AGENDA - Meeting of the Trust Board of Directors held in Public
1.00pm on Friday 28 September 2018
YMCA Crewe

Item no.	Title of item	Objectives/desired outcome	Process	Item presenter	Time allocated (approx.)
18/19/54	Apologies for absence	Receive apologies:	Verbal	Chair	1.00 (2 mins)
18/19/55	Declarations of Interest	Identify and avoid conflicts of interest	Verbal	Chair	1.02 (2 mins)
18/19/56	Meeting Guidelines	To note	Paper	Chair	1.04 (1 mins)
18/19/57	Minutes of the previous meeting held on 25 July 2018	Confirm as an accurate record the minutes of the previous meetings	Paper	Chair	1.05 (5 mins)
18/19/58	Matters arising and action points	Provide an update in respect of ongoing and outstanding items to ensure progress	Paper	Chair	1.10 (5 mins)
18/19/59	Board Meeting business cycle 2018/19	To note	Paper	Chair	1.15 (5 mins)
Strategic Change					
18/19/60	Chair's announcements	Announce items of significance not elsewhere on the agenda	Verbal	Chair	1.20 (10 mins)

Item no.	Title of item	Objectives/desired outcome	Process	Item presenter	Time allocated (approx.)
18/19/61	Chief Executive's announcements *(including overview of items discussed in closed meeting)*	Announce items of significance not elsewhere on the agenda	Verbal	Chief Executive	**1.30 (20 mins)**
18/19/62	Adult & Older People's Specialist Mental Health Redesign: East/South Cheshire/Vale Royal	To note	Paper	Director of Operations	**1.50 (10 mins)**
Quality of Care					
18/19/63	Monthly Ward Staffing Up-date July and August 2018	To note the ward staffing reports	Paper	Director of Nursing, Therapies and Patient Partnership	**2.00 (10 mins)**
18/19/64	Safeguarding Adults and Children's Annual Report	To approve	Paper	Director of Nursing, Therapies and Patient Partnership	**2.10 (5 mins)**
18/19/65	Accountable Officer Annual Report including Medicines Management	To approve	Paper	Medical Director Compliance, Quality and Assurance	**2.15 (5 mins)**
Operational Performance, Finance and Use of Resources					
18/19/66	Freedom 2 Speak Up Self-Assessment	To approve	Paper	Director of Nursing, Therapies and Patient Partnership	**2.20 (5 mins)**
18/19/67	Operational Plan / Board Performance Dashboard	To note performance	Paper	Director of Finance	**2.25 (10 mins)**

Item no.	Title of item	Objectives/desired outcome	Process	Item presenter	Time allocated (approx.)
Well-led (leadership and improvement capability)					
18/19/68	Quality Improvement Report	To note	Paper	Medical Director Compliance, Quality and Assurance	**2.35 (10 mins)**
18/19/69	Board Development Plan	To note	Paper	Chair	**2.45 (10 mins)**
18/19/70	Board Assurance Framework	To note	Paper	Medical Director Compliance, Quality and Assurance	**2.55 (10 mins)**
18/19/71	Learning from Experience Report, inc Learning from Deaths (executive summary)	To note	Paper	Director of Nursing, Therapies and Patient Partnership	**3.05 (10 mins)**
18/19/72	Equality and Diversity Annual Report	To approve	Paper	Director of Nursing, Therapies and Patient Partnership	**3.15 (5 mins)**
Governance and Regulation					
Governance and regulation: Assurance and escalation reports from Board Sub-committees (discussion by exception only)					
18/19/73	Register of Seals	To note	Paper	Director of Finance	**3.20 (5 mins)**

Item no.	Title of item	Objectives/desired outcome	Process	Item presenter	Time allocated (approx.)
18/19/74	Chair's Report of the Operational Committee held on 18 July 2018	To note	Paper	Chair of Operational Committee	**3.25 (5 mins)**
18/19/75	Chair's Report of the Quality Committee held on 12 September 2018	Review Chair's Report and any matters for note/ escalation	Paper	Chair of Quality Committee	**3.30 (5 mins)**
18/19/76	Chair's Report of the Audit Committee held on 4 September 2018	Review Chair's Report and any matters for note/ escalation	Paper	Chair of Audit Committee	**3.35 (5 mins)**
Closing Business					
18/19/77	Any other business	Consider any urgent items of other business	Paper	Chair	**3.40 (10 mins)**
18/19/78	Questions from observers or members of the public. *(relating to specific items on the agenda)*	To encourage openness and transparency	Paper	Chair	**3.50 (10 mins)**
18/19/79	Review of risk impacts of items discussed	Identify any new risk impacts	Paper	Chair/ All	**4.00 (3 mins)**

Item no.	Title of item	Objectives/desired outcome	Process	Item presenter	Time allocated (approx.)
18/19/80	Key messages for communication	Agree items of particular importance to communicate to staff, governors or other key stakeholders	Paper	Chair	**4.03 (5 mins)**
18/19/81	Review of meeting performance	Review the effectiveness of the meeting (achievement of objectives/desired outcomes and management of time)	Paper	Chair/All	**4.08 (2 mins)**
18/19/83	Date, time and place of next meeting: **Wednesday 28 November 2018 1:30pm – Redesmere**	Confirm arrangements for next meeting	Verbal	Chair	**4.10 (2 mins)**

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

Meeting Attendees' Guidance, January 2016

Under the direction and guidance of the Chair, all members are responsible for ensuring that the meeting achieves its duties and runs effectively and smoothly.

Before the meeting

- Prepare for the meeting in good time by reviewing all reports (the amount of time allocated for each agenda item can be used to guide your preparation);
- Submit any reports scheduled for consideration at least 10 days before the meeting to the meeting administrator (using the standard report template);
- Ensure your apologies are sent if you are unable to attend and *arrange for a suitable deputy to attend in your absence.

*some members may send a nominated representative who is sufficiently senior and has the authority to make decisions. Refer to the terms of reference for the meeting to check whether or not this is allowable.

At the meeting

- Arrive on time;
- Switch off mobile phone / blackberry;
- Focus on the meeting at hand and not the next activity or on your emails;
- Actively and constructively participate in the discussions;
- Think about what you want to say before you speak; explain your ideas clearly and concisely and summarise if necessary;
- Make sure your contributions are relevant and help move the meeting forward;
- Respect the contributions of other members of the group and do not speak across others;
- Ensure you understand the decisions, actions, ideas and issues agreed and to whom responsibility for them is allocated;
- Do not use the meeting to highlight issues that are not on the agenda;
- Re-group promptly after any breaks;
- Take account of the Chair's health, safety and fire announcements (fire exits, fire alarm testing, etc).

Attendance

- Members are expected to attend all meetings and at least 50% of all meetings held each year.

After the meeting

- Follow up on actions;
- Inform colleagues appropriately of the issues discussed.

Standards

- All documentation will be prepared using the standard Trust templates. A named person will oversee the administrative arrangements for each meeting;
- Agenda and reports will be issued 7 days before the meeting;
- An action schedule will be prepared and circulated to all members 2 days after the meeting;
- The minutes will be available at the next meeting.

Also under the guidance of the Chair, members are also responsible for the meeting's compliance with relevant legislation and Trust policies, up-to-date versions of which are available on the Trust's website, via the governance team or the Company Secretary.

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Wednesday 25 July 2018
Boardroom, Redesmere commencing at 1.30pm

PRESENT	Mike Maier	Chair
	Sheena Cumiskey	Chief Executive
	Dr Faouzi Alam	Medical Director, Effectiveness, Medical Education and Medical Workforce, Caldicott Guardian
	Gary Flockhart (on behalf of Avril Devaney)	Associate Director of Nursing and Therapies (MH & LD)
	Dr Anushta Sivananthan	Medical Director, Quality, Compliance and Assurance
	Andy Styring,	Director of Operations
	Tim Welch,	Director of Finance
	Jane Woods (on behalf of David Harris)	Deputy Director of People and OD
	Rebecca Burke-Sharples,	Non-Executive Director
	Andrea Campbell	Non-Executive Director
	Dr James O'Connor,	Non-Executive Director
	Lucy Crumplin,	Non-Executive Director
IN ATTENDANCE	Gemma Caprio	Head of Corporate Affairs (interim)
	Katherine Wright	Associate Director of Communications and Engagement
	Suzanne Christopher	Corporate Affairs Manager (mins)
	Dr Amrith Shetty (item 18/19/36)	Clinical Director
	Observing:	
	Sue Wells	Chair of Wirral CCG
	Phil Billington,	Governor
	Derek Bosomworth,	Governor
	Elizabeth Bott,	Governor
APOLOGIES	Avril Devaney	Director of Nursing, Therapies and Patient Partnership
	David Harris	Director of People and OD
	Edward Jenner	Non-Executive Director
	Ann Pennell	Non-Executive Director

	MINUTES	ACTION
18/19/26	**APOLOGIES AND ABSENCE** The Chair welcomed all to the meeting. The meeting was quorate. Apologies were noted as above. The Chair offered a warm welcome to Sue Wells, Chair of Wirral CCG and to our Governor colleagues.	
18/19/27	**DECLARATIONS OF INTEREST** There were none declared.	
18/19/28	**MEETING GUIDELINES**	

	The meeting guidelines were noted.	
18/19/29	**MINUTES OF PREVIOUS MEETINGS** The minutes of the meetings held on the **24 May 2018 (Extraordinary meeting) & 30 May 2018** were reviewed:- **24 May 2018 (Extraordinary meeting)** The minutes were approved as an accurate record. **30 May 2018** 18/19/05 – *Matters Arising – WRES Up-date scheduled for July Open Board* – this will now be part of the Equality and Diversity task and finish group and reported to PACE and also to POD. An action plan is now in place. 18/19/11- *Quarterly Infection Prevention and Control Reports* – L Crumplin wished to clarify her comment that related to the use of safer sharps and how other trusts were managing the process. 18/19/14 – *Central and East Redesign – Consultation Up-date* – Dr J O'Connor's comment to be amended from community services being 'proposed' to 'considered'. The Board of Directors **approved** the minutes of the Open Boards held on the 24 May 2018 and the 30 May 2018 as an accurate record.	
18/19/30	**MATTERS ARISING AND ACTION POINTS** The action log was reviewed as follows:- 17/18/118 – action to be closed. The dashboard has been improved and is now also monitored as part of the Integrated Governance Framework. 17/18/120 – action to be closed. Assurances are now in place to monitor hours and work continues. A new doctor has been appointed to this role.	
18/19/31	**BOARD MEETING BUSINESS CYCLE** In view of the Integrated Governance Framework review, the Board Business cycle had also been reviewed. ICP updates to be amended from Andy Styring to Sheena Cumiskey. The Board of Directors **approved** the business cycle. **Action: Corporate Affairs Team to amend the business cycle.**	**Corporate Affairs Team**
18/19/32	**CHAIR'S ANNOUNCEMENTS** **Launch of new Trust strategy and brand** CWP has now published its new Trust strategy, the CWP Five Year Forward View. The strategy details what CWP wants to achieve by 2023, and can be found on our website. To coincide with the new strategy and revised NHS guidelines, CWP have	

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	also refreshed the Trust branding. The new logo and branding style will be incorporated into Trust materials, digital platforms and signage. **NHS 70** On 5 July the NHS celebrated its 70th birthday. To celebrate, CWP collected stories from people across the Trust. People have shared what the NHS means to them and described their own personal NHS highlights. All the NHS 70 stories are on our website with the CWP celebratory TV feature on our YouTube channel. **CWP leading the way in national best practice** CWP has recently partnered with NHS Improvement and eight other trusts to share learning which has improved services. CWP shared nine case studies to support those in the wider NHS looking to implement improvements. **Mental Health Awareness Week – the benefits of reducing stress** In support of this year's Mental Health Awareness Week, CWP encouraged staff, people accessing our services, their carers, families, and the wider local population to consider how they can help themselves to reduce their stress levels. Stress and the effect that it can have on our health and wellbeing, was the theme of this year's national campaign led by the Mental Health Foundation. **Recognition Awards 2018** On 7 June, over 200 of CWP's dedicated workforce joined together in a festival of celebration. The second CWP Recognition Awards was a great success, with a whole host of prizes handed out in a number of different categories. CWP also honoured some of its long serving members of staff, who have completed 20, 30, 40 and, incredibly, 50 years of service to the NHS. The full list of winners and categories are available to read on our website. **Royal recognition for Linda Johnstone** Linda Johnstone, nurse consultant and clinical director for the Substance Misuse Service, was awarded Queen Elizabeth The Queen Mother's Award for Outstanding Service in 2018. Linda was invited to attend a ceremony held by the Queen's Nursing Institute in London on Monday 25 June, where she was presented with the award.	
18/19/33	**CHIEF EXECUTIVE ANNOUNCEMENTS** S Cumiskey summarised the items discussed at Closed Board that morning as follows:- Board members: • Focused on a patient story, which outlined learning for CWP and the wider system; • Were briefed on the operational risks regarding delivering services in Central and Eastern Cheshire; • Were provided with an up-date in respect of the National Pay Awards; • Considered the CQC well-led review that is due to take place on the 19th and 20th September; • Were presented with the monthly SUI report and reflected on areas for continuous improvement;	

	• Looked at new models of care; • Considered new services; • Considered the development of care groups within CWP; • Reviewed the financial performance of the Trust which was confirmed as on track to achieve its 2018/19 control total; • Considered the full business case and approved the potential transfer of All Age Disability Services to CWP; • Considered ICP plans; and • Approved the amended terms of reference for the Operational Committee (previously named the Operational Board).	
18/19/34	**MONTHLY WARD STAFFING UP-DATE** **Six monthly report – Nov 2017 to April 2018** G Flockhart presented the report, highlighting there has been a number of challenges recently, to which staff have responded positively and continue to show commitment to the delivery of safe care. The report summarised themes including ensuring we have the right staff for the delivery of care, escalation of concerns and providing board assurance, consideration of wider systems to support staffing shortages / complex patient needs, how the quality improvement agenda is driven forward as well as work that is planned for community health services. The Board of Directors was asked to note the report and approve the work plan. Board members queried supervision rates that varied across the Trust, in conjunction with the measures in place to address recruitment and retention issues. It was confirmed that supervision was being managed locally with consideration also being given to how peer supervision may be included. Recruitment methods are also being reviewed, with consideration of options to train in house, rotation and proactively recruiting third year students. The Board of Directors **approved** the forward plans and **noted** the report. **Monthly reports – May and June 2018** G Flockhart presented the monthly report, which demonstrated CWP has been able to respond positively to current staffing pressures to provide for the complex needs of patients. The Board of Directors **noted** the report.	
18/19/35	**GUARDIAN OF SAFE WORKING – QUARTERLY REPORT** Dr F Alam introduced the item and confirmed a new Guardian of Safe Working had been appointed, Dr Sumita Prabharakan. Dr Prabharakan has only recently taken up this post, following Dr Porter moving to a different role. Dr F Alam confirmed no issues have been raised regarding safe working hours and no exceptions of the quarterly report required highlighting to the Board.	

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	The Board were asked to note the report. The Board considered if CWP was an outlier in terms of the current number of vacancies, in addition to the use of locum and agency staff. It was confirmed that the number of vacancies across trusts varies, and CWP are currently absorbing its vacancies through bank arrangements rather than agency costs. The Board of Directors **noted** the report.	
18/19/36	**CWP REHABILITATION STRATEGY** Dr Amrith Shetty joined the meeting. Dr Shetty provided a presentation to the Board that outlined the progress to date of the CWP Rehabilitation Strategy and future plans. Rehabilitation services have undergone a number of reviews over recent years. The three areas that CWP are currently focusing on are: • Reducing long term out of area placements; • Development of in-patient provision; and • Development of community rehabilitation pathway. Work has commenced in these areas along with consideration of current pathways. CWP now need to consider with providers how these are managed in conjunction with current resources available from the CCG. Dr J O'Connor commented that this was a powerful presentation that considered improving quality whilst saving costs, but questioned how we could secure investment and how we use the resources we have. Dr Shetty responded that some of the skills required are already available to us, but the Trust needs to consider how those skills are used creatively and work with the CCG to address the current gaps. The Board discussed economies of scale, obtaining the right level of support, how this links with other current plans, and how the Board ensure value is added. The Board of Directors **noted** the report. Dr Shetty left the meeting.	
18/19/37	**BOARD PERFORMANCE DASHBOARD** T Welch introduced the paper and accompanying dashboard. The following areas were discussed:- Supervision Compliance – The compliance rates in part reflect the transition from locality based teams to the care group approach. This was raised by the Operational Committee to the Board and an update will be provided at the September Board. Safeguarding – this will be reported back to Board in September via the dashboard with an explanation of future workplans. T Welch highlighted that although some indicators appear off-track; this is a reflection of the current reporting practices, which is being reviewed.	

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	T Welch noted that the report provides an overview of these indicators and now needs to be incorporated into the business cycles to ensure timely reporting for the Board to appropriately consider the detail and the action plan to address these areas. A Campbell queried the staffing vacancies and the efforts to resolve the current gaps. J Woods confirmed that there have been some capacity issues during the year which are now resolved. The Trust is considering its recruitment processes. S Cumiskey advised that the recent Operational Committee undertook a deep dive into a number of these issues and we expect to see an improvement during the year. R Burke-Sharples queried the reduction in appraisals and if this was linked to the restructure to care groups. T Welch confirmed that quarter 1 of the appraisal cycle renews appraisals for bands 6, 7 and 8. These are the staff groups who have now moved into new roles within the care groups. There will, therefore, be a period of catch up to appraise staff against their new expectations and objectives. It was suggested that including the narrative in the report would help to provide a richer picture. The Board of Directors **noted** the paper	
18/19/38	**INTEGRATED GOVERNANCE FRAMEWORK** Dr A Sivananthan explained that the Integrated Governance Framework sets out governance and assurance arrangements which link to corporate objectives. As part of the review a number of discussion groups have been held. Dr A Sivananthan also thanked Rebecca Burke-Sharples, Lucy Crumplin and Andrea Campbell for their contribution which has helped to strengthen some of the reporting lines. The next steps will be to encourage a change in behaviours. Support will be provided to the sub-committees to ensure that the necessary assurance is provided to Board. The Board are asked to approve the Integrated Governance Framework. Rebecca Burke-Sharples identified the need to include the Audit Committee on page 12 of the framework. The Board of Directors **approved** the Integrated Governance Framework. **ACTION** – Integrated Governance Framework to be reviewed at Board in 6 months (January 2019). Board members thanked all those involved in the review process.	**Corporate Affairs Team**
18/19/39	**STRATEGIC RISK REGISTER** Dr A Sivananthan presented an amended version of the Board Assurance Framework. It was confirmed that the in scope risk relating to the Corporate Affairs Team could now be removed given the appointment of an interim Head of	

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	Corporate Affairs. It was confirmed that a process is now in place in regards to the in scope bed pressures risk. This risk will now be reviewed. A new in-scope risk added to the register is in relation to contractual obligations for services delivered to or provided by CWP. This will be reviewed by the Quality Committee and an in-depth treatment plan will be drafted. Archived and remodelled risks were outlined to the Board as listed within the report. The Board commented on the layout of the BAF and if this could be considered. **ACTION** – G Caprio to review and consider the presentation of the BAF. The Board of Directors **noted** the report.	**G Caprio, Head of Corporate Affairs**
18/19/40	**GDPR ACTION PLAN** Dr F Alam introduced the paper that considered the new General Data Protection Regulations (European Regulations). The process commenced in September 2016 and every 6 months an up-date has been provided. An implementation group was formed and the Trust has made good progress; no Trust is expected to be fully compliant at this stage but the Board was assured that good progress has been made so far. The report outlines the work completed to date. The Board are asked to note the report and the action plan. Dr F Alam recommended that given the approval by the Board of the Integrated Governance Framework, that the action plan be presented to the Information Governance Committee and a yearly up-date be provided to Board, with reporting by exception as appropriate. The Board of Directors **noted** the paper and **approved** the suggested way forward. **ACTION**- G Caprio to amend the business cycle to include annual reporting.	**Corporate Affairs Team**
18/19/41	**CQUIN – FOOD SERVICES** A Styring introduced the item and reflected that the paper had been presented to Board to meet the requirements of the CCG. The paper relates to a CQUIN and reflects that the Trust is compliant with the targets. It is important to acknowledge the efforts behind reaching this target. The Board of Directors **noted** the report.	
18/19/42	**LIVERPOOL COMMUNITY HEALTH INDEPENDENT REVIEW REPORT (KIRKUP)** Dr A Sivananthan explained that the report raised the issue of governance and how trusts escalate information. The report also includes learning for regulators. From CWP's perspective, it is important that the opportunity is	

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	taken to learn from the issues highlighted in the report and improve what we do. Work has already commenced in that the Trust has mapped itself against some of the key areas in the report, taking into consideration other assessments such as the well-led CQC review. This has resulted in some potential areas for improvement being identified. S Cumiskey reflected how useful the report has been. One of the areas highlighted is the need to review the capability for safety and effectiveness before taking on new business. This will also be applicable in the future when working on integrated care with partners. This is one of a number of reports recently which need to be carefully reviewed to ensure CWP continually learns from the experience of others. The Board of Directors **noted** the report.	
18/19/43	**INFECTION, PREVENTION AND CONTROL ANNUAL REPORT** The annual report was presented by G Flockhart on behalf of Victoria Peach (Director of Infection, Prevention and Control). A summary of the report was presented to Board members and the work priorities for 18/19 outlined as follows:- **Work Priorities for 2018/19** • Maintain compliance and assurances with the Health and Social care Act (2015); • Promote hand hygiene week in May 2018; • Deliver a quality IPC Education event to CWP staff in November 2018; • Roll out sepsis triage tool and e-learning across CWP; • Review and implementation of safety devices; • Actively support the staff influenza campaign to achieve 75% uptake in face to face staff; • Undertake a Trustwide mattress audit; • Implement new IPC e-learning module incorporating ANTT; • Improve compliance to anti-microbial prescribing. The Board were asked to note the report and approve the work priorities for 2018/19. Dr J O'Connor queried the on-going work around sharps given the increase in incidents this year. G Flockhart confirmed that a joint programme was in place that was also detailed in the report. The Board of Directors **noted** the report and **approved** the work priorities for 2018/19.	
18/19/44	**HEALTH AND SAFETY ANNUAL REPORT** G Flockhart introduced the item explaining that the Health and Safety Annual Report 17/18 provides a detailed overview of the considerable work achieved during the year. The main highlights were reported as follows:-	

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	• A programme of training has been introduced in respect of work station assessments, following which there has been significant improvement noted by staff; • There have been changes to RIDDOR reporting from 3 days to 7 days; • There has been a considerable increase in the number of CASS alerts that we are required to respond to; • The overarching Health and Safety meetings are supported by a number of local meetings; and • We are required to perform annual fire evacuation, the Trust currently undertakes this twice yearly. The priorities for the coming year were also outlined within the report. The Board were asked to note the report. The Board of Directors **noted** the report and **approved** the work priorities for the coming year.	
18/19/45	**MEDICAL APPRAISAL ANNUAL REPORT AND ANNUAL DECLARATION** As the Responsible Officer for CWP, Dr F Alam introduced the paper. The report outlined five areas; • fitness to practice; • outcome of medical appraisals; • responding to concerns; • a review of last year's action plan; and • a review of the forthcoming action plan. There are currently 108 doctors within CWP. Last year 12 recommendations were made to the GMC for revalidation. By year five all doctors will be revalidated. Last year 104 doctors were appraised. A patient review process was also undertaken, which validated that the process is supportive. Job plans have been reviewed with doctors to consider how any shortfalls in staffing numbers are addressed. Last year all planned reviews were undertaken with the exception of the friends and family test. This is included in the up-dated action plan for next year. Board members are required to approve the report. Once approved S Cumiskey will sign the required declaration. Dr J O'Connor queried how we get assurance that this process has been completed for doctors who work for us, but have a different responsible officer. It was confirmed that the outcomes of their appraisals are shared with us to confirm that they meet the standards and that they are being put forward for revalidation.	

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	The Board of Directors **approved** the report.	
18/19/46	**QUALITY COMMITTEE CHAIR'S REPORT AND TERMS OF REFERENCE:** July 2018 L Crumplin provided feedback to the Board on the July Quality Committee meeting. L Crumplin confirmed that the committee had; • Considered in detail the Integrated Governance Framework following which the revised paper had been presented to the Board; • Reviewed the risk register and considered progress up-dates; • Received an up-date on the primary care streaming model, which is a collaborative approach with the Countess of Chester Hospital; • Received an up-date on Mental Health Law regulations; • Were appraised how the Trust is managing to maintain safe and effective services at Thorn Heys and plan to provide short break services; and • Revised its terms of reference. The Board of Directors **noted** the minutes of the committee and **approved** the revised terms of reference.	
18/19/47	**AUDIT COMMITTEE CHAIR'S REPORT:** July 2018 R Burke-Sharples provided feedback to the Board on the July Audit Committee meeting. R Burke-Sharples reported that the quality improvement plan was noted by the committee, and reflected what an excellent presentation this had been. The committee commended the plans. It was also reported that NEDs of the committee now meet privately with both sets of auditors prior to the formal committee meeting. The meetings commenced in July and allow an opportunity for NEDs to fulfil their independence role. The Board of Directors **noted** the Chair's report.	
18/19/48	**ANY OTHER BUSINESS OTHER BUSINESS** None reported.	
18/19/49	**QUESTIONS FROM OBSERVERS OR MEMBERS OF THE PUBLIC** **Phil Billington, Governor** – commented on how we ensure effective care pathways for people with moderate psychosis. Dr A Sivananthan commented that it is extremely important to ensure good care pathways and to support people back into the community. We must keep sight of the whole spectrum of care. **Derek Bosomworth, Governor** – commented on the need to focus on the individual and tailor the care to that person's individual needs. Dr F Alam agreed fully and explained how this is reflected in CWP's ethos of person centred care.	

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	Elizabeth Bott, Governor – asked for clarification in terms of the board programme (closed and open boards). S Cumiskey confirmed that the Board meet in private to consider anything that is commercially sensitive or confidential to patients or staff. The Board provides a summary of the items discussed during the Closed Board to the Open Board by way of transparency and openness. Elizabeth commented that she has been pleased by the emphasis the Trust places on openness. Elizabeth queried the number of Out of Area placements and asked if there are any practical lessons that can be learnt from Sheffield. Dr A Sivananthan advised that the Trust is working with and learning from the experiences in Sheffield and is also considering with commissioners how a similar model can be implemented at CWP. **Sue Wells** thanked the Board for allowing her to attend and observe and reflected that this had been very useful.	
18/19/50	**REVIEW OF RISK IMPACTS OF ITEMS DISCUSSED** No new risks identified.	
18/19/51	**KEY MESSAGES FOR COMMUNICATION** The Chair summarised the key items discussed during the Board meeting.	
18/19/52	**REVIEW OF MEETING PERFORMANCE** It was noted that the meeting had been effective.	
18/19/53	**Date, time and place of next meeting:** • Friday 28th September 2018 – 1:30pm – Location TBC	

Signed

Mike Maier, Chair

Date:

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Action points from Board of Directors Meetings
July 2018

Date of Meeting	Minute Number	Action	By when	By who	Progress Update	Status
25/07/18	18/19/31	**BOARD MEETING BUSINESS CYCLE** ICP up-dates to be amended from AS to SC.	Sept 2018	Corporate Affairs Team	Business Cycle updated.	Closed
25/07/18	18/19/38	**INTEGRATED GOVERNANCE FRAMEWORK** Add IGF to business cycle – review in six months (January 2019).	Sept 2018	Corporate Affairs Team	Business Cycle updated.	Closed
25/07/18	18/19/39	**STRATEGIC RISK REGISTER** Review and consider the presentation of the BAF.	Sept 2018	Head of Corporate Affairs	In progress	Open
25/07/18	18/19/40	**GDPR ACTION PLAN** Amend business cycle – annual reporting.	Sept 2018	Corporate Affairs Team	Business Cycle updated.	Closed

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

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

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

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

STANDARDISED REPORT COMMUNICATION

REPORT DETAILS

Report subject:	Adult & Older People's Specialist Mental Health Redesign: East/South Cheshire/Vale Royal
Agenda ref. no:	18.19.62
Report to (meeting):	Board of Directors
Action required:	For noting
Date of meeting:	28 September 2018
Presented by:	Director of Operations

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

REPORT BRIEFING

Situation – *a concise statement of the purpose of this report*
This report updates the Board on the consultation findings that were published in September by the clinical commissioning groups, relating to the proposed redesign of adult and older people's mental health services in South, East Cheshire and Vale Royal.
Background – *contextual and background information pertinent to the situation/ purpose of the report*
The Five Year Forward View for Mental Health is a national framework for improvement. It recognises the need to address capacity in the community and reduce the over reliance on hospital services. Locally in Eastern Cheshire, South Cheshire and Vale Royal there is rising demand for care and support. Since 2010 there has been an increase in activity across the three CCGs of 35% in functional services and 60% in dementia services. CWP supports circa 7,000 people in the community for secondary mental health needs across this geography. Lack of capacity in the home treatment teams (who offer step up care) and community mental health teams (who offer ongoing support for stable patients) leads to an over-reliance on inpatient services of up to 16%, which equates to approximately 10 beds. Inpatient services are currently provided at a number of sites across Cheshire and Wirral including Millbrook in Macclesfield. The facilities at Millbrook are in need of significant refurbishment to comply with CQC standards and, due to the layout of the unit, require a disproportionately higher staffing model to maintain clinical safety. The local health and social care system is showing a deteriorating financial position. The cost of the current adult and older people's mental health service model exceeds the funding available and change is required for the local NHS to operate within mandated financial controls.

Assessment – *analysis and considerations of options and risks*

The Clinical Commissioning Groups are leading on the reporting and decision-making stage of the consultation. They issued the consultation report on Monday 10th September on their website. A copy of the stakeholder briefing and the executive summary of the report is attached as appendices. Further background documents can be sourced at https://www.easterncheshireccg.nhs.uk/Your-Views/ccg-consultations.htm

The CCGs' stakeholder briefing contained the following key points:

- Findings show support for the development of a new care model to improve outcomes for people with severe mental ill health, which includes a proposed crisis service and dementia support service to care for people in the community.

- However, the commissioners recognise the concern expressed that some people would have to travel further to visit loved ones in hospital if some inpatient services were transferred from Macclesfield to Chester.

- The findings will be presented and discussed in a number of meetings held in public over the coming month:

Tuesday 25 September Cheshire East Health and Wellbeing Board
Wednesday 26 September NHS Eastern Cheshire CCG Governing Body
Thursday 27 September Cheshire East Council Health, Adult Social Care & Communities Overview & Scrutiny Committee
Friday 28 September Cheshire CCGs' Joint Commissioning Committee
Thursday – 04 October NHS South Cheshire CCG & NHS Vale Royal CCG Governing Bodies' meeting
Monday 15 October Cheshire West & Chester Council People's Scrutiny Meeting.

- The decision-making business case will take full account of the consultation findings, including any additional ideas and suggestions, plus other considerations set out in the pre-consultation

business case available at www.easterncheshireccg.nhs.uk. These issues include clinical safety, affordability and compliance with national best practice. No decisions will be made until November 2018.

CWP shared the stakeholder briefing document with staff and held staff briefing sessions, led by the commissioners, on Tuesday 11th and Thursday 13th September at inpatient and community settings across Eastern Cheshire, South Cheshire and Vale Royal.

We await confirmation from the CCGs on any further information they require from CWP to complete their Decision Making Business Case.

Recommendation – *what action/ recommendation is needed, what needs to happen and by when?*
The Board is asked to note the publication of the report and the timeline for next steps.

Who/ which group has approved this report for receipt at the above meeting?		
Contributing authors:		Katherine Wright
Distribution to other people/ groups/ meetings:		
Version	Name/ group/ meeting	Date issued
Appendices provided for reference and to give supporting/ contextual information: *Provide only necessary detail, do not embed appendices, provide as separate reports*		
Appendix no.	Appendix title	
1	CCG stakeholder briefing	
2	Executive summary of Consultation Report	

Briefing for stakeholders

Date: 10 September 2018

Reference: 10/09/2018/CM

Further update on next steps regarding the consultation on the redesign of adult and older people's specialist mental health services in Eastern Cheshire, South Cheshire and Vale Royal

As a valued stakeholder, we are committed to continuing to update you on the next steps in relation to the recent 12-week public consultation regarding proposals to redesign adult and older people's specialist mental health services in Eastern Cheshire, South Cheshire and Vale Royal.

These important services serve a population of 480,000.

Thousands of people across Eastern Cheshire, South Cheshire and Vale Royal engaged actively in the consultation on the proposals to introduce a new model of care for adults and older people experiencing severe mental ill health across community and hospital care settings. The findings of a survey that formed part of the consultation were analysed independently by the University of Chester while feedback from the seven public meetings, 26 community events and numerous items of correspondence was analysed independently by NHS Midlands and Lancashire Commissioning Support Unit.

The commissioners, namely NHS Eastern Cheshire CCG, NHS South Cheshire CCG and NHS Vale Royal CCG, are giving full consideration to all the feedback received in order to develop a decision-making business case that will be presented in November to their Governing Bodies.

Findings show support for the development of a new care model to improve outcomes for people with severe mental ill health, which includes a proposed crisis service and dementia support service to care for people in the community. However, the commissioners recognise the concern expressed that some people would have to travel further to visit loved ones in hospital if some inpatient services were transferred from Macclesfield to Chester.

The findings, which will be published on Monday 10 September 2018 at https://www.easterncheshireccg.nhs.uk/Your-Views/ccg-consultations.htm will also be presented and discussed in a number of meetings held in public over the coming month, namely:

Tuesday 25 September	Cheshire East Health and Wellbeing Board
Wednesday 26 September	NHS Eastern Cheshire CCG Governing Body
Thursday 27 September	Cheshire East Council Health, Adult Social Care and Communities Overview and Scrutiny Committee
Friday 28 September	Cheshire CCGs' Joint Commissioning Committee
Thursday – 04 October	NHS South Cheshire CCG & NHS Vale Royal CCG Governing Bodies' meeting
Monday 15 October	Cheshire West & Chester Council People's Scrutiny Meeting

The decision-making business case will take full account of the consultation findings, including any additional ideas and suggestions, plus other considerations set out in the pre-consultation business case available at www.easterncheshireccg.nhs.uk. These issues include clinical safety, affordability and compliance with national best practice.

No decisions will be made until November 2018.

The consultation partners are grateful to the many people who took part in the consultation to redesign specialist mental health services for the 7,000 or so people in Eastern Cheshire, South Cheshire and Vale Royal who need care every year for severe mental ill health. The aim of the proposals is to ensure that service users get the best possible care, within the resources available, to help them thrive and not just survive.

The consultation, on services for a population of around 480,000 people, was run by the three CCGs in partnership with Cheshire and Wirral Partnership (CWP) NHS Foundation Trust. CWP is the main provider of the area's mental health services.

For more information on the consultation, visit www.easterncheshireccg.nhs.uk and search under "**Consultations**."

We will continue to keep patients and the wider public informed of our next steps.

Yours sincerely,

Alex Mitchell
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Clare Watson
Chief Officer, NHS South Cheshire CCG and NHS Vale Royal CCG
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FURTHER INFORMATION:

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Adult and older people's specialist mental health services consultation

Executive summary of summary report of findings

10 September 2018

Your NHS partner for **improving health** and **integrating care**

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Executive summary

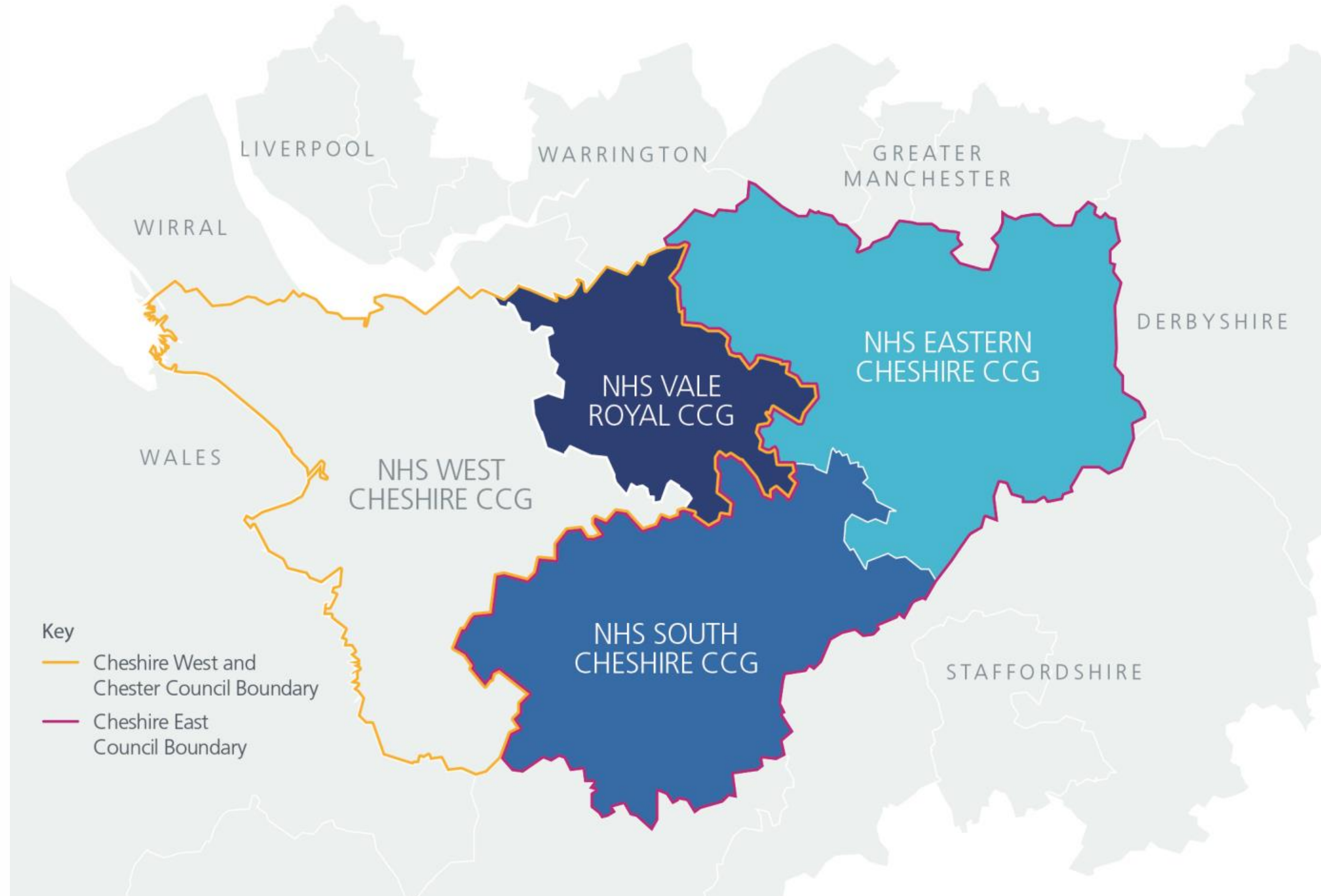
Introduction

This executive summary presents an overview of the key findings from the consultation on the proposed redesign of adult and older people's specialist mental health services, which ran between 6 March and 29 May 2018. The consultation targeted the residents of three CCG areas (listed below) and covered a total population of 480,000 people.

