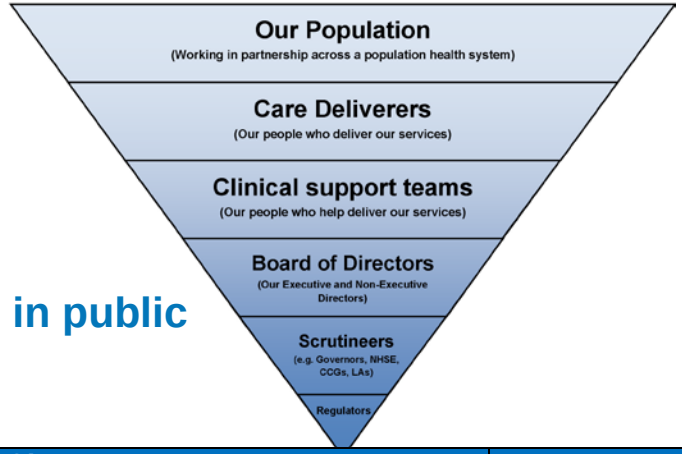

NHS
Cheshire and Wirral Partnership
NHS Foundation Trust

#cwpQI

Board of Directors, meeting held in public

At 1.00pm on Wednesday 29 May 2019
At the Boardroom, Redesmere

Ref	Title of item	Format	Presented by	Time
	Part 1: ASSURANCE			
	Committee Governance			
19/20/13	Welcome, apologies and quoracy	Verbal	Chair	1.00pm (3 mins)
19/20/14	Declarations of interest			
19/20/15	Minutes of previous public meeting held on Wednesday 27 March 2019	Paper		1.03pm (5 mins)
19/20/16	Matters arising and action points	Paper		
19/20/17	2019/20 cycle of business	Paper		1.08pm (2 mins)
19/20/18	Chair's Annoucements	Verbal		1.10pm (10 mins)
19/20/19	Chief Executive's Annoucements	Verbal	Chief Executive	1.20pm (10 mins)
	Reporting from Committees and Matters of Governance			
19/20/20	Audit Committee: • a. Chair's report of the Audit Committee held 7 May 2019 • b. 2019/20 Terms of Reference • c. 2018/19 Annual Report (click here)	Paper	Audit Committee Chair	1.20pm (5 mins)
19/20/21	Quality Committee: • Chair's Report of the Quality Committee held 8 May 2019	Paper	Quality Committee Chair	1.25pm (5 mins)

Ref	Title of item	Format	Presented by	Time
	• 2019/20 Terms of Reference • 2018/19 Committee effectiveness review (Click here)			
19/20/22	Statutory Registers: a. Directors interests and gifts and hospitality b. Governors interests	Papers	Head of Corporate Affairs	1.30pm (5 mins)
19/20/23	Chair and Chief Executive: Division of Responsibilities	Paper	Head of Corporate Affairs	1.35pm (5 mins)
19/20/24	Board Assurance Framework and Strategic Risk Register	Paper	Medical Director	1.40pm (10 mins)
19/20/25	Safer Staffing (January – April 2019)	Paper	Director of Nursing, Therapies and Patient Partnership	1.50pm (10 mins)
19/20/26	Guardian of Safe Working	Paper	Medical Director	2.00pm (10 mins)
19/20/27	Learning from Experience report	Paper	Director of Nursing, Therapies and Patient Partnership	2.10pm (10 mins)
19/20/28	Operational Plan Dashboard: update on 2019/20 process	Verbal	Director of Finance	2.20pm (5 mins)
19/20/29	Workforce Disability Equality Standard report	Paper and presentation	Director of Nursing, Therapies and Patient Partnership	2.25pm (30 mins)
Part 2: IMPROVEMENT (10 minute break)				
19/20/30	Central and East Cheshire resdesign progress report	Paper	Director of Operations	3.05pm (15 mins)
19/20/31	CWP Forward View: Care Group priorities 2019/20	Paper	Director of Finance	3.20pm (15 mins)
19/20/32	Quality Improvement Report	Paper	Medical Director	3.35pm (10 mins)
	Any other business			

Ref	Title of item	Format	Presented by	Time
19/20/33	Any other business	Verbal	Chair/ All	3.45pm (5 mins)
19/2034	Matters for referral to any other groups			
19/20/35	Matters impacting on policy and/ or practice			
19/20/36	Review risk impact of items discussed			
19/20/37	Three things to communicate			
19/20/38	Review the effectiveness of today's meeting https://www.smartsurvey.co.uk/s/CWPmeetingsurvey/			
CLOSE [3.50pm]				
Date, time and venue of the next meeting: Wednesday 26 June 2019, 9.30am Sycamore House (seminar session)				

Version No	1	Date issued	23.05.2019

Quality Improvement Hub

Minutes of Board of Directors Meeting – held in Public

at 13:00 on 27 March, 2019 at Boardroom, Redesmere

Present	Mike Maier	Chairman
	Sheena Cumiskey	Chief Executive
	Tim Welch	Director of Finance
	Avril Devaney	Director of Nursing, Therapies and Patient Partnership
	Dr Anushta Sivananthan	Medical Director, Quality, Compliance and Assurance
	Dr Faouzi Alam	Medical Director, Effectiveness, Medical Education and Medical Workforce & Caldicott Guardian
	Andy Styring	Director of Operations
	Jane Woods	Deputy Director of People and Organisational Development (on behalf of David Harris)
	Rebecca Burke-Sharples	Non-Executive Director
	Andrea Campbell	Non-Executive Director
	Lucy Crumplin	Non-Executive Director
	Edward Jenner	Non-Executive Director
	Jim O'Connor	Non-Executive Director
In attendance	Louise Brereton	Head of Corporate Affairs
	Katherine Wright	Associate Director of Communications and Engagement
	Suzanne Christopher	Corporate Affairs Manager (mins)
	Hayley Curran	Head of OD (for item 18/19/149)
	Stephanie Culson	Accountancy Trainee - observing
	Peter Ashley-Mudie	Service User Carer Governor – observing
	Fergie McQuarrie	Service User Carer Governor – observing
	Anne Farrell	Public Governor – Wirral – Observing
Apologies	David Harris	Director of People and Organisational Development

Ref	Title of item	Action
	Meeting governance	
18/19/138	**Welcome, apologies and quoracy** The Chair welcomed all to the meeting. The meeting was confirmed as quorate. Apologies were noted as above. Observers to the meeting (as noted above) were warmly welcomed.	
18/19/139	**Declarations of interest** None were declared.	
18/19/140	**Meeting Guidelines** The meeting guidelines were noted.	
18/19/141	**Minutes of the previous meeting held 30 January 2019**	

Ref	Title of item	Action
	One amendment was requested to item 18/19/127 in relation to complaints. Further to the above, the minutes of the meeting of the Board of Directors held in Public on the **30 January 2019** were **approved** as a correct record.	
18/19/142	**Matters arising and action points** The Board of Directors **noted** the updates. All actions were confirmed as closed.	
18/19/143	**Board Meeting Business Cycle - 2018/ 19 and draft 2019/20** The Board of Directors **noted** the Business Cycle. The Board of Directors also **noted** the draft Business Cycle for 2019/20.	
18/19/144	**Chair's announcements** The Chairman provided the following updates: **Nursing Associates** The Cheshire and Wirral Nursing Associates Partnership led by Avril Devaney has been shortlisted for three Nursing Times awards, including partnership of the year. The results will be announced in April. **Nursing Associates Graduation** Eight Trainee Nursing Associates were amongst the inaugural cohort to graduate from the University of Chester at a ceremony held last week. CWP were amongst the first 11 pilot sites across the country selected by Health Education England to pioneer nursing associate training in England. The Board congratulated the graduates. **Staff Survey** CWP were featured at the top of the HSJ North West mental health table relating to staff survey results for staff recommendations as a place to work or receive care as has been the case for the past three years. **HSJ – top 50 Chief Executives** Sheena Cumiskey has been recognised in the Health Service Journal's (HSJ) 2019 Top 50 Chief Executives. Sheena is one of eleven leaders who have recorded five or more appearances in the annual list of top NHS leaders. Board members offered their congratulations to Sheena Cumiskey. **Big Book of Best Practice shortlisted for HSJ Value Award** CWP's Big Book of Best Practice has been shortlisted in the Communications Initiative category of this year's HSJ Value Awards. The overall winner will be announced at a ceremony in May. The Trust's current Big Book has so far been downloaded over 4000 times, with 500 physical copies being shared among local healthcare staff, people accessing services, their carers and families. **Mental Health First Programme Launch** This initiative has been launched in three GP practices across Cheshire and aims to provide people with mental health difficulties receive improved access to support. The programme sees the introduction of mental health	

Ref	Title of item	Action
	experts from CWP into local GP practices. The on-site presence will allow patients with mental health difficulties such as depression and anxiety to speak directly with a mental health practitioner upon first appointment, rather than via a GP referral. **Non-Executive Director Recruitment** Non-Executive Director recruitment is underway. The process is led by the Remuneration and Nominations Committee of the Council of Governors and will involve formal interviews and values-based panels. Successful candidates will be proposed to the July 2019 Council of Governors for approval. The Board of Directors **noted** the updates.	
18/19/145	**Chief Executive's announcements** The Chief Executive provided the following summary of the items discussed at the Board meeting held in private. **Patient story** Board members received a patient story prior to the meeting held in private. The story outlined a very positive experience of care and highlighted the compassion of staff. Board members reflected on the need to consider the context in which people live their lives and how the Trust can continue to support people's recovery and well-being. **Risk and mitigations** Positive assurance was provided to the Board regarding Trust's state of preparedness for leaving the EU. The Board were updated on the plans to implement the electronic discharge document system – DOCMAN. Plans are in place for this to be effective from the 1 April 2019. Operational pressures are currently evident within inpatient services and work is being undertaken to mitigate these. **Operational planning and place based working** Board were updated on the developments of 'place based' working across the Trust footprint. It was reported that the Trust is on target to achieve its control total for this year and Board members had approved the Operational Plan for 2019/20 which is due to be submitted on the 4 April 2019. (Didn't the Board approve the Op Plan rather than (some) Board members)??? **Director of Nursing** The Board of Directors had approved the recommendation of the Remuneration and Nominations Committee of the Board to appoint Gary Flockhart as the new Director of Nursing. Gary will take up post following Avril Devaney's retirement in September 2019. The Board of Directors **noted** the summary.	
	Strategic Change	
18/19/146	**West Cheshire Integrated Care Partnership (IPC) Integration Agreement**	

Ref	Title of item	Action
	Sheena Cumiskey introduced the item. Board members were reminded that CWP is working in partnership with other providers and local authorities in Cheshire West and Chester regarding the integration of services. The aim of the work is to ensure a population health based approach and improve outcomes for people. The Integration Agreement sets out the principles of how the different partners will work together to ensure services are brought around people and that focus is on the needs of the communities. The document is not legally binding. Approval is sought from Board members to sign up to the agreement. Board members commented on the positive outcomes this work will have for the local populations and recognised the need to work together with different partners to ensure this was successful. It was noted that CWP need to maintain line of sight to the services it provides and also considered how other partners may become involved in this process (such as voluntary / third sector organisations). It was confirmed that the intention over time is to develop extended partnerships to further improve outcomes for patients. It was also noted that whilst the plans will bring opportunities and the potential to influence partners, they may also present some risks. It was suggested that all systematic change that CWP is involved in is monitored via the Quality Committee. It was felt that CWP was in a good position to support this work, given its experience of working closely with partners in its current work. It was also recognised that the development of the ICP will potentially be challenging. It was suggested that support could be provided to our Governors to assist their understanding of ICP's and how NEDs could be held to account within the wider system. **ACTION** – ICP information session for Governors to be arranged as above. Should the Board be willing to accept the agreement, further updates will be provided to Board members regarding governance arrangements and further progress. The Board of Directors **noted** the report and **endorsed** CWP becoming a signatory of the integration agreement. Formal signatory was delegated to the Chief Executive as Accountable Officer, on behalf of CWP.	**Corporate Affairs**
	Quality of Care / Quality Improvement	
18/19/147	**Monthly Ward Staffing update January & February 2019** Avril Devaney introduced the item. It was noted that some errors in recording of staffing had been identified for this month. This resulted in no report being provided to Board members for the March meeting. As a consequence, four months' worth of data will be presented to the Board of Directors at the next scheduled meeting. All other evidence supports that the Trust is continuing to staff wards safely. Once the report has been provided to Board, it will then be published on the website as required.	

Ref	Title of item	Action
	NEDs noted that the events described above demonstrated that Executive Colleagues have line of sight to these issues and, therefore, provides good assurance. The Board of Directors **noted** the update.	
	Operational Performance, Finance and Use of Resources	
18/19/148	**Operational Plan / Board Performance Dashboard** Tim Welch introduced the item. The report and the dashboard were reviewed. No new issues had been raised at Operational Committee that required escalation to Board members. The report states that a deep dive paper regarding attendance will be presented to the March Operational Committee. This was noted as an error and the information is actually scheduled to be presented to the April Operational Committee Meeting. The Board of Directors **noted** the report.	
	Well-led (leadership and quality improvement capability)	
18/19/149	**Staff Survey** *(Hayley Curran joined the meeting)* Hayley Curran introduced the item and provided a presentation to Board members to outline the key themes, learning and actions to be taken forward following the recent staff survey. The presentation provided a high level overview of the results and outlined for Board Members how the Trust is addressing areas for improvement, as well as celebrating areas of good practice. Overall the response rate was 5% lower than last year, but remained above the national average for our sector. Board members were advised that the criteria had changed this year, which may have contributed to the reduction. The following key points were highlighted: • 65% of respondents would recommend the Trust as a place to work. • 72% of respondents would recommend the Trust to a relative or friend for treatment. • 77% of respondents recognise that care is the number one priority • The Trust is above average and one of the top rated nationally for staff engagement (advocacy). Board members had a lengthy discussion in respect of appraisals. The large amount of work undertaken to ensure compliance with appraisals was noted. However, it was recognised that further work is required in respect of the quality of appraisals. It was noted that the questions relating to quality are very subjective and present a cultural challenge for the Trust, and for Trusts nationally. A recent CELF session considered how the appraisal experience could be further improved to better meet the expectations of staff. Board members	

Ref	Title of item	Action
	suggested seeking feedback from both the appraiser and the appraisee to help inform this process. Board members commented that evidence aligns quality of care to quality of appraisals, and stressed the importance of striving to improve on this going forward. Discussion was also held in respect of the use of language, how questions in the survey were phrased, and the cut of the data, which can present varying pictures. A glossary of terms was suggested to support staff when completing the survey next year. It was also noted that the feedback to NEDs when undertaking quality visits has been different and contradicts some of the data. Board Members also scrutinised in detail the results relating to BME data and the experiences of different staff groups. The positive work being taken forward in respect of Equality and Diversity was noted; however, it was acknowledged that further work is required. The priorities for 2019 were outlined to Board members. This work will be taken forward within Care Groups. Board members thanked Hayley Curran for the presentation. A request was made for the presentation to be sent in advance of the meeting next year to allow time for Board members to absorb all the data. Board Members also requested that next year's report includes the priorities identified this year and progress made against these in year. It was suggested that context to the year would also help to support the analysis (i.e. the significant redesign processes undertaken this year). **ACTION** – presentation to be sent to Board members further to this meeting. Peter Ashley-Mudie (observing) enquired if the results would also be shared at the next Council of Governors Meeting. It was confirmed the results would ????? be shared with Governors. **ACTION** – Equality and Diversity annual report to be considered against the Board Business Cycle. Executive Lead to consider if the annual report will provide satisfactory assurance to Board members regarding the actions taken to support BME staff groups. The Board of Directors **noted** the presentation of the staff survey and proposed action plan. The Board of Directors requested that the People and Organisational Development sub-committee review the action plan and escalate to Board accordingly. *(Hayley Curran left the meeting)*	**SC/LB** **AD**
18/19/150	**Strategic Risk Register and Board Assurance Framework** Dr. Sivananthan introduced the item. Attendees were reminded that the strategic risk register provides the assurance that the risks to the delivery of the Trust's strategic objectives is being effectively managed. Quality Committee monitor the strategic risk register and escalate matters to Operational Committee and the Board of Directors as appropriate. The register currently shows nine risks, two of which are red and seven amber.	

Ref	Title of item	Action
	The register also lists three risks in-scope. • The risk that patients' privacy and safety is compromised as a result of breaches in relation to the Department of Health guidance on mixed sex accommodation – final assurance is being sought to ensure that all wards are compliant. Risk treatment plans will be fully developed by the 31 March 2019 and will include detailed assurance plans. It was noted that there have been no incidents in the reported period of mixed sex accommodation breaches, however this continues to be closely monitored. • Electronic discharge processes – assurances around the implementation of the Docman system have been received, however further work is needed to ensure consistent uptake in clinical services. • Gaps in consultant staffing (medical) – a risk treatment plan is in place. A monthly impact assessment dashboard is also in place to monitor care and quality impacts and ensure appropriate mitigation. It was recommended to Board members that the risk relating to staff competence using safety critical policies should now be archived. This had been reviewed and considered by the Quality Committee as per the information detailed in the report. The risk will be archived but will be subject to review. It was highlighted that there are currently four risk actions that are overdue. All actions are expected to be completed by May 2019 and will be considered by the Quality Committee. NEDs reflected the dynamic nature of the register and how this has evolved over time. It was felt that the register is an effective measure of the Trust's performance against its objectives. Sheena Cumiskey described the developments that have also taken place within the Operational Committee to refine the way the Committee is working. Care Group governance meeting Chair's reports are now reported to the Operational Committee each month, which provides a good line of sight to clinical teams. The Committee also considers the Care Group risk registers on a regular basis and work continues in respect of the maturity of the Care Groups. It is evident that each of the Care Groups is further refining their governance approach. Care Groups are learning themselves what works well and are continually developing their thinking which will further mature over time. Questions were raised in regards local impacts of the medical staffing issues. Dr Alam reflected that staff have been extremely helpful to the situation and positions have been filled internally avoiding the need to use locum doctors. The situation is being closely monitored and regular meetings are held with the consultants to ensure their well-being. Some have indicated they felt under pressure, but this was recognised early and appropriate support has been provided. Andy Styring commented on the positive effect of linking the medical workforce with the Emergency Planning team. Only two localities have reached business continuity mode, which has now reduced to one. The links have provided structure to the process and provided a line of sight on statutory targets which are now being achieved.	

Ref	Title of item	Action
	The Board of Directors **approved** the amendments to the corporate assurance framework.	
18/19/151	**Annual Information Governance Board Report 2018/19** Dr. Alam introduced the item. It was noted that the SIRO report had been presented to the March 2019 Operational Committee Meeting. Board members were reminded that GDPR regulations came into force in May 2018. Board have been kept informed of the Trust's progress against these requirements. Board members were advised that the IG Toolkit had been replaced by the Data Security and Protection Toolkit, with effect from May 2018. The new toolkit has a greater emphasis on security and assesses the Trust against 10 security standards. The Trust is required to demonstrate compliance against all 10 standards. An interim report was required for submission in October 2018. It was confirmed that the Trust is compliant with all elements of the toolkit. MIAA (internal auditors) have audited the Trust and awarded substantial assurance for the seventh consecutive year. The Data Protection Sub-Committee monitor the standards and the Trust's progress against requirements. Any risks identified are then escalated to the Operational Committee. It was reported that all GDPR requirements have also been met and assurance was provided to Board members that the Trust is compliant with all elements. One reportable incident was recorded for 2018/19 in relation to incorrect data being sent. This has been escalated to the ICO. The ICO have advised that the Trust's plan is credible to ensure this is not repeated in the future. An overview of the priorities for next year's work plan was outlined to Board members that included the need for greater awareness of leads, roles, the FOI process, Caldicott Guardian and GDPR. Work will continue to improve in these areas. The Board of Directors is asked to approve the report and the final submission which is due this month. The Board members thanked Dr Faouzi Alam, Gill Monteith and the team for all their efforts. It was acknowledged that the amount of work required to maintain the Trust's status is significant, which in turn ensures the safety of our staff. The Board of Directors **approved** the Annual Information Governance Report, **approved** the submission of the 18/19 Data Security & Protection Toolkit and **approved** the statement that current information governance arrangements are fit for purpose.	
18/19/152	**Guardian of Safe Working report** Dr. Alam tabled the report and reminded Board members that the Guardian of Safe Working report is provided on a quarterly basis.	

Ref	Title of item	Action
	The number of Doctors reported as in training for this period was 52, 40 of whom are under new contract arrangements. 9 vacancies currently exist. During the last three months, 11 exception reports were submitted, 10 of which were submitted by the same doctor. This related to additional hours worked, for which time was returned in lieu. No areas of concern were highlighted in respect of safe working or access to educational and training needs further to these exception reports. No fines were received by the Trust. An overview was also provided of the locum arrangements during the three month period in each of the localities. Some shifts have been covered by higher trainees 'acting down' when locums could not be sourced. Rebecca Burke-Sharples commented that the report is now much clearer in its presentation. Questions were raised in respect of the doctor who had submitted 10 exception reports during the period. Assurance was sought regarding the amount of support being provided and mitigating actions in place to avoid this in the future. It was confirmed that the issues were raised at the Junior Doctor Forum with the Guardian of Safe Working. Support has been provided and systems are being reviewed to consider better methods of resolution. Administrative support was queried as this appeared to be a repeated theme in each report. It was confirmed that admin support is provided to produce this report from both the People Services Department and the Education Team. The Board of Directors **noted** the report.	
	Governance and Regulation (Assurance and escalation reports from Board Sub-committees (discussion by exception only)	
18/19/153	**Chair's Report of the Quality Committee held on 6 March 2019** Dr O'Connor introduced the item and gave an overview of the items discussed. It was suggested that the item presented to Quality Committee regarding the Mental Capacity Amendment Bill would also be valuable for Board members. This would be added to the Board schedule. The Board of Directors **received** the Chair's report.	
18/19/154	**Chair's Report of the Audit Committee held on 12 March 2019** Edward Jenner introduced the item and highlighted the key points. It was noted that substantial assurance was provided by MIAA during a recent audit regarding the financial systems and key controls. High assurance was awarded for financial reporting and integrity. The Board congratulated the finance team on their efforts. It was highlighted to the Board that the Committee received the assurance framework. One amber rating was received regarding Board minutes and Board discussions in respect of the strategic risk register. The Committee concluded that consideration needs to be given to ensure due discussion	

Ref	Title of item	Action
	takes place and is recorded accordingly. The Board of Directors **received** the Chair's report.	
	Closing Business	
18/19/155	**Any other business** Andy Styring advised that the Trust had been successful in securing the East Cheshire Emotionally Healthy Children and Families Partnership contract. This is a two year contract with the option to extend for a further two years. Andy Styring also reported that the Trust is now in the implementation phase of the central and east Cheshire redesign plans. Limewalk House patients have successfully transferred to Maple Ward. Lucy Crumplin expressed her thanks to all those involved in the planning of the NTW event held this week. Board members reflected that this was a very useful experience. Sheena Cumiskey expanded on the above, reflecting that the event held with partners from NTW was a great success. Board members were invited to visit some of their services to understand quality improvement in action. Discussions were also held with Board members to consider how NTW are developing their framework in quality improvement. Thanks were extended for the organisation of this event and for the positive participation of Board members.	
18/19/156	**Questions from observers or members of the public (relating to specific items on the agenda)** Peter Ashley-Mudie requested clarification on Caldicott 2. Dr. Alam confirmed this related to confidentiality issues and how information can be appropriately shared. Anne Ferrell thanked the Board for the opportunity to observe the meeting. Anne commended the Trust's involved in the Integrated Care Partnership.	
18/19/157	**Review of risk impacts of items discussed** No new risks identified.	
18/19/158	**Key messages for communication** • the Trust has agreed and will duly sign the west Cheshire Integration Agreement • Board detailed consideration of the staff survey results, celebrating the positives and acknowledging areas for improvement.	
18/19/159	**Review of meeting performance** No concerns raised.	
CLOSE		
Date, time and venue of the next meeting: **Wednesday 29 May 2019, Board Room, Redesmere**		

Cheshire and Wirral Partnership NHS Foundation Trust
Open Actions Action Schedule

