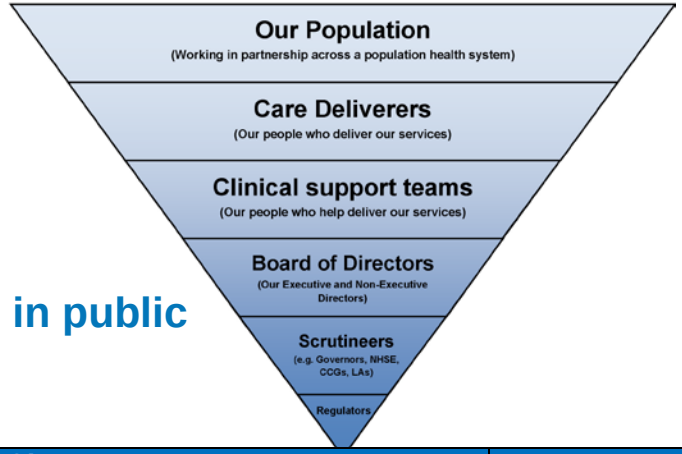

NHS
Cheshire and Wirral Partnership
NHS Foundation Trust

#cwpQI

Board of Directors, meeting held in public

At 1.00pm on Wednesday 31 July 2019
At the Boardroom, Redesmere

Ref	Title of item	Format	Presented by	Time
	Part 1: ASSURANCE			
	Committee Governance			
19/20/39	Welcome, apologies and quoracy	Verbal	Chair	1.00pm (3 mins)
19/20/40	Declarations of interest			
19/20/41	Minutes of previous public meeting held on: • Wednesday 22 May 2019 • Wednesday 29 May 2019	Paper		1.03pm (5 mins)
19/20/42	Matters arising and action points	Paper		
19/20/43	2019/20 cycle of business	Paper		1.08pm (2 mins)
19/20/44	Chair's Announcements	Verbal		1.10pm (10 mins)
19/20/45	Chief Executive's Announcements	Verbal	Chief Executive	1.20pm (10 mins)
	Reporting from Committees and Matters of Governance			
19/20/46	Audit Committee: • Chair's report of the Audit Committee held 9 July 2019	Paper	Audit Committee Chair	1.30pm (5 mins)

Ref	Title of item	Format	Presented by	Time
19/20/47	Quality Committee: • Chair's Report of the Quality Committee held 3 July 2019	Paper	Quality Committee Chair	1.35pm (5 mins)
	Operational Performance			
19/20/48	Board Dashboard development	Presentation	Director of Finance	1.40pm (25 mins)
	Quality of Care			
19/20/49	Safer Staffing: • a. Ward staffing: May and June 2019 • b. Six monthly report	Papers	Director of Nursing, Therapies and Patient Partnership	2.05pm (15 mins)
19/20/50	Freedom to Speak up Guardian 2018/29 Annual Report	Paper	Director of Nursing, Therapies and Patient Partnership	2.20pm (10 mins)
19/20/51	Medical Appraisal 2018/19 Annual Report	Paper	Medical Director	2.30pm (10 mins)
19/20/52	Infection, Prevention and Control 2018/19 Annual Report	Paper	Director of Infection, Prevention and Control	2.40pm (10 mins)
19/20/53	Medicines Management 2018/19 Annual Report	Paper	Medical Director	2.50pm (10 mins)
19/20/54	Data Protection 2018/19 Annual Report	Paper	Medical Director	3.00pm (10 mins)
	Part 2: IMPROVEMENT (10 minute break)			
	Strategy			
19/20/55a	People Strategy 2019/2022	Paper/Presentation	Director of People and OD	3.20pm (50 mins)
19/20/55b	Learning lessons to improve our people practices	Paper	Director of People and OD	4.10pm (10 mins)

Ref	Title of item	Format	Presented by	Time
19/20/56	Quality Improvement Strategy 2019/20 implementation	Paper	Medical Director	4.20 (15 mins)
19/20/57	Care Group development review process	Verbal	Director of Finance	4.35pm (5 mins
	Any other business			
19/20/58	Any other business	Verbal	Chair/ All	4.40pm (5 mins)
19/20/59	Matters for referral to any other groups			
19/20/60	Matters impacting on policy and/ or practice			
19/20/61	Review risk impact of items discussed			
19/20/62	Three things to communicate			
19/20/63	Review the effectiveness of today's meeting https://www.smartsurvey.co.uk/s/CWPmeetingsurvey/			
	CLOSE [4.45pm]			
Date, time and venue of the next meeting: **Wednesday 25 September 2019, 9.30am, Boardroom, Redesmere**				

Version No	1	Date issued	24.07.2019

Quality Improvement Hub

NHS
Cheshire and Wirral Partnership
NHS Foundation Trust

Board of Directors

At 1.00pm on Wednesday 22 May 2019
At Boardroom, Redesmere

Present	Mike Maier	Chairman
	Sheena Cumiskey	Chief Executive
	Andrea Campbell	Non-Executive Director
	Dr Jim O'Connor	Non-Executive Director
	Lucy Crumplin	Non-Executive Director (via telephone)
	Edward Jenner	Non-Executive Director
	Rebecca Burke-Sharples	Non-Executive Director
	Dr Faouzi Alam	
	Tim Welch	Joint Medical Director Director of Finance
In attendance	Louise Brereton	Head of Corporate Affairs
	Suzanne Christopher	Corporate Affairs Manager (minutes)
	David Wood	Associate Director of Safe Services (on behalf of Dr Anushta Sivananthan)
	Gary Flockhart	Associate Director of Nursing (on behalf of Avril Devaney
Apologies	Avril Devaney	Director of Nursing, Therapies and Patient Partnership
	David Harris	Director of People and OD
	Dr Anushta Sivananthan	Joint Medical Director
	Andy Styring	Director of Operations

Ref	Title of item	Action
	Part 1: ASSURANCE	
	Meeting governance	
19/20/1	**Welcome, apologies and quoracy** The Chair welcomed all to the meeting. Apologies were noted as above and the meeting was confirmed as quorate. Gary Flockhart was welcomed on behalf of Avril Devaney, and David Wood was welcomed on behalf of Dr Anushta Sivananthan.	
19/20/2	**Declarations of interest** No declarations of interest were expressed.	
19/20/3	**Chair's Announcements** No formal announcements.	
19/20/4	**Chief Executive's Announcements** No formal announcements.	
	Financial and Operational Performance	
19/20/5	**Annual Reporting 2018/19:**	

Ref	Title of item	Action
	As Chair of Audit Committee, Edward Jenner introduced the item. Edward Jenner advised that the annual report, quality account and financial accounts had been presented to Audit Committee. Edward Jenner advised that there were matters to highlight in relation to the ISA260, however, assurance had been provided to the Audit Committee in respect of these matters. On that basis, the Audit Committee recommended the approval of the documents for submission to NHSI. Tim Welch summaried the position further to the recent audit conducted by KPMG. The annual report, financial accounts and quality account have been reviewed by KPMG as part of the annual audit. KPMG are required to provide the Trust with three formal opinions; one relating to the financial accounts, one for value for money and one for the quality account. Clean opinions were awarded for 'use of resources' and 'value for money', which is a continuation of performance in previous years. From KPMG's perspective, this is significant and becoming less common within the NHS. Their assessment takes account of the finance performance as well recent CQC and Well-Led inspections. It was noted, that this is again testament to the efforts of Trust colleagues in achieving this. Tim Welch advised that overall the Quality Report also achieved a clean opinion (limited assurance). However, auditors raised some concerns in respect of the indicators that sit within that. As part of the audit process, three performance indicators are audited, two of which are mandatory (IAPT and EI). The third indicator is the locally selected indicator (CHEDS), selected by Governors. This indicator does not require a formal opinion from the auditors. The IAPT indicator was awarded a clean limited assurance opinion. The EI (early intervention) indicator obtained an adverse, qualified option due to the lack of sufficient evidence to support a clean opinion. This is due to issues with the accuracy, completeness and validity, which suggests that data may not be presented in line with national guidance. Board Members were reminded of the purpose of the EI target. This is set is to ensure that 56% of referrals receive treatment within 16 days. The target is set at 56% due to some of the complexities that exist within the pathway. Many of the individuals on this pathway are usually accessing a number of other different services. For 2018/19, the Trust scored 68% against the target, and so did achieve the target set. This indicator was also subject to a national deep dive process in year, which provided the Trust with external assurance against this target. Targets continue to be reviewed on a 6 monthly basis, at the request of the Trust. EI delivery was a Trust priority project, with a primary aim of reducing unwarranted variation across the Trust footprint. A key strand of the work has focused on how to improve data capture for	