The purpose of this report is to provide feedback to the commissioners – as the consulting organisations - on the results of the public consultation. This will inform the decision-making business case for adult and older people's mental health services, to be developed by the commissioners later in the year.

The consultation was led by:

- NHS Eastern Cheshire Clinical Commissioning Group (CCG)
- NHS South Cheshire Clinical Commissioning Group (CCG)
- NHS Vale Royal Clinical Commissioning Group (CCG)



The population of NHS Eastern Cheshire CCG live in the main towns and surrounding areas of Alderley Edge, Bollington, Chelford, Congleton, Disley, Handforth, Holmes Chapel, Knutsford, Macclesfield, Poynton, and Wilmslow. The population of NHS South Cheshire CCG live in the main towns and surrounding areas of Alsager, Crewe, Middlewich, Nantwich and Sandbach. Together, the geographies of both CCGs are coterminous with Cheshire East Council. Cheshire East Council was not a consulting organisation.

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The population of NHS Vale Royal CCG live in the main towns and surrounding areas of Northwich and Winsford. The geography of and population living within NHS Vale Royal CCG, along with that of NHS West Cheshire CCG are coterminous with that of Cheshire West and Chester Council. Both NHS West Cheshire CCG and Cheshire West and Chester Council were not consulting organisations.

In delivering the consultation, the commissioners worked in partnership with Cheshire and Wirral Partnership NHS Foundation Trust (CWP), which is the main provider of mental health services across the four CCGs.

Background to the Consultation

The consultation document set out the proposals for adult and older people's specialist mental health services. The proposals were developed through 12 months of collaboration with service users, carers, patient representatives, clinical staff, experts by experience, local authority overview and scrutiny committees, commissioners and service providers.

This document described the case for change, which was based on feedback from the collaborative engagement activities, as well as recent audit recommendations and inspections. This showed that changes are needed to improve quality and safety standards, to improve accommodation standards and to ensure that the funds available, for mental health services, achieve the best impact.

The document also set out the objectives for service redesign, a proposed new model of care, with two service delivery options, alongside an option to maintain current service configuration for adults and older people experiencing severe or mental ill-health across community and hospital care settings.

Three options for public consultation

The three options which were taken to public consultation are outlined below.

- **Option 1:** To not introduce the proposed new model of care. In this option there would be no prospect of improvement or development of the following services: community care, crisis care / choice of service, dementia outreach, or inpatient care unless funding was taken or diverted from other current local NHS services. All inpatient care would be retained in the Millbrook Unit, Macclesfield.
- **Option 2:** To improve community and home treatment (crisis) teams, and provide local crisis beds within the community, older people's inpatient care at Lime Walk House, Macclesfield and adult inpatient care at Bowmere, Chester. This option proposes to enhance community and home treatment (crisis) teams to provide a wider range of services and improve access to care locally for the 7,000 adults and older people in the community who currently access specialist mental health services.
- **Option 3:** To improve community and home treatment (crisis) teams, provide local crisis beds within the community and provide adult inpatient care at Lime Walk House, Macclesfield and older people's inpatient care at Bowmere, Chester. This option proposes to enhance community and home treatment (crisis) teams. This would provide a wider range of services and improved access to care locally for the 7,000 adults and older people in our communities who currently access specialist mental health services.

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Approach to the analysis of feedback

The University of Chester was commissioned to undertake an independent review of the consultation survey feedback and findings. NHS Midlands and Lancashire Commissioning Support Unit (MLCSU) worked closely with commissioners and was contracted to provide a range of support services, including the production of this report of findings and the analysis of the public events, correspondence and other information collected at 'pop-in' events and meetings. The report draws on several supporting documents, which are referenced in the main report.

Communications and engagement activity

The communications and engagement strategy aimed to both inform and consult all stakeholders, including patients and public, carers and staff. Activities were planned to explain the proposed model and options and gather feedback.

- Consultation document sent to each of the 7,000 patients currently receiving specialist mental health services from CWP
- 3,000 copies of the consultation document, including an easy-read version, distributed in healthcare and community settings
- Consultation questionnaire, which was designed and distributed both online and as a hard copy (and reproduced as an easy read version) to enable easy feedback by all to the consultation proposals
- Seven formal public meetings, with a total of 223 attendees
- Engagement with a further 500+ people at an additional 26 events, meetings and briefing opportunities at local mental health forums and other health and community settings were undertaken
- Widespread print, broadcast and social media reach, including with over 2,000 people actively engaging with social media content such as videos, reaching circa 160,000 newsfeeds
- Over 100 media articles, adverts and advertorials was generated across all platforms including TV, print, radio and internet
- Targeted updates to over 500 CWP members in Vale Royal, South Cheshire and Eastern Cheshire
- 97 enquiries received via the freephone Patient Advice and Liaison Service (PALS) line.

Respondent / participant and demographic profiles

A total of 324 people responded to the consultation survey**.** The survey respondents included:

- 186 (57%) from the Eastern Cheshire CCG area
- 81 (25%) from South Cheshire CCG area
- 34 (10%) from Vale Royal CCG area
- 23 (7%) from other/unknown.

The largest proportion of respondents were female, 175 (54%) compared to 111 (34%) males. The remainder did not provide this detail. Most respondents were under 65 years (62%) and most were white British (88%). Of the total respondents, 65 (20%) were carers of people who accessed mental health services.

A total of 223 people attended the seven public consultation events.

- Four of the events were in the Eastern Cheshire CCG area, with 163 participants.
- Two of the events were in the South Cheshire CCG area, with 36 participants.
- One event was in the Vale Royal CCG area, with 24 participants.

There was an almost even split between females and males with 71 (56%) females and 52 (41%) males in attendance. The remainder did not provide this detail. Just over three quarters were aged 45 to 79 years and 118 of the 120 (98%) attendees were white British.

A total of 23 pieces of correspondence were received**.** Most of the correspondence was from members of the public.

Findings from the consultation survey and seven public events

This section summarises findings from the consultation survey and key themes from the seven public events. For each option an overview of the key findings is presented followed by findings by CCG area.

Survey respondents were asked to rank the three options from most to least preferred. Option 2 was most preferred, being ranked first by 115 respondents, followed by option 1 with 84 respondents and option 3 with 57 respondents.

Survey respondents were also asked the extent to which they agreed with each option. Table A compares the level of agreement for each option. Most agreement was for option 2 (52%) compared to options 1 (36.1%) and 3 (37.5%).

Table A: Respondents level of agreement/disagreement with each of the three options

	Numbers agreeing with option	Number neither agree or disagree	Number disagreeing with option
Option 1	109 (36.1%)	40 (13.2%)	153 (50.7%)
Option 2	150 (52.0%)	32 (11.0%)	107 (37.0%)
Option 3	104 (37.5%)	67 (24.2%)	106 (38.3%)

Survey respondents were asked to review a list of eight outcome statements and identify the top three in order of importance. Table B identifies these outcome statements in order of importance.

Table B: The eight service delivery outcome statements in order of importance

Number	Service delivery outcome statements
1	Option x will improve outcomes for people with mental ill-health
2	Option x will provide 24-hour access to crisis services
3	Option x means people being able to visit hospital easily
4	Option x will offer a dementia outreach service supporting people in their own homes
5	Option x offers access to a better range of treatment options
6	Option x will offer more choice about the services available for people in crisis
7	Option x will provide better access to community services
8	Option x provides inpatient services meeting privacy and dignity standards

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Respondents were then asked to rate the extent to which the options fulfilled each service delivery outcome statement. See table C.

When the top three most important service delivery outcome statements are compared against the three options, option 2 received the overall highest score. Comparison of the scores for each of the top three outcome statements, show that option 2 received the highest scores for outcome statement 1 and 2. Option 1 received the highest score for outcome statement 3.

Table C: Respondents most important three service delivery outcome statements and the extent to which the three options meet these.

	Service delivery outcome statements	Most selected outcome statement	Option 1	Option 2	Option 3
1	Improve outcomes for people with mental ill-health	248	82 (32%)	145 (58%)	120 (50%)
2	24-hour access to crisis services	181	74 (30%)	168 (67%)	127 (54%)
3	Being able to visit hospital easily	118	141 (56%)	72 (29%)	52 (22%)
Total for top three			297	385	299
Base – number of survey respondents to question			*247-255*	*245-251*	*231-238*

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Feedback on option 1

Overall feedback on option 1

153 (51%) of survey respondents disagreed with option 1, compared to 109 (36%) who agreed. By respondent type there was a greater proportion of service users disagreeing, whilst carers and members of the public were more evenly split. Table D provides an overview of the response to key survey questions and commentary on key messages from event participants.

Table D: Survey and event participant feedback on option 1

Reasons for agreeing with the option	• ‘The location of services’ • ‘The minimisation of stress and anxiety’ • ‘Minimisation of travel’ • ‘The Millbrook Unit would be kept open or improved’.
Reasons for disagreeing with the option	• ‘The finance/ cost of the option’ • ‘The service levels provided’ • ‘The idea that change is needed’.
Feedback on the eight service delivery outcome statements (extent respondents agree / disagree that outcomes will be delivered by the option)	• The most agreed with statement (receiving over 50%) was statement 3 (Table B) – ‘means people being able to visit hospital easily’ • The remaining seven statements had between 15% and 35% agreement.
People disproportionately impacted	• Dementia patients • People using community services.
Suggestions on how to overcome issues / challenges	• ‘Service structure and coverage’ • ‘Finance and building usage’.
Public event commentary 7 events = 223 participants	• Some support for option 1, but also a recognition that the current system is not working properly and that doing nothing is not an option. • Support for quality of care provided by the Millbrook Unit, however mixed views on the current facilities (e.g. ward size, en-suite facilities). • An understanding that there would not be enough resource to improve crisis care and community teams. • Some event participants were confused about the financial modelling and concerned about the perceived limits in the supporting detail provided.

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Eastern Cheshire CCG area feedback on option 1

There was an even split between survey respondents agreeing and disagreeing with option 1. 79 (44%) respondents disagreed with this option, whilst 78 (43%) respondents agreed.

Table E: Survey and event participant feedback from Eastern Cheshire CCG area on option 1

Key reasons for agreeing with the option	• 'The location of services' • 'The minimisation of stress and anxiety' • 'The Millbrook Unit would be kept open / improved' • 'Minimisation in travel requirements'.
Key reasons for disagreeing with the option	• 'Finance / cost of the option' • 'The impact on service levels' • 'The need for change'.
Feedback on the eight service delivery outcome statements (extent respondents agree / disagree that outcomes will be delivered by the option)	• The most agreed with statement with over 70% agreement, was statement 3 (table B) – 'means people being able to visit hospital easily' • The remaining seven statements had between 20% and 45% agreement.
People disproportionately impacted	• Dementia patients • People using community services.
Suggestions on how to overcome issues / challenges	• 'Finance' • 'Building usage' • 'Service structure and coverage'.
Public event commentary 4 events: 3 events in Macclesfield = 133 attendees 1 event in Congleton = 30 attendees	• **Macclesfield events:** participants felt the option was presented in a way that made it difficult for attendees to select it as their preferred choice • **Congleton event:** some felt the Millbrook Unit remaining open would be a positive outcome for current service users. • **Macclesfield and Congleton events:** agreed on the need for community care and dementia outreach and that this would reduce demand on emergency care; but questioned how these could be implemented.

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South Cheshire CCG area feedback on option 1

43 (61%) of survey respondents disagreed with option 1, compared to 18 (26%) who agreed.

Table F: Survey and event participant feedback from South Cheshire CCG area on option 1

Key reasons for agreeing with the option	• 'Location of the service' • 'Stress and anxiety minimised' • 'Agree with nothing'.
Key reasons for disagreeing with the option	• 'Change is needed' • 'Finance / cost of option' • 'Service levels'.
Feedback on the eight service delivery outcome statements (extent respondents agree / disagree that outcomes will be delivered by the option)	• The eight service delivery statements received low levels of agreement (all under 30%).
People disproportionately impacted	• People using community services.
Suggestions on how to overcome issues / challenges	• 'Service structure and coverage' • 'Staff' • 'Finance' • 'Building usage'.
Public event commentary 2 events: 1 event in Crewe = 19 attendees 1 event in Middlewich = 17 attendees	• **Crewe event:** participants commented that facilities in the area could be improved, however there was concern how this would be financed. Participants also sought reassurance that any changes are implemented fully. • **Crewe event:** travel was not seen to be such an issue for people in Crewe as the distance is similar. However, it was commented that it is easier to travel to Chester from Crewe. • **Crewe event:** concern that decisions have already been made to lose the Millbrook Unit. • **Middlewich event:** limited comments regarding this option.

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Vale Royal CCG area feedback on option 1

More survey respondents disagreed with option 1 than agreed. 21 (68%) disagreed with this option, whilst six (19%) agreed.

Table G: Survey and event participant feedback from Vale Royal CCG area on option 1

Key reasons for agreeing with the option	• 'Location of service' • 'Travel minimised' • 'Finance / cost of options'.
Key reasons for disagreeing with the option	• 'Change is needed' • 'Service levels' • 'Finance / cost of options'.
Feedback on the eight service delivery outcome statements (extent respondents agree / disagree that outcomes will be delivered by the option)	• There was more agreement with the service delivery outcome statements in this area, but none received more than 40% agreement.
People disproportionately impacted	• Dementia patients • People using community services • 'Crisis' • Minority groups (e.g. Traveller, Bangladeshi).
Suggestions on how to overcome issues / challenges	• 'Finance' • 'Service structure and coverage'.
Public event commentary 1 event in Northwich = 24 attendees	• Some support for the Millbrook Unit to remain open due to quality of staff.

Other consultation survey feedback on option 1

There were four respondents from the West Cheshire CCG area. Of these, one agreed with the option and two disagreed.

There were also 19 survey respondents with an unknown CCG area. Of these, nine disagreed with this option, compared to four who agreed.

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Feedback on option 2

Overall feedback on option 2

150 (52%) respondents agreed or strongly agreed with this option, compared to 107 (37%) disagreeing or strongly disagreeing. When analysed by respondent type, there was a greater number of service users 63 (57%) and carers 35 (58%) agreeing, whilst more NHS employees and other respondents disagreed with this option.

Table H: Survey and event participant feedback on option 2

Key reasons for agreeing with the option	• 'Level of service' • 'Dementia care' • 'Location of service'.
Key reasons for disagreeing with the option	• 'Distance / travel' • 'Adult care worse' • 'Service levels would decrease'.
Feedback on the eight service delivery outcome statements (extent respondents agree / disagree that outcomes will be delivered by the option)	• There were seven most agreed with statements (with between 50% and 70% agreement). • Statement 3 (table B) – 'means people being able to visit hospital easily' - received least agreement with between 25 and 30%.
People disproportionately impacted	• Adults and younger people • Those based in the Eastern Cheshire area • Service users and carers, families and relatives.
Suggestions on how to overcome issues / challenges	• 'Building usage' • 'Service structure and coverage' • 'Travel' • 'Finance'.
Public event commentary 7 events = 223 participants	• Option 2 was generally positively received with some saying it was the most sensible option • Reasons for supporting the option included: additional clinical and support staff offering 24-hour crisis care; improvement in community care, which could result in a reduction in hospital admissions; and the provision of 53 beds to mention the key comments • This was considered a preventative option which could reduce hospital admissions, however, greater co-ordinated care would be required. • Although it was thought that implementation would be difficult due to cost and accessibility, this option was considered to provide the greatest value for money. Some questioned whether this option would be cheaper than refurbishing the Millbrook Unit. • Main concerns related to travel implications for adults. To address this, the use of technology, social media and contracts with taxi firms or assistance from volunteers was suggested. • There was some mixed reaction towards crisis cafés because of possible safety and security concerns. • Further clarification was asked for regarding how capacity would be managed; access to public transport, the need for refurbishment and any impact on Bowmere.

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Eastern Cheshire CCG area feedback on option 2

84 (50%) of respondents disagreed with this option, compared to 70 (42%) who agreed.

Table I: Survey and event participant feedback from Eastern Cheshire CCG area on option 2

Key reasons for agreeing with the option	• 'Level of service' • 'Dementia care' • 'Location of service'.
Key reasons for disagreeing with the option	• 'Distance / travel' • 'Adult care worse' • 'Service levels would decrease'.
Feedback on the eight service delivery outcome statements (extent respondents agree / disagree that outcomes will be delivered by the option)	• The seven most agreed with statements received between 45% and 60% agreement. • Statement 3 (table B) – 'means people being able to visit hospital easily' - received around 20% agreement.
People disproportionately impacted	• Adults and younger people • People living in Eastern Cheshire • Carers, family and relatives • Current service users.
Suggestions on how to overcome issues / challenges	• 'Building usage' • 'Service structure and coverage' • 'Finance' • 'Travel'.
Public event commentary 4 events: 3 in Macclesfield = 133 attendees 1 event in Congleton = 30 attendees	• **Macclesfield and Congleton events:** agreement that this option would provide older patients the ability to remain in the area and a feeling that this option offers greater value for money than option 1. Some concerns raised at the need for patient groups to travel further, placing burden on their support network. Some suggestions of the need for a more robust travel and transport plan and to review the use of technology to stay in touch. • **Congleton event:** some recognition of the benefits of community care, however implementation was perceived to be an area of concern. More access with improved opening hours would be beneficial.

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South Cheshire CCG area feedback on option 2

46 (60%) survey respondents agreed with this option compared to 13 (18%) who disagreed.

Table J: Survey and event participant feedback from South Cheshire CCG area on option 2

Key reasons for agreeing with the option	• 'Level of service' • 'Agree with everything in option 2' • 'Dementia care'.
Key reasons for disagreeing with the option	• 'Distance / travel' • 'Inequality of service' • 'Disagree with nothing in option 2' • 'Adult care worse'.
Feedback on the eight service delivery outcome statements (extent respondents agree / disagree that outcomes will be delivered by the option)	• The seven most agreed with statements received between 60% and 80% agreement. • Statement 3 (table B) – 'means people being able to visit hospital easily' - received less than 45% agreement.
People disproportionately impacted	• Those based in the Eastern Cheshire area • Adults and younger people • Carers, family and relatives • Those based in the South Cheshire area.
Suggestions on how to overcome issues / challenges	• 'Service structure and coverage' • 'Finance' • 'Travel'.
Public event commentary 2 events: 1 event in Crewe = 19 attendees 1 event in Middlewich = 17 attendees	• **Crewe event:** some participants commented that the option supports older people being cared for closer to home and more generally provides less focus on beds, providing more care out of hospital, including crisis support. • **Crewe event:** some saw travelling to Chester as not a as big an issue, especially for adults who will be able to travel more easily than older patients. • **Middlewich event:** recognition of value for money – but thought that it would be difficult to implement due to the recruitment challenges and the expected growth in demand.

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Vale Royal CCG area feedback on option 2

23 (68%) survey respondents agreed with option 2, compared with four (12%) who disagreed.

Table K: Survey and event participant feedback from Vale Royal CCG area on option 2

Key reasons for agreeing with the option	• 'Level of service' • 'Dementia care' • 'Location of service' • 'Agree with everything in option 2'.
Key reasons for disagreeing with the option	• 'Distance / travel' • 'Inequality of service' • 'Finance'.
Feedback on the eight service delivery outcome statements (extent respondents agree / disagree that outcomes will be delivered by the option)	• The seven most agreed with statements received between 60% and 85% agreement. • Statement 3 (table B) – 'means people being able to visit hospital easily' - was least agreed with, receiving 50% agreement.
People disproportionately impacted	• Those based in the Eastern and South Cheshire areas • Carers, families and relatives.
Suggestions on how to overcome issues / challenges	• 'Service structure and coverage' • 'Finance' • 'Building usage' • 'Travel'.
Public event commentary 1 event in Northwich = 24 attendees	• General comments were that this was the best option of the three, but travel requirements were an issue. To overcome these concerns suggestions were made around the use of private transport and technology. • Participants suggested enhanced community care could aid shorter inpatient stays. The provision of crisis cafés was also positively received. • The provision of 53 beds was a positive influencer. However, some expressed concerns about the number of available beds in Chester. Also, some suggestions that underutilised estate in Macclesfield could be used to provide a small unit in the area.

Other feedback on option 2

There were three respondents from the West Cheshire CCG area. Of these, two agreed with option 2 and one disagreed.

There were 19 survey respondents with an unknown CCG area. Of these, eight (40%) agreed with option 2, compared to five (25%) who disagreed.

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Feedback on option 3

Overall feedback on option 3

There were equal proportions of people agreeing and disagreeing with this option. 106 (38%) disagreed with this option, whilst 104 (38%) agreed. Segmentation by respondent type showed around 60% of service users and carers supported this option. There was a split in the level of agreement amongst NHS mental health employees and other respondent types.

Table L: Survey and event participant feedback on option 3

Key reasons for agreeing with the option	• 'Level of service' • 'Comparison of options i.e. better than 1 or 2' • 'Location of service' • 'Community care and support'.
Key reasons for disagreeing with the option	• 'Distance / travel' • 'Service levels would decrease' • 'Distress to patients'.
Feedback on the eight service delivery outcome statements (extent respondents agree / disagree that outcomes will be delivered by the option)	• Only statements 1 and 2 (table B) received 50% or more support • The remaining six statements received less than 50% agreement.
People disproportionately impacted	• Older people • Carers, families and relatives • Dementia patients • Current service users • Those living in Eastern Cheshire.
Suggestions on how to overcome issues / challenges	• 'Building usage' • 'Service structure and coverage'.
Public event commentary 7 events = 223 participants	• This was the second most preferred option. During the table discussions options 2 and 3 were frequently compared. • Option 3 was supported because it provides good crisis support services and home treatment, however there was a greater preference for option 2 because this option is not accessible for older patients. • An acknowledgement that this option is preventative, as it offers access to out of hospital services, which could reduce hospital admissions. • The majority of concerns related to the travel implications for older patients, those requiring access to psychiatric care and patients' support networks. • Other concerns raised included the movement of dementia services to Chester; the lack of Psychiatric Intensive Care Unit at Lime Walk House and difficulties in implementation due to costs and the availability of staff to provide community care. • Some also raised safety and security concerns with crisis cafés.

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Eastern Cheshire CCG area feedback on option 3

76 (47%) respondents disagreed with this option, compared to 50 (31%) who agreed.

Table M: Survey and event participant feedback from Eastern Cheshire CCG area on option 3

Key reasons for agreeing with the option	• 'Level of service' • 'Comparison of options i.e. better than 1 or 2' • 'Location of service'
Key reasons for disagreeing with the option	• 'Distance / travel' • 'Service levels would decrease' • 'Distress to patients'.
Feedback on the eight service delivery outcome statements (extent respondents agree / disagree that outcomes will be delivered by the option)	• Seven statements received between 40% and 50% support. • Statement 3 (table B) – 'means people being able to visit hospital easily' - had just over 20% agreement.
People disproportionately impacted	• Older people • Service users • Carers, family and relatives • Dementia patients.
Suggestions on how to overcome issues / challenges	• 'Building usage' • 'Service structure and coverage' • 'Travel'.
Public event commentary 4 events: 3 in Macclesfield = 133 attendees 1 event in Congleton = 30 attendees	• Respondents supported having fewer people in hospital due to the provision of community care and community services. • It was acknowledged that this option is preventative as it offers access to out of hospital services which could reduce hospital admissions. • Public event attendees expressed concern at the travel requirements. Some suggested the need for volunteer support to help overcome this issue. • Concerns were raised at the costs of this option. • Attendees sought clarity on the number and usage of crisis beds outlined in this option.

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South Cheshire CCG area feedback on option 3

32 (48%) survey respondents agreed with this option compared to 14 (21%) who disagreed.

Table N: Survey and event participant feedback from South Cheshire CCG area on option 3

Key reasons for agreeing with the option	• 'Level of service', 'comparison of options i.e. better than 1 or 2' and 'community care and support'.
Key reasons for disagreeing with the option	• 'Distance / travel', 'service levels would decrease' and 'inequality of service'.
Feedback on the eight service delivery outcome statements (extent respondents agree / disagree that outcomes will be delivered by the option)	• The five most agreed with statements received between 50% and 65% agreement. • Statements 3, 5 and 8 (table B) received between 25% and 50% agreement.
People disproportionately impacted	• Older people, • Those living in Eastern Cheshire • Adults and younger people • Carers, family and relatives.
Suggestions on how to overcome issues / challenges	• 'Service structure and coverage', • 'Building usage' • 'Finance'.
Public event commentary 2 events: 1 event in Crewe = 19 attendees 1 event in Middlewich = 17 attendees	• Those attending the event recognised the provisions of community support in this option. • Concerns regarding travel were raised – particularly the cost and accessibility for visiting families and carers.

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Vale Royal CCG area feedback on option 3

15 (54%) respondents agreed with this option compared to seven (25%) who disagreed.

Table O: Survey and participant feedback from Vale Royal CCG area on option 3

Key reasons for agreeing with the option	• 'Comparison of options i.e. better than 1 or 2' • 'Level of service' • 'Location of service'
Key reasons for disagreeing with the option	• 'Distance / travel' • 'Inequality of service' • 'Service levels would decrease' • 'Carer or family impact'.
Feedback on the eight service delivery outcome statements (extent respondents agree/ disagree that outcomes will be delivered by the option)	• Statements 1, 2 and 4 (table B) received most agreement with between 50% and 60%. • The remaining statements received less than 50% support.
People disproportionately impacted	• Older people, carers, family and relatives, those based in South Cheshire.
Suggestions on how to overcome issues/challenges	• 'Travel', 'service structure and coverage', 'building usage' and 'finance'
Public event commentary 1 event in Northwich = 24 attendees	• Event participants noted option 3 provides crisis and home treatments but considered the option not accessible for older patients due, to travel requirements. • Some requested an online resource to provide information on service access and self-help.

Other feedback on option 3

There were three respondents from the West Cheshire CCG area. Of these, two agreed with option 3 and one disagreed.

There were 19 survey respondents with an unknown CCG area. Of these, four agreed with this option, compared to seven who disagreed.

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Findings: correspondence, 26 additional events and PALS

Several themes have emerged from the 23 pieces of correspondence, the 26 meetings and staff events, and the PALS feedback. This feedback has been brought together under broad themes by CCG area. Unlike the survey and events, the feedback from these sources is unstructured and is themed around the comments raised.

The **PALS** feedback reported people registering on events, requesting consultation information and requesting assistance to complete the consultation survey.

Eastern Cheshire CCG area

The Eastern Cheshire area received the most amount of feedback from these channels.

Event feedback discussed the following themes: **comments and ideas** such as alternative options and other suggestions for proposals; **funding** for the options and funding levels for mental health across Cheshire; **travel, distance and facilities** with concern around distances to travel if the Millbrook Unit closes and where new facilities could be placed; pleased with quality of care at the Millbrook Unit but concern at proposed number of beds for Eastern Cheshire; **new care model** aspects were supported such as crisis provision and **crisis care**; concerns about the **consultation process** e.g. access to documents and some perceived bias; **staffing**, specifically around getting the appropriate staff for the proposed new model of care and services to be provided.

Correspondence feedback discussed the following themes: concern about the loss of **services within the Eastern Cheshire area**; the impact on **travel times and transport** implications for all service users from the proposed closure of the Millbrook Unit; queries about the **consultation process** including how options were reached; some **support for the options**; service redesign – focused on: access to acute beds and their location and **dementia outreach**, **pressures on partner demand** from any service change, **support for the process**, appreciation of the proposed crisis centres, **crisis care / cafés** but some mixed views, negative **pressures on users and carers** from any service change.

South Cheshire and Vale Royal CCGs area

Event feedback discussed the following themes: **new care model** and welcoming the enhanced **community care and crisis care** though concern about where new beds would be located; **travel, transport and facilities** – concern about whether transport promises would be kept which previously were not, some comments and alternative ideas put forward; some consultation **process**, **staffing** and **funding** questions around the cost to redevelop the Millbrook Unit.

Correspondence: none received from these areas.

Unknown/other CCG areas

Event feedback discussed the following themes: **funding**; **travel, distance and transport**; **new care model and crisis care**; **comments and ideas** and **consultation process**.

Correspondence feedback discussed the following themes: concern over the loss and future provision of **services within the Eastern Cheshire area**; impact on distance and **travel times and transport** of any service changes; queries over the **consultation process**; **support for the options**, service redesign; **dementia outreach**; **pressures on partners demand** from service changes e.g. social services; **support for the process**; mixed views on **crisis centres** and **crisis care / cafés**.

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Additional ideas and suggestions

A number of ideas and suggestions were identified during the consultation. These have been grouped and summarised and are listed below:

Combination of options: Combination from existing ones – with inpatient beds for adults and older patients kept locally, in Macclesfield.	**Pressures on service users and carers:** More home treatment should also help carers as well as service users.	**Crisis care modelling:** Crisis care centres should reflect practice in other places where it is shown to work, e.g. Cambrian House Crisis Centre.	**Awareness of external changes:** Awareness of Department of Health and Social Care definition of out of area placements and how decision makers should consider this.
Improved access to resources: Improved website, which contains easily accessible information and resources. This could also be provided through a mobile app.	**Visitor spaces:** Dedicated space / rooms for visitors (family, relatives) within hospitals for them to relax.	**Understanding clinical pathways:** Use carers' knowledge to gain an understanding of their experiences.	**Dealing with service users in crisis:** Safe places should be available near to home and in the community rather than at a distance (e.g. Macclesfield to Chester).
Overcoming travel issues: Contracts with taxi firms and using volunteers to provide transport for service users and their support network. Use of technology between service users and support network to stay in touch. Accessing services using technology such as video conferencing to minimise travel.	**Use of other facilities instead of the Millbrook Unit:** Using other CWP land or buildings, for instance within the Rosemount site, expanding Soss Moss, or siting specialist support at Leighton Hospital.	**Use of other facilities:** Can CWP be given the Millbrook Unit so they can make changes as a capital project, without the landlord approval. Macclesfield once had a 1,500 bed mental hospital, reduced to 450 beds.	**Commissioning charities:** Commissioning charities and voluntary services to provide services for mental health that are specific.
Community services: Provide community care services in-line with service user demand – e.g. consider reviewing opening hours.	**Provision of crisis cafés:** There should be three crisis cafés located in major urban areas and sufficient transport to take users to them.	**Presenting all the options:** Seeing more of the options that were initially considered.	**Reducing repetition:** Service users sharing their history multiple times is considered frustrating, suggestions for system which avoids this repetition.
Supporting carers: Support for carers and family members through similarly styled cafés.	**The Autism model:** The Autism model has reduced hospital admissions. This could be referenced to help reduce admissions within this proposed model of care.	**Providing local care:** A 'crisis bus' that travels around the county like a mobile library providing help, advice and support.	**Caring for young adults:** Suggestions whether another step is needed between children and adult wards for those neither are suitable.

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Conclusions

This section summarises the key findings from the consultation on the proposed redesign of adult and older people's services.

Ranking the Options

Within the consultation survey respondents were asked to rank the three options from most to least preferred (best, mid and lowest). Option 2 was identified as the most preferred option, followed by options 1 and 3.

Option 2 – 115 (best), 72 (mid) and 59 (lowest)

Option 1 – 84 (best), 38 (mid) and 137 (lowest)

Option 3 – 57 (best), 136 (mid) and 53 (lowest)

The ranking of options by CCG area shows the following:

South Cheshire and Vale Royal CCG area respondents – ranked **option 2** as the most preferred

Eastern Cheshire CCG area respondents – ranked **option 1** as the most preferred.

The ranking of options by respondent type shows the following:

Services users, mental health carers, the public, other public sector employees and other organisation employees – ranked **option 2** as the most preferred

NHS (mental health) employees and other ranked **option 1** as the most preferred.

Agreement with the options

Respondents were asked to rate the extent to which they agreed with each option. Most agreement was for option 2. The options have been listed by level of agreement received:

Option 2 – 150 (52%) strongly agree/agree

Option 1 – 109 (37%) strongly agree/agree

Option 3 – 104 (38%) strongly agree/agree (please note opinion was almost evenly split with 106 (38%) strongly disagree/disagree)

Delivery of options against outcome statements

Respondents were asked to rate the extent to which they agreed each option would deliver against eight service outcome statements. When comparing the results against the top three (most important) outcome statements option 2 received the highest score overall.

Overall findings

Overall, **option 2** was identified as the option receiving the highest scores. There was a recognition that services had to change, however there were strong concerns regarding the difficulties this would cause. In particular, transport costs, travel time, less opportunity for carers, family, friends and staff to visit and the detrimental impact on recovery of patients, were raised as concerns.

For all options there were also concerns regarding the implementation of proposed changes and the associated costs.

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Supporting documents for this executive summary

Item
Main report of findings
Appendix A - Engagement report – produced by the consultation partners
Appendix B - Independent consultation survey report of findings – produced by the University of Chester
Appendix C - Analysis of correspondence received during the consultation – produced by MLCSU
Appendix D - Feedback provided from 26 additional meetings and events – produced by MLCSU using evidence supplied by the consultation partners
Appendix E - Seven public events report of findings – produced by MLCSU using evidence gathered by MLCSU who were contracted to design and manage the seven events
Appendix F - Analysis of calls made to the Patient Advice and Liaison Service (PALS) during the consultation period – produced by the consultation partners

All supporting documents for this executive summary can be found at:

www.easterncheshireccg.nhs.uk/Your-Views/ccg-consultations.htm

10.09.18: Summary Report of Findings Final version (2.6)

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STANDARDISED REPORT COMMUNICATION

REPORT DETAILS

Report subject:	Ward Daily Staffing Levels July and August Data 2018
Agenda ref. no:	18.19.63
Report to (meeting):	Board of Directors
Action required:	Information and noting
Date of meeting:	28/09/2018
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 months of July and August 2018 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. The recommendations made within the latest six monthly report are being followed through and will be monitored via the Inpatient Service Improvement Forum and the People Planning group which oversees the strategic approach to safe staffing. The Trust is engaged in the national Optimum Staffing Project a programme of work commissioned by Health Education England to develop a generic tool (multi-disciplinary) for Safe Staffing that can be used in any service setting for inpatient mental health services.

