-based exercises to prevent musculoskeletal problems.

The Senior Health and Safety Advisor and the Medical Device and Safety Officer have been responsible for the set up and roll out of this new programme which has been hugely successful.

Currently (at time of writing report) there are 2,047 staff that have completed the training and assessment programme which equates to 81% of those invited (Figure 2). Further information to encourage a greater uptake will be published in CWP Essentials and via Safety assessments with ward and team managers. Training from the company will be delivered to key staff in the Estates department to enable streamlined reporting to line managers so assessments may be reviewed in appraisals/ supervision sessions.

An online ‘catalogue’ of workstation standard and corrective equipment has been produced showing images, codes and suppliers.

The Procurement team have secured a supplier who can offer standard and corrective workstation equipment for our users at very competitive prices.

Originally 42.86% of staff who have completed the training and assessment were classed as high risk and this has now reduced to 21.13% with interventions (Figures 3 & 4).

Users classed as low risk at the first assessment totalled 534 and this has now increased to 1316 users showing that training and interventions have reduced the risks from high and medium to low risk (Figures 3 & 4).

Following the delivery of further training for key staff in Estates, the system can be used to generate individual reports for staff and managers if required.

Figure 2 - Cardinus workstation users with completed training records

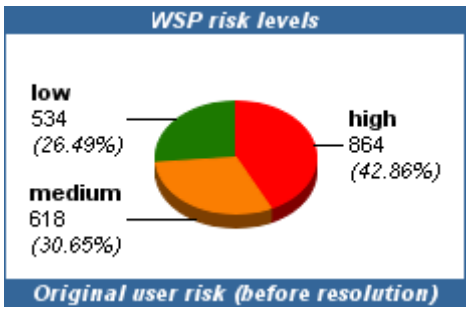

Figure 3 - Cardinus workstation user risk level before interventions

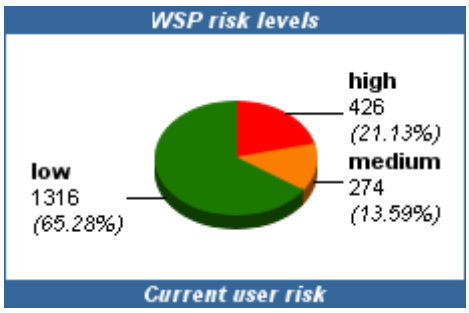

Figure 4 - Cardinus workstation current user risk following intervention

5. RIDDOR- (Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995) (As amended April 2012)

As a result of the report by Lord Young 'Common Sense, Common Safety', improvements to 84% of Health and Safety Legislation was recommended, RIDDOR being one of them- The law now requires for injuries requiring more than seven days incapacitation to be reported to the Health and Safety Executive (HSE) as opposed to injuries resulting in three days absence previously.

Reporting and recording is a legal requirement, the reports made to the HSE informs the enforcing authorities about deaths, injuries, occupational diseases and dangerous occurrences so they can identify where and how risks arise and whether they need to be investigated. This allows HSE and Local Authorities to target their work and provide advice about how to avoid work related deaths, injuries, ill health and accidental loss.
For the period April 2016 - March 2017 there was a further decrease of reportable RIDDOR reports from the previous year. Nine incidents were reported to the HSE for this period.
In 2015-2016, there were 11 incidents that required reporting compared to 18 during 2014-2015. A downward trend has been observed over the last five years (Table 2).
For 2016-2017, CWP have recorded the lowest reportable number of RIDDOR incidents since 2004 when the Senior Health and Safety Advisor commenced reporting RIDDOR incidents to the HSE.

There had been a marked reduction in RIDDOR incidents relating to manual handling injuries over several years from seven requiring reporting to HSE in 2008 to one incident requiring reporting during 2012-2013; This figure rose in 2013-2014 to six incidents, with no identified reason, however, Since 2014 the number of reportable incidents has again decreased to one per year.

The number of Violence/Physical assault incidents to be reported to HSE decreased from 20 incidents during 2012-2013 to nine incidents during 2013-2014; however, this rose slightly to 12 incidents for 2014-2015. During 2015- 2016, this figure again fell to five reports during the reporting period and has remained at five incidents reported for 2016- 2017
Further details will be reported in the annual security report which will be prepared by the Local Security Management Specialist.

The marked reduction in RIDDOR incidents reported to the HSE in line with the RIDDOR Regulations may be due to the new restrictive practices techniques.
Figure 5 displays the highest three categories of incidents requiring notification to the HSE since 2011.
The Senior Health and Safety Advisor has requested that the resource managers contact her when any member of staff is on sick leave following any incidents to ensure with their support CWP complies with the Regulations.

CWP have not received any visits or interventions from the Health and Safety Executive for the reporting period.

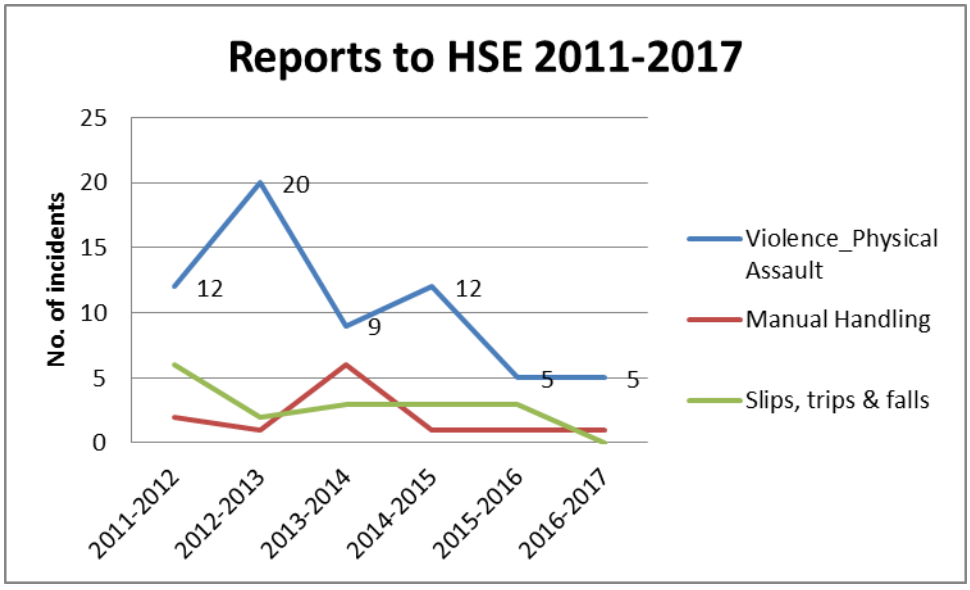

Figure 5 - RIDDOR reports made to the HSE 2011-2017 (Highest three categories reported)

Table 2 - RIDDOR reported incidents for CWP annually since 2007

Year	2007-2008	2008-2009	2009-2010	2010-2011	2011-2012	2012-2013	2013-2014	2014-2015	2015-2016	2016-2017
Reports	29	37	30	28	20	26	21	18	11	9

Table 3 - Classification of RIDDOR reports to the Health and Safety Executive since 2011

