Cheshire and Wirral Partnership NHS
NHS Foundation Trust

Meeting of the Foundation Trust Board of Directors
Wednesday 27 September 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
17/18/43	Apologies for absence	Receive apologies	Verbal	Chair	1 min (1330)
17/18/44	Declarations of Interest	Identify and avoid conflicts of interest	Verbal	Chair	2 min (1331)
17/18/45	Minutes of the previous meeting held 26 July 2017	Confirm as an accurate record the minutes of the previous meetings	Written minutes	Chair	2 mins (1333)
17/18/46	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)
17/18/47	Board Meeting 2017/18 business cycle	Confirm that agenda items provide assurance that the Board is undertaking its duties	Written	Chair	3 mins (1337)
17/18/48	Chair's announcements	Announce items of significance not elsewhere on the agenda	Verbal	Chair	10 mins (1340)
17/18/49	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					
17/18/50	Operational Plan and Performance dashboard: August 2017 data	To note performance	Written Report	Director of Finance	10 mins (1400)
Strategic Change					
17/18/51	Involvement review and framework	To note outcomes of review and approve new framework	Written Report	Director of Nursing, Therapies and Patient Partnership	15 mins (1410)
Quality of Care					
17/18/52	Learning from Experience Report	To review and note report	Written Report	Director of Nursing, Therapies and Patient Partnership	15 mins (1425)
17/18/53	Quality Improvement Report	To review and note report	Written Report	Medical Director	15 mins (1440)
17/18/54	Safer Staffing: Daily ward staffing figures: July and August 2017	To note the ward staffing reports	Written Report	Director of Nursing, Therapies and Patient Partnership	5 mins (1455)

Item no.	Title of item	Objectives/desired outcome	Process	Item presenter	Time allocated to item
Governance					
17/18/55	Annual Report 2016/17: Equality and Diversity	To review and note report	Written Report	Director of Nursing, Therapies and Patient Partnership	10 mins (1500)
17/18/56	Q1 2017/18: Infection, Prevention and Control report	To note report	Written Report	Andrea Hughes, Deputy Director of Nursing/ Director of IPC	5 mins (1510)
17/18/57	Emergency Planning Core Standards Assurance submission	To approve submission	Written Report	Emergency Planning Manager	5 mins (1515)
17/18/58	Audit Committee reporting: • Chair's report of meeting held 5 September 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 (1520)
17/18/59	Quality Committee reporting : • Chair's report of meeting held 6 September 2017	Review Chair's Report and any matters for note/ escalation	Written Report	Chair of Quality Committee	3 mins (1523)
17/18/60	Review of risk impacts of items discussed	Identify any new risk impacts	Verbal	Chair/ All	5 mins (1526)
17/18/61	Any other business	Consider any urgent items of other business	Verbal or written	Chair	2 mins (1531)

Item no.	Title of item	Objectives/desired outcome	Process	Item presenter	Time allocated to item
17/18/62	Review of meeting	Review the effectiveness of the meeting (achievement of objectives/desired outcomes and management of time)	Verbal	Chair/All	2 mins (1533)
17/18/63	Date, time and place of next meeting: **Wednesday 29 November 2017, 9.30 Boardroom, Redesmere**	Confirm arrangements for next meeting	Verbal	Chair	1535

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

Minutes of the Board of Directors Meeting
Wednesday 26th July 2017
Romero Centre, Macclesfield
1.30pm

PRESENT	Mike Maier, Chair Dr Faouzi Alam, Medical Director 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 Sarah McKenna, Non-Executive Director Rebecca Burke-Sharples, Non-Executive Director Dr Anushta Sivananthan, Medical Director, Quality, Compliance and Assurance
IN ATTENDANCE	Louise Brereton, Head of Corporate Affairs Katherine Wright, Associate Director Communications and Engagement Andy Harland, Deputy Director of Finance Gary Flockhart, Deputy Director of Nursing (MH) (until end of item 17/18/31) Andrea Hughes, Deputy Director of Nursing (PH) (for items 17/18/33 and 34) Rob Robertson, Public Governor West Cheshire Keith Miller, Service User/ Carer Governor Rob Walker, Public Governor, East Cheshire Jasmeen Islam, Acting Chief Pharmacist
APOLOGIES	Tim Welch, Director of Finance

	MINUTES	**ACTION**
17/18/21	**Apologies for absence** Mike Maier welcomed all and advised that the meeting was a meeting held in public. Apologies were noted from Tim Welch. The meeting was quorate.	
17/18/22	**Declarations of Interest** None was declared.	
17/18/23	**Minutes of the previous meeting held 24th May 2017** The minutes of the last meeting held 24th May 2017 were reviewed. With regard to page 4, it was requested that 'circa' be added to qualify the £80k deficit figure recorded.	

	It was noted the final position was £72k. Subject to the amendment, the minutes of the meeting **held 24th May 2017** were **approved** as a correct record.	
17/18/24	**Matters arising and action points** All actions had been completed.	
17/18/25	**Board Meeting 2017/18 business cycle** The business cycle 2017/18 was noted.	
17/18/26	**Chair's announcements** The Chair announced the following: **Non-Executive Director Sarah McKenna** The Chair advised that this meeting was Sarah's last Board meeting as she would be stepping down from her Non-Executive Director role as of 31 July 2017. Thanks and good wishes were extended to Sarah for her contribution. **Starting well-0-19 service** Cheshire West and Chester Council (CWAC) have chosen CWP to deliver the Starting Well 0-19 Service from January 2018. This service will help many young people across West Cheshire to maximise their life chances. The service will specifically support early identification and prevention, risk reduction and health improvement. **Westminster Surgery CQC rating of good** Westminster GP Practice in Ellesmere Port has been rated as 'Good' by the Care Quality Commission (CQC) following a recent inspection. Inspectors were impressed with the systems in place to avoid risks to patient safety and praised the way services accounted for the needs of different patient groups. Even more importantly, our patients said that they were treated with compassion, dignity and respect. **Well led inspection pilot inspection** Earlier this year we volunteered to support the Care Quality Commission (CQC) in their national pilot to test their new "well-led" inspection model. CQC visited Trust Board offices at the end of June. The inspection was much smaller than the Trust-wide inspection in 2015, where CWP was rated 'Good' overall and 'Outstanding' for care. There were no visits to clinical areas as the main focus of the visit was to inspect Trust-wide governance processes. We are yet to receive feedback from CQC, but the Trust sees this pilot as an opportunity to identify areas where we can make positive change, therefore taking part fits well with the Trust's commitment to continuous improvement **Launch of perinatal service** Last month saw the launch of Cheshire and Mersey Specialist Perinatal Service. This new, regional service is being launched as part of the Cheshire and Merseyside Sustainability and Transformation Partnership (STP), with CWP leading the service alongside Mersey Care and North West Boroughs Healthcare NHS Foundation Trusts.	

	This new service provides perinatal mental health care to women and families during pregnancies and in the year after birth. As one in five local births involve some sort of mental health issue, the service will be of use to thousands of local people. **Annual Members Meeting – Thursday 5th October 2017** A reminder that our Annual Members' Meeting will take place at Macclesfield Town Hall from approximately 1pm on Thursday 5th October. All members are welcome to attend this important event, as well as the Big Book of Best Practice event which is due to take place in the morning.	
17/18/27	**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 developments. • Ellesmere Port regeneration and public services hub. • Developments with Central and East Cheshire service redesign. • Clinical support services and delivering best value. • Outcome of the recent CQC pilot inspection.	
17/18/28	**Operational Plan and Performance dashboard: June 2017** Andy Harland presented the report and provided an overview of Trust performance. A discussion followed on some of the exceptions. The Board noted that despite some areas of underperformance on contracts, there is no risk of financial penalties. With regard to sickness reporting, it was noted that the figures in the dashboard are not adjusted therefore these are often higher than the actual figures. Work is underway to look at how to make this process more accurate at the time of Board reporting. Reporting on appraisal, current compliance is 96%. This is the second year of the new process which is expected to be challenging, however plans are in place to ensure to replicate last year's outstanding performance. A discussion followed on workforce recruitment and retention. CWP benchmarks positively for vacancies and staff turnover however resourcing plans for the future need to take broader workforce issues such as later retirements and flexible working options in to account while also looking at the range of roles and other options such as apprenticeships. The Board of Directors **noted** the report.	
17/18/29	**Strategic Risk Register and Assurance Framework** Dr Anushta Sivananthan presented the assurance framework and risk register and reported that there are currently 4 red risks and 3 new risks in scope at present. The Board were reminded that the Quality Committee review the	

	assurance framework and risk register at each meeting. The Audit Committee also undertake a quarterly review for assurance on risk management processes. An overview of the new risks was provided which included: • LD transformation due to the complexity and number of partners involved. • The re-modelled workforce risk now has a comprehensive risk treatment plan in place, due for completion in December 2017. • The IT infrastructure risk continues to be reviewed and modelled and will be established as a formal new risk shortly. Reporting on the risks in-scope, Dr Sivananthan advised that a new risk in scope had been added to the assurance framework on community mental health services in East Cheshire due to the increasing risks arising from capacity issues. It was noted that the Junior Doctors shortage risk had been archived and the data quality risk score had been lowered reflecting the near completion of the risk treatment plan. A discussion followed regarding the recent discussions at Audit Committee around service redesign and emerging transformation risks. Dr Sivananthan provided an overview of the assessments of emerging risks within the governance structure. The Board of Directors **approved** the report.	
17/18/30	**National Quality Board Mortality reporting guidance overview** Avril Devaney presented the report and provided an overview of the recently issued guidance. The guidance sets out to ensure problems in care are investigated in order to learn and prevent reoccurrence. The following was highlighted: • A mortality task and finish group has been formed to take forward guidance recommendations though quality improvement methodologies. • The guidance stresses that staff must have protected time to undertake investigations. • The importance of continued connections with families during investigations is emphasised. • Current CWP policy on learning from deaths and supporting families is currently being reviewed in line with NQB guidance. The systems working approach to implementation of the guidance was noted as a positive feature. The recent CQC assurance on incident reporting was also noted positively. The Board of Directors **noted** the report.	
17/18/31	**Safer Staffing:** **• a. Six monthly report** **• b. Daily ward staffing figures: May & June 2017**	

	The Chair welcomed Gary Flockhart to the meeting. The report was presented the meeting and the following points were highlighted: • The report covers staffing levels from November 2016 to April 2017. This is the sixth report to the CWP Board of Directors. • Ward reviews have been undertaken using the Hurst safer staffing model. The reviews have a number of recommendations predicated on the ward type. • Reviews of impacts on breaks/ staff activities cancelled due to staffing levels/ clinical activity. Resource managers report on the cancellation of staff activities and will be reporting into future safer staffing groups. An escalation of breaks form has been introduced to allow analysis and understanding of why staff are not taking breaks to ensure that action is taken to manage staff breaks to support staff health and wellbeing. • Of the follow up actions relating to E-Roster update, one objective remains outstanding around the roster policy update. • Widening the consideration of the MDT in relation to safer staffing has been looked at further following a review of occupational therapy and it was agreed that these staff should be included in the next six monthly report. Gary Flockhart concluded by providing an overview of the five recommendations. A discussion followed. The report was positively received by Board members with the focus on MDT elements and the future inclusion of pharmacy noted as pleasing developments. Additionally, the levels of analysis within the report were highlighted as giving good levels of assurance. A further discussion followed on the MDT and looking at the role of extended practitioners in AHPs. Recent discussions in LD services show staff to be very keen to develop their careers in CWP and advanced workforce modelling will support this. Staff are anchored in their own registration but they should have the flexibility to work across professional boundaries. CWP is encouraging teams to start thinking more laterally as multi-professional roles will become the system norm, but we have to create the pathways to drive this, looking at longer term skill mix. The Board of Directors **approved** the report and recommendations. Gary Flockhart updated the Board on work on community mental health teams which has commenced as part of the CWP Forward View. The current position is that there is a lot of variation in how teams implement the clinical model and there are inconsistencies in caseload profiling meaning that reviewing overall complexity in caseload management is difficult. A task and finish group has been established to take forward this work on standardisation. Gary Flockhart also updated that in physical health, a safe caseload group is in place to monitor caseloads in physical health services. There is recognition that caseloads vary dramatically particularly in district nursing. • **daily staffing for May and June 2017** It was felt that the data in this report had been adequately covered by	

	discussions as part of the previous item. The Board of Directors **noted** the report. (Gary Flockhart left the meeting)	
17/18/32	**Data Security, Caldicott3 and the new General Data Protection Regulation (GDPR).** Dr Faouzi Alam presented the report and advised the Board that the CQC undertook a review of data security in the NHS and in parallel Dame Fiona Caldicott, the National Data Guardian (NDG), was asked to develop new data security standards and a method for testing compliance. A national draft compliance tool has been published for consultation and the final version will form part of the revised information governance toolkit. The NDG was also asked to recommend a new consent model for data sharing in the NHS and social care, known as Caldicott 3. A combined action plan has been developed in the Trust to monitor compliance with the data security standards and the new consent model. It also incorporates the new General Data Protection Regulation (GDPR), due to come into force in May 2018 The action plan is broadly on track with any amber rated actions due to being work in progress or work awaiting national developments. The Records and Clinical Systems Group are monitoring the action plan. The Board of Directors **noted** the report. (Andrea Hughes joined the meeting)	
17/18/33	**Annual Report 2016/17: Safeguarding Children and Adults** Andrea Hughes presented the report and the following points were highlighted: • The 2016/17 annual report is reflective of the complexity of safeguarding activity across the Trust in the period which reflects the national picture. • Overall training compliance levels of 89% were achieved. • Participation in Serious Case Reviews totalled 6 reviews and 11 learning reviews which has been challenging for the team to support due to capacity. There has been acknowledgement from partners on the quality of CWP reports. Directors commended the report. It was acknowledged that safeguarding is complex and pressurised and a query was raised regarding support to the team. Andrea Hughes advised that support is provided through regular supervision. It was noted that the team is a limited resource and they have incurred a significant increase in demand which is likely to continue. It was noted that this is an area of strength and expertise and whether the service has potential for system wide development. Avril Devaney advised that some early discussions had been held with CCGs to look at the potential to pool some resource and share expertise. The Board of Directors **noted** the report.	

17/18/34	**Annual Report 2016/17: Infection, Prevention and Control** Andrea Hughes presented the Infection, Prevention and Control (IPC) Annual Report 2016/17 and highlighted the summary of achievements. These included: • The Trust had incurred no preventable MRSA and C- Diff cases in the year. • There is a focus on needle stick injuries which will be addressed through the further development of a safe sharps programme. • Good IPC practice by clinicians and their responses to outbreaks on inpatient wards has led to a lower number of infected individuals. • IPC training compliance in 2016/17 was 81%. There will be a drive to improve this in 2017/18 by refreshing the training programme. • A sepsis care improvement programme has been developed which is due for roll-out in August 2017. The IPC team consistently uphold standards of appropriate antimicrobial usage. • High levels of target achievement by the facilities cleaning teams as set out in the National Standards of Cleanliness code of practice. The Board of Directors **noted** the report and approved the work programme for 2017/18. (Andrea Hughes left the meeting)	
17/18/35	**Annual Report 2016/17: Medicines Management** Dr Anushta Sivananthan introduced the report. Thanks were extended to Jasmeen Islam who is currently undertaking the interim Chief Pharmacist Officer position in place of Fiona Couper. Dr Sivananthan highlighted the following points: • CWP operates a medicine formulary to support with appropriate prescribing in an efficient and effective way. • There has been improved patient safety, through enhanced management of incidents and learning from these via the Medicines Safety Officer. • Developments in antimicrobial stewardship both for inpatient care and physical health services. • A reduction of patient harm using quality improvement methodologies for medicines optimisation. • Developments in prescribing guidance as ratified by Medicines Management Group for implementation across services. • The increasing value of the Pharmacy Team in multidisciplinary team working. Lucy Crumplin queried the current tenure of contract with Lloyds pharmacy and the present market position on suppliers. The Board were advised that the contract is shortly due for renewal however there are options for contract extension. There is potential for collaboration with other Trusts on this. Sheena Cumiskey advised that Jocelyn Solly House hold excellent leaflets explaining about medications for people accessing services and there is a need to ensure these are available on the Trust website.	

	Action: Communications team to check on availability of medicines leaflets on the CWP website. The work of the pharmacy team was commended, particularly in light of them being relatively small team and also their external connections across the sector. Avril Devaney commented on the potential for non -medical prescribing is as an area for strategic development. A pilot has started in East Cheshire which needs further review and modelling to assess future potential. The Board of Directors **noted** the report.	**KW**
17/18/36	**Matters of Governance:** **a. Guardian of Safe Working hours (Junior Doctors) quarterly declaration** Dr Faouzi Alam presented the quarterly report and confirmed there had been no breaches to Junior Doctors working hours and that there is a system in place to monitor compliance. Further work is to be undertaken with the team to further shape future reports to ensure they are fit for purpose. The Board of Director **noted** the report. **b. Medical Appraisal and Revalidation** Dr Faouzi Alam presented the annual declaration of appraisal revalidation. 107 doctors are employed by CWP. The revalidation cycle is a 5 year cycle. 2016 was the end of the last cycle and all doctors were revalidated except two, due to longer term sickness or maternity leave. The cycle has now commenced again. Appraisals have been completed for 101 doctors; the remaining 6 were on sick or maternity leave. A priority for this year is reviewing the quality of appraisals. There is assurance that the process is good but there is a need to look at quality. The Board of Directors **approved** the report and approved the submission of the Chief Executives declaration of statement of compliance, on behalf of the Board. **c. Fit and Proper Persons Register of Checks and Declarations** David Harris updated the Board on the Trust's approach to upholding the Fit and Proper Persons regulations. The Board were reminded that for existing directors, an annual self-declaration is undertaken along with annual searches of the disqualified and insolvent Directors registers. Annual appraisals for both Executive and Non-Executive Directors will also include a review by the appraiser of individuals continued compliance with the regulations. An internal audit will also be undertaken later this year to provide additional assurance around compliance. It was noted that the Trust must ensure that people with mental health conditions should not be disadvantaged by the regulations when Director roles are being recruited to. It was noted that the Trust recruits on the basis on individuals having the skills and expertise to undertake the role.	

	d. Register of Seals 2016/17 The Register of Seals for 2016/17 was review. The Board of Directors **noted** the Register of Seals for 2016/17.	
17/18/37	**Audit Committee reporting:** • Chair's report of meeting held 4 July 2017 Edward Jenner (Chair of Audit Committee from 1 July 2017) gave an overview of items discussed.	
17/18/38	**Quality Committee reporting :** • Chair's report of meeting held 5 July 2017 Rebecca Burke Sharples provided an overview of discussions at the recent Quality Committee. It was noted that this meeting had been in-quorate therefore all decisions to be formally ratified at the next meeting.	
17/18/39	**Review of risk impacts of items discussed** All risks had been adequately covered during the meeting.	
17/18/40	**Any other business** The Chair offered members of the public gallery an opportunity to comment on meeting proceedings. There were no further items of business.	
17/18/41	**Review of meeting** All agreed the meeting had been effective.	
17/18/42	**Date, time and place of next meeting:** Wednesday 27th September, 9.30am, Boardroom, Redesmere.	

Signed

Mike Maier, Chair

Date:

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

Action points from Board of Directors Meetings
July 2017

Date of Meeting	Minute Number	Action	By when	By who	Progress Update	Status
26.7.17	17/1835	**Annual Report 2016/17: Medicines Management** Communications team to check on availability of medicines leaflets on the CWP website.	August 2017	KW	This has been confirmed by the Comms team	Closed

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 [August data]
Agenda ref. no:	17-18-50.
Report to (meeting):	Board of Directors
Action required:	Discussion and Approval
Date of meeting:	27/09/2017
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
Click here to enter text.	
Does this report indicate any new strategic risks? If so, describe and indicate risk score:	
See current integrated governance strategy: CWP policies – policy code FR1	No
Click here to enter text.	

REPORT BRIEFING

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

The 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 August 2017 Performance.

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

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

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 5 with the following metrics being off track from the indicative baseline:

- Priority project 4: Redesign Adult & Older People MH Services Central and East; and
- Priority project 5: LD Transforming Care; and
- Priority project 6: Community Mental Health Teams Review

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 August 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:	Click here to enter text.

Distribution to other people/ groups/ meetings:

Version	Name/ group/ meeting	Date issued
1	Tim Welch	14/09/2017

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	August 2017 Board Operational Plan Dashboard. Operational Plan 2017/18 – Delivery Indicators/ Board KPIs

Appendix 1: Trust Dashboard

	Indicator	Outturn 2016/17	Target or Thresholds for escalation	Q1	Jul-16	Aug-16	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)	65.4	75.3	80.8	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	785	269		Baseline may change, following the setting of the baseline at Q1
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%	87.72%	87.26%	
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%	4.14%	4.44%	This is the first month performance has risen above the target. This will be monitored and be escalated in line with any quarter in which each of the three months the staff vacancy rate is above the base line position
SO3: 2.2	Competence: % of staff receiving annual appraisal (via new proposed framework)	97.6%	100.0%	95.72%			Please note outturn position has been updated to reflect position as at the end of 2016/17.
SO3: 2.3	% staff absence due to sickness	5.04%	Above annual plan projection for 3 months	5.46%	5.47%	5.43%	Performance measurement against Annual Plan Trajectory. Please n
Operational Performance / Priority areas							
SO3: 3.1	100% of the 13 NHSI operational performance targets achieved (including waiting times)	100%	100%	100%	100.00%	100.00%	Please note outturn position has been updated to reflect position as at the end of 2016/17.
SO3: 3.2	100% Contractual targets met	324 (98.1%)	100%		96.9%		Wirral CCG -10 indicators have been red for 3 or more months [6 due to underperformance, 4 due to over performance West Cheshire CCG Physical Health - 1 indicator has been red for 3 or more months due to underperformance
	CQUIN performance quarterly review	TBC	100%				Reporting for this indicator will be two months after the end of a quarter
SO3: 3.3	Priority project 1: West Physical Health Financial Recovery Plan	N/A	Delivery of Key Milestones				
SO3: 3.4	Priority project 2: Starting Well 0-19 services	N/A	Delivery of Key Milestones				
SO3: 3.5	Priority project 3: CAMHS T4	N/A	Delivery of Key Milestones				
SO3: 3.6	Priority project 4: Redesigning Adult & Older Peoples MH Services In Central and East Cheshire	N/A	Delivery of Key Milestones				External sign off of the draft consultation documents is still required. Presentation to Governing Bodies and OSC has been delayed by a month to October; this will impact upon the public consultation timetable. The CWP project programme is being amended to reflect the revised timescales.
SO3: 3.7	Priority project 5: LD Transforming Care	N/A	Delivery of Key Milestones				Exec decision sought on bed costs.
SO3 3.8	Priority project 6: Community Mental Health Teams Review	N/A	Delivery of Key Milestones				Due to the current degree of immaturity associated with this project
Strategic Objective 6: Financial Planning							
SO6: 1	Use of resources		Use of Resources [UoR]	3	3	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 Lead	Operational 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
SO3: 3.2	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
	CQUIN Achievement of milestones	(100% of CQUIN Milestones achieved)		Report quarterly on CCG confirmed achievement against milestones	By exception	Operational Board	written report	Andy Styring/ Tim Welch	Service Directors	Risk 14 Financial performance/ CIP delivery (rated red 16)
SO3: 3.3	Strategy priority 1: CAMHS T4	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	Sharon Vernon	Risk 13 – tendering of services (rated amber 12)
SO3: 3.4	Strategy priority 2: West Cheshire 0-19 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	Andy Styring	Val Sturgess	Risk 13 – tendering of services (rated amber 12)
SO3: 3.5	Strategy priority 3: Local implementation of the transforming Learning Disability services strategy	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	Kate Fleming	

SO3: 3.6	Strategy priority 4: Physical Community Services (South & Vale Royal contract)	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	Karen Moore	Risk 13 – tendering of services (rated amber 12)
SO3: 3.7	Strategic priority 5: Developing potential options for enhancing inpatient provision	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	Suzanne Edwards	
SO3: 3.8	Strategic priority 6: West Financial Recovery Plan	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	Jane Palombella	Risk in scope re. IAPT delivery
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	

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

STANDARDISED REPORT COMMUNICATION

REPORT DETAILS

Report subject:	Involvement and Volunteering Progress Report
Agenda ref. no:	17-18-51
Report to (meeting):	Board of Directors
Action required:	Discussion and Approval
Date of meeting:	06/09/2017
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	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*

In November 2016, the Trust's Quality Committee agreed that there should be a review of the Involvement Programme. This paper provides a description of work so far and a draft proposal for reward and recognition for involvement and seeks ratification prior to submitting to Board for approval.