Assessment – *analysis and considerations of options and risks*
During July 2018 the trust achieved staffing levels of 95.3% for registered nurses and 95.7% for clinical support workers on day shifts and 96% and 94.2% respectively on nights. During August 2018 the trust achieved staffing levels of 95% for registered nurses and 96.9% for clinical support workers on day shifts and 95.5% and 97.9% respectively on nights. In the months of July and August the wards continued to experience pressures in terms of staffing in particular on the wards in Central and East locality due to staff sickness, maternity leave, patients on increased levels of observations and vacancies. Staffing related to inpatient units has been coordinated during August, through the participation of all inpatient services in a daily conference calls to review and understand staffing levels across all inpatient Units. This has allowed for the staffing resource to be used in the most effective way to ensure high quality, patient centred care continues to be delivered safely across all inpatient units. 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] and Avril Devaney, Director of Nursing, Therapies and Patient Partnership
Contributing authors:		Charlotte Hughes
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	12/09/2018 12/09/2018

Appendices provided for reference and to give supporting/ contextual information: *Provide only necessary detail, do not embed appendices, provide as separate reports*	
Appendix no.	Appendix title
1 2	Ward Daily Staffing July 2018 Ward Daily Staffing August 2018

Area	Ward	Day – Registered: Total monthly planned staff hours	Day – Registered: Total monthly actual staff hours	Day – Care Staff: Total monthly planned staff hours	Day – Care Staff: Total monthly actual staff hours	Night – Registered: Total monthly planned staff hours	Night – Registered: Total monthly actual staff hours	Night – Care Staff: Total monthly planned staff hours	Night – Care Staff: Total monthly actual staff hours	Fill Rate – Day: Average fill rate - registered nurses/ midwives (%)	Fill Rate – Day: Average fill rate - care staff (%)	Fill Rate – Night: Average fill rate - registered nurses/ midwives (%)	Fill Rate – Night: Average fill rate - care staff (%)	Safe Staffing was maintained by:
East	Adelphi	1100.5	1066	1461.5	1328.5	759	747.5	1113.5	964	96.9%	90.9%	98.5%	86.6%	Nursing staff working additional unplanned hours. Cross cover arrangements.
	Alderley Unit	1007.5	950	1574	1428.5	701.5	632.5	724.5	733.5	94.3%	90.8%	90.2%	101.2%	Nursing staff working additional unplanned hours. Cross cover arrangements.
	Bollin	1170	960	1589	1397	713	701.5	1356	1253	82.1%	87.9%	98.4%	92.4%	Nursing staff working additional unplanned hours. Cross cover arrangements. Multi Disciplinary Team actively worked within the staffing estlishment.
	Croft	1234.5	1016	1493.5	1521	713	638.5	1276.5	1213.5	82.3%	101.8%	89.6%	95.1%	Nursing staff working additional unplanned hours. Cross cover arrangements. Multi Disciplinary Team actively worked within the staffing estlishment.
	Greenways A&T	1197.7	937	2184	1833	713	621	1592	1305.5	78.2%	83.9%	87.1%	82.0%	Nursing staff working additional unplanned hours. Cross cover arrangements. Non mandatory staffing activity was cancelled.Multi Disciplinary Team actively worked within the staffing estlishment .
	LimeWalk Rehab	1127.5	1022.5	1058	877	713	644	713	606.5	90.7%	82.9%	90.3%	85.1%	Nursing staff working additional unplanned hours. Cross cover arrangements.
	Saddlebridge	1031.5	1021.5	1299.5	1278	713	701.5	713	713	99.0%	98.3%	98.4%	100.0%	
Wirral	Brackendale	1062.5	1064.5	1051.5	1051.5	736	736	736	667	100.2%	100.0%	100.0%	90.6%	Nursing staff working additional unplanned hours.
	Brooklands	964.5	941	1015.5	1004	713	690	789	754.5	97.6%	98.9%	96.8%	95.6%	
	Lakefield	1061.1	1034.6	977.5	966	704.5	693	884.5	873	97.5%	98.8%	98.4%	98.7%	
	Meadowbank	1250.5	1250.5	1575.5	1575.5	747.5	690	1357	1046.5	100.0%	100.0%	92.3%	77.1%	Nursing staff working additional unplanned hours.
	Oaktrees	1303.5	1293	1308	1331	690	667	414	391	99.2%	101.8%	96.7%	94.4%	Nursing staff working additional unplanned hours.
	Willow PICU	1037	1025.5	766.5	755	713	632.5	732.5	732.5	98.9%	98.5%	88.7%	100.0%	Nursing staff working additional unplanned hours.
West	Beech	1436	1418.5	943.5	882	745	742	680.5	639.5	98.8%	93.5%	99.6%	94.0%	Nursing staff working additional unplanned hours. Cross cover arrangements.
	Cherry	1240	1233.25	1322.5	1311	805.5	805.5	954.5	954.5	99.5%	99.1%	100.0%	100.0%	
	Eastway A&T	941	910.8	1952	1894.5	556	556	1350.5	1350.5	96.8%	97.1%	100.0%	100.0%	
	Juniper	1399	1348	784.5	724.5	738.5	728	655	613	96.4%	92.4%	98.6%	93.6%	Nursing staff working additional unplanned hours. Cross cover arrangements.
	Coral	1322	1322	1164	1164	605.5	605.5	1057.65	1057.75	100.0%	100.0%	100.0%	100.0%	
	Indigo	993.5	993.5	946.5	935	673.5	662	760.5	749	100.0%	98.8%	98.3%	98.5%	
	Rosewood	985.25	965.25	1394	1371	580	568.5	678.25	678.25	98.0%	98.4%	98.0%	100.0%	
	Trustwide									95.3%	95.7%	96.0%	94.2%	

	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	1177.5	1028	1360.5	1304	782	759	1078.5	1037	87.3%	95.8%	97.1%	96.2%	Nursing staff working additional unplanned hours. Cross cover arrangements.
	Alderley Unit	857	803	1470.5	1400	713	621	713	745	93.7%	95.2%	87.1%	104.5%	Nursing staff working additional unplanned hours. Cross cover arrangements.
	Bollin	1281.5	1185.5	1479	1395	713	690	1322.5	1192	92.5%	94.3%	96.8%	90.1%	Nursing staff working additional unplanned hours. Cross cover arrangements.
	Croft	1029.5	886.5	1744	1524.75	694.5	602.5	1374	1277.5	86.1%	87.4%	86.8%	93.0%	Nursing staff working additional unplanned hours. Cross cover arrangements. Members of the Multi Disciplinary Team actively worked in the staffing numbers to ensure safer staffing levels.
	Greenways A&T	1182.4	931	2139	1963.45	713	563.5	1426	1437.5	78.7%	91.8%	79.0%	100.8%	Nursing staff working additional unplanned hours. Cross cover arrangements. Members of the Multi Disciplinary Team actively worked in the staffing numbers to ensure safer staffing levels.
	LimeWalk Rehab	1151.5	1035.75	1069.5	956	713	586.5	713	656	89.9%	89.4%	82.3%	92.0%	Nursing staff working additional unplanned hours. Cross cover arrangements.
	Saddlebridge	955.5	879	1318.5	1278.8	667	667	736	735.5	92.0%	97.0%	100.0%	99.9%	Cross cover arrangements.
Wirral	Brackendale	1053.5	1053.5	1023.5	1023.5	713	678.5	747.5	747.5	100.0%	100.0%	95.2%	100.0%	
	Brooklands	890	893.5	1295	1329.5	713	736	816.5	759	100.4%	102.7%	103.2%	93.0%	Cross cover arrangements.
	Lakefield	1091.5	1042	1017	1016.5	678.5	678.5	874	874	95.5%	100.0%	100.0%	100.0%	
	Meadowbank	890.5	833	1928.5	1928.5	805	793.5	1242	1242	93.5%	100.0%	98.6%	100.0%	Nursing staff working additional unplanned hours.
	Oaktrees	1169	1169	1294	1271	713	598	397	391.5	100.0%	98.2%	83.9%	98.6%	Nursing staff working additional unplanned hours.
	Willow PICU	938	938	989	954.5	713	713	816.5	782	100.0%	96.5%	100.0%	95.8%	Cross cover arrangements.
West	Beech	1360.7	1297.7	1065	1019	682.5	682.5	723	713.5	95.4%	95.7%	100.0%	98.7%	
	Cherry	950.5	950.5	1541	1541	736	736	1012	1012	100.0%	100.0%	100.0%	100.0%	
	Eastway A&T	1124	1124	1503	1491.5	517.4	517.5	1551.5	1551.5	100.0%	99.2%	100.0%	100.0%	Ward manager activel worked within the daily staffing numbers. Cross cover arrangements.
	Juniper	1320.5	1275.5	922.5	876.5	667	667	763.5	740.5	96.6%	95.0%	100.0%	97.0%	
	Coral	1071.5	1071.5	1346	1346.5	708	708	975.5	975.5	100.0%	100.0%	100.0%	100.0%	
	Indigo	904.5	891.5	1037.5	1026	590.5	590.5	855	847	98.6%	98.9%	100.0%	99.1%	
	Rosewood	811.5	811.25	1633	1633	552	552	655.5	655.5	100.0%	100.0%	100.0%	100.0%	
	Trustwide	21210.6	20099.7	27176	26279	13784.4	13140.5	18792.5	18372	95.0%	96.9%	95.5%	97.9%	

STANDARDISED REPORT COMMUNICATION

REPORT DETAILS

Report subject:	Safeguarding Annual Report – 2017 -2018
Agenda ref. no:	18.19.64
Report to (meeting):	Board of Directors
Action required:	Information and noting
Date of meeting:	28/09/2017
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	No
Ensure meaningful involvement of service users, carers, staff and the wider community	Yes
Be a model employer and have a caring, competent and motivated workforce	Yes
Maintain and develop robust partnerships with existing and potential new stakeholders	No
Improve quality of information to improve service delivery, evaluation and planning	Yes
Sustain financial viability and deliver value for money	No
Be recognised as an open, progressive organisation that is about care, well-being and partnership	No
Which CQC quality of service domains this report reflects:	
Safe services	Yes
Effective services	Yes
Caring services	No
Well-led services	No
Services that are responsive to people's needs	Yes
Which Monitor quality governance framework/ well-led domains this report reflects:	
Strategy	
Capability and culture	Yes
Process and structures	Yes
Measurement	
Does this report provide any information to update any current strategic risks? If so, which?	
See current risk register in the agenda of the public meeting of the Board of Directors at http://www.cwp.nhs.uk/about-us/board-members/our-board-meetings	No
35T	
Does this report indicate any new strategic risks? If so, describe and indicate risk score:	
See current integrated governance strategy: CWP policies – policy code FR1	
35T	

REPORT BRIEFING

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

This report is to give the Board an overview of Safeguarding activity during 2017-2018 and a position statement on the implementation of key objectives set.

The report gives an overview of safeguarding inspections and reviews that CWP have been involved with.

Background – *contextual and background information pertinent to the situation/ purpose of the report*
This is an annual Safeguarding report for 2017 / 2018 to the Board to provide assurance that CWP are meeting their safeguarding responsibilities.

Assessment – *analysis and considerations of options and risks*
CWP have been involved in a number of safeguarding inspections and reviews since April 2017 and have implemented a number of recommendations as a result. This report gives an overview of safeguarding activity for the period April 2017 until the end of March 2018. The report sets objectives for the year 2018-2019.

Recommendation – *what action/ recommendation is needed, what needs to happen and by when?*
The Board is asked to note the report, receive assurance and approve the key objectives for 2018 - 2019.

Who/ which group has approved this report for receipt at the above meeting?		Trustwide Safeguarding Sub committee
Contributing authors:		Satwinder Lotay
Distribution to other people/ groups/ meetings:		
Version	Name/ group/ meeting	Date issued
0.1	Trustwide Safeguarding Sub committee	May 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
A	Safeguarding Annual Report 2016-2017.

CWP Safeguarding Adults and Children (including Children in Care) Annual 2017/18 Board Report (includes Quarter 4 Activity)

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7. Safeguarding Looked After Children and Prevent Training
8. Serious Case Reviews/Serious Adults Reviews/Domestic Homicide Reviews
9. Inspections
10. Assurance Process and Audits
11. Review of Trust Wide Objectives for 2016/2017
12. Objectives for 2017/2018
13. Conclusion

Appendix 1
CWP Safeguarding Structure

Appendix 2
CWP Safeguarding Governance Arrangements

1.0 Purpose Of The Report

This annual report to the board is to give the Board assurance that CWP are meeting their safeguarding responsibilities and to provide both an overview of the Safeguarding activity during 2017/2018 and a position statement on the implementation of key objectives set.

The report supports the quarterly reports to Board in providing continuing assurance of how the Trust has met its responsibilities and requirements as a regulated provider; under Regulation 13 of the Health and Social Care Act 2008, The Care Act 2014, The Children Acts of 2004 and 1989 the statutory guidance Working Together to Safeguard Children, 2015 and Promoting the Health of Looked After Children, 2015. The report is inclusive of the quarter four report.

2.0 Summary

CWP continues to meet the responsibilities across the safeguarding agenda including Prevent, Modern Slavery, Domestic Abuse, Harmful Practices, Sexual Exploitation as well as Adult Safeguarding and Safeguarding Children. CWP continues to respond to a high volume of case review consideration across all local authorities in which CWP delivers services.

Central to effective safeguarding practice is ensuring staff are supervised, supported and competent, this has been reflected in the contracting frameworks. To support continued learning, CWP staff are regularly updated on the ever-changing safeguarding landscape in addition to producing shared learning bulletins to disseminate the learning from case reviews and audits.

Safeguarding governance arrangements and practice within CWP continues to develop in an integrated way. This year CWP board have received regular updates of safeguarding activity and performance throughout the year and have been updated against the CWP Safeguarding strategy 2017-2020. The number of Safeguarding Practice Links (SPL) identified across the trust is increasing, and the uptake of safeguarding group supervision has increased. The SPL now has a focus on all aspects of safeguarding practice.

CWP continues to work closely with the respective Local Safeguarding Children Board (LSCB), Local Safeguarding Adult Board (LSAB) and Domestic Abuse Boards and ensures engagement with appropriate subgroups is maintained. This will become crucial for the forthcoming year as LSCBs begin to plan the implementation of aspects of the Children and Social Work Act 2017, which ends LSCBs, and the formation of a new body.

The report is structured to provide the overarching Trustwide perspective on safeguarding responsibilities and performance. The report will then review performance against the previous year's priorities. The final section of the report sets out the objectives for the forthcoming year.

3.0 Safeguarding Leadership and Accountability

The Director of Nursing, Therapies and Patient Partnership champions Safeguarding and represents the Trust on the LSCBs. The Associate Director of Nursing and Therapies (physical health) represents the Trust at LSABs and supports the Director for Nursing. The Head of Safeguarding deputises as needed for both Director of Nursing and Associate Director at the respective safeguarding boards as well as represent CWP on the Domestic Abuse partnership boards across Cheshire. Refer to appendix 1 for the CWP structure.

4.0 Safeguarding Governance Arrangements and Assurance

The Quality Committee has established the Trust wide Safeguarding Subcommittee to provide assurance that safeguarding responsibilities are met through the activities of the Trust in line with the terms of reference (see Appendix 2 for the safeguarding governance structure).

CWP provides assurance to commissioning CCGs and Designated Nurses for Safeguarding via completion of Safeguarding Assurance Frameworks (SAF). This includes data submissions in relation to various aspects of safeguarding training, supervision and activity. In addition, the annual self-assessment for both adult and children's safeguarding is undertaken and submitted for scrutiny to the CCGs. Feedback for the safeguarding adult self-assessment 2017/2018 was received from the Cheshire CCGs and CWP were commended for the high standard of the audit submission. All standards were Rag rated as Green except one with the requirement to update the adult safeguarding policy; this has been completed. The self-assessment for children, incorporating the Section 11 LSCB audit, has been completed and the resulting continuous improvement plan is being implemented and overseen by the trust wide Safeguarding subcommittee.

5.0 Board Assurance Frameworks - Risk Register

The risks relating to safeguarding on the CWP Board Assurance Framework are reviewed, mitigated and monitored by the trust wide Safeguarding Sub-committee. On 16th November 2017 the safeguarding risks was added to the Corporate Risk Register. The risk is as follows:

> Risk of not achieving contractual obligations and subsequent reputational impact, due to increased inspectoratory burden and acute increase in the volume of multiagency case reviews.

The risk reflected the reduced capacity in CWP Safeguarding Service (due to vacancies and long-term staff sickness), as well as an increase in activity demand. Mitigations have been put in place to manage the risk; inclusive of an increase in band 7 Adult Safeguarding Nurse hours, priorisation of work and cross cover with partners to external meetings where possible, whilst a safeguarding review is undertaken.

6.0 Safeguarding Activity

6.1 Safeguarding Adults

CWP Nurse Specialists for Safeguarding Adults receive enquiries for advice and support from CWP staff in relation to safeguarding issues. In quarter 4 there have been **289** enquires which is comparable to the quarter 3. This year, CWP have strengthened process to capture the number of section 42's undertaken. Presently, CWP are capturing the Section 42's that CWP Safeguarding adult nurses are undertaking. Since (this when reporting has commenced) CWP adult team have undertaken 12 Section 42 enquires on behalf of the respective local authority. Currently, systems are not yet robust to capture data for Section 42's undertaken by Community Mental Health Care teams.

During 2017-18 the overall figures for safeguarding adult enquiries has been 1142 which is comparable to last year. Of these enquiries 136 referrals have been made to the local authority which is a 100 % increase.

The adult safeguarding team have undertaken 5 case supervisions in quarter 4. In total 22 complex case supervisions have been undertaken for the year. It needs to be noted that this does not encompass ad hoc supervision which may be undertaken.

This year, a complex adult safeguarding case led by a CWP Safeguarding Adult Nurse resulted in a forced marriage order being granted to safeguarding an adult at risk.

6.2 Safeguarding Children

The early help agenda continues to be embedded with a wide range of staff across CWP engaged with the Common Assessment Framework (CAF)/Team Around the Family (TAF) process.

The number of children social care referrals in 2017/2018 was 72 which is a decrease from the 115 in 2016/2017 (a 37% reduction). It is unclear why this is the case. Further analysis needs to be undertaken to ensure that all referrals are being reported in and that practitioners are undertaking and applying thresholds appropriately to safeguard children and young people.

CWP continue to be engaged within the Child Protection Process. CWP staff have attended 702 case conferences in total and have provided information for a further 231 conferences (where CWP had relevant historical information regarding the family but were not actively involved at the time). Processes are in place to ensure service managers are informed if there are concerns of attendance or quality of information shared falls below the standards of practice expected.

The safeguarding children team have supported 127 staff members in the provision of court statements for public court proceedings in 2017/2018, which is comparable to 2016/17.

The Safeguarding children team continue to be actively involved with the Child Sexual Exploitation agenda across the localities. During 2017/18 the nurse specialists have attended 24 CSE meetings (a fall by 33%). This decrease in attendance has been achieved by CWP having a reciprocal arrangement with Wirral Community NHS Foundation Trust to represent each other at CSE meeting.

The number of enquiries made to the safeguarding children team from CWP staff for quarter 4 is 408. The number of enquires for 2017/2018 overall was 1,555. This has now established a baseline figure for CWP to benchmark against for the future.

Safeguarding children supervision uptake remains high with 136 cases being discussed within this reporting period. Overall 811 cases have received face to face supervision by the safeguarding children team as this is an increase from the previous year by 55. The introduction of a new safeguarding model being introduced in Wirral CAMHS and also in the substance misuse service in Cheshire East has not resulted in a decline on the demand for safeguarding supervision. A new supervision process involving reflective practice will be introduced for 2018/19 and will be initially trialled within the starting well service.

6.3 Mental Capacity Act and Deprivation of Liberty Safeguards

CWP has continued to strengthen practice in relation to Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DOLS). CWP has developed processes to monitor the application and authorisations for DOLS and has provided guidance and training for staff to ensure the requirements of the MCA are met. Table 1 provides the compliance figures for MCA and DOLs training.

Table 1: Training compliance rate as at end of March 2018.

Training	%compliance on 31st March 2018
Mental capacity and DOLS	78%

Table 2: Summary of DOLs authorised across CWP

DOLS Figures	2016/17	2017/2018
Urgent authorisations (self-authorised by CWP)	40	24
Standard applications	139	49
Standard Authorisations	12	1

Table 2 sets out the number of standard authorisations granted by Local Authorities and the number of CWP self-authorised urgent DOLS authorisations. There has been a change in the application process for standard authorisations; instead of doing one application per period of respite several planned respite periods may be included in one application. This has resulted in a substantial decrease in the number of applications submitted by the respite units Thorn Heyes and Crook Lane.

6.4 Prevent

The Safeguarding Nurse specialists provide representation on behalf of CWP to the Channel Panel meetings across Cheshire and Wirral. In quarter 4, CWP have made three referrals via the Prevent route, which has been discussed at the respective Channel Panel. There has been a 75% increase in referrals made by CWP; seven being made this year. CWP have attended 16 Channel meetings and provided information on all relevant cases.

6.5 Multi Agency Public Protection Arrangement

CWP continue to develop public protection strategies to further support previous work in this area. An internal audit commissioned in 2017 has identified training requirements and this package is currently being discussed for implementation across CWP services later in 2018. CWP representation/input is now embedded within the Cheshire and Merseyside MAPPA Strategic management Board (SMB) process, including sub-group and strategic planning forums. Work has also commenced to support individuals leaving prison that require CWP service input, to support identification of MAPPA nominals. CWP practitioners form visible representation and a proactive approach at all MAPPA level 2 meetings across Cheshire and Merseyside, with senior representation at all MAPPA level 3 meeting to support service mobilisation as required. New editions to the National MAPPA Guidance continue to be filtered through to Duty to Cooperate Agencies and will inform a MAPPA policy review annually.

6.6 Domestic Abuse

CWP continues to attend and support Multi Agency Risk Assessment Conference (MARAC) meetings, which operate across Cheshire East, Cheshire West and Wirral. CWP have increased the pool of MARAC representatives to support the safeguarding Nurse Specialists in managing the process. The number of meetings attended by CWP is comparable to last year with CWP attending **86** MARAC meetings.

CWP continues to support the respective Domestic Abuse Partnership Boards and subgroups across Cheshire and support Domestic Abuse subgroups in Wirral.

6.7 Modern Slavery/Human Trafficking

CWP have a published statement in line with Modern Slavery Act. Awareness of modern slavery and human trafficking has been incorporated within CWP Safeguarding e-learning

level 1 and level 2. During 2017/2018, two adults have been identified and referred via the National Referral Mechanism System by CWP.

6.8 Children in Care

There has been a significant change in January 2017 within the Children in Care service with CWP becoming responsible for the Vale Royal CCG area, which included the transfer of the Nurse Specialist joining CWP from the previous provider.

The team continue to provide training at Level 3 for Health Visitors, School Nurses, and Family Nurses to ensure quality review health assessments for children in care are undertaken. They also contribute to the Level 2 Safeguarding Training programme for CWP clinical staff to ensure all CWP have an understanding of Children in Care. The Nurse Specialists also participate in induction training for foster carers in Cheshire West and Chester (CWAC) local authority area, to ensure they have an understanding of the health needs of this most vulnerable group.

The Nurse Specialists continue to provide child in care supervision for clinicians who carry children in care caseload. In 2017/2018, 283 cases were discussed at face-to-face supervision. Nurse Specialists receive supervision from Named Nurse Safeguarding Children. A new supervision process involving reflective practice has been introduced for 2018/19. This will be trialled by the Starting Well Service.

The Children in Care Team have a responsibility for overseeing the requests for Review Health Assessments ensuring they are undertaken in a timely manner and are of a high quality. The team works closely with CWAC Social Care to ensure the health of children in care is being addressed and data for Ofsted reporting is robust.

Monthly reporting of activity relating to children in care continues to be reported to the respective CCGs using the Safeguarding Assurance Framework. Overall, in 2017/2018, CWP staff has completed 414 Review Health Assessments. Where delays/quality issues are identified this is escalated to the appropriate Designated Nurse.

Following on from a recommendation from the Serious Case Review (SCR) for Child B, a number of processes and pathways have been strengthened with social care to ensure information sharing is more robust and timely. Within the last quarter CWP have placed their 16-19 children in care nurse into the equivalent social care team to enhance joint working.

6.9 Child Death and Paediatric Liaison

The Nurse Specialist for Health Visitor liaison communicates directly with Health visitors, School Nurses and other community health practitioners. As such has an essential role in the sharing of appropriate information between professionals across all areas, such as acute Trusts' (primarily The Countess of Chester NHS Foundation Trust) accident and emergency departments, neonatal units, paediatric wards and CWP services.

The nurse specialist attends regional liaison meetings. Effective regional communication and information sharing is valuable and ideas can be shared and developed to increase the effectiveness of the liaison role, processes and learning.

Child Death Overview Panel

The Nurse Specialist is a core member of the Pan Cheshire Child Death Overview Panel (CDOP). The panel reports on its findings with reference to the review of the child deaths across Cheshire, identification of trends and statistics and identification of public health issues.

The Nurse Specialist coordinates the health response to the CDOP panel in a timely way in order for the panel to adequately review deaths. This includes completion of the appropriate department of health child death forms and significant liaison between any involved professionals and where necessary provision of support. Additionally supervision to CWP staff involved and signposting them to staff services if required is provided.

The Nurse Specialist is able to communicate trends and public health issues to community practitioners to enable consideration for service improvement and training.

7.0 Safeguarding, Looked After Children and Prevent Training

A robust training programme for all staff working within CWP underpins effective evidence based safeguarding practice. Compliance rates for training are scrutinised at Trust wide Safeguarding Subcommittee and localities are held to account. This is replicated at locality level with services. The Safeguarding, Looked After Children and Prevent Training compliance rates are detailed in the respective tables below. The level 1 and level 2 Safeguarding family training has been updated to reflect changes in guidance and to incorporate learning from case reviews. It now also includes information about MAPPA.

The level 3 safeguarding children training compliance has increased by 4% in quarter 4 to 84%. CWP Board received safeguarding training the Head of Safeguarding in April 2017.

The level 1 and level 2 safeguarding family training has been updated to reflect changes in guidance and to incorporate learning from case reviews. It now also includes information about MAPPA.

Table 3: Safeguarding Training Compliance Rates for CWP at end of March 2018

Safeguarding Training	Trustwide Compliance Rate at End of March 2018
Level 1 (children and adults includes domestic abuse)	88%
Level 2 (children and adults includes domestic abuse)	87%
Level 3 (safeguarding children only)	84%
Level 4	100%

Table 4: Looked After Children Compliance Rate for CWP 2017/2018

Looked After children 2017/2018	Trustwide Compliance Rate
Level 1 & 2	90%
Level 3 –Undertaking Quality Health Assessments (Health Visitors, 5-19 and FNP only)	96%
Level 4	100%

The Prevent Workshop to raise awareness and prevention (WRAP) training for CWP staff is mandatory and the compliance as at end of March 2018 are detailed in Table 5.

Table 5: PREVENT WRAP Training Compliance on 31 March 2018

PREVENT	Trustwide Compliance Rate as at 31/03/2018
Level 1 and 2 **Clinical** **Non Clinical**	 90% 89%
WRAP 3 (level 3)	90%

8.0 Serious Case Reviews / Serious Adults Reviews/ Domestic Homicide Reviews

During 2017/18, CWP have provided nine case chronologies for Serious Case Review (SCR) consideration for the LSCBs. This has resulted in one new SCR commencing, five multi case reviews being undertaken (that did not meet SCR thresholds). This was in addition to three SCRs that CWP were involved with that commenced in the previous year and concluded in 2017/2018.

The Named Nurse has been actively involved in two SCR panels.

CWP have provided chronologies on four cases for Serious Adult Review (SAR) panels for LSABs, with one resulting in a SAR. The Head of Safeguarding is a panel member for this review.

CWP have referred one case into the Domestic Homicide Review (DHR) panel for case consideration, which resulted in a DHR being commenced. There have been three DHRs that required CWP involvement. The Head of Safeguarding has been a panel member in two of the cases. One of the DHR was disbanded in 2018.

9.0 Inspections

During 2017/2018, CWP have been involved in a Joint Targeted Inspection Cheshire West and Chester Joint (Neglect theme).

As a result of this inspection, CWP are actively implementing the multi-agency action plan that is being overseen by CWAC LSCB.

In addition, CWP have continued to support the improvement plan in Wirral and participated in ongoing Ofsted inspections. Head of Safeguarding also involved in the CQC well led pilot.

10.0 Assurance Process and Audits

The majority of 2017/2018 Safeguarding Audit Programme has been completed (two audits are being carried forward to 2018/2019). The learning themes from these audits are summarised in Box 1.

Box 1: Summary of outcomes from CWP Safeguarding Audits

Safeguarding Children

- There is inconsistent practice across the Trust in terms of how safeguarding children supervision is recorded.
- Children services generally evidence the Child's Lived experience.
- Quality assurance of social care referrals have demonstrated that the majority of referrals contain all the information that is required.

Looked After Children

- Quality assurance audits undertaken by the children in care service demonstrates high quality assessments are being maintained an evidence of engagement with child/ young person involved.
- Completion of a review health assessments are not always received in a timely manner form external health providers.

Safeguarding Adults

- Staff have a good understanding of identification of risk and the process that is required to be followed in ensuring that the case is managed appropriately in referring it to the Local Authority.
- The majority of cases referred to the Local Authority were accepted as referrals indicating that the threshold for referral criteria was understood by staff.
- Mental Capacity assessments are not clearly evidenced.

CWP have also participated in numerous multi-agency case audits. These audits have demonstrated that practitioners can enhance their assessments by utilising evidence-based assessment, such as the graded care profile used for assessment for neglect.

In addition internal assurance is gained through a variety of methods including spot checks, unannounced walk arounds by the safeguarding team, senior leaders and executive directors.

Processes are in place to review reported safeguarding incidents via DATIX reporting system. Head of Safeguarding receives notification of all serious incidents reported within the Trust.

11.0 Review of Trust Wide Objectives for 2017/18

<u>To work with respective boards to embed learning from case reviews and evidence based Practice:</u>

There are various examples, and the key ones identified are as follows:

CWP have worked with CWAC LSCB/LSAB on implementation of Neglect and Think Family agenda. The Named Nurse has been a pivotal member on key work streams.

In Wirral, CWP have championed Supporting Family Enhancing Futures (SFEF) work. A CWP Nurse Specialist delivers training and delivers SFEF model in supervision and the day-to-day practice in Wirral. In Cheshire East, CWP have engaged with Sign of Safety work and identified a Sign of Safety Champion who will be delivering this and supporting practitioners working in East Cheshire Locality.

<u>Promote and Embed Safeguarding Strategy:</u>
CWP have increased members of SPLs. Supervision is embedded in practice. Close working with LSCB, LSAB, and Domestic Abuse partnerships.

<u>Support and Promote work of Truth Project:</u>
CWP have highlighted and promoted work of Truth Project by including within CWP Life Magazine, distributing information. CWP have also provided feedback to the Health Promotion lead for the Truth Project to help design future national campaign material.

<u>Continue to work with services in ensuring robust safeguarding processes are in place in response to the integrated agenda:</u>
Head of Safeguarding and Named Nurse for Children have been pivotal in the preparation and mobilisation of Starting Well Services. Head of Safeguarding has been working with Wirral services to look at the future of integration of All Age Disability and Adult Mental Health Services.

12.0 Objectives for 2018/19

Review the governance structure for safeguarding in line with the organisational restructure into care groups to ensure appropriate assurance of a locality level is provided.

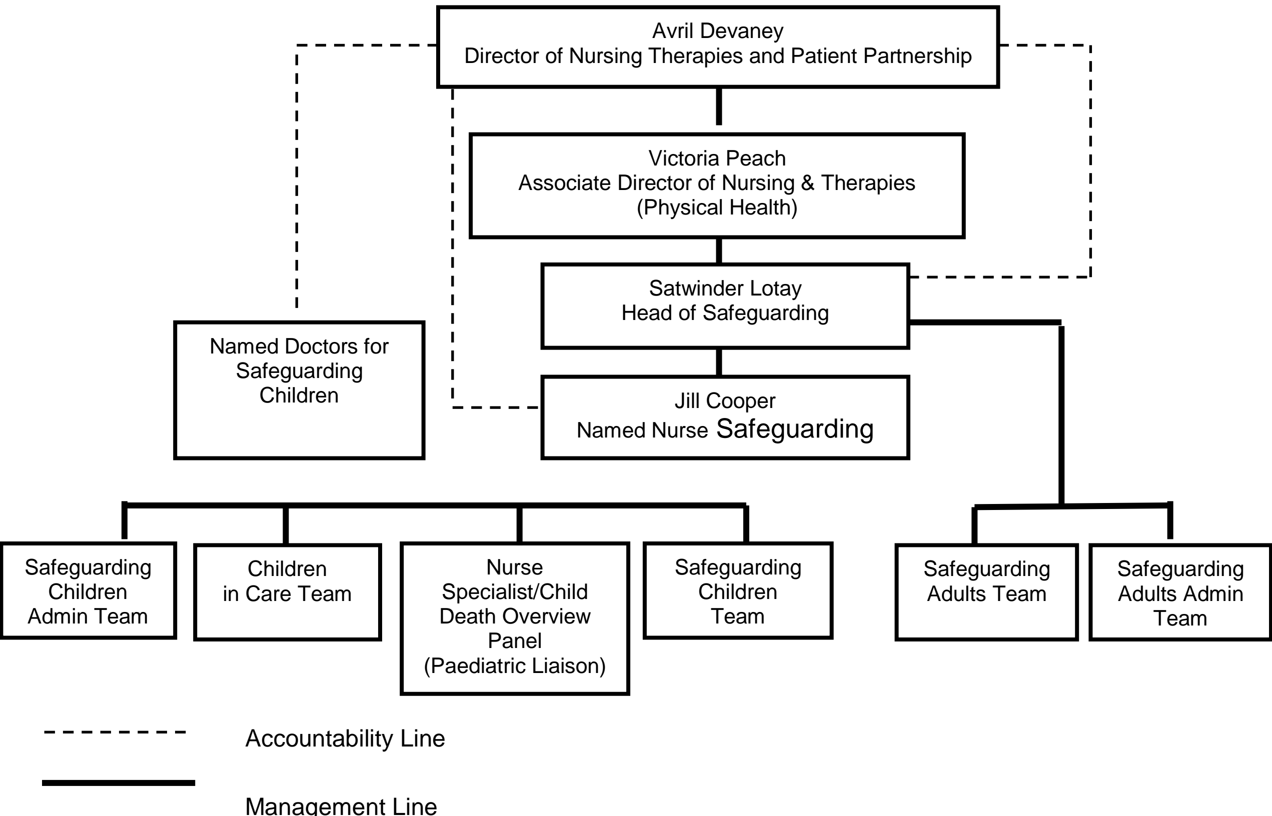
- Undertake a safeguarding training review in line with the expected publication of the Adult Safeguarding Intercollegiate document.
- A safeguarding service review is undertaken.
- A review of safeguarding supervision and supervision model.
- To incorporate 'Think Family' within the Care Groups, inclusive of the All Age Disability services.

13.0 Conclusion

CWP has continued to work in partnership across each of the local Safeguarding Boards for both adults and children. Safeguarding activity continues to remain at a high level across the organisation. The report demonstrates how CWP has met its requirements and statutory duties and has responded to the key objectives set for 2017/18 and outlines the ones set for 2018/2019. The safeguarding team will continue to work with services to ensure that robust safeguarding process are in place in response to the integrated agenda.

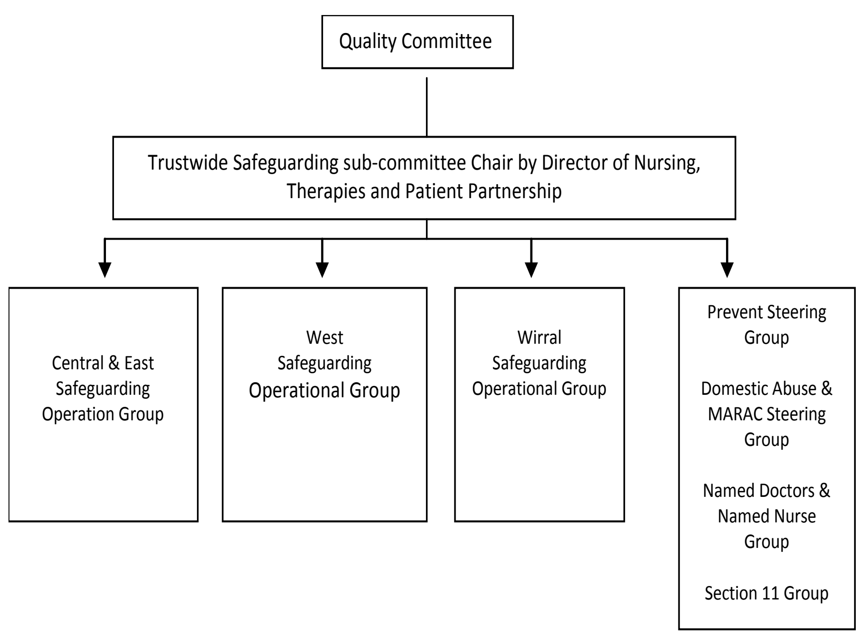
Appendix 1 **CWP Safeguarding Structure**

Diagram 1: Organisational Safeguarding Structure



Appendix 2

CWP Safeguarding Governance Arrangements



STANDARDISED REPORT COMMUNICATION

REPORT DETAILS

Report subject:	Medicines Management & Optimisation Annual Report 2017-18
Agenda ref. no:	18.19.65
Report to (meeting):	Board of Directors
Action required:	Discussion and Approval
Date of meeting:	28/09/2018
Presented by:	Fiona Couper, Chief Pharmacist & Associate Director of Medicines Management

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
Services that are responsive to people's needs	Yes
Well-led services	Yes
Which NHSI quality governance framework/ well-led domains this report reflects:	
Strategy	Yes
Capability and culture	Yes
Process and structures	Yes
Measurement	Yes
Does this report provide any information to update any current strategic risks? If so, which?	
See current risk register in the agenda of the public meeting of the Board of Directors at http://www.cwp.nhs.uk/about-us/board-members/our-board-meetings	No
Click here to enter text.	
Does this report indicate any new strategic risks? If so, describe and indicate risk score:	
See current integrated governance strategy: CWP policies – policy code FR1	No
Click here to enter text.	

REPORT BRIEFING

Situation – *a concise statement of the purpose of this report*
The Medicines Management Annual Report for 2017 – 18 describes the progress with the Trust's journey towards improved medicines optimisation as well as providing assurance with the framework for medicines governance across the Trust.

Background – *contextual and background information pertinent to the situation/ purpose of the report*
This report provides a summary of the activity and progress that has been made by the Medicines Management Group (MMG) and the Pharmacy Team against the group's annual business cycle.

Assessment – *analysis and considerations of options and risks*
The progress, achievements and challenges over 2017 – 18 relating to Medicines Management have been highlighted and assurance is provided of the underpinning mechanisms across the Trust to provide high quality, effective and safe services relating to medicines. As we progress further into 2018-19 there is scope to enhance the collaborative work developed over 2017-18 to optimise medicines for people who access our services. This is in line with the Trust's strategic objectives.

Recommendation – *what action/ recommendation is needed, what needs to happen and by when?*
Board of Directors are asked to discuss and approve the Annual Report.

Who/ which group has approved this report for receipt at the above meeting?		Quality Committee
Contributing authors:		Various from MMG membership
Distribution to other people/ groups/ meetings:		
Version	Name/ group/ meeting	Date issued
Version 6	Medicines Management	21.6.18
Final	Dr. A. Sivananthan	29.8.18
Final	Quality Committee	07.9.18

Appendices provided for reference and to give supporting/ contextual information: *Provide only necessary detail, do not embed appendices, provide as separate reports*	
Appendix no.	Appendix title
Click here to enter text.	Click here to enter text.

Medicines Management & Optimisation Annual Report 2017-18

Pharmacy Team, Cheshire & Wirral Partnership NHS Foundation Trust in Collaboration with the Medicines Management Group
June 2018

Executive Sponsor: Dr Anushta Sivananthan, Medical Director

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Executive Summary

This report highlights the journey towards Medicines Optimisation, aligned with CWP's Forward View. Key achievements are outlined as:

- Quality Improvement approaches to medicines optimisation
- Assurance for statutory obligations including controlled drugs
- Medicines Management Group outputs and development of this group
- Multi-sector pharmacy integrated work-streams
- Medicines safety assurance

Much has been achieved over 2017-18 and there is much more to do over the coming years to continue to build on previous years' high standards in pharmaceutical care, including the continuous strive for excellent patient care, innovation and value.

Achievements

1. Quality Improvement (QI) in Prescribing and Medicines Optimisation

There were two key focus areas for QI in prescribing

a) Valproate and Risk to Unborn Babies
b) High Dose Antipsychotic Therapy – Reduction of Risks to Patients

1.1 Valproate

Building on the quality improvement journey that commenced in October 2016, we developed a programme of work to allow for continuous improvement methods in this area of prescribing.

a) In April 2017, a National Patient Safety Alert was issued further propelling the local work to reduce risks. An electronic tool on CareNotes to support review and document consent of patients prescribed valproate in women of childbearing potential was implemented together with multiple communications to Clinicians about risk. By quarter 3 2017-18 the majority of patients had the required documentation and there was still room for improvement, particularly for patients under the care of community teams.

c) In March 2018, the medicine was allocated Named Patient Only Status allowing for further rigour which was timely given new Medicines Healthcare Regulatory Authority regulations in April 2018.

d) 84% of patients had a review (n=87) completed by April 2018. This is undergoing further improvement work in light of the new national recommendations for valproate prescribing.