Classification of incident	2011-2012	2012-2013	2013-2014	2014-2015	2015-2016	2016-2017
Violence / Physical Assault	12	20	9	12	5 ↓	5 ↔
Manual Handling	2	1	6	1	1	1↔
Slips, trips and falls	6	2	3	3	3	
Struck by an object		1		1		1
Exposure			1			
Cuts		1	1		1	
Twisting injury (knee) (wrist)		1		1		
Collision			1			1
Distress following incident					1	1
Total	**20**	**26**	**21**	**18**	**11**	**9**

6. Central Alerting System (CAS)

The Central Alerting System superseded the Safety Alert Broadcast System and is an electronic cascade system developed by the Department of Health.
It is a key means by which to communicate and disseminate important safety and device alerts information within the NHS.
The CAS facilitates distribution of safety alerts, Medical Device Alerts, NHS England and NHS Improvement Patient Safety alerts, emergency alerts, drug alerts, public health alerts, field safety notices, Dear Doctor letters, Chief Medical Officer Messages and Estates and Facilities alerts including electrical safety notifications.

All alerts are sent to one nominated person in each Trust, known as the CAS Officer (CWP Senior Health and Safety Advisor) for them to action and disseminate appropriately throughout the organisation. The system of dissemination has been established within CWP for the alerts and this is reviewed annually. The Central Alerting System Policy has been reviewed during 2016- 2017.
The National Patient Safety Alerting System (NPSAS) was launched by NHS England to strengthen the rapid dissemination of urgent patient safety alerts to healthcare providers via the Central Alerting System (CAS).
NHS England produced their first Patient Safety Alerts during December 2013 and by March 2017, NHS England and NHS Improvement had produced 46 Patient Safety Alerts.

The system was launched for alerting the NHS to emerging patient safety risks. The system allows for timely dissemination of relevant safety information to providers, as well as acting as an educational and implementation resource. It builds on the best elements of the former National Patient Safety Agency (NPSA) system. The system is known as the National Patient Safety Alert System (NPSAS)

It is a three-stage system, based on that used in other high risk industries and is used to disseminate patient safety information at different stages of development, to ensure newly identified risks can be quickly highlighted to providers.

The system allows rapid dissemination of urgent information, as well as encouraging information sharing between organisations and providing useful education and implementation resources for use by providers.

Alerts are issued in up to three stages, each denoted by a letter (W, Re and D) although all stages may not be issued as an alert.

6.1 Stage One Alert: Warning (W)

This stage 'warns' organisations of emerging risk. It can be issued very quickly once a new risk has been identified to allow rapid dissemination of information. Trusts will be asked to consider if immediate action is required and to develop an action plan to reduce risk of a similar incident occurring. Organisations are asked to share learning from their investigations and locally developed good practice.

6.2 Stage Two Alert: Resource (Re)

This alert may be issued some weeks or months after the stage one alert, and could consist of:

- sharing of relevant local information identified by providers following a stage one alert;
- sharing of examples of local good practice that mitigates the risk identified in the stage one alert;
- access to tools and resources that help providers implement solutions to the stage one alert; and
- access to learning resources that are relevant to all healthcare workers and can be used as evidence of continued professional development.

6.3 Stage Three Alert: Directive (D)

When this stage of alert is issued, organisations will be required to confirm they have implemented specific solutions or actions to mitigate the risk. A checklist will be issued of required actions to be signed-off in a set timeframe. These actions will be tailored to the patient safety issue
Every alert issued to NHS Trusts has a set completion date to ensure all of the actions required are completed within a specific timeframe.

6.4 Supply Distribution Alerts

A new type of alert has been issued via the CAS system since 2016. This new alert concerns supply disruption – affecting medical devices and clinical consumables – and are issued by the Department of Health.

The supply disruption team at the Department of Health already have routes for contacting NHS organisations in relation to small scale and low impact supply problems - these arrangements will continue. A Supply Disruption Alert will only be issued through CAS in the event of a significant supply disruption event with potential for widespread and severe impact on patient safety and outcomes.
CWP have received 2 Supply Distribution Alerts, but no action was required.

6.5 Reporting and Monitoring

- Patient Safety Alerts with actions required are monitored by the Patient Safety Effectiveness Sub Committee, by way of a prepared report by the CAS Officer; this Subcommittee is chaired by the Trust's Medical Director.
- Reports are prepared as per the Business Cycle for the Health and Safety Sub Committee which is chaired by The Director of Nursing, Therapies and Patient Partnership.
- A report was also produced for the bi-monthly Compliance and Assurance Learning Sub Committee which has now ceased operating.
- CAS reports are also an agenda item on the Medical Devices Group and all the local and Estates Health and Safety meetings.

- The Head of Clinical Governance is supplied with a monthly status report for sharing with the Commissioning Groups.

Since 2013, electrical alerts relating to notices for High and Low voltage equipment have been received from the Energy Networks Association (ENA) by the Department of Health Estates and Facilities Team. They have been issued in the format of Estates and Facilities Notifications (EFN's). The decision was made to utilise CAS to deliver this information to those responsible for the safety of electrical systems within healthcare organisations. All alerts are notified to our Authorised Engineer (Electrical). This arrangement resulted in a sharp increase in alerts received via the CAS function from 91 to 177 during the initial year of operation.

Monthly CAS data is published by NHS England, showing all responses to alerts due for completion and identifies if Trusts do not sign off alerts by the deadline date. Patient safety alerts and notices are issued by NHS England and NHS Improvement.

All NHS Trusts are monitored on their alert responses and actions by the Care Quality Commission.

Table 4 demonstrates a summary of all alerts received by the CAS officer during 2016-2017 and the originator E.G MHRA, NHS England.

Table 4 - Summary of alerts received by CWP - April 2016- March 2017

All alerts received by CAS Officer	116
Medical Device Alerts (MHRA)	24
DH Estates and Facilities Alerts Electrical Facilities Notifications (incl. updates)	76 6
NHS England / NHS Improvement	10
DH Supply Disruption	0
Alerts with 'No action required'	13
Alerts with 'Action required- Ongoing'	1
Alerts with 'Action complete'	102
Total	**116**

At the end of the reporting period **(31.03.17)**, CWP had 1 alert open with actions required or their relevance to the Trust being assessed.
A total of 103 alerts required actions throughout the year compared to 76 the previous year and this coincided with the increase in the number of alerts issued via the CAS System from 97 in 2015-2016 to 116 for this year.
The process for acknowledgement of alerts has been reviewed and the standard operating procedure is in place for business continuity purposes.
Contingency plans have been put in place in the absence of the CAS Officer and 2 deputies are now allocated this role.

Figure 6 shows a marked increase in total number of alerts received during 2013-2014 and this was due to the publication of Estates and Facilities Alerts and Notifications relating to electrical equipment originating from the Department of Health.