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

Involvement plays a crucial role in the National Health Service (NHS) as a whole and in Cheshire and Wirral Partnership NHS Foundation Trust (CWP). Listening to the views of people with lived experience ensures that the Trust routinely takes into account, and responds to, the experience of service users and carers in its everyday work, including service planning, service re-design and service monitoring. This deeper appreciation of patient and carer experience has led the Trust to develop a Person Centred Framework which aims to embed these values into everything it does. The aim of the involvement review was to develop an involvement scheme for 2017 and beyond that is inclusive , transparent and fair within a robust governance framework.

Assessment – *analysis and considerations of options and risks*

The document at Appendix 1 contains a draft framework. The framework was co-produced by the Involvement Task and Finish Group. The Framework outlines a model of involvement that acknowledges the diverse ways in which people can get involved and be rewarded; it embraces service users, carers, volunteers, and members of the public. The next steps will be to develop an implementation plan and it is intended that the new approach will be introduced in January 2018.

The Framework is underpinned by relevant national legislation and CWP policies. It was discussed at the Patient and Carer Experience (PACE) Sub-committee on 9 August 2017 with the recommendation that it be taken for ratification to Quality Committee – 6 September 2017, Operations Board – 20 September 2017 and for approval to Trust Board – 27 September 2017.

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

The Board of Directors are recommended to **approve** the new Involvement framework.

Who/ which group has approved this report for receipt at the above meeting?	Cathy Walsh, Associate Director of Patient and Carer Experience (interim)
Contributing authors:	Jane Holland Head of Participation and Inclusion Development Social Inclusion and Participation Team Mersey Care NHS Trust Cathy Walsh, Associate Director of Patient and Carer Experience (interim)

Distribution to other people/ groups/ meetings:

Version	Name/ group/ meeting	Date issued
1	Quality Committee	31 August 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
Appendix 1	Involvement and Volunteering Progress Report

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

17-18-51 Appendix 1

Involvement and Volunteering Progress Report

1. Background

Since the beginning of the 21st century the needs of service users has been recognised in legislation and policy documents; one result of this focus was that it brought service user and carer involvement to the fore. Involvement plays a crucial role in the National Health Service (NHS) as a whole and in Cheshire and Wirral Partnership NHS Foundation Trust (CWP). Listening to the views of people with lived experience ensures that the Trust routinely takes into account, and responds to, the experience of service users and carers in its everyday work, including service planning, service re-design and service monitoring. This deeper appreciation of patient and carer experience has led the Trust to develop a Person Centred Framework which aims to embed these values into everything it does[1].

2. Introduction

The main purpose of involvement is to improve the effectiveness, experience, efficiency and safety of services for patients and carers. The Trust has developed its approach over the years from a corporate (meetings) focused approach to a more locality focused approach and we now have participation workers across all localities to support involvement as well as a Patient And Carer Experience Team who support trust wide activity.

A budget of £30,000 is ring fenced to support people with lived experience who support the Trust as involvement representatives. There is no intention to reduce this budget but there is a commitment to ensuring it is used most effectively to support involvement. Currently out of the total budget, an honorarium of £8.50 per hour plus travel expenses is offered to all those who get involved, irrespective of the type or quality of involvement.

Running alongside the Involvement Programme is a Volunteer Programme; new roles have been developed over the years including Peer Support Worker and Lived Experience Connector. The two approaches have become increasingly blurred and there is a need for clarity on roles and rewards.

In November 2016, the Trust's Quality Committee agreed that there should be a review of the Involvement Programme in order to develop and involvement scheme for 2017 and beyond that is inclusive, transparent and fair within a robust governance framework.

[1] http://www.cwp.nhs.uk/about-us/our-campaigns/person-centred-framework/

The Involvement Review

Locality events and questionnaires enabled people to take part in shaping the involvement review during June 2017; participants were asked to describe how they saw involvement currently and in the future. In summary, people wanted a wider cross section of individuals to be involved and a broader range of non-financial rewards.

A Co-production Involvement Task and Finish Group met on four occasions to develop a draft proposal around:

- Type of involvement
- Type of activity associated with the involvement
- Type of reward and recognition associated with the activity

The Framework is underpinned by relevant national legislation and CWP policies. It was discussed at the Patient and Carer Experience (PACE) Sub-committee on 9 August 2017 with the recommendation that it be taken for ratification to: Quality Committee – 6 September 2017 Operations Board – 20 September 2017 and for approval at Trust Board – 27 September 2017

1. The Framework

The Draft Framework at Appendix A was co-produced by the Involvement Task and Finish Group.

The Framework outlines a model of involvement that acknowledges the diverse ways in which people can get involved and be rewarded; it embraces service users, carers, volunteers, and members of the public.

1.1. Voluntary activity

It clarifies which activities will be co-produced and co-delivered on a voluntary basis; travel and out of pocket expenses will always be reimbursed in these instances.

1.2. Employment activity

Some activities are identified as being provided in co-production and co-delivery under direct line management by staff. In these instances people getting involved will be required to be employed by the Trust either directly or through the Bank, fulfilling role descriptions that have been agreed under the Agenda for Change process. In this way the activity can be governed under the auspices of the People Services through well established strategies and recruitment and employment policies.

1.3. Procured activity

Procured activities will be time limited and subject to CWP procurement regulations and HMRC IR35 Guidance on Working through an Intermediary, with defined targets and outcome measurements.

Underpinning the entire Framework is the philosophy that CWP seeks to give those involved with the Trust, in whatever capacity, a package of support that facilitates individual recovery and social inclusion in a person centred way; allowing them to move on to a meaningful pathways beyond the Trust.

It is proposed that CWP replaces its current Involvement Programme with this new model open to service users, carers, volunteers and members of the public on a voluntary basis.

In the main, the rewards and recognition involved in this model will not involve monetary payment, rather they will be focussed on investment in skills and development that enhance the quality of the individual's gift to the Trust and support their personal and social development.

2. Implementation

It is proposed that two Co-production Implementation Task and Finish Group work streams be established to consider the finer aspects of a future Involvement Programme and produce a detailed implementation plan in order to ensure that the change and resultant communication is handled coherently, effectively and sensitively. The work streams will concentrate on:

- Further developing involvement in CWP's approach to values based recruitment
- Processes to support the move to the new Involvement Programme

Information on the draft proposal has been provided to participation and engagement workers, to involvement representatives, both those who attended the task and finish group and those that expressed an interest to attend. In addition it was distributed to the CWP governors and featured in 'CWP Essentials' to enable staff to feedback.

The work streams will formulate an agreed definition of co-production and finalise their proposals in an implementation plan at the end of November 2017 with a view to implementation in early January 2018.

Authors

Jane Holland
Head of Participation and Inclusion Development, Mersey Care NHS Trust
Cathy Walsh
Associate Director of Patient & Carer Experience, CWP.

Proposed Guidance in relation to Reward and Recognition for Involvement

Type of Involvement	Type of Activity	Reward and Recognition	Relevant Legislation and CWP Policy
Voluntary	Co-production and delivery of: • Peer training, courses and workshops. • Peer learning support, coaching and mentoring, including facilitation of peer special interest groups and activities. • Learning support for staff during training e.g. Lived Experience Connectors • Communication and PR materials e.g. leaflets, guidance and information. • Input into Trust committees, meetings, focus groups and other discussions, for example, to develop services, policies and/or strategies for service delivery. • Research, audits and surveys. • Capturing patient and carer stories • Values based recruitment and selection processes e.g. stakeholder and observation panels • Service visits to aid improvement e.g. PLACE, Compliance, 15 Step Challenge • Support for staff in the Trust which aids the volunteers own personal development e.g. administration	Payment of travel and subsistence allowances via the payroll in accordance with HMRC legislation*. Reward and recognition could also include: • A person centred development plan. • Certificated training and development opportunities. • Coaching, mentoring and supervision. • Support in accessing the world of work, including access to internal vacancies (for those wishing to pursue this). • Access to the Workforce Wellbeing Service. • NHS Discounts. • Confidence building. • Networking/socialising opportunities, including with other Trusts. • Recognition and celebration of achievement events. A small token of appreciation may be awarded at these events. • Written acknowledgements/thank you/feedback letters. • Valuing each other – recognition that all staff and reps involved have something valuable to bring to the process.	HR20 Volunteerin policy and proced
Employment (including via Bank)	Co-production and delivery under line management of: • Formal staff training, courses and workshops. • Commissioned pieces of specific work e.g. CCG requiring consultation with the Young Advisors. These projects could be commissioned by the Trust (including using fixed term funding, CQUINN etc.), individual departments or external organisations e.g. CCG.	As above, plus payment via payroll in accordance with the agreed Agenda for Change rate of pay for the post, travel and subsistence and HMRC legislation. Access to Apprenticeships for those working more than 16 hours per week.	HR2.1 Recruitme and selection polic HR2.2 Pre-employment c

Procured Services (including working through an intermediary e.g. a Social Enterprise or Agency)	Responsibility and accountability for the design, development and delivery of specific time limited projects or pieces of work in line with pre-determined objectives, outcomes and service specifications. Examples include projects like: strategic development of the Peer Support Programme, Experience Based Design, developing a Self-care Hub for specific conditions e.g. diabetes. Amongst other things, these projects or pieces of work may include identifying and bidding for funding, working with external organisations and developing and implementing strategies, policies, procedures and associated training programmes for the Trust. These projects could be commissioned by the Trust (including using fixed term funding, CQUINN etc.), individual departments or external organisations e.g. CCG. All service specifications will include quality improvement standards and will ensure that the work undertaken will enable the Trust to meet its purpose, vision and values. **Our purpose:** To help people be the best they can be. **Our vision:** To lead in partnership to improve health and wellbeing by providing high quality care. **Our values:** Courage, care, competence, compassion, commitment and communication.	As for voluntary, but with payment in accordance with CWP Procurement regulations and HMRC legislation, as follows: The Trust Head of Human Resources and/or Head of Resourcing will use the HMRC Employment Status Indicator Tool to determine employment status for each piece of work. If the tool indicates that an individual has employment status (for tax purposes) they will be paid via a payroll. Where intermediaries are provided through a third party such as their own Limited Company, a Social Enterprise or other Agency, the Trust will need to inform the third party whether it considers that the Intermediaries Legislation (IR35) applies and whether the individual will need to be paid via their payroll. If services are provided by an individual, they may be issued with a contract of/for service by the Trust and paid via the Trust payroll. Where it is deemed that the employment status is one of self-employment (for tax purposes) e.g. sole traders, then individuals may continue to be paid via invoice and will remain responsible for making their own arrangements directly with HMRC. Before entering into any arrangements to procure services, managers are required to contact the Head of Human Resources and/or the Head of Procurement (depending on the value of the contract – see Corporate Governance Manual for further details).	Corporate Governance Manu Recruitment Proce IR35 flow chart 20 HMRC IR35 Guidance on Working Through an Intermediary

***HMRC Business Car Mileage Rates**

Type of Transport	First 10,000 miles	Each mile over 10,000
Cars and vans	45p	25p
Motor cycles	24p	24p
Bicycles	20p	20p

Second class rail and bus fare can also be reimbursed, with submission of tickets, outside of the payroll process. Taxi fares may also be reimbursed in this way, with the submission of a receipt, where the Person Centred Plan recognises the need for this form of transport.

***HMRC Subsistence Rates**

Description	Amount (up to)
Breakfast rate	£5
One meal (5 hour) rate	£5
Two meal (10 hour) rate	£10
Late evening meal rate	£10

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

Report subject:	Learning from Experience report – trimester 1 2017/18 (incorporating an update on the national Learning from Deaths framework)
Agenda ref. no:	17-18-52
Report to (meeting):	Board of Directors meeting in public
Action required:	Discussion and approval
Date of meeting:	27/09/2017
Presented by:	Avril Devaney, Director of Nursing, Therapies & Patient Partnership

Which strategic objectives this report provides information about:	
Deliver high quality, integrated and innovative services that improve outcomes	Yes
Ensure meaningful involvement of service users, carers, staff and the wider community	No
Be a model employer and have a caring, competent and motivated workforce	Yes
Maintain and develop robust partnerships with existing and potential new stakeholders	Yes
Improve quality of information to improve service delivery, evaluation and planning	Yes
Sustain financial viability and deliver value for money	Yes
Be recognised as an open, progressive organisation that is about care, well-being and partnership	No
Which CQC quality of service domains this report reflects:	
Safe services	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	

1. Situation

This Learning from Experience report aggregates qualitative and quantitative analysis from key sources of feedback from people who access the Trust's services and people who deliver the Trust's services, and other relevant sources of learning, covering the period from April 2016 to July 2017, trimester 1 of 2017/18. The report compares current performance across a four trimester time series to mitigate seasonal variations, whilst also facilitating the identification of potential triggers to detect and prevent incidents by comparing current performance with the previous trimester.

The in-depth Learning from Experience report received by the Quality Committee in September 2017 piloted the use of Statistical Process Control (SPC) charts to help with more effective and visual depiction of learning from experience and identification of recommendations, as well as to alert, as part of an early warning framework, any emerging trends. This report will be emergent in its use of SPC, which will be reflected more in future reports to the Board of Directors.

2. Background – Key performance indicators

2.1 Performance indicators

Performance indicator			2016/17 T1	2016/17 T2	2016/17 T3	2017/18 T1	4-trimester trendline
Number of safety incidents reported			**3379**	**3027**	**3178**	**3186**	
Number of safety incidents by speciality	*Inpatient*		*2202*	*2010*	*2002*	*2154*	
	Community physical health		*674*	*577*	*742*	*602*	
	Community mental health		*434*	*359*	*364*	*370*	
	Other		*69*	*81*	*70*	*60*	
Mortality monitoring	Inpatient deaths (including deaths 30 days after discharge)		7/ *43%	5/ *80%	9/ *78%	3/ *100%	
	Deaths reported to the Trust		**732/ *10%	**660/ *17%	**628/ *14%	**477/ *16%	
Reports to external agencies	**StEIS** (not including incidents withdrawn, e.g. pressure ulcers not meeting threshold)		52	69	45	**33**	
	National Reporting & Learning System		1790	1418	1686	**1576**	
	NHS Resolution	Non clinical claims	8	4	2	**0**	
		Clinical claims	2	0	1	**1**	
	NHS Protect	Staff assaults/ Involving police	324	288	258	**288**	
		Missing patient	46	40	36	**44**	
		Suspected theft	5	8	5	**3**	
		Damage to property	11	24	19	**18**	
		Lost or missing items	82	75	92	**65**	
Number of complaints			90	124	108	**82**	
Number of compliments			1267	987	1040	**822**	

All incident and compliment numbers above and as detailed in the main body of this report represent a snapshot at the time of publication of the report and are subject to change over time, for example: re-categorisation of incidents following receipt of further information since the previous report, receipt of compliments retrospectively.

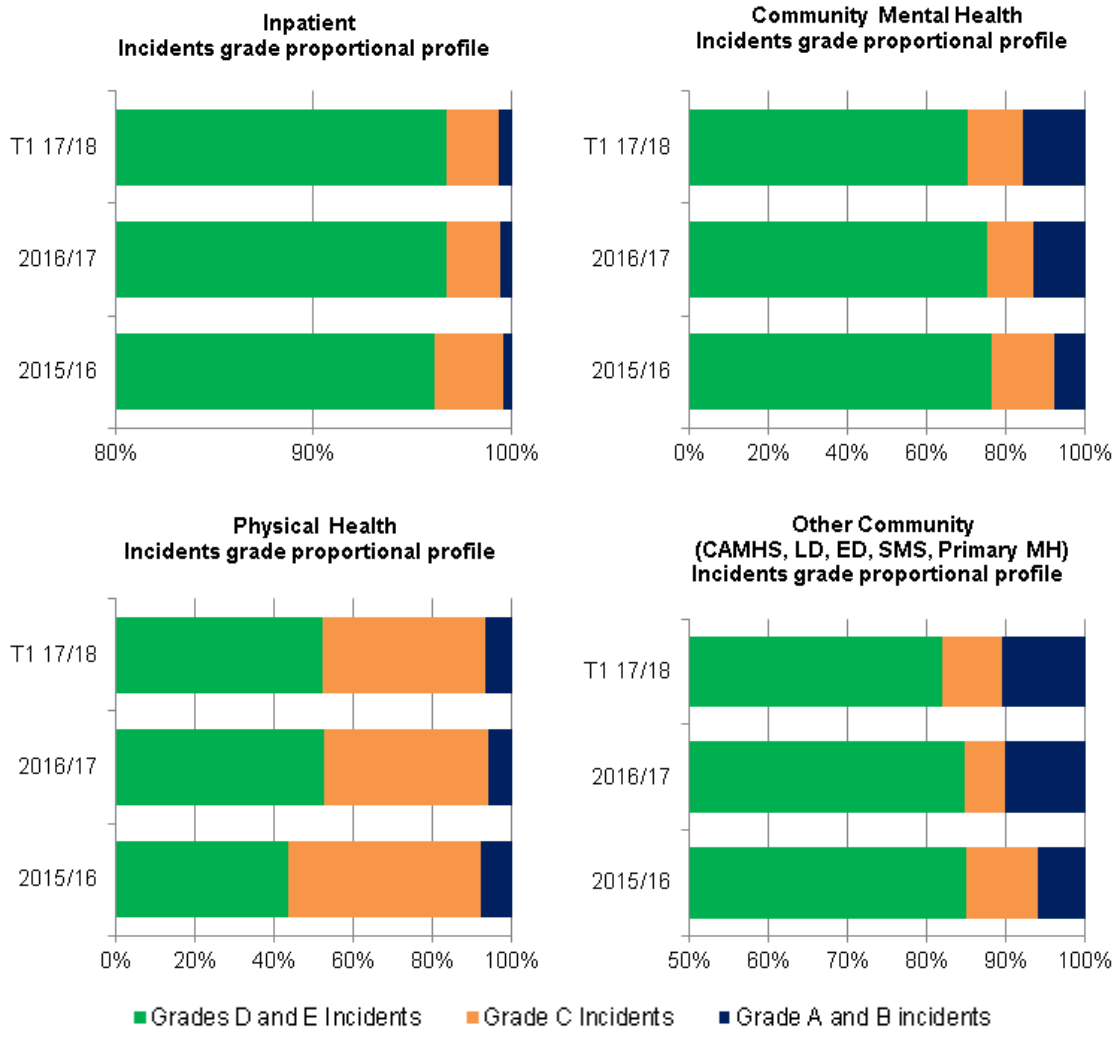
*The application of a case record/ note review to determine whether there were any problems in the care provided to the patient who died in order to learn from what happened.

**Denominator is all deaths reported on CAREnotes, EMIS and PCMIS, less inpatient deaths, where there has been an episode of care open to CWP.

2.2 Proportional reporting performance indicators – Incident reporting

The Heinrich model is a variation of 'proportional reporting' which measures against a fixed target or ratio. CWP has successfully been using this as a guide to monitor how services report different severities of incidents and thus the maturity of the organisational safety culture. Its limitation is that it was designed for a manufacturing process. Removing the Heinrich fixed ratio and instead measuring against the specific history and service specifications of a service type achieves the first stage of the Quality Account aspiration to develop how CWP measures incident reporting profiles – for example physical health community teams reporting profiles are influenced by pressure ulcer incident reporting because of the way they are reported as required nationally.

The charts below show a proportional split of incident grades measured against the previous two financial years and are grouped to four service type levels: Inpatient, Community Mental Health, Other Community (CAMHS, Learning Disability, Eating Disorder, Substance Misuse Services, Primary Mental Health) and Physical Health.



By presenting the incident reporting profiles in this way, the charts reveal fundamental differences between the service types that can be used to identify where focus is needed to reinforce the Zero Harm message that reporting no or lower harm incidents promotes learning to be able to potentially mitigate future actual or significant harm incidents. The charts can further inform potential opportunities for both Service Improvement and Quality Improvement activity.

The next step will be to further refine the four levels, with consideration whether the:

- 'other community' group should be broken down to smaller specific service types;
- levels are reset as per the emerging care groups;
- inpatient groups should be further divided between inpatient speciality.

3. Analysis

3.1 Incidents

3.1.1 Incident reporting

Analysis of the last four trimesters of incident reports shows little variation in the number of incidents reported. The number of incidents reported in trimester 1 of 2017/18 *n. 3186* is an increase on the previous reporting period but there is still scope to increase this further towards the real time (since April 2015) median *n. 3301* incidents.

33 serious incidents were reported to StEIS, a decrease of 12 on the previous reporting period. There has been a downward trajectory since April 2015 in the number of serious incidents reported and there is currently a downward trend. Detailed statistical process control reporting to the Quality Committee suggests that the current reporting period's downward trend could be temporal, whilst the longitudinal reporting remains within all statistical process control limits.

The top ranking incident reporting categories remain consistent, with self-harm continuing to be the highest reported incident type. Of the top ranking incident reports, there is no significant variation in the numbers of incidents reported, with the exception of a 39% increase in the number of Estates and Facilities incidents. In-depth analysis provided to the Quality Committee indicated that this is associated with an increase in the reports of incidents where patients had access to an ignition sources. This relates mainly to the Rosewood unit; the Nicotine Replacement Therapy Lead has been identified to work with the team to build their confidence in applying safety critical policies that will enable the maintenance of safe environments for people who access and deliver services.

3.1.2 Mortality reporting

As per the expectations of national guidance regarding improving learning from deaths and mortality reporting, CWP is continuing to increase the learning from those deaths reported to the Trust that do not meet the criteria as a serious incident.

In July 2017, NHS Improvement published further guidance following on from the National Quality Board guidance: 'Implementing the Learning from Deaths framework: key requirements for Trust Boards'. NHS Improvement is encouraging NHS trusts to learn from each other and challenge each other to continuously improve the quality of their learning from deaths processes and the implementation of effective and sustainable improvements as a result. CWP has been working closely with Mersey Care NHS Foundation Trust to ensure a consistent and collaborative approach as this agenda evolves.