Meeting date	Group/ Ref	Action	By Whom	By when	Status
27.03.2019	18/19/146	**West Cheshire Integrated Care Partnership (IPC) Integration Agreement.** To ensure Governors are updated on the development of the ICP**.**	LB	April 2019	Closed - scheduled for July COG (disucssion session)
27.03.2019	18/19/149	**Staff Survey** Send presentation to Board Members	LB	April 2019	Closed- completed
27.03.2019	18/19/149	**Staff Survey** Equality and Diversity annual report to be considered against the Board Business cycle. Executive Lead to consider if the annual report will provide satisfactory assurance to Board Members regarding the actions taken to support BME staff groups.	AD	April 2019	Closed - Assurances to be included in E&D annual report and to report to Board six monthly on actions responding to the staff survey issues.
27.03.2019	18/19/155	**Any Other Business** East Cheshire Emotionally Healthy Children and Families Partnership paper to be circulated to Board Members.	LB	April 2019	Open

Cheshire and Wirral Partnership NHS Foundation Trust

#cwpQI

Board of Directors
Business Cycle 2019/20 (Public Meeting)

	Item	Lead	Apr	May	Jun	Jul	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Assurance	Chair and CEO report and Announcements	MM/SC		✓		✓	✓		✓		✓		✓
	Review minutes of the previous meeting	MM		✓		✓	✓		✓		✓		✓
	ICP Board/s (minutes)	SC		✓		✓	✓		✓		✓		✓
	Receive Chair's Report of the Quality Committee	JOC		✓		✓	✓		✓		✓		✓
	Receive Chair's Report of the Audit Committee	EJ		✓		✓	✓		✓		✓		✓
	Freedom to speak up six monthly report	AD				✓			✓		✓		
	Six monthly Infection Prevention Control Report	Director of IPC							✓				
	Director of Infection Prevention and Control Annual Report Inc. PLACE	Director of IPC				✓							
	Safeguarding Adults and Children Annual Report and six monthly report	AD				✓					✓		
	Accountable Officer Annual report Inc. Medicines Management	AS				✓							
	Monthly Ward Staffing update (monthly and six monthly reporting)	AD		✓		✓	✓		✓		✓		✓

Item	Lead	Apr	May	Jun	Jul	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Research Annual Report	FA					✓						
Medical Appraisal Annual Report and annual declaration of Medical revalidation	FA				✓							
Operational Plan/Board performance dashboard (incorporating Operational and Quality Dashboard)	TW		✓		✓	✓		✓		✓		✓
Annual Report, Accounts and Quality Account	TW		✓									
Health and Safety Annual Report and Fire and Link Certification	AD				✓							
Board Assurance Framework	AS		✓			✓				✓		✓
Learning from Experience report, Inc. Learning from Deaths	AD		✓			✓				✓		
Integrated Governance Framework	AS									✓		
Equality and Diversity responsibilities inc. WRES and WDES	AD		✓		✓	✓						
Guardian of Safe Working quarterly report	FA		✓		✓			✓		✓		
Provider Licence Compliance	TW		✓					✓				
CQC Statement of Purpose	AS							✓				

	Item	Lead	Apr	May	Jun	Jul	Sep	Oct	Nov	Dec	Jan	Feb	Mar
	Data Protection and Security toolkit	FA											✓
	GDPR compliance annual review	FA				✓							
	Register of Sealings	TW					✓						
	Register of Interests (Directors and Governors)	MM		✓									
	Self-certification statements	TW		✓									
	Corporate Governance Manual	TW				✓					✓		
	Fit and Proper Persons annual assurance	DH				✓							
	Terms of Reference and effectiveness reviews: • Quality Committee • Audit Committee • Operational Committee	JOC/SC		✓		✓							
	Review risk impacts of items	MM/SC		✓		✓	✓		✓		✓		✓
	CEO/Chair Division of Responsibilities	MM/SC		✓									
	BOD draft Business Cycle 20/21	MM/SC											✓
	AOB (including matters that are NOT commercial in-confidence	MM/SC		✓		✓	✓		✓		✓		✓

	Item	Lead	Apr	May	Jun	Jul	Sep	Oct	Nov	Dec	Jan	Feb	Mar
IMPROVEMENT	Quality Improvement report	AS				✓			✓				✓
	CQC Community Patient Survey Report (themes and improvement plan)	AD							✓				
	NHS Staff Survey (themes and improvement plan)	DH											✓
	People and OD strategy inc. workforce planning)	DH		✓							✓		

NHS
Cheshire and Wirral Partnership
NHS Foundation Trust

STANDARDISED CHAIR'S REPORT

CHAIR'S REPORT DETAILS	
Name of meeting:	Audit Committee
Chair of meeting:	Edward Jenner, Non-Executive Director
Date of meeting:	07/05/2019

(ESCALATION) Quality, clinical, care, other risks identified that require escalation:

A review of the Directors and Governors registers of interests were reviewed. These were commended to the Board of Directors in line with business cycle requirements.

(ASSURANCE) Matters discussed:

A number of corporate governance matters were considered by the Committee including the annual governance statement considered and noted in draft form ahead of final approval as part of the annual report and accounts 2018/19 and the Director of Audit Opinion 2018/29 which concluded a substantial assurance opinion of the assurance framework.

The Committee received an update on audit progress including the patient cash and valuables audit which attained substantial assurance, an improvement on previous opinions.

An update was provided from Exteral audit on the progress of the annual audit 2018/19. All is progressing as expected with no significant risks identified. Some issues have been identified through the testing of data for the mandated and locally selected indicators however this is currently being worked through and is unlikely to pose any risks to the overall audit opinions.

(IMPROVEMENT) Achievements:

The NHS code of governance assessment of assurance for 2018/19 was presented to the Committee. It was confirmed that all provisions had been complied with and this would be referenced as such in the annual report.

The Anti-Fraud annual report was presented to the Committee providing a summary of the work undertaken in 2018/19. The Committee reviewed the Trust's compliance with anti-fraud standards, via the self assessment. Three standards were rated as amber which have remedial action in place.

Administrator Guidance
Print as a PDF once all fields are completed before combining files in Acrobat and issuing the agenda.

#cwpQI

Cheshire and Wirral Partnership
NHS Foundation Trust

Audit Committee

Terms of Reference

1. Constitution

The Board of Directors hereby resolves to establish a Committee to be known as the Audit Committee. The Committee is a non-executive Committee of the Board and has no executive powers other than those specifically delegated in these Terms of Reference.

2. Duties

The Committee is responsible for:

a. Governance, risk management and internal control

The Committee shall have primary responsibility and review the establishment and maintenance of an effective system of integrated governance, risk management and internal control across the whole of the Trust's activities (both clinical and non-clinical) that supports the achievements of the Trust's objectives. It will provide an independent and objective view on internal control and probity. In addition, the Committee will monitor any formal announcements relating to its financial performance, reviewing significant financial reports and the judgements contained in them.

In particular the Committee will review the adequacy of:

- All risk and control related disclosure statements (in particular the Annual Governance Statement and declarations of compliance to external bodies), together with any accompanying Head of Internal Audit statement, external audit opinion or other appropriate independent assurances, prior to endorsement by the Board.
- The underlying assurance processes that indicate the degree of the achievement of corporate objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements.
- The policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements, licence requirements and related reporting and self-certification.
- Finance-related policies and procedures including Standing Orders, Standing Financial Instructions, Scheme of Delegation.
- The policies and procedures for all work related to fraud and corruption as required by the NHS Counter Fraud Authority.
- The arrangements by which Trust staff may raise, in confidence, concerns about possible improprieties in matters of financial reporting and control, clinical quality, patient safety or other matters. In so doing the Committee's objective should be to ensure that arrangements are in place for the proportionate and independent investigation of such matters and for appropriate follow-up action.

In carrying out this work the Committee will utilise the work of internal audit, external audit and other assurance functions but will not be limited to these sources. It will also seek reports and assurances from directors and managers as appropriate, concentrating on the overarching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness. This will be evidenced through the Committee's use of an effective Assurance Framework to guide its work and that of the audit and assurance functions that report to it.

b. Internal audit

The Committee will ensure that there is an effective internal audit function established by management that meets public sector internal audit standards and NHS internal audit standards and provides appropriate independent assurance to the Audit Committee, Chief Executive and Board. This will be achieved by:

- Consideration of the provision of the internal audit service, the cost of the audit and any questions of resignation and dismissal.
- Review and approval of the internal audit strategy, operational plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the Trust as identified in the Assurance Framework.
- Consideration of the major findings of internal audit work (and management's response) and ensuring coordination between internal and external auditors to optimise audit resources.
- Ensuring that the internal audit function is adequately resourced and has appropriate standing within the Trust.
- Annual review of the effectiveness of internal audit.
- Annual self-assessment of the Committee, facilitated by Internal Audit.

c. External audit

The Committee shall review the independence, objectivity and work of the external auditor appointed by the Council of Governors and consider the implications and management's responses to their work. This will be achieved by:

- Consideration of the appointment and performance of the external auditor, including liaising with and making recommendations to the Council of Governors regarding the former.
- The duration of each term will be three years with an option for an additional two years. Once the term has expired, the appointment must be subject to open tender.
- Discussion and agreement with the external auditor, before the audit commences, of the nature and scope of the audit as set out in the annual plan and ensure coordination with internal auditors and with other external auditors in the local health economy.
- Discussion with the external auditors of their local evaluation of audit risks and assessment of the Trust and associated impact on the audit fee.
- Review all external audit reports, including the report to those charged with governance, agreement of the annual audit letter before submission to the Board and any audit work performed outside the annual audit plan, together with the appropriateness of management responses.

- Approval of the engagement of the external auditor in respect of non-audit work where the cost is over £5,000, taking into account relevant ethical guidance regarding the provision of such services. The Director of Finance will inform the Committee of any non-audit engagements below this figure and in all cases the Committee will report them to the Council of Governors.
- Annual review of the effectiveness of external audit.

d. Other assurance functions

The Audit Committee shall review the findings of other significant assurance functions, both internal and external to the Trust, and consider the implications to the governance of the Trust. It will review, appraise and report in accordance with Public Sector Internal Audit Standards (PSIAS) and best practice. These will include, but will not be limited to, reviews and reports by Department of Health and Social Care's arm's length bodies or regulators/inspectors e.g. Care Quality Commission, NHS Resolution, etc, professional bodies with responsibility for the performance of staff or functions (e.g. Royal Colleges, accreditation bodies, etc), the Local Counter-Fraud Specialist (LCFS).

In addition the Committee will review the work of other committees within the Trust, whose work can provide relevant assurance to the Audit Committee's own scope of work. This will particularly include the Quality Committee and Operational Committee. With regard to the former and issues around clinical risk management the Audit Committee will wish to satisfy itself on the assurance that can be gained from the clinical audit function.

The Committee will also review all suspensions of Standing Orders and variation or amendment to Standing Orders.

At each meeting, the Committee may wish to review any "red" rated risk from the Risk Register and may request it receives a presentation in person from the senior clinical / other professional responsible for addressing this particular risk.

The Audit Committee will report to the Board and to the Council of Governors any matters in respect of which it considers action or improvement is needed.

e. Counter- fraud

The Audit Committee shall satisfy itself that the Trust has adequate arrangements in place for countering fraud and will approve the appointment of the Local Counter-Fraud Specialist. The Committee will review the outcomes of counter-fraud work.

f. Management

The Committee shall request and review reports and positive assurances from directors and managers on the overall arrangements for governance, risk management and internal control. They may also request specific reports from individual functions within the Trust (e.g. clinical audit) as they may be appropriate to the overall arrangements.

g. Statutory reporting (Financial & Quality Accounts)

The Audit Committee shall review the Trust's annual report and associated accounting statements before submission to the Board, focusing particularly on:

- The wording in the Annual Governance Statement and other disclosures relevant to the Terms of Reference of the Committee
- Changes in, and compliance with, accounting policies, practices and estimation techniques
- Unadjusted mis-statements in the financial statements
- Major judgemental areas
- Significant adjustments resulting from the audit
- Letter of representation
- Qualitative aspects of statutory reporting

The Committee shall monitor the integrity of the accounting statements of the Trust and any formal announcements relating to the Trust's reported performance. The Committee should also ensure that the systems for both financial and qualitative reporting to the Board are subject to review as to completeness and accuracy of the information provided to the Board.

3. Membership

Membership will be appointed by the Board of Directors from amongst its Non-Executive members and will consist of not less than three members, at least one of whom should have recent and relevant financial experience. The Chair of the Quality Committee shall be a member of the Audit Committee.

Members can participate in meetings by two-way audio link including telephone, video or computer link (excepting email communication). Participation in this way shall be deemed to constitute presence in person at the meeting and count towards the quorum.

The Board will appoint one of the members to be Chair and another Vice Chair from the outset. The Vice Chair will automatically assume the authority of the Chair should the latter be absent. The Chair of the Trust shall not be a member of the Committee.

a. Quorum

A quorum shall be two members.

b. Voting

Each member will have one vote with the Chair having a second and casting vote, if required. Should a vote be necessary a decision will be determined by a simple majority.

c. Attendance by members

Members will be required to attend a minimum of 50% of all meetings. The Committee shall be able to co-opt further members to the Committee for special purposes.

d. Attendance by officers or others

Either the Director of Finance or the Deputy Director of Finance and appropriate internal and external audit representatives shall normally attend meetings. At least once a year the Committee will meet privately with the external and internal auditors.

The Chief Executive and other executive directors will be invited to attend, particularly when the Committee is discussing areas of risk or operation that are the responsibility of that director.

The Chief Executive will also be required to attend when the Audit Committee discussed the process for assurance that supports the Annual Governance Statement.

The Trust's Head of Corporate Affairs will be Secretary to the Committee and will attend to take minutes of the meeting and provide appropriate support to the Chair and the Committee members.

Officers of the Trust will be invited to attend the meeting as appropriate when an issue relating to their area of operation or responsibility is being discussed.

Governors may be invited to observe meetings of the Audit Committee.

4. Accountability and reporting arrangements

The Audit Committee will be accountable to the Board of Directors.

The minutes of the Audit Committee will be formally recorded and submitted to the Board of Directors. The Chair of the Audit Committee shall draw to the attention of the Board of Directors any issues that require disclosure to it, or require executive action.

The Audit Committee will refer to the other two Board governance Committees (the Quality Committee and the Operational Committee) matters considered by the Committee deemed relevant for their attention. The Committee will consider matters referred to it by those two governance Committees.

The Audit Committee will receive reports from the Quality Committee regarding assurances relating to the effective operation of controls and in the event of a significant risk arising, the risk will be reported as per the Trust's integrated governance framework and risk management processes.

The Committee will report to the Board annually on its work and performance in the preceding year and, as part of this report, will provide commentary in support of the Annual Governance Statement, specifically dealing with the fitness for purpose of the Assurance Framework, the completeness and embeddedness of risk management in the Trust, the integration of governance arrangements and the appropriateness of the evidence compiled

to demonstrate fitness to register with the Care Quality Commission and the robustness of the processes behind the quality accounts.

Trust Standing Orders and Standing Financial Instructions apply to the operation of the Audit Committee.

5. Frequency

Meetings will normally be held bi-monthly.

The external auditor or Head of Internal Audit may request a meeting if they consider that one is necessary.

6. Authority

The Audit Committee is authorised by the Board of Directors to investigate any activity within its Terms of Reference. The Committee is authorised to seek any information it requires from any employee and all employees are directed to cooperate with any request made by the Committee.

The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise, subject always to compliance with Trust delegated authorities.

7. Monitoring effectiveness

The Committee will undertake an annual review of its performance against its duties in order to evaluate its achievements.

8. Administration

The Committee shall be supported administratively by Corporate Affairs whose duties in this respect will include:

- Agreement of the agenda with the Chair
- Collation and review of reports
- Distribution of agenda and reports to members in accordance with the Trust's corporate governance standards
- Taking the minutes of the meeting
- Preparing a record of actions
- Advising the Committee on pertinent areas.

9. Review

These terms of reference will be reviewed at least annually by the Committee.

Date reviewed by Committee	September 2018

Date approved by Board of Directors	September 2018
Review date	September 2019

10. Version control

Version control	Date	Comments
1	7 July 2010	Amends made by Audit Committee members and by Company Secretary following review of (as yet unpublished) Department of Health Audit Committee Handbook 2010
2	26 July 2010	Amends made by Audit Committee members and Deputy Director of Finance
3	27 July 2010	Further amends made by Audit Committee members
4	4 May 2011	Further amends made by Audit Committee members
5	6 March 2012	Further amends made by Audit Committee members
6	5 March 2013	Reviewed by Audit Committee
7	1st May 2014	Reviewed by Audit Committee, amendments agreed
8	5th May 2015	Reviewed by Audit Committee, amendments agreed (references to anti-fraud and annual governance statement)
9	1st March 2016	Amendment to section 2a.
10	5th July 2016	Addition of co-option of members to membership section.
11	2nd May 2017	Amendments made as follows: • Requirement for Chair of Quality Committee to be a formal member of the Audit Committee • Addition of Audit Committee Chair to have 'recent and relevant financial experience.' • Removal of reference to Operational Board in section 2a • Addition of reference to Licence requirements in section 2a. • Addition of Governor attendance in section 3d. • Addition of reference to Quality Committee reporting in section 4.
12	4 September 2018	Amendments made in accordance with HFMA NHS Audit Committee Handbook as follows: • NHS Litigation Authority amended to NHS Resolution. • Operational Board amended to Operational Committee. • Government Internal Audit Standards amended to Public Sector Internal Audit Standards (PSIAS).
13	7 March 2019	Reviewed and approved as ToR for 2019/20

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STANDARDISED CHAIR'S REPORT

CHAIR'S REPORT DETAILS	
Name of meeting:	Quality Committee
Chair of meeting:	Dr J O'Connor, Non-Executive Director
Date of meeting:	08/05/2019

(ESCALATION) Quality, clinical, care, other risks identified that require escalation:

Serious incidents involving compliance with the Mental Health Act will be specifically escalated as a sub category in the routine incidents report to the Board to provide a more real time appraisal and assurance of the remedial response to these incidents. This will complement assurance reporting to the Board, and Board oversight, as part of the current strategic risk that is in-scope regarding risk of breach of legislation and CQC regulation in respect of adherence to the Mental Health Act.

The IPC Sub Committee has escalated that uptake of influenza vaccine for the 2018/19 season was 60%; 15% short of the 75% target. Planning has commenced for 2019/20 and the target is 80%. The Quality Committee has escalated the need to consider different approaches to significantly improve uptake as part of these planning processes. This work will be overseen by the Operational Committee, with care and quality impacts escalated to the Quality Committee as appropriate.

(ASSURANCE) Matters discussed:

The Quality Committee has undertaken a structured annual review of its effectiveness and identified subsequent changes to its business cycle and terms of reference. The latter will be approved by the Board of Directors.

All actions identified for improvement following the CQC inspection in 2018 are on track and in progress or have been completed. The Quality Committee will continue to receive assurance on progress with the identified improvement trajectories.

The Quality Account is being shared with Quality Committee members week commencing 13 May 2019 for their comments. The Quality Account will be approved by the Board of Directors as part of the annual report.

The statutory annual complaints report for 2018/19 was received by the Quality Committee and will be provided to the external auditors of the Quality Account to comply with Department of Health and Social Care regulations.

(IMPROVEMENT) Achievements:

The quality assurance dashboard has continued to provide assurance around quality performance and improvement, with plans for further development of how it is presented and to how Care Groups contribute to identifying (and assurance that they are implementing) improvements required.

The Quality Improvement strategy delivery plan for 2019/20 was approved and plans identified, as part of the business cycle, to receive updates on quality improvement work.

The Quality Improvement report for December 2018 - March 2019 was received and detailed a number of achievements on the part of clinical and clinical support services, as well as progress made in delivering the Trust's quality improvement priorities for 2018/19. This report will be presented to the Board of Directors.

Administrator Guidance
Print as a PDF once all fields are completed before combining files in Acrobat and issuing the agenda.

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QUALITY COMMITTEE

Terms of Reference

1. Constitution

The Board of Directors hereby resolves to establish a committee to be known as the Quality Committee.

2. Duties

The Quality Committee is responsible for:

Assurance
Receiving assurance on organisational quality governance, current performance regarding quality of care, and quality performance against the quality framework as detailed in the Trust's quality improvement strategy.

Improvement
Ensuring that that the strategic priorities for quality improvement are identified, implemented and monitored, to support the ambition of the Trust's quality improvement strategy.

The Quality Committee has delegated responsibility from the Board of Directors for oversight of the integrated governance framework, has overarching responsibility for risk, and therefore for monitoring strategic risks within the organisation.

The Quality Committee's duties can be categorised as:

Assurance

a) Monitoring and reporting on the Trust's delivery of integrated governance, exercising oversight of the systems and escalating any matters of concern as appropriate. Specifically:
   - Receiving and reviewing the corporate strategic risks (including those referred from other committees which are concerned with quality matters) allocated to the Quality Committee, monitoring progress made in mitigating those risks, identifying any areas where additional assurance is required and escalating to the Board of Directors as agreed by Quality Committee members.

b) Receiving assurance, via assurance reports and via a quality assurance dashboard, on organisational quality of care, aligned to the national "Single Oversight Framework", across the domains of safe, effective, caring and responsive services and the Trust's quality framework.

c) Seeking assurances that the Trust complies with external regulations and standards of quality and governance, including Care Quality Commission registration requirements.

d) Receiving assurance on the clinical and quality impact of the delivery of:
   - the key priority projects identified as part of the CWP Forward View/ Trust strategy (routine reporting of activity);
   - all current services (exception reporting of real/ near-real time issues);
   - CQUIN schemes (exception reporting care and quality impacts relating to any shortfalls in compliance); and
   - programmes identified to deliver better outcomes at lower cost (overseeing the accountability framework, as part of the Trust's quality and equality impact assessment process, for the operating principle of delivering better value as defined as a principle in the Trust's quality improvement strategy).

e) Review of the draft of the Trust's Quality Account and recommending its approval to the Board of Directors.

f) Receiving reports from the Board of Directors and Operational Committee for information, context, assurance and/ or action as appropriate.
g) Approving the terms of reference and membership of its reporting sub committees and overseeing the work of those sub committees, receiving reports from them for consideration and action as necessary and routinely receiving the Chair's reports of their meetings. These meetings are:
   - Infection Prevention & Control Sub Committee
   - Clinical Practice & Standards Sub Committee
   - Safeguarding Sub Committee
   - Patient and Carer Experience Sub Committee

Improvement

h) Identifying the strategic priorities in relation to quality improvement as per the Trust's Quality Improvement strategy, including:
   - Quality improvement priorities required on an annual basis as part of the regulatory Quality Account, and oversight of the implementation of these.
   - Oversight of future planning, in conjunction with Care Group representatives, ensuring capacity to respond proactively to new models of care delivery.
i) Receiving and monitoring service-level quality performance improvement plans as identified as exceptions from the quality assurance dashboard.
j) Ensuring that the Trust is responding and improving to learning identified in implementing the patient safety agenda throughout the Trust. This includes:
   - Updates from patient safety initiatives, including thematic reports, quality improvement initiatives, and patient safety cultural work identified as an output of implementing the Trust's safety management system.
   - Oversight of serious incident management processes, including the learning from deaths agenda, response to Regulation 28 reports and oversight of identified quality improvement initiatives.
   - Learning from complaints and claims processes.
   - Receipt of assurance in relation to whether the Trust is learning from internal experience (including from complaints and claims) and learning from external experience and recommendations, past harm and integrating best practice, through receipt of the Learning from Experience report and Quality Improvement report.
k) Ensuring that the Trust is responding to and improving from learning identified in implementing the clinical effectiveness agenda throughout the Trust. This includes:
   - Updates from clinical effectiveness initiatives, including quality improvement initiatives identified as an output of implementing the Trust's transformation, change, and effectiveness work programme.
   - Through service-level outcome reporting, identification of priority NICE/ evidence based guidelines and standards incorporated into improvement work.
   - Oversight of priority quality improvement projects, identified as part of the implementation of the Quality Improvement strategy, to tackle unwarranted variations in clinical care.
l) Ensuring that the Trust is responding and improving to learning identified in implementing the patient and carer experience agenda throughout the Trust. This includes:
   - Updates from improvement work co-ordinated by the Lived Experience, Volunteering and Engagement Network.
   - Receipt of assurance in relation to whether the Trust is learning from patient and carer experience initiatives, through receipt of the Learning from Experience report and Quality Improvement report.
   - Receipt of the annual CQC community mental health survey (and, by exception, any quality of care issues from analysis of the NHS Staff Survey via Operational Committee) to inform themes and quality improvement work for endorsement by the Board of Directors.