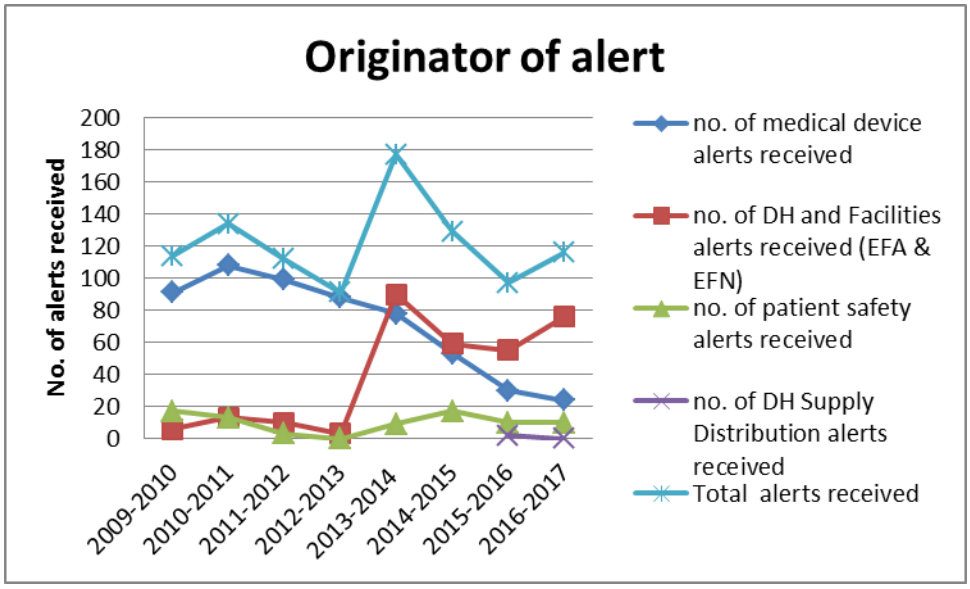

Figure 6 - Alerts received via the Central Alerting System

7. Medicines and Healthcare Products Regulatory Agency (MHRA)

The MHRA is the government agency responsible for ensuring that medicines and medical devices work, and are acceptably safe. The MHRA is an executive agency of the Department of Health. Adverse incidents relating to medical device failure or malfunction should be reported to the MHRA. There has been 1 incident recorded relating to medical devices that needed reporting to the MHRA by CWP relating to a catheter balloon deflating whilst in situ. The manufacturer was also made aware and the affected item was sent for Quality Control. No further action was required by CWP.

8. Medical Devices and Equipment

Following the completion of TCS (Transferring Community Services) there has been an ongoing internal review of the existing processes and contracts involved in the management of all medical devices and equipment.

Currently, one external provider services and maintains all medical devices and equipment with the exception of anesthetic machines and Thymatron ECT machines which require more specialised providers.
The medical device maintenance and servicing contract is the responsibility of the Estates and Facilities Department and is managed day to day by the Medical Device and Safety Officer and the Senior Health and Safety Advisor.
Physical health trainers within Education CWP work closely with the Medical Devices personnel in order to develop and maintain a programme to standardise medical devices equipment. CWP now having an in house Procurement Department has assisted greatly in the implementation of this programme.

- We currently have 1775 pieces of equipment which are managed by our external provider.
- We also have a contract with Dantec Thymatron to service specialised ECT equipment and Penlon for the anaesthetic machines.
- The Estates Department also manages the contract for servicing patient lifting equipment such as beds, hoists and slings.

The Medical Devices group meeting is held every three months and has membership from clinical areas within the Trust. The information from this group feeds into the Patient Safety Effectiveness Subcommittee.

9. Manual Handling

HSE developed and published an information sheet giving advice to employers in the health and social care sector in 2012. This guidance covered the requirements of the Lifting Operations and Lifting Equipment Regulations (LOLER) 1998 and how they applied to the health and social care Sector. The Guidance showed which types of equipment were considered as lifting devices and which were not, the risks associated with each type of equipment and the law in relation to statutory checks required. Advice was also published by the HSE concerning the use of hoists and slings by staff and what factors should be considered prior to each use of the equipment to help reduce risk of injury, this information is cascaded to staff via training sessions.

9.1 Servicing of Equipment

The contract for the servicing, testing and checking of all hoists, slings and adjustable baths is with an external provider who also checks bedrails. The contract applies to inpatient areas and is managed and monitored by CWP Estates department, any issues and concerns are reported via Medical Devices Group and are monitored in the management of Statutory Standards within the Estates department.

9.2 Training

Manual handling training is accessible to all staff via Education CWP as part of the Essentials Framework, EE1 for inpatient staff on identified wards and EE2 for West Physical Health staff which is role specific. This training includes the safe methods of moving and handling, safe use of bed rails and also covers slips, trips and falls. For all non-clinical staff, manual handling training is via e-learning and is a mandatory, once only requirement and compliance with this was 96% at year end. During 2017-2018 bespoke training is to be delivered to portering staff at Bowmere following discussions with Facilities management to help reduce risks to those staff.

9.3 New training venue

Manual handling people movement training is now delivered at Churton House, Chester. The training venue provides greater space for the storage and practical use of the equipment during training sessions and enhances the learning environment for staff. The feedback from staff following training has been extremely positive.

The training delivery for manual handling has also changed and now provides a balance between theory and practice allowing staff to have more time for practical work and some simulated scenarios.

The training for East Cheshire staff has now transferred to Millbrook Unit, in the old Complex Assessment and Rehabilitation (CARS) unit. Staff feedback for this has been very positive as they now do not have any travel or experience parking issues compared to when the training was held at Ropewalks.

10. Estates Department

There are requirements under Health and Safety Law to control the risks from exposure to asbestos, control of risks associated with Legionella, management of electrical safety, safe work at height for employees and delivery of other safety specific training.
All measures required for the control of exposure to asbestos and control of Legionella are managed by the Estates department. Estates activity risk assessments for many related tasks including work at height are available for staff and staff receive training in safe systems of work. All training reports and personal development are carried out as part of the staff appraisal process.

There is a compliance section on the Estates Intranet page for ease of reference for all CWP staff.

The Estates Department has a training group meeting that ensures all relevant maintenance staff receive training required according to their area of work, for example, Asbestos Awareness training, Safe Work at height and electrical safety training. The Estates Health and Safety Group develop and review any new risk assessment documents and update the local risk register.

The Estates Statutory Standards and Compliance group are responsible for ensuring that all CWP premises are designed and maintained in accordance with all relevant legislative requirements, each statutory standard has an identified lead within the estates department.
Specific standards include asbestos management, legionella management, electrical and gas safety LOLER (Lifting Operations and Lifting Equipment Regulations) and fire safety management. The Estates department also leads on the Environmental Ligature Management plans and programme.

The asbestos register is held and managed in accordance with the Control of Asbestos Regulations 2012. The register is held within the estates department and updated regularly when in situ asbestos is routinely inspected or where known asbestos is removed. The database covers all premises either owned or occupied by the Trust including former CWP West Physical Health Services premises. During 2016-2017 relevant information has been input into the MICAD IPR Asbestos module (Internet Property Register) (IPR) to enable improved controls.