Ref	Title of item	Action
	this indicator. Oversight has been maintained via the Trust Operational Committee. A detailed report was also provided to June 2018 Board of Directors. A discussion followed regarding the definitions applied to the data capture and the challenges this has presented on a national scale. Extraction of data from electronic systems (such as care notes) has also presented a challenge. Work as part of the key priority project set out to establish clear standard operating procedures from a clinician's perspective to streamline the process. These were implemented with effect from April 2018. However, it was identified that further improvements were required. In November 2018 attempts were made to automate the process. The audit process has since highlighted that further improvements are required, and work has already commenced. It very recently became known to executive colleagues that this was likely to affect the audit opinion for this indicator. It was confirmed that the sample tested by auditors was very narrow, considering just 25 records. Of those 25, 11 records were queried. Auditors have commented that they do not feel that there is any positive bias from the Trust to influence the standards. The issues relate to the data accuracy component in respect of the pathway and national definitions. Actions taken to date were summarised for the Board Members which included a review with clinicians of the current standard operating procedures (SOPs) and the recent approval of new electronic solutions to support this work. More rigorous testing procedures have also been established and are now built into the (SOPs) going forward. All data systems are currently being reviewed along with support to EI Functions. D Wood advised that the current strategic risk associated with this is being reviewed. The risk treatment plan will be presented to the Board of Directors next month. Oversight to the Board of Directors will continue to be via the strategic risk register. Assurance dashboards will continue to be presented to Quality Committee. In line with continuous quality improvement, a PDSA approach will be implemented. Tim Welch advised that a detailed discussion took place at the Audit Committee meeting focusing on the extraction of data, the close down of data at various intervals, how that is used to inform continuous improvement and how internal assurance is gained in respect of governance structures. It is proposed that, in future, a different approach is applied to the indicators in terms of both the recording and evidencing of information which will in turn support the audit process. Dr Faouzi Alam provided assurance that based on the national clinical audit, CWP is providing excellent standards of care in this area. At recent meetings with NHS England, the work of the Trust in this area has been acknowledged and congratulated and nationally, CWP is one of the top performing trusts in this area. Non-Executive Directors reflected on the process followed as a Board and commented that perhaps on reflection the key priority	

Ref	Title of item	Action
	project was premature. Greater consideration of the closure of priority projects will be considered by the Operational Committee. Louise Brereton advised the Board Members that some minor changes had been made to the Annual Report and Accounts since the Board pack was issued. However, Board Members were advised that some of the performance figures had been updated, which had resulted in the Trust now stating it had achieved all of its regulatory targets. The statement of the accounting officer had also been amended on the advice of the auditors. However, it was later confirmed that the Trust should revert to the original version in accordance with NHSI Guidance. Tim Welch noted the work involved to produce the Annual Report and Accounts, thanking Andy Harland and the finance team, David Wood and the safe services team and Louise Brereton and Suzanne Christopher in Corporate Affairs for the co-ordination of this work and ensuring we are compliant with all relevant guidance. The Board of Directors **approved** the Annual Report and Accounts 2018/19. Sheena Cumiskey reflected that although it was important to focus on the areas above, it was also worth noting the Trust's achievements. This is testament to the work of a number of colleagues across CWP and Sheena thanked everyone for their efforts. Maier Maier concurred and extended thanks to all involved.	
19/20/6	**Board of Directors provider licence self-assessment and self-certifications:** It was confirmed that the certificates and declarations listed below, along with assurances had been reviewed by the Audit Committee Members at the May 2019 meeting. E Jenner confirmed that the Audit Committee were recommending the approval of these documents to the Board of Directors. The following certificates and declarations were **approved** by the Board of Directors • Q4 2018/19 Licence self-assessment • Condition G6(3): Licence compliance • Condition FT(4): Systems and processes for good governance • Condition CoS7: Continuity of Services • Certification of Governors Training	
	Any other business	
19/20/7	**Any other business** No other business.	
19/20/8	**Matters for referral to any other groups** No matters for referral were identified.	
19/20/9	**Matters impacting on policy and/ or practice** No matters impacting policy or practice were noted**.**	

Ref	Title of item	Action
19/20/10	**Review risk impact of items discussed** No new risks were identified.	
19/20/11	**Three things to communicate** Deferred to open Board – 29 May 2019.	
19/20/12	**Evaluation of meeting effectiveness** The meeting was confirmed as effective.	
CLOSE [Time]		
Date, time and venue of the next meeting: **Wednesday 29 May, 9.30am, Redesmere**		

NHS
Cheshire and Wirral Partnership
NHS Foundation Trust

#cwpQI

Minutes of Board of Directors Meeting – held in Public

At 1:00pm on Wednesday 29th May 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	Joint Medical Director, Quality, Compliance and Assurance
	Dr Faouzi Alam	Joint Medical Director, Effectiveness, Medical Education and Medical Workforce & Caldicott Guardian
	David Harris	Director of People and Organisational Development
	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
	Rachel McLoughlin	Consultant Psychiatrist
	Peter Ashley-Mudie	Governor
	Keith Miller	Governor
	Justin Pidcock	Associate Director of Operations (for item 19/20/29)
	Cathy Walsh	Associate Director: Patient Experience (for item 19/20/28)
	Philip Makin	Equality and Diversity Officer (for item 19/20/28)
	Paul Hughes	Domestic Assistant (for item 19/20/38)
Apologies	Andy Styring	Director of Operations
	Lucy Crumplin	Non-Executive Director

Ref	Title of item	Action
	Meeting governance	
19/20/13	**Welcome, apologies and quoracy** The Chair welcomed all to the meeting. The meeting was confirmed as quorate. Apologies were noted from Lucy Crumplin and Andy Styring.	
19/20/14	**Declarations of interest** None was declared.	
19/20/15	**Minutes of the previous meeting held 27 March 2019** The minutes of the meeting held 27 March 2019 were reviewed. A typographical amendment was required. Subject to this amendment, the minutes of the meeting held 27 March 2019	

Ref	Title of item	Action
	were **approved** as a correct record.	
19/20/16	**Matters arising and action points** The action points were reviewed. Action 18/19/155 remains open but will be closed shortly. All other actions were closed or in progress.	
19/20/17	**2019/20 Cycle of Business** The business cycle for 2019/20 was reviewed and noted.	
19/20/18	**Chair's announcements** The Chairman announced the following: **Ancora House** Ancora House were announced as winners in the inpatient care category at this year's National Children and Young People's Mental Health Awards, where they were praised for including young people and their families/carers in all stages of development, from initial design through to continued improvement of services. **Pharmacy Team** Our Pharmacy service has been shortlisted in five separate categories at the Health Service Journal (HSJ) Patient Safety Awards for its pioneering new initiative enhancing safe and effective communication with community pharmacies. **International Nurses day** As part of International Nurses', the Trust hosted a 'Bring your future nurse to work day' where budding young nurses came along to meet some of those who work in the profession and learnt all about how rewarding a career in healthcare can be. **Wirral Birch Centre opening** The Trust welcomed chief nursing officer for England Ruth May to an opening ceremony for our Wirral Birch Centre. She also honoured Avril Devaney, Director of Nursing, Therapies and Patient Partnerships with a special nursing award. **Candid conference** The first annual conference of CANDDID (Centre of Autism, Neuro-developmental Disorders and Intellectual Disability) took place last week in Chester. Over 175 delegates attended with speeches from colleagues, partners and other professionals.	
19/20/19	**Chief Executive's announcements** Tim Welch briefed the Board and those observing on the proceedings in the closed meeting. An overview was given on the items discussed. Sheena Cumiskey updated on the following: **Emergency planning** The Trust has achieved the emergency planning standards core	

Ref	Title of item	Action
	standards full compliance. Thanks were extended to Tim Jenkins and his team. **Recent awards** The Trust was highly commended in the HSJ award for effective communications and the spread of best practice via the Big Book of Best Practice. This was highly commended from a field of 14 nominees. **Poppy factory and Wirral IPS project** The Trust is involved in a three year project lead by the Poppy Factory supporting veterans into employment, while supporting them with managing physical and mental health conditions. **NICHE report** The NICHE report, an independent investigation into the care and treatment of a mental health service user (MN) in Cheshire was published last month, thereby concluding the investigation process.	
	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** Edward Jenner provided an overview of the business conducted at the Audit Committee meeting held 7 May 2019. The terms of reference and the annual report 2018/19 were reviewed. The Board of Directors **noted** the Chair's report of 7 May and the annual report 2018/19. The terms of reference were **approved.**	
19/20/21	**Quality Committee:** • **Chair's Report of the Quality Committee held 8 May 2019** • **2019/20 Terms of Reference** • **2018/19 Committee effectiveness review** Dr Jim O'Connor briefed on proceedings at the last Quality Committee meeting held 8 May 2019. Levels of compliance with the process with regards to the use of mental health law has been escalated and is now on the risk register as a risk in-scope. The Board of Directors **noted** the Chair's Report of 7 May and the Committee effectiveness review 2018/19. The terms of reference were **approved.**	
19/20/22	**Statutory Registers**: a. **Directors interests and gifts and hospitality** b. **Governors interests**	