3. Membership

Membership will be appointed by the Board of Directors and will consist of the following:

i. Non Executive Director (Chair)
ii. Two additional Non Executive Directors (one of whom shall be Vice Chair)
iii. Chief Executive (Accountable Officer)
iv. Medical Director (Quality)
v. Medical Director (Effectiveness and Medical Staffing)
vi. Director of Finance
vii. Director of Nursing, Therapies & Patient Partnership
viii. *Director of Operations
ix. *Director of People & Organisational Development
x. [+]Associate Director of Nursing & Therapies (Mental Health)
xi. [+]Associate Director of Nursing & Therapies (Physical Health)/ Director of Infection Prevention and Control (DIPC)
xii. ** Strategic Clinical Directors
xiii. ** Associate Directors of Operations
xiv. Associate Director of Safe Services
xv. Associate Director of Effective Services
xvi. Associate Director of Patient & Carer Experience
xvii. [+]Head of Clinical Governance
xviii. [+]Head of Quality Assurance & Improvement

*or their nominated representative who will be sufficiently senior and have the authority to make decisions
** or their nominated representative who will be sufficiently senior and have the authority to make decisions – quoracy requires at least one representative of each Care Group from the membership listed at xii or xiii (sufficient seniority for xii includes Speciality or Place Based Clinical Directors; sufficient seniority for xiii includes Head of Operations)

[+]responsive attendance based on agenda

(otherwise, core members)

If core members cannot attend meetings, they must ensure that a nominated deputy attends.

The following individuals may be in attendance at meetings:
Committee Secretary
Governors

Members can participate in meetings by two-way audio link including telephone, video or computer link (excepting email communication). Participation in this way shall be deemed to constitute presence in person at the meeting and count towards the quorum.

The Board of Directors will appoint one of the members to be Chair and another Vice Chair from the outset. The Vice Chair will automatically assume the authority of the Chair should the former be absent.

a. Quorum
A quorum shall be 50% of core membership including the Chair or Vice Chair, two Executive Directors, two Non Executive Directors (which can include the Chair) and a representative from each CWP Care Group.

b. Voting
Each member will have one vote with the Chair having a second and casting vote, if required. Should a vote be necessary, a decision will be determined by a simple majority.

c. Attendance by members

Core members identified above will be required to attend a minimum of 50% of all meetings in-year, this is in addition to the requirement to ensure that a nominated deputy attends.

d. Attendance by officers

Officers and staff of the Trust will be invited to attend the meeting as appropriate when an issue relating to their area of operation or responsibility is being discussed.

4. Accountability and reporting arrangements

The Quality Committee will be accountable to the Board of Directors.

The minutes of the Quality Committee will be formally recorded and submitted to the Board of Directors. The Chair of the Quality Committee shall draw to the attention of the Board of Directors any issues that require disclosure to it, or require executive action, via a Chair's report.

The Chair's report will also be circulated to the meeting of the Board in public, Audit Committee and Operational Board for information.

Members of the Quality Committee will provide reports to the Audit Committee on assurances relating to the effective operation of controls and in the event of a significant risk arising, the risk will be reported as per the Trust's integrated governance framework and risk management processes.

5. Frequency

Meetings shall be held every two months, with at least 5 meetings per year, and additional meetings may be arranged from time to time, if required, to support the effective functioning of the Trust.

6. Authority

The Quality Committee is authorised by the Board of Directors to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Quality Committee.

The Quality Committee is authorised to obtain legal or other independent professional advice and to secure the attendance of other parties with relevant experience and expertise to facilitate its understanding of the issues if it considers necessary.

7. Monitoring effectiveness

The Committee will undertake an annual review of its performance against its duties in order to evaluate its achievements.

8. Administration

The Committee shall be supported administratively by a member of the corporate affairs/ board support team, whose duties in this respect will include:

- Agreement of the agenda with the Chair
- Collation and review of reports
- Distribution of agenda and reports to members in accordance with the Trust's corporate governance standards
- Taking the minutes of the meeting
- Preparing a record of actions
- Advising the Committee on pertinent areas

9. Review

These terms of reference will be reviewed at least annually by the Committee.

Date reviewed by Committee	8 May 2019
Date approved by Board of Directors	31 July 2019 (pending)
Review date	As per 2020/21 business cycle

The latest version of the terms of reference are held on the Trust's website at www.cwp.nhs.uk

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STANDARDISED SBAR COMMUNICATION

REPORT DETAILS	
Report subject:	Board of Directors: Register of Declared Interest and Register of Gifts and Hospitality
Agenda ref. number:	19.20.22a
Report to (meeting):	Board of Directors
Action required:	Information and noting
Date of meeting:	12/03/2019
Presented by:	Louise Brereton, Head of Corporate Affairs

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

Which NHSI Single Oversight Framework themes this report reflects:		CWP Quality Framework:		
Quality	Yes	Patient Safety	Safe	Yes
Finance and use of resources	Yes	Clinical Effectiveness	Effective	Yes
Operational performance	Yes		Affordable	Yes
Strategic change	Yes		Sustainable	Yes
Leadership and improvement capability	Yes	Patient Experience	Acceptable	Yes
			Accessible	Yes
		http://www.cwp.nhs.uk/media/4142/quality-improvement-strategy-2018.pdf		

Does this report provide any information to update any current strategic risks? If so, which?	
Contact the corporate affairs teams for the most current strategic risk register.	Yes

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

REPORT BRIEFING

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

The Directors Register of Interests and Gifts and Hospitality 2018/19 are presented to the Audit Committee to provide assurance regarding compliance with the national and local conflicts of interest policies.

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

The NHS as a public sector organisation must be impartial and honest in the conduct of its business.

NHS England issued guidance on Managing Conflicts of Interest in the NHS which came into force from 1 June 2017. The guidance introduces common principles and rules for managing conflicts of interests, provides simple advice to staff and organisations about what to do in common situations, supports good judgement about how interests should be approached and managed and sets out the issues and rationale behind the policy.

The guidance is applicable to CCGs, NHS Trusts, NHS Foundation Trusts and NHS England. NHS Trusts and NHS Foundation Trusts must have regard to this guidance through its incorporation into the NHS

Standard Contract pursuant to General Condition 27.

Assessment – *analysis and considerations of the options and risks*

As an NHS Trust and in accordance with the Trust's Corporate Governance Manual requires that "the Trust shall have a register of interests of the directors". Furthermore, it states that "the Trust shall make the registers available for inspection by members of the public. This information is held to ensure the Trust conducts business honestly and impartially and employees remain beyond suspicion. As a public sector employer the Trust must operate systems which allow public accountability and openness maintaining the highest standards of integrity and probity while supporting and engaging in collaboration and partnership working.

The updated register of directors' interests for 2018/19 is included at Appendix 1 and these details are made available on the Trust's website and will also be reported in the Trust's Annual Report. In addition, at each meeting of the Board of Directors, and its Committees, members are asked to declare any further interests since the date of the last declaration and to notify the Chair of any conflicts of interest in relation to the agenda items for discussion (for which they may need to abstain). Any such declaration is recorded in the minutes.

Directors and members of staff are now also required to register any sponsorship, gifts and hospitality, whether offered or accepted. The current register is included as Appendix 2. These declarations are normally submitted on an ad-hoc basis throughout the year following which the register is updated accordingly.

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

The Board of Directors are recommended to note:

- The Directors Register of Interests 2018/19
- The Directors Register of Gifts and Hospitality 2018/19

Who has approved this report for receipt at the above meeting?	N/A
Contributing authors:	N/A

Distribution to other people/ groups/ meetings:

Version	Name/ group/ meeting	Date issued
N/A	N/A	N/A

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

Appendix No.	Appendix title
1.	Directors Register of Interests 2018/19
2.	Directors Register of Gifts and Hospitality 2018/19

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DIRECTOR REGISTER OF INTERESTS 2018/19
(updated March 2019)

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

NAME, DESIGNATION/ BOARD DIRECTORSHIP	NOTHING TO DECLARE	TITLE OF INTEREST	DETAILS OF RELEVANT ORGANISATION	COMMENCEMENT OF INTEREST	LENGTH OF APPOINTMENT
Dr Faouzi ALAM Joint Medical Director and Caldicott Guardian	✓				
Andrea CAMPBELL Non-Executive Director		Director	A.Campbell Consultancy – Health/ Social Care Consultancy	December 2004	On-going
		Non-Executive Director	Belong – Social Care Provider	January 2016	On-going
		Chair	Aspire CIC, Salford – Social Care Provider	October 2016	On-going
Dr James O'CONNOR Non-Executive Director/ Chair of Quality Committee		Chair	General Council – Eastham Lodge, Golf Club.	December 2018	12 months

Lucy CRUMPLIN Non-Executive Director		Director	Tiger Bright Ltd (consultancy)	May 2012	On-going
		Director	Villicare, Limited Liability Partnership	March 2017	On-going
Sheena CUMISKEY Chief Executive		Chair	Board of the NHS North West Leadership Academy	February 2010	Ongoing
		Member	NHS Employers Board	2016	Ongoing
Avril DEVANEY Director of Nursing, Therapies and Patient Partnership		Trustee Of Jamie Devaney Memorial Fund	Charity supporting mental health care in Uganda	March 2013	Ongoing
		Chair	Mental Health and Learning Disabilities Nurse Directors and leads' Forum	March 2016	March 2019
		Visiting Professor at University Of Chester	University of Chester, Parkgate Road, Chester	December 2016	December 2019

David HARRIS Director of People and OD		Associate Teaching Fellow	University of Lancaster Bailrigg Lancaster. LA1 4YW	November 2017	On-going-assignments on an ad-hoc basis. Any remuneration received will be donated to the CWP charitable fund
Edward JENNER Non-Executive Director	✓				
Mike MAIER CHAIR	✓				
Rebecca BURKE-SHARPLES Non-Executive Director/ Senior Independent Director		Spouse (Alan Sharples) is a NED/ Chair of Audit Committee (currently in 2nd term of office).	Walton Centre NHS Foundation Trust	Appointed 2010	May 2019
Dr Anushta SIVANANTHAN Joint Medical Director	✓				

Andy STYRING Director of Operations		Director	Nevexia Ltd, Redesmere, Countess of Chester Health Park.	January 2017	On-going
		Governor of Ancora School	Ancora House, Countess of Chester Health Park, Chester.	December 2016	On-going
Tim WELCH Director of Finance/ Deputy Chief Executive		Director	Nevexia Ltd, Redesmere, Countess of Chester Health Park.	January 2017	On-going
		Director	Villicare, Limited Liability Partnership	November 2013	On-going

DIRECTOR DECLARATION OF GIFTS AND HOSPITALITY REGISTER

2018-19 (Up-dated February 2019)

Name	Designation	Department	Date of Declaration	Details of Gift and/or Hospitality
Dr Faouzi Alam	Medical Director	Trust Board	NIL	
Andrea Campbell	Non-Executive Director	Trust Board	NIL	
Dr James O'Connor	Non-Executive Director	Trust Board	NIL	
Lucy Crumplin	Non-Executive Director	Trust Board	NIL	
Sheena Cumiskey	Chief Executive	Trust Board	30 January 2019	Speaker at HSJ Mental Health summit In Nottingham on 24/25 Jan2019. Received overnight accommodation in a hotel to the value circa £100
Avril Devaney	Director of Nursing, Therapies and Patient Partnership	Trust Board	NIL	
David Harris	Director of HR and OD	Trust Board	NIL	

Name	Designation	Department	Date of Declaration	Details of Gift and/or Hospitality
Edward Jenner	Non-Executive Director	Trust Board	NIL	
Mike Maier	Chair	Trust Board	NIL	
Ann Pennell (until 31.12.18)	Non-Executive Director	Trust Board	NIL	
Rebecca Burke Sharples	Non-Executive Director	Trust Board	NIL	
Dr Anushta Sivananthan	Medical Director	Trust Board	27 May 2018	Evening meal by NHS Scotland Gifts from NHS Lanarkshire- a mug, coasters, shortbread. Less than £20.
			29 January 2019	Attendance at the HSJ Mental Health summit- including overnight stay and meals.
Andy Styring	Director of Operations	Trust Board	NIL	
Tim Welch	Director of Finance	Trust Board	NIL	

NHS
Cheshire and Wirral Partnership
NHS Foundation Trust

STANDARDISED SBAR COMMUNICATION

REPORT DETAILS	
Report subject:	Statutory Registers: Directors and Council of Governors declarations of interest 2018/19
Agenda ref. number:	19/20/22b
Report to (meeting):	Board of Directors
Action required:	Information and noting
Date of meeting:	29/05/2019
Presented by:	Louise Brereton , Head of Corporate Affairs

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

Which NHSI Single Oversight Framework themes this report reflects:	
Quality	Yes
Finance and use of resources	Yes
Operational performance	Yes
Strategic change	Yes
Leadership and improvement capability	Yes

CWP Quality Framework:		
Patient Safety	Safe	Yes
Clinical Effectiveness	Effective	Yes
	Affordable	Yes
	Sustainable	Yes
Patient Experience	Acceptable	Yes
	Accessible	Yes
http://www.cwp.nhs.uk/media/4142/quality-improvement-strategy-2018.pdf		

Does this report provide any information to update any current strategic risks? If so, which?	
Contact the corporate affairs teams for the most current strategic risk register.	No

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

REPORT BRIEFING

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

To inform the Board of the Directors of the Council of Governors Register of Interests 2018/19 as per the Board business cycle and constitutional requirements.

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

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

The Registers are published and are available at www.cwp.nhs.uk

Assessment – *analysis and considerations of the options and risks*

In order to assist with the identification and declaration of interests, Governors are requested to declare their interests upon initial appointment and annually thereafter. There is also the opportunity at each meeting of the Council for Governors to declare their interests and for the declared interests to be managed appropriately.

Governors are provided with guidance and support to inform their declarations. Where Governors have no declarations of interest, they are asked to provide NIL response.

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

The Audit Committee are recommended to note the 2018/19 Governors' Register of Interests.

Who has approved this report for receipt at the above meeting?	N/A
Contributing authors:	Louise Brereton, Head of Corporate Affairs

Distribution to other people/ groups/ meetings:

Version	Name/ group/ meeting	Date issued
1	Audit Committee	May 2019

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

Appendix No.	Appendix title
1.	2018/19 Governors' Register of Interest

NHS
Cheshire and Wirral Partnership
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Declaration of Interest – as at February 2019

Public Governors			
Name	Area	Declaration of Interest	Date
Derek Bosomwoth	Cheshire East	Nil	21/08/2018
Elizabeth Bott	Cheshire West and Chester	Healthwatch Cheshire Board member & Volunteer: Enter & View Visits to health & social care services Member of 3 committee groups supporting work with elderly, adult safeguarding, diversity & human rights re Countess of Chester NHS Foundation Trust West Cheshire Mental Health Forum West Cheshire Mental Health Partnership Board West Cheshire A& E Delivery Board – Patient Representative Cheshire Asian & Minority Communities Council (CAMCC) West Cheshire Multicultural Women's Group (WCMWG) Board Member, Cheshire, Halton & Warrington Race & Equality Centre (CHAWREC Affiliated Member of Chester Volunteer Forum Member of Cheshire Older People's Network + Brightlife	14/09/2018
Helen Nellist	Cheshire West and Chester	Nil	08/01/2019
Nigel Richardson	Out of Area	Nil	23/01/2019
Richard Agar	Wirral	Nil	14/09/2018
Rob Walker	Cheshire East	Nil (Governor advised to reconsider)	14/09/2018
Anne-Marie Farrell	Wirral	Paid Employment at Age UK Cheshire	03/10/2018

Staff Governors			
Name	Area	Declaration of Interest	Date
Deepak Agnihotri	Therapies	Nil	14/09/2018
Jill Doble	Therapies	Nil	14/09/2018
Ken Edwards	Nursing	Nil	23/01/2019
Philip Mook	Non-Clinical	Nil	14/02/2019

Partnership Governors			
Name	Area	Declaration of Interest	Date
Carol Gahan	Cheshire West and Chester Council	Avenue Services Ltd – Director Councillor Cheshire West & Chester Council	23/01/2019
Graham Pollard	Universities	Nil	16/08/2018
Iain Stewart	Wirral CCG	Employee of NHS Wirral Clinical Commissioning Group Spouse is Head of Contracting at Wirral University Teaching Hospital FT.	23/01/2019
Liz Wardlaw	East Cheshire Council	Cabinet Member Cheshire East Council Governor for Cheshire & Merseyside Clinical Senate Portfolio Holder – Health CEC CEC Rep – Cheshire and Merseyside STP Board Member Cheshire East Health & Well Being Board CEC Rep – Connecting Care CEC CEC Rep – Caring Together CEC	04/02/2019
Pam Smith	Western Cheshire CCG	Lay Member on West Cheshire CCG Governing Body Director of Pam Smith Consultancy Ltd Director of Sutton Electrical contractors Ltd	23/01/2019
Phil Gilchrist	Wirral Metropolitan Borough Council	Councillor - Wirral Council	14/09/2018

Sean Boyle	Staff Side	Trust Wide Lead – Mental Health Practitioner – CRHTT Clinical Director for acute care in April 2018 for up to three years.	08/06/2018

Service User/Carer		
Name	Declaration of Interest	Date
Arlo King	Chester Plus – Trustee	23/01/2019
Brian Crouch	Nil	08/08/2018
David Bull	Chair of Board of Trustees, Chester Voluntary Action Lived Experience Volunteer, CWP Lived Experience Connector, CWP West Cheshire Mental Health Partnership Board West Cheshire Mental Health Forum	14/09/2018
Ferguson McQuarrie	NIL	12/02/2019
Gordon Cairns	Community Director Avenue Services (NW)Ltd Cheshire West and Chester Mental Health Partnership Board CWAC Autism Strength Group CWP Autism Strategy Group West Cheshire CCG Cancer during and Post Treatment Steering Group – Patient Representative	14/09/2018
Jacqueline McGhee	Nil	06/02/2019
Keith Millar	West Cheshire Mental Health Forum Cheshire West & Chester Council Mental Health Partnership Board West Cheshire CCG Patient Support Group Forum Health Watch Cheshire Neston Medical Centre PPG	14/09/2018
Michael Brassington	Nil	02/10/2018

Philip Billington	Nil	16/08/2018
Peter Ashley-Mudie	Trustee Wirral Churches ARK Project	01/10/2018
Phil Jarrold	Attendance at various third sector meetings that have an interest in Mental Health including; Crewe and Nantwhich Open Minds Mental Health Forum and Making Space Carers' Group (Northwich)	02/10/2018

Cheshire and Wirral Partnership NHS Foundation Trust

STANDARDISED SBAR COMMUNICATION

REPORT DETAILS	
Report subject:	Chair and Chief Executive - Division of Responsibilities
Agenda ref. number:	19.20.23
Report to (meeting):	Board of Directors
Action required:	Discussion and Approval
Date of meeting:	29/05/2019
Presented by:	Mike Maier, Chairman

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

Which NHSI Single Oversight Framework themes this report reflects:	
Quality	No
Finance and use of resources	No
Operational performance	No
Strategic change	No
Leadership and improvement capability	No

CWP Quality Framework:		
Patient Safety	Safe	No
Clinical Effectiveness	Effective	No
	Affordable	No
	Sustainable	No
Patient Experience	Acceptable	No
	Accessible	No

http://www.cwp.nhs.uk/media/4142/quality-improvement-strategy-2018.pdf

Does this report provide any information to update any current strategic risks? If so, which?	
Contact the corporate affairs teams for the most current strategic risk register.	No

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

REPORT BRIEFING

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

To inform the Board of the requirements in the NHS Foundation Trust Code of Governance regarding the division of responsibilities between the Chair and the Chief Executive

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

The division of responsibilities between the Chairperson and Chief Executive should be clearly established, set out in writing and agreed by the board of directors. They should be used to inform objectives for the Chair and Chief Executive.

Section 7.11.7 of The Corporate Governance Manual sets out that the division of responsibilities for the Chair and the Chief Executive to be set out in writing and approved by the Board of Directors on an annual basis.

Assessment – *analysis and considerations of the options and risks*

The responsibilities of the Chair and Chief Executive are set out at appendix 2. The NHS Foundation Trust Code of Governance is available at https://www.gov.uk/government/publications/nhs-foundation-trusts-code-of-governance

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

The Board of Directors is recommended to **approve** the division of responsibilities as set out in the NHS Code of Governance for Foundation Trusts and that this is reviewed on an annual basis

Who has approved this report for receipt at the above meeting?	N/A
Contributing authors:	N/A

Distribution to other people/ groups/ meetings:

Version	Name/ group/ meeting	Date issued
N/A	N/A	N/A

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

Appendix No.	Appendix title
1.	CEO and Chair division of responsibilities

19.20.23 Appendix 1

The responsibilities of the Chair are as follows:

- To ensure the effective operation of the Board of Directors and the Council of Governors
- To promote the highest standards of integrity, probity and corporate governance throughout the organisation and particularly at the Board of Director level
- To ensure that the Board of Directors as a whole plays a full part in the development and determination of the Foundation Trust's strategy and overall objectives, having regard to the Council of Governors
- To lead the Board of Directors, to preside and lead the Council of Governors and to be the guardian of the Board of Directors decision making processes
- To ensure that the Board of Directors and the Council of Governors work together effectively
- To set clear expectations concerning the Trust's culture, values and behaviours including setting the style and tone of discussions at Board meetings
- To ensure the Board of Directors and Council of Governors agendas take full account of the important issues facing the Trust
- To ensure compliance with the Board of Directors approved procedures including schedule of matters, terms of reference and other Board policies and procedures
- To facilitate the effective contribution of all members of the Board of Directors and the Council of Governors ensuring that constructive relationships exist between Directors, between Governors and between Governors and Directors themselves
- To ensure that the Non-Executive Directors understand their accountability, individually and collectively to the Council for Governors for the performance of the Board
- To preside over the Council of Governors in holding the Non-Executive Directors to account
- Ensure the provision of appropriate development and training for the council of governors
- To ensure that accountability processes work effectively
- To Chair the Remuneration and Nominations Committees
- To initiate succession planning at Board level with the Nominations Committee to ensure appropriate Board composition and refreshment
- To ensure effective communication on the part of the foundation trust with patients, members, staff and other stakeholders
- To lead an induction programme for new Non-Executive Directors
- Working with the Chief Executive, to lead in updating the skills and knowledge and in meeting the development needs of individual Directors and the Board of Directors as a whole
- To ensure that the Governors have the skills, knowledge and familiarity within the Foundation Trust to fulfil their role
- To ensure that the performance of the Board of Directors and the Council of Governors as a whole, including an externally led assessment at least once in every three years

- To ensure a good flow of information each way between the Board of Directors, committees, the Council of Governors, Non-Executive Directors and management

The responsibilities of the Chief Executive are as follows:

- To report to the Chair and the Board of Directors and lead the Executive Team ensuring high standards of performance.
- Conduct the affairs of the Foundation Trust in compliance with the highest standards of integrity, probity and corporate governance and promote continuing compliance across the organisation.
- To lead and be responsible for proposing and developing, in consultation with the Board, the Foundation Trust's strategy and overall objectives, and to lead the implementation of these, ensuring appropriate resources and control and risk management systems are in place
- As the Accountable Officer to maintain a sound system of internal control that supports the organisation's policies, aims and objectives and manages risks to a reasonable level, including responsibility for safeguarding the public funds and organisations assets ensuring the efficient and effective use of all the resources in their charge to ensure the quality of services delivered.
- To ensure the appropriate and timely flow of information to the Board that enables an assessment of risk and a level of assurance in internal control.
- To ensure the provision of information and support with the Board of Directors and the Council of Governors
- To facilitate and support effective joint working between the Board of Directors and the Council of Governors
- To communicate the expectations of the Board, concerning culture, values and behaviours to all employees
- To ensure the Chair is aware of any important issues facing the Foundation Trust and to ensure the provision of reports to the Board containing accurate, timely and clear information
- To ensure the compliance of the Executive Team with the Board of Directors procedures
- To support the Chair in facilitating effective contributions and sustaining constructive relations between Executive and Non-Executive directors of the Board. Between governors and between the Board of Directors and Council of Governors
- To provide, with Executive team, support to the Non-Executive Directors in order to facilitate the accountability relationship
- To support the Chair in delivering an effective accountability process
- To support with Board succession planning, particularly in respect of executive directors
- Lead the communication programme with members and stakeholders including staff, particularly around Trust strategy, vision and values
- Ensure that the development needs of the Executive Directors and other senior management are identified and are met
- Ensure that performance reviews are carried out at least annually for each of the Executive Directors and provide input to the wider Board of Directors and Council of Governors evaluation process

Last reviewed: May 2019
Next review: May 2020

NHS
Cheshire and Wirral Partnership
NHS Foundation Trust

STANDARDISED SBAR COMMUNICATION

REPORT DETAILS	
Report subject:	Board assurance framework and strategic risk register
Agenda ref. number:	19.20.24
Report to (meeting):	Board of Directors
Action required:	Discussion and Approval
Date of meeting:	29/05/2019
Presented by:	Dr Anushta Sivananthan, Joint 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 NHSI Single Oversight Framework themes this report reflects:		CWP Quality Framework:		
Quality	Yes	Patient Safety	Safe	Yes
Finance and use of resources	Yes	Clinical Effectiveness	Effective	Yes
Operational performance	Yes		Affordable	Yes
Strategic change	Yes		Sustainable	Yes
Leadership and improvement capability	Yes	Patient Experience	Acceptable	Yes
			Accessible	Yes
		http://www.cwp.nhs.uk/media/4142/quality-improvement-strategy-2018.pdf		

Does this report provide any information to update any current strategic risks? If so, which?	
Contact the corporate affairs teams for the most current strategic risk register.	Yes
All risks	

Does this report indicate any new strategic risks? If so, describe and indicate risk score:	
See current integrated governance strategy: CWP policies – policy code FR1	No

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 the time of writing this report, the Trust has 9 strategic risks – 2 are rated red and 7 are rated amber. There are 2 risks currently in-scope – 1 rated red and 1 rated amber.