The Trust has a policy for the control of risks of legionella and water safety; in implementing this policy the Trust uses as a general source of practical guidance, the Health and Safety Commission's Approved Code of Practice (ACoP) L8 Legionnaires' disease –The control of Legionellae bacteria in water systems 2013, made with the consent of the Secretary of State under Section 16 of the Health and Safety at Work etc. Act 1974.

With regard to the detailed practical guidance of implementing this policy, Estates Department use the detailed technical advice on design, maintenance, operation and management of water systems given in the Health and Safety Commission guidance section of the L8 ACoP and the NHS Estates two documents entitled "Health Technical Memorandum 04 01, The Control of Legionellae, hygiene, "safe" hot water, cold water and drinking water systems" Part A: Design, installation and testing and Part B: Operational management. Health Technical Memorandum 04 now supersedes Health Technical Memorandum 2027 and Health Technical Memorandum 2040.

All the above management is in full compliance with the regulations and covers water quality. The governance arrangements are reported on a bi-monthly basis to the Infection Prevention and Control Subcommittee with an internally agreed compliance level of 92%.

The policy for the Control of Contractors has been reviewed and meets all the requirements of the revised CDM Regulations Construction (Design and Management) Regulations 2015.

Estates and Facilities Infrastructure Services are currently working towards implementation of the premises assurance model standards (PAM). Nominated competent persons have been identified as the lead for electrical safety, statutory standards, legionella etc. and these compliance arrangements are clearly communicated on the Estates Intranet page

11. Fire Safety

All CWP premises have a Fire Risk Assessment as required by The Regulatory Reform (Fire Safety) Order 2005 (RRO) and all have been reviewed during the year starting 1 April 2016 – 31 March 2017. Those premises which required work or change have been issued with an amendment to the Fire Risk Assessment ensuring all premises have an up to date assessment. A schedule of actions detailing any such work has been passed to the Estates Department for action. There is a monitoring system in

place to ensure any such work in this schedule is complete. Buildings that are not the responsibility of CWP which house members of Trust staff will be informed by letter of their obligations.

The new hospital Ancora House opened during September 2016. Since opening, all staff have received induction training by the Trust Fire Advisors, a Fire Risk Assessment has been carried out and all documentation and fire drawings have been produced.

A new Fire Risk Assessment Exemplar has been produced by the Fire Advisors to ensure we meet the exacting requirements of the enforcing authority (Fire Service). The document covers all aspects of fire risk as well as Trust policies and procedures appertaining to smoking, training, construction controls etc. It also contains up to date fire drawings of the premises. All inpatient units have been issued with this new assessment and the Modern Matrons have been made aware of the importance of the document.

A certificate of compliance has been completed and sent to the Chief Executive and a copy has been kept on file.

11.1 Fire Strategies for Inpatient Units

The Fire Safety Advisors recognise that the highest risk buildings in the Trust are the in-patient areas. Site Specific fire strategies for these risks have been produced and are located on the Intranet. The inpatient buildings are Alderley, Ancora House, Bowmere, Crook Lane, Eastway, Greenways, Lime Walk House, Millbrook, Saddlebridge, Springview and Thornheyes Bungalow.

The site specific strategies give all staff access to the actions, roles and responsibilities required during a fire in their premises.

The strategies are located on the Trust intranet in the Estates section under ‘Fire Safety’.

11.2 Fire Evacuation Exercises

CWP now have in place a programme for carrying out fire drills in all inpatient units. The Modern Matrons have been issued with a timetable with two dates per year per inpatient Unit. The Fire Advisors attend the drills and both oversee and direct the evacuation drills. This continues to produce very positive results with both management and staff benefitting from the procedures.

Following the exercise, staff must complete a written document relating to the drill as evidence for the enforcing authority (Fire Brigade) that drills have taken place. The law only requires one drill per year to be carried out as against the two CWP complete.

All non-inpatient units carried out at least one fire drill during the year.

11.3 Fire Alarms

In line with CWP policy for installing voice over fire alarm systems wherever possible, the new build Ancora House has been fitted with this system.

11.4 Fires

The number of fires reported in the Trust on the DATIX system for this period was five. Four started by service users with ignition sources (lighters) and one was a small Christmas light plugged into a computer USB. All fires were contained in the room of origin. One of the fires occurred on Adelphi ward, Millbrook and although was contained in the room of origin in the initial stages, caused substantial smoke damage.

The Fire Advisors believe this is good evidence that CWP staff response teams responded quickly and efficiently. Procedures and actions were followed to the letter.

It has been reiterated during all the fire safety training sessions to ensure service users do not have ignition sources on the wards and staff have been supported to better understand and use the policies available to them.

11.5 Cause of Unwanted Fire Signals (False Alarms)

The number of false alarms has reduced from 55 recorded in 2015-2016 to 43 during 2016- 2017 and the causes are listed in table 5.

Table 5 - Causes of unwanted fire signals

Cause of unwanted fire signal	Number
Service user smoking	10
Fault on system/unknown activation of detector	9
Unknown cause	6
Deodorant spray	4
Cooking	4
Service user using E- cigarettes	3
Service user abusing break glass alarm point	2
Accidental activation by the engineer	1
Electrical fault activated alarm	1
Washing machine overheated	1
Science lab experiment caused detector to operate	1
Smoke from hairdryer	1

11.6 Fire Training

As well as the Trust mandatory training fire training the Fire Advisors have carried out specific training for fire wardens, competent persons and bleep holders. The plan is to carry further competent persons training as there have been numerous staff changes. Table 6 identifies courses carried out with number of staff completions.

Table 6 - Fire training course completions

Course name	Staff completions
Fire Warden (Hospitals)	14
Fire Warden (Offices and Clinics)	18
Competent person (Fire)	1
Hospital Bleep Holder Training	55

12. Health, Safety and Security Assessments

The Senior Health and Safety Advisor has been monitoring the effectiveness of the measures and processes in place to prevent harm to staff by carrying out health, safety and security assessments in different areas and monitoring incidents on a daily basis that are reported on the Datix system.
All in-patient areas are assessed on an annual basis. Health Centres and Physical Health clinics and resource centres will be assessed every 2 years.
The Local Security Management Specialist role sits in Education CWP, the security element of the assessments requires review by the LSMS in line with the requirements of NHS Protect.
100 Health and Safety Law posters were obtained and have been issued to Departments that did not have the new version of the poster displayed. The poster allows for details of specialist contacts within the Trust and Staff Side Representative contact names to be displayed.

13. Priorities for 2017-2018

1. All policies which the Health and Safety function have responsibility for will be reviewed and updated as required.

2. Coordination between the Medical Devices and Safety Officer and Senior Health and Safety Advisor will continue in maintaining and monitoring the external contract for servicing and maintenance of medical devices. A review of current outsourced arrangements will be undertaken to establish whether any efficiency gains are possible.

3. A replacement programme for Automatic External Defibrillators (AED) will be commenced to replace the current models as consumables such as pads for the current models in use will become obsolete in the following two years.

4. Management of the Cardinus Workstation Safety Assessment and Training Programme will continue. With further training, reports can be compiled for teams / wards as requested by managers. Workstation corrective equipment is standardised, updated on the intranet and available through the procurement department.