Figure 1: Kate Baxter, QI Lead and Julie Orton, Medicines Safety Pharmacist at the Book of Best Practice Event

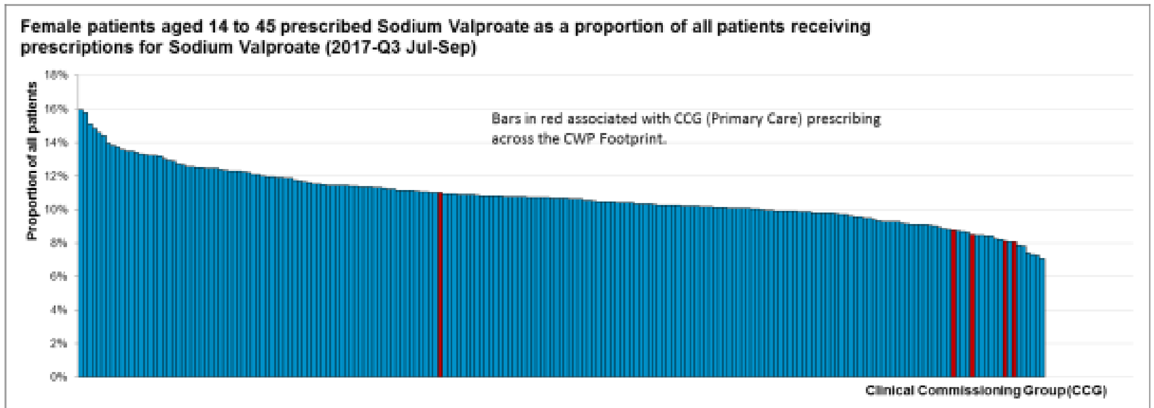


Figure 2: National Benchmarked Data at CCG level. Quarter 3 2017-18

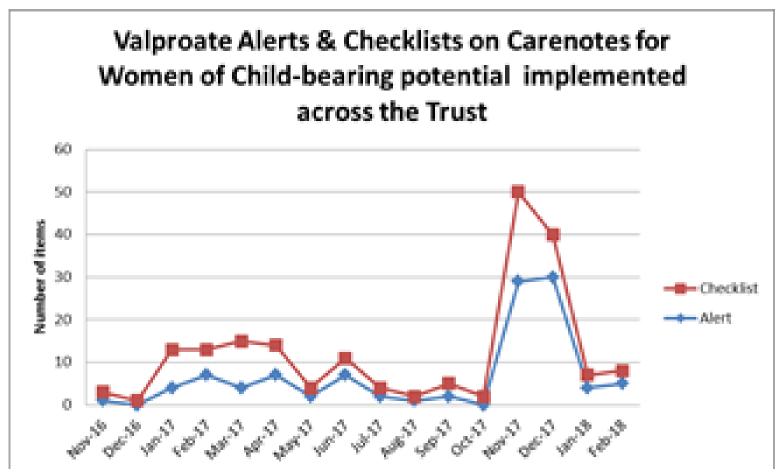


Figure 3: Chart of Valproate Alerts and Checklists Implemented Trust-Wide

1.2 High Dose Antipsychotic Therapy

a) As part of the Trust-wide Quality Improvement Quality areas, a metric for the following was approved at Quality Committee in Quarter 1 2017-18, namely 'an incremental number of patients identified as being prescribed high dose antipsychotic therapy and of these, an 80% achievement in the rate of physical health monitoring as documented on CareNotes.

b) There are greater risks, including serious physical side effects, when antipsychotic drugs are taken in high dose or in combination.

c) 38 HDAT Alerts were added to patients' records compared to a baseline of zero over October 2017 to March 2018. 82% of these were documented as having the appropriate physical health monitoring, reaching the aspiration that was set.

d) Further continuous improvement for HDAT prescribing has been identified for over 2018-19.

e) A similar approach to the methodology for HDAT and Sodium Valproate is also being employed for safer clozapine and lithium prescribing over 2018-19.

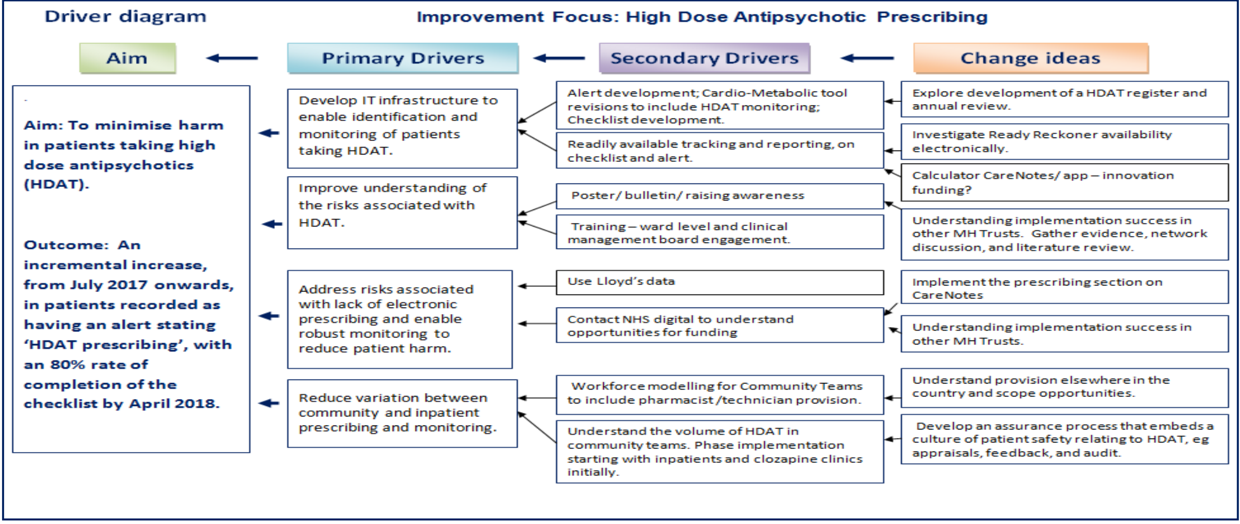


Figure 4: HDAT Driver Diagram

2. Innovation & Making Every Contact Count

a) Tackling health inequalities is a priority in the Five Year Forward View. Data shows that mental health patients are at risk of dying on average 15 to 20 years earlier due to avoidable physical illnesses. Patients taking medication visit their community pharmacy regularly presenting an opportunity to make physical health interventions, however systems need to be in place to underpin this.

b) We identified a best practice NHS England project for acute trusts that could help; differing clinical systems made this challenging. We adopted an ambitious approach to become the first Mental Health Trust to introduce Electronic Transfer of Care to Community Pharmacies (ETCP) launched in November 2017 using the PharmOutcomes Tool developed by Pinnacle LLP and refined by CWP Pharmacy for mental health use commencing with in-patients with planned expansion to community services.

c) An example of the difference the project is making, and its future potential, is feedback from one community pharmacist who said they would not have targeted the patient for a Medicines Use Review and that it was simple to do. The discussion held between the ward pharmacist and the in-patient helped the community dialogue post discharge. The patient now has a greater understanding of her inhaler use.

d) NHS England and North West Coast Innovation Agency held an event where we were one of 5 speakers to an audience of 70 community pharmacy representatives.

e) At the event, CWP was approached by an Innovation Agency in the south of the country for the slides and in order to replicate approach and has since been approached by 4 other organisations for shared learning.

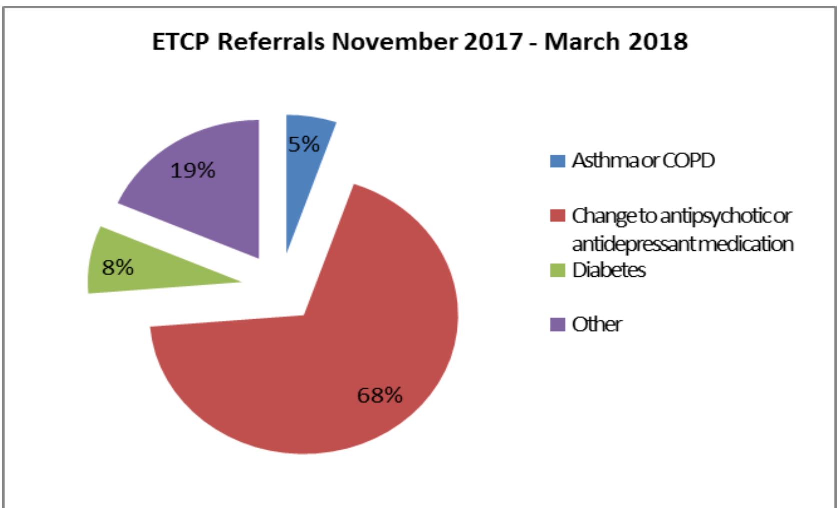


Figure 5: ETCP Referrals to Community Pharmacy

3. Medicines Management Group

a) The Medicines Management Group (MMG) is chaired by Dr Sumit Sehgal, Consultant Psychiatrist. The group met 5 times over 2017-18 and quoracy achieved for 100% of the meetings. Attendance at

meetings and all declarations of interest from members are documented. A new patient representative was appointed through interview commencing June 2017.

b) The key developments from the MMG business cycle over the last 12 months are detailed in the following 9 sections.

1. Introduction of New Medicines
2. Named Patient Requests
3. Medicines Safety – Incident Reporting
4. Formulary
5. Patient Group Directions
6. Trust Assurance for Controlled Drugs
7. Antimicrobial Stewardship
8. Medicines Reconciliation Audit
9. Medicine's waste audit / cost savings

3.1 Introduction of New Medicines

Table 1 below illustrates decisions that have been made regarding applications for medicines:

Table 1: Introduction of New Medicines

Medicine	Indication	Decision of MMG
Melatonin	Those individuals who fit the licensed indication for Circadin who have not responded adequately to Z-hypnotics or other hypnotics such as temazepam and whose physical health status in terms of reduction of risks of falls would outweigh the additional cost of this treatment option.	The group agreed that Melatonin should be approved for use in over 55's for inpatients and therefore no named patient requests are required for this age group. This was not accepted for shared care by either Wirral or West Cheshire CCGs but approved as shared care for Central and East Cheshire CCGs.
IM Clozapine	Treatment Resistant Schizophrenia	Not approved
Vortioxetine	Depression	Approved for specialist initiation through the Named Patient Request route
Lurasidone	Schizophrenia	Shared Care Prescribing agreed for Wirral and Central and East Cheshire CCGs. Already in place for West Cheshire CCG
Guanfacine	Treatment of attention deficit hyperactivity disorder (ADHD) in children and adolescents 6-17 years old for whom stimulants are not suitable, not tolerated or have been shown to be ineffective.	Approved for named patient request status – specialist only

3.2 Named Patient Requests

a) Throughout the year, MMG have received a total of 146 named patient requests (NPRs), the majority of which were approved for use. These are divided into antipsychotic named patient requests and other named patient requests. In all approved cases, MMG request feedback from the consultant prescriber for assurance that the treatment continues to be beneficial to patient care. The feedback period was recently changed from 3 monthly to 6 monthly intervals.

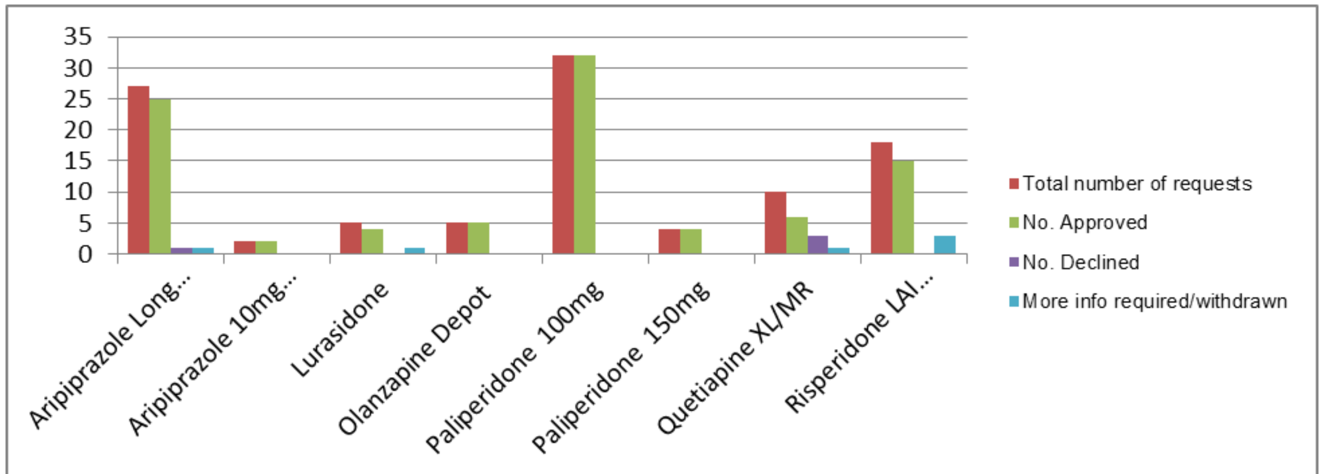


Figure 6: Antipsychotic Named Patient Requests 2017-18

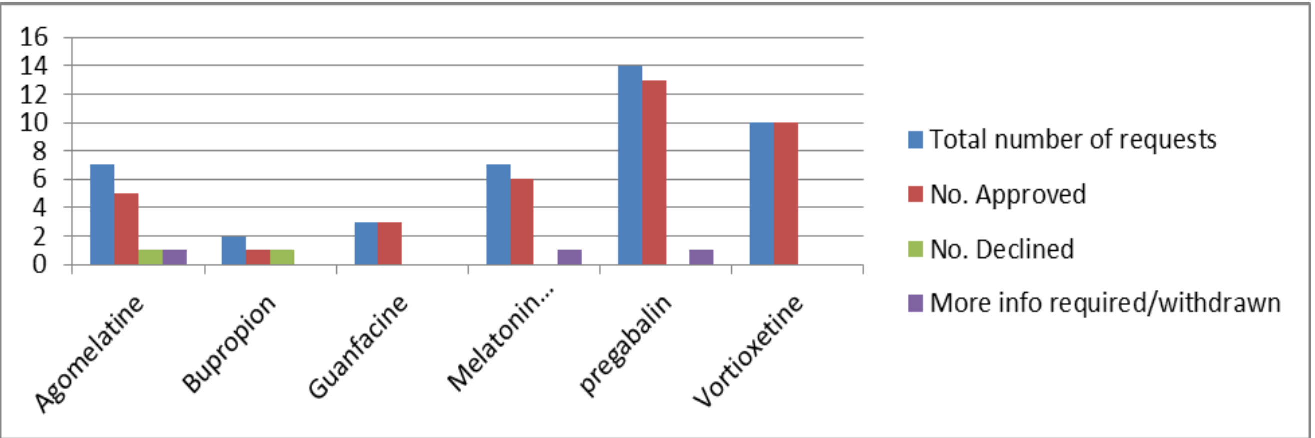


Figure 7: General Named Patient Requests 2017-18

3.3 Medicines Safety - Incident Reporting

a) Incident Reporting of Medication Errors

(i) Revised medication categories and sub categories were introduced in Datix on April 1st 2017 to more accurately align to the National Reporting & Learning System (NRLS). This change, together with the introduction of the Medication Safety Officer (MSO) finally approving medication incidents has led to improved data quality, and ultimately will enable more accurate analysis of medication incidents. The medication categories were separated into patient safety incidents, non patient safety incidents and 'other'. It is not possible to make direct comparisons for many of the categories from previous years due to the revision of the reporting categories.

(ii) Table 2 below shows the context of this year's medicines-related incidents, within the previous five years of data. The number of incidents has fallen from 2016/17, which is due to incidents previously being reported as medication when another category may have been more appropriate. The proportion of moderate incidents has continued to decrease over the years. This is in line with the overall pattern of increased low level harm incident reporting for the Trust indicating a positive safety culture.

Table 2: Five year trend of medication incidents by severity: April 2013– March 2017

Year/Severity	A	B	C	D	E	Total
2013/14	1	1	47	184	433	**666**
2014/15	0	0	45	109	276	**430**

2015/16	0	0	50	126	342	**518**
2016/17	0	0	27	98	392	**517**
2017/18	0	0	20	85	304	**409**
Totals	**1**	**1**	**189**	**602**	**1747**	**2540**

(iii) Figure 8 below illustrates the number of reported medicines-related incidents over the last 12 months broken down by severity. The majority of the incidents fall into category E. It can be seen that there were no category A or B medication incidents in 2017/18.

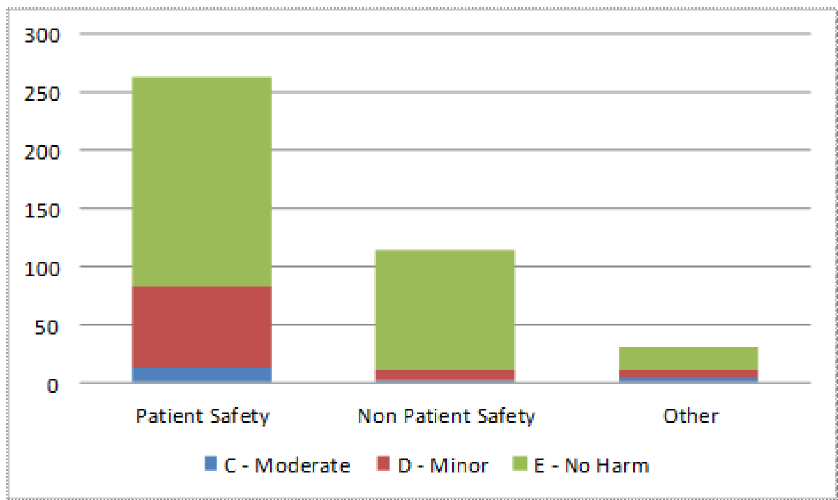


Figure 8: Medicines Safety Incidents by Severity over 2017-18

b) Number of Medicines Safety Incidents

(i) The highest number of reported incidents relates to the administration of medicines n=154. In previous years the highest number of incidents related to 'failure to administer' medicines'. This sub-category can be compared directly and the number of incidents reported in 2017/18 was 43 compared to 92 in 2016/17, a reduction of more than 50%.

(ii) 60% of incidents are related to prescribing of incorrect dose (20), omissions (12), frequency (5) and incorrect drug (4). The majority of these incidents were identified by the Medicines Management Team during the process of medicines reconciliation and ward visits. Any trends are highlighted at the Medicines Safety Sub-Group and Medicines Management Group where recommendations are made for improvement.

(iii) Categorisation has been reviewed an updated to more accurately reflect the incidents, hence the improved quality of reporting accuracy. In 2017/18 there were 72 prescribing incidents compared with 49 in the previous year.

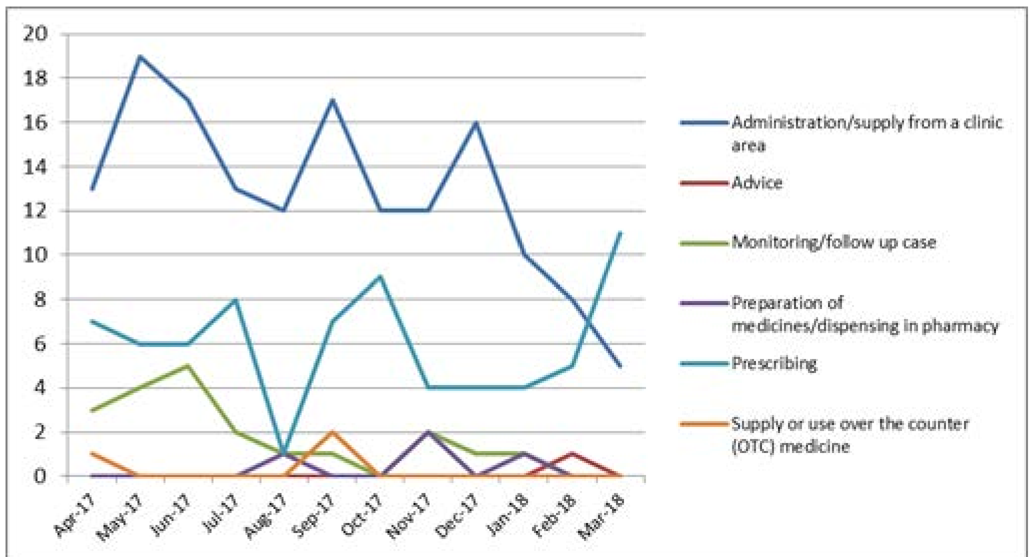


Figure 9: Medicines Incidents by Category

c) Non patient safety incidents

(i) These include incidents involving damage, discrepancy, missing keys etc.

(ii) There were 49 incidents that were related to discrepancies with controlled drugs. There appears to be no pattern to incidents reported and no evidence that any failures are deliberate. All incidents rated 'moderate' or above are reported to the Local Intelligence Network for further scrutiny

3.4 Mental Health Medicines Formulary

The CWP Mental Health medicines formulary was launched in March 2013. It has recently been updated and was approved by MMG in November 2017. It can be accessed via the intranet and in line with the recommendations from NICE, is accessible from the Trust public facing website. The formulary is a reference guide that highlights the formulary decisions approved by the CWP Medicines Management Group in conjunction with Primary Care. The review of the mental health formulary is a dynamic process and the contents are updated in line with any new drug review decisions undertaken within CWP and any technology appraisals from NICE.

3.5 Patient Group Directions (PGDs)

The PGD subgroup of Medicines Management Group meets every 2 months and undertakes a programme of work to review and update PGDs in line with an agreed schedule.

Table 4: PGD approved over 2017/18

PGD	Detail
Seasonal Flu	1. Supply and administration of intramuscular inactivated influenza vaccine 2. Supply and administration of live attenuated influenza vaccine nasal spray suspension (Fluenz Tetra®▼),.
Corticosteroid injections	Administration of Corticosteroid Injection Therapy by registered physiotherapists
Hepatitis B	Supply and administration of Hepatitis B Vaccine (Brands: Engerix B® , HBVaxPro®)
Hepatitis A + Hepatitis B	Supply and administration of combined vaccine hepatitis A and Hepatitis B (Twinrix adultT®)
Human Papilloma Virus	Administration of human papillomavirus vaccine [Types 6, 11, 16, 18] (Recombinant, adsorbed)
Paracetamol	Supply and/or administration of Paracetamol 500mg tablets.
Levonorgestrel	Supply and / or administration of LEVONORGESTREL for Emergency Hormonal Contraception

Typhoid	Supply and administration of Typhoid Vaccine Typherix® or TYPHIM Vi®
Rotavirus	Administration of rotavirus vaccine (live) to infants aged 6 weeks to 23 weeks and 6 days
Ciprofloxacin	Supply of ciprofloxacin tablets or suspension for the management of clusters of meningococcal disease
Shingles	Administration of shingles (herpes zoster, live) vaccine
Meningococcal group A,C,W and Y	1. Administration of meningococcal group A, C, W and Y conjugate vaccine (MenACWY) to individuals eligible for national routine MenACWY vaccination programme; university freshers (catch-up); outbreak control and contacts of confirmed cases 2. Administration of meningococcal group A, C, W, and Y conjugate vaccine (MenACWY) to individuals with an underlying medical condition which puts them at increased risk from Neisseria meningitides
Low dose diphtheria, tetanus and inactivated poliomyelitis	Administration of low-dose diphtheria, tetanus and inactivated poliomyelitis vaccine (Td/IPV) to individuals from 10 years of age
Measles, mumps and rubella (MMR)	Administration of measles, mumps and rubella (MMR) vaccine to individuals from 1 year of age for routine immunisation, or from 6 months of age if early protection is required

3.6 Trust Assurance for Controlled Drugs

a) The Trust Accountable Officer for Controlled Drugs is the Chief Pharmacist & Associate Director for Medicines Management, who has a statutory duty to report to the Local Intelligence Network (LIN). Quarterly reports, compiled from datix reports and CD audits across all inpatient wards and GP Out of Hours are submitted to the LIN and a contribution made to shared learning. Twice yearly controlled drugs reports were discussed at MMG to provide Trust Wide assurance for the prescribing and administration of controlled drugs.

b) Mersey Internal Audit Agency completed a Controlled Drugs Review for the Trust in December 2017. The review found that the management of controlled drugs met the requirements defined within the Trust policy and with one exception all wards were clear regarding ward based roles and responsibilities. The audit resulted in significant assurance being provided with one high level risk which has been addressed. An action plan is underway and being monitored by MMG to ensure all recommendations are completed.

3.7 CWP's Antimicrobial Resistance (AMR) Strategy

a) Context

This section should be read in conjunction with the Infection Prevention and Control Annual Report 2017/18.

(i) Public Health England aims to reduce AMR by 50% by 2020. AMR is a high priority within the Trust and antimicrobial stewardship represents an organisational and system-wide approach to promoting and monitoring the prudent use of antimicrobials by:

- optimising therapy for individual patients;
- preventing overuse and misuse;
- minimising the development of resistance at patient and community levels.

(ii) A member of the pharmacy physical health team attends the infection, prevention and control sub-committee (IPCSC), works alongside the IPC team to review antibiotic usage and audit results, contributes to the Trust influenza immunisation programme and promotes the antibiotic formulary.

b) Inpatient Services antibiotic audit 2017/18

(i) Antibiotic prescribing on the inpatient wards is audited and compliance with West Cheshire CCG (WCCCG) Antimicrobial Prescribing Guidelines reported quarterly at IPCSC and MMG. The most common infections treated on the CWP inpatient wards are urinary tract infections, respiratory infections and skin infections.

(ii) 449 antibiotic forms were collected during 2017/18. 374 prescriptions were written by CWP medical staff and 75 by other providers prior to admission.

(iii) 61% of these prescriptions complied with the WCCCG guidelines, while 12% were prescribed according to sensitivities or on the advice of a microbiologist. 17% of prescriptions originated outside the trust. This demonstrates an actual compliance rate for CWP medical prescribers, prescribing correctly to guideline formulary, of 90%.

(iv) Whilst this is an improvement of 6% from 2016/17, the results were discussed at MMG, and further collaborative work between pharmacy, IPCT and the medical teams has commenced in Q1 of 2018/19 to improve this figure.

(v) For UTI, overall, the first line recommended treatment for UTI with Nitrofurantoin appears to be adhered to in all localities. Of the 36 prescriptions for Trimethoprim, 10 were based on laboratory sensitivities and 4 because the patient's eGFR was low. However, the remaining presciptions (22) were not prescribed in line with guidance. The new antimicrobial guidelines were published towards the end of Q3 and Nitrofurantoin remains first line treatment choice for UTI. This data is now also presented to Junior Doctors on their Induction

c) West Cheshire Physical Health Services Antibiotic Prescribing

(i) Adherence to the antibiotic formulary is excellent in GPOOH, with GPs achieving 99% adherence and non-medical prescribers 100%. For cephalosporins, quinolones and co-amoxiclav prescribing rates are 10.8% (12% for GPs and 6% for NMPs) against a quality standard of 10%.

(ii) Antibiotics are not routinely prescribed by NMPs in community clinics.

d) Westminster and Willaston Surgeries

(i) Overall antibiotic prescribing for Willaston Surgery is at national average while Westminster Surgery is below both West Cheshire and National averages, which demonstrates prescribing in line with local and national strategy

3.8 Medicines Reconciliation Audit

(i) Results showed that we continue to complete medicines reconciliation for 100% of our in-patient admissions in the 'in hours period' (Monday – Friday) which has an impact on patient outcomes.

(ii) There have been measures undertaken to improve medicines reconciliation for weekend / out of hours admissions through awareness raising with junior doctors and nursing staff who conduct the clerking in of patients. The percentage of weekend admissions with medicines reconciliation by pharmacy within 72 hours is at 96%

3.9 Medicines Waste Audit

a) An audit was undertaken to establish the level of waste generated by the following factors, on the inpatient wards across the three CWP sites,

- Discharge medication being changed prior to discharge when discharge medicines had already been ordered and delivered to the ward.
- Leave medication being changed prior to leave when leave medication had already been ordered and delivered to the ward.
- Discharge medication not been collected post discharge from the ward.
- Leave medication not being collected from the ward.

b) The total across the three sites totalled just **£384.72** over Quarter 4 2017-18. In addition to this, at least £13.8K was made in efficiency saving by the Technicians over 2017-18 which included re-distribution of stock across the wards.

4. Prescribing Observatory for Mental Health

a) The national Prescribing Observatory for Mental Health (POMH-UK) aims to help Specialist Mental Health Trusts improve their prescribing practice and allows for National Benchmarking. A CWP POMH Steering Group provides leadership to this work programme across the Trust, comprising of Healthcare Quality Improvement, Pharmacy and 3 Consultant Psychiatrists

POMH audits over 2017-18:

Audit Results Learning & Dissemination	Prescribing of High Dose and Combined Antipsychotics Prescribing of Antipsychotics in Dementia Monitoring of Patients Prescribed Lithium
Audit Undertaken	Prescribing of High Dose and Combined Antipsychotics Valproate for Bipolar Disorder

b) The results as obtained centrally from POMH are discussed at Patient Safety and Effectiveness Sub-Committee and action taken based on gaps identified, following the development of an implementation plan by the CWP POMH Steering Group.

5. Overview of Medicines Governance

a) The Trust continues to monitor compliance with policies in relation to medicines management via the annual audit programme and via review of incidents, as outlined in the relevant sections of this annual report.

c) A Chair's report for MMG is provided to Clinical Practice & Standards Sub Committee, allowing for escalation of risks.

6. National Patient Safety Alerts

a) CWP have responded to two patient safety alerts relating to medicines from NHS Improvement this year, namely:

(i) Resource alert: Supporting the safety of girls and women being treated with valproate
(ii) Warning alert: Risk of death and severe harm from failure to obtain and continue flow from oxygen cylinder

b) The alerts were closed within the required time-frame although there is on-going work with valproate due to recent changes in its licensing.

c) The Medicines Safety Sub Group meets every 2 months and reviews the action plans required to ensure compliance with alerts.

7. Medicines Supply Service

a) The contract with Lloydspharmacy was robustly monitored monthly by the senior pharmacy technician and the Acting Chief Pharmacist via the contract monitoring meetings at which the key performance indicators of the contract were reviewed, discussed and appropriate action taken.

8. Pharmaceutical Interventions and Multi-disciplinary Team (MDT) Working

a) The clinical pharmacy team are an integral component of inpatient MDTs and undertake pharmaceutical interventions which are recorded in the CareNotes clinical system. The top three categories of interventions made in 2017/18 were:
   - Medicines education & patient counselling - 23%
   - Adverse Drug Reactions/Side Effects - 20%
   - Choice of Therapy -15%

   12% interventions relate to reducing the risk of falls due to medication.

b) The clinical pharmacy team provide pharmaceutical advice to teams including those for complex specialist cases

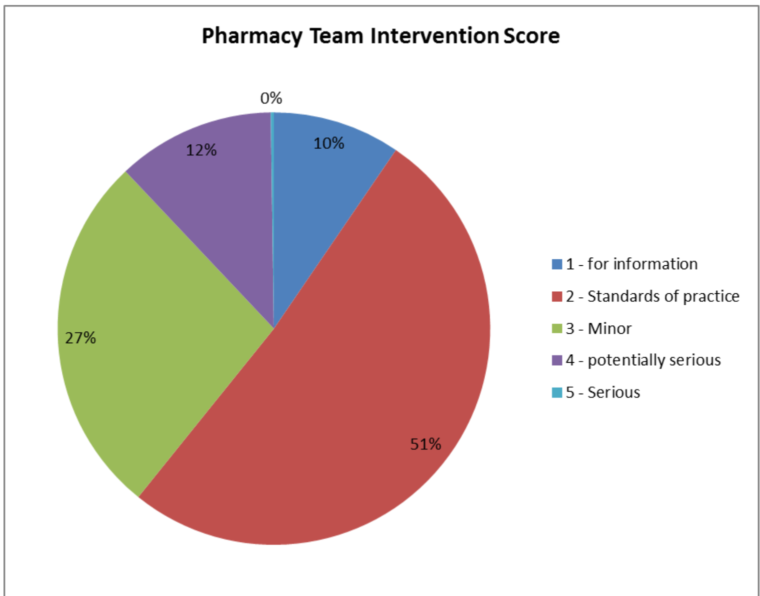


Figure 10. Interventions by category of risk

9. Community Mental Health Teams / Home Treatment Teams

a) The clinical pharmacy team receive adhoc queries from the CMHTs and HTT, of which 353 queries were recorded for 2017/18. . These included a high number of complex queries about medicines in pregnancy and choice of medicines for people with physical health concerns that the pharmacy team responded to.

10. NHSE Commissioned Stopping the Over-Use of Psychotropic Medication in Learning Disabilities (STOMP-LD) Pilot for GP Practices and the STP

Figure 11: CWP's STOMP-LD Stakeholder Meeting October 2017

a) In January NHSE requested our input into a small scale STOMP-LD pilot, funding pharmacy resource to review a cohort of patients with a Learning Disability prescribed antipsychotics to manage challenging behaviour. CWP Pharmacy team were chosen to undertake this in the STP area as a result of established local cross boundary meeting infrastructure for the area of Prescribing.

b) Each of our locality lead pharmacists have subsequently been out into local GP practices to review over 60 cases where antipsychotics have been prescribed for this indication.

c) They have met with GPs and been able to offer advice on how to safely reduce antipsychotic doses where appropriate.

d) The work programme was commissioned at the end of February 2018 initially for completion by the end of March 2018 but negotiated to the end of May 2018.

e) As part of the funding received from NHSE, the pharmacy team have been working with the CWP e-learning facilitator to build a 'Moodle' platform for STOMPLD resources. This includes a recording of presentations given to West GP prescribing leads by two LD consultants and the pharmacy team in order to implement learning at scale across the STP footprint.

11. Education Provided to Other Teams

a) Each year the team supports pre-registration pharmacists from neighbouring acute trusts for week long placements. Positive feedback was received from the eleven trainees. The team also gave lectures about mental health illnesses and their treatments at the pre-registration study day.

b) For the first time, the East team hosted two on-site teaching sessions for six pharmacy students from Manchester University. Feedback was extremely positive and included the quote *'I was always considering MH but after this placement, I'm certain it's the area I want to work in'*

c) In early 2018, Liverpool John Moore's University invited the Pharmacy Team back for the eighth time to facilitate the Psychiatry study day for their Postgraduate Diploma in Clinical Pharmacy which was an excellent platform to generate interest in Psychiatric Pharmacy.

Figure 12: Pharmacy Psychiatric study day for Postgraduate Pharmacy Students at LJMU - February 2018

d) As in previous years the pharmacy team has provided medicines management training sessions, including antimicrobial stewardship, at the trust-wide junior doctors' induction.

e) A positive example of collaborative working included one of the East team pharmacists delivering a clozapine session at MCHFT. We then welcomed an MCHFT pharmacist to our team meeting to deliver a reciprocal session on diabetes.

f) Recently, we have been working alongside the Education and Training team and now facilitate a 30 minute session on rapid tranquillisation medication on the Prevention Management of Violence and Aggression course.

g) The Medication Safety Officer is a key collaborator with the mandatory risk sessions on the induction programme

12. Team Development

a) In June 2017, the team underwent a full day coaching session on Personal Profiling and how this impacts on communication with other colleagues.

b) Team meetings continued to be held quarterly to allow for shared learning, reflection and ideas generation.

13. Non-Medical Prescribing

a) The trust employs a total of 205 non-medical prescribers; 42 work in mental health, with the remainder working in physical health services.

b) The Pharmacy Team holds the register for the NMPs for mental health and the Nursing and Therapies Team holds the register for physical health services.

c) One member of the East pharmacy team has completed her NMP training and is utilising her qualification on in-patient wards and some input to the Home Treatment Team.

14. Westminster Surgery and Willaston Surgeries

a) The pharmacist from Well Pharmacy (adjacent to the surgery) holds a Medication Review clinic once a week for patients with chronic and long term conditions at Westminister Surgery. He is currently working with the practice to ensure all frail elderly patients have an annual medication review. The Senior Clinical Pharmacist for Physical Health supervises this pharmacist and monitors the impact of his interventions.

b) The addition of Willaston surgery to our trust has given pharmacy a great footing to build and maintain a relationship with the practice. We have conducted two clinical standards reviews and have been involved with case planning for a complex patient. Sourcing a Pharmacist for Willaston Surgery is currently in progress.

15. New Post: Medicines Administration Technician

a) Medicines administration was one area highlighted by the Trusted to Care report, in particular missed and omitted doses. The administration of medicines on wards has always been the responsibility of qualified nursing staff.

b) A pharmacy technician is considered as an appropriate registrant who could administer medicines in these circumstances. They are ward-based, have a good knowledge of medication and have daily contact with patients as part of their usual role. A pilot to train a pharmacy technician to safely administer medicines on ward Croft ward commenced in Quarter 4 2017-18.

c) The service will be audited, with a review in October 2018. The review will audit the following to ensure outcomes are met for the safe and timely administration of medication including:
- Reduction in missed doses including critical medication.
- Patient / carer education including appropriate use of their medication.
- Prudent use of staff, utilising technician's knowledge of medicines.
- Allow nurses to prioritise sick patients and focus on other roles.
- Reduction in pressure ulcers and falls through better medicines optimisation.

16. Medicines Management Operational Plan 2016-2020

a) A Medicines Management Operational plan was developed in October 2016 to set out key deliverables required to implement the Medicines Management Strategy 2015-2019 and can be accessed here

17. System – wide working

a) At the Chief Pharmaceutical Officer's Conference held in March 2017 Sir Bruce Keogh highlighted the need to work together across all sectors for better patient outcomes, to continue to innovate and break down silos of professional groups. Keith Ridge, Chief Pharmaceutical Officer for NHS England highlighted the need to collaborate across sectors for a sustainable NHS and not to compete.

b) Work has been ongoing over a number of years, collaborating across sectors allowing for excellent professional relationships. Over 2017-18 the diagram shows some of the collaboration that took place outside of CWP for cross sector working.

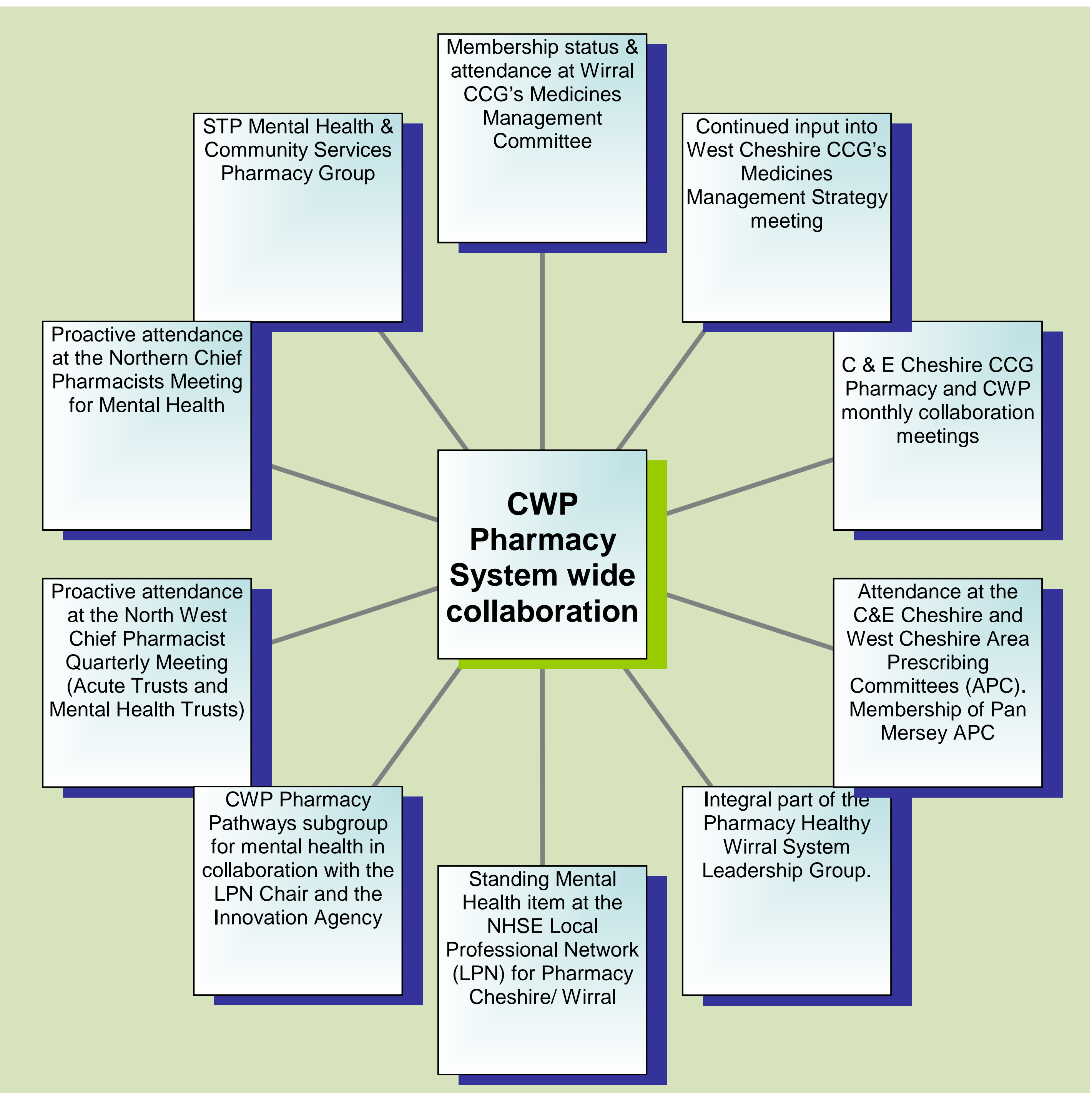


Figure 13: Chart highlighting collaboration across sectors

Challenges

18. A number of challenges were present over 2017-18 and included:

a) The lean model of the pharmacy team meant that the shortage in staff was allocated to the risk register over the summer of 2017, due to inability to cover vacancies and leave, predisposing a risk to patient care. This coupled with shortage of doctors across the 3 localities was challenging and at times went below the minimum staffing level, demonstrating the risks with such a lean team. A locum pharmacist was eventually recruited to.

b) The absence of electronic prescribing and administration of medicines was highlighted as a risk following feedback from clinicians. In Quarter 2 2017-18, a response to the digital maturity questionnaire was provided to NHS England as well as a Strategic Needs Analysis relating to EPMA for NHS Digital. A demonstration of the EPMA functionality of CareNotes was pulled together in winter 2017 and further discussions have been ongoing in collaboration with the IT team and the Chief Clinical Information Officer regarding solutions. Over 2018-19 this will be taken through the Specialist Mental Health Care Group

19. Conclusion

This report provides the Board with assurance for the delivery of the medicines optimisation work plan over 2017-18, allowing for the safe and effective use of medicines within the Trust.