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 reviews and oversees the strategic risk register. The Board of Directors monitors and reviews the corporate assurance framework and receives assurances on risk via the Quality Committee. Complemented by Audit Committee's oversight of the system of internal control, this framework provides assurance regarding the quality and safety of the services that the Trust provides.

Assessment – *analysis and considerations of the options and risks*

New risks/ risks in-scope (since the last report to Board of Directors in March 2019):

• One risk continues to be in-scope: Risk that patients' privacy, dignity and safety is compromised as a result of breaches in relation to the Department of Health guidance on mixed sex accommodation – rated 9 (amber). The risk treatment plan is progressing and is being overseen by Quality Committee as part of CQC action plan reporting. Compliance is being monitored by reviewing ongoing assurance that staff are providing and delivering care that maximises people's privacy and dignity.

• One new risk is in-scope: Risk of breach of legislation and CQC regulation in respect of adherence to the Mental Health Act, potentially impacting on patient safety, safeguards and experience; likelihood of legal challenges; reputation of the Trust – rated 15 (red). The Quality Committee agreed that the Clinical Practice & Standards Sub Committee will develop terms of reference for a Trustwide task and finish group to review minimum controls that should be established to assure mitigation of this risk and this should inform the risk treatment plan.

Amended risk scores:

• Risk 10 (acute care bed usage): The residual risk score has decreased from 16 (red) to 12 (amber) as a result of a number of assurances including a sustained period of being at OPEL level 1.

• Risk 12 (data quality): The residual risk score has increased from 12 to 20 as a consequence of the conclusions of the independent audit of data quality undertaken as part of the Quality Account regulations. A revised risk treatment plan is in development which will be aligned to the recommendations from the external audit and will be reviewed by the July Quality Committee.

Archived risks

The Quality Committee recommended archive of the following two strategic risks, based on evidence of progress with/ completion of the agreed risk treatment plans:

• Risk that the CWP workforce may not have sufficient capability (capacity, confidence, competence) to deliver place-based, person-centred care. This risk has been archived in its current form and work is being taken forward by the People and OD Sub Committee to 'deconstruct' it and examine any emerging risk issues identified through the refresh of the People and OD strategy. These will be reported to the July 2019 Quality Committee.

• 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. This risk has been archived following delivery of the key identified risk treatment actions, the achievement of 90% compliance with safeguarding training and further recruitment to the Safeguarding team. Any residual risk issues will be escalated by the Safeguarding Sub Committee.

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

The Board of Directors is asked to review, discuss and approve the amendments made to the corporate assurance framework as recommended by the Quality Committee.

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

Distribution to other people/ groups/ meetings:

Version	Name/ group/ meeting	Date issued
	Board of Directors	22.05.2019

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

Appendix No.	Appendix title
1	Board assurance framework and strategic risk register

NHS
Cheshire and Wirral Partnership
NHS Foundation Trust

STANDARDISED SBAR COMMUNICATION

REPORT DETAILS	
Report subject:	Ward Daily Staffing Levels January and February 2019
Agenda ref. number:	
Report to (meeting):	Board of Directors
Action required:	Information and noting
Date of meeting:	29/05/2019
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 NHSI Single Oversight Framework themes this report reflects:	
Quality	Yes
Finance and use of resources	Yes
Operational performance	Yes
Strategic change	No
Leadership and improvement capability	Yes

CWP Quality Framework:		
Patient Safety	Safe	Yes
Clinical Effectiveness	Effective	Yes
	Affordable	Yes
	Sustainable	Yes
Patient Experience	Acceptable	Yes
	Accessible	Yes

http://www.cwp.nhs.uk/media/4142/quality-improvement-strategy-2018.pdf

Does this report provide any information to update any current strategic risks? If so, which?	
Contact the corporate affairs teams for the most current strategic risk register.	No

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

REPORT BRIEFING

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

This report details the ward daily staffing levels during the months of January and February 2019 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 the options and risks*

During January 2019 the trust achieved staffing levels of 96.7% for registered nurses and 95.6% for clinical support workers on day shifts and 97% and 99.9% respectively on nights. During February 2019 the trust achieved staffing levels of 95.7% for registered nurses and 98.9% for clinical support workers on day shifts and 97.8% and 102.1% respectively on nights.

In the months of January and February 2019 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.

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 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	07.05.2019

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

Appendix No.	Appendix title
1	Ward Daily Staffing January 2019
2	Ward Daily Staffing February 2019

		Day				Night				Day		Night		
		Registered midwives/nurses		Care Staff		Registered midwives/nurses		Care Staff						
Service Line	Ward	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 (%)	Safe Staffing was maintained by:
SMH - Bed Based West & East	Adelphi	1367.5	1347	1096	1022	690	690	1058	1058	98.5%	93.2%	100.0%	100.0%	Nursing staff working additional unplanned hours. Cross cover arrangements. Non mandatory staffing activity was cancelled.
	Bollin	1351.5	1278	1375	1225.5	701.5	625	1426	1311	94.6%	89.1%	89.1%	91.9%	Nursing staff working additional unplanned hours. Cross cover arrangements.
	Croft	1229.75	1230	1418.5	1150.75	717.5	683	1407.5	1253.5	100.0%	81.1%	95.2%	89.1%	Nursing staff working additional unplanned hours. Cross cover arrangements.
	Beech	1329	1275	1021.5	980.5	625	625	766.5	766.5	95.9%	96.0%	100.0%	100.0%	
	Cherry	1308.235	1182	1058	1046.5	713	678.5	1000.5	954.5	90.4%	98.9%	95.2%	95.4%	Nursing staff working additional unplanned hours. Cross cover arrangements. Non mandatory staffing activity was cancelled.Multi Disciplinary Team actively worked within the staffing establishment .
	Juniper	865.5	842.5	1101.5	1090	667	667	750.5	788.5	97.3%	99.0%	100.0%	105.1%	
	Willow PICU	1001.5	1001.5	828	816.5	609.5	586.5	736	736	100.0%	98.6%	96.2%	100.0%	
SMH - Forensic, Rehab, CRAC	Alderley Unit	1083.5	1028	1321	1309.5	632.5	639.5	821	824	94.9%	99.1%	101.1%	100.4%	Nursing staff working additional unplanned hours. Cross cover arrangements. Non mandatory staffing activity was cancelled.
	LimeWalk Rehab	1210	1111.25	1069.5	969.5	713	649.5	713	637.5	91.8%	90.6%	91.1%	89.4%	Nursing staff working additional unplanned hours. Cross cover arrangements.
	Rosewood	1120	1136.75	1276.5	1218.5	655.5	655.5	1150	1122.5	101.5%	95.5%	100.0%	97.6%	Nursing staff working additional unplanned hours. Cross cover
	Saddlebridge	828.04	804.5	1380	1365	621	621	736	736	97.2%	98.9%	100.0%	100.0%	
Learning Disabilities & NDD	Eastway A&T	1274.5	1276.25	1219	1219	517.5	517.5	1557	1522.5	100.1%	100.0%	100.0%	97.8%	
	Greenways A&T	1216.75	1185.75	2140.5	1906	713	669.5	1426	1414.5	97.5%	89.0%	93.9%	99.2%	Nursing staff working additional unplanned hours. Cross cover arrangements. Multi Disciplinary Team actively worked within the staffing establishment .
CYP - Tier 4 CAMHS & Outreach	Coral Ward	1051	1052	1462.5	1439.5	691.55	691.55	1293	1258.5	100.1%	98.4%	100.0%	97.3%	Nursing staff working additional unplanned hours. Cross cover arrangements. Non mandatory staffing activity was cancelled.
	Indigo Ward	888.9	808.4	1044	1075	563.5	483	744	753	90.9%	103.0%	85.7%	101.2%	Nursing staff working additional unplanned hours. Cross cover arrangements.
SMH - Bed Based Wirral & PICU	Brackendale	1145.5	1134	1000.5	1000.5	713	713	713	713	99.0%	100.0%	100.0%	100.0%	
	Brooklands	839.75	839.75	1246.5	1246.5	642.5	642.5	851	851	100.0%	100.0%	100.0%	100.0%	
	Lakefield	1137.5	1107.5	816.5	816.5	724.5	724.5	828	828	97.4%	100.0%	100.0%	100.0%	
	Meadowbank	1027.5	1027.5	1949	1949	673	661.5	1098.5	1087	100.0%	100.0%	98.3%	99.0%	
	Oaktrees	1356	1267.5	897	803	756.5	745	406	383	93.5%	89.5%	98.5%	94.3%	Nursing staff working additional unplanned hours.
	Trustwide	22631.925	21935.15	24721	23649.25	13340.55	12968.55	19481.5	18998.5	97.0%	96.0%	97.2%	97.9%	

		Day				Night				Day		Night		
		Registered midwives/nurses		Care Staff		Registered midwives/nurses		Care Staff						
Service Line	Ward	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 (%)	Safe Staffing was maintained by:
SMH - Bed Based West & East	Adelphi	1285.50	1042.50	874.50	1035.00	644.00	655.50	943.00	920.00	81.1%	118.4%	101.8%	97.6%	Nursing staff working additional unplanned hours. Cross cover arrangements. Non mandatory staffing activity was cancelled.
	Bollin	1391.50	974.00	970.00	1239.50	644.00	569.50	1288.00	1226.50	70.0%	127.8%	88.4%	95.2%	Nursing staff working additional unplanned hours. Cross cover arrangements. Non mandatory staffing activity was cancelled.
	Croft	999.75	928.25	1540.50	1535.75	653.00	634.20	1427.00	1338.50	92.8%	99.7%	97.1%	93.8%	Nursing staff working additional unplanned hours. Cross cover arrangements. Multi Disciplinary Team actively worked within the staffing establishment .
	Beech	1184.00	1152.00	884.00	860.00	621.00	619.50	667.00	655.50	97.3%	97.3%	99.8%	98.3%	
	Cherry	1082.50	1044.00	1161.50	1023.50	667.00	609.50	943.00	885.50	96.4%	88.1%	91.4%	93.9%	Nursing staff working additional unplanned hours. Cross cover arrangements.
	Juniper	972.00	960.50	1070.00	1058.50	480.00	480.00	724.50	724.50	98.8%	98.9%	100.0%	100.0%	
	Willow PICU	857.00	845.50	880.00	880.00	483.00	460.00	621.00	609.50	98.7%	100.0%	95.2%	98.1%	
SMH - Forensic, Rehab, CRAC	Alderley Unit	964.00	925.50	1097.00	1104.50	621.00	621.00	655.50	630.50	96.0%	100.7%	100.0%	96.2%	
	LimeWalk Rehab	1084.00	1044.00	966.00	797.90	644.00	552.10	644.00	609.50	96.3%	82.6%	85.7%	94.6%	Nursing staff working additional unplanned hours. Cross cover arrangements.
	Rosewood	1060.50	1060.50	1063.50	1017.50	655.50	609.50	966.00	908.50	100.0%	95.7%	93.0%	94.0%	Nursing staff working additional unplanned hours. Cross cover arrangements.
	Saddlebridge	708.50	697.00	1196.00	1178.50	621.00	590.00	690.00	701.50	98.4%	98.5%	95.0%	101.7%	
Learning Disabilities & NDD	Eastway A&T	1132.00	1114.50	1243.40	1243.40	543.50	543.50	1269.00	1269.00	98.5%	100.0%	100.0%	100.0%	
	Greenways A&T	1065.50	932.05	1932.00	1723.50	644.00	713.00	1288.00	1189.00	87.5%	89.2%	110.7%	92.3%	Nursing staff working additional unplanned hours. Cross cover arrangements. Non mandatory staffing activity was cancelled.Multi Disciplinary Team actively worked within the staffing establishment .
CYP - Tier 4 CAMHS & Outreach	Coral Ward	1041.50	989.00	1247.00	1247.00	636.25	636.25	1258.50	1258.50	95.0%	100.0%	100.0%	100.0%	Nursing staff working additional unplanned hours. Cross cover arrangements. Non mandatory staffing activity was cancelled.
	Indigo Ward	750.00	750.00	902.20	894.20	487.00	487.00	744.50	744.50	100.0%	99.1%	100.0%	100.0%	
SMH - Bed Based Wirral & PICU	Brackendale	1080.00	1083.50	1060.00	1060.00	644.00	644.00	658.00	635.00	100.3%	100.0%	100.0%	96.5%	
	Brooklands	751.50	766.50	937.00	947.00	611.50	611.50	724.50	724.50	102.0%	101.1%	100.0%	100.0%	
	Lakefield	952.25	955.75	869.75	869.75	599.00	599.00	772.00	772.00	100.4%	100.0%	100.0%	100.0%	
	Meadowbank	1028.50	1028.50	1672.00	1732.00	598.00	598.00	1042.00	1042.00	100.0%	103.6%	100.0%	100.0%	
	Oaktrees	1084.00	1116.00	713.00	713.00	512.00	512.00	496.00	466.00	103.0%	100.0%	100.0%	94.0%	Nursing staff working additional unplanned hours.
	Trustwide	20474.50	19409.55	22279.35	22160.50	12008.75	11745.05	17821.50	17310.50	95.6%	100.0%	97.9%	97.3%	

Cheshire and Wirral Partnership NHS Foundation Trust

STANDARDISED SBAR COMMUNICATION

REPORT DETAILS	
Report subject:	Ward Daily Staffing Levels March and April 2019
Agenda ref. number:	
Report to (meeting):	Board of Directors
Action required:	Information and noting
Date of meeting:	29/05/2019
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 NHSI Single Oversight Framework themes this report reflects:	
Quality	Yes
Finance and use of resources	Yes
Operational performance	Yes
Strategic change	No
Leadership and improvement capability	Yes

CWP Quality Framework:		
Patient Safety	Safe	Yes
Clinical Effectiveness	Effective	Yes
	Affordable	Yes
	Sustainable	Yes
Patient Experience	Acceptable	Yes
	Accessible	Yes

http://www.cwp.nhs.uk/media/4142/quality-improvement-strategy-2018.pdf

Does this report provide any information to update any current strategic risks? If so, which?	
Contact the corporate affairs teams for the most current strategic risk register.	No

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

REPORT BRIEFING

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

This report details the ward daily staffing levels during the months of March and April 2019 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 the options and risks*

During March 2019 the trust achieved staffing levels of 92.3% for registered nurses and 100.8% for clinical support workers on day shifts and 95.6% and 99.5% respectively on nights. During April 2019 the trust achieved staffing levels of 94.8% for registered nurses and 102.3% for clinical support workers on day shifts and 99% and 99% respectively on nights.

In the months of March and April 2019 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 levels for registered nurses on Bollin ward were low due to increased vacancies, the ward were able to implement the following measures to give assurance that the ward staffing remained safe:

- Staffing levels were monitored closely at the twice weekly staffing meetings.
- The staffing levels for Bollin were escalated to the Head of Clinical Services and the Matron on a daily basis and reviewed at the end of each day to ensure RN cover was in place.
- Occupational therapy worked in the numbers supporting observations and section 17 leave (this is not captured as part of the return).
- RNs were moved from Adelphi at the beginning of April 1 RN for the whole month to support Bollin to ensure safety and consistency of care; RN cover was also moved from the secure wards for the same reason on a daily basis.
- Head of Clinical Services had a more visible presence on the wards to support the team to ensure any shortfalls were addresses without any delay.
- The ward manager was included in the numbers to support the team on a regular basis.
- The ward has now recruited an acting band 6 to backfill into vacant post to provide some additional support and leadership
- The acting Matron has also spent more time on Bollin supporting the team and working in the numbers when needed. This is not reflected on the staffer staffing sheets
- Bollin had 5 RN vacancies a preceptor has now moved onto Bollin leaving 4 RN vacancies.

Note: Only full shifts are covered within the percentage rates, where wards are supported for less than this, this is not captured in the return. For example if the matron spends 2 hours on the ward this is not reflected in the return.

Appendix 1 and 2 details how all 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 has approved this report for receipt at the above meeting?	Gary Flockhart, Associate Director of Nursing [MH and LD]Avril Devaney, 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	13.05.2019

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

Appendix No.	Appendix title
1. 2.	Ward Daily Staffing March 2019 Ward Daily Staffing April 2019

		Day				Night				Day		Night		
		Registered midwives/nurses		Care Staff		Registered midwives/nurses		Care Staff						
Service Line	Ward	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 (%)	Safe Staffing was maintained by:
SMH - Bed Based West & East	Adelphi	1304.5	1099	1089	1196	724.5	721	1288	1138.5	84.2%	109.8%	99.5%	88.4%	Nursing staff working additional unplanned hours. Cross cover arrangements. Non mandatory staffing activity was cancelled.
	Bollin	1522.5	924	1071.5	1458.5	713	639	1426	1335.5	60.7%	136.1%	89.6%	93.7%	Nursing staff working additional unplanned hours. Cross cover arrangements. Non mandatory staffing activity was cancelled.
	Croft	1209.25	1112.75	1657.75	1452.2	749	726	1431	1456	92.0%	87.6%	96.9%	101.7%	Nursing staff working additional unplanned hours. Cross cover arrangements. Non mandatory staffing activity was cancelled.Multi Disciplinary Team actively worked within the staffing establishment .
	Beech	1353	1320	920	885.5	713	630.5	713	784	97.6%	96.3%	88.4%	110.0%	Nursing staff working additional unplanned hours. Cross cover arrangements.
	Cherry	1243.5	1122	1138.5	1104	678.5	596	966	966	90.2%	97.0%	87.8%	100.0%	Nursing staff working additional unplanned hours. Cross cover arrangements. Non mandatory staffing activity was cancelled.Multi Disciplinary Team actively worked within the staffing establishment .
	Juniper	1097.9	1086.4	1102	1079	693	687.5	759	749.5	99.0%	97.9%	99.2%	98.7%	
	Willow PICU	922	857	880	880	506	494.5	644	644	93.0%	100.0%	97.7%	100.0%	Nursing staff working additional unplanned hours. Cross cover arrangements.
SMH - Forensic, Rehab, CRAC	Alderley Unit	977.6	971.9	1241.5	1230	805	748.5	688	660	99.4%	99.1%	93.0%	95.9%	Nursing staff working additional unplanned hours. Cross cover arrangements. Non mandatory staffing activity was cancelled.
	LimeWalk Rehab	916	766.5	828	829.5	552	494.5	552	558.5	83.7%	100.2%	89.6%	101.2%	Nursing staff working additional unplanned hours. Cross cover arrangements.
	Rosewood	949	942	1311	1299.5	645	557.5	759	713	99.3%	99.1%	86.4%	93.9%	Nursing staff working additional unplanned hours. Cross cover arrangements.
	Saddlebridge	997	916.5	1242	1242	621	621	747.5	747.5	91.9%	100.0%	100.0%	100.0%	Nursing staff working additional unplanned hours. Cross cover arrangements.
Learning Disabilities & NDD	Eastway A&T	1233.5	1211.5	1243.5	1243.5	620	620	1254	1254	98.2%	100.0%	100.0%	100.0%	
	Greenways A&T	1212	990.9	1834.5	1692.5	713	690	1265	1269.5	81.8%	92.3%	96.8%	100.4%	Nursing staff working additional unplanned hours. Cross cover arrangements. Multi Disciplinary Team actively worked within the staffing establishment .
CYP - Tier 4 CAMHS & Outreach	Coral	1021.75	987.25	1407	1407	719.75	719.75	1179.5	1179.5	96.6%	100.0%	100.0%	100.0%	
	Indigo	1135.5	891	927.5	927.5	690	602	746.5	790.5	78.5%	100.0%	87.2%	105.9%	Nursing staff working additional unplanned hours. Cross cover arrangements.
SMH - Bed Based Wirral & PICU	Brackendale	1032	1032	1132.5	1132.5	677.5	677.5	736	736	100.0%	100.0%	100.0%	100.0%	
	Brooklands	670.25	670.75	1454.75	1454.75	646	646	921	921	100.1%	100.0%	100.0%	100.0%	
	Lakefield	1058.75	1058.75	930	930	657	657	921	921	100.0%	100.0%	100.0%	100.0%	
	Meadowbank	1005	1005	1942.75	1942.75	635	635	1226	1226	100.0%	100.0%	100.0%	100.0%	
	Oaktrees	1032	1032	1100.5	1100.5	525	525	1006	1006	100.0%	100.0%	100.0%	100.0%	
	Trustwide	21893	19997.2	24454.25	24487.2	13283.25	12688.25	19228.5	19056	92.3%	100.8%	95.6%	99.5%	

Only complete sites your organisation is accountable for	Day				Night	
Ward name	Registered midwives/nur	Care Staff			Registered midwives/r	
	Total monthly	Total mont	Total mont	Total mont	Total mont	Total mont
Adelphi	1304.5	1099	1089	1196	724.5	721
Alderley Unit	977.6	971.9	1241.5	1230	805	748.5
Beech	1353	1320	920	885.5	713	630.5
Bollin	1522.5	924	1071.5	1458.5	713	639
Brackendale	1032	1032	1132.5	1132.5	677.5	677.5
Brooklands	670.25	670.75	1454.75	1454.75	646	646
Cherry	982.5	879	897	862.5	540.5	458
Coral	1021.75	987.25	1407	1407	719.75	719.75
Croft	1209.25	1112.75	1657.75	1452.2	749	726
Eastway A&T	1262.5	1211.5	1033.5	1243.5	686.5	620
Greenways A&T	1212	990.9	1834.5	1692.5	713	690
Indigo	1135.5	891	927.5	927.5	690	602
Juniper	1097.9	1086.4	1102	1079	693	687.5
Lakefield	1058.75	1058.75	930	930	657	657
LimeWalk Rehab	916	766.5	828	829.5	552	494.5
Meadowbank	1005	1005	1942.75	1942.75	635	635
Oaktrees	1032	1032	1100.5	1100.5	525	525
Rosewood	949	942	1311	1299.5	645	557.5
Saddlebridge	997	916.5	1242	1242	621	621
Willow PICU	922	857	880	880	506	494.5

		Day		Night	
Care Staff		Average fill	Average fill	Average fill	Average fill rate - care staff (%)
Total mont	Total monthly actual staff hours				
1288	1138.5	84.2%	109.8%	99.5%	88.4%
688	660	99.4%	99.1%	93.0%	95.9%
713	784	97.6%	96.3%	88.4%	110.0%
1426	1335.5	60.7%	136.1%	89.6%	93.7%
736	736	100.0%	100.0%	100.0%	100.0%
921	921	100.1%	100.0%	100.0%	100.0%
724.5	724.5	89.5%	96.2%	84.7%	100.0%
1179.5	1179.5	96.6%	100.0%	100.0%	100.0%
1431	1456	92.0%	87.6%	96.9%	101.7%
572	1254	96.0%	120.3%	90.3%	219.2%
1265	1269.5	81.8%	92.3%	96.8%	100.4%
746.5	790.5	78.5%	100.0%	87.2%	105.9%
759	749.5	99.0%	97.9%	99.2%	98.7%
921	921	100.0%	100.0%	100.0%	100.0%
552	558.5	83.7%	100.2%	89.6%	101.2%
1226	1226	100.0%	100.0%	100.0%	100.0%
1006	1006	100.0%	100.0%	100.0%	100.0%
759	713	99.3%	99.1%	86.4%	93.9%
747.5	747.5	91.9%	100.0%	100.0%	100.0%
644	644	93.0%	100.0%	97.7%	100.0%