5. The Senior Health and Safety Advisor will continue to work in conjunction with ward and resource managers and the incidents team to identify incidents where staff may be injured whilst at work, offer support to staff and ensure reports are made to the HSE as appropriate.

6. Support will be available to managers in supporting staff back to work and carrying out workplace and risk assessments.

7. Health, safety and security assessments will continue and any corrective actions implemented.

8. Locality Health and Safety meetings will continue and exception reports will be prepared for the Operational Board.

9. Trust wide Health and Safety Committee will continue to meet twice per year- The agenda will be prepared by senior health and safety advisor and Estates business support assistant.

10. The Senior Health and Safety Advisor in conjunction with the Authorised Engineer (Electrical) will produce detailed guidance in relation to electrical safety for all staff.

14. Recommendations

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

15. References

Helping Great Britain work well, HSE 2016

The Health and Safety at Work etc. Act 1974 (HASAW)

The Management of Health and Safety at Work Regulations 1992 (as amended)

Workplace (Health and Safety) Regulations 1992

RIDDOR- Reporting of Injuries, Diseases & Dangerous Occurrences Regulations 1995 (as amended 2012)

Governance and Risk Policies- Cheshire and Wirral Partnership NHS Foundation Trust

Clinical Practice Policies - Cheshire and Wirral Partnership NHS Foundation Trust

Work with Display Screen Equipment 1992 (as amended 2002)

LOLER- Lifting Operations and Lifting Equipment Regulations 1998

Health Technical Memorandum – Firecode

The Regulatory Reform (Fire Safety) Order 2005

Control of Substances Hazardous to Health 1988 (as amended 2009)

Control of Asbestos at Work Regulations 1987 (as amended 2012)

Health and Safety Commission Approved Code of Practice L8 Legionnaires' disease –The control of Legionellae bacteria in water systems 1991 (as amended 2013)
Health Technical Memorandum 04.01 Part A and Part B

Work at Height Regulations 2005 (as amended 2015)

Construction (Design and Management) Regulations 1994 (as amended 2015)

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

STANDARDISED REPORT COMMUNICATION

REPORT DETAILS

Report subject:	Director of Infection Prevention & Control Quarter 2 Report 2017/18
Agenda ref. no:	17-18-81a
Report to (meeting):	Board of Directors
Action required:	Information and noting
Date of meeting:	29/11/2017
Presented by:	Andrea Hughes, Director of IPC

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 2 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 and Nurse Consultant for IPC, delivers a quarterly report to appraise the IPCSC and Board of Directors regarding IPC activity and any associated risks.

Assessment – *analysis and considerations of options and risks*

The report will detail the work undertaken prior to, and during Quarter 2, and highlights future actions to minimise the infection risks associated with healthcare including invasive / medical devices and skin integrity issues, to help prevent avoidable harm to service users.

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

The IPCSC is asked to agree and approve the Quarter 2 report 2017/18 and forward to the Board of Directors for discussion and noting at the November meeting.

Who/ which group has approved this report for receipt at the above meeting?		IPCSC
Contributing authors:		Julie Spendlove
Distribution to other people/ groups/ meetings:		
Version	Name/ group/ meeting	Date issued
2	Chief Executive	November 2017

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

Appendix no.	Appendix title
Click here to enter text.	Click here to enter text.

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

17-18-81a Appendix 1

Director of Infection Prevention and Control (DIPC) Quarterly Board Report, Quarter 2 2017/18 - (July – September 2017)

Contents

1. The purpose of the report

The purpose of this report is to provide Cheshire and Wirral Partnership (CWP) Board of Directors with an update in respect of assurance activity and performance for infection prevention and control (IPC), for which CWP is responsible for during Quarter 2 (Q2) – (July – September 2017).

2. Infection Prevention and Control Activity

During Q2 there have been no reportable or avoidable infections and no cases of *Methicillin Resistant Staphylococcus Aureus* (MRSA) bacteraemia or *Clostridium Difficile* within CWP.

2.1 Outbreaks

There has been one ward closure due to an outbreak of diarrhoea. No causative organism was identified. This was on Adelphi ward in September; four patients were affected but no staff. The ward was closed for four days and was full at the time of closure. A post outbreak meeting will be arranged with the ward.

2.2 Audits

Audits have been undertaken on 25 wards or clinics and 20 of these have passed their audits with scores of over 93%. 3 areas scored less than 90%. Only 2 of the 3 areas are CWP premises and the main issues found were around dustiness and cleanliness of both equipment and the environment. Both areas also hand weaknesses around hand hygiene facilities including access to alcohol gel, soap and paper towels. Action plans have been agreed and re audit dates booked to assess improvements.

2.3 Training

A total of 530 staff have attended IPC training, including induction during the period of Q2 and within this period 74% of staff Trust wide were compliant with IPC training. The infection prevention and control team continue to work closely with the education department to review how training is delivered and to look at creative ways to improve compliance including the development of an e-learning programme. The IPC training received very positive evaluations in Q2 with 95% of the attendees rating the training as good or excellent.

An Infection Prevention and Control Study Day has been planned for November 2017 and will cover topics including urosepsis, antimicrobial resistance, influenza and sepsis and will be open to all CWP staff.

3. Antimicrobial Resistance

Within Q2, there have been no multi drug resistant organisms (MDRO) brought to the attention of the IPC team.

The team continue to work very closely with pharmacy teams across the Trust and collect data around antimicrobial prescribing and compliance to formulary. The data shows that 58% of all antimicrobial prescribing was in line with West Cheshire Clinical Commissioning Group prescribing guidelines but a further 11% was prescribed based on sensitivities or advice from the microbiologist and 21% had been commenced by another provider. Therefore, actual non – adherence to formulary was 10% which is a 2% improvement from Q1.

A new public health campaign is due to commence during autumn and early winter and it will be aligned to the ‘Take Doctors Advice’ and ‘Stay Well this Winter’ Campaigns. It also links into the Antibiotic Guardian Campaign, European Antibiotic Awareness Day and World Antibiotic week. The campaign aims to motivate the audience to change their behaviour without deterring those who need antibiotics and will be promoted through a range of media including TV, radio, leaflets and posters.

The key audiences are those most likely to use antibiotics and include young children and their carers; also women aged 20-45 who generally have primary responsibility for family health; and older men and women aged 50+, with a focus on those with recurrent conditions and high levels of contact with their GP’s.

An action plan has been created to share information to help raise awareness and knowledge amongst staff in CWP around these key messages, both internally with their patients but also for themselves and their families. IPC and the pharmacy team are working together to promote these messages across different forums throughout the trust, including mandatory updates and induction. Prescribers within the organisation will also be targeted as part of the campaign to help improve compliance to antimicrobial prescribing in line with current formulary. The campaign will be supported by promotional leaflets and posters provided by Public Health England.

4 Influenza

The influenza campaign commenced at the beginning of October 2017. A new in-house immuniser update training programme has been introduced within CWP and delivers information to both new immunisers and those attending for their annual update. It has been delivered throughout August, September and October, across all localities, and has prevented the need to send new immunisers to an external 2 day course. The course has been approved by Public Health England and has evaluated very well. A total of 145 staff have attended flu immuniser update training either as new immunisers or an annual update.