Medicines optimisation and reducing patient harm in line with the Zero Harm Strategy is a common thread underpinning the work-streams that have been highlighted. Innovation is also being adopted to further develop the medicines programme and this is expected to be further enhanced over 2018-19. There is a clear acknowledgement that there is significantly more to do over 2018-19 and beyond and this will be implemented through the revised 5 year Medicines Optimisation Strategy which is being developed over 2018.

20. Recommendation

The Board of Directors is requested to:

- **Discuss** the Annual Report
- **Approve** the Annual Report.

21. Contributors to this Annual Report

Jasmeen Islam	Deputy Chief Pharmacist (Acting Chief Pharmacist and Associate Director of Medicines Management 2017-2018)
Dr Sumit Sehgal	Consultant Psychiatrist and MMG Chair
Julie Orton	Medicines Safety Pharmacist
Hazel Sharp	Deputy Chief Pharmacist
Ian Winton	Clinical Pharmacy Technician for Physical Health
Lesley Irvin	Senior Clinical Pharmacist, Physical Health Services
Jennifer Southern	Senior Clinical Pharmacist

Julie Spendlove	Head of Infection, Prevention and Control
Kate Baxter	Quality Improvement Lead
Shane Williams	Senior Clinical Pharmacy Technician
Nina Geiger	Senior Clinical Pharmacist
Beth Thorpe	Senior Clinical Pharmacist
Colin Lewis Conde	Clinical pharmacy Technician
Vicky Lewis	PA to Chief Pharmacist
Lisa Bellis	Pharmacy Business Information Officer

Consultation with MMG Members including:

Dr Sandhya Gaur	Consultant Psychiatrist
Dr Warren Levine	Consultant Psychiatrist
Chris Turnbull	Modern Matron
Dr Julia Payne	Consultant Psychiatrist
Dr Nagraj Thiagarajan	Consultant Psychiatrist
Dr Rajni Kullu	Consultant Psychiatrist
Beverly Trafford	Modern Matron
Linda Wain	Professional Development Lead
Maryrose Livesey	Senior Occupational Health Nurse

Reviewers:

Dr Anushta Sivananthan	Medical Director and Consultant Psychiatrist
Fiona Couper	Chief Pharmacist and Associate Director of Medicines Management

STANDARDISED REPORT COMMUNICATION

REPORT DETAILS

Report subject:	Freedom to Speak Up – Self Review
Agenda ref. no:	18.19.66
Report to (meeting):	Board of Directors
Action required:	Discussion and Approval
Date of meeting:	28/09/2018
Presented by:	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	No
Improve quality of information to improve service delivery, evaluation and planning	Yes
Sustain financial viability and deliver value for money	No
Be recognised as an open, progressive organisation that is about care, well-being and partnership	Yes
Which CQC quality of service domains this report reflects:	
Safe services	Yes
Effective services	Yes
Caring services	Yes
Well-led services	Yes
Services that are responsive to people's needs	Yes
Which Monitor quality governance framework/ well-led domains this report reflects:	
Strategy	Yes
Capability and culture	Yes
Process and structures	Yes
Measurement	Yes
Does this report provide any information to update any current strategic risks? If so, which?	
See current risk register in the agenda of the public meeting of the Board of Directors at http://www.cwp.nhs.uk/about-us/board-members/our-board-meetings	
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*
A Freedom to Speak Up self review has been undertaken using the self review tool from the National Guardian Office. The self review is presented for discussion and agreement.

Background – *contextual and background information pertinent to the situation/ purpose of the report*
In May 2018 the National Guardian Office published a self review tool for Trusts' to determine their position in line with identified key indicators. Effective speaking up arrangements help to protect patients and improve the experience of NHS workers. Having a healthy speaking up culture is evidence of a well-led trust.

Assessment – *analysis and considerations of options and risks*
A self review has been completed using the National Guardian Office self review tool. Board members contributed to a board session to assess progress in August 2018. This reports outlines the findings of that session. Completion of the self review has enabled the Trust to determine and evidence the Trust's commitment to the Freedom to Speak Up agenda. The outcome of the review has enabled senior leaders, inclusive of the Freedom to Speak Up Guardians, to identify that the majority of the key indicators are consistently being met. Importantly key areas for development have been determined and an improvement plan has been devised, approved through the Trust governance structure and is currently being implemented.

Recommendation – *what action/ recommendation is needed, what needs to happen and by when?*
The Board is requested to discuss and agree the Board position in relation to the Freedom to Speak Up Self Review tool published by National Guardian Office May 2018.

Who/ which group has approved this report for receipt at the above meeting?		Director of Nursing, Therapies and Patient Participation
Contributing authors:		Freedom to Speak Up Guardians
Distribution to other people/ groups/ meetings:		
Version	Name/ group/ meeting	Date issued
35T	35T	35T

Appendices provided for reference and to give supporting/ contextual information: *Provide only necessary detail, do not embed appendices, provide as separate reports*	
Appendix no.	Appendix title
35T	FTSU Guide for Boards – Completed Self Review September 18 (v6)

Freedom to Speak Up self-review tool for NHS trusts and foundation trusts

May 2018

How to use this tool

Effective speaking up arrangements help to protect patients and improve the experience of NHS workers. Having a healthy speaking up culture is evidence of a well-led trust.

NHS Improvement and the National Guardian's Office have published a guide setting out expectations of boards in relation to Freedom to Speak Up (FTSU) to help boards create a culture that is responsive to feedback and focused on learning and continual improvement.

This self-review tool accompanying the guide will enable boards to carry out in-depth reviews of leadership and governance arrangements in relation to FTSU and identify areas to develop and improve.

The Care Quality Commission (CQC) assesses a trust's speaking up culture during inspections under key line of enquiry (KLOE) 3 as part of the well-led question. This guide is aligned with the good practice set out in the well-led framework, which contains references to speaking up in KLOE 3 and will be shared with Inspectors as part of the CQC's assessment framework for well-led.

Completing the self-review tool and developing an improvement action plan will help trusts to evidence their commitment to embedding speaking up and help oversight bodies to evaluate how healthy a trust's speaking up culture is.

Self review indicator (Aligned to well-led KLOEs)	To what extent is this expectation being met?	What are the principal actions required for development?	How is the board assured it is meeting the expectation? Evidence
Our expectations			
Leaders are knowledgeable about FTSU			
Senior leaders are knowledgeable and up to date about FTSU and the executive and non-executive leads are aware of guidance from the National Guardian's Office.	Met	Chief Executive and Director of Nursing and Therapies have received Guidance for boards and leading on the review against such.	The Trust has an identified Non Executive lead supporting the FTSU agenda. Board has received annual report for FTSU.
Senior leaders can readily articulate the trust's FTSU vision and key learning from issues that workers have spoken up about and regularly communicate the value of speaking up.	Met	Quality Charter and improvement plans to be shared for clarification and further development.	Board has received annual report for FTSU inclusive of future actions and progress to be taken.
They can provide evidence that they have a leadership strategy and development programme that emphasises the importance of learning from issues raised by people who speak up.	Met		Board annual report details future plans. FTSU Strategy - Quality improvement charter / and improvement plan via driver diagram

			developed and shared with senior leaders / board members. Same approved by People and Organisational Development sub-committee September 2018.
Senior leaders can describe the part they played in creating and launching the trust's FTSU vision and strategy.	Met	Quality strategy to be implemented and support / feedback to be gained from senior leaders.	Quality improvement strategy developed from discussions and feedback with senior leaders; through informal processes and at formal meetings.
Leaders have a structured approach to FTSU			
There is a clear FTSU vision, translated into a robust and realistic strategy that links speaking up with patient safety, staff experience and continuous improvement.	Met		FTSU Strategy - Quality improvement charter / and improvement plan via driver diagram developed.
There is an up-to-date speaking up policy that reflects the minimum standards set out by NHS Improvement.	Met	Speak Up policy is in the process of being reviewed in line with revised working	Current policy has been approved and is available on the Trust intranet.

		processes; alignment to new NGO guidance.	
The FTSU strategy has been developed using a structured approach in collaboration with a range of stakeholders (including the FTSU Guardian) and it aligns with existing guidance from the National Guardian.	Met	For the strategy that has been co-developed with FTSU Guardians and Ambassadors to be shared across senior leaders for individual to further understand their role in contributing to the Trust's vision.	FTSU Strategy - Quality improvement charter / and improvement plan via driver diagram developed.
Progress against the strategy and compliance with the policy are regularly reviewed using a range of qualitative and quantitative measures.	Met	Identified areas for progress are evident within the strategy; progress of improvement strategy will be monitored by Quality Committee – Trust Board sub Committee.	Annual report; development of Speak Up strategy utilising Trust's approach to quality improvement.
Leaders actively shape the speaking up culture			
All senior leaders take an interest in the trust's speaking up culture and are proactive in developing ideas and initiatives to support speaking up.	Met	Momentum of enhancing Speak Up Culture to continue and progress of quality	Trust board actively seeks Speak Up reports – 6 monthly.

		improvement plans to be monitored.	Trust has an identified an executive lead and non-executive lead to ensure the Speak Up agenda progresses. Key senior leaders – People and Organisational development / Patient Safety / Patient and Career Experience and Professional leads are engaged with the Speak Up agenda demonstrated by the developed of a bi-annual network / shared learning event.
They can evidence that they robustly challenge themselves to improve patient safety, and develop a culture of continuous improvement, openness and honesty.	Met		Quality Committee and Board have Speak Up reports within their business cycle; minutes of meetings available.
Senior leaders are visible, approachable and use a variety of methods to seek and act on feedback from	Met		Quality visits to areas by member so the Trust board. Non-Execs take

workers.			the opportunity to meet and speak with staff throughout the Trust through their attendance at structured events e.g. Staff Awards Ceremony, AMM, launch of person centred framework, as well as informally as they meet people incidentally during their time at Trust premises. Friends and Family test. Professional advisor and professional network meetings. Chief Executive drop in sessions. Speak up cases. Findings from investigations. Associate Directors of Nursing and Therapies accessible and regularly

			spend time in clinical settings.
Senior leaders prioritise speaking up and work in partnership with their FTSU Guardian.	Met		DoN, CEO, DoOps, Chairman and DHR/OD have all discussed possible and actual F2SU issues with the F2SU guardian.
Senior leaders model speaking up by acknowledging mistakes and making improvements.	Met		The Trust is committed to learning from incidents/issues and has adopted QI initiatives.
The board can state with confidence that workers know how to speak up; do so with confidence and are treated fairly.	Met	Further developments are required to enhance understanding of barriers that may inhibit staff to speak up.	The Trust has a FTSU App, dedicated raising concern email and two Speak Up Guardians. Board report.
Leaders are clear about their role and responsibilities			
The trust has a named executive and a named non-executive director responsible for speaking up and both are clear about their role and responsibility.	Met		Director of Nursing is the executive lead for Speaking Up; the Non-Executive lead with a focus on quality is the

			named lead for Speaking Up.
They, along with the chief executive and chair, meet regularly with the FTSU Guardian and provide appropriate advice and support.	Met	Arrangements are in place for the newly appointment Speak Up Guardian to meet formally to discuss the Speak Up agenda with the Chief Executive and Chair.	Arrangements are in place for FTSU Guardians to meet with Chief Executive and Chair.
Other senior leaders support the FTSU Guardian as required.	Met		Head of HR / Patient Safety Lead / Associate Director PACE and Associate Director of Communications are key roles with supporting the Speak Up agenda alongside the FTSU Guardians.
Leaders are confident that wider concerns are identified and managed			
Senior leaders have ensured that the FTSU Guardian has ready access to applicable sources of data to enable them to triangulate speaking up issues to proactively identify potential concerns.	Met	Due to relatively low numbers, it is difficult to identify trends.	The F2SU Guardians are well informed and connected and work closely with corporate

			and clinical services.
The FTSU Guardian has ready access to senior leaders and others to enable them to escalate patient safety issues rapidly, preserving confidence as appropriate.	Met		
Leaders receive assurance in a variety of forms			
Workers in all areas know, understand and support the FTSU vision, are aware of the policy and have confidence in the speaking up process.	Partially Met	F2SU Charter and QI driver diagram sets out ambitions and plans to further increase awareness, knowledge and accessibility.	
Steps are taken to identify and remove barriers to speaking up for those in more vulnerable groups, such as Black, Asian or minority ethnic (BAME), workers and agency workers	Partially Met	As detailed in QI driver, F2SU Guardians will work with the Trusts E&D Leads and HR temporary staffing to improve awareness.	
Speak up issues that raise immediate patient safety concerns are quickly escalated	Met		Case files.

Action is taken to address evidence that workers have been victimised as a result of speaking up, regardless of seniority	None reported to date		
Lessons learnt are shared widely both within relevant service areas and across the trust	Partially met	Relatively low numbers of concerns raised therefore themes and trends from FTSU cases have not yet been extracted. Positive outcomes from cases of speaking up need to be promoted and shared across the organisation.	Themes The last F2SU Board Report contained details in relation to how CWP compared with comparable sized trusts and showed we were not an outlier in relation to numbers reported. The Trust has co-produced a person centred framework which sets out clear values and behaviours for patients, carers and staff.
The handling of speaking up issues is routinely audited to ensure that the FTSU policy is being implemented	Partially met	Policy audit will be completed as part of QI: frequency of quality assurance processes to be determined.	F2SU returns are sent to the NGO Qtly. The Board receives reports 6 monthly. F2SU themes are highlighted in the

			exception report.
FTSU policies and procedures are reviewed and improved using feedback from workers	Partially Met	F2SU Network Group has been established with two events planned (October 2018 and February 2019): The network group will enhance the review of missed opportunities to raise concerns collectively across services.	Processes for gaining feedback have been strengthened: Feedback template and database.
The board receives a report, at least every six months, from the FTSU Guardian.	Met		Board reports
Leaders engage with all relevant stakeholders			
A diverse range of workers' views are sought, heard and acted upon to shape the culture of the organisation in relation to speaking up; these are reflected in the FTSU vision and plan.	Partially Met	Refer to QI driver diagram and improvement plan. Offer opportunities for staff to be Ambassadors to reflect diversity of workers; ensure staff group are aware of the	Breakfast with CEO includes discussions regarding Speak Up.

		importance of FTSU and know how to raise concerns by sharing information through networks.	
Issues raised via speaking up are part of the performance data discussed openly with commissioners, CQC and NHS Improvement.	Met		Data submitted as part of NGO return. FTSU Guardians involved with CQC inspection and responses.
Discussion of FTSU matters regularly takes place in the public section of the board meetings (while respecting the confidentiality of individuals).	Met		Report to board – 6 monthly.
The trust's annual report contains high level, anonymised data relating to speaking up as well as information on actions the trust is taking to support a positive speaking up culture.	Not met	Future Trust annual reports will include speaking up data.	Currently separate FTSU report to Trust Board.
Reviews and audits are shared externally to support improvement elsewhere.	Met		Data requests submitted to the NGO. Following completion self-review will be shared as required within QRM with NHSI.

Senior leaders work openly and positively with regional FTSU Guardians and the National Guardian to continually improve the trust's speaking up culture	Met		F2SU Guardians part of the North West Network and have recently attended a National event in London.
Senior leaders encourage their FTSU Guardians to develop bilateral relationships with regulators, inspectors and other local FTSU Guardians	Met		F2SU Guardians due to be interviewed as part of CQC well led. F2SU Guardians part of regional network.
Senior leaders request external improvement support when required.	Not yet required for FTSU.		Senior leaders have gained external support for other matters not directly as a result of FTSU.
Leaders are focused on learning and continual improvement			
Senior leaders use speaking up as an opportunity for learning that can be embedded in future practice to deliver better quality care and improve workers' experience.	Met		Learning is extracted from FTSU concerns and shared directly with teams and services as well as across organisation; evidenced within the Learning from

			Experience report.
Senior leaders and the FTSU Guardian engage with other trusts to identify best practice.	Met		As above re F2SU network
Executive and non-executive leads, and the FTSU Guardian, review all guidance and case review reports from the National Guardian to identify improvement possibilities.	Met		F2SU Guardians receive and review information from NGO with the executive lead. Executive lead has shared / discussed the information with the Non-Executive lead.
Senior leaders regularly reflect on how they respond to feedback, learn and continually improve and encourage the same throughout the organisation.	Met		Learning from Experience report. Exception Report Staff Survey
The executive lead responsible for FTSU reviews the FTSU strategy annually, using a range of qualitative and quantitative measures, to assess what has been achieved and what hasn't; what the barriers have been and how they can be overcome; and whether the right indicators are being used to measure success.	Met		Executive Director of Nursing, Therapies and Patient Partnerships has strong oversight of F2SU

The FTSU policy and process is reviewed annually to check they are fit for purpose and realistic; up to date; and takes account of feedback from workers who have used them.	Met		Policy and process have been reviewed; QI strategy is a result of the review.
A sample of cases is quality assured to ensure: • the investigation process is of high quality; that outcomes and recommendations are reasonable and that the impact of change is being measured • workers are thanked for speaking up, are kept up to date though out the investigation and are told of the outcome • Investigations are independent, fair and objective; recommendations are designed to promote patient safety and learning; and change will be monitored	Partially met	Process of quality assurance to be embedded as part of F2SU QI strategy.	Review of cases has taken place; processes have been strengthened to ensure progress of cases can be more easily recognised.
Positive outcomes from speaking up cases are promoted and as a result workers are more confident to speak up.	Not met	Communication strategy to support FTSU to be determined; refer to the QI plan.	
Individual responsibilities			

Chief executive and chair			
The chief executive is responsible for appointing the FTSU Guardian.	Met		
The chief executive is accountable for ensuring that FTSU arrangements meet the needs of the workers in their trust.	Met		
The chief executive and chair are responsible for ensuring the annual report contains information about FTSU.	Not met	To be included within the annual report for 2018 / 2019.	F2SU was not statutory reporting requirement for 2017/18.
The chief executive and chair are responsible for ensuring the trust is engaged with both the regional Guardian network and the National Guardian's Office.	Met		As above; NGO submissions and FTSU Guardian attendance / engagement with regional networks.
Both the chief executive and chair are key sources of advice and support for their FTSU Guardian and meet with them regularly.	Met		CEO and Chair have had regularly discussions in relation to F2SU
Executive lead for FTSU			

Ensuring they are aware of latest guidance from National Guardian's Office.	Met		
Overseeing the creation of the FTSU vision and strategy	Met		
Ensuring the FTSU Guardian role has been implemented, using a fair recruitment process in accordance with the example job description and other guidance published by the National Guardian.	Met		
Ensuring that the FTSU Guardian has a suitable amount of ring fenced time and other resources and there is cover for planned and unplanned absence.	Met		Introduced FTSU Guardian role to both Associate Director of Nursing posts.

Ensuring that a sample of speaking up cases have been quality assured.	Met	Process of quality assurance to be embedded as part of F2SU QI strategy.	Review of cases has taken place; processes have been strengthened to ensure progress of cases can be more easily recognised. Feedback processes have been reviewed and strengthened.
Conducting an annual review of the strategy, policy and process.	Met		Review completed and as a result QI strategy developed.
Operationalising the learning derived from speaking up issues.	Met		
Ensuring allegations of detriment are promptly and fairly investigated and acted on.	Met		

Providing the board with a variety of assurance about the effectiveness of the trusts strategy, policy and process.	Met		Review completed and as a result QI strategy developed. 6 monthly and annual report to open Board meeting.
Non-executive lead for FTSU			
Ensuring they are aware of latest guidance from National Guardian's Office.	Met		
Holding the chief executive, executive FTSU lead and the board to account for implementing the speaking up strategy.	Met		Oversight of the FTSU strategy and progress of ambition.
Robustly challenge the board to reflect on whether it could do more to create a culture responsive to feedback and focused on learning and continual improvement.	Met		
Role-modelling high standards of conduct around FTSU.	Met		Shared role of Senior Independent Director and Freedom to Speak up champion.

Acting as an alternative source of advice and support for the FTSU Guardian.	Met		Accessible to FTSU Guardians and regular meetings in place.
Overseeing speaking up concerns regarding board members.	Met		Aware of role and responsibilities.
Human resource and organisational development directors			
Ensuring that the FTSU Guardian has the support of HR staff and appropriate access to information to enable them to triangulate intelligence from speaking up issues with other information that may be used as measures of FTSU culture or indicators of barriers to speaking up.	Met	FTSU extended network meeting arranged for October 2018 and February 2019 – as per QI improvement strategy.	FTSU Guardian regularly meets with HR and OD to progress individual cases as well as sharing wider learning.
Ensuring that HR culture and practice encourage and support speaking up and that learning in relation to workers' experience is disseminated across the trust.	Met		The FTSU Guardians network with the HR to continue to make improvements to support people to speak up.
Ensuring that workers have the right knowledge, skills and capability to speak up and that managers listen well and respond to issues raised effectively.	Met		Leadership and Management skills programmes Staff Survey

Medical director and director of nursing			
Ensuring that the FTSU Guardian has appropriate support and advice on patient safety and safeguarding issues.	Met		
Ensuring that effective and, as appropriate, immediate action is taken when potential patient safety issues are highlighted by speaking up.	Met		
Ensuring learning is operationalised within the teams and departments that they oversee.	Met		

STANDARDISED REPORT COMMUNICATION

REPORT DETAILS

Report subject:	Operational Plan 2018/19- delivery indicators dashboard [August data]
Agenda ref. no:	18.19.67
Report to (meeting):	Board of Directors
Action required:	Discussion and Approval
Date of meeting:	28/09/2018
Presented by:	Tim Welch, Director of Finance/Deputy Chief Executive

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

REPORT BRIEFING

Situation – *a concise statement of the purpose of this report*
The Operational Plan 2018/19 sets out the Trust's approach to activity, quality, workforce planning and financial planning. The dashboard attached in **appendix 1** reflects the key performance indicators (KPIs) defined to enable the Board to monitor the delivery of the Operational Plan and the Trust's strategic objectives and any risks to achievement and has been updated to reflect the priorities for 2018/19. This report relates to June 2018 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.
All priority projects have been aligned to Care Groups and there are three new projects identified this year (two are enabling projects).
Following the Board seminar earlier this year work is being undertaken to align reporting formats/ styles/ definitions across the Trusts committee structures, phase one of this work is focusing on the Quality Committee and Trust Board dashboard reporting. The current dashboard report has also been updated to include spark line graphics, for illustration of trends for the current year.

Assessment – *analysis and considerations of options and risks*

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

The dashboard reflects month 5 (August) performance and there are 11 indicators off track.
SO1: 1.2 Patient experience
SO1: 1.3 Clinical Effectiveness
SO1.1.6 Patient Safety Indicator
SO3: 2.2 Competence
SO3: 2.2 Staff in month turnover rate

SO3: 3.3/6/7a & b /9/12 Priority Projects, with the ADHD Priority Project remaining as red rated.

Following review of the operational performance dashboard, at Operational Committee, it was agreed that the following indicators would be escalated to Trust Board for oversight and discussion:

- NHSI targets
  - **CHEDS Routine (4 week) waiting time *(88.89% both months)***: this is the second consecutive month the trust has not met this indicator.
  - **Gatekeeping 87.8%** (72/82) this is the first occasion this year that this indicator has not been met.
- Staffing
  - **Capacity % of staff vacancies:** Continues to be red rated across the trust, however the position is an improving one.
  - **Ward Staffing:**
- Service
  - **CYP waiting times:** A Quality Improvement project has been initiated to improve this position
  - **All age Disability service**: The service transferred to CWP on the 19th August from Wirral Borough council

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 2018 Board Operational Plan dashboard.

Who/ which group has approved this report for receipt at the above meeting?		Tim Welch, Director of Finance
Contributing authors:		Mandy Skelding-Jones, Associate Director Performance & Redesign
Distribution to other people/ groups/ meetings:		
Version	Name/ group/ meeting	Date issued
1	Tim Welch	21/09/2018

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	August 2018 Board Operational Plan Dashboard.
2	Operational Plan 2017/18 – Delivery Indicators/ Board KPIs

Appendix 1: Trust Dashboard

	Indicator	Outturn 2017/18	Target or Thresholds for escalation	Q1	Jul-18	Aug-18	Sep-17	Q2	Q3	Q4	Year End	General Comment
Strategic Objective 1 – Quality												
SO1: 1.8	Patient Safety: Reduction in the severity of harm (by 20%) sustained by those people accessing CWP services that cause harm to themselves	121 (10 per month)	97 (8 per month)	31	10	7						The first quarter was acting as a baseline for quality improvement work for the year ahead. A driver diagram has been approved for this work (Edition 1 Quality Improvement report 2018/19) and is now being taken forward. The spark line below illustrates trend for 2018/19
SO1: 1.2	Patient experience: Demonstrable increase in the uptake of the Friends and Family Test (FFT) each quarter	Average 201 (per month)	330 per month	841	259	230						The new FFT system went live for Mental Health services (excluding IAPT) in May. Work is being undertaken to progress the development for IAPT & Physical Health services FFT feedback.
SO1: 1.3	Clinical Effectiveness: Demonstrable improvement in the Trustwide average bed occupancy rate, excluding leave, for working age adult wards	93.30%	Improvement to 85% by KH03's month 12 (December 2017)	93.58%	91.43%	90.60%						
SO1: 1.4	Patient Safety: Total % inpatient deaths subject to a case record review	100%	100%	100%	N/A	N/A						
SO1: 1.5	Patient Safety: Total number of inpatient deaths subject to a case record review identifying that there may have been a problem in the care provided	3	2 in 2018/19 (1 in any month)	1	N/A	N/A						Inpatient death following non-fixed ligature incident (Apr-18). A level 3 investigation is in progress. April and Q1 outturn will be reviewed retrospectively on completion of level 3 investigation.
SO1: 1.6	Patient Safety: Total % deaths reported by and to the Trust (including inpatient deaths) subject to a case record review	18%	15%	* 34%	* 42%	* 33%						* Includes only CAREnotes and PCMIS data in the denominator - Amber rating reflects this position. The mortality monitoring group will meet in November 2018 to discuss inclusion of EMIS data in the denominator due to the difference to the deaths in scope for this population. However, 4 case record reviews were completed in July and 6 case record reviews were completed in August.
SO1: 1.7	Patient Safety: Total number of deaths (including inpatient deaths) subject to a case record review identifying that there may have been a problem in the care provided	4	3 in 2018/19 (1 in any month)	0	0	0						

Strategic Objective 2: People and OD/ Approach to workforce												
SO3: 2.1	Capacity: % of staff vacancies (Contracted)	5.00%	equal to or below baseline 5.31%	5.98%	6.35%	6.65%						
SO3: 2.2	Competence: % of staff receiving annual appraisal (via new proposed framework)	97.6%	100.0%	89.14%	86.67%	86.00%						The Care Groups have been tasked with improving performance as soon as possible. A contributing factor has been the move to Care Groups leading to changes in reporting lines. The reporting structure on ESR has not yet caught up with the changes making it harder for managers to report completed appraisals. This work is expected to be completed by the end of September and, in the meantime, a work around has been put in place to ensure that all completed appraisals are recorded on the system.
SO3: 2.3	% staff absence due to sickness	5.89%	Above annual plan (appendix 3) projection for 3 months	5.24%	5.46%	5.69%						Spark line illustrates trend for 2018/19
SO3: 2.4	Staff, in month, Turnover rate (as a percentage)	0.91%	3 consecutive months where the turnover rate is 25% above the planned rate	0.78%	0.86%	0.94%						Spark line illustrates trend for 2018/19

Ref	Indicator	Baseline	Target									Commentary
Operational Performance / Priority areas												
SO3: 3.1	100% of the 13 NHSI operational performance targets achieved (including waiting times)	100%	100%	100.00%	93.00%	86.0%						The trust has not achieved 100% compliance for two consecutive months due to: o CHEDS Routine (4 week) waiting time (88.89% both months): this is the second consecutive month the trust has not met this indicator. o Gatekeeping 87.8% (72/82) this is the first occasion this year that this indicator has not been met.
SO3: 3.2	100% Contractual targets met	324 (98.1%)	100%	95.5%	94.5%							This indicator reports a month behind 4 West PH, 2 West MH, 14 Wirral (4 for over performance), 1 East
	CQUIN performance quarterly review		100%									This indicator is reported as amber due to East Cheshire CCG not finalising payment. A briefing is being provided to Quality Committee.
Trust Priority Projects												
Care Group: Neighbourhood Care												
SO3: 3.3	Single Model for Integrated Care	N/A	Delivery of Key Milestones									Further detail is available in the PSO report
Care Group: Specialist mental Health												
SO3: 3.7a	Redesign Adult OP MH services - Responsive Care in Communities	N/A	Delivery of Key Milestones									
SO3: 3.7b	Redesign Adult & Older peoples MH services - Bed based	N/A	Delivery of Key Milestones									
SO3: 3.10	Wirral All Age Disability	N/A	Delivery of Key Milestones									
Care Group: Children Young People & Families												
SO3: 3.5	Children and Young Families Prevention/ Early interventions:	N/A	Delivery of Key Milestones									
SO3: 3.4	0-19 Starting Well Service Implementation	N/A	Delivery of Key Milestones									
Care Group: Learning Disabilities & Nuero Developmental (LD&ND)												
SO3: 3.6	Transforming Care - LD	N/A	Delivery of Key Milestones									Further detail is available in the PSO report
SO3: 3.9	ADHD	N/A	Delivery of Key Milestones									Further detail is available in the PSO report
Enablers												
SO3: 3.11	People& OD Strategy	N/A	Delivery of Key Milestones									
SO3: 3.12	Health Informatics	N/A	Delivery of Key Milestones									Further detail is available in the PSO report
SO3: 3.13	Quality Improvement Strategy	N/A	Delivery of Key Milestones									
SO3: 3.14	Communications & engagement	N/A	Delivery of Key Milestones									
Strategic Objective 6: Financial Planning												
SO6: 1	Use of resources	1	Use of Resources [UoR]	1	1	2						Further detail is available in Finance Report

STANDARDISED REPORT COMMUNICATION

REPORT DETAILS

Report subject:	Quality Improvement Report: Edition 1, 2018/19
Agenda ref. no:	18.19.68
Report to (meeting):	Board of Directors – meeting in public
Action required:	Information and noting
Date of meeting:	28/09/2018
Presented by:	Dr Anushta Sivananthan, Medical Director – Executive Lead for Quality

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

REPORT BRIEFING

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

The purpose of this paper is to update the Board on Edition 1 (April 2018 – July 2018) of the Quality Improvement report. This is produced three times a year with the aim of updating people who access and deliver the Trust's services, and other stakeholders, on progress in improving quality across CWP's services. The report describes projects that are improving the quality of care.

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

The aim of the Quality Improvement report is to provide a detailed focus on individual projects, describing the aims, methodology, results and next steps in the spirit of continuous improvement. This edition of the Quality Improvement report was approved by the Quality Committee on 12/09/2018.

Assessment – *analysis and considerations of options and risks*
Alongside the QI portal and the annual Big Book of Best Practice, the Quality Improvement report is a vehicle for staff to share examples of quality improvement projects, share learning and celebrate successes. The report describes projects in an accessible way with an aim of encouraging more staff to get involved in quality improvement in their areas. It will be shared via CWP Essential and via email to ward and team managers, and management teams, copies are also provided to the Trust's Governors. The Healthcare Quality Improvement team will continue to work with clinical teams to ensure that examples of best practice are publicised and that a culture of sharing best practice and learning becomes embedded. Highlights in this edition are: ▪ A Non-Medical Prescriber initiative has reduced the risk of medication errors. ▪ The Emotionally Healthy Schools Links Team has successfully rolled out a self-harm pathway and built the confidence of staff in responding to children and young people who self-harm. ▪ Previous successes of the Red2Green pilot project have successfully been sustained and spread to other wards Trustwide, optimising patient flow and reducing lengths of stay. ▪ Trainee Nursing Associates have changed the way they think and work and fostered person-centred care approaches, supported by Lived Experience Connectors© during their two year training programme. ▪ The ECT Service at Bowmere Hospital has improved the service they provide by capturing patient feedback. ▪ Focus Groups supported by Psychosexual Therapists are empowering the patient voice through art.

Recommendation – *what action/ recommendation is needed, what needs to happen and by when?*
The Board is asked to **endorse** the Quality Improvement report.

Who/ which group has approved this report for receipt at the above meeting?		David Wood, Associate Director of Safe Services
Contributing authors:		Hayley Cavanagh, Head of Quality Assurance & Improvement
Distribution to other people/ groups/ meetings:		
Version	Name/ group/ meeting	Date issued
1	Board of Directors	21/09/2018

Appendices provided for reference and to give supporting/ contextual information:	
Appendix no.	Appendix title
1	Quality Improvement Report, Edition 1: April 2018 – July 2018

Quality Improvement Report

Edition 1
April – July 2018

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

Emotionally Healthy Schools Links Team's
successful roll out of self-harm pathway (see page 8)

Helping people to be **the best they can be**

Welcome to CWP's first *Quality Improvement* Report of 2018/19

These reports are produced three times a year, this being the first edition of 2018/19, 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*.

At CWP, we look at **quality** in detail to better demonstrate where we are making real improvements, with the aspiration to achieve **equity** of care through **Quality Improvement (QI)**. We are using international ways of defining quality to help us with this aim.

CWP's *Quality Account* and *Quality Improvement Reports* are available via:
http://www.cwp.nhs.uk/resources/reports/?ResourceCategory=2335&Search=&HasSearched=True

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.

<table>
<tr><th colspan="6">QUALITY</th></tr>
<tr><th>Patient safety</th><th colspan="3">Clinical effectiveness</th><th colspan="2">Patient experience</th></tr>
<tr><td>Safe</td><td>Effective</td><td>Affordable</td><td>Sustainable</td><td>Acceptable</td><td>Accessible</td></tr>
<tr><td colspan="6">Achieving Equity and Person-centred Care through
CO-PRODUCTION, CO-DELIVERY, QUALITY IMPROVEMENT & WELL-LED SERVICES</td></tr>
<tr><td>Delivering care in a way which increases safety by using effective approaches that mitigate unwarranted risks</td><td>Delivering care that follows an evidence base and results in improved health outcomes, based on people's needs</td><td>Delivering care in a way which maximises use of resources and minimises waste</td><td>Delivering care that can be supported within the limits of financial, social and environmental resources</td><td>Delivering care which takes into account the preferences and aspirations of people</td><td>Delivering care that is timely, geographically reasonable, and provided in a place where skills and resources are appropriate to meet people's needs</td></tr>
</table>

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 (QI)** projects.

Implementation of our new Quality Improvement strategy commenced in April 2018. Phase 1 of the strategy stretches across three years and describes how our people and teams who deliver and support the delivery of our services will work together to create a culture where QI can flourish.

EXECUTIVE SUMMARY
QUALITY IMPROVEMENT HEADLINES THIS EDITION

Non-Medical Prescriber initiative has reduced the risk of medication errors
⇨see page 7

Emotionally Healthy Schools Links Team has successfully rolled out a self-harm pathway and built the confidence of staff in responding to children and young people who self-harm
⇨ see page 8

Previous successes of the Red2Green pilot project have successfully been sustained and spread to other wards Trustwide, optimising patient flow and reducing lengths of stay
⇨see page 12

Trainee Nursing Associates have changed the way they think and work and fostered person-centred care approaches, supported by Lived Experience Connectors© during their two year training programme
⇨see page 16

The ECT Service at Bowmere Hospital has improved the service they provide by capturing patient feedback
⇨see page 17

Focus Groups supported by Psychosexual Therapists are empowering the patient voice through art
⇨see page 18

QUALITY IMPROVEMENT PRIORITIES

We have set three **Trustwide QI priorities** for 2018/19, which reflect our current vision of "**working 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 goal driven measures in our *Quality Improvement Reports*.