		Day				Night				Day		Night		
		Registered midwives/nurses		Care Staff		Registered midwives/nurses		Care Staff						
Service Line	Ward	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 (%)	Safe Staffing was maintained by:
SMH - Bed Based West & East	Adelphi	1115	1037.5	1304.5	1326	701.5	692	1138.5	1103	93.0%	101.6%	98.6%	96.9%	Nursing staff working additional unplanned hours. Cross cover arrangements. Non mandatory staffing activity was cancelled.
	Bollin	1452.5	784.5	1043	1696	690	663.5	1380	1315	54.0%	162.6%	96.2%	95.3%	Nursing staff working additional unplanned hours. Cross cover arrangements.Multi Disciplinary Team actively worked within the staffing establishment .
	Croft	1251	1199.5	1441.25	1390.75	699.5	701.5	1281	1175	95.9%	96.5%	100.3%	91.7%	Nursing staff working additional unplanned hours. Cross cover arrangements.
	Beech	1293.5	1236	976	964.5	597.5	597.5	782	782	95.6%	98.8%	100.0%	100.0%	
	Cherry	1249	1167	1067	955	471.5	425.5	1104	1081	93.4%	89.5%	90.2%	97.9%	Nursing staff working additional unplanned hours. Cross cover arrangements. Non mandatory staffing activity was cancelled.Multi Disciplinary Team actively worked within the staffing establishment .
	Juniper	1030.4	1010.5	1078.5	1070.5	655.5	655.5	782	782	98.1%	99.3%	100.0%	100.0%	
	Willow PICU	939.5	939.5	989.5	989.5	437	437	927.5	927.5	100.0%	100.0%	100.0%	100.0%	
SMH - Forensic, Rehab, CRAC	Alderley Unit	899	900.5	1495.23	1495	637	637	1262	1262	100.2%	100.0%	100.0%	100.0%	
	Maple	1063.5	995	1099	1053.3	575	572	713	713	93.6%	95.8%	99.5%	100.0%	Nursing staff working additional unplanned hours. Cross cover arrangements.
	Rosewood	1007.5	1006.5	1311	1311	632.5	615	701.05	690	99.9%	100.0%	97.2%	98.4%	
	Saddlebridge	256	244.5	276	276	161	161	149.5	149.5	95.5%	100.0%	100.0%	100.0%	
Learning Disabilities & NDD	Eastway A&T	1227	1227	1296	1277	666.25	666.25	1044.25	1027.25	100.0%	98.5%	100.0%	98.4%	
	Greenways A&T	1169.5	934.75	1564	1685.5	690	678.5	1035	1046.5	79.9%	107.8%	98.3%	101.1%	Nursing staff working additional unplanned hours. Cross cover arrangements. Multi Disciplinary Team actively worked within the staffing establishment .
CYP - Tier 4 CAMHS & Outreach	Coral	899	900.5	1495.23	1495	637	637	1262	1262	100.2%	100.0%	100.0%	100.0%	
	Indigo	827.5	809.5	1080	1057	632.5	632.5	1062.6	1062.6	97.8%	97.9%	100.0%	100.0%	
SMH - Bed Based Wirral & PICU	Brackendale	1027.5	1027.5	1137	1137	605.5	605.5	724.5	724.5	100.0%	100.0%	100.0%	100.0%	
	Brooklands	769	769	1388.5	1388.5	661.5	661.5	966	966	100.0%	100.0%	100.0%	100.0%	
	Lakefield	970.5	970.5	953	953	690	690	747.5	747.5	100.0%	100.0%	100.0%	100.0%	
	Meadowbank	1066.25	1053.75	1720.5	1676.5	590.5	590.5	1086	1086	98.8%	97.4%	100.0%	100.0%	
	Oaktrees	1099.75	1099.75	1034	1033	595.25	595.25	577.25	577.25	100.0%	99.9%	100.0%	100.0%	
	Trustwide	20612.9	19313.25	23749.21	24230.05	12026.5	11914.5	18725.65	18479.6	94.8%	102.3%	99.0%	99.0%	

		Day				Night		
		Registered		Care Staff		Registered		Care
	Ward	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
East	Adelphi	1115.00	1037.50	1304.50	1326.00	701.50	692.00	1138.50
	Alderley Unit	960.50	964.50	1252.00	1258.00	690.00	678.50	724.50
	Bollin	1452.50	784.50	1043.00	1696.00	690.00	663.50	1380.00
	Croft	1251.00	1199.50	1441.25	1390.75	699.50	701.50	1281.00
	Greenways A&T	1169.50	934.75	1564.00	1685.50	690.00	678.50	1035.00
	Maple	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	Saddlebridge	256.00	244.50	276.00	276.00	161.00	161.00	149.50
Wirral	Brackendale	1027.50	1027.50	1137.00	1137.00	605.50	605.50	724.50
	Brooklands	769.00	769.00	1388.50	1388.50	661.50	661.50	966.00
	Lakefield	970.50	970.50	953.00	953.00	690.00	690.00	747.50
	Meadowbank	1066.25	1053.75	1720.50	1676.50	590.50	590.50	1086.00
	Oaktrees	1099.75	1099.75	1034.00	1033.00	595.25	595.25	577.25
	Willow PICU	939.50	939.50	989.50	989.50	437.00	437.00	927.50
West	Beech	1293.50	1236.00	976.00	964.50	597.50	597.50	782.00
	Cherry	1249.00	1167.00	1067.00	955.00	471.50	425.50	1104.00
	Eastway A&T	1227.00	1227.00	1296.00	1277.00	666.25	666.25	1044.25
	Juniper	1030.40	1010.50	1078.50	1070.50	655.50	655.50	782.00
	Coral	899.00	900.50	1495.23	1495.00	637.00	637.00	1262.00
	Indigo	827.50	809.50	1080.00	1057.00	632.50	632.50	1062.60
	Rosewood	1007.50	1006.50	1311.00	1311.00	632.50	615.00	701.05

	Fill Rate			
Staff	Day		Night	
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 (%)
1103.00	93.0%	101.6%	98.6%	96.9%
713.00	100.4%	100.5%	98.3%	98.4%
1315.00	54.0%	162.6%	96.2%	95.3%
1175.00	95.9%	96.5%	100.3%	91.7%
1046.50	79.9%	107.8%	98.3%	101.1%
0.00	0.0%	0.0%	0.0%	0.0%
149.50	95.5%	100.0%	100.0%	100.0%
724.50	100.0%	100.0%	100.0%	100.0%
966.00	100.0%	100.0%	100.0%	100.0%
747.50	100.0%	100.0%	100.0%	100.0%
1086.00	98.8%	97.4%	100.0%	100.0%
577.25	100.0%	99.9%	100.0%	100.0%
927.50	100.0%	100.0%	100.0%	100.0%
782.00	95.6%	98.8%	100.0%	100.0%
1081.00	93.4%	89.5%	90.2%	97.9%
1027.25	100.0%	98.5%	100.0%	98.4%
782.00	98.1%	99.3%	100.0%	100.0%
1262.00	100.2%	100.0%	100.0%	100.0%
1062.60	97.8%	97.9%	100.0%	100.0%
690.00	99.9%	100.0%	97.2%	98.4%

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STANDARDISED SBAR COMMUNICATION

REPORT DETAILS	
Report subject:	Guardian of Safe Working Hours report for the period Feb 2019 – April 2019
Agenda ref. number:	19.20.26
Report to (meeting):	Board of Directors
Action required:	Discussion and Approval
Date of meeting:	29/05/2019
Presented by:	Dr Faouzi Alam, Joint Medical Director

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

Which NHSI Single Oversight Framework themes this report reflects:	
Quality	Yes
Finance and use of resources	Yes
Operational performance	Yes
Strategic change	No
Leadership and improvement capability	Yes

CWP Quality Framework:		
Patient Safety	Safe	Yes
Clinical Effectiveness	Effective	Yes
	Affordable	Yes
	Sustainable	Yes
Patient Experience	Acceptable	Yes
	Accessible	Yes

http://www.cwp.nhs.uk/media/4142/quality-improvement-strategy-2018.pdf

Does this report provide any information to update any current strategic risks? If so, which?	
Contact the corporate affairs teams for the most current strategic risk register.	Yes

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

REPORT BRIEFING

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

The following report is the fourth of the quarterly reports to the Trust board and details the months from Feb 2019 to April 2019.

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

The introduction of the 2016 Junior Doctor created the role of the Guardian of Safe Working Hours and ended the previous hours monitoring system, replacing it with a continuous system of reporting exceptions occurring from a previously agreed work schedule aiming to ensure rotas and working hours are safe for Doctors and patients. The Guardian is bound by the Terms and Conditions of the contract to provide reports to the Trust Board regarding the safety of doctor's working hours and areas and plans for improvement.

Assessment – *analysis and considerations of the options and risks*

There have been 11 exception reports made during the period between Feb 2019 and end of April 2019. All of them were resolved as the doctors reporting them received time back in lieu of the additional hours worked. 1 exception report was made by a senior trainee and resolved satisfactorily. Another exception report was due to a junior trainee being on call but the next on call doctor not arriving on time so the first doctor had to stay late to handover and complete documentation, this was resolved by giving the doctor time in lieu of the additional work done.

There have been no highlighted areas of concern regarding safe working or access to educational and training opportunities.

To date there have been no fines levied against the Trust.

Locum spend is £29,947.50.

We have currently 52 doctors working under the terms and conditions of the 2016 contract. There are still some vacancies related to HENW placements not being filled both in CWP and regionally (However the picture is improving).

There have been no concerns raised regarding safe practice or with access to education and training experiences.

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

The Board of Directors is recommended to **note** the Guardian of Safe Working Hours report for the period Feb 2019 – April 2019

Who has approved this report for receipt at the above meeting?	Dr Faouzi Alam
Contributing authors:	Dr Sumita Prabhakaran, Guardian of Safe Working Hours

Distribution to other people/ groups/ meetings:

Version	Name/ group/ meeting	Date issued
1		22nd May 2019

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

Appendix No.	Appendix title
1	Guardian of Safe Working Hours for the period February 2019 – April 2019

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Report subject:	Learning from Experience report – trimester 3 2018/19 (incorporating an update on the national Learning from Deaths framework)
Agenda ref. no:	19.20.27
Report to (meeting):	Board of Directors – meeting in public
Action required:	Discussion and approval
Date of meeting:	29/05/2019
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
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
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 December 2018 to March 2019, trimester 3 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	2018/19		
			T3	T1	T2	T3
Number of safety incidents reported			3007	3370	3331	**3551**
Number of safety incidents by speciality	*Inpatient*		*2030*	*2317*	2160	***2316***
	Community physical health		*517*	*572*	577	***666***
	Community mental health		*411*	*424*	556	***534***
	Other		*49*	*57*	38	***35***
Reports to external agencies	StEIS		50	38	37	**39**
	National Reporting & Learning System		1428	1469	1645	**1720**
	NHSR	Non clinical	4	2	0	**5**
		Clinical	1	0	0	**2**
	Protect:					
	Staff assaults		290	454	446	**495**
	Missing patient		81	98	76	**98**
	Suspected theft		4	3	4	**5**
	Damage to property		13	19	32	**28**
	Lost or missing items		15	20	16	**6**
Number of complaints			70	74	93	**117**
Number of compliments			1032	1041	956	**858**

Note: *All incident associated and compliment numbers represent a snapshot as 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

"Proportional reporting" of incidents measures incidents against the care group. This approach was taken following a Quality Account aspiration to develop how CWP measures incident reporting profiles – for example Neighbourhood integrated care teams' reporting profiles are influenced by pressure ulcer incident reporting because of the way they are reported as (currently) required nationally. By presenting the incident reporting profiles in this way, the charts reveal fundamental differences between the care groups that can be used to identify where focus is needed to reinforce the that reporting no or lower harm incidents promotes learning to be able to potential mitigate future actual or significant harm incidents.

The charts below show a proportional split of incident grade per care group. This illustrates the differences in severity of incident occurrence and can further inform potential opportunities for both Service Improvement and Quality Improvement activity.

3. Analysis

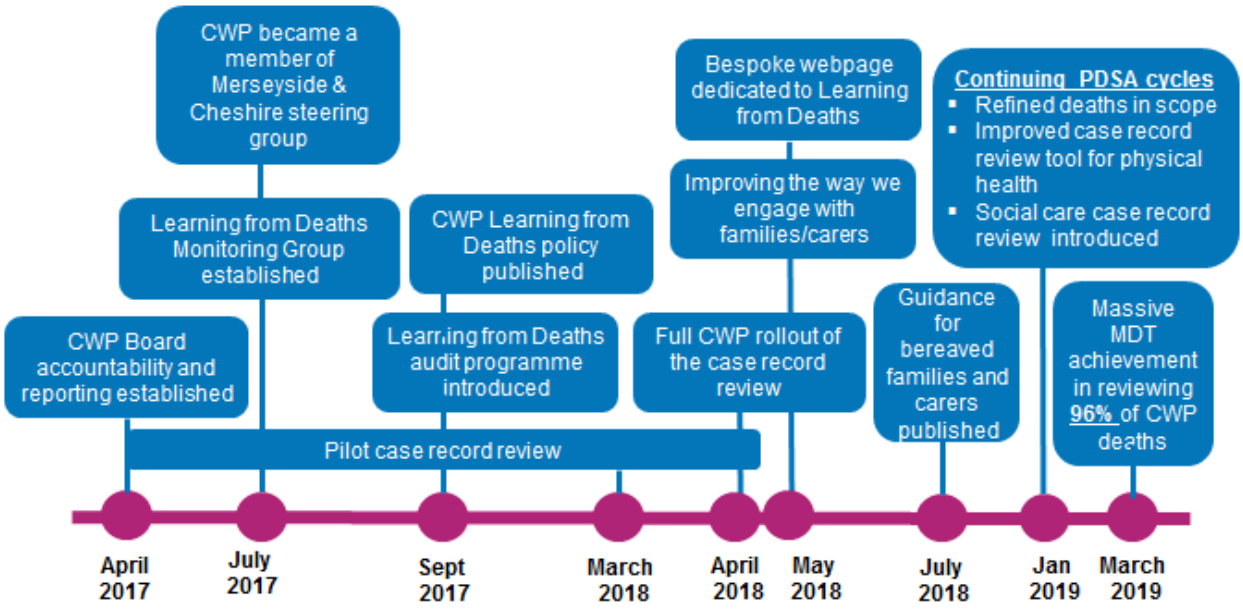
3.1.1 Incident reporting

Overall, the number of incidents reported this trimester internally via the Trust's incident reporting system is the highest of the past four trimester period, which best evidence shows that patient safety is an organisational priority. Organisation Patient Safety Incident Reports for the providers of the NHS in England were published by *NHS Improvement* in March 2019. CWP have reported 2859 patient safety incidents to the *National Reporting & Learning System* (*NRLS*) that occurred between April 2018 and September 2018 (this is the most recently published data – the next data set is due to be published in September 2019). The report showed that CWP continues to rank 19th for reporting of incidents per 1000 bed days when benchmarked against 50 other mental health trusts across the NHS in England. The report indicated that CWP reports 6% more self-harm related incidents compared to the average percentage reported by other mental health trusts. This is an improvement for the third consecutive period, in part due to the success of the patient safety quality improvement priority identified for 2018/19. Given the continuing scope for improvement and to promote sustained improvement, self-harm will continue to be a forward priority area for quality improvement as part of the Quality Account. The self-harm strategic steering

group's quality improvement work in this area continues to focus on the reduction of self-harm. *NRLS* reporting will continue to be monitored through the quality assurance dashboard presented to Quality Committee.

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

CWP milestones since the launch of the Learning from Deaths national guidance 2017:



During trimester 3, 2018/19, CWP have continued to undertake PDSA cycles to improve the quality of case record reviews by refining the scope of deaths identified for review. The Neighbourhoods Care Group have tested the case record review tool and made recommendations for further development. The new case record review, launched in January 2019, has been specifically designed to capture areas for learning relating to integrated care teams. The All Age Disability Care Group have also introduced a case record review tool to integrate social care reviews of deaths. In January 2019, a clinical audit identified scope for improvement regarding formulating care plans and the quality of documentation.

Clinical teams are to be congratulated for continuing to promote the national requirements within their multi-disciplinary teams in completing a case record review form, with an outstanding achievement of **reviewing 96% of deaths in March 2019**. The table below demonstrates an average percentage resulting in 80% overall for trimester 3, 2018/19.

Mortality monitoring	2017/18	2018/19		
	T3	T1	T2	T3
Inpatient deaths (including deaths 30 days after discharge)/ subject to a case record	3/ 100%*	1/ 100%*	1/ 100%*	**4/ 100%**
Deaths reported to the Trust/ subject to a case review record	558/ 18%*	344/ 37%*	334/ 60%*	**302/ 80%**
Deaths reported as a serious incident/ subject to a serious incident investigation	20/ 100%**	21/ 100%**	19/ 100%**	**22/ 100%**

During this trimester, 243 case record reviews have been undertaken, none of which has led to further investigation, though the reviews have identified good practice. For example, Cherry ward demonstrated good inter-agency working relating to end of life care planning. The MDT included ward staff, the Macmillan palliative care nurse and the community district nurse who worked together with family members to provide person-centred care during their relative's end of life. In response to the high number of case record reviews resulting in no problems in care being identified, the clinical audit sample will be increased from 5% to 10% of reviews from April 2019.

The next learning from deaths monitoring group, chaired by the Director of Nursing, Therapies & Patient Partnership, with Care Group and corporate representation, is due to take place in quarter 1 of 2019/20. The group continues to meet a minimum of three times a year with risks, learning and good practice being shared with the relevant committees.

3.1.3 Reporting deaths for people with a learning disability

During trimester 3, 2018/19 there were 17 deaths relating to people with a learning disability who had accessed CWP care. Reviews are allocated centrally by a central national team. There are no learning points to share this trimester. There are 20 investigations allocated for a LeDeR review. NHS England's North Regional LeDeR training is now available online for CWP staff requiring training.

3.2 Falls incidents

Trimester 3 saw the lowest number of falls incidents reported since trimester 1 of 2017/18. Post falls huddles have been used successfully to increase the situational awareness of staff in mitigating the risk of falls. One serious incident was reported this trimester and is currently under review; the initial patient safety review has confirmed compliance with policy and adherence to safeguarding procedures.

3.3 Elimination of use of unwarranted restrictive practices

The progress of the 'Elimination of use of unwarranted restrictive practices' Quality Improvement project is driven by an Expert Clinical Panel focusing on priority areas, with their intention of precipitating the identification of what good care looks like in managing behaviour that challenges. This work is aligned with the CQC's strategic priority of overseeing the use of restrictive practices and their thematic review of the use of restraint, prolonged seclusion and segregation. In April 2019, changes were made to the mental health services dataset (MHSDS) as part of the national programme of work to reduce restrictive practices being developed by NHS England and NHS Improvement, Care Quality Commission, Health Education England and NHS Digital. A share learning bulletin has described the responsibilities of the ward staff. From April 2019, it is mandatory to record:

- the position and duration of physical restraint;
- any injuries to staff/ patients/ others sustained immediately before or during restrictive interventions;
- if a post incident reviews took place.

This change is welcomed, as it will improve the accuracy of comparative analysis of the incidents reported by CWP with other trusts, in light of external feedback that CWP tends to report such incidents with more diligence, in part due to inconsistencies in reporting practice nationally.

3.4 Feedback from people who access the Trust's services

During this trimester, the Trust received 117 complaints under the NHS complaints procedure. On further analysis, complaints for the IAPT Teams in East Cheshire, South Cheshire and Vale Royal have increased from 3 to 11; the themes of these complaints include poor communication, access to services and a breach of confidentiality. Complaints for Specialist Mental Health bed based services have also increased from 19 to 28, whilst there has been a drop in complaints for the All Age Disability Service from 13 to 8.

3.5 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 two such reports discussed within the in-depth Learning from Experience report received by the Quality Committee. A recommendation has been identified to review the CQC report Learning from deaths: A review of the first year of NHS trusts implementing the national guidance, for the purpose of implementing lessons learned and to support ward to Board assurance to Quality Committee and the Board of Directors. The summary of recommendations identified in section 4.4 below describes the next steps identified to enable CWP to identify and implement transferable learning.

4. Recommendation

Recommendations from Trimester 3 analysis

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

4.1 Safe Services to work with the Care Group Learning from Experience meetings to build capability in (i) sharing learning across via the Learning from Experience report and the Patient and Carer Experience Sub Committee; and (ii) reporting, by exception to the Clinical Practice & Standards Sub Committee, on

improvement work being taken to address any identified gaps in the definition of clinical standards and/ or their application of them through building clinical practice capability.

4.2 Head of Clinical Governance to develop a checklist to ensure appropriate standards have been met throughout the investigation and final report. The checklist will be piloted with the governance teams who support the care groups to ensure a consistent approach.

4.3 Patient experience and complaints teams to explore corporate systems to best capture all compliments received to ensure externally we don't under-report compliments and continue to be able to learn from what works well, whilst not increasing the burden on staff to report.

4.4 The learning from deaths monitoring group to consider CQC findings within the Learning from deaths: A review of the first year of NHS trusts implementing the national guidance report. A self-assessment will be undertaken to enable any gaps identified to continuous improvement plans.

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	22/05/2019

Appendices provided for reference and to give supporting/ contextual information:	
Appendix number	Appendix title
1	Updates and assurances received against trimester 3 2018/19 recommendations

Appendix 1 – Updates and assurances received against trimester 2's recommendations

All inpatient staff to implement the learning outlined in share learning bulletin number 93 and confirm this to their Matron for providing assurance to the clinical pharmacy team. The policy will be re-audited in trimester 3 to ensure all the required monitoring is carried out following administration of rapid tranquillisation.
Assurance has been obtained by strategic Clinical Directors regarding the implementation of learning outlined in share learning bulletin number 93. An audit of the use and practice of rapid tranquillisation and physical health observations following administration took place in February 2019. Further recommendations were made which will be monitored through the care groups by the strategic Clinical Directors: ▪ All rapid tranquillisation episodes must be reviewed by the ward manager or matron to support more consistent adherence to Trust policy. ▪ Further understanding of the reasons why people are admitted to inpatient wards and treatment expectations/ outcomes need to be explicit as per acute care pathway. ▪ Further work needs to be undertaken by all bed based services in adult mental health and child and adolescent mental health to review pathways of care for people who may have Emotionally Unstable Personality Disorder and/ or neurotic/ stress related disorders. ▪ Further support is required to give staff capability to give IM injections in non-gluteal sites. ▪ The FOCUS work on reducing restrictive practices must use learning from LD wards to shape their work. ▪ Care groups should consider sending inpatient staff to LD assessment and treatment units to observe and learn how to reduce restrictive practices.
The incidents team to develop a governance framework for the reporting of corporate/ clinical support team incidents and complaints, including making it easier to report these on Datix, to promote parity with Care Group reporting.
The corporate/ clinical teams have been updated onto Datix making it easier for reporters to find their team name when reporting an incident on Datix. This is in line with the Trust's Finance budget coding system filtered through to all Trust systems to improve triangulation of data. A full review of the governance hierarchies structures has been reviewed. The Datix system has been developed to enable real time reporting of incidents, complaints and risks by Care Groups.
The complaints and incidents team to review the support that teams require to enable the accurate reporting of all compliments received.
Discussion took place at the Patient and Carer Experience Sub Committee regarding staff logging compliments. 'Gratitude boards' will be explored on how to capture real time compliments on wards and teams. Further work will take place on how to quantify compliments through our reporting systems of those captured in this way and for this to be celebrated through visual pictures
Complaints and incidents team to undertake further analysis into the longitudinal database of claims to identify opportunities for transferable learning.
Learning is shared through the Learning from Experience reports to identify patterns of learning within that timeframe. Claims score cards over a 10 year period demonstrate the majority of claims being low value but in psychiatry/ mental health suggesting a stable pattern over a longitude period. A specific section in the next Learning from Experience report will demonstrate this analysis.
The complaints and incidents team to self-assess CWP's position relating to recommendations outlined in the Learning from suicide-related claims: a thematic review of NHS Resolution data report in order to identify any areas for improvement.
Further to the recommendations outlined in NHS Resolution's Learning from Suicide Related claims report, CWP are involved in setting standards, with the Royal College of Psychiatrists and 10 other mental health trusts. This will be completed in April 2019, a training programme and information for staff will be developed and consulted on throughout trimester 1 2019/20. An Investigation Manager update and Duty of Candour update programme is being developed for the last week of May and throughout June 2019.