The IPC team will be actively involved in supporting Workforce Wellbeing to deliver this year's staff flu campaign and aim to support the achievement of 75% update of the influenza vaccine amongst frontline staff.

5. Quality Premium - Gram Negative Blood Stream Infections (GNBSI)

There is a national ambition to reduce healthcare associated gram-negative blood stream infections by 50% by March 2021. This is supported by the Quality Premium for Clinical Commissioning Groups (CCG), which has also set a reduction ambition of 10% in all E. coli blood stream infections reported at CCG level, by 2019. The IPCT has supported the local CCG and Public health in the review of all cases of GNBSI during Q1 and have used this information to develop an improvement plan. This was submitted by the CCG to NHS England in September 2017.

CWP does not have a target for GNBSI, but patients affected by the infections may come under the care of the CWP physical health community teams in West Cheshire

Following the review of Q1 data, there were no obvious themes for action to be noted. It has been agreed with Public Health (CWaC), West Cheshire CCG and Vale Royal CCG, to develop an improvement plan that will focus on improving practice in keys areas that could prevent this type of infection, including; catheter care, appropriate management and treatment of patients presenting with a urinary tract infection; appropriate antimicrobial prescribing; PICC line management and chronic wound care management. Implementation of this action plan will take place during Q2 – Q4 2017/18.

6. Safety Devices

Most sharps injuries can be prevented and there are legal requirements for employers to take steps to prevent healthcare staff being exposed to infectious agents from sharp injuries. As of May 2013, new regulations were implemented by the Health and Safety Executive (HSE), to ensure that risks from sharp injuries to healthcare staff are adequately assessed and that appropriate control measures are in place. The regulations build on existing law and provide specific detail on requirements that must be taken by healthcare employers.

Trusts are therefore required to substitute traditional, unprotected medical sharps with a 'safer sharp' where it is reasonably practicable to do so. There are now a wider range of potential devices available therefore CWP will during the next quarter be reviewing all sharps used across the Trust, identify potential substitutes and any associated training required to update our actions taken in response to the HSE regulations.
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7. Recommendations

The Board of Directors is asked to discuss and note the DIPC Quarter 2 report for 2017/18.

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

STANDARDISED REPORT COMMUNICATION

REPORT DETAILS

Report subject:	Safeguarding Report –Quarter 1 and 2 2017/18
Agenda ref. no:	17-18-81b
Report to (meeting):	Board of Directors
Action required:	Information and noting
Date of meeting:	29/11/2017
Presented by:	Avril Devaney Director of Nursing ,Therapies and Patient Partnership

Which strategic objectives this report provides information about:	
Deliver high quality, integrated and innovative services that improve outcomes	No
Ensure meaningful involvement of service users, carers, staff and the wider community	Yes
Be a model employer and have a caring, competent and motivated workforce	Yes
Maintain and develop robust partnerships with existing and potential new stakeholders	No
Improve quality of information to improve service delivery, evaluation and planning	Yes
Sustain financial viability and deliver value for money	No
Be recognised as an open, progressive organisation that is about care, well-being and partnership	No
Which CQC quality of service domains this report reflects:	
Safe services	Yes
Effective services	Yes
Caring services	No
Well-led services	No
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	No
Does this report provide any information to update any current strategic risks? If so, which?	
See current risk register in the agenda of the public meeting of the Board of Directors at http://www.cwp.nhs.uk/about-us/board-members/our-board-meetings	No
35T	
Does this report indicate any new strategic risks? If so, describe and indicate risk score:	
See current integrated governance strategy: CWP policies – policy code FR1	No
35T	

REPORT BRIEFING

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

This report is to give the Board and an overview of Safeguarding activity in quarter 1 and 2 2017/18

The report gives an overview of safeguarding inspections and reviews that CWP have been involved with.

Background – *contextual and background information pertinent to the situation/ purpose of the report*
The quarter 1 and 2 reports to the Board of Directors give the Board assurance that CWP are meeting their safeguarding responsibilities.

Assessment – *analysis and considerations of options and risks*
The reports at appendix 1 and 2 gives an overview of safeguarding activity for quarters 1 and 2.

Recommendation – *what action/ recommendation is needed, what needs to happen and by when?*
The Board of Directors is asked to **note** the reports.

Who/ which group has approved this report for receipt at the above meeting?	Trustwide Safeguarding Sub committee
Contributing authors:	Satwinder Lotay Head of Safeguarding

Distribution to other people/ groups/ meetings:		
Version	Name/ group/ meeting	Date issued
0.1	Trustwide Safeguarding Sub committee	16/11/2017

Appendices provided for reference and to give supporting/ contextual information: *Provide only necessary detail, do not embed appendices, provide as separate reports*	
Appendix no.	Appendix title
1 2	Safeguarding Report Quarter 1 2017/18 Safeguarding Report Quarter 2 2017/18

17-18-81b: Appendix 1

CWP Safeguarding Adults and Children (including Children in Care) Quarter 1 2017/18 Report

Contents

1.0 Purpose of the Report

The purpose of this report is to provide Cheshire and Wirral Partnership (CWP) Board with an update in respect of assurance activity and performance for which CWP is responsible for during Quarter 1.

The report provides continuing assurance of how the Trust has met its responsibilities and requirements as a regulated provider under Regulation 13 of the Health and Social Care Act 2008, The Care Act 2014, the Children Acts of 2004 and 1989, the statutory guidance Working Together to Safeguard Children, 2015 and Promoting the Health of Looked After Children, 2015.

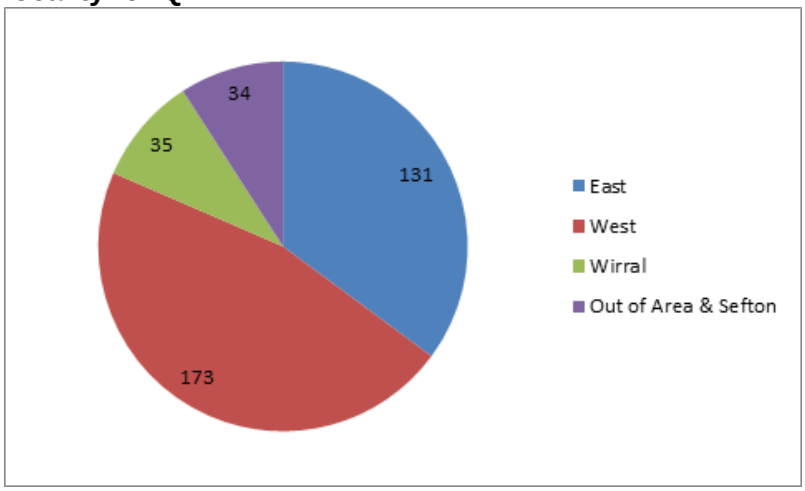
2.0 Board assurance Frameworks- Risk Register

There is currently no risks relating to safeguarding on the CWP Board Assurance Framework .