A quality improvement project plan has been implemented and was reported to the July 2017 Board meeting in public, outlining Board requirements associated with the learning from deaths agenda. The requisite Trust policy on learning from deaths and engaging with bereaved families and carers has been developed and was presented and approved by the Quality Committee in September 2017. This reflects the progress of the work of the Trust's Mortality Task and Finish group, which is chaired by the Director of Nursing, Therapies & Patient Partnership as executive lead for the national learning from deaths agenda, which is now overseeing a pilot of a structured case record review template (to review and learn from all deaths reported to the Trust) via a series of PDSA (Plan, Do, Study, Act) cycles prior to roll out Trustwide.

3.2 Falls incidents

There has been a further Trustwide decrease in the number of reported falls this trimester from 154 to 146, of which 98% of these resulted in either low or no harm. Quality improvement work is continuing (in both inpatient and community settings) in line with the Trust's Zero Harm continuous improvement plans. The first Quality Improvement Report 2017/18, also being received today by the Board meeting in public, demonstrates the improvements made to care where we have learned from experience.

3.3 Incidents associated with the management of challenging behaviour

There were three prone position restraint incidents reported in May 2017, this was the lowest since the monitoring commenced in May 2015. The Wirral locality and Central & East localities reported no instances of prone position restraint in May 2017. The July 2017 Quality Committee recognised the amount of work that has been done, and the significant progress achieved so far, and is therefore has confidence in the ambition to achieve consistent runs of zero prone position restraint incidents and that where these do occur by exception, a comprehensive review is undertaken to identify the maximum learning in order to mitigate future incidents. It therefore endorsed a 90-day quality improvement cycle to work towards this ambition, which will report to the next two meetings of the Patient safety & Effectiveness Sub Committee and will be overseen by the Quality Committee.

3.4 Medication incidents

On 1 April 2017, revised medication incident categories and sub categories were introduced in Datix to more accurately align to the *National Reporting & Learning System* (*NRLS*). These changes, together with the introduction of the Medication Safety Officer giving final sign-off of medication incidents will lead to improved data quality. The medication incident categories have been separated into patient safety incidents, non-patient safety incidents, and other. Administration of medicines incidents and prescribing incidents both show minor increases in reporting compared with the previous reporting period.

3.5 Pressure ulcer incidents

255 pressure ulcers that developed whilst under CWP's care were reported this trimester, an increase of 12 incidents compared with those reported in the previous trimester's report. This trimester, 46 stage 3 or 4 pressure ulcers were reported and were classed as unavoidable pressure ulcers using approved evidence based criteria following local review, this represents an increase of one incident since the last trimester. Stage 3 and 4 pressure ulcers are reported as grade B incidents and a local RCA investigation is undertaken, dependent on the findings of local review. The learning is shared with the Trust's tissue viability service and is communicated back to the teams. Community care teams have shared learning following a serious incident investigation where it was identified that staff could improve their practice further by assessing the risk of malnourishment when undertaking assessments of patients' skin integrity. The importance of ensuring patients' opinions and thoughts being more robustly recorded in the nursing record, along with recording their consent, was also reflected in clinical discussions following the sharing of learning.

3.6 Safeguarding learning from Serious Case Reviews (SCRs)

There have been no SCRs published this trimester.

3.7 Feedback from people who access the Trust's services

During this trimester, the Trust received 82 complaints under the NHS complaints procedure. Of these, they were received per locality as follows: CWP East *n. 27* complaints, CWP West *n. 35* complaints, CWP Wirral *n. 17* complaints and Corporate Support Services *n. 3*. This represents the lowest number of complaints over the last 4-trimester reporting period. Statistical monitoring suggests that staff attitude as a theme associated with complaints is forecasted to continuously increase, and as such a recommendation has been identified as detailed below in part 4.6.

4. Recommendation

Recommendations from trimester 1 analysis

The recommendations below have been identified from the detailed analysis of learning from experience that is received by the Quality Committee. Updates and assurances received against these recommendations will be presented in the next trimesterly report to the Board of Directors.

4.1 The Quality Surveillance team to work with Clinical Service Managers to review why the community mental health teams and other community mental health specialities appear to be increasingly reporting less lower level harm incidents compared with inpatient teams.

4.2 The Nicotine Replacement Therapy Lead to work with the Rosewood unit regarding repeated incidents associated with access to ignition sources.
4.3 The Mortality task and finish group to oversee the pilot of the structured case record review template and undertake a series of PDSA (Plan, Do, Study, Act) cycles prior to roll out across the Trust.
4.4 Croft Ward Manager to seek peer support and advice from inpatient Matrons across the Trust regarding how other wards apply the guidance detailed in the slips, trips and falls policy.
4.5 The Medication Safety Officer (MSO) should work closely with the Safe Services Department to review those medicines incidents classified as 'other'. Analysis of any trends will be undertaken by the MSO once more data becomes available and as learning is discussed at the Medicines Safety Sub Group to identify improvements.
4.6 Head of Education to consider targeting education and training activities for staff around best practice in providing customer care. Consideration should also be given to current e-learning and mandatory training packages available to staff and whether this is adequate based on the current intelligence gathered from feedback across the Trust and increasing numbers of complaints in this thematic area.

In addition, to strengthen 'ward to Board' assurance, the Quality Committee has agreed to a new approach of seeking this assurance, thus:

Clinical support service teams have been asked to:
- Review the findings and key analysis within the report and identify any changes for improvement required to their enabling work programmes.

Clinical services have been asked to:
- Review the findings and key analysis within the report at locality Learning from Experience groups and identify:
    - Any areas of practice that warrant quality improvement work.
    - Any areas of practice that require enabling support from clinical support services.

An update in respect of the above will be sought for the next report to the Quality Committee.

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

Who/ which group has approved this report for receipt at the above meeting?	David Wood Associate Director of Safe Services
Contributing authors:	Audrey Jones, Head of Clinical Governance Lisa Parker, Incidents Manager David Wood, Associate Director of Safe Services

Distribution to other people/ groups/ meetings:		
Version	Name/ group/ meeting	Date issued
1	Board of Directors	20/09/2017

Appendices provided for reference and to give supporting/ contextual information:	
Appendix number	Appendix title
1	Updates and assurances received against trimester 3 2016/17 recommendations

Appendix 1 Updates and assurances received against trimester 3's recommendations

The incidents team and quality surveillance team to develop the current Heinrich ratio to be more reflective of CWP services.
See section 2.2.
The Incidents and Quality Surveillance teams should meet regularly to review past harm data through to near real time, e.g. data per 10000 community contact rates, to identify early warning of emerging trends to identify and enable potential interventional mitigation strategies.
The Incidents and Quality Surveillance team meet on a fortnightly basis to look at data quality issues in order to ensure monthly extracts are ready to analyse to identify if there is an early warning trend emerging.
The Health & Safety Advisor should review the syringe driver incident reported by the Neston & Willaston Community Care Team to critically appraise the learning identified, whether this learning has been spread across the Trust, and whether it meets the threshold for reporting as a national patient safety alert to help other organisations learn.
The syringe driver incident reported by Neston & Willaston Community Care Team was raised at the North West National Association of Medical Devices Educators and Trainers in February 2017 to share learning across the North West. Learning has also been shared with the Ageing Well monthly governance meeting for learning within community care teams. A 72 hour patient safety review was completed which highlighted a lack of availability of access to e-learning training on syringe drivers for community care teams. The Health & Safety Advisor and Medical Devices and Safety Officer arranged for a representative from McKinleys (manufacturers of the syringe drivers) to provide face to face training for key staff in the community care teams.
The Incidents Manager to produce and implement a project plan to ensure CWP embeds the 'National Guidance on Reporting Deaths' into practice and meets the requirements on the Board to report on mortality reporting and management.
See section 3.1.2.
The Head of Clinical Governance and Head of Compliance to undertake a review of the proportion RCA actions that pertain to the apparent root cause of an incident and furthermore review the recording of learning themes for its appropriateness.
The Head of Clinical Governance reviewed completed investigation actions during 2016/17 in relation to the risk management learning theme. This work will continue to include all themes during trimester 2 of 2017/18. Emerging evidence suggests that it would be helpful to agree the definitions of the learning themes prior to allocating each action to a theme. Investigation templates are being developed so that the investigating manager and localities can identify which theme they believe their actions belong to; furthermore, the template will be developed to identify which actions can be attributed to root causes, contributory factors or missed opportunities. Also, a clearer way of identifying incidental learning will be included. This will then be reviewed by the Serious Incidents Review meeting prior to the locality signing the incident off.
CWP Security and Safety Lead to establish local reporting systems to record local police actions which have been taken as a direct result of staff reporting assaults to the police.
Cheshire Police have developed a report for West inpatient areas, which was presented at the Health & Safety Sub Committee. An action was agreed to establish the same process across all inpatient localities; emails sent to local mental health police liaison leads requesting same. Currently awaiting a reply.
Inpatient Matrons should review the 'failed to return' data for their inpatient unit, collectively with other inpatient Matrons, to understand differences in reporting across all localities and establish if there is any particular good practice that can be shared to benefit the practice in all localities.
This action has been arranged to be discussed at locality learning from experience meetings. Failed to return data will be circulated to inpatient Matrons via the locality data packs.
The Safety & Security Lead should work with partner organisations North West Boroughs Healthcare NHS Foundation Trust and Mersey Care NHS Foundation Trust to understand the variance in reporting and management of incidents resulting in staff assaults.
Meeting arranged as part of regional Security Manager Forum meeting in July 2017 to discuss variance of staff assaults across partner organisations; the North West Boroughs Security Lead did not attend due to current role change and a deputy was not sent to discuss outstanding action. At the Security Manager meeting, the action was discussed; overall no real change in each

organisational policy to reporting each 'non-clinical assault', responses by the Police differed, however findings were in line with CWP experiences. Bowmere Hospital is the only unit to have a dedicated Police Liaison Officer and this was seen as a best practice standard by the group.
The Safe Services Department, in conjunction with inpatient Matrons and other corporate support services, to use a 90-day improvement cycle to accelerate further reductions to prone position restraint incidents.
See section 3.3.
Service line managers should continue to monitor action plans to review administration of medicines incidents, including failure to administer and failure to document the administration and implement improvement actions.
See section 3.4.
For future reporting, the Complaints and Incidents Support Manager to report the number of complaints per community 10000 contacts or 1000 bed days rate to strengthen analysis.
The Complaints and Incidents Support Manager has utilised the inpatient bed days data to analyse complaints further during this trimester. This has included the implementation of statistical process control charts to help identify outlining peaks and decreases in reporting of ward teams across the Trust. The data has provided comparative commentary on areas where there is a noted change and assurances in regards to any areas of concern. The requested community contact data has not been available for this report, this will reported upon within the next report.
The Complaints and Incidents Team Manager to share data around staff attitude with Education CWP and clinical services to consider whether a project group is required to begin targeted work around this recurrent theme.
A discussion took place verbally with Education CWP around this and there is currently a 'Providing customer service' within the CMI (Chartered Management Institute) level 2 course that is provided by Education CWP and customer service modules touched upon in other accredited courses. Upon additional research, the Complaints Team have noted that there is an external e-learning package called 'Mixed Messages' that is accessible via ESR that staff can enrol and complete that targets communication and delivering of information to patients and families. This will be taken to the learning from experience groups across the organisation for awareness and signposting staff to this resource. The Complaints and Incidents Support Manager will also liaise further with Education CWP to understand more about current compliance and any further external learning that could be utilised to this effect (additionally see recommendation 4.6 which has subsequently been identified).
The complaints team should ensure that the new compliments reporting system is efficient and encourage staff to report more positive feedback and examples of good practice.
This continues to be an ongoing project through the delivering of local training and individual feedback received from staff when using the form. The system is continuing to be reviewed in light of new compliments added and adaptations are made as and when requested by staff.

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

Quality Improvement Report

Edition 1
April – July 2017

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

Experience based design project delivers an improved quality of service at Upton Lea (see page 20)

Care • Well-being • Partnership

Welcome to CWP's first *Quality Improvement Report* of 2017/18

These reports are produced three times a year to update people who access and deliver the Trust's services, carers, the public, commissioners, internal groups, and external scrutiny groups on progress in improving quality across our services. We are required to formally report on our quality improvement priorities in the annual *Quality Account*.

CWP's *Quality Account* and *Quality Improvement Report*s are available via:

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

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

At CWP, we are starting to look at ***quality*** in more detail to better demonstrate where we are making real improvements, with the aspiration to achieve **equity** of care through ***quality improvement***. We are using international ways of defining quality to help us with this aim. This edition will focus in more detail on other areas of quality such as the **accessibility**, **affordability** and **sustainability** of care.

QUALITY					
Patient safety	Clinical effectiveness			Patient experience	
Safe	Effective	Affordable	Sustainable	Acceptable	Accessible
Achieving Equity and Person-centred Care through CO-PRODUCTION, CO-DELIVERY, QUALITY IMPROVEMENT & WELL-LED SERVICES					
Delivering care which minimises risks	Delivering care that follows an evidence base and results in improved health outcomes, based on people's needs	Delivering care in a way which maximises use of resources and minimises waste	Delivering care that can be supported within the limits of financial, social and environmental resources	Delivering care which takes into account the preferences and aspirations of people	Delivering care that is timely, geographically reasonable, and provided in a place where skills and resources are appropriate to meet people's needs
"Being treated in a safe environment"	*"Receiving care which will help me recover"*			*"Having a positive experience"*	
"Being protected from harm and injury"	*"Having an improved quality of life after treatment"*			*"Being treated with compassion, dignity and respect"*	

This report is just one of many reviewed by the Trust's Board of Directors that, together, give a detailed view of CWP's overall performance.

This *Quality Improvement Report* provides a highlight of what CWP is doing to continuously improve the quality of care and treatment that its services provide. It also provides examples of **quality improvement** projects.

EXECUTIVE SUMMARY
QUALITY IMPROVEMENT HEADLINES THIS EDITION

Improving the effectiveness of pre-admission assessments has reduced lengths of stay by an average of 2 days
➲ see page 4

Central and East Substance Misuse Service has worked on preventing drug related deaths by training carers and other agencies in the use of naloxone
➲ see page 9

Falls prevention programme is reducing the risk of harm from falls on our inpatient wards
➲ see page 10

Winsford CAMHS are working with families to support the emotional well-being of the children and young people accessing their services, as well as building resilience for care givers
➲ see page 12

Croft ward are improving collaborative working with secondary care to provide enhanced access to medical input for frail older patients
➲ see page 16

An experience based design project has involved both staff and patients to improve initial mental health assessments in Chester Adult CMHT
➲ see page 20

Lime Walk are increasing the involvement of carers to aid the recovery of patients accessing their services
➲ see page 22

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

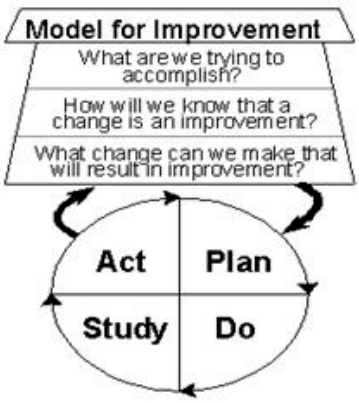
Improving the effectiveness of pre-admission assessments

Background:

People in acute mental health crisis have often been admitted to acute psychiatric hospitals without a clearly articulated rationale of how the admission plans to help them. Sean Boyle, (pictured right), lead practitioner in Wirral Crisis Resolution Home Treatment (HT) team, attended a **Patient Safety Leader** course facilitated by AQuA, and has completed a project to improve the 'gatekeeping' process undertaken by his team. Working with Rachel Fay, the team's administrator, Sean analysed all admissions to Lakefield and Brackendale wards at Springview Hospital. Gatekeeping is a process whereby the HT team assess whether a patient who is experiencing an acute episode of mental illness needs an inpatient admission, or support and treatment at home. This assessment details the reason for the admission, what the treatment aims to achieve, and the estimated length of stay on the ward.

What did we want to achieve?

It was hoped that by improving the gatekeeping process, highlighting reasons for admissions and estimating the length of that admission, that patients would have a clearer idea of how they were going to be treated. This would potentially reduce confusion and delays of how and when patients returned to their original place of residence, thus focusing the admission. An additional benefit would be improved flow of patients through acute inpatient beds, which have been reduced by 60% in number over the past 10 years, following the move towards better community based care.

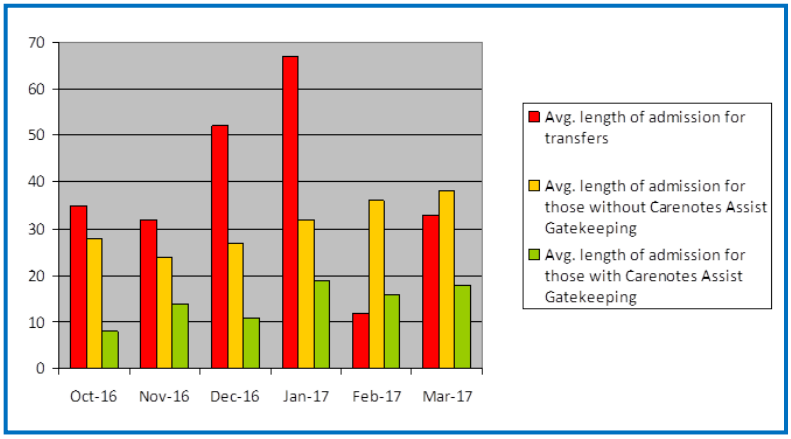


What we did:

We used the **Plan, Do, Study, Act (PDSA) model for improvement**. We wanted to ensure that all admissions to an acute mental health bed on Lakefield and Brackendale wards had an enhanced gatekeeping assessment tool completed on CAREnotes Assist, which is part of the Trust's electronic record system.

Results:

Utilising the PDSA cycle has led to increased usage of the assessment as highlighted in the results below. One result has been a **reduced length of stay** for those patients who have been gate kept via the new tool. Flow has improved and this may mean patients admissions are more focussed and discharges are without delays.



The graph, right, shows the reduction in length of stay following increased use of the new Gatekeeping Assessment tool. This tool has now been introduced in both the West and Central & East localities. Analysis of data in West also demonstrates a reduction in length of stay, with a median of 16 days when the tool is used, and 18 days when not.

This is one example of many in the Trust that shows how our staff are embracing our Zero Harm campaign, which is about **supporting people to deliver the best care possible**. This project demonstrates how staff are using their training in **quality improvement methodology** to deliver **high quality care** which **maximises use of resources**.

For further information, please contact Sean Boyle on 0151 482 7854

Custodial Partnership Groups promote continuity of care

Prison may not always be an appropriate environment for those with severe mental illness, and custody can exacerbate mental ill health, heighten vulnerability and increase the risk of self-harm and suicide. In addition, recent studies of mental health services for prisoners suggest that there is still some way to go in achieving equivalence with mental health services in the community. This project exemplifies how we are achieving **equity** and **person-centred care**.

Key statistics

Since June 1995, the prison population in England and Wales has increased by 60%, or more than 30,000 people, to reach record levels. Figures for July 2017 put the prison population at 86,253.

Background:

Gordon Leonard, Specialist Forensic Lead for CWP (pictured left with Brendan O'Hare, *National Probation Service*), has been working on a project to develop a **Custodial Partnership Group** to address and **improve pathways for patients with mental health problems or a learning disability in prison**, and provide planned support when they are released. The Cheshire and Merseyside Forensic Support Service noted that some patients were being released from prison with no support in place, or at very short notice, consequentially CWP teams had very little time to assess the patient prior to prison release. We considered this to be unacceptable, and that there needed to be a mechanism that identified the patient's needs six months prior to their release, prompting care services to get involved early to ensure an appropriate clinical pathway for each individual.

What did we want to achieve?

Working together, across agencies, criminal justice services needed to join up their thinking and tackle the issues of mental health and learning disabilities through multi agency approaches, so that as individuals go through the system they are treated both consistently and fairly. To achieve this aim, we wanted to:

- Explore ways of working better with the *HM Prison Service*.
- **Improve communication** between prisons and NHS staff.
- Enable sufficient time to undertake effective assessment of an individual's mental health.

What we did:

We set up a Custodial Partnership Group with four local prisons: Risley, Thorn Cross, Altcourse and Styal. We are also working to develop links with the new Berwyn prison in Wrexham.

A meeting is held every 6-8 weeks to discuss new cases we are concerned about. At these meetings we discuss cases where prison staff feel there is a requirement for mental health or learning disability support via CWP services. Following the identification of a vulnerable individual, we identify if he or she is already known to CWP services, or identify the most appropriate Single Point of Access (SPA) team and enable an assessment prior to their release from prison.

Results:

The project has resulted in **integrated working** with the *Prison Service*, through information sharing and pathway identification. There is **improved multi agency public protection** (MAPPA) and **improved support** for individuals leaving prison locally. Following some initial problems with getting attendance from local prisons to the meetings, the group is now working towards improved attendance and currently revising its terms of reference. A number of cases have been highlighted and subsequently supported more effectively when leaving prison because of this initiative.

Next steps:

The group are developing further information sharing agreements and looking at developing links with private sector prisons. Gordon is currently working with one of CWPs Assistant Clinical Psychologists, Felicity Watkin, on an opinion paper, to **recommend national adoption of this process to support continuity of care**. Mike Beasley (Forensic Practitioner CWP) has also worked on this initiative, and supported the chairing of the Custodial Partnership Group meetings.

For more information, please contact Gordon Leonard, Specialist Forensic Lead 01625 862414

Trafford Autism team working in partnership to support independent living

Background:

The national Autism Strategy defines autism as a lifelong condition that affects how a person communicates with and relates to other people. Many people with autism struggle to move on from their family home because they are not a priority for social housing, and often do not qualify for supported living options. Services are generally focused on responding when there is a crisis but struggle to work when a "preventative" approach is needed.

What did you want to achieve?

We worked in partnership with a local social housing provider and *Trafford Council* to support people with autism to move into independent living.

What we did:

Initially, this project involved running focus groups, meetings with families, *Trafford Council* and housing providers to identify the needs of adults with autism.

Individuals are referred to the project by professionals working across different agencies. Once referred, their application is discussed at a housing panel and if accepted they are placed on *Trafford Housing Trust*'s (*THT*) internal transfer list. When suitable properties come up, they are offered to people on the list. If additional social care support is needed, the person can be referred for a social care assessment. By acting as the link between people and families, *THT* and *Trafford Social Services*, we have been able to provide homes and person-centred social care support for 12 people with autism who would otherwise not have had the opportunity to move out of their family home.

Results:

This project provides an example of agencies working together within existing resources without additional staffing costs. This project relied on the recognition of unmet need and a willingness of agencies to work together sharing resources, skills and knowledge. Those involved committed additional time, energy and enthusiasm within their existing job roles to initiate and maintain the project.

Case study:

John (38 years old) moved into a flat reserved for people over 50, but the flat had been empty for some time. Without this project, John would not have been considered for this property

"I felt ready and wanted to see if I could cope. I had been on the waiting list with HOST for ages and hadn't made any progress. There is less strain in the relationship I have now with my parents."