Ref	Title of item	Action
	The 2018/19 Directors' registers of interests and gifts and hospitality were reviewed and **noted.** The 2018/19 Council of Governors' register of interests were reviewed and **noted**.	
19/20/23	**Chair and Chief Executive: Division of Responsibilities** The responsibilities of the Chief Executive and the Chair were reviewed in line with Code of Governance and Corporate Governance Manual requirements. There were no amendments proposed from the 2018 version. The Board of Directors **noted** the Division of Responsibilities for the Chair and the Chief Executive.	
19/20/24	**Board Assurance Framework and Strategic Risk Register** Dr Anushta Sivananthan presented the board assurance framework and the strategic risk register and highlighted the following points: • There are currently 9 strategic risks, 2 rated red and 7 rated amber. • There 2 risks in scope – 1 rated red and 1 rated amber Dr Sivananthan commented on the risk in-scope on mixed sex accommodation and it was noted that compliance is monitored through care group governance, in line with the CQC action plan. A risk is also in-scope regarding mental health law process breaches. The Clinical Standards and Practice sub-committee are considering actions to tackle this issue and will oversee the risk treatment now in development. Risk 10 regarding levels of acute bed usage has achieved an OPEL 1 score (escalation system) for a sustained period therefore the risk has been de-escalated and a lower risk score of 12 has been modelled. Risk 12 regarding data quality weaknesses has been escalated to a risk score of 16 reflecting the qualification of the Quality Account audit findings for the EIP indicator. The risk treatment plan is under development but will include the recommendations from the external auditor. A discussion followed. Non-Executive Directors commented on the good evidence of the dynamism of the risk register evidenced by the movement of risks in the reporting period. The Board of Directors **approved** the amendments to the board assurance framework and strategic risks register.	
19/20/25	**Safer Staffing (January – April 2019)** Avril Devaney introduced the reports and highlighted the following issues:	

Ref	Title of item	Action
	• Two reports are presented at this time due to information completeness issues earlier this year. • Bollin ward is experiencing some staffing challenges due to increased vacancies and sickness. The staffing levels are compliant but this is not reflected in this report as it does not include AHP staffing which is additional. The situation is under review by the project board overseeing the central and east Cheshire redesign work. The Board of Directors **noted** the report.	
19/20/26	**Guardian of Safe Working** Dr Faouzi Alam presented the Q4 2018/19 Guardian of Safe Working report. This was presented to the Board at this time for completeness and to enable the Board to return to quarterly reporting. There were no areas of concern to highlight. The Board of Directors **noted** the report	
19/20/27	**Learning from Experience report** Avril Devaney presented the report and reminded Board members that they will be able to access the full Learning from Experience report considered by the Quality Committee to provide context as requested. Avril Devaney highlighted the following points: • There was a positive increase in the numbers of reported incidents in the period, with around 500 more incidents reported. • Work is progressing with community services to ensure low and no harm incidents are reported. This is having some positive effects on overall reporting numbers. • There was an increase in staff assaults, with particular increases on certain wards, including Greenways. This relates to one patient with challenging behaviour. • 302 case records were reviewed as part of the 'Learning from Deaths' requirements, amounting to 80% of the overall cases in the trimester period. • Ward huddles are being used positively in services to focus on safety and in particular to mitigate risk of falls. • This trimester reported an increase in complaints with communication issues being a particular theme. This will continue to be monitored. • A piece of work will be taken forward to review the national CQC report on the first year of 'Learning from Deaths'. A self-assessment and gap analysis will be untaken and an improvement plan developed. Rebecca Burke-Sharples queried whether the increased number of incidents reported by the Neighbour Care Group was due to the increased impetus on incident reporting. Avril Devaney confirmed this was the case.	

Ref	Title of item	Action
	Andrea Campbell queried the definition of 'unwarranted restrictive practice' and the practices included therein. It was confirmed that this included restraint, seclusion and rapid tranquilisation but that these issues were defined on an individual basis. The Board were informed that the BILD and positive behaviour support principles currently being successfully utilised in learning disability services are being reviewed to see if they could be replicated in acute mental health care. Dr Anushta Sivananthan extended her thanks to staff for their proactive approach to reporting incidents and understanding the need to ensure that this includes the incidents of low or no harm. The Board of Directors **noted** the report	
19/20/28	**Operational Plan Dashboard: update on 2019/20 process** Tim Welch advised Board members that following discussions at the February 2019 Board Seminar where consideration was given to areas of performance the Board wishes to focus on, work continues to develop a dashboard to respond to these requirements. It is intended that this work will be concluded to enable the dashboard to be in place to report from the July 2019 Board meeting. Tim Welch confirmed there were no operational performance matters to escalate to the Board at present. The Board of Directors **noted** the report (Cathy Walsh, Philip Makin and Paul Hughes joined the meeting)	
19/20/29	**Workforce Disability Equality Standard report** The Chair welcomed Cathy Walsh, Philip Makin and Paul Hughes to the meeting. The workforce disability standard report was presented. There is a need for the organisation to be more explicit about the offer to potential staff who have disabilities so they are aware of the support available to them to help them in their roles. Cathy Walsh introduced Paul Hughes, a Domestic Assistant at CWP who provided an overview of his experiences as a member of staff with disabilities. Following this, a number of issues were raised. These included: • The development of a staff passport to enable staff with disabilities to progress opportunities and the development of staff networks to enable support and discussions between staff with disabilities. • The need for even better line management support for staff with disabilities and to ensure support levels are agreed during the induction period of new staff and at regular intervals in future.	

Ref	Title of item	Action
	• CWP's desire to be an organisation of choice for disabled people seeking employment and the need to connect more with existing staff to understand their experiences. Philip Makin advised that from 2019, there are obligations from the Trust in line with the disability equality standards and that the initiatives discussed all contribute towards the Trust meeting these requirements. Providing context to the current position, Philip Makin advised that 20% of the CWP workforce state that they have a disability in the staff survey, however only 4% is recorded on ESR. This requires further exploration and would report back to the Board as part of future reporting on equality and diversity matters later in the year. Avril Devaney extended thanks to Cathy and her team for the progress made in this area and within the equality and diversity networks. The Board of Directors **noted** the report. (Justin Pidcock joined the meeting, Cathy Walsh, Philip Makin and Paul Hughes left the meeting)	
19/20/30	**Central and East Cheshire redesign progress report** The Chair welcomed Justin Pidcock to the meeting. Justin provided Board members with a reminder of the key elements of the central and east Cheshire redesign project, following the approval of option2 plus at the consultation stage. An overview of the work completed to date was provided. This included: • Planning approvals have been submitted and approved for extensions to CARS ward, Macclesfield Hospital site and Limewalk House, Macclesfield. • Building user groups for both schemes including service user representation have been established. • Tenders have been obtained for construction works, with post tender negotiation and appointment of contractor to enable mobilisation. This is due to commence works in late May 2019. • 18 rehabilitation service beds have been relocated to Maple ward, Bowmere. • A comprehensive engagement programme is in place. Reporting on the work currently ongoing, Justin Pidcock informed the Board that this included: • Delivery of an OD programme to prepare staff for the new model of care including a review of IT equipment to better enable agile working, particularly in this geographical area. • ECT capacity and demand modelling to inform the new staffing model.	

Ref	Title of item	Action
	• A specialised induction programme for CRHT staff including OD and cultural development alongside clinical informed by a training gap analysis. • A transition plan is in place to transfer the Millbrook building to the Christie Hospital. Commenting on the staffing impacts of the changes, Justin Pidcock advised that the management of change process is still ongoing. 30 staff were displaced by the redesign, however there has only been one compulsory redundancy and two voluntary redundancies. These processes will complete over the next few months. Justin Pidcock advised that the seclusion suite originally planned in the redeveloped site has now been withdrawn from the plans as recent data shows there is no requirement for a specific area now. Reporting on programme costs, Justin Pidcock advised that there has been a slight increase in gross project costs. There has also been some slippage in the timeline due to tenders coming in over the pre-tender estimated costs. These issues do not pose any significant risk to the overall programme delivery, however the increased tender costs will be reported back to the Operational Committee through the capital plan update which requires resubmission due to recent NHS Improvement requirements. Dr Anushta Sivananthan advised that there has been significant clinical oversight and underpinning work to implement the new model of care which is monitored by the Programme Board. It has taken a significant amount of work to progress the whole programme. The removal of the seclusion suite from the planned works identifies how the Trust is moving forward and placing emphasis on positive behavioural support approaches. Dr Jim O'Connor queried the ongoing staff support offer during the change. David Harris advised that there has been a huge emphasis on the human element of the change, including dedicated OD support working on this project alone. Sheena Cumiskey extended thanks to all the teams involved in the project. She raised some emerging issues with the development of crisis beds which are slightly behind schedule due to commissioning issues. CWP has offered support to the CCG on this issue. Board members agreed with the approach suggested by Sheena Cumiskey that this should be escalated to the CCG senior management for resolution. A discussion followed regarding post project learning from a quality improvement perspective, to inform future redesigns. David Harris commented that the OD team are using case studies to help develop a more consistent approach to management of change. Dr Sivananthan commented that there is no Trust standard operating process for relocating services so this gap has informed the need begin developing one. This would include both the technical and the human elements of a change at this scale.	