3.0 Safeguarding Activity

CWP Nurse Specialists for Safeguarding Adults receive enquiries for advice and support from CWP staff in relation to safeguarding issues. The outcome of these discussions may result in the concern that has been raised, being managed locally within the service or in a referral to the appropriate Local Authority safeguarding services. In quarter 1 there have been 262 enquires. The number of enquiries made to the safeguarding children team has shown that the safeguarding children team have received 382 enquiries. Safeguarding supervision uptake remains high with 352 cases being discussed within this reporting period .As well as this, a new model of supervision has been instigated within Wirral CAMHS, where care coordinators who have received the safeguarding supervision training will be undertaking the safeguarding supervision, they themselves will inturn receive their own supervision for this from the safeguarding team. The adults safeguarding team have supervised 5 cases.

Diagram to illustrate the number of telephone advice calls for child related issues per locality for Q1.



CWP have made 3 referral via the Prevent route, which have been discussed at the respective Channel Panel. CWP continues to attend monthly MARAC meetings, which operate across Cheshire East, Cheshire West and Wirral. Currently the head of safeguarding is part of a multiagency working party looking at how the MARAC process can become moe responsive and timely in Chehsire West and Chester.

The Children in Care team have supervised 69 cases, the RHA compliance levels for the Trust have achieved over 90%, this is since a robust system has been put in place within the team.

4.0 Safeguarding and Prevent Training

Safeguarding and Prevent Training compliance rates are detailed in the respective tables below. The level 3 training compliance is 86%. The Trsutwide Safeguarding subcommittee will monitor to ensure compliance rates remain high.

Table 1 Safeguarding Training Compliance Rates for CWP at end of June 2017

Safeguarding Training	Trustwidompliance Rate at End of June 2017
Level 1 (children and adults includes domestic abuse)	89%
Level 2 (children and adults includes domestic abuse)	88%
Level 3 (safeguarding children only)	86%

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The Prevent Wrap training for CWP staff is mandatory and the compliance as at end of June 2017 are detailed in Table 2 .

Table 2: PREVENT WRAP Training Compliance on June 2017.

PREVENT	Trustwide Compliance Rate as at 30/06/17
Level 1 and 2	89%
WRAP 3 (level 3)	88%

5.0 Serious Case Reviews/ Serious Adults Reviews/ Domestic Homicide Reviews

Since April 2017 the following review activity has been undertaken:

One SCR is still in progress in Wirral and two in CWAC LSCB

One SCR to commence in East Cheshire LSCB

One SAR completed and now published (Trafford LSAB). CWP Action plan being implemented

One Domestic Homicide Review still to commence (East Cheshire Community Safety Partnership).

6.0 Inspections

During this quarter CWP have not been involved in any inspections. However the CQC safeguarding report has been published in December 2016 and CWP are implementing the action plan which is being overseen by Trustwide Safeguarding Subcommittee. CWP continue to support the Improvement Board in Wirral.

7.0 Trust Wide Objectives for 2017/18

CWP objectives are to be approved at Board in July 2017.

8.0 Conclusion

CWP has continued to work in partnership across each of the local Safeguarding Boards for both adults and children. Safeguarding activity continues to remain at a high level across the organisation.

17-18-81b: Appendix 2

CWP Safeguarding Adults and Children (including Children in Care) Quarter 2 2017/18 Report

Contents

1.0 Purpose of the Report

The purpose of this report is to provide Cheshire and Wirral Partnership (CWP) Board with an update in respect of assurance activity and performance for which CWP is responsible for during Quarter 2.

The report provides continuing assurance of how the Trust has met its responsibilities and requirements as a regulated provider under Regulation 13 of the Health and Social Care Act 2008, The Care Act 2014, the Children Acts of 2004 and 1989, the statutory guidance Working Together to Safeguard Children, 2015 and Promoting the Health of Looked After Children, 2015.

2.0 Board assurance Frameworks- Risk Register

There is currently no risk relating to safeguarding on the CWP Board Assurance Framework. However, this quarter has seen significant increase in case reviews being undertaken as well as vacancies and staff sickness affecting CWP safeguarding department to be able to respond effectively and efficiently to the safeguarding agenda/ inspections. This has therefore resulted in the risks being added to the Trustwide Safeguarding Subcommittee Risk register. Risks are being mitigated and on-going risk management plan is in place and regularly reviewed and updated.

3.0 Safeguarding Activity

CWP Nurse Specialists for Safeguarding Adults receive enquiries for advice and support from CWP staff in relation to safeguarding issues. The outcome of these discussions may result in the concern that has been raised, being managed locally within the service or in a referral to the appropriate Local Authority safeguarding services. In quarter 2 there have been 286 enquires. The adults safeguarding team have supervised 5 cases. They have led on 2 section 42 enquiries. The Head of Safeguarding has also supported one large scale safeguarding investigation (Non CWP safeguarding incident). CWP were also asked to support local authorities operationally to 1 large scale safeguarding investigations within this quarter.

The number of enquiries made to the safeguarding children team has shown that the safeguarding children team have received 420 enquiries. Safeguarding supervision uptake remains high with 115 cases being discussed within this reporting period.

The Children in Care team have supervised 98 cases. Since a robust system has been introduced to monitor the completion and timeliness of Review Health Assessments, the compliance levels has significantly increased for CWP completing RHAs within timescales to over 85%.

CWP have made one referral via the Prevent route, which have been discussed at the respective Channel Panel. CWP have been represented at seven Channel Panel meetings this quarter across CWP footprint.

CWP continues to attend MARAC meetings, which operate across Cheshire East, Cheshire West and Wirral and within quarter two 22 MARAC meetings have been attended. Currently the head of safeguarding is part of a multiagency working party looking at how the MARAC process can become more responsive and timely across Cheshire.

The Nurse specialist for Child Death has responded to three child deaths, attended one rapid response meetings and coordinated nine child death clinical information requests. She has also attended two child Death Overview Panels in this quarter.

4.0 Safeguarding and Prevent Training

Safeguarding and Prevent Training compliance rates are detailed in the tables one and two. The Trustwide Safeguarding subcommittee will monitor to ensure compliance rates remains above 80%.

Table 1 Safeguarding Training Compliance Rates for CWP at end of September 2017

Safeguarding Training	Trustwide compliance Rate as on 30th September 2017
Level 1 (children and adults includes domestic abuse)	90%
Level 2 (children and adults includes domestic abuse)	90%
Level 3 (safeguarding children only)	83%

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Table 2: PREVENT WRAP Training Compliance on September 2017.

PREVENT	Trustwide Compliance Rate as at 30/09/17
Level 1 and 2	90%
WRAP 3 (level 3)	89%

CWP safeguarding has supported the launch of Supporting Families and Enhancing Futures and has committed a nurse specialist to support the training pool in Wirral. Within this quarter, CWP nurse specialist has delivered four multi agency training sessions.