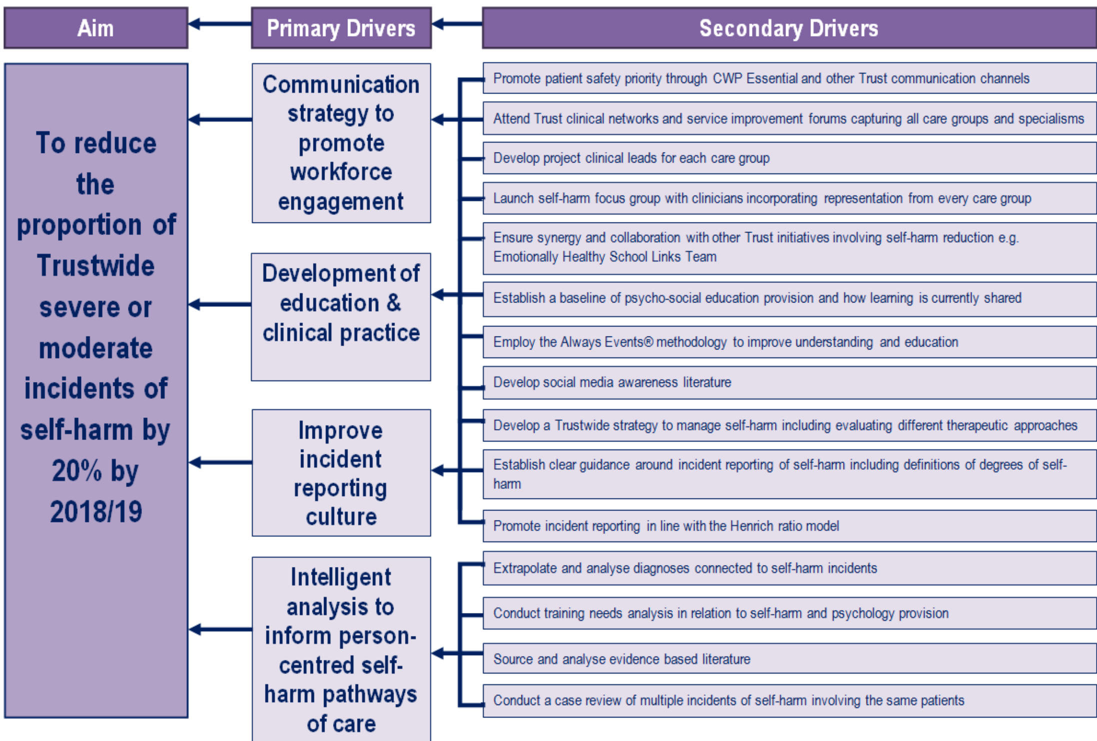
Goal driven measure for **patient safety**

Reduce the severity of the harm sustained by those people accessing CWP services that cause harm to themselves

Nationally, there is wide variation between services in the frequency of self-harm.

We want to:
Reduce Trustwide incidents of severe or moderate self-harm – because the negative impact of self-harm on people and their families can be life-changing and is also associated with a higher risk of suicide.

We have developed this driver diagram to help us describe our aim:



Steps we have taken so far to work towards achieving our aim:

- ✓ Developed an expert group to lead this project and to ensure robust oversight.
- ✓ Arranged meetings to attend Trust clinical networks and service improvement forums to engage with clinicians.
- ✓ Collaborate with our Safe Services Department colleagues to improve incident reporting culture.

These steps all reflect the Trust's vision to work in partnership ensuring that we maximise the potential to improve health by providing high quality care.

For more information, please contact Marjorie Goold, Consultant Nurse CAMHS, on 01244 397623 or Kate Baxter, Acting Healthcare Quality Improvement Manager, on 01244 397410

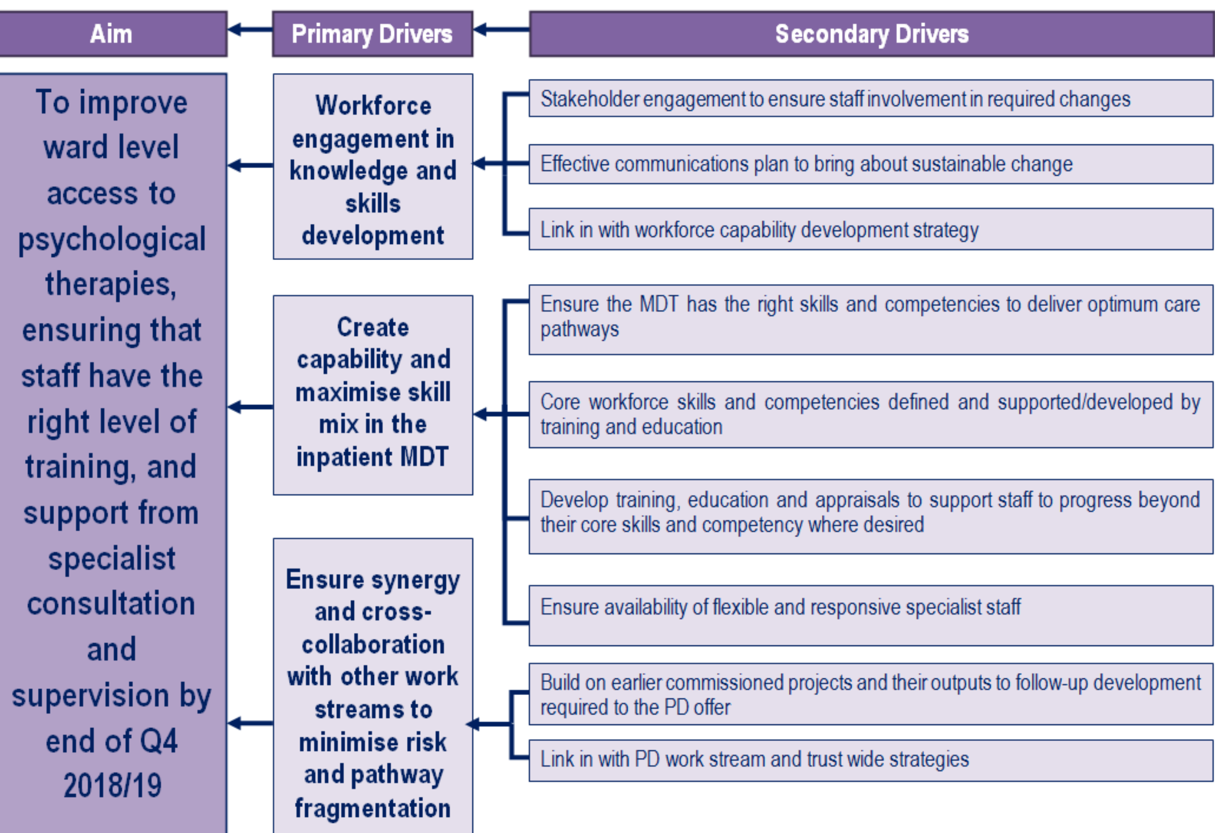
Goal driven measure for **clinical effectiveness**

Improve inpatient access to psychological therapies

Health care organisations should be assured that they are providing effective care that includes psychological interventions.

We want to:
Reduce the gaps and variation in the current psychological therapeutic offer to people accessing care across each inpatient unit – because by using a range of therapeutic interventions, people accessing our services are more actively able to participate in their treatment and recovery, thus reducing length of stay, improving their experience and achieving better outcomes.

We have developed this driver diagram to help us describe our aim:



Steps we have taken so far to work towards achieving our aim:

✓ Engaged with our Effective Services Department colleagues to link in with earlier project work to ensure partnership working.
✓ Attended a workforce planning meeting to collaborate with staff involved in inpatient redesign work.
✓ Gathered literature on the delivery of effective psychological, therapeutic input in inpatient settings.

These steps foster the principles of engagement and partnership working in order to ensure sustainable improvement to CWP's quality of care, incorporating an evidence-based approach.

For more information, please contact Kate Baxter, Acting Healthcare Quality Improvement Manager, on 01244 397410

Goal driven measure for **patient experience**

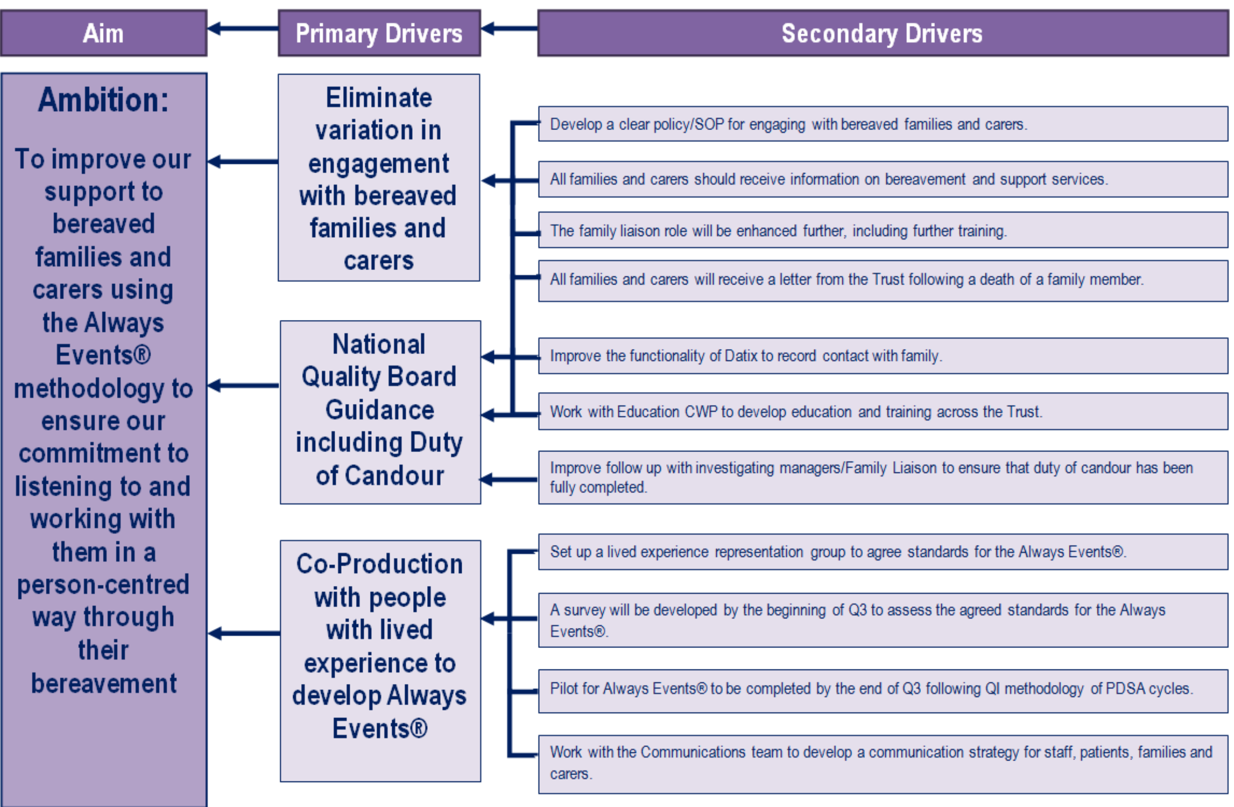
Improve engagement with bereaved families and carers

Health care organisations should prioritise working more closely with bereaved families and carers and ensure that a consistent level of timely, meaningful and compassionate support and engagement is delivered and assured at every stage, from notification of the death to an investigation report and its lessons learned and actions taken.

We want to:

Reduce the variation in the current levels of engagement with bereaved families and carers by using the Always Events ® methodology to ensure our commitment to listening to and working with them to ensure that we provide support in the best and right way through their bereavement.

We have developed this driver diagram to help us describe our aim:



Steps we have taken so far to work towards achieving our aim:

- ✓ Planned a meeting of a representative group of lived experience volunteers to co-produce the project.
- ✓ Identified information to provide to families following bereavement.
- ✓ Development of a bereavement survey with supporting information.

For more information, please contact Audrey Jones, Head of Clinical Governance, on 01244 397387 or Cathy Walsh, Associate Director of Patient & Carer Experience (Interim), on 01244 393173

QUALITY IMPROVEMENT PROJECTS

Patient Safety Improvements

Delivering *Safe* care

The following projects show how CWP teams are delivering care which increases safety by using effective approaches that mitigate unwarranted risks.

Non-Medical Prescriber initiative provides safe and timely access to medicines

Background:

One of the objectives of the pharmacy team is training at least one pharmacist per year as a non-medical prescriber (NMP). Non-medical prescribing has been shown to maximise benefits to patients and the NHS by:

- ✓ Providing better access to and use of medicines.
- ✓ Better and more flexible use of workforce skills.
- ✓ Ensuring that quality and patient safety underpins this provision.

Non-medical prescribing contributes to the delivery of high quality, flexible and person-centred services. It also supports the delivery of Care Quality Commission essential standards and enables organisations to achieve access targets.

What we did:

Nina Geiger, a member of the pharmacy team in Central & East Cheshire, was enrolled onto the NMP course and has now qualified; a further member of the pharmacy team in Wirral is currently undertaking the same NMP training.

Results:

The immediate results were that the NMP within the Central & East pharmacy team has been able to facilitate the writing of new prescriptions and clarifying unclear prescriptions by re-writing them in a timely manner when no medical staff were available. This has **reduced the risk of medication errors** that could have occurred while waiting for the availability of medical staff. The NMP has also been able to undertake patient reviews with the Home Treatment team and facilitate the issuing of prescriptions at the point of patient review rather than having to rely on duty doctors following it up at a later date, which delays the implementation of the necessary interventions.

Next steps are to:

- Complete the training of further members of the pharmacy team to allow for equal use of this valuable skill throughout the Trust.
- Increase the use of non-medical prescribing where staffing allows.
- Consider expanding the use of non-medical prescribers into community teams as part of any skill mix review.

For more information, please contact Hazel Sharp, Deputy Chief Pharmacist, on 01625 508 580

Emotionally Healthy Schools Links Team – Successful roll out of self-harm pathway

Background:

As part of the work with the Cheshire East Emotionally Healthy Schools (EHS) programme, the Emotionally Healthy School Links Team were asked to support schools in their response to children and young people who harm themselves intentionally. Meeting with school leads, the team identified that schools required a clear pathway for self-harm.

What did we want to achieve?

The aim of the project was to support schools and teachers, and ultimately young people who self-harm, to respond in the best way possible where students are known to harm themselves deliberately. The intended goal was to develop a self-harm pathway to enable a consistent approach, enabling school staff to feel more equipped in situations where they encounter young people self-harming.

What we did:

The team, with primary mental health colleagues, met with school leads in Cheshire East to identify what information they would find useful to support their response to self-harm. The information was collated and a review of good practice was conducted to identify existing toolkits and pathways that could be adapted for the EHS Links pathway. A small pilot in a group of schools was undertaken to obtain feedback from school staff. Young people were consulted on the language and content and the pathway was produced and disseminated to all schools and colleges.

Results:

The self-harm pathway has been rolled out to all schools and colleges via the EHS Links Mental Health Awareness Training, which is posted on the MyMind website and the EHS Programme landing page on Middlewich High's website. **School staff have reported feeling more confident and equipped to respond appropriately to children and young people who have harmed themselves deliberately.** School staff attending training have found the pathway informative and easy to use and have valued the scripted questions that can be found in the document to drive questions around an individual's risk to themselves. They report in feedback that the self-harm pathway component of the training is the one they value the most. The team have been working closely with CAMHS, local hospitals and the Local Authority to use the pathway to reduce admissions to A&E by improving the response from school staff.

Next steps:

Since the pathway's successful roll-out across all schools and colleges, the next stages will be continuing to improve the response for children and young people. Further simulation training based on the pathway is being developed with Macclesfield General Hospital and there will be continued monitoring of A&E self-harm admissions to inform impact.

For further information, please contact Rob Lupton, Team Coordinator, Emotionally Healthy Schools Links Team Cheshire East on 07717 714851

Improving the understanding about pain management for people with Learning Disabilities through DisDAT

Background:

DisDAT is the Disability Distress Assessment Tool, which is intended to help identify distress cues in people who, because of cognitive impairment or physical illness, have severely limited communication. It is designed to describe a person's usual content cues, thus enabling distress cues to be identified more clearly.

What did we want to achieve?

To improve the understanding about appropriate pain management and encourage evidence-based practice in order to empower the support staff and families to provide excellent person-centred care to people with learning disabilities in Cheshire West and Chester.

What we did:

We identified variation in practice and liaised with support staff at day centres and agencies supporting people with learning disabilities. As some people with learning disabilities have difficulties in communicating, staff requested training to increase their understanding about pain and its management, as it was difficult for staff to identify when people were in pain to give appropriate pain relief. Staff recognised the impact on quality of life for people with learning disabilities, and how pain could have a negative effect on peoples behaviour at times. We engaged with our stakeholders, i.e. support staff, day centre supervisor, multi-disciplinary team, and co-produced the training in order to assist staff in identifying signs of pain in people with communication difficulties. Training sessions were successfully delivered by the physiotherapist with the assistance of physiotherapy assistants working in community learning disabilities team.

Results:

As a result of the training, staff increased their confidence, which has helped in the management of pain for people with learning disabilities, leading to a **reduction in behaviour that challenges** and **improving their quality of life**. Staff felt empowered to complete the DisDAT tool effectively and now have the courage to use it when attending GP reviews with people, and helping to ensure appropriate pain relief is orescribed. For some people, the pain relief was changed from "as required" to regular and for some the pain relief medications were stopped completely, which in turn supported the STOMP initiative (a national project aiming to stop over medication of people with a learning disability, autism or both with psychotropic medicines). Feedback received was excellent – 100% staff rated training as excellent, describing training as interesting, constructive, helpful and stimulating. Staff said that as a result of the training they would spend more time observing whether a person is in pain or not and record their observations on the DisDAT tool.

Next steps:

Due to popular demand, another session was delivered in East Cheshire to train all therapy assistants working in acute care, children's services, older people and Macmillan services. The plan is to deliver the next two training sessions this year and then review the content of the training as per the feedback before rolling out the training programme for next year. Another aim is to train and empower physiotherapy assistants to deliver the training with an aim to spread it across CWP.

For further information, please contact Deepak Agnihotri, Specialist Physiotherapist, or Gillian Hughes, Associate Practitioner – Physiotherapy, on 07768045789

Using psychological team formulation to improve care planning

Background:

In line with best practice, care plans should be person-centred and collaboratively developed between the multidisciplinary team (MDT) and people accessing services (Royal College of Psychiatrists, 2016). However, in practice, care plans are often nurse-led and can lack MDT input (Whitton, Small, Lyon, Barker & Akiboh, 2016). Team formulations of risk, facilitated by psychologists, are multidisciplinary meetings which allow collaborative discussion of a person's difficulties and needs, drawing on the knowledge and skills of the MDT. While this knowledge can be used to improve care planning, outcomes from team formulations are often not implemented into a person's care plan (Wainwright & Bergin, 2010; Whitton et al., 2016).

What did we want to achieve?

The aim of this pilot project was for three patients to have an MDT care plan informed by psychological formulation by the end of July 2018. This forms part of an overall aim to develop person-centred and MDT informed care plans for all people who access our services on Rosewood, one of our rehabilitation wards. The driver diagram below demonstrates what we wanted to achieve and how we were going to do it.

What we did:

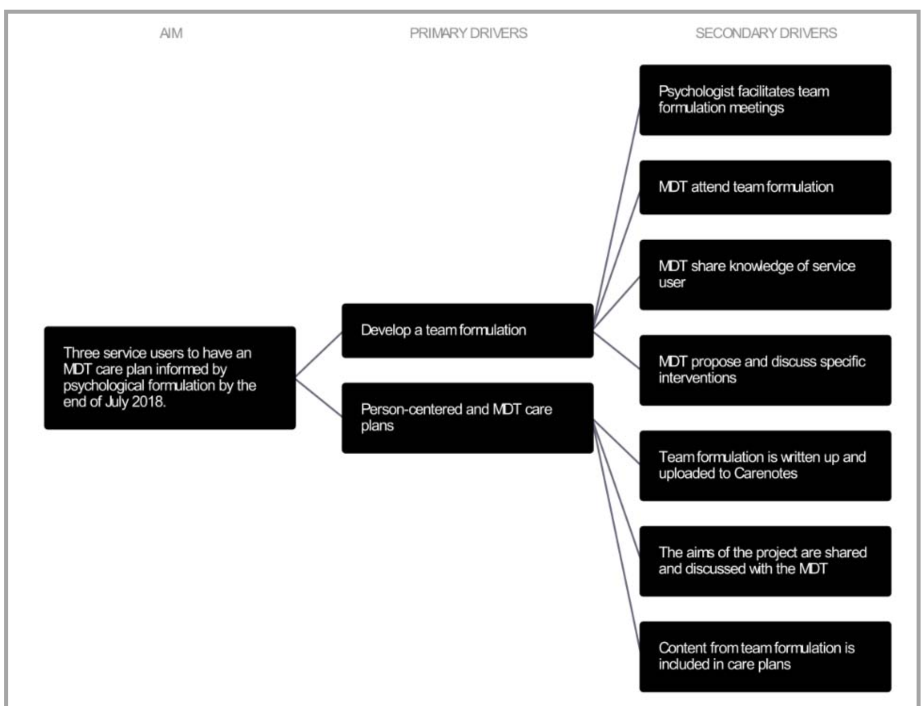
Team formulation meetings were facilitated by the psychology team for three people on Rosewood. Following this, discussions were held between the assistant psychologist and named nurses, where the aim of the project and team formulation was shared. Care plans were reviewed following a short period and were rated for difference (pre and post formulation discussions), inclusion of formulation informed plans, person-centeredness and whether specific MDT interventions were included.

Results:

Results suggested variation between care plans in the degree of person-centeredness and specific MDT intervention content. The results are reflective of the wider literature around care planning, indicating that barriers may exist around developing MDT care plans, which may not be service-specific.

Next steps:

The next phase of the project will involve investigating challenges and barriers around developing MDT care plans in order to explore a variety of methods for implementing formulation informed ideas into care plans.



For more information, contact Amanda Boland, Assistant Clinical Psychologist, at amanda.boland@nhs.net or Sian Bensa, Clinical Psychologist, at sian.bensa@nhs.net

Clinical Effectiveness Improvements

Delivering a*ffordable* care

The following projects show how CWP teams are delivering care which maximises use of resources and minimises waste.

Hitting the triple aim through care pathway redesign to improve access to Adult Autism Assessments

Background:

Wirral and Cheshire CCGs commission the Trust to provide an Autism diagnostic service for adults without Learning Disability. By 2016, the demand for assessments exceeded funded capacity and this was leading to increasing waiting lists. As a result, a decision was taken to redesign the pathway.

What did we want to achieve?

The Trust's aim was to deliver timely care to people trying to access our services, improving the experience of these people, increasing the potential to improve quality of life through robust diagnostic assessments, whilst assuring the financial viability of the service.

What we did:

The pathway was redesigned by reducing face to face assessment time and introducing a pre-assessment questionnaire to enable the assessment to focus on gaining relevant information that was not already available. This was co-produced with a variety of stakeholders including clinicians in the team and people who had been through the service with a diagnosis, carers and GPs to ensure that we maintained the elements that, through their feedback, were identified as key benefits and essentials. The assessment process remained NICE (CG142) compliant (i.e. evidence based to be clinically effective), multi-disciplinary and offered locally.

Results:

The triple aim in relation to improving patient experience, responding to population health need and ensuring financial viability has been achieved:

Patient experience

- ✓ **Waiting lists for assessments have reduced** and **people can access a diagnosis more quickly**. The questionnaire allows people to carefully consider the information they want to provide and they have reported that it helps them anticipate what to expect in the assessment, which **reduces anxiety** and **promotes clinic attendance and engagement**.

Population health need

- ✓ It is known that adults with autism (without a learning disability) die 16 years earlier than the general population. Through having a thorough diagnostic person-centred assessment, the person can access an autism opinion and a psychiatric review informing them, their families and carers what reasonable adjustments are needed to access and engage in healthcare services, how to best **meet people's needs**, play to their strengths, and **support people to achieve their aspirations, optimum functioning and well-being**.

Reduce per capita costs

- ✓ The redesign of the care pathway has resulted in a **75% increase in numbers of people seen for same funding**.

Next steps:
We are developing a "go to" hub for all CWP services needing advice on working with people with autism (without a learning disability). We are working with a range of partners to **make best use of the resources in local communities** and are continuing to campaign at local, regional and national level for more funding of post diagnostic support.

'Friends and Family Test' feedback:

For more information, please contact Clair Haydon, Trustwide Strategic Lead for Complex Care, on 01244 397640

Red2Green project continues to improve quality and effectiveness

Background:
The Red2Green pilot project began on Beech ward between September and December 2017 and since then has been rolled out to other wards across the Trust to achieve similar improved outcomes in improving the quality and effectiveness of the inpatient part of the patient's care pathway, with reduced length of stay being one key measure demonstrating this.

What did we want to achieve?
Red2Green aims to **optimise patient flow** through the identification of wasted time in a patient's journey, and the **reduction of internal and external delays**. The emphasis is on patients receiving active and timely care in the most appropriate setting and for no longer than required, so that patients do not lose one more day of community living than is absolutely necessary. For inpatient settings, this is vital in **improving quality of care and freeing up capacity within the system** by reducing length of stay.

What we did:
The principles of Red2Green include a *daily* multi-disciplinary team (MDT) 'board round' to rapidly assess the progress of each patient, determine whether the current part of their journey is 'Red' or 'Green' and identify, take action on, or escalate, the internal or external barriers or delays to those identified as Red receiving active care, treatment or discharge. The Red2Green and underpinning QI principles were spread to further wards across the Trust, including:

- Upskilling acute care staff to improve quality improvement capability via bespoke Improvement Readiness Training.
- Engagement sessions held with each new ward to increase awareness of Red2Green, tailor the principles and criteria to meet the differing needs of each ward and to train staff.
- Daily 30-45 minute MDT board rounds continue to be held to rapidly assess the progress of each patient, determine whether they are 'Red' or 'Green' and identify, discuss and implement specific same day actions to address barriers or delays to active treatment and facilitate earlier discharge;
- The initial visual management system in the form of a spreadsheet, has been replaced with an electronic database to improve the ease of recording and reporting data within the daily board rounds.
- Lived Experience Volunteers and inpatients on pilot wards engaged to identify what is important to them (Always Events) at each stage of an inpatient stay. Feedback was then analysed to identify themes and action plans developed by each Acute Care Head of Clinical Services to address the issues raised and improve the inpatient pathway by ensuring that specific processes identified as being important to patients always occur.

- The success of the pilots has all been attributable to the buy-in, commitment and input of the full MDT present at the daily ward rounds. This has improved team cohesiveness and communication within and across the inpatient and community teams, due to increased focus and staff proactively identifying, addressing or escalating barriers and delays.
- Red2Green is soon to be piloted in Wirral Home Treatment (HT) Team, with engagement sessions already held with the team to adapt the principles and criteria to make them applicable to a HT setting. Data will be monitored to record outcomes and measure impact in terms of patient flow and length of stay within the team.

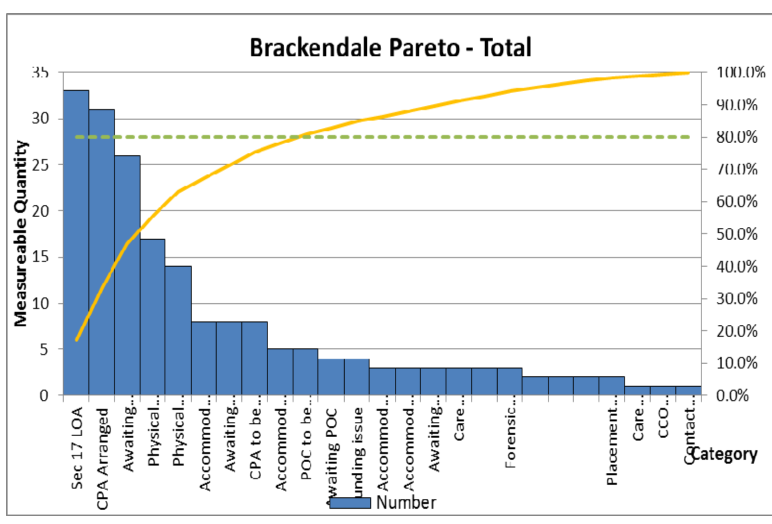
Following the initial successes in reducing length of stay on Beech ward, a 'spread and sustain' plan was implemented and the initiative rolled out to Brackendale in January 2018 and then on to Bollin, Adelphi, Juniper and Lakefield in June/ July 2018. Red2Green continues to be rolled out across the Trust to all acute wards as presented below:

Acute ward	Stage of Red2Green implementation
Beech	Fully implemented
Brackendale	Fully implemented
Bollin	Implemented: in pilot stage
Adelphi	Implemented: in pilot stage
Juniper	Implemented: in pilot stage
Lakefield	Implemented: in pilot stage
Croft	Pilot due to commence August 2018
Cherry	Engagement session due to take place August 2018 – start date to be agreed with team
Meadowbank	Engagement session due to take place August 2018 – start date to be agreed with team

Results:

The Red2Green initiative continues to impact positively on **improving flow** and **reducing length of stay in each of the wards where it has been implemented**. This is reflected within the data analysis, which identifies a reduction in the percentage of Red patients on Beech and Brackendale wards, from 60% and 23% at the start of the initiatives respectively, to end of the pilots 32% (03/01/2018) and 16% (31/05/2018). Most significantly, the data analysis continues to identify a reduction in the average length of stay when patients are discharged (excluding transfers), from 24 days (based on data from 01/01/2017 to 22/09/2017), to 22 days (based on data from 27/09/2017 to 12/07/2018) equating to a reduction of 10% for Beech ward. The reduction in the average length of stay when patients are discharged (excluding transfers), was also experienced on Brackendale ward, from 39 days (based on data from 01/01/2017 to 22/01/2018), to 20 days (based on data from 22/02/2018 to 12/07/2018), equating to a reduction of 48% for Brackendale ward.

Initial findings of the more recent wards implementing Red2Green also demonstrate similar improved outcomes, with a reduction in the average length of stay, when patients are discharged (excluding transfers), on Bollin ward from 22 days (based on data from 01/01/2017 to 11/06/2018) to 20 days (based on data from 16/07/2018 to 12/07/2018), equating to reduction of 9% for Bollin ward.



A thematic analysis of the internal and external barriers continues to be undertaken for each of the wards and displayed in a Pareto chart to clearly present the main causes of internal and external delays and thereby inform further external escalation with partners and focus areas for further QI projects. These Pareto charts continue to highlight the importance of working at all levels (ward, Trust and with external partners) to overcome delays and barriers and thereby reduce the number of Red days and length of stay. Thematic analysis of the barriers and delays is now informing the development of a drop down list within the database for wards to select from, thus improving data recording, reporting, analysis and escalation internally and externally to ensure accountability in addressing the delays and subsequently improving flow so that patients do not lose one more day of community living that is absolutely necessary.

Next steps:

The Red2Green 'spread and sustain' plan will continue to be implemented to roll out the initiative across the Trust. Data will continue to be gathered and analysed in order to validate and monitor the impact and outcomes of the initiative over time to gather a full year effect for each ward and therefore mitigate the risk of 'regression to the mean' (where natural variation in repeated data look like real change, but may be down to variety of factors including chance) and the 'Hawthorne effect' (when people can modify their behavior because they are being observed). Red2Green is also being explored for use within the District Nursing team and rehab wards, with adaption of the criteria and principles to make it applicable to each of team and identification of the outcomes to be measured.

PDSA quality improvement cycles will continue to be used for each pilot and also to refine the electronic database for improved recording and reporting of Red2Green data. Further scoping is also taking place around the incorporation of Red2Green into a real time electronic bed management system solution and possible use of interactive white boards to display data in real time and further improve the recording and reporting process.

For further information, please contact Lauren Connah, Service Improvement Manager on 01244 397396. Further information regarding Red2Green can be found on the QI portal on the intranet.

Delivering *Sustainable* care

Quality services and systems include sustainability as a fundamental principle. The following projects show how CWP teams are delivering care that can be supported within the limits of financial, social and environmental resources.

Telephone triage system generates rapid access to the Early Years Specialist Support Service

Cheshire West and Chester | CWP | Cheshire and Wirral Partnership NHS

Is your child currently involved with the Early Years Specialist Support Service, and aged between 0-5 years?

Are any of these becoming a problem with your child?

- Does your child have sleep difficulties?
- Is your child hurting themselves?
- Is your child having tantrums or meltdowns that last for a long time?

If you answered Yes to any of the above, then we can offer ...

- Library Resources for parents to borrow
- Advice Sessions – to give you the chance to talk to a member of the team
- Group and Individual programmes about how to understand your child's behaviour
- Sleep Assessments and Plans
- Support to help you understand your child's behaviour and to teach them new skills

Please call the LD CAMHS team on: 0151 337 6317, to see how we may be able to offer you support and advice

Care • Well-being • Partnership | Child and Adolescent Mental Health Services

Background:

Research has shown that early intervention in the care of children with learning disabilities can prevent behaviour that challenges from developing. We wanted to help parents of children with a moderate to severe developmental delay (identified through their involvement with the Early Years Specialist Support Service) to develop a set of universal strategies that prevent and manage behavioural difficulties.

What we did:

As of 2016, we developed the capacity to work with 0-5 year olds in a preventative way. We promoted the service to parents through the Early Years Specialist Support Service (EYSS) and encouraged parental self-referral. We offered a telephone triage which ensured rapid access to the service as we could direct inappropriate referrals elsewhere. We developed a stepped model of care approach: initially offering general advice sessions, followed by individualised behaviour support if needed. The content of the advice sessions was created by combining well-researched universal strategies. These strategies are promoted by experts in child behaviour to prevent and manage behaviour difficulties. Although universal in nature, parents completed a worksheet to help them individualise the different strategies to their own child. Wherever necessary, we provided parents with additional materials that they thought would be helpful. For example, creating a visual schedule for children who struggled with particular routines. We created work booklets with all the information given with the aim of empowering parents to use these strategies again in the future if necessary. In addition, we used the Friends & Family Test to ensure parents could provide honest feedback and improvements could be made whenever necessary. We collected additional feedback from parents through use of the 'Experience of Service Questionnaire'.

Results:

As a result of the increased access to the service and telephone triage, we were able to offer an initial choice appointment within five weeks from referral. Urgent referrals were seen within two weeks. By offering initial advice sessions, we have reduced the number of appointments per child whilst still **achieving increases in goal based outcomes**. On an initial audit over a 6 month period, we found an average goal change of 3.5 on a 10 point scale. Research has indicated that a change of 2.46 or above is indicative of **improved outcomes**. More importantly, feedback collected from the Experience of Service Questionnaire was really positive:

"just thank you – because the strategies are really helping"

"just really helpful – I have already recommended the service to a friend!"

"I think more parents need to be made aware of the service and the fact you can refer your own child"

Next steps:

We are still continuing to make improvements to the scheme using the feedback we receive to monitor and improve our work. Our next steps are to continue to offer the service and get more feedback from parents about what they would like from the service.

For further information, please contact Jenni Butler-Meadows, Team Coordinator LD CAMHS West Cheshire, or Carla Brown-Ojeda, Assistant Psychologist, on 0151 337 6317

Total Communication workshops reduces Speech and Language Therapy waiting times

Background:

Historically, there have been significant waiting lists for people accessing speech and language therapy in community learning disability services in West Cheshire; as a result the team have looked at innovative ways for those people referred to access support in a more timely way.

What did we want to achieve?

We wanted to provide person-centred training in relation to speech and language therapy using 'Total Communication' workshops in order to reduce waiting times for people who access services and their families. We wanted to ensure that people received the right care, at the right place, at the right time.

What we did:

We created a 'Total Communication' workshop, which involved speech and language therapeutic training and support in a group setting. People, which included the patient, family and care team, were trained in how to use a Total Communication approach and how to create a person-centred plan to ensure the person receives good quality support.

Results:

The project has **significantly reduced waiting times** for Speech and Language Therapy support using a Total Communication approach. We now offer this support within 2 months of referral compared to a previous wait of approximately 6 months.

Next steps:

We will continue to run the Total Communication workshops and hope to complete an audit on this approach. This will shape the future of the workshop. We also hope to expand the workshops, offering more sessions during the next 12 months.

For further information, please contact Claire Ashworth, Speech and Language Therapist, on 01244 397222

Patient Experience Improvements and Patient Feedback

Delivering *Acceptable* and *Accessible* care

The following projects show how CWP teams are delivering care which takes into account the preferences and aspirations of people. They also show how CWP teams are delivering care that is timely, geographically reasonable, and provided in a place where skills and resources are appropriate to meet people's needs.

Using Lived Experience Connector© Volunteers as a learning support for staff training

Background:

Relationships are at the heart of person-centred care and co-production. Stronger connections with people with lived experience, the third sector, and local communities enhance services. CWP was the lead employer in the CWP partnership pilot for the training of 44 Nursing Associates. As part of the pilot, CWP developed a role for volunteers with lived experience of long-term health conditions. These people are known Lived Experience Connectors©. To foster person-centred care approaches each trainee Nursing Associate was allocated to a Lived Experience Connector© for the duration of their two year training programme. Lived Experience Connectors© are people who have experience accessing services. They inform the whole learning experience and provide trainees with continuous support and feedback in their journey to develop person-centred practices.

What did we want to achieve?

Involving people with lived experience as part of staff training ensures that staff are taught to focus on people's journeys and individual needs, encompassing the whole patient journey from conception to end of life. Connecting trainee staff with someone with lived experience during their training programme enables them to foster person-centred care approaches. They inform the whole learning experience and provide trainees with continuous support and feedback in their journey to develop person-centred practice. Lived Experience Connector© Volunteers use their skills to describe their own experiences, emotions, feelings, fears, concerns and hopes, which will help the trainees to reflect on their practice and to build relational skills to give the best person-centred care.

What we did:

The Lived Experience Connectors© received training for the role and each connector volunteer was carefully matched up with a trainee Nursing Associate to establish and facilitate a narrative with them. Trainee staff matched with a lived experience connector volunteer during their entire training programme can learn to:

- ✓ Focus on what matters to the person in their life and why.
- ✓ Build on their strengths and capabilities.
- ✓ Support people and practitioners to have good outcomes focused conversations that create meaningful engagement.
- ✓ Use approaches to achieve outcomes and recovery in which the person, their family and support networks and all the professionals involved work together to achieve the desired outcome and goals.
- ✓ Involve a shift from service priorities to people's own priorities.

Results:

Typical examples of the shift that occurs in practitioners includes:

- Listening, not making assumptions that they know the answer.
- Involving the right people in conversations.
- Self-awareness, knowing what matters to trainees themselves to enable people they work with to identify what matters to them.
- Seeing people as individuals with their own strengths, needs and aspirations rather than defining people by their illness.

This approach has proved to be successful and feedback has been very positive with trainees acknowledging that they have changed the way they think and work. A trainee recently reported that his Lived Experience Connector© has helped him:

"look beyond the mask of illness and see the person"

This profound statement perfectly describes how our commitment to person-centredness has been the driving force behind the whole programme. There has been a significant amount of interest in the Lived Experience Connectors© role from other NHS trusts nationally.

Next steps:

With the start of the next cohort of trainee nursing associates in 2018, we have now linked these new trainees with new Lived Experience Connectors©. This initiative will continue to be rolled out over the next few years to maximise the Trust's commitment to person-centred practice and improving care for people who access our services.

For further information, please contact Lorraine Van Sluis, Voluntary Services Lead, on 01244 393130

Capturing the patient experience of ECT

Background:

Several changes have taken place within the ECT provision in Wirral and West Cheshire. The ECT suite at Bowmere Hospital has been refurbished and people from Wirral and West Cheshire now come to Bowmere Hospital for ECT. The ECT staff team wanted to understand from people accessing care – what was working well and was there anything that needed to be changed?