Ref	Title of item	Action
	Dr Jim O'Connor queried whether the crisis beds issues required escalation to the strategic the risk register. Dr Sivananthan confirmed that the issue was included on the Project Board risk register. The Board of Directors **noted** the report. (Justin Pidcock left the meeting)	
19/20/31	**CWP Forward View: Care Group priorities 2019/20** Tim Welch presented the report setting out the final overview of Care Group priorities for 2019/20, following the work undertaken at the February Board seminar with Care Group colleagues. The process has involved a period of refinement to identify the most significant projects to progress in line with the resources available. These are monitored via the Programme Support Office process. Some priorities discussed by Care Groups are being taken forward as 'business as usual' reflecting the developing autonomy and maturity of the Care Groups. The Board of Directors **noted** the report.	
19/20/32	**Quality Improvement Report** Dr Anushta Sivananthan introduced the Quality Improvement Report and highlighted the following key achievements: • Neston Community Care team improvements to the patient discharge experience through effective partnership working and 'safety huddles'. • Bowmere's 'Sign up to Safety' kitchen table week raising awareness of staff psychological safety and patient safety. • The introduction of case management across the East Community Learning Disability team which has eradicated their waiting list. Sheena Cumiskey queried how the success of the patient safety huddles was being rolled out. Dr Sivananthan advised that this would be disseminated via the Patient Safety Improvement forum. Board members were advised that there will be a presentation to the Quality Committee in May 2019 setting out the plan to roll out psychological supervisions for staff in inpatient services in line with the principles of trauma informed care. An options appraisal will also be developed linked to the Quality Account priorities allowing visibility to be maintained within the governance structure. The Board of Directors **noted** the report.	
	Closing Business	
19/20/33	**Any other business** There were no further items of business.	

Ref	Title of item	Action
	The Chair invited those observing the meeting to comment on the afternoon's proceedings.	
19/20/34	**Matters for referral to any other groups** **T**here were no matters to refer or escalate to other groups.	
19/20/35	**Matters impacting on policy and/ or practice** There were no matters identified impacting on policy and/or practice.	
19/20/36	**Review risk impact of items discussed** There were no further items to add to the risk register. The Chair reflected the Non-Executive Directors' earlier comments regarding the evident dynamism within the risk register. As the crisis beds issue is reflected at Project Board risk register level, this was felt to be covered at this time.	
19/20/37	**Key messages for communication** The Chair advised that the following items be communicated to the organisation: • Good progress being made with the Trust's strategic priority for Central and East Cheshire redesign. • Progress with the workforce disability equality standard and the reflections from 'Paul's story'.	
19/20/38	**Review of meeting performance** All agreed the meeting had been effective. Board members were encouraged to complete the online meeting survey to enable continuous improvement at Board level.	
CLOSE		
Date, time and venue of the next meeting: **Wednesday 26 June 2019, 9.30am Sycamore House (seminar session)**		

Cheshire and Wirral Partnership NHS Foundation Trust
Open Actions Action Schedule

Meeting date	Group/ Ref	Action	By Whom	By when	Status
		No actions arising from meeting held 29/5/19			

Cheshire and Wirral Partnership NHS Foundation Trust
Closed 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)

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STANDARDISED CHAIR'S REPORT

CHAIR'S REPORT DETAILS	
Name of meeting:	Audit Committee
Chair of meeting:	Rebecca Burke-Sharples
Date of meeting:	9th July 2019

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

Strategic Risk Register

- The Strategic Risk Register was presented to the Committee for quarterly review. This was commended to the Board of Directors in line with Business Cycle requirements.

(ASSURANCE) Matters discussed/decision:

Internal Audit

Progress Report Update

- MIAA provided an update in respect of the assurances, key issues and progress against the Internal Audit Plan for 2019/20. The following audit reviews are in progress and/or planned and will be reported to the Committee on completion: Critical Applications, Cyber Essentials, Quality Spot Checks, Conflicts of Interest, Consultant's Incremental Pay, Access to Services – Waiting Time/Performance Review, Follow-up Reviews. There have been no requests for changes to the Approved Audit Plan for 2019/20.

Insight Report

- Details of future Events, Briefing Note Series and Benchmarking were noted by the Committee.

Follow-Up Report

- The Committee were provided with independent assurance that actions flagged as closed by responsible officers have been completed and can be evidenced.

External Audit

Progress Report and Sector Update

- Grant Thornton were recently appointed as CWP External Auditors. The Progress Report provided the Committee with an outline of the proposed deliverables for 2019/20. A draft engagement letter was discussed as this will need to be signed off by the Trust in respect of Grant Thornton's responsibilities as CWP External Auditors. The Committee noted the Report.

Register of Sealings

- The Register of Sealings was presented to the Committee for yearly review.

Freedom to Speak Up Guardian – Annual Review

- The Annual Report was presented to the Committee. The overview provided:
  - Quality Improvement taken to fulfil the outcomes of the self-review tool for NHS Trusts and Foundation Trusts.
  - Steps taken to build confidence and capability in relation to the Speak Up agenda
  - Analysis of the Speak up activity for 2018/19.

  The Freedom to Speak Up commitments for 2019/20 are detailed within the Annual Report.

(IMPROVEMENT)

Achievements:

Health Care Quality Improvement Plan 2019/20

- The HCQIP 2019/20 was presented. The programme includes Patient Safety Improvement Reviews (PSiRs), quality improvement projects and national clinical audits. It also references the audit programmes that are developed and delivered by individual clinical support services in adherence with the mandated audit activity and local priority audits. The Committee noted the Health Care Quality Improvement Plan 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:	03/07/2019

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

The receipt of a Regulation 28 notification from HM Coroner for Liverpool & Wirral was escalated to the Quality Committee, following the conclusion of an inquest which took place on 17 May 2019. This related to an older person, with a diagnosis mild depressive episode; the Coroner asking the Trust to consider assessing people at different times of the day where diurnal mood variation is a symptom of a person's depressive illness. This learning is being shared Trustwide and the response provided to the Coroner on 12 July 2019 . A further update will be provided to Quality Committee within the Learning from Experience report (September 2019).

As a response to emerging data quality risks identified by the external data quality audit process for 2018/19, risk 12 has been revised as "the risk of potential for adverse impact on the effectiveness of service delivery, evaluation and planning due to shortfalls in data capture by existing clinical systems, staff capability and delivery of the organisational data quality framework". This will enable a short-term response to the more immediate areas for improvement identified as part of this assurance process. An update will be provided to the Audit Committee in September 2019 and thereafter a medium to longer term risk description and treatment plan will be identified.

(ASSURANCE) Matters discussed:

The medicines management and freedom to speak up annual reports were discussed by the Quality Committee and the assurances within noted. Both of these reports will be approved by the Board of Directors.

A proposed quality and equality impact assessment framework was discussed. Amendments were suggested to the use of language regarding positive impacts, and to the proposed process of assessment to enable professional input dependent on the subject matter. The specialist mental health care group agreed to test out the proposed framework and to report their experience of applying it to the next Quality Committee.

Assurance was received on progress with the delivery plan for building sustainable quality improvement capability in line with the quality improvement strategy via operationalisation of a competency framework which sets out five levels of quality improvement. In particular, a level 3 course, mandatory for senior managers, has been agreed and will focus on teaching people in a management role to 'know how and support others' and integrate their learning back to their place of work.

(IMPROVEMENT) Achievements:

The Cheshire integrated health and liaison and diversion service presented on their work, demonstrating the positive outcomes being delivered, by working in partnership, for those people in the criminal justice system.

Update on progress with an improvement project, being sponsored by West Cheshire CCG, was presented, setting out achievements to-date in value stream mapping the serious incident investigation process. The aim of the project is to reduce risk and improve safety through effective investigations of serious incidents that maximises learning and the integration of learning. It is aligned to the new NHS patient safety strategy.

A presentation was delivered by the pharmacy team, in conjunction with the Chair of the Local Professional Network (Cheshire & Merseyside) for NHS England, to demonstrate improvements made to medicines safety and outcomes for people with serious mental illness through interventions made as a result of digital referrals to community pharmacy.

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STANDARDISED SBAR COMMUNICATION

REPORT DETAILS	
Report subject:	Ward Daily Staffing Levels May and June 2019
Agenda ref. number:	19.20.49a
Report to (meeting):	Board of Directors
Action required:	Information and noting
Date of meeting:	31/07/2019
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 May and June 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 May 2019 the trust achieved staffing levels of 96.9% for registered nurses and 100.7% for clinical support workers on day shifts and 98% and 99.4% respectively on nights. During June 2019 the trust achieved staffing levels of 96.3% for registered nurses and 98.5% for clinical support workers on day shifts and 99% and 99.1% respectively on nights.

In the months of May and June 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.