5.0 Serious Case Reviews/ Serious Adults Reviews/ Domestic Homicide Reviews

Since July 2017, the following review activity has been undertaken:

- Serious Adult Review has commenced for Adult H (involves Trafford Learning Disability service) and being overseen by Warrington Safeguarding Board. Head of Safeguarding is a panel member and a joint IMR author with Clinical Service manager.
- Domestic Homicide Review commenced for Adult (involves Adult Mental Health services and 5-19 service) and is being overseen by Cheshire West and Chester Community Safety Partnership Board. Head of Safeguarding is a panel member and Nurse Specialist for safeguarding adult is IMR author.
- Domestic Homicide Review commenced for Adult (16-19 CAMHS and IAPT service) and is being overseen by East Cheshire Community Safety Partnership. Head of Safeguarding is IMR author
- Serious Case Review has commenced for Child E in East Cheshire
- A serious case review in Wirral has been concluded and an action plan subsequently developed.
- There has been three Practice Learning Reviews for children in Cheshire West and Chester where different staff groups from CWP have attended.

In addition, CWP has submitted two chronologies for SAR consideration (1 for Trafford LSAB and 1 for Cheshire West and Chester LSAB) and are awaiting the outcome of the respective panels. CWP has also submitted two chronologies for SCR consideration

6.0 Inspections

During this quarter CWP have been involved in one Joint targeted area inspection in West Cheshire focused on Neglect. This involved case audits, case tracking and case discussions at a multiagency and single agency level. Services involved included 0-19 service, Adult mental health, CAMHS, Safeguarding Children Team and the Children in Care team. The report is due to be published in November 2017. The Head of Safeguarding also participated in the well led CQC pilot in August 2017.

CWP are continuing to implement the CQC action plan in response to the CQC inspection into Safeguarding in East Cheshire and is being overseen by Trustwide Safeguarding Subcommittee. CWP also continues to support the Improvement Board in Wirral.

During quarter 2 CWP completed and submitted the Section 11 Audit and the NHS Self-Assessment Standards for Safeguarding to the respective Cheshire and Wirral CCGs. CWP are currently awaiting feedback.

7.0 Trust Wide Objectives for 2017/18

An update on the progress of meeting CWP objectives as follows:

To work with the respective boards to embed learning from case reviews and evidence based practice. This is in progress with the Named Nurse and Head of Safeguarding working within a number of workstreams with agencies to address this as well as embedding this within CWP safeguarding training and clinical practice.

To promote and embed the safeguarding strategy. Safeguarding strategy has been promoted across the organisation Work to strengthen Safeguarding practice links has commenced. Safeguarding training is maintaining above 80% compliance.

To support and promote the work of the Truth Project. This has commenced and CWP are working closely with the Truth Project to develop material to promote the project.

Continue to work with services in ensuring robust safeguarding processes are in place in response to the integrated agenda. CWP safeguarding leadership team are working with services to respond to this agenda.

8.0 Conclusion

CWP has continued to work in partnership across each of the local Safeguarding Boards for both adults and children. Safeguarding activity continues to remain at a high level across the organisation.

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

CHAIR'S REPORT
AUDIT COMMITTEE – 7 November 2017

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

Internal Audit progress update
Two recently completed audits were reviewed by the Audit Committee. These were:

- Patient Cash & Valuables Review which attained Limited Assurance
- Recruitment review which attained Significant Assurance. .

The Committee discussed the actions arising from the patient cash and valuables review and noted the timescales for completion of the actions, which are due by December 2017.

The Committee was briefed on forthcoming audits. Internal audit confirmed that the reminder of the audit plan was deliverable before the of the financial year.

The Committee also reviewed the follow up to previous audit recommendations report and an insight update report.

External Audit update
A technical update was also provided with recent sector updates. A meeting was held between the Audit Committee members and the external auditors following the Committee meeting to discuss the preparation of the 2017/18 audit plan.

Provider Licence compliance
The Committee reviewed the end of Q2/ six month position for compliance with the provider licence. There were no risks identified.

Healthcare Quality Improvement Plan – six month update

An overview of the delivery to date of the healthcare quality improvement programme was provided. The national move from over-reliance on clinical audit as a means of providing assurance and improving patient safety was noted.

Corporate Governance Manual Review
The Committee reviewed the changes to the Corporate Governance Manual. The most significant change is the inclusion of the new NHS England model policy on Conflicts of Interest. It was noted that as the CWP forward view strategy develops, this will have potential impact on the Standing Financial Instructions; therefore a further review is planned for March 2018.

Governance Matters

The Audit Committee noted the minutes and/ or chair's reports from the Quality Committee and the Operational Board. There were no matters for escalation from the Quality Committee; however, the risk of shortage of CAMHS consultants was noted from the Operational Board minutes (July and September minutes). An action was noted to ensure that this is reflected on eh strategic risk register and to form part of this item at the November 2017 Board meeting.

Edward Jenner
Chair of Audit Committee

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

CHAIR'S REPORT –
QUALITY COMMITTEE
1 NOVEMBER 2017

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 discussed the current status of the risk register. The risk treatment plan regarding the inability to sustain safe and effective services within Central and Eastern Cheshire is progressing well and resilience work has taken place, however the residual risk score has increased to 16 given the current level of risk. The risk of lack of training in respect of mandatory Autism training requirements has been archived due to completion of the risk treatment plan, with the Trust on target to achieve a compliance rate of 85% for Autism training by March 2018.

  The Quality Committee agreed to the scoping of two potential new risks (i) financial risks associated with CQUIN compliance (ii) risks associated with the transition to the Trust's clinician-led operational (Care Group) structure.

  The Quality Committee chose the risk for in-depth review at its next meeting. This was the risk of harm due to deficits in familiarity with and staff confidence in applying safety critical policies, but extended to consider current work commissioned by the Medical Director to review the Trust's current clinical risk assessment framework.
  The Board is asked to note the updates to the strategic risk register.

- **Quality Improvement Strategy**
  The Quality Committee received a presentation from the Medical Director on the draft Quality Improvement strategy (scheduled for approval at today's Board meeting in public). The strategy aims to embed quality improvement as the Trust's operating principle in order to deliver an ambition of delivering the best outcomes nationally for the populations served by CWP. To do this, the strategy requires work with a strategic partner to provide strategic support and leadership coaching for quality improvement, to help in building quality improvement capability, and to support in ensuring there is a sustainable quality improvement support infrastructure in place.
  The Board is asked to approve the Quality Improvement strategy.

- **Community Podiatry Service**
  The Quality Committee received a presentation from the Community Podiatry Service on (i) the impact of service redesign on the Community Podiatry Service (ii) the work of the Community High Risk & Foot Protection Team in helping with the management of diabetes (iii) provision of services to off-load heel ulcers (iv) other initiatives. The team talked about the background to the redesign through to the current service provision. Beneficial impacts of the redesign were an opportunity to close gaps in service provision, development of professional skills in community podiatry care, and achievement of total NICE compliance.
  The Quality Committee recommended that the presentation be delivered to the West Cheshire clinical senate in the new year, given the links to the "West Cheshire Way" regarding taking a holistic approach where services are designed around the needs of the whole person, rather than around individual diagnoses or procedures.

Jim O'Connor
Non Executive Director