John's mother had this to say:

"I wanted him to begin living independently while we were still well enough to provide background support. I felt that if he lived with us until this was no longer viable, and then had to manage on his own, he may have found himself suddenly filled with regret that he hadn't tried while he was younger."

Next steps:

We will continue to work with *THT* and social services to support people to access independent living and the appropriate social care support. We will also work with other housing providers to identify future ventures, and have already presented at a

regional event and a local housing provider forum. We hope that other housing providers will recognise this as an example of good practice.

For more information please contact Jane Forrest, Autism Support Coordinator on 0161 912 2807

Winsford 0-16 CAMHS Team supporting young people to raise awareness about mental health in schools

Background:

The initial catalyst for the project was the 'Takeover Challenge' which took place in November 2016. Takeover Challenge is an annual event, which sees organisations across England invite children and young people to 'take over' their job roles and be involved in decision making, and raise issues that are important to them. As part of this year's 'takeover', young people requested that they be supported in visiting local schools and other agencies to discuss their experiences of mental health. (Pictured left and below are some of the young people who took part in the project.)

What did we want to achieve?

The project's aims were to:

- Raise awareness of 'real life' mental health issues
- Decrease the stigma around mental health
- Encourage schools and agencies to 'rethink' their approach to mental health
- Increase staff's confidence in having conversations around mental health
- Empower the young people to reflect on their journey and share their experiences
- Increase the young people's confidence and give them a sense of 'giving back'

What we did:

A variety of young people attended four school meetings and a CAMHS team meeting as part of the pilot project. This was supported by a Tier 3 mental health practitioner. Five young people took part in the project, and were given autonomy to decide what they wanted to discuss, the messages they wished to portray, and their hopes for the project. The young people volunteered their own time to participate in the project as it was something they felt passionate about.

Results:

Feedback was received from the 34 teaching staff who attended talks given by the young people. Using thematic analysis, the main themes which were prevalent in the feedback were grouped together and analysed.

Next steps:

The young people have expressed clearly that they would like to continue going into schools to do these talks, as they feel it benefits them as well as the professionals involved. The project has already been approached by other services and agencies to request input and to request talks. It is hoped that the school staff who have attended this training will take the lessons and information supplied to build on the mental health information and education in their schools. This will also help to support young people in developing awareness and management of mental health difficulties early on in their journey rather than waiting until things have escalated. The feedback from young people suggests that the project is helping them as part of their therapeutic journey, suggesting that this project is an important part of the service.

For more information, please contact Rebecca Kinnear, Mental Health Practitioner on 01606 565240

QUALITY SUCCESS STORIES

We have set three **Trustwide quality improvement priorities** for 2017/18, which reflect our vision of "**leading in partnership to improve health and well-being by providing high quality care**". They are linked to the Trust's strategic objectives, and reflect an emphasis on **patient safety**, **clinical effectiveness** and **patient experience**.

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

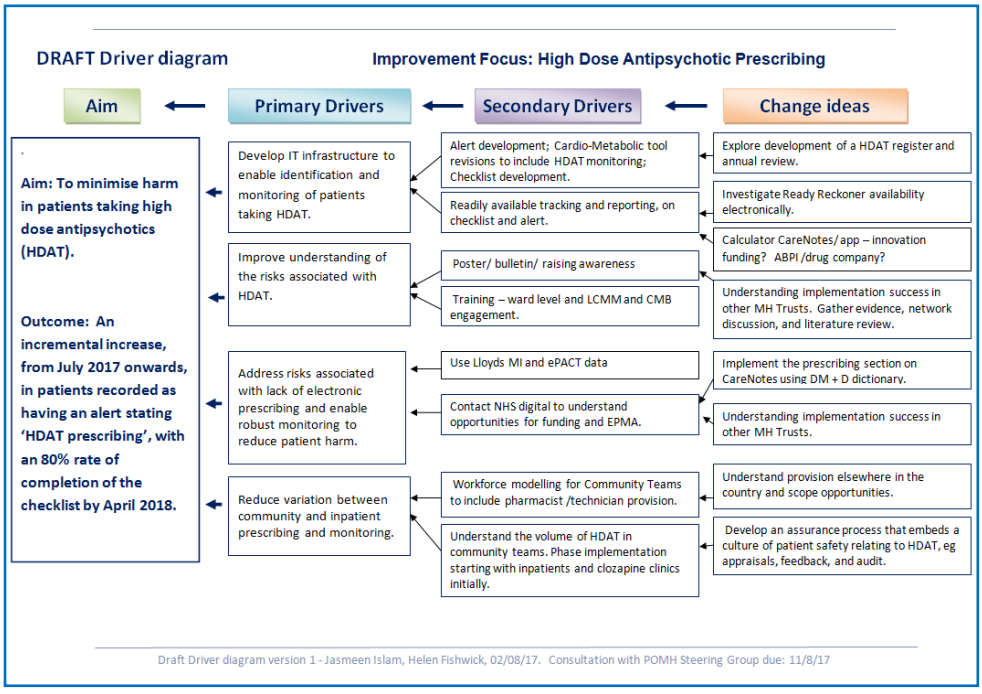
This year, as well as setting a number of areas for overall continuous quality improvement, a number of goal driven measures aligned to the dimensions of our **safety management system**, and to the Trust's forward operational plan for 2017/18, have been set. These are an increase in the identification and monitoring of patients taking high dose antipsychotics (see below); an improvement in the average bed occupancy rate for adults and older people (see page 4 and page 12); and improvement in embedding a person-centred culture across the Trust (see page 19).

Patient Safety Improvements

Goal driven measure for patient safety

CWP *Patient Safety* improvement priority for 2017/18
Increase in the identification of patients taking monotherapy or combination antipsychotic treatment, in which daily doses exceed the recommended maximum limits (according to the British National Formulary) to improve monitoring of the associated risks

At the start of 2017/18, we set a goal to minimise harm in patients taking high dose antipsychotic treatment (HDAT). There are greater risks, including serious physical side effects, when antipsychotic drugs are taken in high dose or in combination.

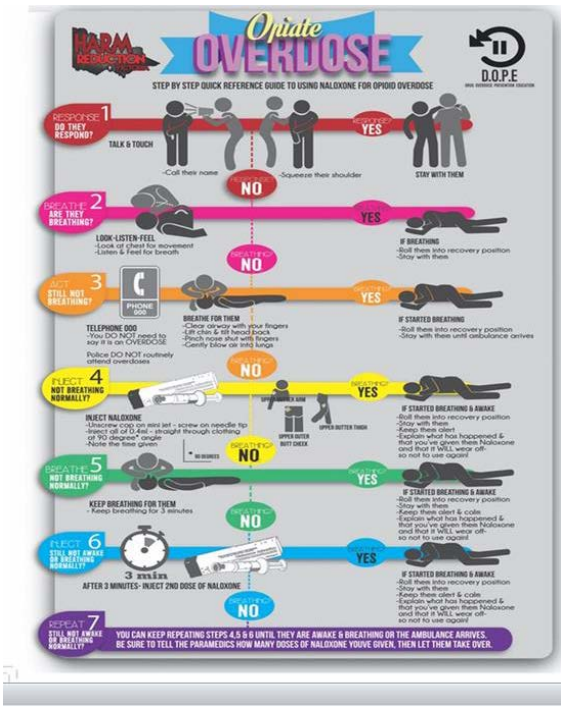


This project aims to increase the identification of patients on this treatment so that we can **improve monitoring of the associated risks**. The driver diagram, left, details the range of quality improvement activity being developed to achieve this goal. These include:

- A checklist and an alert have been produced to assist clinicians in monitoring the risks associated with HDAT.
- We are developing the IT infrastructure so we can flag and monitor patients at risk.
- Raising awareness through bulletins and posters.
- Developing training provision.

For more information, please contact Jasmeen Islam, Acting Chief Pharmacist on 01244 397380

Central and East Substance Misuse Service work on preventing drug related deaths



Background:

The *NHS Substance Misuse Provider Alliance*'s inaugural conference was held in Prestwich on 25 April. CWP is a member of the Alliance and this was a fantastic opportunity for our staff to share good practice, innovative ideas and to network. The conference topic was 'Preventing Drug Related Deaths' which are disappointingly on the increase nationally. The purpose of the conference was to provide an insight into what is causing so many of the people who access Substance Misuse Services (SMS) to die early through what are often avoidable deaths.

Professor John Strang OBE, who delivered the keynote speech (below), talked about the need for better action in preventing opioid deaths – a call to arms for the sector in responding to where the risks are, and applying a broad range of remedies, including the use of naloxone. Naloxone is a prescription medicine that blocks the effects of opioids and reverses an overdose. Professor Strang reported that most people are in the company of others when they overdose, and by being given training, and a take home pack of naloxone to carry with them, this will inevitably save lives. Research has shown that with basic training, non-medical professionals, such as friends or family members, can recognise when an overdose is occurring and give naloxone.

What did we want to achieve?

We wanted to prevent avoidable deaths from opioid overdose by providing training in the use of naloxone, and to cascade this training to others involved in the care of service users at risk of an overdose.

What we did:

All SMS staff have been trained, including how to train people accessing SMS services, family, friends and carers to use naloxone. This enables individuals to administer naloxone in the case of an opiate overdose in the community. In addition, training has been rolled out to the staff at a community housing project (*Emerging Futures*). All their current staff have been trained, and a supply of naloxone has been provided to each accommodation site.

Key statistics

A national overview of the impact of drug related deaths highlighted that although the majority of these deaths are of males, deaths of females are also steadily rising. Where deaths are not directly related to the use of a substance, a person using substances over the age of 45 is 27 times more likely to die by homicide than someone in the general population, and the risk of suicide was also significant.

Next steps:

We will continue to monitor, support and train people. In addition, we will be looking to continue to promote with other agencies and hold an event during *Overdose Prevention Week* in August, in which we will offer further training and naloxone supplies to family, friends and carers.

National data presented at the conference will be used to compare with CWP data on drug related deaths to enable us to identify further opportunities to learn and improve.

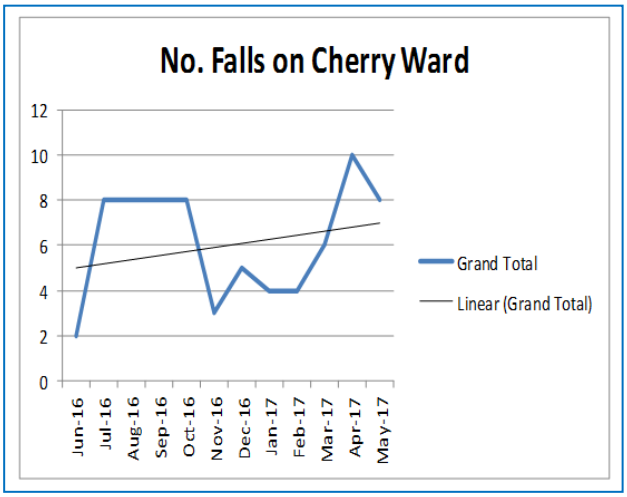
For further information, please contact Suzanne Jones, Substance Misuse Service Lead on 01625 712000

Reducing the risk of harm from falls on our inpatient wards

Background: The Trust has a focus on investigations when things go wrong, or when we have an incident, to be able to identify what we can do to improve our care in the future. In line with the Trust's Zero Harm strategy, this project is also trying to learn from good care so we can spread best practice. The review below is a brief summary of the care and interventions to a patient on Cherry ward who was at a very high risk of falling; however, as a result of the interventions from staff, there have been no falls with this patient. Risk factors included: age, frailty, physical health co-morbidity, and previous fall prior to hospital admission, intermittent confusion, and patients not always wanting to wear appropriate footwear or use their walking aids. The quality improvement project on Cherry ward follows a successful pilot project on Croft ward, which also successfully reduced the number of falls. Sarah Townson, ward manager, and the Cherry ward team are pictured right.

Why focus on falls?

- Patients' incidents of falls are high on the older adult wards.
- Our aim is to reduce all falls, but especially those which cause the most harm.
- We aim to distinguish between avoidable and non-avoidable harm.



Outcomes we wanted to achieve:

- Reduce harm from falls.
- Test pathways to inform policy.
- Improve communication re falls.
- Improve overall knowledge of falls.
- Provide data for analysis.
- Promote involvement.

Learning from good practice - how did we keep one patient safe who was a very high risk of falling?

The 6Cs are the values CWP has adopted to underpin everything we do. We applied the 6Cs to review the care provided to prevent falls for this patient.

Care: included multifactorial interventions, detailed care planning and risk assessment, toileting plan including urinalysis, medication review, review of risks at multidisciplinary team meetings, taking lying and standing blood pressure, and assessment of fear of falling.

Competence: Comprehensive assessments and care plans ensuring they detailed call bell at hand, the wearing of appropriate footwear, glasses due to sight problems, and hearing aid due to hearing problems.

Communication: Communication plan in place ensuring patient and family were aware of all the risks and their responsibilities.

Compassion: A caring and trusting relationship was built with the family and patient, open and honest discussions were evidenced.

Courage: The team showed courage as they asked for further training and support. They recognised that there was an increase in falls and a serious injury from a fall made them question their assessments, management and interventions in relation to falls. The patient was not sleeping and had a long term issue with this, although other interventions were also used to aid sleep, the pharmacist and team worked with patient and family and agreed a regime with increased input and observation for night time.

Commitment: The team is fully committed to reducing falls. Furthermore to reduce harm from any fall. They wish to provide the best care that they possibly can for their patients.

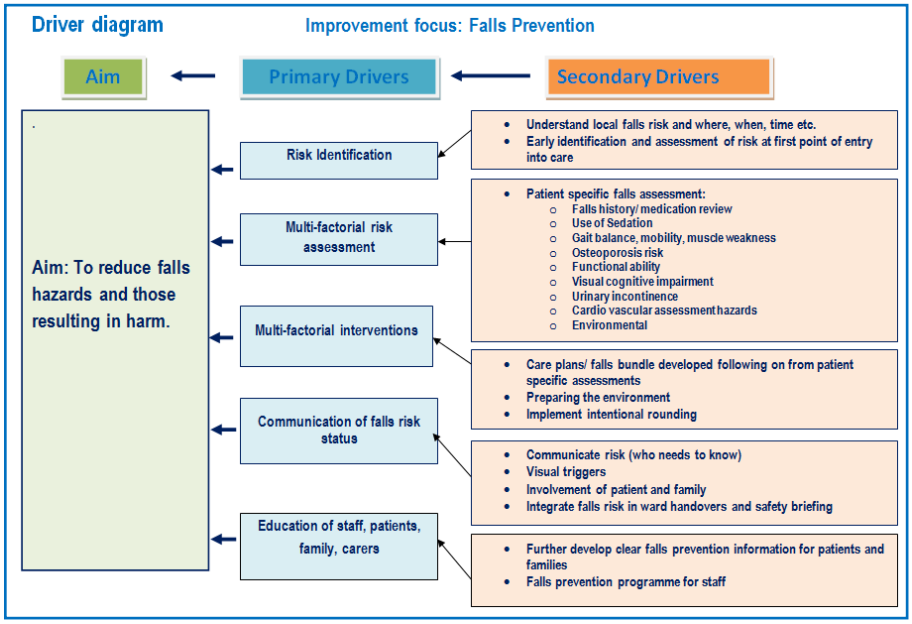
Baseline data	Number of falls Time and place of falls Number of falls that cause serious harm Number of potential avoidable vs unavoidable (PDSA is currently underway to test this methodology)		
	Ongoing measurement		
	Phase 1	**Phase 2**	**Phase 3**
Ongoing measurement	Engage with staff (including whole MDT) Discuss and agree project and plan with timeframes Communicate plans including roles and responsibilities	Collect baseline data and design data collection methodology	Review data and compare to baseline Review impact of learning (audit of staff)
		Pilot multifactorial: risk assessments - PDSA intervention plans - PDSA Safety Huddles – PDSA Plan education for ward staff	Evaluate the individual PDSA Cycles and make changes to documentation prior to next ward Amend and roll out to next ward Policy development in light of feedback from both pilot sites

A 90 day quality improvement plan and driver diagram (below) has been developed to ensure the project is implemented in a timely and robust way.

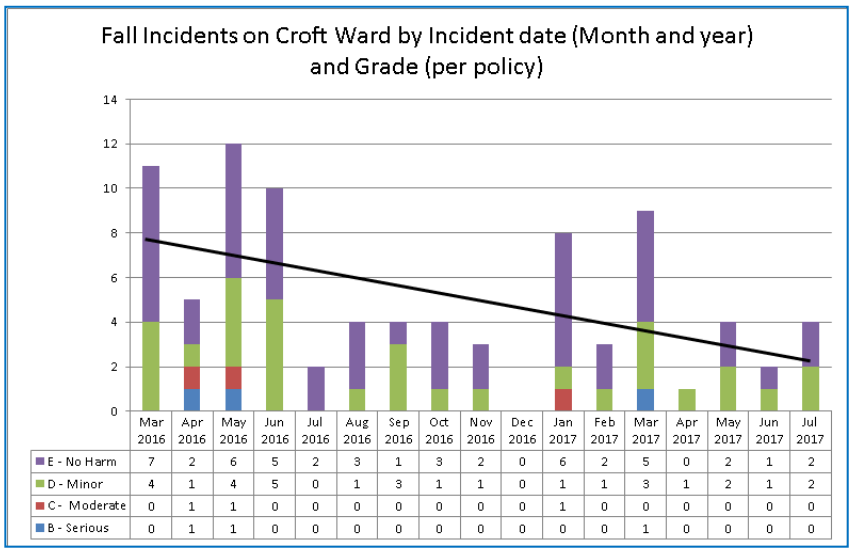
Results: Throughout the project, there was ongoing measurement and data analysis to monitor improvement. We conducted PDSA (plan, do, study act) cycles to evaluate progress as illustrated in the project plan above.

What have we learnt so far?

- We have teams who are committed to drive improvements for patients and to reduce avoidable harm.
- Falls prevention is more successful delivering quality improvements through a multi-disciplinary approach.
- Relatives and patients need to be active partners in the prevention of falls.
- All staff need to be engaged with the completion of the multifactorial risk assessments and interventions.
- Staff need updates on falls prevention.
- Ward teams are preventing falls and harm from falls every day, this needs to be celebrated.



The graph below demonstrates the reduction of falls on Croft ward since the implementation of the falls work; the next stage is to identify how many of the falls that have occurred were avoidable. This methodology is currently being tested.



	Mar 2016	Apr 2016	May 2016	Jun 2016	Jul 2016	Aug 2016	Sep 2016	Oct 2016	Nov 2016	Dec 2016	Jan 2017	Feb 2017	Mar 2017	Apr 2017	May 2017	Jun 2017	Jul 2017
E - No Harm	7	2	6	5	2	3	1	3	2	0	6	2	5	0	2	1	2
D - Minor	4	1	4	5	0	1	3	1	1	0	1	1	3	1	2	1	2
C - Moderate	0	1	1	0	0	0	0	0	0	0	1	0	0	0	0	0	0
B - Serious	0	1	1	0	0	0	0	0	0	0	0	0	1	0	0	0	0

This project is one of many that demonstrate how CWP's teams are using quality improvement methodology to improve patient safety, and applying the 6Cs values to the care they provide.

Next steps:

We are planning to roll out this project to other wards across the Trust, the policy will be finalised in September to include the tools used within the pilot.

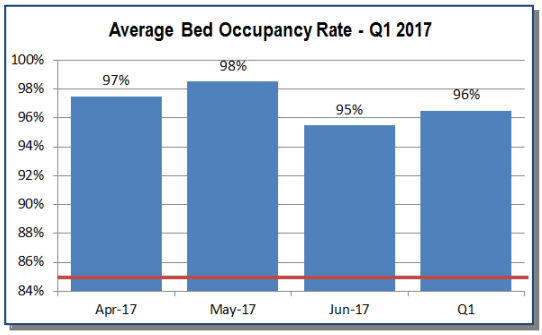
For more information, please contact ward managers Sarah Townson, Cherry ward 01244 397304, or Maurice Egan, Croft ward 01625 663060

Clinical Effectiveness Improvements

Goal driven measure for clinical effectiveness

CWP *Clinical Effectiveness* improvement priority for 2017/18
Improvement in the Trustwide average bed occupancy rate for adults and older people

Very high bed occupancy rates can affect the quality and safety of patient care. We have set ourselves the target of reducing the average Trustwide bed occupancy rate to 85% by the end of December 2017 on our adults and older people's inpatient wards. This target is taken from the *Royal College of Psychiatrist*'s research into the optimal level of bed occupancy *(Looking Ahead – Future Development of UK Mental Health Services, 2010).* Bed occupancy rates are a main driver of inpatient care standards, and a rate of 85% is seen as optimal.



CWP has identified a centralised 'bed hub' to optimise use of our bed stock and ensure everyone needing an inpatient bed is in the best bed for their needs that day. The graph, left, demonstrates our bed occupancy rates for quarter 1 against the 85% target, shown by the red line. A number of projects are underway to support a reduction in our bed occupancy levels. These include:

- 'Red and Green days' improvement project – which identifies and reduces internal and external delays to improve flow.
- Improving use of the 'Gatekeeping Assessment form' (see page 4) – this project has identified reductions in patients' length of stay resulting from a detailed assessment of each patient's need.
- Detailed investigation and analysis of our bed occupancy data is being undertaken and is looking in detail at the number of patients sleeping out from their wards; comparisons between admission and discharge data for different wards; comparisons in bed occupancy between the localities; and the number of transfers between wards, and the reasons behind these.

In addition, an Acute Care Away Day was held on 31 July; this was an opportunity for staff working in our acute wards to share best practice and learning from the number of quality improvement projects underway. Approximately 50 staff from across the Trust attended, drawn from multidisciplinary teams in the acute inpatient wards, Home Treatment teams, and Community Mental Health Teams. Dr Anushta Sivananthan, Medical Director, opened the event and presented CWP's vision for acute care, and Dr Ian Davidson, Clinical expert champion for Zero Harm, gave a presentation on risk management. The event also provided an opportunity for Sarah Quinn, General Manager – Wirral, to update staff on the work of the centralised bed hub and the quality improvement projects that are in progress, such as:

- Zero out of area placements for acute admissions.
- No patient requiring acute admission to wait longer than 4 hours to be allocated a bed (from request to bed manager).
- Acute care pathway is safe and effective.
- Optimal flow is achieved through the acute care system.
- Bed occupancy of 85%.
- Exploring income generation opportunities.

For further information, please contact Sarah Quinn, General Manager on 0151 488 7444

Winsford CAMHS supporting the emotional wellbeing of young people

Background:

In June 2017, Winsford CAMHS set up a pilot group to support the emotional wellbeing of young people, called "Youth Connect." "Youth Connect 5" is a course that was developed with *Merseyside Youth Association*, who then trained various professionals throughout Cheshire and Merseyside to deliver the course to parents.

What did we want to achieve?

Our aim was to support families within CAMHS with supporting and managing their children and young people as well as building their own resilience as caregivers. It was hoped that the course would help families to feel more supported and the course skills would help parents and their children to **achieve their goals** within CAMHS at an earlier stage.

What we did:

One mental health practitioner from the team was trained and recruited participants from within the CAMHS service. The course was delivered to a cohort of 6 caregivers during the initial pilot in July, and ran for 5 consecutive weeks.