Numbers of registered nurses on Bollin were lower 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)..
- 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 3 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?	Avril Devaney, Director of Nursing, Therapies and Patient Partnership
Contributing authors:	Charlotte Hughes, Business and Innovation Manager, Educaion CWP

Distribution to other people/ groups/ meetings:

Version	Name/ group/ meeting	Date issued
1	Avril Devaney, Director of Nursing, Therapies and Patient Partnership	18.07.2019

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

Appendix No.	Appendix title

1 2	Ward Daily Staffing May 2019 Ward Daily Staffing June 2019

		Day				Night				Day		Night		Safe Staffing was maintained by:
		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 (%)	
SMH - Bed Based West & East	Adelphi	773.5	762	734.5	746	426	400	675	686.5	98.5%	101.6%	93.9%	101.7%	Cross cover arrangements. Ward Manager actively worked within the staffing establishment.
	Bollin	1232	817.5	950.5	1246	598	593	1196	1173	66.4%	131.1%	99.2%	98.1%	Nursing staff working additional unplanned hours. Cross cover arrangements. Ward Manager and Multi Disciplinary Team actively worked within the staffing establishment.
	Croft	739	706	757.5	735.5	437	437	716	681.5	95.5%	97.1%	100.0%	95.2%	
	Beech	913	890	529	521	402.5	402.5	471.5	471.5	97.5%	98.5%	100.0%	100.0%	
	Cherry	1035	1001.5	857	834	487.5	430	816.5	839.5	96.8%	97.3%	88.2%	102.8%	Nursing staff working additional unplanned hours. Cross cover arrangements. Ward Manager and Multi Disciplinary Team actively worked within the staffing establishment.
	Juniper	837.9	837.9	931.5	914.5	475.5	464	724.5	724	100.0%	98.2%	97.6%	99.9%	
	Willow PICU	730	726	775	753.5	426.5	426.5	747.5	736	99.5%	97.2%	100.0%	98.5%	
SMH - Forensic, Rehab, CRAC	Alderley Unit	602	602	837.5	837.5	425.5	425.5	471.5	471.5	100.0%	100.0%	100.0%	100.0%	
	Maple	835.5	927.5	1037	968.5	552	471.5	529	505.7	111.0%	93.4%	85.4%	95.6%	Nursing staff working additional unplanned hours. Cross cover arrangements.
	Rosewood	948.5	932	1046.5	1023.5	552	552	598	563.5	98.3%	97.8%	100.0%	94.2%	Nursing staff working additional unplanned hours. Cross cover arrangements.
	Saddlebridge	868	823.5	1127	1112.5	448.5	448.5	701.5	701.5	94.9%	98.7%	100.0%	100.0%	Nursing staff working additional unplanned hours. Cross cover arrangements.
Learning Disabilities & NDD	Eastway A&T	1171	1159.5	1439	1437.5	805	828	1269.5	1291.5	99.0%	99.9%	102.9%	101.7%	
	Greenways A&T	1005.25	855.8	1403	1481.5	598	563.5	897	897	85.1%	105.6%	94.2%	100.0%	Nursing staff working additional unplanned hours. Cross cover arrangements. Ward Manager and Multi Disciplinary Team actively worked within the staffing establishment.
CYP - Tier 4 CAMHS & Outreach	Coral	878	872.5	1295	1270.5	609.5	586.5	1092.5	1104	99.4%	98.1%	96.2%	101.1%	
	Indigo	909.15	874.15	849.5	847.5	538.5	550	816.5	805.5	96.2%	99.8%	102.1%	98.7%	
SMH - Bed Based Wirral & PICU	Brackendale	678.5	678.5	624.5	624.5	392	392	448	448	100.0%	100.0%	100.0%	100.0%	
	Brooklands	500	500	933.5	926	437	437	563.5	563.5	100.0%	99.2%	100.0%	100.0%	
	Lakefield	646.5	646.5	595.5	595.5	427	427	476.5	476.5	100.0%	100.0%	100.0%	100.0%	
	Meadowbank	949	949	1202	1202	382.5	382.5	778	778	100.0%	100.0%	100.0%	100.0%	
	Oaktrees	701.75	701.75	756.25	756.25	407	407	514.5	514.5	100.0%	100.0%	100.0%	100.0%	
	Trustwide	16953.55	16263.6	18681.25	18833.75	9827.5	9624	14503	14432.7	96.9%	100.7%	98.0%	99.4%	

		Day				Night				Day		Night		Safe Staffing was maintained by:
		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 (%)	
SMH - Bed Based West & East	Adelphi	1059.5	956	1151	1159.5	690	670.5	1045.5	1045.5	90.2%	100.7%	97.2%	100.0%	Nursing staff working additional unplanned hours. Cross cover arrangements.
	Bollin	1058.5	837.5	1615.5	1505.5	690	657.5	1406.5	1357.5	79.1%	93.2%	95.3%	96.5%	Nursing staff working additional unplanned hours. Cross cover arrangements. Ward Manager and Multi Disciplinary Team actively worked within the staffing establishment .
	Croft	1251.5	1217	1407.5	1324	690	690	1380	1341.5	97.2%	94.1%	100.0%	97.2%	Nursing staff working additional unplanned hours. Cross cover arrangements.
	Beech	1451.5	1394	874	836.5	674	674	724	724	96.0%	95.7%	100.0%	100.0%	
	Cherry	1151.5	1086	1011	999.5	517.5	506	901	901	94.3%	98.9%	97.8%	100.0%	Nursing staff working additional unplanned hours. Cross cover arrangements. Ward Manager and Multi Disciplinary Team actively worked within the staffing establishment .
	Juniper	1003	991.5	1081.5	1017.5	586.5	586.5	828	778	98.9%	94.1%	100.0%	94.0%	Nursing staff working additional unplanned hours. Cross cover arrangements.
	Willow PICU	898.25	898.25	839.5	816.5	655.5	644	770.5	747.5	100.0%	97.3%	98.2%	97.0%	
SMH - Forensic, Rehab, CRAC	Alderley Unit	905.75	923.75	1252.5	1238	644	644	739.5	739.5	102.0%	98.8%	100.0%	100.0%	
	Maple	942.45	942.45	1046.5	1046.5	667	609.5	575	540.5	100.0%	100.0%	91.4%	94.0%	Nursing staff working additional unplanned hours. Cross cover arrangements.
	Rosewood	984.25	977.25	1083.5	1072	667	667	517.5	506	99.3%	98.9%	100.0%	97.8%	
	Saddlebridge	759	678.5	1253.5	1196	667	667	655.5	655.5	89.4%	95.4%	100.0%	100.0%	Nursing staff working additional unplanned hours. Cross cover arrangements.
Learning Disabilities & NDD	Eastway A&T	1207.5	1150	1490.5	1490.5	667	667	1357	1356.8	95.2%	100.0%	100.0%	100.0%	
	Greenways A&T	1156.5	966.25	1691.75	1726.25	690	644	1449	1437.5	83.5%	102.0%	93.3%	99.2%	Nursing staff working additional unplanned hours. Cross cover arrangements. Ward Manager and Multi Disciplinary Team actively worked within the staffing establishment .
CYP - Tier 4 CAMHS & Outreach	Coral	950.3	950.3	1411	1411	620.4	620.4	1150	1150	100.0%	100.0%	100.0%	100.0%	
	Indigo	966	972	755.1	755.6	489.5	523.9	724.3	764	100.6%	100.1%	107.0%	105.5%	
SMH - Bed Based Wirral & PICU	Brackendale	979.25	979.25	1165.5	1165.5	690	690	897	897	100.0%	100.0%	100.0%	100.0%	
	Brooklands	967.75	967.75	1153.5	1153.5	608.5	608.5	880	880.5	100.0%	100.0%	100.0%	100.1%	
	Lakefield	1050	1050	908	908	697	697	542.5	542.5	100.0%	100.0%	100.0%	100.0%	
	Meadowbank	1354.5	1354.5	1659.75	1659.75	840.5	840.5	1203	1203	100.0%	100.0%	100.0%	100.0%	
	Oaktrees	1122.95	1122.95	996.5	996.5	688	688	698	698	100.0%	100.0%	100.0%	100.0%	
	Trustwide	21219.95	20415.2	23847.6	23478.1	13139.4	12995.3	18443.8	18265.8	96.3%	98.5%	99.0%	99.1%	

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STANDARDISED SBAR COMMUNICATION

REPORT DETAILS	
Report subject:	Safer Staffing Six Monthly Review
Agenda ref. number:	19.20.49bi
Report to (meeting):	Board of Directors
Action required:	Discussion and Approval
Date of meeting:	31/07/2019
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	Yes
Leadership and improvement capability	Yes

CWP Quality Framework:		
Patient Safety	Safe	Yes
Clinical Effectiveness	Effective	Yes
	Affordable	Yes
	Sustainable	Yes
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*

This report presents the six monthly safer staffing review findings from December 2018 to May 2019 in line with NHS England and National Quality Board requirements. The information in this report is based on meetings with staff members, safer staffing group meetings, desk top reviews and analysis of data.

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

Since 2014 the Operational Committee and Board of Directors have received a six monthly safer staffing report to provide assurance that the Trust is fulfilling their safer staffing obligations.

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

The safer staffing six monthly review highlights that there is effective workforce planning to achieve the delivery of safe care. The report is presented in six sections focusing on the areas of service provision:

Section 1 – Inpatient
Section 2 - Improving Access to Psychological Therapies (IAPT)
Section 3 – Specialist Mental Health
Section 4 - Learning Disability
Section 5 - Community Nursing
Section 6 – Community CAMHS

The inpatient review provides an in-depth oversight to determine that there is effective workforce planning employed to maintain ward establishments to achieve the delivery of safe care. There are established mechanisms in place to deploy staff effectively. Clear processes are in place for staff to escalate staffing concerns and for remedial action to be taken to unplanned workforce challenges.

The organisation has continued to invest in advancing its staffing matrix through role redesign, enhancing clinical roles to improve skill mix and, moreover, broaden clinical capability through multi-disciplinary working.