What we did:

A small team including ECT staff, participation and engagement staff, PALS officer and patient stories volunteers (one volunteer had experience of ECT) got together to plan the best way to capture this feedback. From this work an information sheet about the project, consent form and a consultation sheet (covering the key stages of the ECT journey) were developed. ECT staff then gave the information sheet to people who could decide if they wanted to get involved and share their experience of having ECT. Since April 2018 we have met with five people who had accessed ECT therapy, three from Wirral and two from West Cheshire.

Results:

The feedback has highlighted many examples of excellent practice:

> "They've got it down to a tee here. I've had ECT in 4 or 5 different hospitals and they are easily the best. They are consistent here. There have been no occasions when it's been a bad experience. It's not a nice thing to have, but the staff make it as easy as they can"

There were a few actions identified which people felt could improve the experience for them and others. None of the suggestions will cost money and the staff team would not have been aware of these if this work hadn't taken place. A few example actions are:

✓ To ensure all staff are aware of the CWP Information leaflet on ECT, which has been co-produced with people who have received ECT.
✓ To consider the start time of ECT for people travelling from Wirral.
✓ A radio to be on low to help reduce any noise from machines and therefore help people who might be anxious.
✓ All patients to be given the aftercare information before leaving Bowmere Hospital.

Next steps:

The report and feedback will be taken to the ECT Good Practice meeting. By talking to people who are using/ have used the service, their feedback has highlighted many examples of excellent practice, particularly around the staff team and the support they offer to people coming to ECT. This is an ongoing piece of work and the ECT service along with Participation and Engagement staff and volunteers are hoping to incorporate this into routine practice.

For further information, please contact Lesley Gledhill, Participation and Engagement Practitioner on 07825 522489

Sexuality and Breast Cancer – Empowering the patient voice through art

Background:

Patient surveys undertaken by cancer charities (Macmillan, Prostate Cancer UK, Target Ovarian Cancer, and others) recognise opening conversations about sexual and relationship problems is difficult. Patients report finding it difficult to ask for help in their therapeutic encounters, if they have recognised sexual or relationship problems, whilst health professionals in studies report feelings of anxiety and lack of understanding to enable them to open the conversations. Formal educational opportunities looking at sexuality and cancer, although growing, are not readily available for either group. Wellbeing programs are being developed around the UK, but the health professionals running these groups will not always know the significance of the problems. The Health Needs Assessment tool, which is becoming more important at the end of a patient's hospital treatment, does not recognise the issues patients have in admitting to sexual or relationship problems. The question is, how can we enable health professionals to recognise this need for patients, so that they will open the conversations needed by some patients and how can we empower patients to feel able to open the conversations themselves?

What we did:

The research takes a qualitative approach with women with breast cancer to explore the effects of the cancer on their sexuality. Focus Groups of patients were developed to undertake discussions on their sexual difficulties, needs, emotions, relationship effects, body image issues, and communication difficulties and losses resulting from their diagnosis and treatments. The Focus Groups were asked to discuss/ consider several questions. The groups were facilitated by an experienced consultant psychosexual therapist and a consultant psycho-oncologist. Feedback from the group discussions were recorded and then tabulated into common themes. Volunteers from the Focus Groups were invited to work with a group of artists to produce artworks from the themes identified, which acted as a metaphor for the patient voices.

Results:

The artwork is in the process of being evaluated as a tool to enable empowerment of the patient voice in opening up conversations with health professionals. Each of the 6Cs is reflected within the work undertaken, but Communication, Courage and Compassion are uniquely reflected. Courage, working with what is often seen as a "taboo" subject in empowering women to discuss a range of issues and the psychological effects on the sense of sexual self and the impact on both the relationship and social context in which people live their lives. Evidence shows that both patients and health care staff have communication difficulties in this area. Compassion, in giving a voice to issues that often go unspoken, in a manner that is empowering.

Communication, in listening and checking out what has been said and understand what has been meant by the participants. By working with artists, the Focus Groups have been supported to represent difficult and intimate symptoms in a manner that not only representative of their experience, but also results in something that is truly attractive using the medium of fabrics, ceramics etc.

Next steps:

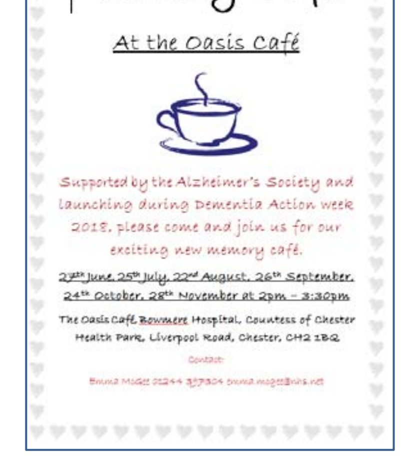
The resultant artwork is continuing to be evaluated by patients, healthcare professionals and the wider audience. It is hoped that a tool to aid communication between patients and healthcare professionals can be developed for use in communication around sexuality and breast cancer. It is hoped also to publish the results from the research work.

For further information, please contact Richard Linford, Psychosexual Therapist, on 01270 655240

Creation of the Memory Café supported by the Alzheimer's Society

Background:

Recognising that carers can feel very isolated looking after a loved one with dementia, the staff at Bowmere Hospital have launched a Memory Café supported by the Alzheimer's Society.



What did we want to achieve?

The aim was to offer a safe, therapeutic and supported environment for carers to engage with the person they care for and to offer and receive informal support from others in a caring role. It also created an opportunity to gain access to formal carer support through the links with the Alzheimer's Society.

What we did:

Links were built with an Alzheimer's Society representative who supported the development of the Memory Café within the Oasis Café at Bowmere Hospital. The sessions include informal carer support and a supportive environment with social activities, including quizzes and reminiscence items available for carers to engage in with the person they care for or with other carers/ facilitators. Carer supports can be identified and addressed immediately due to Alzheimer's Society representation. The session is open to all and the location was chosen to encourage and support attendance of those who have current or who have had previous involvement within the inpatient or community older adult services in Chester. This can allow for graded involvement with the hope of links being built, followed by continued support and attendance following discharge from these services.

Results:

Two sessions have taken place and both carers and those they care for have attended. Attendees have had connections to inpatient or community services or had heard through word of mouth. Carer support needs have been identified as part of the session by the Alzheimer's Society representative and referrals have been discussed and completed. A carer for a gentleman on Cherry ward had previously declined support and following a direct talk to the Alzheimer's Society, consented to a formal referral. It is possible that this would have not been taken up had the session not taken place. Other feedback has been very positive, highlighting:

It is the first time she could talk to others
"in a similar situation"

Next steps:

The café will continue to run on a monthly basis. Options for additional carer support are to be identified, including the Carers Trust and Citizens Advice. A formal review will take place at approximately 6 months to ascertain development strategies, feedback from attendees and what they would like for the future. Further promotion of the café will take place to widen connections to offer informal support to a wider audience.

For further information, please contact Emma McGee, Senior Occupational Therapist, on 01244 397289

Soss Moss Recovery College run workshops and courses to help people gain skills, knowledge and understanding

Background:

Soss Moss Recovery College run workshops and courses to help people who access our services gain skills, knowledge and understanding so that they can live a happier and more fulfilled life. These skills are designed to help overcome mental health challenges and provide successful self-management strategies. The Recovery College is now offering Tai-Chi sessions as part of its wellbeing programme.

What did we want to achieve?

To help build capabilities for all and develop a learning environment and ethos that stands for togetherness and taking health and wellbeing matter into your own hands.

What we did:

Through the Recovery College, a service user and our in-house fitness instructor led a group of staff and service users in practicing Tai-Chi outside in the garden. This has been running every Monday morning in July, encouraging a group of people to come together, get off the wards and do something active, positive and calming as a group. This is a great start to the working week and promotes a healthy mind and a healthy body. Staff and service users alike are encouraged to get active and develop their understanding of an exercise that promotes both physical and mental wellbeing and model this amongst their service user group, thus spreading the word of taking your health needs into your own hands, developing socialisation skills, and being at one with nature.

Results:

So far we have had between **10 and 35 people attending** this tai-chi session each week as a mix of staff and service users. Staff have reported that this 15 minute break has allowed them to take some time to relax and afterwards they feel calmer, or re-energised and have appreciated having a small amount of time to be mindful and get off the wards. Service users reported they enjoyed doing something a bit different and appreciated getting out into the garden and doing something positive as a group. The impact this programme has had on our service user who agreed to help lead the sessions has been massive. He has shown significant development in relation to his levels of motivation to do positive activity, the time he spends out of his room and the increase in his positive attitude. Not only this, but this person has developed considerably in his confidence and his levels of self-esteem. This programme has allowed people to come together and be amongst nature whilst taking some responsibility for their own health and wellbeing. This short activity promotes relaxation, mindfulness and tranquility, alongside getting out and active and has been a huge success.

Next steps:

We are currently collating evaluation sheets and following on from these, we are considering turning these sessions into a more regular occurrence, for example running it twice a month for the rest of the summer/ autumn months.

For further information, please contact Laura Aslan, Assistant Clinical Psychologist, on 01625 862457

Between April and July 2018/19, CWP formally received 1067 compliments from people accessing the Trust's services, and others, about their experience. Below is a selection of the comments and compliments received:

Learning Disabilities, Neuro-Developmental Disorders & Acquired Brain Injuries Care Group

- "You have made me feel so welcome and have encouraged my learning and development, thank you."
- "You were my total lifeline and my comforter, as a mother and carer, I cannot thank you enough for your guidance and that of your colleagues also. The clinic gave me hope and strength to cope and the ability to put in place all of your suggestions and expert guidance. My daughter also benefited by being able to talk to someone other than her father and myself. YOU REALLY CHANGE PEOPLES LIVES, THANK YOU AGAIN ALL STAFF."
- "Staff are lovely, the vicinity is very good and my son really enjoys coming to stay and is well looked after."
- "The staff always go above and beyond to cater for the client and their family and there are no words to say how much we appreciate everything they do for us."

Children & Young People (CYP) Care Group – West Cheshire 0-19

- The family fed back how useful they had found the sessions being regular, with small steps to work on each time, that were specific to the child and family. Having strategies and advice pinpointed for their child was useful for them.
- "You've been easy for us as parents to work with (through some pretty tricky times) and built a lovely relationship with our child."
- Parent thanked Speech And Language Therapy team for input with the family in supporting her and her family with her child's communication and supporting her mental health.

CYP Care Group – Wirral CAMHS

- "I want to say that I could not have gone on without the support of (staff member). I felt hopeless, that no-one was listening to me or willing to help me. He has been amazing."
- "Thank you so much for all the time and effort you've put in to help me get where I am today. After just a few sessions I've become so much happier and confident in myself and others."
- "Thank you so much for everything you have done for me during this difficult time. I feel lucky to have support from somebody who has used every effort to understand me and not stopped at anything to help me. I think it's fair to say you're a one off and one of the main reasons I'm still here today and I will never forget it."
- "Clear, friendly service. Helped find the correct treatment for me."

CYP Care Group – Tier 4 CAMHS & Outreach

- "Thank you for everything you have done for me. I appreciate all the work you've done with me! Your support has really helped me."
- "Thank you for getting me to a place where I am not scared to talk anymore. You have taught me the skills I can use to help me do this. Thanks for making me feel okay about speaking out and accepting myself"
- "You taught me that it doesn't matter what has happened in the past and that it should not affect the person I could be in the future. I loved how you got to know your patients and talked to me about difficulties I have in my life. You and my stay at Ancora has changed me and I now feel more optimistic that things can get better, thanks for not giving up on me, it means everything."
- "Thank you for being there when I was at my lowest. You don't understand what that meant to me. I didn't feel alone or scared or sad. I felt cared for, for once."

Neighbourhoods Care Group – Integrated Teams

- "What an amazing service you provide. Rapid, compassionate and caring. You made a huge difference to dad and us at the end of his life and we can't thank you enough."
- Patient described the service as wonderful, informative and supportive and said the family benefitted enormously from physiotherapist professional involvement.
- Patient described the care provided as outstanding and said the nurse was kind, informative and very gentle when completing the task.

Specialist Mental Health (SMH) Care Group – Place-Based (East Cheshire)

- "Without the fantastic efforts of the team, my father would not be here with us today. He is recovering well and we are truly grateful for everything the drug and alcohol team have been able to offer. This service and team members definitely stands out within Cheshire East. The drug and alcohol team at present are by far the most efficient and effective service currently provided to help people in these situations. Every member of staff dealt with in the team has been respectful, understanding and extremely helpful in every aspect of my father's rehabilitation. The people within this service are a true representation of what CARE is about. And they obtain results."
- "Without your support, understanding and genuine willingness to get to know him as a person, without which his progress would have been far more complex and drawn out, he would undoubtedly still be struggling to fathom out his troubles. He has made huge progress, we are very proud of him and forever grateful to you and the services you represent."

SMH Care Group – Placed-Based (Wirral)

- "She helped me, with no pressure, she understood and made me feel like I could achieve things, see things differently, and deal with them in a different way. She has helped me become a better me."
- "I wanted to take an opportunity to personally thank you on behalf of my family for all the care and attention you and your team showed to my father during his final years. We can't thank you enough. You all do an amazing job at what is a very very difficult time for patients and their families."
- "Just a little card to let you know just how much your help is appreciated. It's good to know that the support is there. Once again that your very much."

SMH Care Group – Place-Based (West Cheshire)

- "Many thanks for all your help as I attended clinic. I was incredibly nervous coming for a diagnosis but your professionalism, kind manner and great communication made it really straightforward and reassuring. Thank you so much."
- "The sessions have helped me identify many issues which I now feel more equipped to deal with. Overall, I have become a much more confident and empowered person. I have learned a lot about myself and hope to continue this progress going forward. Thank you very much."
- "Therapy has helped me overcome my mental battle and helped me develop the skills I already had but had forgotten how to use them when I needed them."

CYP Care Group – Cheshire CAMHS

- "I think (staff member) is fantastic, knowledgeable, and consistent, all things that made a big difference to our family. I can't thank her enough and now knowing I can call if things change gives me strength."
- "The support was tailored to meet my daughter's individual needs and her personality."
- "Good communication and flexible arrangement of appointments. Positive impact on my son, he was very engaged in the process."
- "We have always been listened to, supported through everything that has happened, and offered additional services."

Neighbourhoods Care Group – Front Door

- "He reports that since his discharge from detox he has returned to work, is attending AA groups, playing badminton and basketball. He stated his life has improved no end and he is eternally grateful for the support he received from HALS."
- "She has helped me deal with my anxieties in a positive way and I hope I will continue to do so. She is a very good listener and is also very easy to talk to. She talked through my anxieties with me each week and was always patient and supportive, never making me feel inadequate or silly – a brilliant therapist".
- "I am so grateful for the services I have had , both the talking therapy and CBT Both therapists always really listened and understood my issue and helped me work through a really difficult period in my life, thank you."

SMH Care Group – Bed Based (East & West)

- "I can't thank all the staff enough for their kindness and patience with all the patients and particularly my husband. Nothing was too much trouble. I was always kept in the picture and felt very supported."
- "The staff have worked so hard to help our son. He has made excellent progress in many ways and we could not have managed this at home. The support will breakthrough to the community. The staff introduced a traffic light technique/ system which our son found very useful."
- "I found the art therapy session to be very helpful in my recovery, painting in the group relaxes me. Sitting with peers and chatting is a big help."

SMH Care Group – Bed Based (Wirral & PICU)

- Thanking staff for everything they did for patient. Staff offered help even when she didn't want it, staff never gave up on her, turned a light on when all she could see was darkness, all played a part in rebuilding her piece by piece. Very grateful to staff.
- "With their (HT team's) intervention I am now on the way to living again with a positive approach to my future."
- "All the staff were friendly, helpful and informative. Meadowbank felt like a very caring and safe place for my mother to stay. I think the service you provide is wonderful. Thank you."

SMH Care Group – Forensic, Rehab, CRAC

- "I can't thank the staff at Saddlebridge enough for looking after me and taking time to talk to me. I now feel ready and able to move forward."
- "Thank you for all your help and support over the last 4 years."

SMH Care Group (Place Based – South Cheshire & Vale Royal)

- "Thank you for all your help, it has really made a big change in my life."
- "You have taught me such powerful skills to help me and I am very grateful to you, and for being such a kind and patient listener, thank you."
- "I'm absolutely amazed at the difference in my mood and overall life. The way that I have been shown to overcome problems that may arise has not only worked in the present but can definitely be followed in the future."

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 397410

Look out for more about Quality Improvement in Edition 2 2018/19 of the Quality Improvement Report

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STANDARDISED REPORT COMMUNICATION

REPORT DETAILS

Report subject:	Board Development Plan
Agenda ref. no:	18.19.69
Report to (meeting):	Board of Directors
Action required:	Discussion and Approval
Date of meeting:	28/09/2018
Presented by:	Mike Maier, Chairman

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
Services that are responsive to people's needs	Yes
Well-led services	Yes
Which NHSI 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*
The NHS Leadership Academy defines the purpose of the Board of Directors is to govern effectively, and in doing so build patient, public and stakeholder confidence that their health and healthcare in is safe hands.

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

The Board is proposing to strengthen their knowledge, skills and competencies through the Board Development Plan.

The Board Development Plan is designed to assist the Board to:

- Develop an effective unitary board;
- Effective challenge;
- Risk management;
- Courageous conversations;
- Performance frameworks and the role of the Board in developing an accountability organisation;
- Developing a culture of continuous improvement to support high quality sustainable services;
- System working and the impact on delivering strategic change.

Assessment – *analysis and considerations of options and risks*

The first stage of the Board Development Plan is to commence a diagnostic of the Board to consider how the Board can work together more effectively.

The Trust Board Development Plan is designed to be flexible to reflect the development needs of the Board and changing environment.

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

The Board of Directors is asked to approve the Board Development Plan.

Who/ which group has approved this report for receipt at the above meeting?		35T
Contributing authors:		Head of Corporate Affairs
Distribution to other people/ groups/ meetings:		
Version	Name/ group/ meeting	Date issued
35T	35T	35T

Appendices provided for reference and to give supporting/ contextual information: *Provide only necessary detail, do not embed appendices, provide as separate reports*	
Appendix no.	Appendix title
A	Board Development Plan

Board Evaluation and Development Plan 2018/19

Introduction and purpose

The purpose of NHS Boards is to govern effectively and build public and stakeholder confidence that their health and healthcare is being managed appropriately. To do this requires an effective Board. An effective Board demonstrates leadership by undertaking key roles:

- Formulating strategy;
- Ensuring accountability by holding the organisation to account for the delivery of the strategy and through seeking assurance that systems of control are robust and reliable;
- Shaping a positive culture for the Board and organisation;
- Establish the way the Board works together; and
- Aligning capability across the trust to meet the needs of the local population

Successful Boards continually review effectiveness and identify areas for future development. This development plan will be delivered through scheduled Board seminars and updated as necessary.

An effective development plan should comprise three component parts:

- A Board effectiveness review – assessing whether the Board is effective, identifying strengths together with any areas for development and putting an action plan in place to address them. This process will be undertaken annually;
- Individual director review via the annual formal objective setting and appraisal process;
- Board training and development needs – addressing identified areas for improvement, building Board knowledge, skills, behaviours and confidence both as a unitive Board and as individual directors.

Context

During August 2018, the Board of Directors agreed the key elements of the Board Development Plan for the following 12 to 18 months. The priorities are based on a number of components:

- The changing landscape of the wider NHS and the external environment within which the Trust is operating;
- Partnership working within the health and care social system;
- The effectiveness and maturity of the Board;
- The role of the Board in risk management and patient safety;
- Engagement with Governors and external stakeholders;
- Leadership and strategy.

Performance of the Board's committees
Within the terms of reference for all Committees of the Board, there is a requirement for an annual review of committee effectiveness to be undertaken. The output from these reviews will be analysed to ensure all Committees are fit for purpose and are supporting the Board to discharge its statutory duties effectively.

Individual directors
Each member of the Board will continue to agree a set of objectives with the Chair (NEDs and CEO) or Chief Executive (Executive Directors) each year. The Chair's objectives are agreed with the Lead Governor and Senior Independent Director. These objectives are linked explicitly to the Trust's strategic objectives and inform individual directors' appraisals.

Timetable 2018/2019

Month	Activity
March 2018	All Board committees and sub-committees to undertake evaluation of committee effectiveness for 2017/18.
May 2018	Finalise NED appraisals and 6 month reviews. Finalise Executive appraisals and individual development plans.
July - December 2018	Becoming true champions of Quality Improvement.
August - September 2018	Draft Board development plan produced, shared with Board members and approved at September 2018 Board meeting.
January 2019	6 month monitoring report of progress of Board development plan implementation.

Training and development

The Board effectiveness review and individual performance appraisals will inform and be supported by a training and development programme. This programme will contribute to building whole Board and individual directors' knowledge, skills, behaviours and confidence and so their personal effectiveness. It will comprise:

- Mentoring programme provided by Northumberland, Tyne and Wear NHS Foundation Trust to facilitate the Board to become true champions of Quality Improvement;
- Programme of Board seminars to allow the Board to learn together and agree how to apply that learning;
- Attendance at external conferences and seminars to refresh and update skills and knowledge.

Draft Board seminar programme

Month	Topic	Development Objective/ *Well-led objective*	Facilitators
April 2018 Board Seminar	Organisational form for new Models of Care. Delivering efficiency.	*Engagement*	Hill Dickinson Director of Finance
June 2018 Board Seminar	Learning From Deaths. Measurement for Assurance. Adult and Older People's Specialist Mental Health Services Redesign – Risk management & Assurance.	*Learning, continuous improvement and innovation*	Director of Nursing, Therapies and Patient Partnership Medical Director, Compliance, Quality and Assurance Director of Operations
July 2018 Board Meeting	Board member personal development, including one page profile to share with Board members, to reinforce the culture of working together effectively and the dynamics of the Board.	*Leadership*	All
August 2018 Board Seminar	Freedom to Speak Up Board self-assessment Session with the Board and lived experience connectors.	*Engagement* *Culture*	All
September	QI Strategy Update	Best practice	Medical Director, Compliance,

2018 Board Seminar	Key issues: Engagement with Governors and external stakeholders Strategy including the expected outcomes and the Board behaviours required to achieve the required outcomes.	*Engagement*	Quality and Assurance & Head of Quality Assurance and Improvement Northumberland, Tyne and Wear NHS Foundation Trust.
October 2018 Board Seminar	Diagnostic of Board including psychometric tools. Board Seminar with Northumberland, Tyne and Wear NHS Foundation Trust (NTW) on 18 October. Review of Board NTW seminar and identification of focus areas for executive coaching and mentoring of the Board.	*Leadership* *Vision and Strategy* *Culture*	All Northumberland, Tyne and Wear NHS Foundation Trust.
November 2018 Board Meeting	CQC Inspection Inspection results and action planning. Feedback of Board Diagnostic.	*Governance* *Leadership* *Vision and Strategy* *Culture*	All
December 2018 Board Seminar	Integrated Care Partnership Presentation (TBC) The NHS policy landscape and partnership working. Risk Management Risk management workshop facilitated by Mersey Internal Audit Agency (MIAA).	Governance Leadership Vision and Strategy Culture Best practice risk management and assurance. *Management of risks, issues and performance*	Integrated Care Partnership Presentation Mersey Internal Audit Agency (MIAA)
January 2019 Board Meeting	Effective board level evaluation and review of Board development plan. Board to Board session with Northumberland, Tyne and Wear	Effective meetings	All

	NHS Foundation Trust (date to be arranged).		
February 2019 Board Seminar	Board Away Day to focus on: Board Committee and Sub-committee evaluation. Review of the Integrated Governance Framework, to establish if the sub-committees are effective to demonstrate the Board effectively delegates and is working optimally. Organisational development – leadership and values. NED to Executive Director Session - Building an effective team: • System Leadership • Challenging Conversations • Role of NEDs to hold Directors to account, contribute, influence and use of expertise.	*Governance* Transparent and consistent governance processes across the organisation *Leadership* *Vision and Strategy* *Information management,* *Culture,* *Learning, continuous improvement and innovation*	External facilitator to be confirmed
March 2019 Board Meeting	Review of effectiveness and update of Board Development Plan.	*Learning, continuous improvement and innovation*	All
April 2019 Board Seminar	Proposed external seminar facilitated by NHS Providers or NHS Leadership Academy. Safeguarding & Learning From Deaths.	*Learning, continuous improvement and innovation*	TBC Director of Nursing, Therapies and Patient Partnership
May 2019 Board Meeting	Wider NHS Presentation – Integrated Care Partnership The NHS Policy landscape.	*Learning, continuous improvement and innovation*	Integrated Care Partnership
June 2019 Board Seminar	Delivering Value.	*Learning, continuous improvement and innovation*	Director of Finance
August 2019	Freedom to Speak Up Board self-assessment Session with the Board and lived experience connectors.	*Engagement* *Culture*	All

STANDARDISED REPORT COMMUNICATION

REPORT DETAILS

Report subject:	Strategic Risk Register – update report
Agenda ref. no:	18.19.70
Report to (meeting):	Board of Directors
Action required:	Discussion and Approval
Date of meeting:	28/09/2018
Presented by:	Dr Anushta Sivananthan, Medical Director (Executive Lead for Quality)

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

REPORT BRIEFING

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

To apprise the Board of Directors of the current status of the strategic risk register to inform discussion of the current risks to the delivery of the organisational strategic objectives, and as per the requirements outlined within the Trust's integrated governance framework. The report indicates progress against the mitigating actions identified against the Trust's strategic risks and the controls and assurances in place that act as mitigations against each strategic risk.

As at September 2018, the Trust has 11 strategic risks – 2 red and 9 amber rated. There is 1 risk currently in-scope (amber).

This number and significance level of the risks (as per the corporate assurance framework heat map) is indicative that the Trust's capacity to handle risk is sound.

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

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

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

Assessment – *analysis and considerations of options and risks*

New risks/ risks in-scope

There are three new risks (that were previously in-scope) and one continuing risk in-scope.

Risk 10 – *Due to pressures on acute care bed capacity, there is a risk that people who require admission may have to wait longer than 4 hours for a bed to be allocated.* Pressures are monitored on a daily basis by the Bed Management Hub to ensure the best use of capacity available. Sleeping out is only utilised during a peak in demand, with safeguards in place to ensure patient safety. An incident report is completed each time this event occurs.

Risk 7 – *Potential clinical, operational and financial risks associated with services being delivered to or by CWP for which there is no assurance of adequate documentary contractual documentation being in place.* Risk treatment has commenced between Effective Services, Estates, Finance, IT and Procurement to devise a single contract repository. Processes are currently being established to ensure the effective review and monitoring of this mitigation work.

Risk 9 – *Risk of harm due to deficits in familiarity with and staff capability in applying safety critical policies and frameworks.* The current policy management framework is under review to align policies to pathways. The work of the Clinical Practice & Standards Sub Committee is overseeing a plan of work to ensure clinical practice policies and frameworks are impact assessed to ensure responsive education and training needs analyses to support staff with the guidance, skills and confidence in delivering their clinical practice. Further, assurance and quality improvement processes associated with policies are being developed, aligned to the Trust's safety management system.

Supervision compliance rates are below Trust target of 85% and show varying levels of compliance across clinical and non clinical staff groups. This potential risk remains in-scope; a rapid improvement exercise is planned to ensure accurate capture of supervision and to build capacity to enable supervision compliance.

Amended risk scores

Risk 3 – *Risk of cyber-attack resulting in loss of access to key systems and/ or data files with possible impacts on healthcare delivery, financial penalties and reputational damage*. Software is being implemented to monitor against threats 24/7 and infrastructure is being updated with an estimated completion date of the end of 2018. The current risk score has been reduced to 10, which is the target risk score. The September 2018 meeting of the Quality Committee agreed to monitor this for sustainability ahead of considering its archive; this will be re-considered at the next meeting in November 2018.

Risk 4 – *Potential for ineffective control and management of risks and inattention on business as usual associated with the transition to the Trust's clinician-led operational (Care Group) structure as part of CWP Forward View strategy*. Discussions with Care Groups have commenced to develop meaningful dashboards for presentation at the November 2018 Operational Committee. The risk score has reduced from 12 to 8.

Risk 5 – *Risk of not achieving safeguarding contractual obligations and subsequent reputational impact, due to increased inspectoratory burden and acute increase in the volume of multiagency case reviews.* Enhanced cover, staff development and a full review of the service is being undertaken. Risk tracking since December 2017 indicates no significant consequences to-date, therefore the consequence score has been reduced; the overall risk score is now 9.

Other notable matters

The Safe Services clinical support team is working with MIAA to provide bespoke risk management workshops for Care Groups to strengthen understanding of our revised integrated governance framework and risk management. The workshops will support staff to work collaboratively to identify risks and mitigate their impact, and include critical appraisal of risk registers and reference against compliance-based feedback from external reviews, e.g. PLACE, CQC etc.

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

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

Who/ which group has approved this report for receipt at the above meeting?	Quality Committee – business cycle requirement
Contributing authors:	D Wood, G Caprio, S Christopher

Distribution to other people/ groups/ meetings:

Version	**Name/ group/ meeting**	**Date issued**
1	Quality Committee	21/09/2018

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

Appendix no.	Appendix title
36T	Strategic Risk Register

Report subject:	Learning from Experience report – trimester 1 2018/19 (incorporating an update on the national Learning from Deaths framework)
Agenda ref. no:	18.19.71
Report to (meeting):	Board of Directors
Action required:	Discussion and approval
Date of meeting:	28 September 2018
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 and deliver the Trust's services, and other relevant sources of learning, covering the period from April 2018 to July 2018, trimester 1 of 2018/19. 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 uses 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. The use of SPC will be reflected more in future reports to the Board of Directors.

2. Background – Key performance indicators

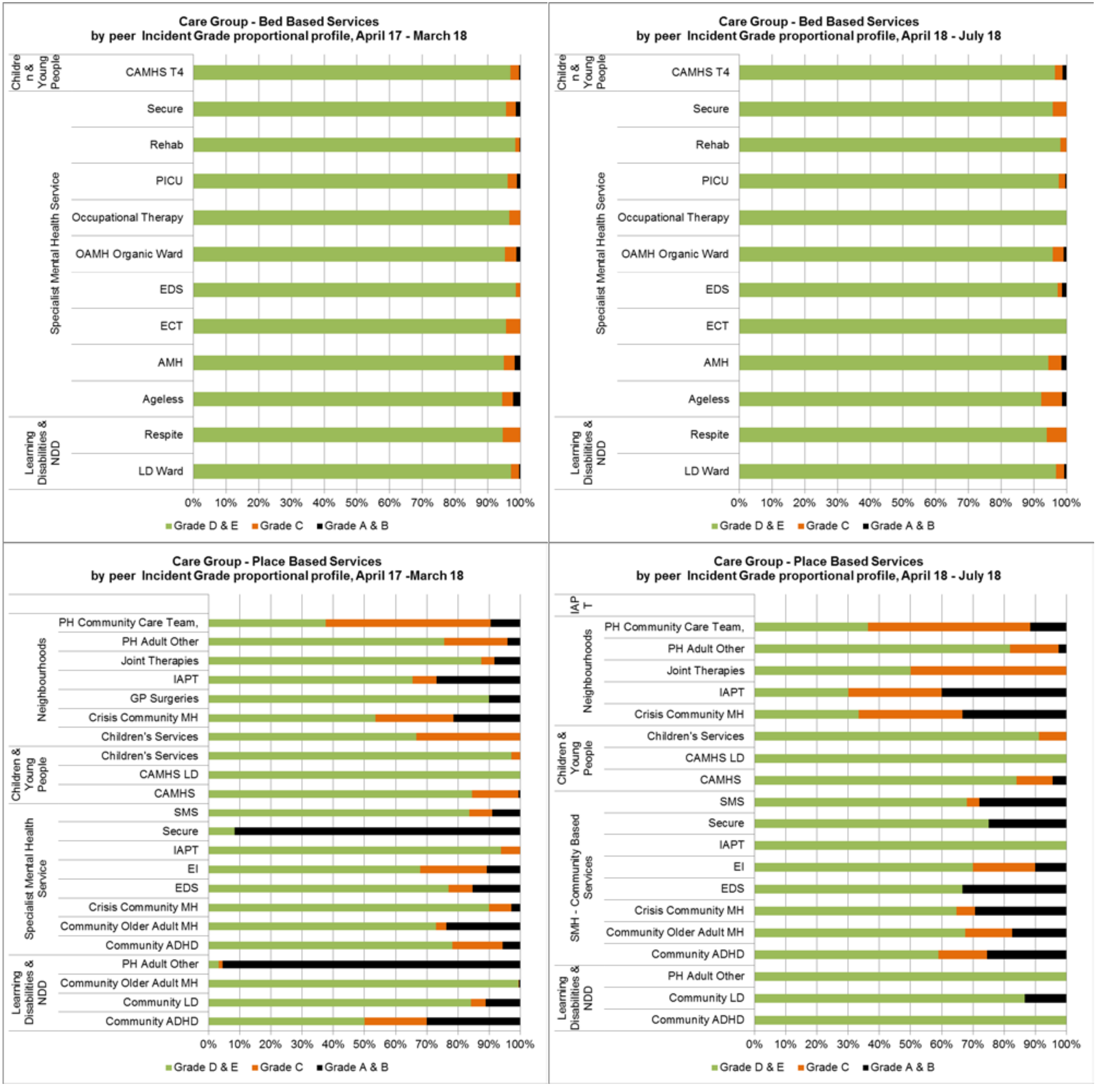
2.1 Performance indicators

Performance indicator			2017/18 T1	2017/18 T2	2017/18 T3	2018/19 T1	RAG rating
Number of safety incidents reported			**3236**	**3348**	**3007**	**3370**	
Number of safety incidents by speciality	*Inpatient*		*2237*	*2372*	*2030*	***2317***	
	Community physical health		*570*	*536*	*517*	***572***	
	Community mental health		*395*	*399*	*411*	***424***	
	Other		*34*	*41*	*49*	***57***	
Reports to external agencies	**StEIS**		33	54	52	**37**	
	National Reporting & Learning System		1614	1758	1428	**1469**	
	NHSR	Non clinical	0	4	4	**2**	
		Clinical	1	2	1	**0**	
	NHS Protect						
	Staff assaults		288	303	290	**455**	
	Missing patient		112	158	108	**117**	
	Suspected theft		3	9	4	**3**	
	Damage to property		20	15	35	**11**	
	Lost or missing items		58	56	47	**39**	
Number of complaints			48	49	73	**79**	
Number of compliments			822	1203	957	**1067**	

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.

2.2 Proportional reporting performance indicators – Incident reporting

The charts below show a proportional split of incident grade per Care Group and service peer group[1]. 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 potential mitigate future actual or significant harm incidents. The charts can further inform potential opportunities for both Service Improvement and Quality Improvement activity.



3. Analysis

3.1.1 Incident reporting

Analysis of the last four trimesters of incident reports shows an increase in reporting, with the current period, positively, reporting the highest number of incidents over the four trimester period. Each service area has contributed to the increase and further, of greater significance, is that the number of externally reportable serious incidents has decreased, therefore it is the lower and no

[1] Service Peer Groups are a tier mechanism to group together teams that provide similar services. The development has been shared with the Learning from Experience Group meetings that they support and are published in each of the ward and community LDPs. They are aligned to the organisational redesign to Care Group structures.

harm incidents that have increased, demonstrating patient safety is a high priority and that we have the capability to learn from experience.

There has been a 29% reduction in the number of serious incidents reported to StEIS this trimester. The top five ranked incident categories are self-harm (1); violence (2); estates and facilities (3); pressure ulcers (4); verbal abuse (5). Each rank has remained the same position as trimester 3 2017/18, with the exception of falls ranked third has moved to the sixth position in trimester 1 2018/19, representing the success of continuous quality improvement work.

Organisation Patient Safety Incident Reports for the providers of the NHS in England was published by *NHS Improvement* in March 2018. CWP have reported 2365 patient safety incidents to the *National Reporting & Learning System* (*NRLS*) that occurred between April 2017 and September 2017 (this is the most recently published data – the next data set is due to be published in October 2018). The report showed that CWP continues to rank 24th for reporting of incidents when benchmarked against 54 other mental health trusts across the NHS in England. CWP are in the upper middle range of reporters, demonstrating a good reporting culture in providing safe services and improving care and quality. The report indicated that CWP reports 20% more self-harm related incidents compared to other mental health trusts, which is a priority area for Quality Improvement that has been identified as part of the developing Quality Account for this year. Since the period of the *NRLS* report however, the number of self-harm incidents last trimester reduced by 30% and this trimester is at typical levels. This represents a good starting point for the said planned quality improvement work in this area.

The incidents team have worked with Education CWP and launched a training programme, available to all staff via ESR, to support staff who report and approve incidents to improve the efficiency and effectiveness of the training offer and to enable ease of incident reporting. This is in direct response to common themes emerging from the outputs of the Trust's safety management system, specifically the patient safety improvement reviews undertaken with individual teams. Suggested changes to the incident form on Datix are in testing mode and envisaged to be launched in trimester 2 2018/19.

3.1.2 Learning from deaths – mortality monitoring and engaging with bereaved families and carers

To help CWP to deliver national guidance associated with learning from deaths, as part of the Quality Account, the Trustwide patient experience priority for 2018/19 is 'Improvement in engagement with bereaved families and carers'. In July 2018, the *National Quality Board* published the first edition of the Learning from deaths: Guidance for NHS trusts on working with bereaved families and carers to help NHS trusts to further develop guidance for bereaved families and carers regarding what local support they can expect when concerns are raised related to the death of their loved one.

Further to a workshop in April 2018 for family liaison officers. working in partnership with 'making families count', a poster was developed: 'top ten tips for family engagement'. The poster has been celebrated on the CWP twitter and the internal CWP facebook page. It has also been shared with colleagues across the Cheshire and Merseyside footprint with recognition from NHS England's patient safety and quality forum as good practice.

Promotional communications for clinical teams were launched in August 2018 to support multi-disciplinary teams in completing a case record review form, which is a national requirement from April 2018. The case record review form is available on CAREnotes and EMIS. Teams using PCMIS are using a paper form until it is available. This approach will help staff to:

- Reflect as a team
- Review the care provided
- Review and raise care and service delivery problems
- Consider feedback from families and carers
- Plan the next steps to help
- Improve people's experience of care

To identify all deaths and therefore to increase the number of case record reviews that CWP can complete to identify learning, the Trust has devised a mortality comparison report from the national list of deceased persons held by NHS Digital. The report compares the list to the information held on the CWP clinical care record to identify people who have died while accessing our care, including people discharged from our care within six months of their death. The report is updated in retrospect of a person's death, thus increasing the scope and number of deaths to review further. From August 2018, the former mortality task and finish group, chaired by the Director of Nursing, Therapies & Patient Partnership, became the mortality monitoring group with Care Group and corporate representation, who plan to meet a minimum of three times a year. Risks, learning and good practice will be shared with the relevant committees. An action was agreed for the information team to work with clinical services to enable an automated alert to team managers when a person who has accessed their services during the time parameters referred to above, further ensuring the scope of deaths we are able to learn from is as many as possible.