Throughout the course, parents requested more of a mental health focus and wished to focus on certain issues such as self-harm or bullying. As this was not written into the course content, it was agreed that time would be put aside to try and cover these areas and that the facilitator would offer resources to address some of the questions and topics parents wished to cover. Additionally, parents were directed to use the duty service within CAMHS or speak to their child's clinician. Sessions included topics such as:

- Defining and understanding what is mental health
- Looking at risks and resilience
- Seeing things from a teenager's point of view – e.g. pressures
- The teenage brain
- Seeing the positives

Results:

Parents/ carers (some are pictured above) were asked to complete a session evaluation sheet each week which asked whether they enjoyed the session, found it useful, how much they thought it would help them to support their child, and how confident they were feeling. The majority of the session evaluation forms rated the sessions as either "really useful" or "invaluable" and that they felt the session had "helped them" to support their child. Feedback from one parent said:

> "Invaluable meeting other parents "in the same boat" as me and sharing ideas and experiences"

Next steps:

It is hoped that the course will continue to run within Winsford CAMHS, and possibly extend to West Cheshire CAMHS, with some of the parents/ caregivers from this cohort co-facilitating the next group alongside the mental health practitioner. This project exemplifies how CWP teams are **promoting accessible and affordable solutions** to improve the quality of their service, by working together with those who access our services.

For more information, please contact Rebecca Kinnear, Mental Health Practitioner on 01606 555240

Speech and Language Therapy team in Central and East ensure good communication standards are in place

Background:

Most people with learning disabilities have some speech, language and communication difficulties. The *Royal College of Speech & Language Therapists* published a report in 2013 called "Five good communication standards". It was written to highlight what reasonable adjustments to communication that people with a learning disability and/ or autism should expect when they are an inpatient in a specialist hospital or residential setting.

5 Good Communication standards

1. *There is good information that tells you how best to communicate with someone.*
2. *People are helped to be involved in making decisions about their care and support.*
3. *Others are good at supporting someone with their communication.*
4. *People have lots of chances to communicate.*
5. *People are helped to understand and communicate about their health*

Advanced Speech and Language Therapist (SLT) Natalie Hewitt, and Specialist SLT Leanne Veale have conducted two audits of communication

practice in Greenways and the Alderley Unit to assess communication standards and make recommendations for improvement.

What did we want to achieve?

We wanted to ensure that we were meeting the 5 good communication standards, and that our patients at Greenways and Alderley Unit received the best possible support to express their needs.

Results: The two audits demonstrated high levels of compliance with the 5 good communication standards at Greenways and the Alderley Unit. Now the audit is complete, it has highlighted the need for continuously overseeing good communication standards, and this will be one of the main roles of a new SLT post for inpatient units in East Cheshire.

Next steps: One of the key themes was the provision of communication training for staff working in learning disabilities, and discussions are taking place to improve this.

For more information, please contact Natalie Hewitt, or Leanne Veale on 01625 509013

Service Improvement Forums

Background:

Service Improvement Forums were established towards the end of 2016 to facilitate networking and collaboration across inpatient and community teams, with the aim of **reducing variation**, and **improving services and outcomes across CWP**. Inpatient and Community Service Improvement Forums are led by Gary Flockhart, Associate Director of Nursing & Therapies, with support of the Service Improvement Team and the Safe Services Department, and include staff from a range of specialties meeting every 6 weeks to discuss issues, **identify improvements** and **share learning and knowledge**.

What did we want to achieve?

We aimed to develop a forum which supported the **sharing of best practice**, **facilitated engagement with operational staff** of key issues being faced, and provided an opportunity for problem solving and **initiating improvements**. The forums aim to support **improvement in quality and efficiency within services**, as well as resilience of staff through peer support.

What we did:

Presentations are given to share data analysis or initiatives across the Trust, with staff then engaged through workshop sessions in order to gather their views to inform developments. A recent example is focused work undertaken on self-harm. This was raised as an issue following an analysis of available incident data and an ensuing discussion regarding the management of self-harm within CWP. The 'Unconference' approach that was used to explore the issue of self-harm began with the 'burning question' of "How do we reduce and manage self-harm within CWP?"

Results:

The Service Improvement Forums have enabled **improved communication and engagement** within and across inpatient and community teams, through the provision of information and updates regarding new initiatives, or the sharing of data and best practice, as well as the gathering of feedback on key issues raised such as *NICE* guidance compliance, outcome measurement and the management of self-harm. Following the self-harm 'Unconference', and further work undertaken with the Inpatient Service Improvement Forum, the key issues have been collated to enable further exploration and implementation. The Service Improvement Forums continue to strengthen, with **positive feedback** from attendees:

"Unconference went very well, very good opportunity to be creative and think out of the box"
"Loved the Unconference"
"Good to have thinking and talking time with colleagues, also interaction with executive and corporate services"

For more information, please contact Safieh Fraser or Lauren Connah, Service Improvement Managers, on 01244 397386

Croft ward working with East Cheshire NHS Trust to facilitate seamless services for dementia patients and their carers

Background:

Admission to hospital is exceptionally difficult for people with dementia. Illness or injury, loss of familiar surroundings and routine, and a busy environment can all worsen the symptoms of dementia. Figures from the *Department of Health* estimate that people with dementia account for around 3.2 million bed days a year. Common reasons for admission to an acute trust include falls, hip fractures, urinary and chest infections. Staff from Croft ward have been working with colleagues at *East Cheshire NHS Trust* to improve care for patients with dementia and their carers.

What did we want to achieve?

The aim was to strengthen staff networks, improve knowledge and share best practice between the two trusts who provide care for the same group of patients, with complex needs, requiring a combination of treatments from physical and mental health services, so that they receive the best possible care. Pictured above are Kate Chapman, Matron, and Maurice Egan, Ward Manager on Croft ward, with members of their team and staff from *East Cheshire NHS Trust*.

What did it involve?

Celebrating 'Nurses Day' and 'Dementia Awareness Week,' CWP and *East Cheshire NHS Trust* facilitated a number of events to share knowledge and best practice. Staff from both trusts were involved. Information was provided on falls prevention; improving the care environment; helpful therapies including music, sensory, art, occupational and physiotherapy; 'John's Campaign'; 'Dementia Friend' sessions; ensuring individualised end-of-life care; use of one-page-profiles; accessing continence services; tissue viability. The two trusts pledged to continue to jointly foster high quality, person-centred care.

Results:

The initiative has highlighted much common ground between physical and mental health care and strengthened relationships between teams; staff reported how valuable they found it, describing that they felt more confident dealing with problems which were not within their specialty and more able to seek specialist advice from partner organisations. Building positive relationships between the trusts has ensured that patients are treated in the place best suited to their primary needs, with ongoing support and expert consultation from the partner trust. This helps treatment continuity, benefitting and reassuring patients and carers. The initiative empowered staff by giving them the knowledge that allows them to signpost patients in an effective way, providing seamless transitions between the two trusts. 37 people attended Dementia Friends sessions; including 4 carers, 19 staff from the acute trust and 14 staff from Millbrook; one carer said "the session inspired me to become more involved raising awareness about dementia". Pictured right are the Croft team meeting carers who attended the event.

Next steps:

CWP and East Cheshire NHS Trust have pledged to continue to work together to improve the experiences of patients living with dementia and carers. Clinical expertise will be shared to ensure that patients receive the best possible healthcare; strategically the two trusts continue to work together through an operational dementia steering group.

For more information, please contact Maurice Egan, Ward Manager, or Kate Chapman, Matron on 01625 663060

Improving access to medical input for our frail older patients

Background:

Croft ward frequently works with frail older adults with dementia who have multiple physical health problems. Patients with dementia are vulnerable and they are highly susceptible to environmental change. It is imperative, therefore, that there is good access to physical health care on our ward, and that we can prevent several transfers for patients so that they don't become unsettled unnecessarily.

What is frailty?

Frailty is a distinctive health state related to the ageing process in which multiple body systems gradually lose their in-built reserves. Around 10% of people aged over 65 years have frailty, rising to between a quarter and a half of those aged over 85 years. Older people living with frailty are at risk of adverse outcomes such as dramatic changes in their physical and mental wellbeing after an apparently minor event which challenges their health, such as an infection or new medication. (Clegg, A et al, *Frailty in elderly people*, Lancet, 2013)

What did we want to achieve?

Our aim was to predict what care needs a person has more accurately, plan to prevent problems, and plan future care following discharge. We also aimed to:

- Reduce unnecessary moves, and unnecessary treatments (polypharmacy), involving our patients.
- To improve management of physical healthcare needs for our patients on the ward.

What we did:

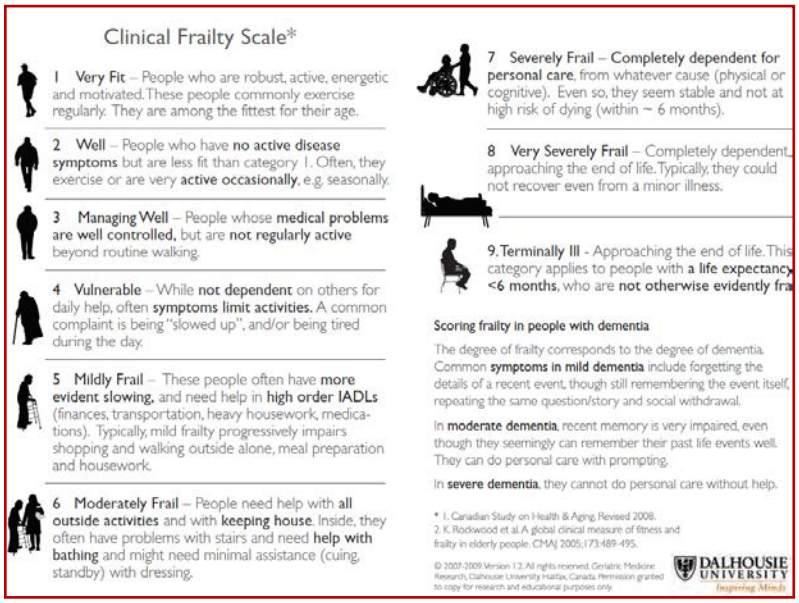
Croft's Consultant, Dr Sadia Ahmed (pictured left with Kate Chapman and Maurice Egan) identified a "Clinical Frailty Scale" (see below) that is currently being used in the community to indicate what stage a patient is at. This was a useful tool to score a patient's level of frailty upon admission, and then again at discharge planning stage. It provides a great indication to recognise when patients are declining in their health, but also helps to assist us in establishing what care setting is going to be appropriate at discharge.

The ward Consultant and Matron attended the 'Frailty Groups' held at East Cheshire NHS Trust, and arranged for a GP Specialist, Dr Dawn Moody, who works within their Frailty Team, to offer her expertise once a week for patients with acute medical issues on Croft ward. This joint working role provides advice on pending medical issues, in order to avoid potential admissions or transfers to the medical wards, and to limit polypharmacy. This extra medical support for our patients is important due to their complex medical needs.

Outcome:

Staff are now using the frailty scale each week to comment on patients' assessments. It's a simple tool and takes seconds to complete. This happens when the patient is admitted in their first ward round and then again when planning discharge. This process has been cascaded to all staff on the ward to ensure frailty is planned for.

This project demonstrates the benefits of working together, sharing best practice, and placing the patient and carers at the heart of practice. This project also exemplifies how quality of care can be improved in an affordable and sustainable way, as it has been achieved at no additional financial requirement.



Clinical Frailty Scale*

1 **Very Fit** – People who are robust, active, energetic and motivated. These people commonly exercise regularly. They are among the fittest for their age.

2 **Well** – People who have **no active disease symptoms** but are less fit than category 1. Often, they exercise or are very **active occasionally**, e.g. seasonally.

3 **Managing Well** – People whose **medical problems are well controlled**, but are **not regularly active** beyond routine walking.

4 **Vulnerable** – While **not dependent** on others for daily help, often **symptoms limit activities**. A common complaint is being "slowed up", and/or being tired during the day.

5 **Mildly Frail** – These people often have **more evident slowing**, and need help in **high order IADLs** (finances, transportation, heavy housework, medications). Typically, mild frailty progressively impairs shopping and walking outside alone, meal preparation and housework.

6 **Moderately Frail** – People need help with **all outside activities** and with **keeping house**. Inside, they often have problems with stairs and need **help with bathing** and might need minimal assistance (cuing, standby) with dressing.

7 **Severely Frail** – **Completely dependent for personal care**, from whatever cause (physical or cognitive). Even so, they seem stable and not at high risk of dying (within ~ 6 months).

8 **Very Severely Frail** – Completely dependent, approaching the end of life. Typically, they could not recover even from a minor illness.

9. **Terminally Ill** - Approaching the end of life. This category applies to people with **a life expectancy <6 months**, who are **not otherwise evidently fra**

Scoring frailty in people with dementia

The degree of frailty corresponds to the degree of dementia. Common **symptoms in mild dementia** include forgetting the details of a recent event, though still remembering the event itself, repeating the same question/story and social withdrawal.

In **moderate dementia**, recent memory is very impaired, even though they seemingly can remember their past life events well. They can do personal care with prompting.

In **severe dementia**, they cannot do personal care without help.

* 1. Canadian Study on Health & Aging. Revised 2008.
2. K. Rockwood et al. A global clinical measure of fitness and frailty in elderly people. CMAJ 2005;173:489-495.

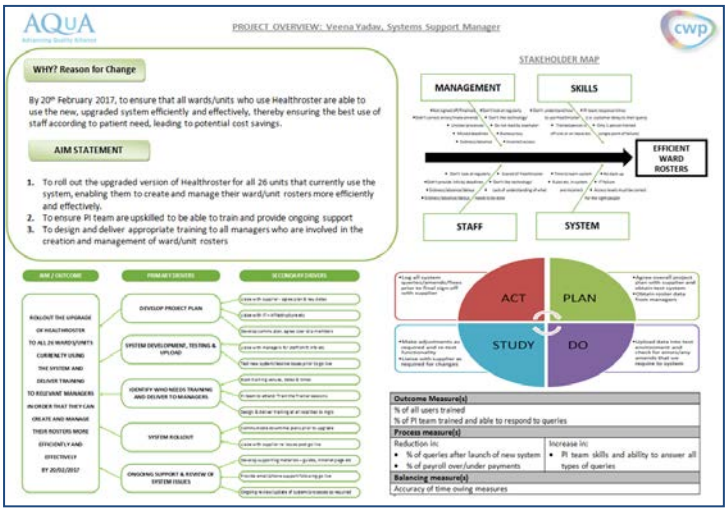
DALHOUSIE UNIVERSITY Inspiring Minds

For further information, please contact Dr Sadia Ahmed, or Kate Chapman on 01625 663021

Introduction to Improvement Training

Background:

The Service Improvement Team, based within Effective Services, works across the Trust to help build capacity and capability for **continuous improvement** and support services to be well-led, with **effective and efficient pathways** and **delivering high quality care**. The team facilitates improvement through responding to data, supporting teams with improvement projects, facilitating and leading projects via strategic groups and developing and delivering improvement training, coaching, advice and support to staff at all levels within the Trust.



What did we want to achieve?

The aim of the *Introduction to Improvement* (*i2i*) training is to increase capacity and capability across the Trust through improving the knowledge, skills and confidence of staff in using improvement methodologies. Applying new improvement skills throughout the course empowers staff to make improvements that will bring about **positive change** and **improve outcomes for patients**.

What we did:

The Service Improvement Team has been running *Introduction to Improvement* (*i2i*) training for staff over the last 12 months. This 3.5 day training programme has been developed in conjunction with AQuA (the North West Quality Observatory), and has recently been tailored and targeted to the needs of CWP staff following the Improvement Survey that provided a snap shot of the skills and competencies across the Trust. All members of the Service Improvement Team are fully equipped with the knowledge and skills to undertake improvements and to deliver this training to staff.

Results:

Over the last 12 months, a total of 42 people have completed the *i2i* course, equipping staff with a thorough knowledge and understanding of improvement methodologies. An example of an improvement project which has been supported includes rolling out the upgraded version of "HealthRoster" (an e-rostering solution) for all 26 units that currently use it, enabling them to create and manage their ward/ unit rosters more efficiently and effectively. Posters are submitted to present the outcomes of the projects and we have more than doubled the number of submissions of posters (22 in total) over the last few months (see example above). As of September 2017, all attendees will also work through their projects via *Life* QI (software designed to support and manage quality improvement work) and become Improvement Champions, providing additional resource within services to offer advice and support. This network of Improvement Champions will be supported by the Service Improvement Team to ensure their skills are further developed and refreshed in order to assist them in their role. The retention rate, and percentage of attendees completing the course, remains high at almost 100%. Feedback also continues to be positive, with one delegate saying:

> *"Excellent, the space to think, plan and reflect. Has improved my motivation and focus on service user need and not resource led. Everyone would benefit from this no matter their role."*

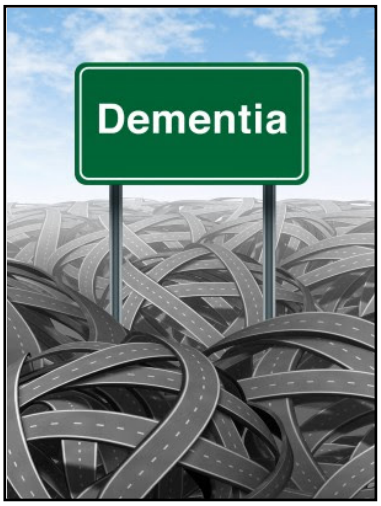
Next Steps:

Cohort 4 of the *i2i* training will commence in September 2017, with high demand for the 3.5 day course. Three cohorts of the *i2i* training course will be provided each year. We have also developed a broad training and support offer, including one to one improvement coaching, bespoke improvement activities for teams, improvement surgeries and bite size improvement modules. We are also developing an e-learning module, and considering a level 2 improvement practitioner course in collaboration with AQuA, in order to build on the content of the *i2i* course at a higher level.

For more information, please contact Safieh Fraser or Lauren Connah, Service Improvement managers, on 01244 397386

Central and East Older people's CMHT work on improving the Dementia Pathway

Background:



With a rapidly expanding population of older adults, caseloads within the older people's teams have grown significantly over recent years; it was therefore imperative that we look towards a more **streamlined and more integrated approach** within the Memory Service. Our approach was to redesign the existing pathway, in line with current *NICE* guidelines, in order to **create efficiency through the reduction of duplicated activity**, and as a result, improve the rate of diagnosis and treatment initiation in a timelier manner, and provide increased support to people who with dementia.

What did you want to achieve?

As a result of burgeoning caseloads, and growing waiting times, we set out to **redesign the pathway** whilst **reducing waste through duplication** and to work more closely with our primary care colleagues as part of the '*Caring Together*' transformation programme and the development of '*Primary Care Homes*'.

What we did:

- A workshop was held for the whole team to explain the current financial position across health and social care, and the system wide transformation plans that were being developed in response. The team identified ways in which they could work differently in line with current *NICE* guidance, together with ideas for new developments.
- The consultant psychiatrists and team manager have met with key GPs within the two prototype *Primary Care Homes* to redesign the clinical pathway and to develop new ways of working together.
- The team are active members of the multi-disciplinary team (MDT) process within nursing and residential homes.
- The consultant psychiatrist now holds her clinics within GP practices, with full access to the primary care clinical records. Nursing staff have access to hot-desking office space alongside health and social care colleagues within the local area.

Results:

This programme of work is still at an early stage, but the results are already beginning to show that:

- Caseloads have started to reduce due to more people's care and treatment being managed by primary care services, **creating space and capacity** for the team to begin to work differently with primary care services.
- **Waiting times for assessment and diagnosis have reduced** from 9 weeks to a maximum of 5 weeks and involve fewer appointments for the person to attend, which means less travel for older people across a large semi-rural geography.
- Communication between the GPs and the team has significantly increased.
- Costs for the team have been reduced as clinic rooms within GP practices have been offered free of charge.

Next steps:

- Update the service specifications and formalise the revised clinical pathway with commissioners.
- Extend the current urgent response to people up to 8pm Monday – Friday.
- Extend the input into the other three Primary Care Homes being currently developed across Eastern Cheshire.
- Share the learning with the Central Cheshire team.

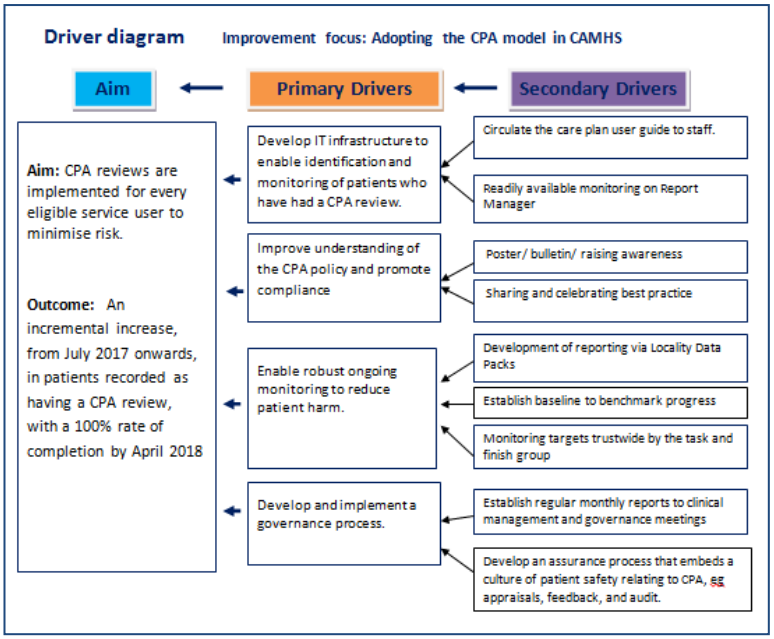
This project demonstrates how CWP teams are undertaking quality improvement initiatives which provide **accessible and affordable care**. It exemplifies how a team can **increase efficiency** and **reduce duplication** of effort in order to enable system **sustainability**.

For more information, please contact Josie Worthington on 01625 505611

Adopting the Care Programme Approach in Community CAMHS teams

What did we want to achieve?

The Care Programme Approach (CPA) is a way that care is assessed, planned, co-ordinated and reviewed for someone with severe mental health problems or a range of related complex needs. Following the Trustwide *Care Quality Commission* inspection, it was established that CAMHS teams needed to improve patient safety by adopting the CPA. Although bulletins had been circulated, it was recognised that there needed to be a **more sustained approach to implementation**, which included raising awareness, and ongoing monitoring, to ensure all patients received a CPA review where appropriate.



What we did:

At the Trustwide CAMHS Transformation Data meeting held in Winsford in July, it was agreed that a standardised approach was needed to ensure implementation of CPA within community CAMHS. A multidisciplinary task and finish group (Dr Rachel Mcloughlin, Dr Steve Earnshaw, Nicky Robinson, Dave Hedges, Sophie Holt, and Clare Cooper) has now been set up and have planned a series of meetings to discuss, plan and implement this Trustwide project.

Results and next steps:

A small group of patients are now on CPA, and this is **steadily expanding** as the project progresses. We have established a baseline report via the Trust's Performance & Information team and will monitor further progress through regular reporting. We will work with the Quality Surveillance Analysts in the Safe Services Department to ensure that the Locality Data Packs for CAMHS teams accurately reflect compliance.