Recommendation – *what action/ recommendation is needed, what needs to happen and by when?*
The Board of Directors are asked to **approve** the recommendations and approach to future work streams as set out in appendix 1: "Six Monthly Safer Staffing Review"

Who has approved this report for receipt at the above meeting?	Avril Devaney
Contributing authors:	Gary Flockhart, Vic Peach, Marjorie Goold

Distribution to other people/ groups/ meetings:

Version	Name/ group/ meeting	Date issued
1	Operational Committee	July 2019

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

Appendix No.	Appendix title
1	Safe Staffing six monthly report – November 2018 – May 2019

Cheshire and Wirral Partnership NHS Foundation Trust

Six Monthly Safer Staffing Report

Period of review: November 2018 – April 2019

Introduction

This report details the six month overview of safer staffing for Cheshire and Wirral Partnership NHS Foundation Trust (thereafter referred to as the Trust) for the period November 2018 to April 2019 (inclusive). This is in addition to monthly fill rates reported to the Trust Board. The aim is to provide an overarching review across the six month period to include workforce planning, deployment of staff, skill mix and workforce challenges. Collectively evidencing, the Trust's capacity and capability to provide high quality care[1] via safer staffing.

The guidance for safer staffing is determined by the National Quality Board (NQB). The NQB standards require trusts to provide assurance that organisational practices, skills development and evidence based tools are in place. Primarily this is to assure the delivery of quality clinical care to patients across the range of specialisms in the Trust, including in-patient, community and specialist services. Specifics that are requested to be considered include:

- Evidence-based tools employed to inform nursing and care staff requirements.
- Fostering a professional and responsive culture where staff feel able to raise concerns.
- Employing a multi-professional approach when setting nursing, midwifery and care staff, staffing establishments.
- Providing sufficient time for care staff to fulfil responsibilities beyond direct care delivery.
- Communicating the daily staffing provision per shift.
- Securing staff in line with the workforce requirements.

The information included in this report is derived through various means including data analysis (for example fill rates), temporary staffing and agency use. Additionally, qualitative views from inpatient safer staffing meetings and project updates are considered. Specific project updates are attached as appendices to this report due to the body of the report having the necessary focus on in-patient settings.

[1] The National Quality Board (2013) How to ensure the right people, with the right skills, are in the right place at the right time A guide to nursing, midwifery and care staffing capacity and capability https://www.england.nhs.uk/wp-content/uploads/2013/11/nqb-how-to-guid.pdf

Recommendations:

The Trust Board are asked to receive assurance that the NQB safer staffing standards are being met and to approve the recommendations contained within each section of the report.

Process:

The Trust contract requires that information is presented bi-annually to ensure that there is "sufficient appropriately registered, qualified and experienced staff to enable the services to be provided in all respects". The achievement of this is continuous across the year through various work streams, task and finish groups, data accumulation and analysis.

The information received and the contributions towards this six month period have included:

Evidence Based Tools

The previous safer staffing report to Trust Board made reference to the commencement of Care Hours per Patient Day (CHPPD) data. This data has now been submitted for the past six months and an update is reported later in the paper. Additionally, implementation of the Hurst Tool has continued which also provides an evidence based approach which has contributed to our safer staffing enquiry.

Temporary Staffing

A summary position statement relating to Temporary Staffing was obtained and considered, as part of the overall safer staffing evaluation.

The information accumulated for the Inpatient six monthly safer staffing review (section 1) has been expansive and evidences the depth of Trust's investment in its approach to safer staffing. To assist the discursive aspects of the report the key headings of; Effective Workforce Planning, Deploying Staff Effectively, Redesigning Roles & Skill Mix and Responding to Unplanned Workforce Challenges are adopted. These are the headings detailed by NHS Improvement in their *Developing Workforce Safeguards, Supporting providers to deliver high quality care through safe and effective staffing* (NQB, 2018) [2] report.

[2] NHS Improvement (January 2018) Developing Workforce Safeguards Supporting providers to deliver high quality care through safe and effective staffing
https://improvement.nhs.uk/documents/3320/Developing_workforce_safeguards.pdf

The safer staffing review has continued to extend and includes approaches underway in relation to safer staffing in the following areas:

Section 1 – Inpatient
Section 2 - Improving Access to Psychological Therapies (IAPT)
Section 3 – Specialist Mental Health
Section 4 - Learning Disability
Section 5 - Community Nursing
Section 6 – Community CAMHS

Section 1 – Inpatient Six Month Safer Staffing

Contents

Effective Workforce Planning

Inpatient services roster staff via Healthroster, which enables proactive and planned allocation of nursing staff per shift to be achieved. It also facilitates an evidence base for staff allocation and distribution per shift, week or monthly as required. The planned rostering within Healthroster allows nursing skill mix to be taken into account. This supports clinical care pathways through having the right staff on duty, for example staff trained in the management of violence and aggression, and staff gender mix. The employment of Healthroster facilitates the early identification of staffing deficits whereupon contingency planning can occur, such as in the realigning of existing staff or seeking nursing cover through planned temporary staff use.

Staff working in inpatient areas are able to make requests regarding their shift pattern. However, the pre agreed shift patterns are not always meeting the requests of staff. Ward managers and people services are reviewing this to ensure that the wellbeing needs of staff are met alongside the provision of safe and responsive planned staffing per shift.

Ward establishments have the capacity to permit staff time to maintain planned activities such as training requirements, supervision and planned leave. The use of Healthroster permits data to be extracted that contributes to the recording of planned fill rates and actual fill rates per shift within the inpatient areas. This data is submitted to NHS Digital's Strategic Data Collection Service (SCDS) and permits data analysis. Unexpected absence results in unplanned deficits and consequently results in staff moves from one clinical area to another;

where this happens the staff cross cover cannot be captured within the safer staffing returns as only whole shifts can be captured.

New Models of Care

New models of care for adult inpatient/bed based services has continued to be appraised and to consider the most effective way to reconfigure services to meet the clinical needs of patients. As part of the appraisal there are separate work streams that will contribute to the wider adult and older adult workforce planning. The established work streams are; Overarching work stream including nursing; Psychological therapies; Allied health Professionals; Personality Disorder Hub.

A model for psychological therapies and the introduction of an enhanced psychological framework within inpatient areas has been endorsed; the forward plan is to fund posts through existing budgets. The Allied Health Professional work stream has continued to focus on determining the required need. Ongoing analysis of data has taken place during this time period to understand the information before formalising a model of provision.

It is recognised that staff have been responsive to the wider services requirements to maintain safer staffing. Escalation processes have proven to be effective. Staff escalate and seek to redress short term staffing deficits via bleep holders and senior managers. Staff have maintained a professional approach when required to support other wards to maintain safe staffing levels. Staff meetings are held daily and weekly within inpatient units to appraise staffing needs, prioritise safe care and consider the distribution of staff accordingly. The staffing meetings are well established and can assist in the identification of themes and ward specific issues.

There have been challenges at times in achieving the required number of planned registered nurses to fill shifts throughout the day. This has been successfully managed in most instances through the Trust's temporary staffing or by overtime. There were particular challenges for Bollin Ward from February to April 2019 where the fill rate for registered nurses was below the expected level during the day and night. This was resolved through discussion and a multi-disciplinary approach to support the ward and maintain safety.

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 registered nurse cover was in place.
- Occupational therapists worked as part of the multidisciplinary team supporting observations and section 17 leave (this is not captured as part of the return).
- A registered nurse was moved from Adelphi at the beginning of April for a month to support Bollin to ensure safety and consistency of care; registered nurse cover was also rom Saddlebridge and Alderley Unit 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 registered nurses vacancies a preceptor has now moved onto Bollin leaving 4 registered nurse vacancies.
- Where registered nursing numbers were below planned fill rate there was a corresponding increase in care staff in addition to the increase in registered professionals as outlined above..

Six Month Aggregate Fill Rate by Bed Based Area

Fig 1 Specialist Mental Health - Bed Based Wirral & Psychiatrist Intensive Care Unit (PICU)

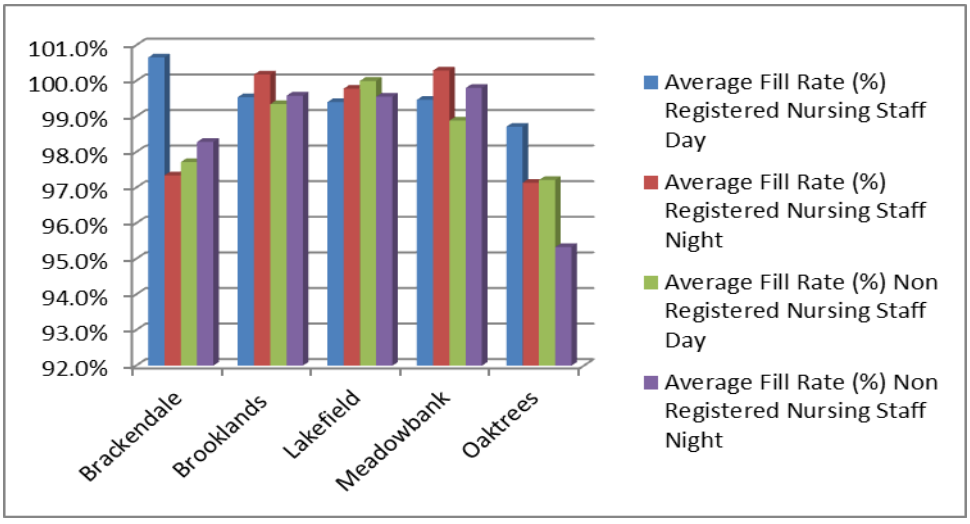


Fig. 2 Children and Young People - Tier 4 Children Adolescent Mental Health Service (CAMHS) & Outreach