CWP representatives at the Emergency Department Delivery Boards to ensure discussion regarding the Healthcare Safety Investigation Branch Investigation report into the Provision of Mental Health Care to Patients Presenting at the Emergency Department.
External learning is disseminated through the Learning from Experience report to the Learning from Experience meetings held locally and at Care Group level. Any external learning identified for dissemination through partnership and system-wide fora is also taken forward by the lead individuals.

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STANDARDISED SBAR COMMUNICATION

REPORT DETAILS	
Report subject:	Workforce Disability Equality Standard (WDES)
Agenda ref. number:	19.20.29
Report to (meeting):	Board of Directors
Action required:	Discussion and Approval
Date of meeting:	30/05/2019
Presented by:	Philip Makin, Equality and Dviersity Coordinator

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 NHSI Single Oversight Framework themes this report reflects:	
Quality	Yes
Finance and use of resources	No
Operational performance	Yes
Strategic change	Yes
Leadership and improvement capability	Yes

CWP Quality Framework:		
Patient Safety	Safe	No
Clinical Effectiveness	Effective	Yes
	Affordable	No
	Sustainable	No
Patient Experience	Acceptable	Yes
	Accessible	Yes

http://www.cwp.nhs.uk/media/4142/quality-improvement-strategy-2018.pdf

Does this report provide any information to update any current strategic risks? If so, which?	
Contact the corporate affairs teams for the most current strategic risk register.	No

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

REPORT BRIEFING

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

From 2019 onwards, the new Workforce Disability Equality Standard (WDES) is to form part of the NHS Standard Contract.

The WDES will consist of a set of specific measures to enable NHS Trusts and NHS Foundation Trusts to compare the experiences of disabled and non-disabled staff and formulate action plans to address any areas for development.

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

During May and June 2019, the online WDES reporting form is to be published by NHS England.
• During June 2019, a prepopulated data spreadsheet is to be sent to NHS Trusts and NHS Foundation Trusts.
• August 2019 is the publication date for Trusts.
• During April / May 2020, the first national annual WDES report will be published.

Assessment – *analysis and considerations of the options and risks*

Research shows that, if people delivering services are motivated, included and valued, it will help to deliver high quality patient care, increased patient satisfaction and improved patient safety.

The new WDES will enable us to better understand the experiences of disabled staff. It will also support positive change for existing and potential people working in our services and enable a more inclusive environment for disabled people delivering services within CWP.

Trust Board is also asked to note that data sets providing statistics of disabled and non disabled people employed within our services will be submitted during June 2019 and annually thereafter and that this data will be published during August 2019 and annually thereafter.

Trust Board is also asked to note that an associated action plan will form part of the WDES process and that members will be kept appraised of developments in regard to this moving forward.

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

The Board of Directors is asked to note the contents of this report as well as the contents of both the NHS England Fact Sheet and the NHS England WDES Metrics Document.

Who has approved this report for receipt at the above meeting?	Avril Devaney, Director of Nursing,Therapies and Patient Partnership
Contributing authors:	Philip Makin, Equality and Diversity Co-ordinator

Distribution to other people/ groups/ meetings:

Version	Name/ group/ meeting	Date issued
	People and OD subcommittee	16 May 2019

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

Appendix No.	Appendix title
1	NHS England WDES Fact Sheet
2	NHS England WDES Metrics Document

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STANDARDISED SBAR COMMUNICATION

REPORT DETAILS	
Report subject:	Update in respect of Trust Key Priority Projects
Agenda ref. number:	19.20.30
Report to (meeting):	Board of Directors
Action required:	Information and noting
Date of meeting:	29/05/2019
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 NHSI Single Oversight Framework themes this report reflects:		CWP Quality Framework:		
Quality	Yes	Patient Safety	Safe	Yes
Finance and use of resources	Yes	Clinical Effectiveness	Effective	Yes
Operational performance	Yes		Affordable	Yes
Strategic change	Yes		Sustainable	Yes
Leadership and improvement capability	Yes	Patient Experience	Acceptable	Yes
			Accessible	Yes
		http://www.cwp.nhs.uk/media/4142/quality-improvement-strategy-2018.pdf		

Does this report provide any information to update any current strategic risks? If so, which?	
Contact the corporate affairs teams for the most current strategic risk register.	No

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

REPORT BRIEFING

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

The Programme Support Office (PSO) monitors progress of the Trust's key priority projects and monthly updates are presented to Operational Committee.

This report will update BoD on the end of year position in respect of 2018/19 key priority projects and outline the 2019/20 key priority projects that will be reported by the PSO.

BoD will receive six-monthly updates to provide an overview of the 2019/20 progress against plans.

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

Seven key priority projects were concluded during 2018/19 and project close down reports were shared with Operational Committee, as outlined in appendix 1. A further two projects have been closed to PSO reporting and will be managed in a different way.

Discussions to determine key priorities for 2019/20 have taken place in a number of forums, including the BoD Seminar held in February.

Assessment – *analysis and considerations of the options and risks*

Building on the Care Group Charters developed over the past 18 months, and following a review of key national deliverables for 2019/20, Care Groups have identified their individual priorities.

Consideration has then been given to cross-cutting themes and strategic enablers leading to the identification of seven key priority projects for 2019/20. Two of these have been carried forward from the previous year, namely;

- Transforming Care: This project will continue to report status updates via PSO until quarter 2 when the Care Group dashboards are finalised and can provide ongoing assurance.
- ADHD: This project will continue to report status updates via PSO until quarter 2 when the project will evolve into business as usual and can also be monitored via Care Group dashboards.

New projects have been identified as follows;

- Redesigning Adult and Older People Services - PID approved February 2019
- Information Technology and Informatics (3 work streams) - new PID in development
- Community CAMHs Model of Care - new PID to be presented to Operational Committee in May 2019

In addition, two strategic enablers will continue to report status updates via PSO and they will be monitored on their 2019/20 plans;

- Communications and engagement
- Quality Improvement Strategy

A critical path of projects will be developed to ensure that the resourcing of priority projects is managed alongside other areas of time-limited work that take up clinical and corporate services capacity, such as tender responses.

The Neighbourhood Based key priority project "Enhancing our teams", monitored by the PSO throughout 2018/19, is contained within the ICP Care Community Transformation programme. The ICP has a strategic PMO function and this will oversee the implementation of this priority.

Care Groups have also identified Care Group QI initiatives; projects that are priorities to the Care Groups themselves. Care Groups may be able to deliver these projects independently and progress accordingly as 'business as usual'. Scrutiny will be via Care Group governance and Care Group dashboards (currently under development).

If additional support is required, each project lead will identify the specifics of such support and make a request via the Heads of Clinical Support Services Forum. They will endeavour to identify specific support resource and allocate appropriately, this will include the newly qualified QI Experts within CWP who can support with transformation skills and project management.

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

BoD is asked to note the 2018/19 end of year summary and 2019/20 new key priority projects

Who has approved this report for receipt at the above meeting?	Tim Welch
Contributing authors:	Tracey Collins Claire James

Distribution to other people/ groups/ meetings:

Version	Name/ group/ meeting	Date issued
1.	Tim Welch	

Appendices provided for reference and to give supporting/ contextual information:	
Appendix No.	Appendix title
1. 2.	2018/19 year end summary Proposed 2019/20 key priority project programme

2018 / 2019 END OF YEAR SUMMARY

Appendix 1

CARE GROUP Current Key Priority Projects	**CURRENT STATUS**	**PROJECT END DATE**	**EXEC SPONSOR**
NEIGHBOURHOOD BASED SERVICE			
Single Model for Integrated Care Teams	**CLOSE DOWN REPORT (April 2019 Ops Committee)**	31/03/2019	DH
Enhancing our Teams	**CLOSE DOWN PSO REPORTING – CONTINUE VIA ICP REPORTING**	31/03/2020	DH
SPECIALIST MENTAL HEALTH			
Redesigning Adult OP MH Services – CMHT - Responsive Care in Communities	**CLOSED (February 2019 Ops Committee)**	30/09/2019	AnS/FA
Redesigning Adult OP MH Services – Bed Based	**CLOSED - (February 2019 Ops Committee)**	30/09/2019	AnS/FA
East SMS Exit Project	**CLOSED – (February 2019 Ops Committee)**	31/01/2019	ASt
WIRRAL ALL AGE			
Wirral All Age Disabilities – Phase 2	**CLOSED – (March 2019 Ops Committee)**	01/02/2019	ASt
CHILDREN, YOUNG PEOPLE & FAMILIES			
CYP Model of care	**CLOSED - (January 2019 Ops Committee)**	31/03/2019	AD
0-19 Implementation	**CLOSED – (January 2019 Ops Committee) Now BAU**	31/12/2018	AD
LD, ND & ABI CARE GROUP			
Care Model	**CONTINUE TO REPORT UNTIL Q2 – THEN CARE GROUP DASHBOARDS**	31/03/2020	ASt
ADHD	**CONTINUE TO REPORT UNTIL Q2 – THEN CARE GROUP DASHBOARDS**	01/03/2019	ASt
STRATEGIC ENABLERS			
Deliver People and OD Strategy	**CLOSED as KPP – Continue to deliver as part of POD Strategy**	31/03/2019	DH/AD/FA
Information Technology and Informatics	**NEW PID TO BE DEVELOPED WITH THREE WORKSTREAMS (End User Devices / Intro of Windows 10 / Data Quality)**	30/04/2019	TW
Communications and Engagement Strategy	**Continue with new yearly plan for 2019 2020**	30/05/2019	AD
Quality Improvement Strategy	**Continue with new yearly plan for 2019 2020**	31/03/2019	AnS

2019 / 2020 NEW PROGRAMME SUMMARY

Appendix 2

CARE GROUP Current Key Priority Projects	**CURRENT STATUS**	**PROJECT END DATE**	**EXEC SPONSOR**
SPECIALIST MENTAL HEALTH			
Redesign of Adult and Older people MH Services (Inpatient, Community & Rehab)	**PID APPROVED February 2019**	01/12/2020	AnS/ASt/FA/DH
CHILDREN, YOUNG PEOPLE & FAMILIES			
Community CAMHS Model of Care	**NEW PID APPROVED - May 2019**	30/09/2019	ASt
LD, ND & ABI CARE GROUP			
Transforming Care	**CONTINUE TO REPORT UNTIL Q2 – THEN CARE GROUP DASHBOARDS**	30/06/2019	ASt
ADHD	**CONTINUE TO REPORT UNTIL Q2 – THEN CARE GROUP DASHBOARDS**	30/06/2019	ASt
STRATEGIC ENABLERS			
Information Technology and Informatics	**NEW PID TO BE DEVELOPED WITH THREE WORKSTREAMS (End User Devices / Intro of Windows 10 / Data Quality)**	30/03/2020	TW
Communications and Engagement Strategy	**Continue with new yearly plan for 2019 2020**	30/05/2019	AD
Quality Improvement Strategy	**Continue with new yearly plan for 2019 2020**	31/03/2019	AnS

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STANDARDISED SBAR COMMUNICATION

REPORT DETAILS	
Report subject:	East Cheshire Redesign
Agenda ref. number:	19.20.30
Report to (meeting):	Board of Directors
Action required:	Information and noting
Date of meeting:	29/05/2019
Presented by:	Andy Styring, Director of Operations

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

Which NHSI Single Oversight Framework themes this report reflects:	
Quality	Yes
Finance and use of resources	Yes
Operational performance	Yes
Strategic change	Yes
Leadership and improvement capability	Yes

CWP Quality Framework:		
Patient Safety	Safe	Yes
Clinical Effectiveness	Effective	Yes
	Affordable	Yes
	Sustainable	Yes
Patient Experience	Acceptable	Yes
	Accessible	Yes
http://www.cwp.nhs.uk/media/4142/quality-improvement-strategy-2018.pdf		

Does this report provide any information to update any current strategic risks? If so, which?	
Contact the corporate affairs teams for the most current strategic risk register.	Yes
BAF risk number 2	

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

REPORT BRIEFING

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

This report is to update the Board of Directors on progress against the implementation plan for the redesign in East Cheshire.

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

In October 2018, the final configuration of services was agreed as part of the Central and East redesign following a public consultation.

The final configuration is; 1 adult and older peoples functional ward in Lime Walk House with 26 beds, 1 dementia ward in CARS with 15 beds, rehabilitation and ECT services centralised in Chester and an increased capacity in HTT and CMHT through additional staffing.

Assessment – *analysis and considerations of the options and risks*

Specialist mental health inpatient care for adults and older people- Preparatory building works are starting in May, with full site development beginning early June, on the renovation of Lime Walk House which will become the new inpatient unit for adults and older people. Feedback from service users, carers and staff has been central to the development via the newly established Building User Group. CARS Ward has transferred to CWP ownership to enable the redevelopment of the facilities. TFollowing University of Stirling guidance, the ward will use evidence-based and international best practice to support people and their families with dementia. A management of change (MOC) process to determine the new ward staff teams and the supporting facilities teams has been completed. A specialised induction programme including culture and organisational development is being rolled out currently. After review of the IT equipment, a replacement and new equipment roll out is planned for the summer which will aid staff in being more agile and person centred.

Electro-convulsive therapy (ECT) capacity and demand modelling has been undertaken to determine the number of sessions required and to informed the new staffing model for the centralised service. 1:1 meetings with the small number of current service users will begin shortly, with transition planned for July 2019.

Rehabilitation Services- The rehabilitation service previously provided at Lime Walk House in Macclesfield has now been relocated to Bowmere Hospital. A MOC process for staff has been completed for the new service including the new 'Maple Ward'. Any gaps in staffing have been addressed through successful recruitment with all ward staff receiving induction and appropriate clinical training.
As with acute inpatient services, the rehabilitation team have also benefited from an IT review with the replacement and new equipment roll out planned for the summer. A comprehensive engagement has underpinned the relocation of the service, overall, informal feedback has been positive about the larger ward, more facilities and the Bowmere site and location in general.

CRHTT- A MOC process for staff to deliver the enhanced 24/7 Home Treatment Team has also been confirmed, including pharmacy and consultant support. Transition planning has been completed at a high level; with individual staff level transitions now being developed. A specialised induction programme including culture and organisational development plus a clinical training programme will support staff transfer into new roles. After review of the IT equipment, a replacement and new equipment roll out is planned for the summer which will aid staff in being more agile and person centred, especially with the challenging geography.

CMHT- The staffing structure has been confirmed for the enhanced teams. Detailed plans for efficiency analysis, estates development, clinical/administrative systems review, education, training and cultural development are in progress to underpin the transformation of the service.

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

The Board of Directors is asked to note the information above.

Who has approved this report for receipt at the above meeting?	Andy Styring, Director of Operations
Contributing authors:	Rebecca Cummings, Transformation Manger

Distribution to other people/ groups/ meetings:

Version	Name/ group/ meeting	Date issued

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

Appendix No.	Appendix title
1	Update against plan 1st May 2019

Appendix 1- Update against plan 1st May 2019

Specialist mental health inpatient care for adults and older people
Preparatory building works are starting in May on the renovation of Lime Walk House in Macclesfield which will become the new inpatient unit for adults and older people with serious mental ill health. The project will see a £2million capital investment to extend and modernise the on-site facilities. The renovation will be on a single level allowing for increased access to gardens and includes all en-suite bedrooms, gymnasium and a sensory garden. Feedback from service users, carers and staff has been central to the development via the newly established Building User Group.

In addition, CARS Ward at Macclesfield General Hospital has transferred to CWP ownership to enable the redevelopment of the facilities. The unit will benefit from a £2.5million capital investment and renovation programme to prepare for the relocation of the existing dementia care unit (Croft Ward). Following University of Stirling guidance, the ward will use evidence-based and international best practice to support people and their families with dementia.

A management of change process to determine the new ward staff teams and the supporting facilities teams has been completed. A specialised induction programme including culture and organisational development is being designed alongside a clinical training gap analysis to inform the clinical training programme as staff transfer to new roles.

A review of the IT equipment in the acute service has also been completed to support new ways of working. A replacement and new equipment roll out is planned for the summer which will aid staff in being more agile and person centred.

Electro-convulsive therapy (ECT) capacity and demand modelling has been undertaken to determine the number of sessions required to support service users across the CWP footprint. This insight has informed the new staffing model for the centralised service at Bowmere Hospital with additional staffing roles confirmed. 1:1 meetings with the small number of current service users have been planned and will begin shortly, with transition planned for July 2019. The Trust is also in the process of signing a formal contract with Wirral University Teaching Hospitals to deliver the anaesthetic element of the service.

Rehabilitation Services
In line with the outcome of the public consultation, the rehabilitation service previously provided at Lime Walk House in Macclesfield has now been relocated to Bowmere Hospital in Chester. The facilities at Bowmere are complementary to the rehabilitation process, including being within walking distance of Chester city centre and adjacent to train/bus routes with nearby shops and supermarket. There is also an on-site gym, specialist occupational therapy suite - the 'Clarion Centre' and café.

A management of change process for staff has been completed for the new service including the new 'Maple Ward'. Any gaps in staffing have been addressed through successful recruitment with all ward staff receiving induction and appropriate clinical training.

As with acute inpatient services, the rehabilitation team have also benefited from an IT review with the replacement and new equipment roll out planned for the summer.

A comprehensive engagement has underpinned the relocation of the service including pre-move visits and tours for service users and carers to aid familiarity and continuity of care. The Patient and Carer Experience Team have also continued to support people accessing the service with their families and carers to ensure that any required adjustments are managed efficiently. Overall, informal feedback has been positive about the larger ward, more facilities and the Bowmere site and location in general.

Crisis Resolution Home Treatment
As with acute and rehabilitation staff team, a management of change process for staff to deliver the enhanced 24/7 Home Treatment Team has also been confirmed, including pharmacy and consultant support.

Transition planning has been completed at a high level; with individual staff level transitions now being developed.

A specialised induction programme including culture and organisational development is being designed alongside a clinical training gap analysis to inform the clinical training programme, as staff transfer into new roles.

A review of the IT equipment supporting the staff in the HTT has also been undertaken. With the challenging geography in East Cheshire, the replacement and new equipment roll out will particularly aid staff in being more agile and responsive in delivering patient centred care in the community.

Specialist community mental health care for adults and older people including dementia care
The staffing structure has been confirmed for the enhanced Community Mental Health Teams and staff engagement sessions are continuing.

As with other services, an induction programme including culture and organisational development is being created and clinical training gap analysis is underway to inform the development of a clinical training programme, as staff transfer into new roles.

Detailed plans for efficiency analysis, estates development and a clinical/administrative systems review are in progress to underpin the transformation of the service.

The new dementia outreach service will be staffed by one individual identified as a result of the redesign and management of change process with a further post will be advertised in the summer.

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STANDARDISED SBAR COMMUNICATION

REPORT DETAILS	
Report subject:	Quality Improvement Report, Edition 3 (2018/19)
Agenda ref. number:	19.20.32
Report to (meeting):	Board of Directors – meeting in public
Action required:	Discussion and Approval
Date of meeting:	29/05/2019
Presented by:	Dr Anushta Sivananthan, Joint 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 NHSI Single Oversight Framework themes this report reflects:		CWP Quality Framework:		
Quality	Yes	Patient Safety	Safe	Yes
Finance and use of resources	No	Clinical Effectiveness	Effective	Yes
Operational performance	Yes		Affordable	Yes
Strategic change	Yes		Sustainable	Yes
Leadership and improvement capability	Yes	Patient Experience	Acceptable	Yes
			Accessible	Yes
		http://www.cwp.nhs.uk/media/4142/quality-improvement-strategy-2018.pdf		

Does this report provide any information to update any current strategic risks? If so, which?	
Contact the corporate affairs teams for the most current strategic risk register.	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*

This report is one of many reviewed by the Trust's Board of Directors that, together, give a detailed view of CWP's overall performance in relation to quality. The report highlights and showcases the innovative quality improvement projects being undertaken by staff throughout the organisation. The report is produced three times a year and this is the third and final edition of 2018/19.

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

The Quality Improvement reports are produced three times a year to update people who access and deliver the Trust's services, carers, the public, commissioners, internal groups, and external scrutiny groups on progress in improving quality across our services. The Trust is required to formally report on our quality improvement (QI) priorities in the annual Quality Account. The QI report provides a highlight of what CWP is doing to continuously improve the quality of care and treatment that its services provide.

Assessment – *analysis and considerations of the options and risks*

As the final report of the year, progress against the three Trustwide QI priorities for 2019/20 is detailed in the report to complement the outcomes reported in the Quality Account 2018/19:

- The **patient experience** priority to improve engagement with bereaved families and carers.
- The **clinical effectiveness** priority to improve access to physiological therapies.
- The **patient safety** priority to reduce the severity of the harm sustained by those people accessing CWP services that cause harm to themselves.

Further, 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 across all the domains of the CWP 'quality framework'.

Delivering **'Safe'** care:

- 'Sign up to safety' Bowmere kitchen table week
- CAMHS Out of hours advice line - First birthday

Delivering '**affordable'** care:

- Improving the Dementia Care pathway
- Broxton Community Care team - Improving communication with care agencies to promote safer care
- The Crisis & Reablement Roadshow – creating closer connections and simplifying the referral process
- Introduction of case management across the East Community Learning Disability team

Delivering **'sustainable'** care:

- Liaison and Diversion team newsletter enhances team communication
- Education CWP's SUCCEED programme success

Delivering '**Acceptable**' and '**Accessible**' care:

- Neston Community Care team strive to deliver equitable, accessible care.
- Access Sefton provide a holistic, person-centred approach to people with long-term conditions
- Chester Older People's Community team receive a sustainable mental health service commendation

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

The Board of Directors are asked to **approve** this report.

Who has approved this report for receipt at the above meeting?	David Wood – Associate Director of Safe Services
Contributing authors:	Katherine Evans – Head of Quality Assurance and Improvement

Distribution to other people/ groups/ meetings:

Version	Name/ group/ meeting	Date issued
1	Board of Directors	22/05/2019

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

Appendix No.	Appendix title
1	Quality Improvement Report, Edition 3 2018/19

NHS
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Quality Improvement Report

Edition 3
December 2018 – March 2019

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

Bowmere's successful 'Sign up to Safety'

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

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

These reports are produced three times a year, this being the third 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 Report*s 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.