For more information, please contact Nicky Robinson on 0151 488 8143

Patient Experience Improvements and *patient feedback*

Goal driven measure for patient experience

CWP *Patient Experience* improvement priority for 2017/18
Improvement in embedding a person-centred culture across the organisation

At the start of 2017/18, we set ourselves a goal to demonstrate that 90% or more of our staff are able to respond positively in the *NHS Staff Survey* that they are able to deliver a person-centred approach in their practice/ delivery of care. Following the successful implementation of the person-centred framework, CWP has put in place the following measures to enable us to meet this goal. These include:

- A dedicated page on the Trust's intranet.
- Face to face training sessions facilitated by the nurse consultant for learning disabilities and the participation and engagement lead. Three sessions have been held to date and over 100 mental health staff have attended.

The *NHS Staff Survey* is an annual event and will take place during September and October 2017. Results are expected in spring 2018, and a further update will be reported in Edition 2 of the Quality Improvement Report.

Experience based design improves initial mental health assessments in Chester Adult CMHT

Background:

Experience Based Design (EBD) is a methodology for working with patients, families, carers and staff to improve services together. EBD allows teams to gather insight into how services are experienced, based on the patient's emotional response to the interaction. It helps teams to challenge assumptions and perceptions about what they think the patient or carer feels and needs. Using the insights that are captured, patients, families and staff work together to 'co-design' improvements to services. Chester Adult CMHT has used EBD to improve initial mental health assessments. This exemplifies CWP's commitment to co-production in designing and improving services to meet our patients' needs.

What did we want to achieve?

We wanted to use this co-design approach to ensure that improvements we made truly added value, and ensuring that the services we provide meet the needs of those who access them, and those who provide them.

What we did:

A small project team was formed and included Lesley Gledhill, Participation and Engagement Practitioner, Carl O'Loughlin, Lived Experience representative, Jim McCafferty, service user volunteer and Heather Dutton Clinical lead. The project team attended a master class, providing training on the EBD approach.

The project team chose the initial mental health assessment as the focus for the project, based on discussions with the wider community team. Using flowcharts and process mapping, they were better able to understand the stages of the initial assessment. As the EBD approach places equal emphasis on patient and staff perspective, the project team then went on to interview groups of both patients and staff, and to map their experience.

Results:

The project team identified quotes from patient and staff experience at each stage of the process of attending for an initial assessment. They then mapped the associated emotions connected to these quotes. Consistent themes of experience emerged based on the responses from both staff and patients, enabling the project team to identify key recommendations for improvement.

Next steps:

The EBD project identified a number of improvements which have been completed, including redesigning patient letters and leaflets, improving the reception area and signage, volunteer 'welcomer'. The project team has developed an action plan and is working through further improvements such as training opportunities for staff.

Jim McCafferty, (pictured on the front cover) who was part of the EBD project as a volunteer, and who captured the service user feedback, said:

"I cannot think of many times I have felt valued in my life, if any. To be involved in a project that recognises success, but also gaps in service provision in order to benefit people with same lived experience as myself, was truly rewarding for me. In an emotional investment, and practical sense way, I cannot thank AQuA and CWP enough for the opportunity to be involved in this invaluable project".

For more information, please contact Lesley Gledhill, Participation & Engagement practitioner on 0782 5522489

Improving Access and Support for Veterans

Background: On 11th July staff from across the Trust came together at Sycamore House to learn more about the armed forces covenant, and CWP's commitment to support our veterans. Many of the staff attending had a personal interest as members of their families were serving in the armed forces, or were veterans. Staff listened to presentations from representatives from the Royal British Legion and the role played by the Transition, Intervention and Liaison Service. There was very positive feedback from those who attended, particularly around the range of support that they could signpost patients, who had served in the forces to.

Key statistics:

- There are 2.6 million veterans in the UK, many aged over 75 (many are ex national service)
- The northwest is one of the largest recruitment centres in the country
- 20% of recruits are from the northwest, even though the northwest accounts for only 11% of the population
- Forensic history is high amongst veterans

Pictured right are Jamie Holmes, High Intensity worker IAPT; Adam Gillett, Royal British Legion, Independent Living Lead (North); John Henstock, Transition, Intervention and Liaison; and Julia Cottier, Service Director, and CWP armed forces champion.

Some of the problems faced by veterans were highlighted in the presentations; these included:

- High incidence of mental health problems, and unlikely to seek help
- Struggle to adjust to civilian life, and families also suffer
- Self-medicating, drug and alcohol abuse
- Young men prone to increase risk of suicide

What did we want to achieve?

We wanted to raise awareness of the range of support that veterans can access, and CWP's commitment to the Armed Forces covenant which we signed up to in June 2017. Avril Devaney, Director of Nursing and Therapies, is pictured below signing the covenant. Members of the Armed Services may face many challenges, particularly when returning to civilian life, which is why CWP has signed this Covenant. Julia Cottier, Service Director, in the Central and East Locality is CWP's named officer for military veterans. The Armed Forces Covenant is a voluntary statement of mutual support between a civilian community and its local Armed Forces community. The aims of the covenant are to:

- Encourage local communities to support the Armed Forces Community in their areas
- Nurture public understanding and awareness of issues affecting the Armed Forces Community
- Recognise and remember the sacrifices made by the Armed Forces Community
- Encourage activities which help to integrate the Armed Forces Community into local life
- Improve access and priority treatment

Next steps:

The *Defence People Mental Health Wellbeing Strategy 2017 – 2022* has now been launched, and distributed to all staff who attended the awareness session. We are arranging for the Royal British Legion to provide further sessions for mental health staff in Macclesfield and Crewe. We are also arranging for the *Veterans in Minds* and *Working Well* Talking Therapies, delivered by GMMHT to deliver an information session to staff from across the trust. CWP has signed up to the *Step into Health* programme which is to support veterans who may have transferable skills relevant to vacancies in NHS.

For more information, please contact Julia Cottier, Armed Force Champion 01625 508542

Involving and supporting carers at Lime Walk to aid recovery

Background:

Lime Walk offers assessment, rehabilitation and therapies for mental health patients from across Cheshire. Our patients can be treated here for many months so involving and supporting their families and carers is really important.

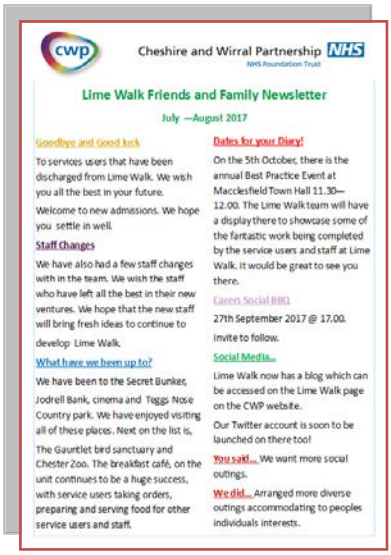
What did we want to achieve?

We wanted to increase carer involvement within an individual's recovery, and we wanted their carers to be more aware of the daily activities that were happening on the unit.

Pictured right are occupational therapists, Megan Burns and Bethan Woodcock, and Sarah Edge, Specialist Occupational Therapist. They were supported by Jane Vincent – Occupational Therapy Assistant.

What we did:

Questionnaires were devised and sent out to ask from carers when it would be best for them to attend events. Events were planned based on the outcome of their feedback. A monthly newsletter, collaboratively created by the occupational therapy team and the service users, has been developed (see right) and sent out to carers. Carers have also been involved in the development and improvement of a carer information pack.



Cheshire and Wirral Partnership NHS
NHS Foundation Trust

Lime Walk Friends and Family Newsletter

July —August 2017

Goodbye and Good luck

To services users that have been discharged from Lime Walk. We wish you all the best in your future.

Welcome to new admissions. We hope you settle in well.

Staff Changes

We have also had a few staff changes with in the team. We wish the staff who have left all the best in their new ventures. We hope that the new staff will bring fresh ideas to continue to develop Lime Walk.

What have we been up to?

We have been to the Secret Bunker, Jodrell Bank, cinema and Tiggs Nose Country park. We have enjoyed visiting all of these places. Next on the list is, The Gauntlet bird sanctuary and Chester Zoo. The breakfast café, on the unit continues to be a huge success, with service users taking orders, preparing and serving food for other service users and staff.

Dates for your Diary!

On the 5th October, there is the annual Best Practice Event at Macclesfield Town Hall 11.30—12.00. The Lime Walk team will have a display there to showcase some of the fantastic work being completed by the service users and staff at Lime Walk. it would be great to see you there.

Carers Social BBQ

27th September 2017 @ 17.00.

Invite to follow.

Social Media...

Lime Walk now has a blog which can be accessed on the Lime Walk page on the CWP website.

Our Twitter account is soon to be launched on there too!

You said... We want more social outings.

We did... Arranged more diverse outings accommodating to peoples individuals interests.

Results:

Rearranging the timing of events had led to an increase of involvement and attendance by carers. Service users are also closely involved in the preparation of events including planning, shopping, cooking, and budgeting. Their feedback has been really positive, with many saying how much that they enjoy their involvement in the events, particularly preparing it for their family and friends. A Recovery Festival held in July (see picture abve) was particularly successful, with more than 50 people joining service users and staff for the event. This was the unit's third annual festival and featured live music and a BBQ. The event raised £540 for charities chosen by patients on the unit.

The events give staff, patients and carers the opportunity to all meet as one and work together, and they enable staff to explore ideas, concerns and expectations of carers. Another benefit is that carers are able to meet one another at the event and gain support from each other. One carer said:

> "….it's great to attend the events, sitting chatting with my son like this, seems so much more natural than just the usual visiting."

Next steps:

Building on the success of previous events held, we are holding another Recovery Festival for the service users and carers to attend. We are also:

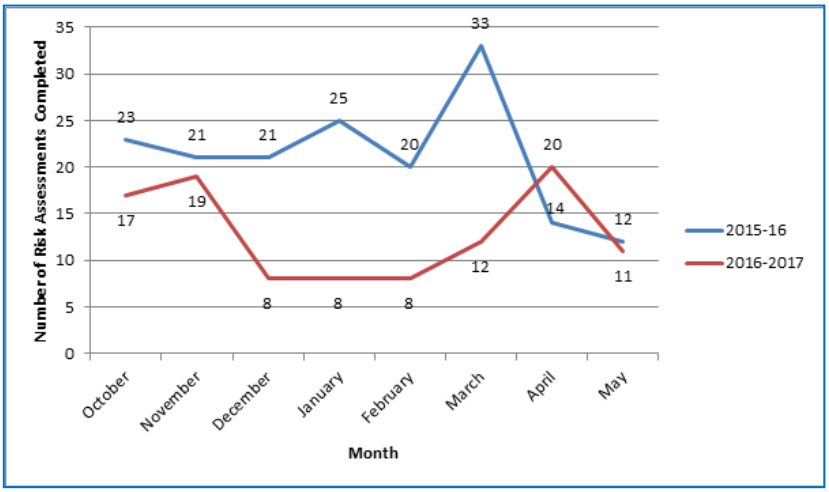
- Planning a BBQ for service users and carers in September
- Setting up a twitter account linked with the unit, that carers will be able to access
- Continuing with the development of the monthly unit newsletter (see previous page)
- Continuing to engage carers
- Starting a patient led blog

For more information, please contact Bethan Woodcock, Occupational Therapist on 01625 505 662

Wirral CAMHS improve access to advice and support

Background:

Wirral CAMHS launched their response to the *Future in Mind* (FiM) transformation plan in October 2016. As part of this response, there was a transformation of the existing Primary Mental Health (PMH) team and model. The new team's aim is to provide specialist mental health support via a training and consultation model, to all the agencies supporting young people's emotional health and well-being on Wirral. Amongst a variety of **transformative quality improvement developments**, the Service and Duty Line has been introduced. This provides a single 'front door' to a CAMHS duty worker that enables people (including parents, carers or healthcare professionals) to **access advice or support** before referring a young person into the service.



What did we want to achieve?

The last FiM survey indicated that schools would like **better communication** with CAMHS.

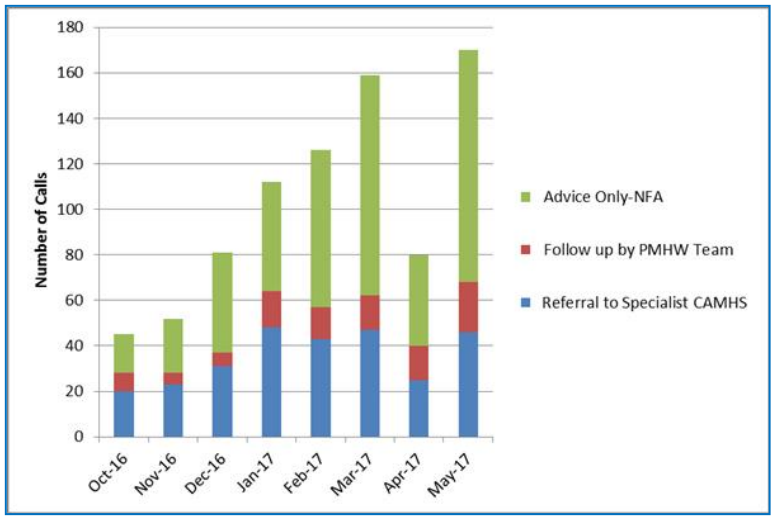
What we did:

The entire Wirral CYP workforce, along with parents and including referrers, can now access specialist mental health advice from our team via the telephone Advice and Duty line, 9 – 4:30, Monday to Friday. The line was set up in November 2016. If needed, this phone call can also act as the referral into CAMHS for the young person. Pictured below, the Advice and Duty line team.

Results:

- 825 phone consultations have been completed since October 2016.
- 34% of these went on to be referred into specialist CAMHS.
- 12% were followed up by the PMH team.
- 53% were given advice only.

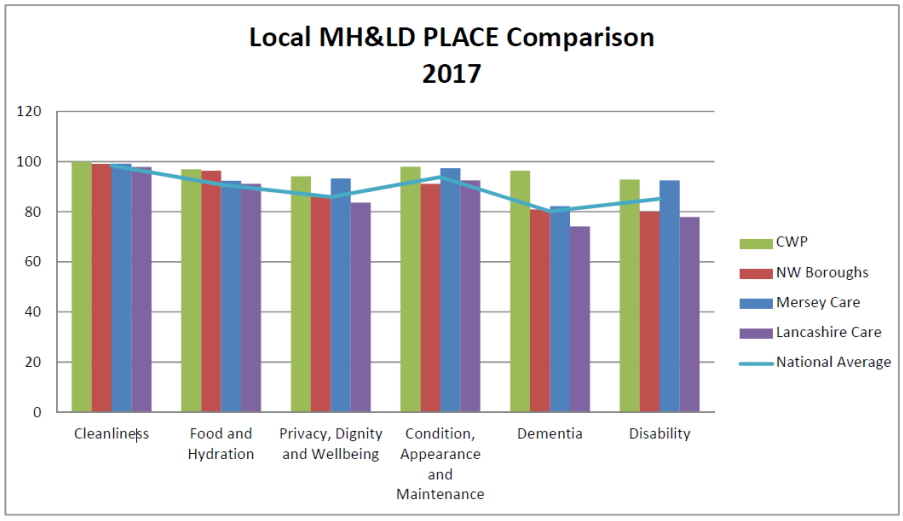
Although we can't draw causal correlations, since the introduction of the advice line, deliberate self-harm risk assessments for under 16s, and therefore admissions for assessment via A&E, are 40% **less between October – May 2017**, compared to the same period the year before. We are also beginning to see a reduction in referrals into CAMHS, though we must be cautious about interpreting our data at this early stage. Evaluations from callers are **overwhelmingly positive**.



This project exemplifies CWP's commitment to **person-centredness and co-production**. Following a recent visit to the team, the Chief Executive described the team as: **"absolutely inspirational... this brilliant but simple idea has led to less immediate pressure on the clinical service while providing an effective and meaningful new offer to our community. The team is a fantastic example of what can be achieved if we work hand in hand with those who access our services, their carers and families, using a learning and reflecting approach".**

For more information, please contact Dr Helen Taylor, Stephanie Ireland, Rachel Nunn or Vicki Dunham on 0151 4888450

High quality standards of care and facilities for CWP patients



Patient-led assessments of the care environment (PLACE) are an annual appraisal of the non-clinical aspects of NHS and independent/ private healthcare settings, undertaken by teams made up of staff and members of the public (known as patient assessors). The team must include a minimum of 50% patient assessors.

Assessments of CWP sites took place between March and June 2017, and provide a framework for assessing quality against common guidelines and standards in order to quantify the environment's cleanliness, food and hydration provision, the extent to which the provision of care with privacy and dignity is supported, and whether the premises are equipped to meet the needs of people with dementia or with a disability. CWP has scored **higher than the national average**, and **higher than our neighbouring mental health trusts** in each of these categories (see above). Furthermore, our scores **have improved from previous visits last year** (see table below).

	Cleanliness	Food	Privacy, Dignity and Wellbeing	Condition, Appearance and Maintenance	Dementia	Disability
2016	99%	92%	92%	97%	95%	89%
2017	99.8%	96%	94%	98%	96%	93%

For more information, please contact David Pearson, Senior Facilities Manager on 01244 397273

Between April and July 2017, CWP formally received 822 ***compliments*** from people accessing the Trust's services, and others, about their experience of the Trust's services. Below is a selection of the comments and compliments received:

CWP East

"Virtually every day we noticed improvements and the staff (on Bollin ward) were helpful in allaying our worst fears. Very soon after the start of treatment, our son improved in leaps and bounds. The atmosphere provided was tremendously beneficial for him, and a combination of great carers, experienced staff, proper medication, and a healthy calming environment all contributed to the near complete rehabilitation of our son within 12 days. Watching so many carers channel their energy into helping the patients was delightful. The care they displayed was very obviously genuine, and we are forever grateful for that. We were allowed to visit often and call every two hours to check on his condition. The staff showed flexibility, sympathy, and were uniformly superb."

"It was a place where I could be open and I was never judged. I've picked up some handy ideas for the future and I've learnt a lot."

"I would just like to express on behalf of myself and my family our heartfelt thanks to all your staff that looked after my mum whilst she was with you. I witnessed great care and dedication to duty every time I visited her, and I too was made welcome which was lovely."

"Words alone cannot express how grateful we are for their service. They gave us our son back, and I cannot praise the staff highly enough."

CWP West

"My therapist has been a great support during my sessions, encouraged me to reflect on my thoughts and never made me feel judged. I feel like I have the right tools to carry on outside of session."

"We would like to thank all the team who looked after (patient), during his last days, with kindness and care. Without your help it would not have been possible for us to grant (patient) his wish to spend his last days at home."

"I just wanted to say thank you for everything and for all your support while I have been on the ward, I really appreciate it. I honestly can't thank you enough for how lovely and kind you have been and it means so much. You have given me hope that it is possible to get through this."

CWP Wirral

"I felt listened to and felt that the people I spoke to knew the best course of action to help me."

"I just feel the support is fantastic, and I actually felt like someone cared about how I was feeling. Brilliant service; proper in depth counselling which helped me to really pull apart my problem. Staff supportive, caring, and very pleasant."

"The support was great and we feel optimistic on the future support our daughter will get."

Share your stories

We welcome your best practice stories and Quality Improvement successes; please share your work via the Safe Services Department using the Best Practice and Outcomes page on the intranet or contact the Healthcare Quality Improvement Team on 01244 393138

Look out for more about Quality Improvement in Edition 2 2017/18 of the *Quality Improvement Report*

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

STANDARDISED REPORT COMMUNICATION

REPORT DETAILS

Report subject:	Ward Daily Staffing Levels July and August Data 2017
Agenda ref. no:	17-18-54
Report to (meeting):	Board of Directors
Action required:	Information and noting
Date of meeting:	27/09/2017
Presented by:	Avril Devaney, Director of Nursing, Therapies and Patient Partnership

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

REPORT BRIEFING

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

This report details the ward daily staffing levels during the month of July and August 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.

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 July 2017 the trust achieved staffing levels of 97.5% for registered nurses and 91% for clinical support workers on day shifts and 94.5% and 96.3% respectively on nights. During August 2017 the trust achieved staffing levels of 97.1% for registered nurses and 92% for clinical support workers on day shifts and 94.8% and 99.8% respectively on nights.

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.