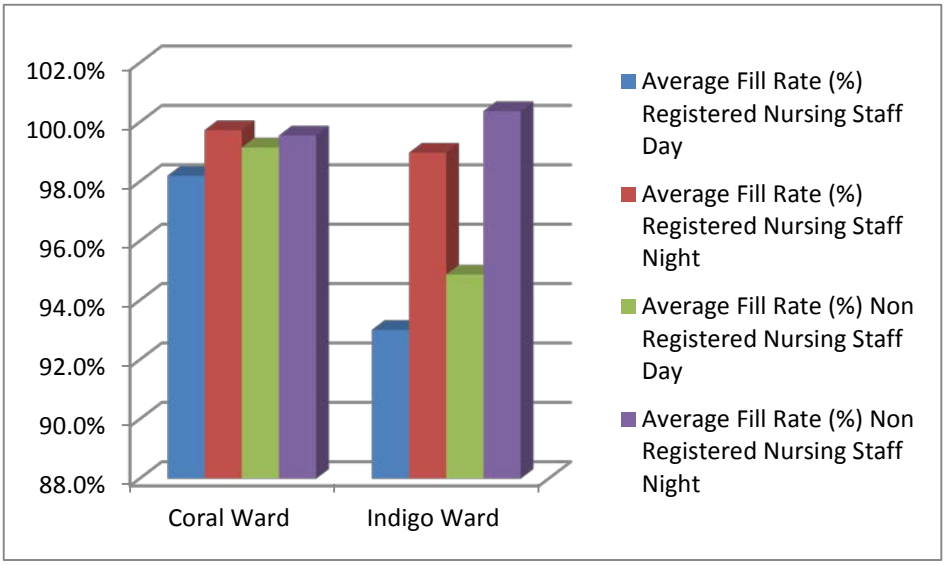


Fig 3 Learning Disabilities & Neurodevelopment Disorder

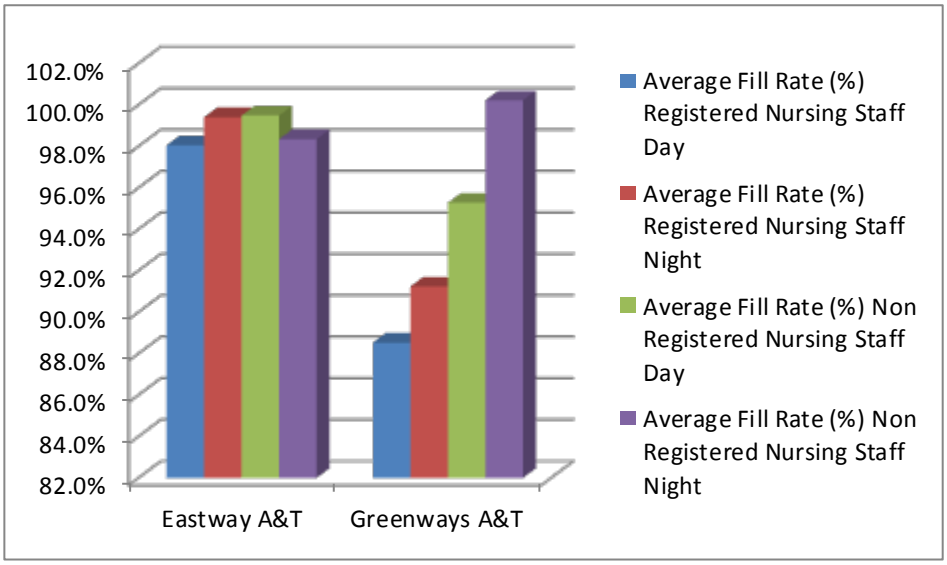


Fig 4 Specialist Mental Health - Forensic, Rehab, Complex Recovery Assessment and Consultation Service (CRAC)

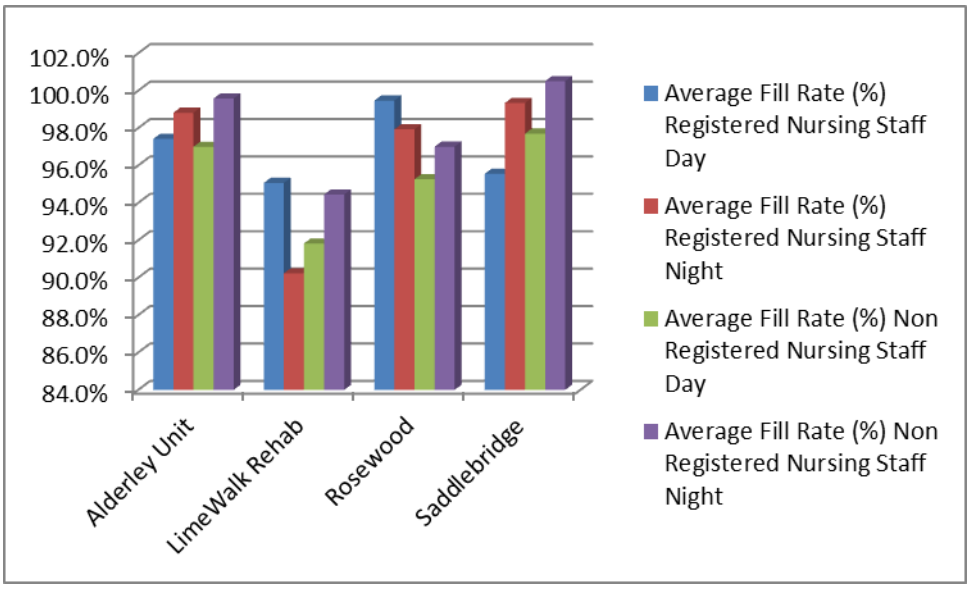
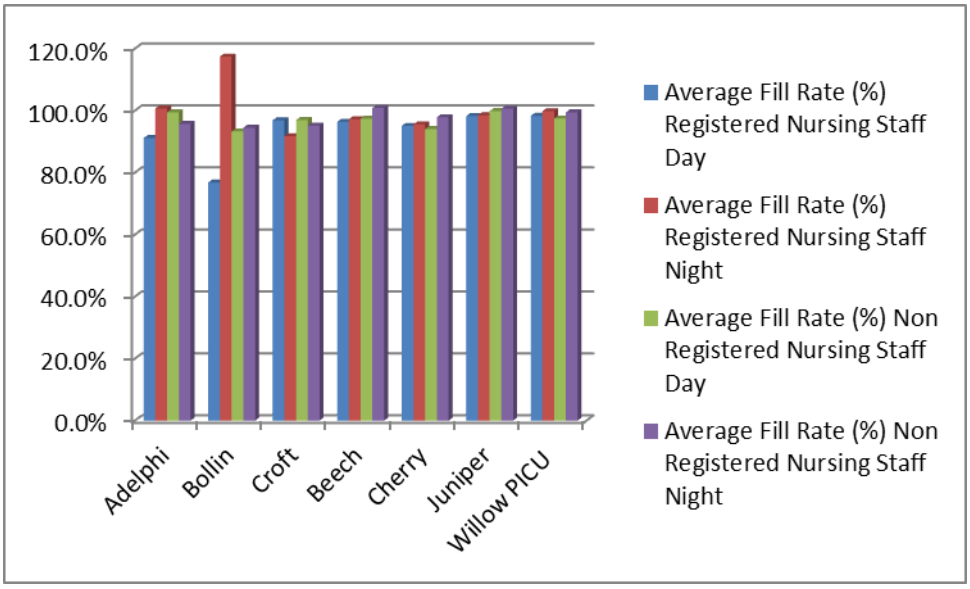


Fig 5 Specialist Mental Health - Bed Based West & East



Recruitment

There are challenges in recruitment of registered nurses nationally; this is an area of priority for the Trust. A rolling programme of recruitment has continued during this period with agreement to recruit in advance of need. Ward managers' report that this has been successful primarily in knowing that there are identified new starters due to commence at a specific time. Furthermore, understanding the turnover rate has enabled the determination of recruitment in advance of need and has helped reduce the impact of any recruitment attrition thus not resulting in longer term vacancy rates.

The recruitment programme has targeted pre-registration nurses due to qualify in March and September 2019. The employment of newly registered nurses requires that there are sufficient numbers of preceptors to provide and support effective learning opportunities. Facilitating learning opportunities to enable experienced registered nurses to gain sign off preceptor status is a priority for Ward Managers and Clinical Leads. Staff are being creative in their approach to the development of preceptors to ensure that preceptees are robustly supported in practice via effective role modelling and in practice training. For example tier 4 CAMHS have facilitated a monthly preceptorship meeting to enhance learning opportunities and aid proficiency.

The table below indicates the establishments, vacancies and numbers in recruitment as at April 2019. The time to hire from vacancy created to contract letter as at April 2019 was 46.4 working days and the average time to hire during this reporting period for the same criteria was 49.8 working days (compared with 52.9 during the last reporting period).