Mortality monitoring	2017/18 – 2018/19	
	T3	T1
Inpatient deaths (including deaths 30 days after discharge)/ subject to a case record review	0/ 100%	**1/ *100%**
Deaths reported by and to the Trust (including inpatient deaths)/ subject to a case review record	558/ 18%	**352/ 35%**
Deaths reported as a serious incident/ subject to a serious incident investigation	**25/ 100%****	**17/ 100%****

*The % reflects the case record reviews undertaken by teams subject to a pilot of the new mortality review process. From Q1 2018/19, the aim is to implement the new mortality review process Trustwide, when the target will be 100%.

**For deaths meeting NHS England criteria as a serious incident, investigatory performance is 100%.

During this trimester, n.124 case record reviews have been undertaken, none of which has led to further investigation. A clinical audit programme is in place and the second audit is due to be completed in August 2018 for case record reviews completed in trimester 1 2018/19. There is a 5% quality control process in place for reviewing case record reviews that judged as there having been no problems in care. The audit will be monitored by the mortality monitoring group who are next due to meet in November 2018; findings will be analysed and shared in the trimester 2 2018/19 learning from experience report. The data relating to learning from deaths is available on the Board dashboard; it is published every two months with the agenda for the meeting of the Board in public. Further work has been undertaken during trimester 1 2018/19 to design a bespoke learning from deaths webpage. The webpage has now been implemented and provides bereaved families and carers with information on how to access bereavement support services. It provides information as to what people can expect to happen when a person who access CWP services dies. The accessibility of the aforementioned mortality monitoring data has also been improved – the webpage has been designed to display the data for people to view easily.

3.2 Estates and facilities incidents

An increase in estates and facilities incidents [*T3, 2017/18 n.136* and *T1, 2018/19 n.199*] is noted in relation to the number of people found with access to an ignition source, although this number of reports continues to remain lower than the first two trimesters within the reporting period [*T1, 2017/18 n.331* and *T2, 2017/18 n.261*]. The Nicotine Replacement Therapy group continues to promote the reporting of incidents to identify learning and to increase safety by using effective approaches that mitigate unwarranted risks. The group has met to review the ignition source categories reported on Datix, subsequent changes will be made in trimester 2 2018/19 to enable targeted activity to further promote mitigation of any unwarranted risks.

3.3 Falls incidents

There has been a Trustwide decrease in the reported number of falls this trimester from 299 to 210, of which 96% of incidents resulted in either low or no harm. Quality Improvement work is continuing (in both inpatient and community settings) in line with the Trust's Quality Improvement work.

3.4 Incidents associated with the management of behaviour that challenges

Following the restraint reduction 90-day quality improvement project in 2017, three priority areas for further work have been identified. These are: to improve reporting and data quality of restraint episodes; capturing the experience of people who have been restrained; and developing more effective clinical education and training. A Quality Improvement project is in progress, with multi-disciplinary involvement, and is being led by the Clinical Champion for Quality Improvement and the Associate Director of Safe Services. The current specific Quality Improvement work is focussing on people who experience multiple prone position restraint incidents, with reviews of these incidents taking place as part of the 'improving reporting, data analysis and data quality workstream'. These reviews involve the in-depth review of multiple prone position restraint incidences and they are being undertaken in collaboration with the wards in order to understand any issues and themes where these occur. The findings are due to be presented to the November 2018 Quality Committee. An Expert Clinical Panel will also be convened in quarter 3 of 2018/19 and will be responsible for advising on the development of the care pathway for managing behaviour that challenges to promote further opportunities for enhancing the current structured, multi-disciplinary approach, and to nurture a positive and therapeutic culture underpinned by the Trust's person-centred approach.

3.5 Feedback from people who access the Trust's services

During this trimester, the Trust received 79 complaints under the NHS complaints procedure. Of these, they were received per Care Group as follows: SMH (community-based) *n.33* complaints, SMH (bed-based) *n.19,* Neighbourhoods *n.12* complaints, CYP & Families *n.11* complaints, LD, NDD & ABI *n. 3* complaints, Corporate Support Services *n.0*. The 'communication/ information' category associated as a theme continues to be the highest ranked theme the past two trimesters. The complaints team have been working with services to gather feedback in order to make

improvements to the way we capture compliments; this trimester, there has been an increase in the number of compliments recorded, from 957 to 1067.

3.6 Learning from external reviews and investigations
As well as learning from our own experience, the Trust welcomes the opportunity to learn from reviews and investigations undertaken externally to the Trust. There were five such reports discussed within the in-depth Learning from Experience report received by the Quality Committee. Recommendations have been identified to review these for the purpose of implementing lessons learned as they apply to CWP, and to support ward to Board assurance. This includes learning from lessons identified in reviews and investigations commissioned or conducted by NHS Resolution, the Care Quality Commission, NHS England, the Betsi Cadwaladr University Health Board and the Healthcare Safety Investigation Branch. The summary of recommendations identified in 4.1 describes the next steps identified to enable CWP to identify and implement transferable learning.

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 report to the Board of Directors.

4.1 All appraisers should add to their oversight that all relevant staff have completed the mandatory and role specific e-learning related to insulin.

4.2 The Safe Services Department should facilitate the establishment of a task and finish group to theme learning identified within currently relevant externally produced investigation reports from NHS Resolution, the Care Quality Commission, NHS England and the Betsi Cadwaladr University Health Board and undertake a gap analysis of current CWP service provision. Where transferable learning is identified, this should be taken forward as quality improvement work with the relevant locality and/ or experience meetings – with an exception report provided in subsequent and ongoing (for future external investigation reports) Trustwide Learning from Experience reports for ward to Board assurance to Quality Committee and the Board of Directors.

4.3 The Head of Clinical Governance and Head of Quality Assurance & Improvement to work with Strategic Clinical Directors, as part of the review of the Green Light Toolkit 'Better Audit' to identify any recommendations for CWP, as contained in the Healthcare Safety Investigation Branch investigation into the transition from child and adolescent mental health services to adult mental health services, to feed into the Care Group governance and effectiveness meetings. This will inform quality improvement work in relation to:

1. Clinical and pathway variation.
2. Effectiveness of transition arrangements including planning.
3. Risk assessment and care planning (including CPA).
4. Person-centredness (this was lacking in this reference case).

In addition, to strengthen 'ward to Board assurance', the Quality Committee has agreed to a new approach of seeking assurance of learning from experience, 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 local 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?		Avril Devaney, Director of Nursing, Therapies & Patient Partnership
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	21/09/2018

Appendices provided for reference and to give supporting/ contextual information:	
Appendix number	Appendix title
1	Updates and assurances received against trimester 3 2017/18 recommendations

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

The Safe Services Department should develop, by May 2018, an accessible learning from deaths web page to (a) publish the nationally required mortality monitoring data, and (b) provide information to describe the support that bereaved families can access.
See section 3.1.2.
Head of Clinical Governance to allocate investigation managers to the 16 outstanding investigations to ensure that CWP contributes to the national LeDeR programme.
NHS England's North Regional LeDeR coordinator provided further LeDeR training to CWP staff in April 2018; there are currently six new reviews underway. These investigations are under review and CWP are working closely with NHS England to keep them updated on progress.
Further analysis to be undertaken by the Safe Services Department and the Care Groups to streamline complaints categories to ensure they capture the best description of the actual theme to enable the identification of better learning from experience.
The Complaints Team has an ongoing project to improve people's experience of complaint investigations, ensuring lessons learnt are embedded into practice. The trigger form for new complaints that are received has been developed and the team is working closely with the Care Groups to allocate investigation managers and in choosing suitable categories for complaints. The investigation report has also been developed to be a simpler document with the focus on the improvement plan.
The Complaints Team should review the complaints received by the Trust over the 2017/18 year to assess whether the themes that highlighted in the PHSO report are similar to those in the report and where they are, the national learning should be shared. A report should be presented to each of the local governance/ learning from experience meetings in July 2018 to help to identify quality improvement plans.
Complaints data for 2017/18 has been reviewed against the findings highlighted as themes in the 2017/18 PHSO annual report. Overall the 'communication' and 'treatment or care plan' theme were ranked within the same position. The other areas act as a good benchmark for suggesting areas for improvement for CWP or where CWP is better at local resolution. A report has been developed for presentation at the local governance/ learning from experience meetings to consider this.

STANDARDISED REPORT COMMUNICATION

REPORT DETAILS

Report subject:	Annual Report Equality and Diversity Activity Annual Report 2017-18
Agenda ref. no:	18.19.72
Report to (meeting):	Board of Directors
Action required:	Information and noting
Date of meeting:	26/09/2018
Presented by:	Avril Devaney Director of Nursing, Therapies and Partnerships

Which strategic objectives this report provides information about:	
Deliver high quality, integrated and innovative services that improve outcomes	Yes
Ensure meaningful involvement of service users, carers, staff and the wider community	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 SBAR provides a brief prelude to the detailed report of activity of equality and diversity in the organisation. Following submission to the Board there is a requirement that this information is made publically available on the Trust website. The report is detailed and includes a number of appendices:

- Equality Delivery Standard 2 (EDS2) Appendix 1
- Workforce Race Equality Standard (WRES) Appendix 2
- Staff Equality Monitoring Report 2017-18 Appendix 3
- CWP Interpretation and Translation Report 2017-18: Appendix 4
- CWP Equality & Diversity 4 Year Objective Action Plan 2016-2020 Appendix 5
- CWP Personal Fair and Diverse Commitment 2016-2020 Appendix 6

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

This report provides the Board with information in relation to the activity that the organisation has taken in regard to equality and diversity in the last year. There is a requirement that this document is publically available on the CWP public website following submission to the Board.

Assessment – *analysis and considerations of options and risks*

The report and appendices provide detail on activities undertaken, the challenges for 2018-2019 are identified as:

- EDS2 evidence needs to be more specific on how services are provided to all members of the diverse communities. A decision has to be made regarding EDS2 assessments being locality based or service groups based.

- Changes to Carenotes in relation to gathering information on gender, example 'asking if you are male or female' it had been highlighted by our partners in the LGBT community that some people don't see themselves a male or female hence the reason for asking for an option of other/ prefer not to say.

- Introduction of the Workforce Disability Equality Standard (WDES) in late 2018- the NHS staff survey (2017) highlights CWP staff with a disability responses to non- disabled staff and these need addressing for staff with a disability, the setting up of the CWP Disabled Staff Network should assist in addressing the points highlighted in the report.

- Workforce Race Equality Standard (WRES) the 2018 report has highlighted the positive improvements in BME staff not entering the disciplinary process compared to 2016-17 the Trust will continue to monitor BME staff entering the disciplinary process as an action in the WRES action plan.

- Accessible Information Standard (AIS) the Trust will continue to raise the profile of the AIS to staff and monitor developments and progress against the standards although the CWP IT systems need upgrading in order to achieve improvements in the collection of data.

- The development of staff networks for BME LGBT Disability Woman and Staff who have been Adopted, the challenge relates to the Trusts geographical footprint and how staff can be actively involved in the networks.

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

The Board of Directors are asked to note the following:

- Regarding the responses to point three of the WRES Report: Relative likelihood of BME staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation. The increase was recognised, an action plan implemented and there has been a significant reduction in BME entering the disciplinary process.
- 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 have been completed by the Healthwatch. A process for collecting evidence for the EDS2 assessments for 2018-19 has been agreed and the updates will be presented to the Healthwatch at stages throughout the year, and the Trusts progress with be updated to the Trust wide Equality and Diversity Group.
- 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 and updates will be provided to the various CWP committees.

Who/ which group has approved this report for receipt at the above meeting?		Avril Devaney, Director of Nursing, therapies and Partnerships and Cathy Walsh, Associate Director of Patient and Carer Experience (interim)
Contributing authors:		Robert Davies E&D Officer
Distribution to other people/ groups/ meetings:		
Version	Name/ group/ meeting	Date issued
Version 2	Equality and Diversity Group	25 September 2018
Version 2	Board of Directors	26 September 2018
Version 2	PODsc	17 September 2018

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	Annual Report Equality and Diversity Activity report 2017-18

Report to:	**Board of Directors (Trust Board)**
Date of Meeting:	26th September 2018
Title of Report:	**Annual report** Equality and Diversity Activity Report 2017-18
Action sought:	For Noting
Author:	Robert Davies Equality and Diversity Co-ordinator
Authorised by:	Cathy Walsh Associate Director of Patient and Carer Experience
Presented by	Avril Devaney, Director of Nursing Therapies and Patient Partnerships

Strategic Objectives that this report covers:

- **SO1 Deliver improved and innovative services that achieve excellence.**
- **SO2 Ensure meaningful involvement of service users, carers, staff and the wider public.**
- **SO3 Be a model employer and have a competent and motivated workforce.**
- **SO5 Performance Manage all services using an evidence based approach within a Risk**
- **Management Framework.**
- **SO6 Improve quality of information to improve service delivery and longer term planning.**
- **SO8 Develop Trust's brand value**

Distribution

Version	Name(s)/Group(s)	Date Issued
2	Trust wide Equality & Diversity Group	25th September 2018
1 & 2	POD SC	17th September 2018
2	Trust Board	26th September 2018

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

Person Centred Framework

CWP's person-centred approach is about connecting with people as unique individuals with their own strengths, abilities, needs and goals. The eight overarching principles celebrate and support us and shares how we relate to the people who access our services as well as how we relate to each other as colleagues.

It is important for the Trust to know what matters to each person we meet. CWP will be adaptable in our approach, working in partnership to provide care, which, as far as possible, takes into account each person's preferences

NHS England Diversity and Inclusion Partners Programme

CWP were successful with their application to be chosen to be part of the NHS England 2017/18 diversity and inclusion partners' programme. The programme supports participating trusts to progress and develop their equality performance over a period of 12 months, and is closely aligned to the Equality Delivery System(EDS2).

The focus of the programme was based on four developmental modules that provided trust with detailed strategic policy support and opportunity to undertake personal development. It also provided a forum to share good practice and network with fellow colleagues in the NHS, and other diversity and inclusion subject matter experts.

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 four 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 four 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

Healthwatch for Cheshire East and West were invited to attend the CWP NHS Equality Delivery System 2 assessments, to score the Trust against EDS2 Goals 1 and 2. The events took place at CWP Redesmere Trust Board base in Chester in May 2018. The assessment was designed to allow key partners such as Healthwatch to undertake and contribute to assessing the performance by CWP in their strategic implementation of the Equality Delivery System 2 (EDS2).

Organisations have also been involved in a number of equality and diversity meetings throughout the year across the trust. The various meetings and visits by CWP provided the trust with the opportunity to update the groups on the trusts work in the area of equality and diversity and provided the various groups the opportunity to inform CWP of their achievements and work in the local communities.

Stakeholders - Partners CWP had worked with throughout the year:

Wirral	Cheshire West	Cheshire East
• Wirral Cultural Network • Wirral Change • Wirral Older People's Parliament • Mencap • Wirral Royal Society for the Blind • Age UK	• Deafness Support Network, • Cheshire Halton and Warrington Race Equality Centre, • Body Positive. • Healthwatch Cheshire West	• Body Positive Healthwatch Cheshire East • Cheshire East Multi Cultural Forum • Motherswell • Deafness Support Network

The EDS2 assessment provided opportunities for Healthwatch to ask questions of CWP staff. CWP provided evidence produced by respective services against the EDS2 goals. The Healthwatch representatives then rated and scored the CWP Trust performance against the EDS2 rating scale.

The EDS2 assessment for Goals 3 and 4' was completed by staff side representatives the Trust equality and diversity co-ordinator presented the information at the staffside meeting which consist of all staffside partners i.e. Royal Collage of Nursing (RCN) UNITE and UNISON the Trust scored 'Achieving' for both goals.

EDS2 partners' assessment grades for goals 1 and 2 with comparison between 2016-2017 and 2017-18

The information below highlights the difference in the assessment scoring for each goal and outcomes between last year 2016-17 and this year 2017-18.

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

Outcome grades for:: Goal 1 **1. 'Better health outcomes for all'** **CWP Trustwide:**	**Trustwide**	
	2016-17	**2017-18**
EDS2 Outcome 1.1 Services are commissioned, procured, designed and delivered to meet the health needs of local communities	**Achieving**	**Achieving**
EDS2 Outcome 1.2 Individual people's health needs are assessed and met in appropriate and effective ways	**Achieving**	**Achieving**
EDS2 Outcome 1.3 Transitions from one service to another, for people on care pathways, are made smoothly with everyone well-informed	**Achieving**	**Achieving**
EDS2 Outcome 1.4 When people use NHS services their safety is prioritised and they are free from mistakes, mistreatment and abuse	**Achieving**	**Achieving**
EDS2 Outcome 1.5 Screening, vaccination and other health promotion services reach and benefit all local communities	**Achieving**	**Achieving**

Outcome grades for:: Goal 2 **2. 'Improved patient access and experience'** **CWP Trustwide:**	**Trustwide**	
	2016-17	**2017-18**
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	**Achieving**	**Developing** **Additional evidence being provided for Achieving**

EDS2 Outcome 2.2 People are informed and supported to be as involved as they wish to be in decisions about their care	**Achieving**	**Achieving**
EDS2 Outcome 2.3 People report positive experiences of the NHS	**Achieving**	**Achieving**
EDS2 Outcome 2.4 People's complaints about services are handled respectfully and efficiently	**Achieving**	**Achieving**

Equality Delivery System 2 Goal 3:	
Goal 3. 'Empowered, engaged and well-supported staff'	**Verified by: Staffside Reps Unison Unite and RCN: March 2018**
CWP Trustwide	**2016-17 and 2017-18** **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	**2016-17 and 2017-18** **Received the same assessment score**

EDS2 Outcome	Grade
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 some business plans completed by the clinical service units to improve services to people accessing services 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 how we provide 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.

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 on the percentage difference between organisations' Board voting membership and its overall workforce.

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 2017 NHS Staff Survey was completed by 1683 staff, which is a response rate of 53%, which is above average (45%) for combined mental health / learning disability trust in England. It compares with a response rate in the Trust in 2016 of (47%) in 2016 staff highlighted their ethnic background as white 97% and BME 3% in 2017 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 a significant decrease in BME staff entering the formal disciplinary route in 2017-18 compared to 2016-17, and BME staff entering the disciplinary process has returned to the 2015-16 figure of 1 BME staff member.

	Entering Formal Disciplinary Process		**Headcount**		**Relative likelihood of staff entering the Disciplinary process**	
	2016-17	**2017-18**	**2016-17**	**2017-18**	**2016-17**	**2017-18**
White	53	29	3224	3272	1.64%	0.89%
BME	4	1	126	139	3.17%	0.72%
Not Stated	1	0	1	77		
2016-17	Relative likelihood of BME staff entering the formal Disciplinary Process compared to white staff				1.93 Times more likely	
2017-18					0.81	

The organisation recognised the increase of BME staff entering the formal disciplinary process. The Trust included this issue within the action plan for improvement. Data analysis was completed to understand the cause of the increase and to breakdown the information into locality service lines, reasons and possible themes. Disciplinary cases involving BME staff members were examined to look for common themes/issues.

The subject of ethnicity was also built into HR team meetings to ensure that this subject was raised and explored. The 2017-18 WRES results have seen a significant improvement in the 2016-17 WRES data. In addition, opportunities to set up a focus group for BME staff to get a better understanding of BME issues in the workplace and how best to implement these have been debated and examined and these have been advertised widely across the organisation.

NHS Staff survey: there are four questions regarding the NHS staff survey and responses are highlighted below comparing 2016-17 results to the 2017-18 results

	Indicator	**Data for reporting year 2017**	**Data for previous year 2016**
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 months has seen the figures for white staff stay the same and increase by **6%** for BME staff.	White staff: **24%** BME staff: **42%** **Average (median) for combined MH/LD and Community Trusts** White staff– **25%** BME staff- **28%**	White staff: **24%** BME staff: **34%**

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 an increase of **1%** for white staff and **2%** for BME staff.	White staff: **17%** BME staff: **17%** **Average (median) for combined MH/LD and Community Trusts** White staff– **20%** BME staff- **23**%	White staff: **16%** BME staff: 1**5%**
7	KF 21. Percentage believing that Trust provides equal opportunities for career progression or promotion Experience of white staff has seen a decrease of **1%** and BME staff **7%** believing the Trust provides equal opportunities for career progression.	White staff: 90% BME staff: 90% Average (median) for combined MH/LD and Community Trusts White staff: 88% BME staff: 76%	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%** increase from 2017 and there has been an increase of **5%** from 2017 for BME staff	White staff: **5%** BME staff: **8%** **Average (median) for combined MH/LD and Community Trusts** White staff: **6%** BME staff: **11%**	White staff: **4%** BME staff: **3%**

Workforce Race Equality Standard (WRES) action plan 2017-18

At a NHS England WRES workshop in 2017 the NHS England lead for the WRES at the time 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 consisted 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 is still an area for development although there has been a slight increase in 2017-18. 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 2017-18 data highlighted a significant decrease in BME staff entering the formal disciplinary route compared to 2016-17, and BME staff entering the disciplinary process has returned to the 2015-16 figure of one BME staff member the Trust will monitor data throughout the year and address issues if they arise.

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	**Change to question in 2017-18** Percentage difference between the organisations' Board voting membership and its overall workforce • membership and its overall workforce disaggregated by voting membership of the board • By executive membership of the board **2017-18** 14 Board members: 1 BME and 12 White 1 not stated **2016-17** 14 Board members: 1 BME and 13 White	Percentage difference between the organisations' Board voting membership and its overall workforce 3.16% 2017-18 Board Member- Overall W/F White 85.71% 93.81% BME 7.14% 3.98% Not Stated 7.14% 2.20%	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%**

Data: Appendix 3

CWPs workforce for April 2017–March 2018 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 3% 2016-17 to 4% in 2017-18. 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 2018 CWP employed 3489 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 do not 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 Browse Aloud 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 five 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
- Provide opportunities for staff to be involved in the setting up of staff network groups for BME LGBT, Woman Adopted Staff and staff with a disability or long term medical condition

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, 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 2017-18 Appendix 3
- CWP Interpretation and Translation Report 2017-18: 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 2018-19

Challenges identified 2018/19

- EDS2 evidence needs to be more specific on how services are provided to all members of the diverse communities. A decision has to be made regarding EDS2 assessments being locality based or service groups based
- Changes to Carenotes in relation to gathering information on gender, example 'asking if you are male or female' it had been highlighted by our partners in the LGBT community that some people don't see themselves a male or female hence the reason for asking for an option of other/ prefer not to say
- Introduction of the Workforce Disability Equality Standard (WDES) in late 2018- the NHS staff survey (2017) highlights CWP staff with a disability responses to non- disabled staff and these need addressing for staff with a disability, the setting up of the CWP Disabled Staff Network should assist in addressing the points highlighted in the report
- Workforce Race Equality Standard (WRES) the 2018 report has highlighted the positive improvements in BME staff not entering the disciplinary process compared to 2016-17 the Trust will continue to monitor BME staff entering the disciplinary process as an action in the WRES action plan.
- Accessible Information Standard (AIS) the Trust will continue to raise the profile of the AIS to staff and monitor developments and progress against the standards although the CWP IT systems need upgrading in order to achieve improvements in the collection of data
- The development of staff networks for BME LGBT Disability Woman and Staff who have been Adopted, the challenge relates to the Trusts geographical footprint and how staff can be actively involved in the networks

Action taken or in progress:

- EDS2 Evidence: worked with Healthwatch and have had guest speakers coming to the Trust to meet the CWP Equality Champions to discuss issues relevant to their specific groups: i.e. Unique: Transgender Organisations, Body Positive: LGBT group Wirral Change Refugees & Asylum Seekers
- To address the issues relating to data collection the Trust have: highlighted certain areas that need to be improved on care notes, the collection of data on sexual orientation.
- The Trust have promoted Stonewalls publication ' What's it got to do with you' this publication highlights reasons for collecting data, this has been promoted on the CWP internet, CWP Essential and will be promoted across the Trust in 2018-19
- Copies have been sent to all 3 Locality Equality leads and Champions and raised at the CWP Equality & Diversity Committees
- Workforce Disability Equality Standard (WDES) begin to prepare for its introduction towards the end of 2018.
- Staff network groups the process of setting up staff network groups for BME Disability Woman and LGBT has begun, a request has been made to set up a group for staff who have been through the adopting process.

The Trust wide equality and diversity group will continue to monitor the actions in response to these challenges.

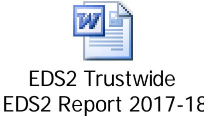
Recommendations, The Board of Directors are asked to note the following:

- Regarding the responses to point three of the WRES Report: Relative likelihood of BME staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation. The increase was recognised, an action plan implemented and there has been a significant reduction in BME entering the disciplinary process.
- 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 have been completed by the Healthwatch and a process for collecting evidence for the EDS2 assessments for 2018-19 has been agreed and the updates will be presented to the Healthwatch at stages throughout the year, and the Trusts progress with be updated to the Trust wide Equality and Diversity Group
- 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 and updates will be provided to the various CWP committees.

Appendix: 1: Workforce Race Equality Standard Report (WRES) 2017-18

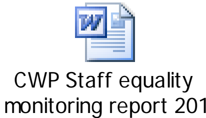
18-19-107 WRES to
Ops Board July 2018 I

Appendix: 2 Equality Delivery System 2 (EDS2) 2017-18



EDS2 Trustwide
EDS2 Report 2017-18

Appendix: 3 CWP Staff Equality Monitoring Report 2017-18



CWP Staff equality
monitoring report 201

Appendix: 4 CWP Translation and Interpretation Report 2017-18

Translation and
Interpretation Report

Appendix: 5 NHS England Accessible Information Standard

Accessible+Informati
on+Standard+poster

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

4 Year Equality Objective Plan 2016-2

E&D poster priorities 2018-19.pdf

STANDARDISED REPORT COMMUNICATION

REPORT DETAILS

Report subject:	Register of Seals
Agenda ref. no:	18.19.73
Report to (meeting):	Board of Directors
Action required:	Discussion and Approval
Date of meeting:	28/09/2018
Presented by:	Tim Welch, Director of Finance

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

The use of the corporate seal formally signifies the Trust's act of entering into the transactions evidenced by the documents to which it is fixed. The Board of Directors is invited to note the Register of Sealing which demonstrates the documents (and the underlying transactions) to which the Trust's corporate seal has been affixed for the period April 2018 – September 2018.

Background – *contextual and background information pertinent to the situation/ purpose of the report*
The use of the corporate seal is regulated by Board of Directors' Standing Orders. In accordance with the NHS Constitution, the affairs of NHS organisations should be managed with excellence and professionalism. Before any building, engineering, property or capital document is sealed it must be approved and signed by the Director of Finance (or an officer nominated by them) and authorised and countersigned by the Chief Executive (or an officer nominated by them who shall not be within the originating division or department). The Chief Executive keeps a register in which they, or the Head of Corporate Affairs as authorised by them enters a record of the sealing of every document.

Assessment – *analysis and considerations of options and risks*
The Sealing Report for the period April 2018 – September 2018 is set out below for review by the Board of Directors. The Register of Sealing is required to be noted by the Board of Directors on an annual basis, following Audit Committee review. The Audit Committee reviewed the register at their meeting held 4 September 2018.

Recommendation – *what action/ recommendation is needed, what needs to happen and by when?*
The Board of Directors is invited to **note** the Register of Sealing.

Who/ which group has approved this report for receipt at the above meeting?		35T
Contributing authors:		Head of Corporate Affairs
Distribution to other people/ groups/ meetings:		
Version	Name/ group/ meeting	Date issued
1	Audit Committee	4 September 2018

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
A	Register of Seals

Register of Seals April 2018 – March 2019

Cheshire & Wirral Partnership NHS Foundation Trust (CWP) *April 2018 – March 2019*			
Entry no.	**Details**	**Value**	**Date of Sealing**
01	Counterpart Licence for Alterations – North West Industrial Estates Limited, CWP & The Oaks Office Park	N/A	22/05/2018
02	Agreement for Lease with Access for Tenants Works - Coronation Road Office, Coronation Road, Ellesmere Port between Chester Council and CWP	N/A	09/08/2018
03	Lease relating to Coronation Road Office, Coronation Road, Ellesmere Port between Chester Council and CWP	N/A	09/08/2018
04	Section 75 Agreement with Wirral Borough Council and CWP for All Age Disability Service	N/A	17/08/2018

CHAIR'S REPORT
OPERATIONAL COMMITTEE - 19th September 2018

The following is a summary of issues discussed and any matters for escalation from the September 2018 meeting of the Operational Committee:

Operational Committee Dashboard
Significant work has taken place to change the reporting from a locality focus to care groups. Additional work remains in some areas to further refine the data. Each care group provided a summary of their performance against the dashboard highlighting areas identified as red. Common areas that require further attention included gatekeeping, staff appraisal compliance, staff absence and use of bank / agency, and recruitment. People services are currently working with care group leads to consider a number of these areas. The Committee noted the reports.

Care Group Risk Registers
Each of the care group risk registers were explored during the meeting, with a particular focus being given to amber and red risks. An update was provided on the read across from the previous locality risk registers to the care group risk registers, including consideration of those risks being considered across care groups. Risks are being mitigated accordingly and monitored locally via appropriate sub-committees. There is also evidence that risks are being escalated appropriately in accordance with the Trust Integrated Governance framework. The Committee noted the registers.

East and Central Redesign
It was reported that the public consultation had now concluded and the findings were published on the 10th September. A decision making business case is in the process of being developed and will be presented to the Governing Bodies as a Committee in Common later in the year (November / December). The CCG's will consider the available options and undertake further analysis. A number of staff briefings have been held to inform staff of the outcome of the consultation process. The continued hard work of staff in this area was acknowledged by the Committee. The Committee noted the up-date.

All Age Disability Services
The transfer of the services took place on 19th August 2018, following approval by Board. The services have been transferred to CWP under a section 75 agreement and a five year contract is now in place. A mobilisation plan has been established to ensure a smooth transition and staff are being supported in their transfer to CWP. Shared access rights to appropriate systems are currently being worked through. During the transition period, the All Age Disability Service will be treated as a separate service before integrating into an appropriate care group. The Committee noted the report.

Medicine Supply Business Case
Further to an earlier report to this Committee a number of possible delivery models have been considered. In conclusion the most cost effective model for CWP would be to outsource these services. During August expressions of interest were invited to test the market. A summary of the findings were presented to the Committee. The Committee endorses the outsourced model to Board and proposes that the tender process now commence.

CWP FT Approvals Panel
Phase one of the approval panels have now taken place. Phase two is due to be held in October. A draft maturity matrix was presented to the Committee. Further consideration will be given to the maturity matrix at Execs later in October. The Committee endorses to Board the use of the proposed maturity matrix for use in the October panels.

Sheena Cumiskey
Chair of Operational Committee / Chief Executive

CHAIR'S REPORT –
QUALITY COMMITTEE
12 SEPTEMBER 2018

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

- **Integrated governance framework**
  The Quality Committee received the integrated governance framework and Trust meetings structure that was approved at the July 2018 meeting of the Board. The framework strengthens and streamlines the Trust's governance arrangements and further, frees up capacity to support the delivery of care and systems working.
  In the spirit of continuous improvement, the effectiveness of the new arrangements will be reviewed after six months, to assure the Board that the improvements made are having a positive impact on managing the burden on the Board agenda, providing assurance, and facilitating an improvement ethos.

- **Strategic risk register – including improving clinical risk assessment and management**
  The Quality Committee received assurance on progress against the mitigating actions identified against the Trust's strategic risks and the controls and assurances in place that act as mitigations against each current strategic risk. As at 12 September 2018, the Trust has 8 strategic risks – 2 red and 6 amber rated. There are 4 risks currently in-scope – 1 red and 3 amber rated. An in-depth review was received against the risks associated with deficits in familiarity with and staff capability in applying safety critical policies and frameworks, specifically clinical risk assessment and management. This previous strategic risk has been re-escalated to the strategic risk register, demonstrating the sensitivity of the Trust's assurance framework. The review was presented by Professor Nathan (Consultant Forensic Psychiatrist) who updated on quality improvement work to-date in exploring the core components to improving risk assessment and management. The Quality Committee agreed to pilot this quality improvement work with an acute ward, where the focus would be on improving clinical decision-making and clinical assessment to achieve gains in improvements to clinical risk assessment. Further, work by the Safe Services Department was outlined in relation to the provision of bespoke risk management workshops for Care Groups to strengthen understanding of CWP's revised integrated governance framework and the risk management process. The workshops will support staff to work collaboratively to identify risks and mitigate their impact, and will include critical appraisal of risk registers, including 'check and challenge', and cross reference against compliance-based feedback from external reviews, e.g. PLACE, CQC etc.
  The Quality Committee approved the amendments made to the strategic risk register for update of the corporate assurance framework to the Board.

- **Quality Improvement strategy**
  An update was provided on progress in implementing phase one of the Quality Improvement strategy. Task and finish groups are continuing to meet to progress the year one deliverables of each of the four elements of the strategy. The Quality Improvement Faculty also continues to meet to ensure that the Trustwide infrastructure supports a Quality Improvement environment for all staff to operate within. An in-depth progress update of element one (strategic support from the Trust's external partner – Northumberland, Tyne and Wear NHS Foundation Trust [NTW]) was provided. This support offer will nurture the Board and other senior leaders to become motivated leaders for improvement, in order to support the development and delivery of the Quality Improvement strategy and ensure that people who access services, their families and carers, are central to the Trust's improvement activity.
  A baseline of current Board capability in relation to quality improvement will be determined and reviewed by NTW ahead of and to inform a Board development session, scheduled for 18 October 2018.

- **Quality Improvement Report – Edition 1, 2018/19**
  Edition 1 of the Quality Improvement report has demonstrated significant improvement in implementing the Trust's Quality Improvement strategy. The quality improvement work undertaken by teams across the Trust demonstrates how teams have taken issues, problems or change ideas, and implemented continuous quality improvement cycles to achieve real results and improvements. Further, all projects have continuous improvement plans. The report also detailed the driver diagrams that have been developed to implement all three of the Trust's Quality Account quality improvement priorities for 2018/19 and the progress made to-date.
  The Quality Improvement report has now been shared with staff and stakeholders. Staff are being encouraged to use the Trust's Quality Improvement portal to share their Quality Improvement work with others, and also to access the portal for support with Quality Improvement.

- **Ancora House rapid improvement task and finish group**
  The Strategic Clinical Director and Consultant Nurse for the Children & Young People Care Group presented the rapid quality improvement work that had been co-delivered by the multi-disciplinary team at Ancora House and the Safe Services clinical support team. The work was identified following feedback from a CQC Mental Health Act Reviewer visit to Coral ward where there were areas requiring improvement. The team used an evidence-based approach to successfully deliver rapid and sustainable improvement. The team reflected on the values-based improvements in addition to compliance-based improvements.
  The sustainability plan will continue to be assured through the completion of monitoring and audit activities undertaken by clinical leads, the Matron, Consultant Nurse and the Strategic Clinical Director.

- **Reducing restrictive inteventions**
  An update was provided on overarching quality improvement work that is being undertaken that is responding directly and comprehensively to national priorities for action to reduce restrictive interventions in healthcare, including the CQC's "State of Care in Mental Health Services 2014–2017" regarding the nationally reported variation in relation to physical restraint. The CQC has set out three areas as strategic priorities, which are currently being taken forward via the Trust's Quality Improvement work. An update was also provided in relation to a specific Quality Improvement project being undertaken to look at people associated with multiple prone position restraint incidents, given that these instances will highlight more learning in terms of how a person's plan of care could be more effective by integrating learning from the initial episode of prone position restraint. The conclusion of this work will be reported to the November 2018 meeting of the Quality Committee.
  The Medical Director is commissioning an Expert Clinical Panel, to meet in quarter 3 2018/19, which will be responsible for advising on the development of the care pathway for managing behaviour that challenges to promote further opportunities for enhancing the current structured, multidisciplinary approach and to nurture a positive and therapeutic culture underpinned by the Trust's person-centred approach.

- **Sexual safety**
  Quality Improvement work associated with the driver diagram for this work, presented at the July 2018 meeting of the Quality Committee, is now being implemented. The outputs will facilitate in ensuring that the Trust is doing all that it can to meet its responsibility to ensure that inpatients and staff are safe from sexual harassment and sexual violence. This work is also a national driver – the CQC have now developed a report, co-produced with 50 NHS trusts via the National Mental Health Nurse Directors Forum. The report outlines 8 recommendations, which are now being considered by an operational group; the driver diagram will be refined to reflect these recommendations.
  The Quality Improvement work will be undertaken as a 12-month rapid improvement project and will report to the Quality Committee through its business cycle.

- **Learning from Experience report (trimester 1 2018/19)**
  The Quality Committee received and discussed the internal and external learning, and plans to integrate this learning, identified over the period April 2018 – July 2018. Of note is an increase in incident reporting across all service areas, with the number of externally reportable serious incidents decreasing, which is indicative that patient safety is a high priority and that the Trust has the capability to learn from experience.
  This Learning from Experience report also details in-depth work which will be undertaken over the next period to review learning from reviews and investigations undertaken externally to the Trust. Transferable lessons learned will be implemented to support ward to Board assurance to Quality Committee and the Board of Directors.

- **Policy for the recording, investigation and management of complaints/ concerns**
  This policy has been reviewed to bring CWP's timeframes associated with the management of complaints in line national regulations (currently CWP's timeframes are more stretching). This will strengthen further the Trust's approach to reviewing people's concerns in partnership with them; in addition an improved monitoring system has been put in place to make it easier to track the complaints process and escalate to an appropriate person if and when timeframes are exceeding what has been agreed.
  This policy will be kept under review and based on emerging feedback will be continuously reviewed and improved upon.

- **Mental Health Law Report (trimester 1 2018/19)**
  This report provided an update in relation to Mental Health Law activity covering the period from April 2018 to July 2018; and further learning from the CQC Mental Health Act Reviewer visits.
  A strengthened assurance framework has been identified to ensure that learning from CQC MHA Reviewer visits is integrated into practice and monitoring of this implementation identified to assure of sustainability.

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

CHAIR'S REPORT –
AUDIT COMMITTEE 4 SEPTEMBER 2018

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

- **ICP Governance**
  The Audit Committee discussed the current arrangements for the Integrated Care Partnership governance. The Committee discussed their role to support the Board. Clarity about responsibilities is required to enable clinicians to work together and share learning. The Audit Committee agreed to monitor the status at future meetings.

- **Workforce Planning**
  The Audit Committee has requested an update at the next meeting on the implementation of strategic workforce planning across the Trust. The current work of the revised governance framework and mapping out business cycles will provide clarity on roles and responsibilities.

- **Gifts**
  The Audit Committee reviewed the results of the MIAA Conflicts of Interest Audit which recommended the threshold for the acceptance of gifts be increase to £50 in alignment with national guidance. Due to the vulnerability of patients, frequency of admissions and the likelihood of cumulative gifts, the threshold was increased from £20 to £30. This will be reviewed again in 12 months.

Edward Jenner
Non Executive Director/ Chair of Audit Committee