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, Head of Performance and Information

Distribution to other people/ groups/ meetings:

Version	Name/ group/ meeting	Date issued
1	Gary Flockhart, Associate Director of Nursing [MH and LD] Avril Devaney, Avril Devaney, Director of Nursing, Therapies and Patient Partnership	15/09/2017 15/09/2017

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

Appendix no.	Appendix title
1	Ward Daily Staffing July 2017
2	Ward Daily Staffing August 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	1214.5	1202	1169.5	1111	713	686.5	1391.5	1334	99.0%	95.0%	96.3%	95.9%	*
	Alderley Unit	984	916.5	1656	1546.5	713	667	713	713	93.1%	93.4%	93.5%	100.0%	Staff cross covered from other wards. Cross cover arrangements. Ward Manager working in the clinical team. Nursing staff working additional unplanned hours.
	Bollin	1417.5	1340	1306.5	1262.5	713	724.5	1246.5	1191	94.5%	96.6%	101.6%	95.5%	*
	Croft	1227	1228.9	1922	1399.4	713	649	1529.5	1510.5	100.2%	72.8%	91.0%	98.8%	Staff cross covered from other wards. Cross cover arrangements. Ward Manager working in the clinical team.
	Greenways A&T	1228	1278.75	1925	1499.5	713	736	1334	1160.5	104.1%	77.9%	103.2%	87.0%	Ward Manager working in the clinical team. Nursing staff working additional unplanned hours. Cross cover arrangements.
	LimeWalk Rehab	1234	1129	1038.5	860.5	713	618.5	724.5	707.5	91.5%	82.9%	86.7%	97.7%	Cross cover arrangements. Staff cross covered from other wards. MDT supported the team.
	Saddlebridge	1018	987	1248.5	1206	644	609.5	782	793.5	97.0%	96.6%	94.6%	101.5%	*
Wirral	Brackendale	1020.5	1009.55	1007	892	709.5	686.5	724.5	713	98.9%	88.6%	96.8%	98.4%	Ward Manager working in the clinical team.
	Brooklands	1110.5	1015.5	1229	1217.5	733	637	1084	1060.5	91.4%	99.1%	86.9%	97.8%	Nursing staff working additional unplanned hours.
	Lakefield	1076	996.1	1046.5	1023.5	713	586.5	839.5	885.5	92.6%	97.8%	82.3%	105.5%	Staff cross covered from other wards. Cross cover arrangements. Ward Manager working in the clinical team. Nursing staff working additional unplanned hours.
	Meadowbank	1088.9	986	1661	1649.5	701.5	655.5	1122	1059	90.6%	99.3%	93.4%	94.4%	Staff cross covered from other wards.
	Oaktrees	1295	1242	796	589	713	690	356.5	333.5	95.9%	74.0%	96.8%	93.5%	Ward Manager working in the clinical team. Nursing staff working additional unplanned hours.
	Willow PICU	1147.5	1147.5	920	885.5	754	700.5	839.5	828	100.0%	96.3%	92.9%	98.6%	*
West	Beech	1341	1338.5	1057.5	1040.5	686.5	686.5	747.5	736	99.8%	98.4%	100.0%	98.5%	*
	Cherry	1220	1203	1259	1187.5	724.5	713	1035	933.5	98.6%	94.3%	98.4%	90.2%	Staff cross covered from other wards. Ward Manager working in the clinical team. Nursing staff working additional unplanned hours.
	Eastway A&T	1133	1134	865.5	858	495.5	495.5	1063.5	1053.75	100.1%	99.1%	100.0%	99.1%	*
	Juniper	1335.5	1323	966	920	644	644	759	757	99.1%	95.2%	100.0%	99.7%	*
	Coral	1223	1108	1414.5	1334	701.5	598	1058	862.5	90.6%	94.3%	85.2%	81.5%	Staff cross covered from other wards. Cross cover arrangements
	Indigo	964	1120.5	1281.5	1017	690	636.5	713	736	116.2%	79.4%	92.2%	103.2%	Ward Manager working in the clinical team. Nursing staff working additional unplanned hours. Cross cover arrangementsx. MDT supported the team.
	Rosewood	1020	1020	1542	1542	704.5	704.5	785	785	100.0%	100.0%	100.0%	100.0%	*
	Trustwide	23297.9	22725.8	25311.5	23041.4	13892.5	13125	18848	18153.25	97.5%	91.0%	94.5%	96.3%	

	Ward	Day				Night				Fill Rate				Safe Staffing was maintained by:
		Registered		Care Staff		Registered		Care Staff		Day		Night		
		Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Average fill rate - registered nurses/ midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/ midwives (%)	Average fill rate - care staff (%)	
East	Adelphi	1340.25	1261.75	1152.5	1149.95	713	708	1196	1148	94.1%	99.8%	99.3%	96.0%	*
	Alderley Unit	963.5	937.5	1665.5	1527.5	713	655.5	713	770.5	97.3%	91.7%	91.9%	108.1%	Staff cross covered from other wards. Nursing staff working additional unplanned hours.
	Bollin	1284.5	1219.5	1369.5	1218	723	732	1414.5	1370	94.9%	88.9%	101.2%	96.9%	Cross cover arrangements. Nursing staff working additional unplanned hours. Ward Manager working in the clinical team.
	Croft	1204.5	1215	1922	1487.5	713	667.5	1426	1392.5	100.9%	77.4%	93.6%	97.7%	Staff cross covered from other wards. Cross cover arrangements. Ward Manager working in the clinical team. Nursing staff working additional unplanned hours.
	Greenways A&T	1237.5	1340	1759.5	1210.5	713	609.5	1000.5	1069.5	108.3%	68.8%	85.5%	106.9%	Staff cross covered from other wards. Cross cover arrangements. Ward Manager working in the clinical team. Nursing staff working additional unplanned hours.
	LimeWalk Rehab	1112.5	922.5	1069.5	1167.5	713	631.5	713	747.5	82.9%	109.2%	88.6%	104.8%	Staff cross covered from other wards. Cross cover arrangements.
	Saddlebridge	905.5	914.55	1331.5	1279	713	575	701.5	832	101.0%	96.1%	80.6%	118.6%	Cross cover arrangements. Ward Manager working in the clinical team.
Wirral	Brackendale	1000	977.5	1016	884	724.5	713	701.5	678.5	97.8%	87.0%	98.4%	96.7%	Cross cover arrangements. Ward Manager working in the clinical team.
	Brooklands	867	771	1148.5	1144.5	704.5	613	931.5	1025	88.9%	99.7%	87.0%	110.0%	Nursing staff working additional unplanned hours.
	Lakefield	1028.5	981.5	1022.5	965	713	644	762	839.5	95.4%	94.4%	90.3%	110.2%	Staff cross covered from other wards. Cross cover arrangements. Ward Manager working in the clinical team. Nursing staff working additional unplanned hours.
	Meadowbank	1099	1099	1433	1345.5	747.5	701.5	1008.5	744	100.0%	93.9%	93.8%	73.8%	Staff cross covered from other wards.
	Oaktrees	1250.5	1178.5	872.5	515.5	713	678.5	356.5	345	94.2%	59.1%	95.2%	96.8%	Staff cross covered from other wards. Ward Manager working in the clinical team.
	Willow PICU	1024.5	1024.5	888	842	644	621	897	885.5	100.0%	94.8%	96.4%	98.7%	*
West	Beech	1475.5	1474.5	920	920	745.5	745.5	793.5	770.5	99.9%	100.0%	100.0%	97.1%	*
	Cherry	1178.5	1147.25	1150	1117	560	561.5	782	782	97.3%	97.1%	100.3%	100.0%	*
	Eastway A&T	1077.75	1023.75	1080	1080	533	533	893.5	870.5	95.0%	100.0%	100.0%	97.4%	*
	Juniper	1410.5	1399	1012	1012	751.5	740	736	719.5	99.2%	100.0%	98.5%	97.8%	*
	Coral	942.25	953.75	1294	1294	532.75	532.75	1071	1071	101.2%	100.0%	100.0%	100.0%	*
	Indigo	1018.25	993.5	1002.5	1002.5	473.25	473.25	877	877	97.6%	100.0%	100.0%	100.0%	*
	Rosewood	962	904.5	1481	1469.5	678.5	678.5	752	752	94.0%	99.2%	100.0%	100.0%	*
	Trustwide	22382.5	21739.05	24590	22631.45	13522	12814.5	17726.5	17690	97.1%	92.0%	94.8%	99.8%	

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

STANDARDISED REPORT COMMUNICATION

REPORT DETAILS

Report subject:	Equality and Diversity Board Report 2016-17
Agenda ref. no:	17-18-55
Report to (meeting):	Board of Directors
Action required:	Information and noting
Date of meeting:	27/09/2017
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	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 provide the Board with evidence and assurance that CWP continued to meet their equality and diversity (E&D) obligations during 2016-17. The report provides details of current performance, how the Trust is meeting its legal obligations, ongoing work to date, identifies challenges and sets out the Trust priorities for 2017 - 2018.

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

This report provides information on the various equality initiatives and legal equality requirements that the Trust has put in place to ensure the Trust is meeting equality obligations under the Equality Act (2010). The report highlights the actions the Trust has implemented to ensure we are compliant with the NHS England Initiatives Workforce Race Equality Standard (WRES) and the Equality Delivery Standard 2 (EDS2)

Assessment – *analysis and considerations of options and risks*

The Trust is obliged to provide written evidence and data against the various reporting systems put in place by NHS England and the commissioners.
EDS2 assessments have been completed by CWP community network partners in localities and by staff side representatives for trustwide goals and is rated as Achieving across all 4 Goals.
Evidence for the Workforce Race Equality Standard (WRES) is obtained from the NHS Staff Survey 2016 and CWP Electronic Staff Records and shows minor changes to the ethnicity of the CWP workforce; however data has identified potential areas for further investigation which are discussed in the report. The increases in monitoring requirements of E & D continue with the introduction of the Workforce Disability Equality Standard (WDES) in 2018 and illustrate the national drive to reduce inequalities which will continue to increase the resource required to demonstrate how CWP meets this agenda. Regular updates on CWP equality and diversity activity is provided to the CWP Trust-wide Equality and Diversity Group which reports to the CWP People Organisational Committee and to the Board via the Quality Committee.

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

The Board of Directors is recommended to **note**:

- The Trust is compliant with the requirements of the Equality Act and the CCGs Equality and Diversity Quality Requirements, regular updates are provided to the various commissioners as requested in the quality contact
- The progress made in embedding the Equality and Diversity Framework across Trust is updated at the Trust Equality & Diversity Group the Equality Delivery System 2 (EDS2) assessments carried out by various local organisations in the 3 localities also monitor Trust progress
- CWP's Commitment to Delivering Personal, Fair and Diverse Healthcare Services 2016—2020 There are governance arrangements in place to monitor progress of the Trust Equality and Diversity 4 year 2016-2020 objective action plan.

Who/ which group has approved this report for receipt at the above meeting?	Avril Devaney and David Harris
Contributing authors:	Andrea Hughes Bob Davies

Distribution to other people/ groups/ meetings:

Version	Name/ group/ meeting	Date issued
1	Peoples Organisational Committee	TBC

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	Equality and Diversity Annual Report 2016/17

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

17-18-55 Appendix 1

Equality and Diversity Annual Report 2016/17

1. Purpose of the report

This report is to provide the Board with assurance that CWP are meeting their equality and diversity obligations. The report also provides details of our current performance, ongoing work to date, identified challenges and sets key actions for moving forward.

2. Background

The Equality Act (2010) brought together existing legislation and frameworks that relate to discrimination and inclusion. The spirit of the Act is intended to recognise that people are all different and everyone has characteristics about them that mean they may be subject to discrimination or exclusion. The Act clarifies characteristics that lead to discrimination and places a duty on public sector organisations to eliminate unlawful discrimination and promote equality between people who have protected characteristics and those who do not. The characteristics are;

Protected Characteristics		
Age	Disability	Gender
Gender Reassignment (Trans)	Marriage/Civil Partnership	Pregnancy/Maternity
Race	Religion or Belief (including lack of belief)	Sexual Orientation

The Equality and Human Rights Commission (EHRC) is the body that is charged with ensuring compliance and has similar powers to the CQC. As future guidance emerges from the EHRC the Trust will incorporate it into plans and actions around equality:

3. Progress

Equality Delivery System Assessment 2 (EDS2): Appendix 1

The main purpose of the EDS2 was, and remains, to help local NHS organisations, in discussion with local partner's including local people, review and improve their performance for people with characteristics protected by the Equality Act 2010. By using the EDS2, NHS organisations can also deliver on the public sector Equality Duty (PSED).

The EDS2 assessment has 4 Goals;

Goal 1 Better outcomes for all
Goal 2 Improved patient access and experience
Goal 3 Empowered, engaged and well supported staff
Goal 4 Inclusive Leadership'

The rating scale is graded using 4 levels Underdeveloped, Developing, Achieving and Excellent.

Grading is based on simple criteria for each of the standards as highlighted below.

1. Undeveloped	Evidence provided for 0-2 protected characteristics
2. Developing	Evidence provided for 3-4 protected characteristics
3. Achieving	Evidence provided for 5-7 protected characteristics
4. Excelling	Evidence provided for 8-9 (all) protected characteristics

Local community network groups representing members of the diverse community groups across the 3 localities were invited to attend CWP NHS Equality Delivery System 2 assessments across the Trust to score the Trust against EDS2 Goals:1 and 2 The events took place in the Wirral and Cheshire

Central / East in September 2016 and in Cheshire West in March 2017. The events were designed to allow key community partners across the Trust to undertake and contribute to assessing performance by CWP in their strategic implementation of the Equality Delivery System 2 (EDS2).

Organisations had been chosen for their location and expertise within the communities in which they operate; all organisations involved or invited provide services for groups classed under the nine equality 'Protected Characteristics' of the Equality Act 2010.

Stakeholders - Partners on the assessment panel:

Wirral	Cheshire West	Cheshire East
• Wirral Cultural Network • Wirral Change • Wirral Older People's Parliament • Mencap • Wirral Royal Society for the Blind • Age UK • Healthwatch Wirral unable to attend the event, copies of the EDS2 assessment evidence sent to Healthwatch	• Deafness Support Network, • Cheshire Halton and Warrington Race Equality Centre, • Body Positive. • Healthwatch Cheshire West unable to attend the event, copies of the EDS2 assessment evidence sent to Healthwatch	• Body Positive • East Cheshire CCG • South Cheshire CCG • Vale Royal CCG • Healthwatch Cheshire East • Cheshire East Multi Cultural Forum • Motherswell • Deafness Support Network • Cheshire East Council

The assessment events involved presentations from locality services to local community network groups and provided opportunities for them to ask questions of CWP Teams and Service Managers. CWP provided evidence produced by respective services against the EDS2 goals. The groups then rated and scored the CWP Trust performance against the EDS2 rating scale.

The Trust has worked in partnership with various organisations i.e. Local Healthwatch, Deafness Support Network, Body Positive: LGBT and their representatives to get a better understanding of the best formats evidence can be provided for future assessments.

The EDS2 assessment for Goals 3 and 4 was completed by staff side representatives from the Royal Collage of Nursing (RCN) and Unison the Trust scored 'Achieving' for both goals.

EDS2 partners' assessment grades for goals 1 and 2 with comparison between 2015-2016 and 2016-17

The assessment score for the Trust wide grade has been calculated by adding the assessment grade for each locality.

The information below highlights the difference in the assessment scoring for each goal and outcomes between last year 2015-16 and this year 2016-17 in the 3 localities and Trust wide.

- The Wirral have scored Achieving in all areas again in 2016-17.
- Cheshire Central / East has seen an improvement in all 9 outcomes from Developing to Achieving in 2016-17
- Cheshire West has seen an improvement in the scoring of 5 of the 9 outcomes that scored Developing in 2015-2016 to Achieving in 2016-17

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Equality Delivery System 2: Goal 1								
1. 'Better health outcomes for all'								
Individual Outcome grades for Goal 1:	**Grade:**							
CWP Locality:	**Wirral**		**Cheshire East**		**Cheshire West**		**Trust wide**	
	15-16	**16-17**	**15-16**	**16-17**	**15-16**	**16-17**	**15-16**	**16-17**
EDS2 Outcome 1.1 Services are commissioned, procured, designed and delivered to meet the health needs of local communities	**A**	**A**	**D**	**A**	**D**	**D**	**D**	**A**
EDS2 Outcome 1.2 Individual people's health needs are assessed and met in appropriate and effective ways	**A**	**A**	**D**	**A**	**D**	**D**	**D**	**A**
EDS2 Outcome 1.3 Transitions from one service to another, for people on care pathways, are made smoothly with everyone well-informed	**A**	**A**	**D**	**A**	**D**	**A**	**D**	**A**
EDS2 Outcome 1.4 When people use NHS services their safety is prioritised and they are free from mistakes, mistreatment and abuse	**A**	**A**	**D**	**A**	**D**	**A**	**D**	**A**
EDS2 Outcome 1.5 Screening, vaccination and other health promotion services reach and benefit all local communities	**A**	**A**	**D**	**A**	**D**	**D**	**D**	**A**

Developing (D) = **Achieving (A) =**

Equality Delivery System 2: Goal 2								
2. 'Improved patient access and experience'								
Individual Outcome grades for Goal 2:	**Grade:**							
CWP Locality:	**Wirral**		**Cheshire East**		**Cheshire West**		**Trust wide**	
	15-16	**16-17**	**15-16**	**16-17**	**15-16**	**16-17**	**15-16**	**16-17**
EDS2 Outcome 2.1 People, carers and communities can readily access hospital, community health or primary care services and should not be denied access on unreasonable grounds	**A**	**A**	**D**	**A**	**D**	**A**	**D**	**A**
EDS2 Outcome 2.2 People are informed and supported to be as involved as they wish to be in decisions about their care	**A**	**A**	**D**	**A**	**D**	**A**	**D**	**A**
EDS2 Outcome 2.3 People report positive experiences of the NHS	**A**	**A**	**D**	**A**	**D**	**D**	**D**	**A**
EDS2 Outcome 2.4 People's complaints about services are handled respectfully and efficiently	**A**	**A**	**D**	**A**	**D**	**A**	**D**	**A**

Equality Delivery System 2 Goal 3:	
Goal 3. 'Empowered, engaged and well-supported staff'	**Verified by: Staffside**

	Reps Unison and RCN: March 2017
CWP Trustwide	**2015-16 and 2016-17 Received the same assessment score**
EDS2 Outcome 3.1 Fair NHS recruitment and selection processes lead to a more representative workforce at all levels	**Achieving**
EDS2 Outcome 3.2 The NHS is committed to equal pay for work of equal value and expects employers to use equal pay audits to help fulfil their legal obligations	**Achieving**
EDS2 Outcome 3.4 When at work, staff are free from abuse, harassment, bullying and violence from any source	**Achieving**
EDS2 Outcome 3.5 Flexible working options are available to all staff consistent with the needs of the service and the way people lead their lives	**Achieving**
EDS2 Outcome 3.6 Staff report positive experiences of their membership of the workforce	**Achieving**

Equality Delivery System 2 Goal 4:	
4. 'Inclusive Leadership'	
CWP Trustwide	**2015-16 and 2016-17 Received the same assessment score**
EDS2 Outcome 4.1 Boards and senior leaders routinely demonstrate their commitment to promoting equality within and beyond their organisations	**Achieving**
EDS2 Outcome 4.2 Papers that come before the Board and other major Committees identify equality-related impacts including risks, and say how these risks are to be managed	**Achieving**
EDS2 Outcome 4.3 Middle managers and other line managers support their staff to work in culturally competent ways within a work environment free from discrimination	**Achieving**

Responses and actions to the Equality Delivery System 2 (EDS2) assessments will be developed and embedded into the Trust 4 year Equality Objective Plan 2016-20 action plan and business plans completed by the clinical service units to improve services to services users that help support delivery of personal fair diverse services and monitored via the diversity framework.

Diversity Framework

The Trust Diversity Framework continues to develop and embed into the locality structure. Each locality has established a locality wide partnership network / group which consists of members from the diverse community, the three groups are at different stages of maturity and effectiveness. The purpose of the locality groups is to respond to the EDS2 assessment and drive improvement in the provision of services locally to people with protected characteristics and provide assurance to the Trust wide Equality and Diversity Group of the quality of equality and diversity in their local services. This group reports through the People Operational and Development group to the Quality Committee and the Trust Board.

Diversity partners: Tomorrows Woman, Age UK, Deafness Support Network, Irish Community Care Merseyside, Wirral Lesbian Gay Bisexual Transgender (LGBT) / Terrence Higgins Trust, Wirral Multicultural Centre (BME), Merseyside Society for Deaf People, Body Positive LGBT, Cheshire East Multi Cultural Forum (BME) Sahir House, Older Peoples Parliament

Workforce Race Equality Standard (WRES) Appendix 2

The NHS Equality and Diversity Council agreed in July 2014 that action across the NHS needs to be taken to ensure employees from black and ethnic minority (BME) backgrounds have equal access to career opportunities and receive fair treatment in the workplace.
The Workforce Race Equality Standard (WRES) consists of nine metrics. Four of the metrics are specifically on workforce data and one metric requires provider organisations to ensure that their Boards are broadly representative of the communities they serve.

Four of the metrics are based on data derived from the national NHS Staff Survey indicators and highlights the differences between the experience and treatment of White staff and BME staff in the NHS.

The CWP 2016 NHS Staff Survey was completed by 1580 staff which is a response rate of 47% which is above average for combined mental health / learning disability trust in England and compares with a response rate in the Trust in 2015 of (49%) in 2015 staff highlighted their ethnic background as white 97% and BME 3% in 2016 the ethnic background figures were white 96% and BME 4%.

Workforce: There are four workforce indicators and the standard compares the metrics for White and BME staff, indicator 3: Relative likelihood of BME staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation has highlighted an increase in BME staff entering the formal disciplinary route in 2016-17 compared to 2015-16, although there has been an increase the actual number of BME Staff entering the disciplinary process the numbers are relatively low 5 in 2016-17 compared to 1 in 2015-16.

		2016-17	**2015-16**
3	Relative likelihood of BME staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation Total Number of BME Staff entering the disciplinary process 2016-17=5 BME- Staff 2015-16=1 BME- Staff *Note: this indicator will be based on data from a two year rolling average of the current year and the previous year	Relative likelihood of BME staff entering the formal disciplinary process, is **3.05** times more likely compared to White staff **0.01** of White staff enter the formal disciplinary process compared to **0.04** BME staff	Relative likelihood of BME staff entering the formal disciplinary process, is **0.35** times more likely compared to White staff **0.02** of White staff enter the formal disciplinary process compared to **0.01** BME staff

The Trust has put in place a process to analyse the data to obtain a better understanding of the root cause of the increase and to breakdown the information into locality service lines, reasons and possible themes

Of the four questions covering the NHS Staff survey 3 have seen an improvement for BME staff and one has stayed the same. Figures in green highlight an improvement in last year's figures Key Finding and question numbers are the same in 2016 as 2015.
Figures in green highlight an improvement in last year's figures

	Indicator	**Data for reporting year 2016**	**Data for previous year 2015**
5	**KF 25.** Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months Experiences of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12	White staff**: 24%** BME staff**: 34%** **Average (median) for combined MH/LD and**	White staff: **27%** BME staff: **40%**

	months has seen a reduction of **3%** for white staff and **6%** for BME staff.	**Community Trusts** White staff– **27%** BME staff- **32%**	
6	KF 26. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months Experiences of experiencing harassment, bullying or abuse from staff in last 12 months has seen a reduction of **3%** for white staff and **8%** for BME staff.	White staff**: 16%** BME staff: **15%** **Average (median) for combined MH/LD and Community Trusts** White staff– **20%** BME staff- **24**%	White staff: **19%** BME staff: **23%**
7	KF 21. Percentage believing that Trust provides equal opportunities for career progression or promotion Experience of white staff and BME staff were the same as 2015 and highlights that staff believe the Trust provides equal opportunities for career progression.	White staff: 91% BME staff: 97% Average (median) for combined MH/LD and Community Trusts White staff: 89% BME staff: 78%	White staff:91% BME staff: 97%
8	Q17. In the last 12 months have you personally experienced discrimination at work from any of the following? b) Manager/team leader or other colleagues Experience of white staff has seen a **1%** decrease from 2015 and there has been a decrease of **9%** from 2015 for BME staff	White staff**: 4%** BME staff**: 3%** **Average (median) for combined MH/LD and Community Trusts** White staff: **3%** BME staff: **5%**	White staff: **5%** BME staff: **12%**

Workforce Race Equality Standard (WRES) action plan 2017-18
At a recent NHS England WRES workshop earlier in the year the NHS England lead on the WRES Roger Kline made the recommendation that WRES action plans need to more specific with only a few actions therefore the CWP 2017-18 WRES action plan consist of only 3 specific actions covering Diverse Workforce, Recruitment, Disciplinary Processes

Diverse Workforce
Whilst the Trust can show representation in the various bandings in our workforce as a whole there is work to be done to attract minority staff across the range of job opportunities and in particular into senior roles.

Recruitment
Relative likelihood of BME staff being appointed from shortlisting compared to that of White staff being appointed from shortlisting across all posts. The Trust will monitor and address any imbalance and review reasons for the outcome of BME staff not being appointed after interview.

Disciplinary Processes
Relative likelihood of BME staff entering the formal disciplinary process, compared to that of White staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation, the Trust will monitor data throughout the year and address issues if they arise and have set about reviewing the reasons for the increase in BME staff entering the formal disciplinary process in 2016-17.

4.3 Board Representation Indicator:
For this indicator, compare the difference for white and BME staff

	Indicator	Data for reporting year	Data for previous year
9	Percentage difference between the organisations' Board and its overall workforce disaggregated: • membership and its overall workforce disaggregated by voting membership of the board • By executive membership of the board **2016** 14 Board members: 1 BME and 13 White **2015** 13 Board members: 1 BME and 12 White	Percentage difference between the organisations' Board voting membership and its overall workforce is **3.44%** By executive membership of the board Board Directors: White: **92.86%** BME: **7.14%**	Percentage difference between the organisations' Board voting membership and its overall workforce is **4.10%** By executive membership of the board Board Directors: White: **92.31%** BME: **7.69**%

Data: Appendix 3
CWPs workforce for April 2016–March 2017 reasonably reflects the characteristics of local populations across the areas that CWP serves; there has been a slight increase over the last twelve months in the number of staff from Black and Minority ethnic backgrounds **0.09%**.The challenges for the Trust in improving representation is understanding the distinct differences in community make up across the large geographical area we serve and working with the number of small and locality based services that are spread out across the Trust.