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

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

Bowmere's successful 'Sign up to Safety' kitchen table week raises awareness of staff psychological safety and patient safety
⇨see page 7

Having reached its first birthday, CAMHS Out of Hours Advice Line describes the positive impact the service is now having on children, young people and their families
⇨ see page 8

Improving the dementia care pathway is now enabling faster diagnoses of dementia
⇨see page 9

The Crisis & Reablement Roadshow creates closer connections with fellow Community Care team colleagues, raising awareness around referrals and their offer
⇨see page 12

Introduction of case management across the East Community Learning Disability team eradicates their waiting list
⇨see page 13

Neston Community Care team improve the patient discharge experience through effective partnership working
⇨see page 17

Access Sefton provide a holistic, person-centred approach to people with long-term conditions
⇨see page 18

Chester Older People's Community team have received a sustainable mental health service commendation from the Royal College of Psychiatrists
⇨see page 19

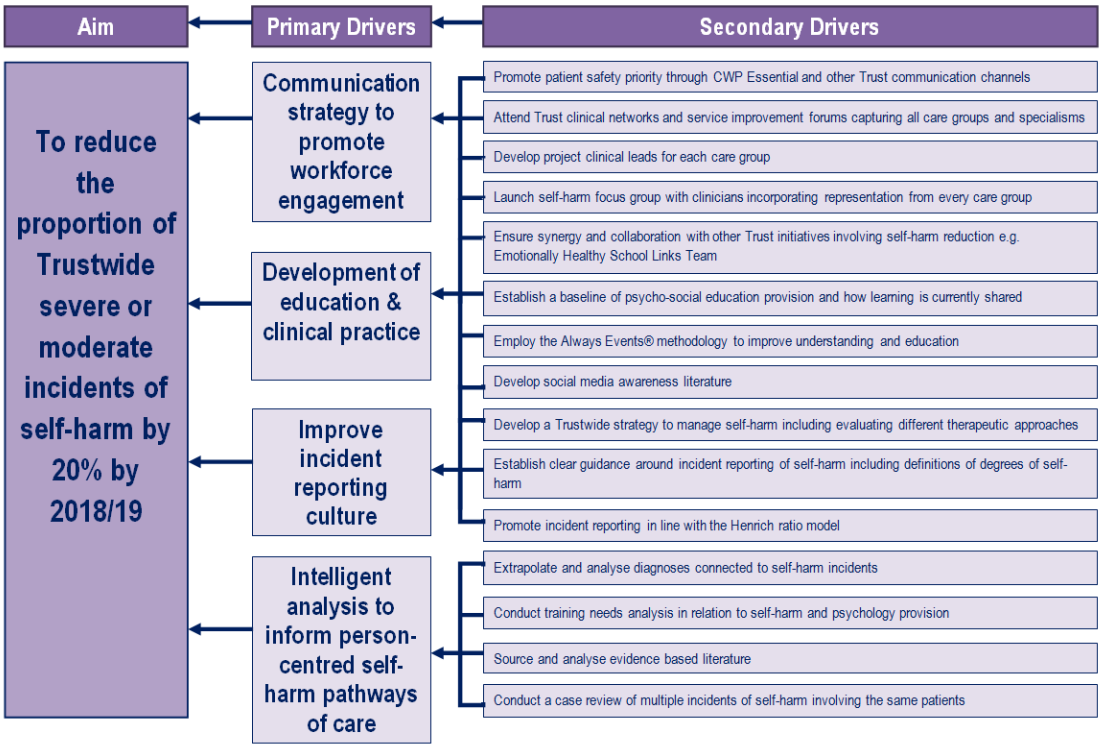
QUALITY IMPROVEMENT PRIORITIES

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*.

The **patient safety** QI priority identified for this year was:

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

For each of our Trustwide QI priorities, the starting point was identifying the aim, mapping the current state and identifying drivers and critical change ideas to improve care for the people we serve. The driver diagram below describes this for the patient safety priority:



The following describes the achievements the Trust has made in response to this priority this year:

- ✓ Developed an expert group to lead this project and to ensure robust oversight
- ✓ Arranged meetings to attend Trust clinical networks and service improvement meetings to engage with clinicians
- ✓ Collaborated with our Safe Services team colleagues to improve incident reporting processes
- ✓ Presented at Clinical Networks and QI events to promote this project and gather feedback from staff
- ✓ Developed a self-harm strategic steering group, collaborating closely with other related initiatives such as suicide prevention
- ✓ In-depth analysis undertaken of self-harm data to identify themes and specific areas/ opportunities for improvement
- ✓ Developed a share learning bulletin clarifying the definition of self-harm in line with NICE guidance

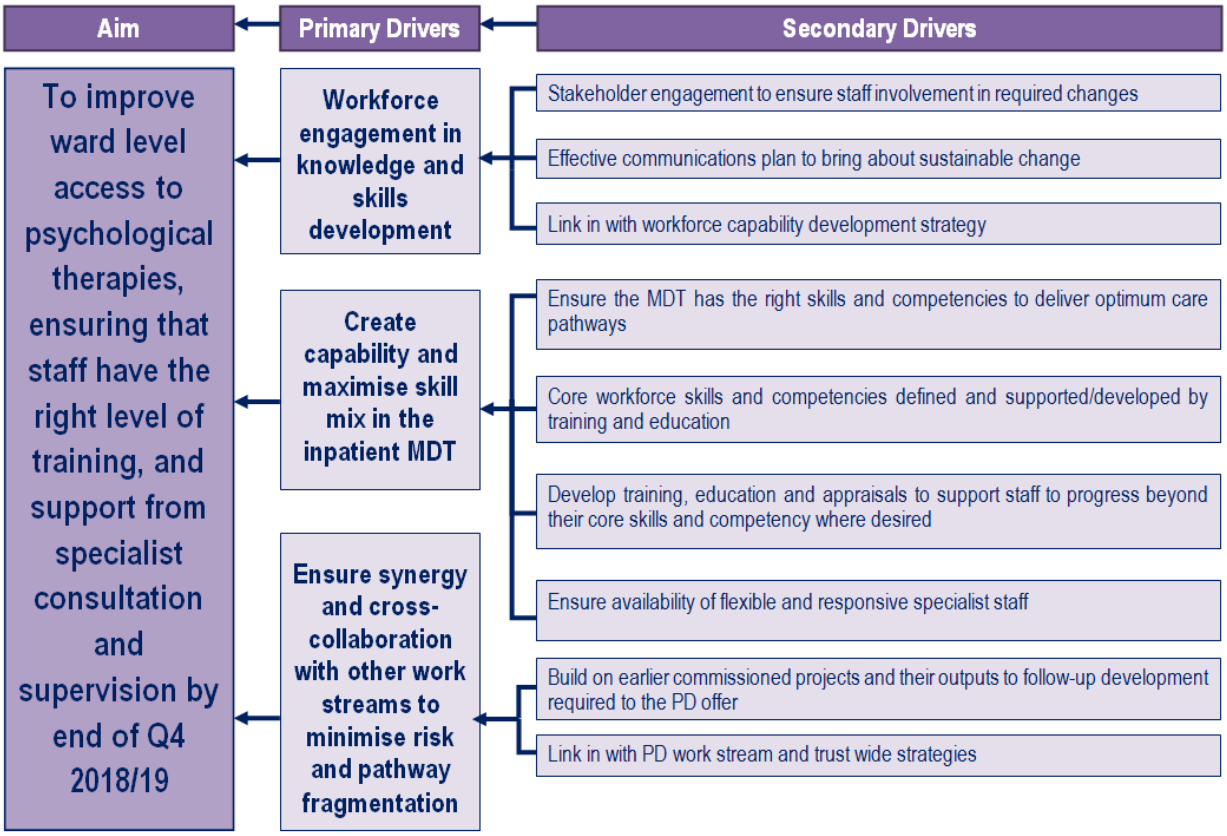
The Trust has made significant progress in reducing moderate and severe incidents of self-harm, achieving a commendable **12% reduction**. The establishment of this project has increased the profile of self-harm within the organisation and continuous improvements are being seen as a result, so we are going to continue with this priority over the next year. Furthermore, the Trust has now established a clinical expert panel, with the strategic aim of eliminating the use of unwarranted restrictive interventions and has identified this critical QI project as an interdependent workstream within this.

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

The clinical effectiveness QI priority identified for this year was:

To improve inpatient access to psychological therapies

As aforementioned, the starting point was identifying the aim, mapping the current state and identifying drivers and critical change ideas to improve care for the people we serve. The driver diagram below describes this for the clinical effectiveness priority:



The following describes the achievements the Trust has made in response to this priority this year:

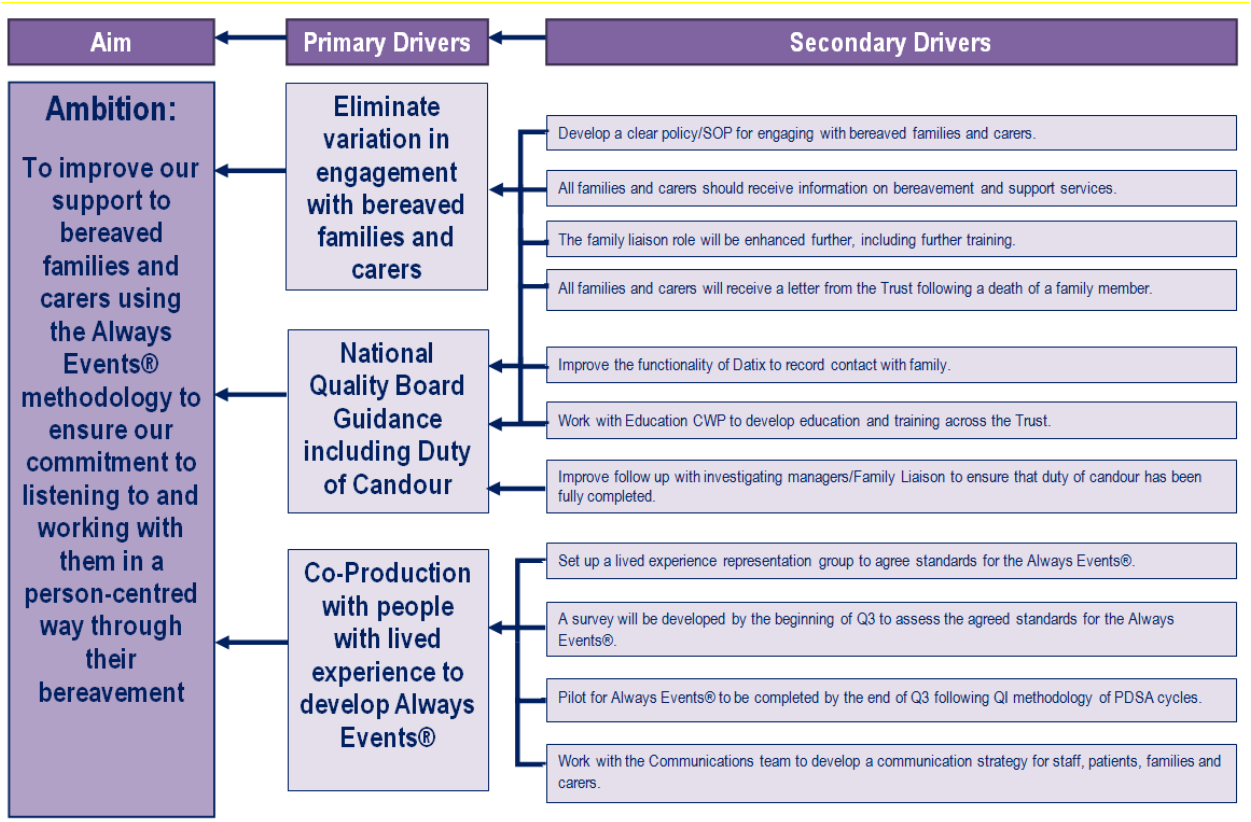
✓ Developed an expert group to lead this project and to ensure robust oversight
✓ Arranged meetings to attend Trust clinical networks and service improvement meetings to engage with clinicians
✓ Collaborated with our Safe Services team colleagues to improve incident reporting processes
✓ Multi-disciplinary psychology work stream has been convened focusing on the application of psychology skills on wards
✓ Developed the work stream, ensuring that it brings together people across the Trust already exploring ward psychology provision
✓ Linked closely with the Personality Disorder work stream, developing Trustwide guidelines to support staff in this area
✓ Reviewed national standards for psychology
✓ Reviewed role of psychology in the wards and support required by ward staff
✓ Confirmed Trust model for psychology support to wards, starting with cultural development and leading to short term interventions
✓Business case developed outlining national standards and CWP are now determining which option to support and mobilise

For more information, please contact Beccy Cummings, Service Improvement Manager, at rebecca.cummings1@nhs.net

The patient experience QI priority identified for this year was:

To improve engagement with bereaved families and carers

As aforementioned, the starting point was identifying the aim, mapping the current state and identifying drivers and critical change ideas to improve care for the people we serve. The driver diagram below describes this for the patient safety priority:



The following describes the achievements the Trust has made so far in working towards this aim:

✓ A set of standards and principles were drafted to share with a lived experience representation group
✓ The project has ensured that these standards, adopting the concept of Always Events, include the fundamental principle that all families and carers receive information on bereavement and support services; this includes the development of appropriate and person-centred communication. The group have also commenced co-production of a survey of the experience of bereaved families and carers.
✓ Further training has been provided to the family liaison officers to enhance the support provided to families and those bereaved, and a further cohort of training is to be delivered in May 2019
✓ Incident reporting processes have been enhanced to facilitate delivery of the principles of the Duty of Candour, which includes the key aim of supporting bereaved families and carers

This project is a national priority and as such is considered by the Trust to be a critical piece of QI; as a result, this work will continue, ensuring that true co-production is realised and sustained. The overarching principle is to offer bereaved families and carers with information that is as person-centred and supportive as possible, ensuring they are able to provide feedback on their experiences in order for the Trust to learn from these and improve where concerns have been raised. Furthermore, it allows the Trust to identify, capture and sustain best practice where positive feedback has been provided.

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

Bowmere's successful 'Sign up to Safety' kitchen table week

Background:

Education CWP are responsible for supporting people who deliver and support the delivery of CWP's services to develop their management and leadership behaviours to ensure they have the competence and confidence to support their teams. Historically, this training has been delivered in a series of one off face-to-face workshops which staff can access at any point in their development. The 'Sign up to Safety' campaign promotes a yearly kitchen table event to raise awareness of staff psychological safety and patient safety. The matron and head of clinical service implemented this initiative on Beech, Juniper, Cherry and Willow wards.

What did we want to achieve?

We wanted to make this as relevant and applicable as possible, in particular for our clinical colleagues who struggle to get time out of practice. We were also aware that some delegates attended development programmes, but weren't confident of putting their learning into practice and didn't always have the support they needed in their day to day work.

What we did:

- ✓ We set up the kitchen table events on each ward and ensured that staff were able to attend.
- ✓ We made the sessions informal and asked staff to be open and honest with us.
- ✓ We spoke to staff about what they enjoyed about their job, what they thought could be improved for them, in relation to support, what they found difficult about their job and how we could work together to improve patient care and experience.
- ✓ We then fed back to the teams what the themes were across all areas and what ideas we had for moving forward.

Results:

All staff were engaged in the sessions and reported that they thought they were beneficial. There were a number of common themes across the wards, all of which have been developed into short term and long term goals and all of which will be fed back to the teams, as new initiatives are implemented. Staff wanted the events to continue, so we will plan to do this again in six months' time.

Next steps:

The actions have been split into short term goals and long term goals. Some 'quick wins' have already been actioned and other

work has started on some of the long term projects. The kitchen table events will be organised again in six months' time, where actions will be fed back and then further suggestions can be made for moving forward.

For further information, please contact Louise Gill, Matron, Bowmere, at louise.gill4@nhs.net

CAMHS Out of Hours Advice Line reaches its 1st birthday!

Background:

As part of the Cheshire and Merseyside Forward View, CWP were successful in securing funds to develop out of hours support for children and young people requiring support for mental health needs outside of working hours. There are currently very few out of hours services available for children and young people and their families, however, based on the success of the Wirral CAMHS Advice Line, the bid aimed to extend this CWP service out of hours and across the Trustwide footprint.

What did we want to achieve?

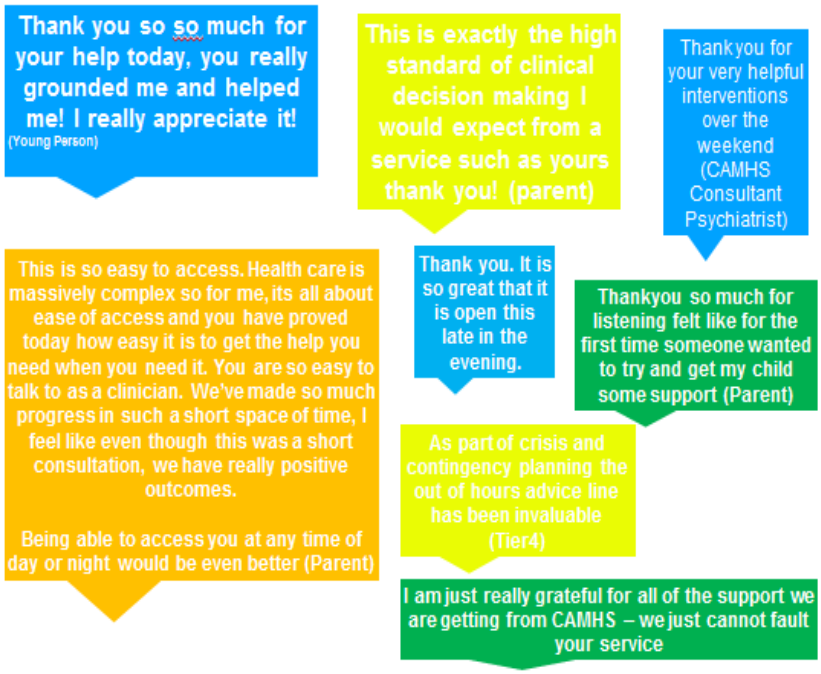
Wirral CAMHS developed a telephone advice line in January 2017 as part of the newly expanded Wirral CAMHS Primary Mental Health Team. The advice line is open to young people, professionals and their families in Wirral. NICE guidelines recommend that if a child or young person self harms or has severe suicidal thoughts, that they are admitted to their local paediatric ward overnight and CAMHS then carry out a risk assessment the following day, or when medically fit for discharge, as part of their discharge plan. As a result of this new service, Wirral saw a drop in the number of children and young people admitted to our partner acute trust and a reduction in paediatric bed days by over 40%. This represents a significant saving to the acute trust but also ensures children and young people are not having unnecessary admissions to hospital with all the disruption and trauma this can bring. Within a year of the Wirral Advice Line being launched, they saw a 44% reduction in children being admitted to the paediatric ward. The success of this project was something that CAMHS wanted to spread across the Trust, ensuring that all children, young people and their families living in the Cheshire and Wirral area (including West Cheshire, East Cheshire, South Cheshire, Vale Royal and Wirral) had access to the same support out of hours.

What we did:

Once CAMHS secured the funding, a project group was set up, workstreams and leads were identified including Communications, HR, and Performance and Information, with an operational model established. The service successfully met their target launch date of March 2018 and they have now been operating for over a year.

Results:

The advice line is operational from 5pm until 10pm Monday to Friday, and 12pm until 8pm on Saturdays, Sundays and bank holidays. The team offers several types of support including mental health advice, resources, signposting and mental health support calls and consist of a mental health nurses, counsellors, social workers and a teacher with a masters in psychology and lengthy CAMHS experience. The staff also cover four paediatric wards at the weekend, offering risk assessment to children that have been admitted via the self-harm pathway to try and discharge them in a timely way, who would have ordinarily had to wait until Monday to be assessed. Furthermore, we can also complete a mental health assessment over the phone and then this will then be passed on to the relevant CAMHS team for triage.



The team often have calls regarding young people that have already been referred to CAMHS and are on the waiting list, and they offer support in that period. Feedback from colleagues within specialist CAMHS have described young people finding this really helpful, and that they have recognised that **young people are attending sessions better prepared and ready to engage**, such as having goals already identified.

For children already accessing CAMHS, their team can request that the advice line makes "planned support calls" during times of increased distress or risk. Feedback is indicating that children and families appreciate "being held in mind" and **they report it helps them feel less alone** during periods other services are not available. We also hope that it provides CAMHS practitioners with peace of mind that there is a service offering that child support during a difficult time whilst they are not on duty.

Next steps:

The team are continuing to collect and analyse the data relating to their service's activity to ensure that they are using the resources in the best possible way to meet demand, facilitating access to the right care at the right time, in the right place. A recently conducted audit of calls identified that a significant amount were made by children either diagnosed with Autism Spectrum Disorder, or there was significant evidence that they would meet the threshold for a diagnosis. This information is incredibly valuable, as it can further assist in identifying where gaps in provision of service are, that otherwise may have gone undetected. The team also wish to record a primary and secondary presenting problem, so that they can more accurately capture an overall picture of what a child and family are experiencing.

For more information, please contact Louise Smith, CAMHS Out of Hours Advice Line Team Manager, at louise.smith66@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.

Improving the dementia care pathway

Background:

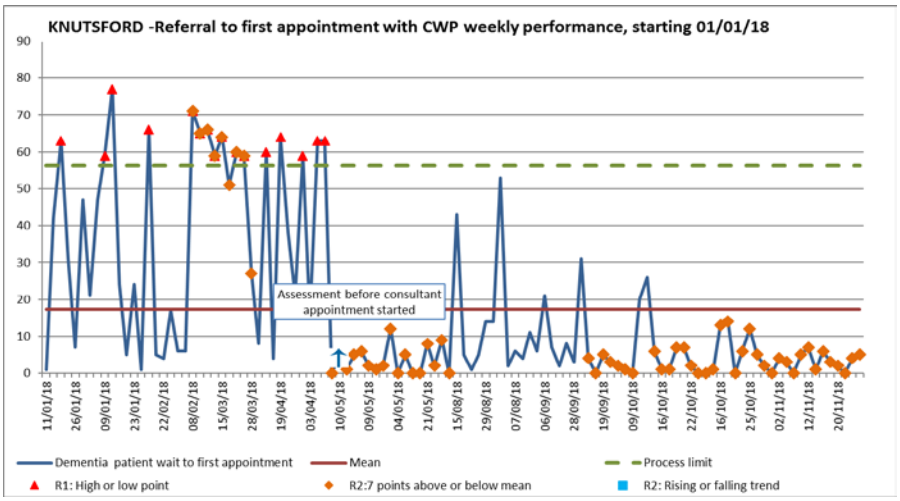
Knutsford has a higher than the national average of people aged 70 and over and 1 in 6 people over the age of 80 will get dementia, therefore the demand for dementia services in Knutsford is likely to increase. In June 2017, the wait for a new consultant was 7 to 8 weeks and there were examples of where the service for people could be improved. Therefore, a joint initiative was created, led by Dr David Hans, GP at Toft Road and supported by Josephine Worthington – Team Manager of the Older People's Community Mental Health Team and Dr Sadia Ahmed – Consultant Psychiatrist.

What we wanted to achieve?

The aim of the initiative was to **improve the quality of the care pathway**, enable quicker initial dementia diagnosis and, provide a local primary care review clinic, and provide greater access to consultant clinic for people with complex needs.

What we did:

We have established a CWP Consultant Clinic in Knutsford. GPs in Knutsford agreed to carry out the annual reviews of people stable with dementia. Where people had other long term conditions, their dementia review was built into their annual review appointment. CWP use the released resources of staff time to carry out an initial assessment of the person before an appointment with the consultant. These assessments are carried out in the person's home to personalise the service and provide valuable information on people's living environment and their functioning abilities. The assessments include referral on to services such as Dementia Reablement Team, Frailty Team, Continence Service, SMART team, DVLA, plus any other services required prior to seeing the consultant.



Results:

✓ Enable quicker initial dementia diagnosis

The majority of people referred to the dementia clinic are now seen within 2 – 10 days for a thorough assessment.

✓ Provide a local review clinic

Approximately two people who are stable per month are referred back to the Knutsford GP practices from CWP. The majority of these have other long-term conditions. The annual review for people who are stable is carried out in the GP Practices by the Practice Nurse and there have been no issues raised to-date with this process.

✓ Provide greater access to consultant clinic for people with complex needs/ advanced care needs

A CWP Consultant Clinic has been established and is held each week at Manchester Road Medical Centre with the consultant seeing approximately 8 – 9 patients. This gives the Knutsford GPs greater access to the Consultant which they have found very useful in terms of learning, improving relationships and general access to consultant advice; enabling a quicker response time to queries.

Next steps:

Moving forward, the intention is to implement the dementia pathway, in a phased approach, across other surgeries in East Cheshire.

For more information, please contact Josephine Worthington, Team Manager Older People's Community Mental Health Team, or Dr Sadia Ahmed, Consultant Psychiatrist, on sadia.ahmed7@nhs.net

Broxton Community Care team - Improving communication with care agencies to promote safer care

Background:

Broxton Community Care Team (CCT), work with people in their own homes to provide safe and effective care. The team have realised over time that the care agencies also working with these people do not have knowledge of the community staff involved. They may pass each other on the street or have a telephone conversation with each other, but this is not forming good working relationships, which in turn would enable person-centred care.

What did we want to achieve?

As a community care team within the neighbourhood of Broxton, they wanted to know who the carers were in the local area, looking after their patients and build up an open door approach for the carers to access the team and for the team to access them. They wanted to achieve seamless care, by all parties in the person's care working to the same goals and standards.

What we did:

The CCT discussed how they could achieve open channels of communication and a thought was to have a carers' event within the neighbourhood. The team were able to utilise the waiting room within Malpas doctors' surgery and set about inviting carers that worked in the area. The team also identified some speakers from outside of the team who could attend this event to offer advice and support, the CWP Tissue Viability (TV) nurse, Urology Specialist Nurse, and a representative from Brightlife.