CWP aim to provide a personal, fair and diverse working environment for all of our staff and the majority of the Trusts evidence from the NHS Staff Survey results to demographic information suggest this is felt by our staff too.

Staff Profile Highlights Headlines: As of March 2017 CWP employed 3431 people of which;
- **80%** are women
- **25.67%** are aged under 35 and **26.95%** are aged over 55
- Across Cheshire West & Chester, Cheshire East, Wirral and Trafford there are between **3% - 9.38%** of staff from Black Minority and Ethnic Communities depending on where staff are located across the Trust.
- **3.53%** of staff disclosed that they consider themselves to have a disability, **90.43%** of staff told us they don't consider themselves to have a disability with the remainder either unknown or chosen not to disclose.
- **80.10%** of staff disclosed as Heterosexual and **1.54%** as Lesbian, Gay or Bisexual with the remainder unknown or chose not to disclose.
- **50.88%** of staff considers themselves Christian, **14.61%** as Atheists and the third biggest group at **8.56%** choosing to define their religion as Other
- **20.15%** choose not to disclose their religion or belief.

Interpretation & Translation: Appendix 4
In order to meet the needs of people accessing our services whose first language is not English, the Trust has a varied list of recognised service providers in place to meet interpretation and translation requirements. This includes telephone interpretation, face to face interpretation, written translation, British Sign Language, Easy Read, Audio, Braille and Large Print.

The Trust continues to promote its Interpretation & Translation Best Practice Guidance for booking interpretation and translation services. The CWP website has the BrowseAloud facility which adds

speech, reading and translation support to the Trust website facilitating access and participation for those people with print disabilities, dyslexia, low literacy, mild visual impairments and those with English as a second language

Accessible Information Standard: Appendix 5

The Accessible Information Standard aims to ensure that people who have a disability, impairment or sensory loss are provided with information that they can easily read or understand with support so they can communicate effectively with services. Examples of the types of support that might be required include large print, braille or using a British Sign Language (BSL) interpreter.

The Trust has promoted and the Accessible Information Standard and has begun to implement the 5 requirements of the standard:

- Ask people if they have any information or communication needs, and find out how to meet their needs.
- Record those needs clearly and in a set way.
- Highlight or 'flag' the person's file or notes so it is clear that they have information or communication needs and how those needs should be met.
- Share information about people's information and communication needs with other providers of NHS and adult social care, when they have consent or permission to do so.
- Take steps to ensure that people receive information which they can access and understand, and receive communication support if they need it

CWP's Commitment to Delivering Personal, Fair and Diverse Healthcare Services Equality Priorities 2016—2020: Appendix 6

In 2016 CWP produced its Trust wide 4 year Equality Objective Action Plan 2016-2020, the actions in the plan were agreed after reviewing information and evidence from the various EDS2 assessments, NHS England initiatives and issues raised by staff and the local E&D network groups

CWP Equality Priorities for 2016-2020

Improving our Intelligence:

- Develop a Trust-wide approach to collecting equality information
- Review the data available relating to those currently accessing CWP services data/information in order to identify gaps in equality and diversity information reporting.
- Work with lived experience representatives to further consult with people who access CWP services and their carers in relation to Trust E & D objectives and action plan
- Formalise relationships with Local Authority, third sector and other statutory bodies to enable greater sharing of data and intelligence information in relation to equality groups and health inequalities

Developing our Staff:

- Continue to review the training offered for staff and provide a summary of mandatory and non - mandatory training by ethnic groups providing data for the Trust wide Equality & Diversity group
- Develop a WRES action plan to encourage a more diverse workface in the various bandings and attract minority staff across the range of job opportunities and in particular into senior roles.
- Develop a range of successful community and staff engagement events and activities that highlight different communities and demonstrate the Trusts commitment to being a personal, fair and diverse organisation

Working with our Communities:

- Corporately and locally develop robust partnership working with third sector providers including the sharing of information and intelligence, partnership service delivery and shared training events

- Develop leaflets with partnership organisations to ensure they are reflective and meet the needs of our targeted communities and ensure our website is truly reflective of our personal, fair and diverse services we deliver.
- Invite representatives from the various diverse community to present information and training sessions on issue relating to their specific group,
- Support local community events across the CWP footprint example: Chester Pride

Quality Contracts

Contract Guidance recommends that commissioners' service specifications should clearly set out requirements for protected groups where there is a need to do so. Through their contract monitoring, commissioners ensure that providers are working towards better health outcomes for all and improved patient access and experience. The EDS2 provides a tool to flag issues of concern that can be dealt with through the contract monitoring process.

Trust Diversity Information

This year the Trust has published a variety of reports and information to meet both its statutory and contractual obligations: these reports can be found on the CWP website:.
http://www.cwp.nhs.uk/about-us/our-vision-and-values/equality-and-diversity/

- Equality Delivery Standard 2 (EDS2) Appendix 1
- Workforce Race Equality Standard (WRES) Appendix 2
- Staff Equality Monitoring Report 2016-17 Appendix 3
- CWP Interpretation and Translation Report 2016-17: Appendix 4
- CWP Equality & Diversity 4 Year Objective Action Plan 2016-2020 Appendix 5

Equality Impact Assessments

Equality Impact Assessments are completed on all CWP policies strategies and proposed changes to services. The CQC CWP inspection report published in December 2015 after the inspection in June 2015 highlighted 'All the policies we saw had a comprehensive equality impact assessment'. The Trust has reviewed its Equality Impact Assessment process and guidelines and will review it in partnership with 3rd sector organisations in 2017-18

Progress on Challenges identified 2016/17

Challenge	Action taken or in progress
EDS2 Evidence needs to be more specific on how services are provided to all members of the diverse communities.	EDS2 Evidence strengthened by collaboration with Healthwatch and others to meet the CWP Equality Champions to discuss issues relevant to their specific groups: i.e. Unique: Transgender Organisations, Body Positive: LGBT group
Sexual Orientation Monitoring Information Standard to be introduced in 2017 this will provide a standardised approach to the collection of equality data for service users'	The Trust has highlighted areas that need to be improved e.g. The collection of data on sexuality and ethnicity, regarding sexuality data a plan is in place to address.
Changes to Carenotes to support sensitive gathering of gender information.	The Trust has promoted the Stonewall publication "What's it got to do with you" with people who use our services and our staff. The publication highlights reasons for collecting data.
Introduction of the Workforce Disability Equality Standard (WDES) to be introduce late 2017-early 2018	Awareness raising of the new Standard has commenced with Locality Equality leads and Champions and HR
Workforce Race Equality Standard (WRES) highlighted a significant increase in the number of BME staff being disciplined compared to 2016	Actions identified as previously described.

Priorities 17/18

Improving our Intelligence:

Analysis of reasonable adjustments made to enable vulnerable groups to access services, and plans to improve access for vulnerable groups

Analysis of patient experience information (PALS, Complaints, Friends and Family Test, patient surveys) disaggregated by protected characteristics action to address as required.

Develop WDES action plan and prepare to promote the future WDES

Developing our Staff:

Provide opportunities for staff to be involved in the setting up of staff network groups for BME LGBT and staff with a disability or long term medical condition

Implement the learning from NHS Employers – Diversity and Inclusion Partners Programme

Working with our Communities:

Implement the range of actions identified in the WRES plan to support increasing the diversity of workforce employed by CWP.

Develop and implement an Accessible Information policy and action plan

Recommendations It is recommended that the Board of Directors note;

- The Trust responses contained in this report to point 3 of the WRES report : Relative likelihood of BME staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation.
- The Trust is compliant with the requirements of the Equality Act and the CCGs Equality and Diversity Quality Requirements, regular updates are provided to the various commissioners as requested in the quality contact
- The progress made in embedding the Equality and Diversity Framework across Trust is updated at the Trust Equality & Diversity Group the Equality Delivery System 2 (EDS2) assessments carried out by various local organisations in the 3 localities also monitor Trust progress
- CWP's Commitment to Delivering Personal, Fair and Diverse Healthcare Services 2016—2020 There are governance arrangements in place to monitor progress of the Trust Equality and Diversity 4 year 2016-2020 objective action plan.
- The priorities for 2017/18

Appendix: 1: Workforce Race Equality Standard Report (WRES) 2016-17

Appendix: 2 Equality Delivery System 2 (EDS2) 2016-17

Appendix: 3 CWP Staff Equality Monitoring Report 2016-17

Appendix: 4 CWP Translation and Interpretation Report 2016-17

Appendix: 5 NHS England Accessible Information Standard

Appendix: 6 CWP Personal Fair and Diverse Commitment 2016-2020

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

STANDARDISED REPORT COMMUNICATION

REPORT DETAILS

Report subject:	Director of Infection Prevention & Control Quarter One Report 2017/18
Agenda ref. no:	17-18-56
Report to (meeting):	Board of Directors
Action required:	Information and noting
Date of meeting:	27/09/2017
Presented by:	Andrea Hughes, Director of Infection, Prevention and Control

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

Please find Q1 201718 report for Infection Prevention and Control (IPC). This is a mandatory requirement and requires noting.

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

Assessment – *analysis and considerations of options and risks*
The report will detail the work undertaken prior to and during Q1 2017/18

Recommendation – *what action/ recommendation is needed, what needs to happen and by when?*
The Board of Directors is recommended to **note** the IPC Quarter One report for 2017/18.

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	September 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	Q1 2017/18 Infection, Prevention and Control report.

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

17-18-56 Appendix 1

Infection, Prevention and Control Q1 2017/18 report

1. The 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 infection prevention and control (IPC), for which CWP is responsible for during Quarter 1.

2. Infection Prevention and Control Activity

During Q1 there have been no 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 and vomiting. No causative organism was identified. This was on Juniper ward in May, four patients were affected and one member of staff. The ward was closed for five days. A post outbreak meeting took place, once the ward had re-opened, to discuss what went well and any areas for improvement. It was noted that the ward staff responded well to the initial onset of diarrhoea and that correct procedures were adhered to by all staff, however there was feedback that the outbreak signs on the doors were difficult to see and did not act as a deterrent to people wishing to enter the ward environment. New posters have been designed that are clearer and more visible in response to this.

2.2 Audits

Audits have been undertaken on 18 wards or clinics and 13 of these have passed their audits with scores of over 95%. 2 areas scored less than 90% and action plans have been agreed and re audit dates booked to assess improvements.

2.3 Training

A total of 311 staff have attended IPC training, including induction during the period of Q1 and within this period 83% of staff Trust wide were compliant with IPC training. The infection prevention and control team are working closely with the education department to review how training is delivered and to look at creative ways to improve compliance including e-learning. The IPC training received very positive evaluations in Q1 with 95% of the attendees rating the training as good or excellent.

3. Antimicrobial Resistance

Within Q1, the IPC team have given advice and support for the management of 2 patients with Multi Drug Resistant (MDRO) Urinary Tract Infections (Extended Spectrum Beta Lactamase – ESBL), one in the West Locality and one in the Wirral Locality. Often these infections require intravenous antibiotics as the organisms are resistant to oral antibiotics. With the support of microbiology, one patient was successfully treated with oral antibiotics. The remaining patient received intravenous antibiotics, initially in the acute hospital but then on the ward within CWP supported by the Wirral Outpatient Parenteral Antimicrobial Therapy (OPAT) team. This had a very successful outcome demonstrating person centredness, whereby the most appropriate treatment was given, in the most appropriate setting for the patient at that time. This is likely to become a more frequent occurrence, due to the increasing incidence of MDRO within healthcare settings, in particular in urine infections.

The team work very closely with pharmacy teams across the Trust and continue to collect data around antimicrobial prescribing and compliance to formulary. The data shows that only 54% of all antimicrobial prescribing was in line with West Cheshire Clinical Commissioning Group prescribing guidelines but a further 18% was prescribed based on sensitivities or advice from the microbiologist and 18% had been commenced by another provider. Therefore, actual non – adherence to formulary was 12%.

A new public health campaign will run 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.

A member of the IPCT is working with one of the pharmacy leads to pull together an action plan 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. 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

4 Sepsis

The Sepsis Care Improvement Programme (SCIP) continues to raise awareness through education to our patient facing staff and aims to reduce mortality & morbidity for our service users and reduce delay to acute care for our patients with identified sepsis triggers.

The group have developed triage forms to help support and record observations and identify required actions. These forms will work alongside the existing National Early Warning Score (NEWS) and will help to prompt staff to ask the question, "Could this be sepsis?" There will be a pilot programme across 2 identified sites; Meadowbank Ward at Springview, and the Out of Hours Service. This is anticipated to commence in early October 17, for approximately 3 months, prior to the main roll out Trust wide early next year. An e-learning programme is currently being written that will be specific to CWP's needs and will be used as part of the pilot.

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. These are devastating infections and often result in admission to critical care and in some cases mortality. In 2017/18 the aim is to focus on E.coli (*Escherichia coli)* as one of the largest GNBSIs infection groups. This is supported by the Quality Premium for Clinical Commissioning Groups (CCG), which has set a reduction target of 10% in all E. coli blood stream infections reported at CCG level, by 2019. The IPCT has supported the CCG and Public health in the review of all cases of GNBSI in Q1 to develop an improvement plan for submission 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 Therefore, whilst most of the data collecting is undertaken by the external facing part of the IPC team (CWAC contract), it is thought that the reduction plan will impact on the internal part of the team as it is likely to include the review of indwelling catheters, peripherally inserted central catheter (PICC) lines and chronic wound care. An update on the improvement plan and actions will be included in the Q2 report.

6. Recommendations

The Board of Directors is asked to note the DIPC Quarter One report for 2017/17.

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

STANDARDISED REPORT COMMUNICATION

REPORT DETAILS

Report subject:	Emergency Preparedness Resilience and Response (EPRR) Core Standards Assurance 2017/18
Agenda ref. no:	17-18-57
Report to (meeting):	Board of Directors
Action required:	Discussion and Approval
Date of meeting:	27/09/2017
Presented by:	Tim Jenkins, Emergency Planning and Business Continuity Co-Ordinator

Which strategic objectives this report provides information about:	
Deliver high quality, integrated and innovative services that improve outcomes	Yes
Ensure meaningful involvement of service users, carers, staff and the wider community	Yes
Be a model employer and have a caring, competent and motivated workforce	Yes
Maintain and develop robust partnerships with existing and potential new stakeholders	Yes
Improve quality of information to improve service delivery, evaluation and planning	Yes
Sustain financial viability and deliver value for money	No
Be recognised as an open, progressive organisation that is about care, well-being and partnership	Yes
Which CQC quality of service domains this report reflects:	
Safe services	Yes
Effective services	Yes
Caring services	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	Yes
Capability and culture	Yes
Process and structures	Yes
Measurement	No
Does this report provide any information to update any current strategic risks? If so, which?	
See current risk register in the agenda of the public meeting of the Board of Directors at http://www.cwp.nhs.uk/about-us/board-members/our-board-meetings	No
36T	
Does this report indicate any new strategic risks? If so, describe and indicate risk score:	
See current integrated governance strategy: CWP policies – policy code FR1	No
36T	

REPORT BRIEFING

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

To present CWP's 2017/18 Emergency Preparedness Resilience and Response (EPRR) core standards assurance.

Background – *contextual and background information pertinent to the situation/ purpose of the report*
All NHS Provider organisations are required to complete an annual NHS England EPRR assurance process. This year there are 50 compliance standards for CWP to achieve.

Assessment – *analysis and considerations of options and risks*
CWP has completed the NHS England EPRR assurance within the required time-scale and has recorded full compliance across the 50 core standards required of a mental health and community provider.

Recommendation – *what action/ recommendation is needed, what needs to happen and by when?*
The Board of Directors is recommended to **approve** the report.

Who/ which group has approved this report for receipt at the above meeting?		Emergency Planning Sub-Committee 12th September 2017
Contributing authors:		Danielle Burton
Distribution to other people/ groups/ meetings:		
Version	Name/ group/ meeting	Date issued
V1	Julia Cottier, Emergency Accountable Officer Andy Styring, Director of Operations.	23rd August 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
01	EPRR Core Standards – Annual Assurance Template
02	Statement of Compliance

Cheshire & Merseyside Local Health Resilience Partnership (LHRP)
Emergency Preparedness, Resilience and Response (EPRR) assurance 2017-2018

STATEMENT OF COMPLIANCE

Cheshire and Wirral Partnership NHS Foundation Trust has undertaken a self-assessment against required areas of the the NHS England Core Standards for EPRR v5.0.

Following assessment, the organisation has been self-assessed as demonstrating the Full compliance level (from the four options in the table below) against the core standards.

Compliance Level	Evaluation and Testing Conclusion
Full	Arrangements are in place and the organisation is fully compliant with all core standards that the organisation is expected to achieve. The Board has agreed with this position statement.
Substantial	Arrangements are in place however the organisation is not fully compliant with one to five of the core standards that the organisation is expected to achieve. A work plan is in place that the Board or Governing Body has agreed.
Partial	Arrangements are in place however the organisation is not fully compliant with six to ten of the core standards that the organisation is expected to achieve. A work plan is in place that the Board or Governing Body has agreed.
Non-compliant	Arrangements in place do not appropriately address 11 or more core standards that the organisation is expected to achieve. A work plan has been agreed by the Board or Governing Body and will be monitored on a quarterly basis in order to demonstrate future compliance.

The results of the self-assessment were as follows:

Number of applicable standards	Standards rated as **Red**	Standards rated as **Amber**	Standards rated as **Green**
50	0	0	50
Acute providers: **60**** Specialist providers: **51**** Community providers: **50**** Mental health providers:**48**** CCGs: **38**			

Also includes **HAZMAT/CBRN standards** applicable to providers: **Standards:** Acutes **14** / Specialist, Community, Mental health **7
Ambulance Service are required to report statements for 3 compliance levels as stated on page 6 of the Gateway letter 06967

Where areas require further action, this is detailed in the attached core standards improvement plan and will be reviewed in line with the organisation's EPRR governance arrangements.

I confirm that the above level of compliance with the core standards has been agreed by the organisation's board / governing body along with the enclosed action plan and governance deep dive responses.

Julia Cottier, Service Director Central & East

Signed by the organisation's Accountable Emergency Officer

20/09/2017
Date of board / governing body meeting

23/08/2017
Date signed

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

CHAIR'S REPORT
AUDIT COMMITTEE – 5 September 2017

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

Internal Audit progress update
Two recently completed audits were reviewed by the Audit Committee. These were:

- Incremental Pay Progression Policy review which attained Limited Assurance
- CQUIN Activity Data Capture review which attained Significant Assurance, however on Committee review, this was agreed to be amended to Limited Assurance reflecting the higher risk actions identified.

The Committee was briefed on forthcoming audits which were either in planning or fieldwork stages including Patient cash and valuables, Locality governance assurance, Contracting and contract monitoring, recruitment processes and Core IT infrastructure.

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.

Anti-Fraud
A progress report was provided. There were no exceptions to note.

NHS England Conflicts of Interest guidance
Following the discussions at the July Committee meeting, the Committee reviewed the draft policy on Managing of Conflicts of Interest for the Trust. The Committee approved the proposed thresholds for reporting gifts, hospitality and sponsorship. A further report will be provided to the November 2017 meeting to update on the implementation of the policy.

Corporate Assurance Framework and Risk Register
The Committee undertook their quarterly review of the corporate assurance framework and the risk register. A number of new risks were noted however there were no matters for escalation to other Committees or the Board.

Governance Matters

The Audit Committee noted the minutes and/ or chair's reports from the Quality Committee and the Operational Board. There were no specific matters for escalation, however the Committee noted that the July 2017 Quality Committee had been inquorate therefore a number of decisions would be ratified at the September 2017 meeting.

Edward Jenner
Chair of Audit Committee

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

CHAIR'S REPORT –
QUALITY COMMITTEE
6 SEPTEMBER 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 of IT infrastructure failure has been remodelled to extend the scope to take greater account of the need for ensuring that clinical systems, infrastructure and the business intelligence offer evolve quickly to respond to strategic and transformational need associated with the Trust strategy (CWP Forward View), the various strategic Forward View frameworks, and the developing Quality Improvement Strategy.

  The Quality Committee is now also monitoring closely exceptions to risk treatment action points that are overdue, so that any additional support can be agreed to ensure that mitigation of risks to strategic objectives do not drift. This has informed the first of a series of in-depth reviews that the Quality Committee will start to identify: the risk that the CWP workforce may not have sufficient capability to deliver place-based, person-centred care. Further, the Medical Director and Associate Director of Safe Services will be meeting with the Chairs of each corporate meeting to discuss how the agendas of these meetings are comprised of matters that reflect treatment of current strategic risks. This will improve the dynamism of the corporate assurance framework process.
  The Board is asked to note the updates to the strategic risk register.

- **Benchmarking analysis – use of CTOs**
  The Quality Committee received an analysis of the use of CTOs within CWP compared with use nationally during 2015/16, as commissioned by the Board in January 2017. This was in response to the annual NHS Benchmarking dataset that showed CWP as an outlier for the year in question. The detailed five-year analysis, from 2012/13:
  - Confirms CWP as an outlier for the numbers of CTOs and number of CTO revocations for the period of benchmarking that triggered this review (2015/16).
  - Suggests that CWP's use of CTO, longitudinally, is comparable with the national picture.
  - Shows that within CWP, the use of CTOs varies across localities.

  CWP localities have been asked to review variation and ensure that the data and practice is well understood.
  The Board is asked to note that the Locality Data Packs will include a CTO dataset to allow adult and older adult community mental health teams to benchmark their use of CTOs (including duration) against other teams within the same specialty.

- **Learning from deaths**
  The Quality Committee approved the requisite policy on the organisational approach to learning from deaths and the support offer to bereaved families. This requirement is set out in National Quality Board guidance. The Quality Committee also received a presentation on the quality improvement approach it is taking to iteratively implement an effective approach to this agenda, particularly multi-disciplinary reviews of all deaths notified to the Trust to encourage reflection and identify any learning.
  The Board of Directors will continue to receive individual updates and updates within the routine Learning from Experience report to ensure the required Board oversight of this agenda.

- **Regulatory updates**
  In March 2017, the Trust was successful in a tendered bid to deliver the Starting Well service across the Cheshire West and Chester Local Authority footprint. The service is due to commence in January 2018. The Quality Committee received assurance that CWP's CQC registration will be updated by the end of October, new locality information and activity registrations will be included within the annual review of Statement of Purpose which will be approved by the Board in January, and a scoping exercise is planned and will be reported to November's Quality Committee to ensure knowledge and skills gaps of relevant Board members and sub Board officers, in relation the Ofsted children's centre inspection process, are mitigated.
  The Board of Directors is asked to note the Trust's plans to ensure regulatory preparedness.

Jim O'Connor
Non Executive Director
The previous meeting was not quorate. Those decisions for approval that were agreed in principle previously were endorsed.