Results:

The event was attended by approximately 18 carers from the community, and the local care home in addition to patients and carers. Over hot and cold drinks, cakes and biscuits, introductions were made; through putting faces to names, it enabled carers to know who, how and when to contact the office, and also where the office was for face-to-face conversations in order to ensure the best possible support is provided to the people they jointly care for.

Brightlife COMMUNITY FUND

Katherine Hussey, from Brightlife, an organisation that works with partner agencies to reduce loneliness and social isolation, spoke about what they have to offer in the area and how to make referrals to service.

Corrine Caley, one of CWP's Tissue Viability Nurses, spoke about pressure relief and how best to manage in a person's home and the equipment devices available to help. A practical demonstration of the 30 degree tilt for the carers was also given so they are better informed when communicating with the CCT staff about pressure sores.

Caroline Tomlinson, a Urology Nurse Specialist gave an education session on the use of convenes in the community and the benefits to patients. A carer of a patient also spoke about how the use of the convene instead of a catheter had given them control of their life and reduced the risk of catheter acquired infections.

The event took place over 2 hours and following the brief presentations, the room continued to buzz with lots of questions to the speakers and the team. This event has improved communication with the carers in the neighbourhood, feedback from those that attended has been excellent and the team are looking to organising another event in the next 6 months.

Next steps:

Due to the success of this event, the team plan to continue these events twice a year and discuss with carers topics that they would like covering.

For further information, please contact Emma Lea, Neighbourhood Lead, Broxton CCT, at elea@nhs.net

The Crisis & Reablement Roadshow – creating closer connections and simplifying the referral process

Background:

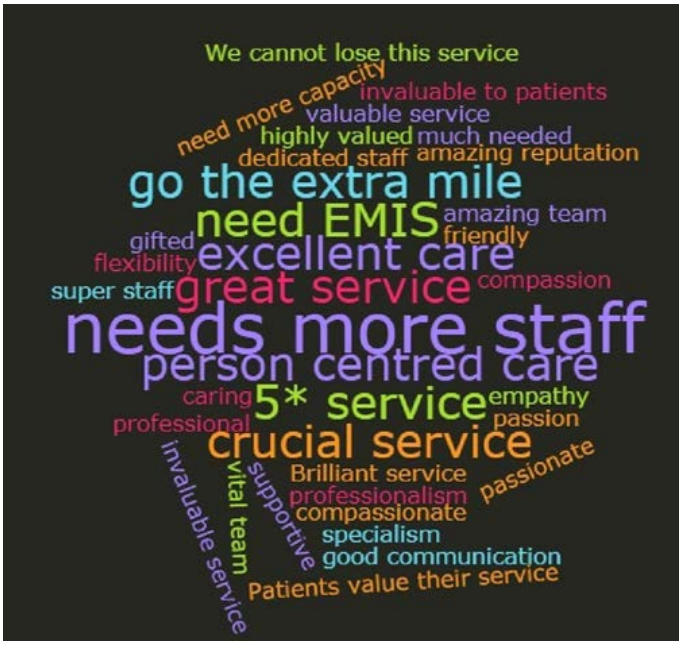
The Crisis and Reablement Team (CART) visit people in their own homes who have an acute physical health crisis and are at risk of hospital admission without the appropriate care. They also support the community care teams by providing care for people in their final days of life whose preferred place of care is home and provide valuable emotional support to patients and their carers.

What did we want to achieve?

The purpose of our piece of work was to raise awareness of CART, clarify our role, the criteria for referral and to simplify the referral process.

What we did:

Our project involved visiting the community care teams (CCTs) in their own bases to promote communication between teams, facilitate discussion around how CART could better support the CCTs and their patients and improve understanding of the operational running of CART. We also wanted to become familiar with the staff in each of the teams so that a more personal approach could be used when communicating with regard to patients. The team manager, care co-ordinator and some support workers visited each base. We took cake (always appreciated) and instigated informal discussion around shared issues and concerns with regard to providing a person's care to a complex caseload over a large geographical area. The CART team had already introduced an extended "nursing & therapy" competency programme in order to provide more person-centred care and to increase support to the community care teams who also have a highly pressured workload. These competencies involve both nursing and therapy skills such as monitoring blood sugars, taking blood pressure, carrying out simple dressings, recommending therapy equipment, and fitting appropriate equipment following prescription by a therapist. Support workers are able to identify different gait patterns to assist in rehabilitation and highlight any acute changes in a person's medical condition by reporting to trained staff with clearly identifiable facts and results. Our care co-ordinator developed a leaflet for health professionals and allied health professionals to help staff identify what the team consists of, which people were appropriate to refer to the service and the telephone numbers of the various professionals within the team. By providing phone numbers, we hoped to encourage colleagues to call us to discuss patients and formulate the most appropriate plan of care including signposting to other services.



Results:

Sessions were well received and provided valuable networking opportunities. CCT staff reported that they had a better understanding of our service and the constraints we operated within. CART staff enjoyed the sessions

> " The team is always very helpful on the phone; always ready with advice and very supportive"

> "A team that we cannot lose, we rely on it completely when our patients are in a crisis"

and the rapport between ourselves and teams. We also enjoyed the cake! We followed up our visits with a survey to gain feedback on the sessions as well as the service and support provided by CART.

"I have always found the Crisis Team very helpful and supportive – thank you, we are really appreciative of all the great work you do"

Next steps:

Due to the success of the roadshow, the team are exploring further innovative ways in which to increase engagement, partnership working and opportunities to streamline and improve processes, which they hope to report on in future QI report editions.

For more information, please contact Sue McGuigan, CART Manager, at sue.mcguigan@nhs.net

Introduction of case management across the East Community Learning Disability team

Background:

Clinical supervision is a routine meeting held on a six weekly basis. The service recognised that every professional in the team had substantial waiting lists. The team's ambition was to completely eliminate waiting lists and in effect made a positive impact on the person's journey. The service wanted to enhance clinical effectiveness and so they introduced case management to actively engage with clinicians' caseloads and to think proactively and improve standards of care.

What we wanted to achieve:

The aim of using case management in a community learning disability team was to help staff to manage the professional demands created by the nature of their work. This is particularly important for those who work with people who have complex or challenging needs. Furthermore, case management helps to support managing risks and increases clinical accountability.

What we did:

We have introduced the case management form, which is based on a traffic light system highlighting the complexity of the clinical involvement. Initial pilot of the form has been implemented for 6 months after which the team collaboratively reviewed the outcomes. It was then decided that the team would adopt the case management form permanently.

Results:

Since the introduction of the case management form, the team has entirely eradicated waiting lists. Case management has proven to be very effective and has improved the experiences of people accessing the service. Some of the successful outcomes include assigned accountability of an individual to the person accessing the service; clarity about the clinical involvement; proactive approach to care; delivering better and more cost effective care.

Next steps:

Moving forward, the intention is to measure effectiveness using quantitative indicators and monitor feedback from people accessing the service. Ultimately, the plan is to spread the case management form to all community learning disability teams.

For more information, please contact Jill Tompkins-Gibbins, Specialist Physical Health Facilitator, jilltompkins-gibbins@nhs.net

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.

Liaison and Diversion team newsletter enhances team communication

Background:

The Liaison and Diversion team are geographically spread, so it is not always possible for all team members to attend the monthly team meetings. To get around this, the team manager, Shelley Saunders, offers informal staff meet-ups so that those who need help, advice or just somebody to talk to, can have the reassurance of their colleagues.

One of the team, Christina Bromfield, signed up to complete i2i training as a result of the Safe Services' patient safety improvement review of the team. The training provided Christina with the knowledge and resources to look at the Liaison and Diversion team and identify ways to improve as a team.

What did we want to achieve?

Christina already held peer reviews with the band 4 and band 6 team members, but realised there was an opportunity to improve communication within the team, particularly the staff who covered the more diverse geographic footprint.

Ensuring that all team members were kept fully up to date of events, news, information, etc., was of paramount importance to Christina. She did not want any team members, especially those located further away, or unable to attend team meetings to feel uninformed or at a disadvantage as a result of their location/ posting. Christina was aware that team meetings are a great opportunity to catch up with colleagues, but also a chance to discuss work and utilise the skills of other team members for advice. With this in mind, Christina proposed the idea of a regular newsletter to be sent out to all team members.

What we did:

Christina enlisted another member of the Liaison and Diversion team, David Bell, to work on the newsletter initiative, collating information, ideas and content for the newsletter. This includes information such as upcoming birthdays within the team, any updates relating to recruitment, compliments and thanks to staff for a variety of things. An example of this is when team member, Emily, utilised the newsletter to send out links and information for World Autism Awareness Week. Another example of the usefulness of the newsletter is when a member of the team was leaving to commence maternity leave, the team used the newsletter to wish her well and planned to meet up outside of work for the team member's baby shower.

Results:

The team manager, Shelley, is confident that the newsletter is further enhancing communication within the team. The Liaison and Diversion team underwent a patient safety improvement review in 2017 and scored highly for communication and teamwork, so the newsletter is an excellent resource to continue in sustaining this standard.

The newsletter also has a Q&A feature for staff to ask any questions that they feel they can't ordinarily ask. So far, this hasn't been used by staff, but the option is there and ensures that members of the team always have an option for gaining help/ advice.

Next steps:

Feedback for the newsletter from staff has been positive. So, the team will continue to coordinate the newsletter to ensure high levels of communication are maintained. It is hoped that the Q&A section will be utilised by those who need it.

Staff are asked for their feedback on aspects of the newsletter and this information is captured by David to aid evaluation and inform continuous improvement and progression.

For further information, please contact Shelley Saunders, Liaison and Diversion Team Manager, at shelley.saunders@nhs.net

Education CWP's SUCCEED programme success

Background:

In Autumn 2017, a review was undertaken by the Education CWP's Personal and Professional Development (P&PD) team to inform and support a refresh of our in house Leadership and Management training programmes. The team wanted to better understand the impact of attending these programmes and how they have influenced changes in participants' leadership and management behaviour. The review looked at the 'Manager Essentials' training courses and the 'CWP Leadership Programme'. An electronic survey was distributed to all staff who had taken part in the programmes (and their managers), to gather an initial quantitative measurement of programme satisfaction. This was supplemented by qualitative feedback where individual was then invited to take part in a face to face interview.

146 relevant courses ran over the time period, comprising:

- ✓ Performance Through People
- ✓ Recruit, Select, Induct (RSI)
- ✓ Leading Staff Through Change Transitions
- ✓ Effective Appraisal and Supervision
- ✓ Managing Attendance
- ✓ Investigating Managers
- ✓ CWP Leadership Development Programme

Face to face interview feedback raised the challenge of the first step into a new role, that there was "no transition period for clinical staff to become managers". There was support and appreciation of the value of gaining management skills (both process and interpersonal skills) at the start of a management role and it was suggested that introduction to management courses with a focus on difficult conversations should become mandatory for all new and existing managers. Further feedback from managers acknowledged that equipping staff who are aspiring managers with these skills is also a good opportunity to support staff retention. There was broad acceptance that there is line management responsibility in developing new managers within teams. Whilst managers were keen to stress the need for development of new staff, there was little evidence to suggest they had taken action to enable their staff to apply knowledge gained or access development available.

While most staff believed that the 'Manager Essential' programmes gave a good overview, it was believed that there was a need for refresher courses, 'especially as policies/ processes changed and were updated'. The willingness of other members of staff to accept practice or process change in pressurised environments was noted as having significant impact, meaning on occasions, learning from these programmes has been difficult to apply. Questionnaire responses indicated that there was little or no obligation to demonstrate or feedback learning from programmes when delegates returned to the workplace. Of those who completed the questionnaire, 36% believed there were no barriers to applying their learning. However, for those who did identify issues with the application of skills and behaviours in practice, the key constraints were time, staffing levels and external pressures within the relative services.

These issues caused delegates frustrations as they were not able to spend time after the course developing the softer skills, taking time to reflect and bringing staff together to discuss objectives and aims. Delegates reported finding it hard to take time

out to reflect or find the opportunities to have meaningful conversations with their members of staff. A further barrier to application of learning in practice was the confidence which delegates had, either in themselves as a leader or in their capability to apply newly learnt skills and behaviours. There was believed to be an immediate uplift in motivation on return to the workplace, to ensure good working is pursued; although others described the feeling of "crawling back into a shell" or comfort zone.

What did we want to achieve?

Create a development intervention which addressed the findings of the review in ensuring that:

- ✓ Delegates both support and held to account for the application of their learning and encouraged to reflect on changes in management practice
- ✓ Line managers took an active role in the development of their staff as managers
- ✓ Learning made a genuine, lasting difference to the delegates
- ✓ Time away from practice was effectively used
- ✓ Development was valued by all parties

What we did:

We designed a 6 month development programme called SUCCEED, targeted at staff with line management responsibilities who had not previously accessed development in this area. Organising the learning into a programme enabled us to develop a 'community of learning' rather than ad hoc groups. Cohorts were encouraged to share experiences of management throughout the course and how they had applying learning in between face to face sessions.

As part of their course application, delegates were required to complete a 'Personal Development Discussion' form with their manager. This required them to agree learning objectives and specify how this learning would benefit their teams and the people they look after. This was revisited both immediately the course finished and 3 months after the last workshop to ensure delegates could evidence long term changes in behaviour. We insisted delegates commit to attending all stages of the programme and their managers commit to releasing them to attend. This meant all those concerned demonstrated they valued high quality management for their staff and managers.

We rationalised the development on offer. Splitting learning into 'procedure and policy' – delivered via self-managed e-learning and face to face 'skills and behaviours' sessions which supported application of learning. 'Skills and behaviours' could not be accessed until delegates had gained the e-learning competency and therefore had a good grasp of the processes being discussed.

Results:

The first Cohort of the SUCCEED programme launched in September 2018 and delegates attended the 3 month review session in March 2019. The programme was reviewed via standard course evaluation to give a comparison to other programmes offered; results were overwhelmingly positive in all aspects. Over the duration of the course, delegates were sharing examples of how they had used skills and behaviours they had learnt and what the outcomes had been – this not only re-inforced learning but also raised confidence levels. Due to the regular meetings, delegates were able to share their reflections of the previous session, re-visit questions, or unpick their understanding, which again delivered more effective learning than a one off session would have done. Facilitators were able to link workshops and evidence how behaviours and models had implications across subject areas. Additionally they were able to tailor the sessions for the specific needs of the cohort.

However the principal measure of success was the immediate and 3 month review of personal development discussions and the discussions of application of learning into practice. Delegates had numerous examples of how they had changed their management behaviours including:

" I've realised the 'they' that need to 'sort it out' is actually me"

" Holding regular supervision for all my team and setting proper objectives in appraisals"

"I've actually had tough conversations with my team and got a rota issue sorted that has been causing problems for months"

" I'm using the project management principles in the work I am doing now"

In addition, managers of delegates have fed back directly to Education CWP on areas such as improved confidence in managing HR issues, tackling challenging conversations and a more professional approach to managing a team.

There were a small number of delegates who didn't complete the programme due to clinical demands a few have already signed up to the second cohort and we hope to see the remainder in the future.

Next steps:

Based on feedback from the first and current cohort, we are expanding the course content to include a wider range of subject matter. In addition, as with any ongoing training, we continue to develop and review the sessions to ensure they remain fresh, engaging and relevant. The programme has received Board approval to be a compulsory part of the Trust's Leadership and Management offering, which we hope will mean new delegates continuing to come forward, and more importantly, a consistent approach to quality management across the Trust. We hope that this support will also enable us to push for more support from managers of delegates.

In addition to SUCCEED, we have also launched ASPIRE for those looking to move into a management role and CHALLENGE for clinical leaders. These have followed a similar format and been well received.

We are looking forward to launching a new senior leaders offering in the future.

For further information, please contact Anna Beaver, Senior Education Practitioner, at anna.beaver@nhs.net

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.

Neston Community Care team strive to deliver equitable, accessible care

Background:

As Neston borders on Arrowe Park Hospital, the majority of people accessing the care of Neston Community Care Team attend there rather than the Countess of Chester Hospital. Neston Community Care Team have engaged with the discharge team at Arrowe Park Hospital in order to initiate a discharge liaison meeting between

Arrowe Park Hospital

the two providers to try to improve the hospital admission and discharge experience for CWP patients. During this process, it was discovered that people from Neston could not access the step down beds at Ellesmere Port Hospital unless there was a side room available. As side rooms are few, this meant that CWP patients could very rarely access step down beds at Ellesmere Port Hospital.

What did we want to achieve?

We wanted equity for all CWP patients regardless of postcode. It was recognised that CWP patients were disadvantaged due to postcode, as inpatients of the Countess of Chester Hospital did not have to step down to a side room and they could access any step down bed on Bluebell and Poppy wards at Ellesmere Port Hospital.

What we did:

After negotiation with the discharge team from the Countess of Chester Hospital, and in liaison with our consultant infection prevention and control nurse, we were able to change the process of our patients needing a side room.

Results:

Now, patients from Neston and any other patients from CWP who have been inpatients in hospitals other than the Countess of Chester can access all beds as equally as other people who step down to Ellesmere Port Hospital. This has improved the patient discharge experience as a whole and access to step down beds, not only for patients from Neston but the wider CWP footprint from areas such as Tarporley who often are admitted to Wrexham Hospital.

Next steps:

The plan is to initiate regular meetings between the Arrowe Park Hospital discharge team and Neston Community Care Team to continue to improve people's experience on discharge and ensure that these improvements are sustained.

For further information, please contact Fran Johnston, Neston and Willaston Community Care Team Manager and Clinical Case Manager, on 0151 488 844

Access Sefton provide a holistic, person-centred approach to people with long-term conditions

Background:

Improving Access to Psychological Therapies (IAPT) services are now well established across England, and have demonstrated their effectiveness, delivering therapy in line with NICE guidelines. The Five Year Forward View for Mental Health set out the planned expansion of IAPT services to those people with long term conditions or medically unexplained symptoms, up to 70% of whom also have a common mental health problem. This therapy provision would be integrated into existing medical pathways and services.

What did we want to achieve?

Access Sefton wanted to increase the numbers of people with existing long term conditions (LTC) and/ or medically unexplained symptoms who were able to access psychological therapies in Primary Care. We wanted to develop a pathway that would deliver therapy in an environment that people would feel comfortable, and remove stigma from mental health services.

What we did:

Initially we worked with one GP practice, meeting with staff and providing training to support the identification of people who would benefit from psychological interventions. The GP practice provided a room for a therapist, who was based in the surgery for one day a week offering assessments and therapy. The practice administration staff manage the appointments, directly booking in people at the request of GPs and nurses within the surgery. The nominated therapist was given access to the GP system and is able to add brief notes to support the holistic care of each individual. Therapists working on this project have had training in working with people with long term conditions, and as we expect this to continue to expand, additional training places have been secured for the New Year.

Results:

Although this initiative is still in the early stages of implementation, the number of referrals into the service from the GP practice has increased significantly. This includes the number of people accessing the core service thought to be a by-product of the closer working relationships of the therapist and GP practice staff, as well as the general increased awareness and promotion of the service.

The development of the IAPT-LTC clinic has increased the number of referrals of people who have a long term physical health condition from the GP practice. People are now able to access therapy which will focus on the impact that an LTC may have on their psychological wellbeing, and also the effect that their psychological health has on their management of their LTC. This approach has shown to be valuable in treating the person as a whole and recognising that these two aspects are inextricably linked.

Next steps:

We will continue to evaluate the service in collaboration with GP practices and roll out the model to other GP practices within Sefton.

For further information, please contact Ryan Forrest, Deputy Operations Manager – Access Sefton, at ryan.forrest@nhs.net

Chester Older People's Community team receive a Sustainable Mental Health Service Commendation!

Background:

The Royal College of Psychiatrists' College Centre for Quality Improvement (CCQI) has developed an approach to supporting local service improvement that has proved successful in a range of settings. One of the service improvement initiatives that the Royal College offers is the Memory Services National Accreditation Programme (MSNAP). MSNAP is a quality improvement and accreditation network for services that assess, diagnose and treat dementia in the UK. The Chester Older People's Community Mental Health team were accredited in January 2019 for the fifth consecutive time! In addition, their MSNAP accreditation by the Royal College of Psychiatry has studied their recent review and found that the team meet the criteria for receiving a Sustainable Mental Health Service Commendation.

What did we want to achieve?

Being awarded the MSNAP accreditation is a quality improvement initiative that the team wanted to be a part of and have successfully achieved from MSNAP over the past 10 years. It demonstrates that they are working to and providing best practice against criteria for memory service provision that is recommended by the Royal College of Psychiatrists and that services should aspire to meet. Continuing the reaccreditation is a vehicle to ensure that the team sustain best practice and aspire continually to improve the care they provide to older people within their care.

What we did:

For the accreditation itself, the Royal College have developed a series of audit tools to support the measurement of adherence to criteria associated with best practice, which include a patient questionnaire, carer questionnaire, staff questionnaire and referrer questionnaire, in addition to a casenote audit. On completion of the audit tool, there is a self-review by the team of their local policies and procedures, reviewing their practice against the MSNAP standards to start making the changes required to achieve accreditation. On completion of the self-review, an external peer review conducted by MSNAP and a patient or carer representative is carried out and a subsequent report is written, which summarises the service's strengths and areas for improvement.

Results:

Not only did the service achieve reaccreditation, the report highlighted some examples of excellent practice, with the service being recognised as above and beyond with regards to their provision of care. Indicative of this is their Sustainable Mental Health Service Commendation. The Royal College of Psychiatrists' Sustainability Committee has been working with CCQI to assess the sustainability of various mental health services. They have been reviewing memory services accredited over the past year against the sustainability standards based on the principles below:

- ✓ Prevent mental illness
- ✓ Empower patients and carers to manage their own mental health
- ✓ Eliminate wasteful activity
- ✓ Make use of low-carbon alternatives
- ✓ Empower staff in their daily work

The committee mapped Chester Older People's Community Mental Health team and have established that they have achieved at least 90% against these sustainability standards. The team have been congratulated by the committee on their high impact work and hope that the service continues to provide high quality sustainable care in the future.

Qualitative findings from the report included:

"There is excellent continuity within the service; patients and carers see the same staff member for their assessment, diagnosis and follow-up reviews"

"They always remember me as a person, not a number "

"the staff treat me as me and they are like friends"

"The service is doing a considerable amount more than what it is commissioned for"

Next steps:

The team are focusing on the actions recommended by MSNAP in order to further develop their service, whilst sustaining the excellent provision of care.

For further information, please contact Susie Green, Clinical Coordinator, at susie.green3@nhs.net

Between December 2018 and March 2019, CWP formally received 858 compliments from people accessing the Trust's services, and others, about their experience. Below is a selection of the comments and compliments received:

Learning Disability, Neuro Developmental Disorders & Acquired Brain Injury:

- "I always like hearing your calm and friendly voice when I ring and seeing your smiling face when I come to Rosemount! It makes a big difference!"

Specialist Mental Health – Bed based:

- Thanking staff nurse for support during admission. Staff nurse gave patient so much time and help, how she listened, held her hand, mopped up her tears. Gave support in darkest moments and made patient feel safe, understood and cared for. She can never thank staff member enough for her support and care.

Specialist Mental Health – Place based:

- "I have felt so supported. It has been so helpful to be able to talk and rationalise my thoughts and feelings. I have been able to see my progress in a positive way and ask for help when needed."

Children, Young People & Families:

- "Thank you for being so kind and lovely to me. You really make me laugh. Thank you for all the support you have given me over the past month."

Neighbourhood Based Services:

- "Thank you for all the help and support you provided for me and my husband in the last few days of his life. The CART team and all DNs have been amazing. Cannot fault the service."

Joint Therapies:

- Excellent care of our mother – compassionate, keeping her dignity, treating her with respect ,and us, her family, with understanding and care we felt supported during a very difficult time.

All Age Disability

- We would be lost without you and appreciate everything you do every day to help me to get him to school. Though at times things are challenging, you all smile and do such a wonderful job. You are all kind and patient and that means so much to us and although our son cannot express it, I'm sure if he could he would say a massive thank you too!

Share your stories

We welcome your best practice stories and Quality Improvement successes; please share your work via the Safe Services Department using the QI Hub page on the intranet or contact the Patient Safety Improvement Team on 01244 397410

Look out for more about Quality Improvement in Edition 1 2019/20 of the Quality Improvement Report