Trust Wards	**WTE [budgeted establishment] as at Apr 19**	**WTE [Staff in post] as at Apr 19**	**Staffing differential**	**% of vacancies against establishment**	**WTE in recruitment as at Apr 19 (from out to advert to start date booked)**
Registered Nurses	300.70	286.07	-14.63	-5.74%	28.80
Clinical	302.45	301.46	-0.99	-0.17%	23.14

Support Workers					

Training and Supervision

Training and supervision are contract compliance areas and staff are given time to attend supervision and training so as to maintain practice proficiencies. Training and supervision compliance can be referenced through the monthly Locality Data Packs (LDPs). The Associate Director of Nursing and Therapies collaboratively with People and Organisational Development and Education are leading a quality improvement programme of supervision; recommendations will be reported to People and Organisation Development sub-committee who will oversee the implementation of such.

In some clinical areas challenges in achieving training compliance was not necessarily about attending the specified training but the associated travel time to get to and from training. East Cheshire, for example, has on-site training resulting in staff only needing to be released for the period that the training runs, whereas in Wirral the impact is that there is additional travel time as training is off site. The impact on workforce planning is that in Wirral there needs to be account for staffing deficit for a longer period of time and account of this is taken into staff cover arrangements. There is a preference for staff to attend a full day's training rather than for ad-hoc a few hours as this assists capability to consider staffing gaps and fill rates. During the reporting period a review of mandatory training has taken place resulting in the development of "one stop" training in alignment with the regional core skills framework; it is envisaged that this will have a significant positive impact in releasing time to care through the reduction in travel times.

An enquiry was made to the ward managers for the inpatient areas where Registered Nurses (Adult) were employed to understand the supervision elements of their clinical proficiencies as general nurses. The current supervision structure in place is that the Physical Health and Resuscitation Manager facilitates this supervision. There were no expressed concerns with this arrangement but it was recognised that should there be an increase in the number of Registered Nurses (Adult) that the current infrastructure may require review to achieve broader supervisory support. The approach to supervision is a priority area for the Trust; the quality improvement programme will inform the expectations for all clinical staff across all areas.

Deploying Staff Effectively

The Trust has a number of inpatient clinical specialisms including acute mental health, psychiatric intensive care, learning disability (LD), older adult mental health and children and adolescent mental health (CAMHS), therefore it is understandable that the staffing configuration for each area including the multi-disciplinary varies. However, core proficiencies are attained as part of mandatory training for clinical staff groups and this strengthens the capacity to deploy staff to other clinical areas as their shared baseline knowledge and skills; this is the case for both substantive and temporary staff. By achieving baseline competencies there is the ability to cross cover across clinical areas especially where care demands are dynamic, such as changes in staff requirements due to increased risk and levels of therapeutic observations.

The rostering of staff per shift in a clinical area is the overall responsibility of the Ward Manager. The deployment of staff also includes the wider MDT such as Occupational Therapy, which is managed centrally and allocated to wards in response to patient need. The exception is that in-patient CAMHS, Eating Disorder and LD wards have OTs included in the ward establishment to meet the needs of the patient. The OT provision is valued and seen as integral to team composition to maintain safe and effective care. Ward Managers sought to strengthen their ward staffing through other means including stepping into the shift establishment or seeking assistance from extended team members, such as Occupational Therapy staff. It is recognised that safer staffing is a multidisciplinary responsibility and not purely a nursing responsibility.

Evidence Based Tools

<u>Care Hours per Patient per Day (CHPPPD)</u>
Care hours per patient per day (CHPPPD) consider the distribution of staff to patient ratio with attention to the time allocated to direct patient care. The data submission includes temporary and permanent nursing staff and Occupational Therapy staff; excluding student learners.

The average CHPPD is calculated using information extracted at 23.59 hours, each night against the number of inpatients on the ward at that time. It is difficult to make comparison between wards and determining what the data entails as numbers do not reflect the nature of the care need per patient. The distribution has not allowed for ward specialisms and individual care complexities. CHPPD on its own does not provide qualitative overview of the effectiveness or safety of care thereby contributing as part of the overall safer staffing

process. During the next reporting period a more focused piece of work will be undertaken to understand how we can make best use of this data to inform workforce planning.

Redesigning Roles and Skill Mix

All wards with the exception of Eastway have had a quality audit completed in accordance with the Safer Staffing Audit Tool by Dr Hurst (as reported in previous reports) contributing to the safer staffing matrix. The Eastway quality audit will be completed following the refurbishment project.

Following on from the quality audits, focused work has been completed on Brackendale, Cherry and Lakefield using the "Psychiatric Staff Activity Analysis" from the Hurst Tool. The study and analysis of each ward took place in November 2018, December 2018 and January 2019 respectively, auditing three twelve hour shifts, inclusive of one day at the weekend. Understanding the tasks that staff complete and accounting for the activities that engage most of staffs' time will help inform Specialist Mental Health bed based care group developments. The results of the three audits have contributed towards the Specialist Mental Health IT project work.

Fig.6 Results from all bands of ward based staff

	Friday			Sunday			Monday		
	Direct	Indirect	Associate	Direct	Indirect	Associate	Direct	Indirect	Associate
Brackendale *Ageless*	48%	29%	23%	55%	21%	24%	49%	25%	26%
Cherry *Organic*	47%	17%	36%	59%	15%	26%	51%	19%	30%
Lakefield *Acute*	38%	36%	26%	60%	21%	19%	40%	31%	29%

Direct – direct patient care for names patient

Indirect – meetings, red /green board rounds, admin – reports and patient notes

Associate – any other work Inc. breaks

Workforce Initiatives

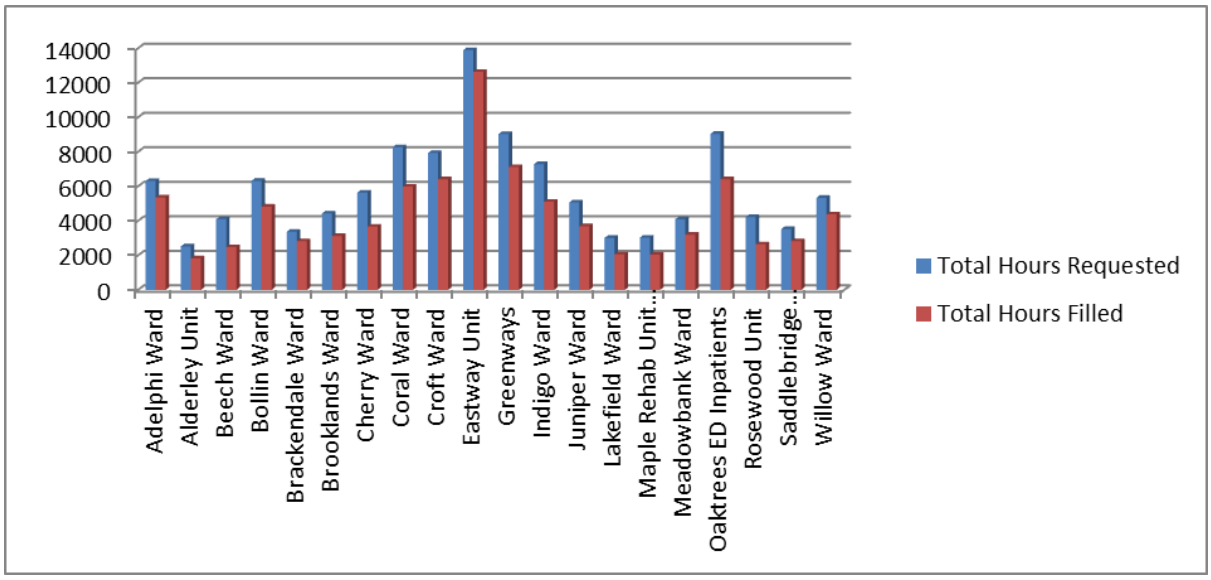
The need to embrace a multi-disciplinary team approach to safer staffing has been discussed alongside the recognition that ward managers when required to do so are included within establishments to meet clinical demands and maintain clinical safety. It is noteworthy to recognise that this period has seen the continuation of bespoke roles such as the Pharmacy Technician on Croft Ward and Registered Adult Nurses in a number of inpatient areas. The evaluations and quality impact assessments of the developing roles are being overseen by the People and Planning group.

The first cohort of Trainee Nursing Associate has successfully qualified and seven staff are successfully registered as Nursing Associates with the Nursing and Midwifery Council (NMC). A total of two are working within in-patient areas and the role is continuing to be embedded. Quality impact assessments have been completed and will be reviewed in six months. There are two current cohorts of Trainee Nursing Associates who will be finishing in March 2020 (4 TNAs) and December 2020 (6 TNAs). The accelerated Masters nursing students are scheduled to complete their training in June 2019 and have been successful in securing a post within their preferred area of practice.

Responding to Unplanned Workforce Challenges – Openness and Transparency

An important factor in the consideration of safer staffing requirement is having a culture of being able to escalate staffing concerns. All inpatient areas, including LD respite (Thorn Heys and Crook Lane) confirmed during the staffing meetings that they were able to raise and escalate staffing concerns. Positive reports of improved support mechanisms for safer staffing in terms of establishment have been received from Thorn Heys; acknowledging that Thorn Heys is now managerially aligned to Wirral place based adult mental health. There was agreement that achieving staffing establishments was essential; staff took a realistic approach to this in offsetting staffing numbers against factors such as having a responsive and capable staff shift. Many of the discussions in this area were related to employing agency staff when other alternatives were assessed as not suitable.

Demand for temporary staffing has fallen (120.7 WTE filled May – Oct 18 to 90.9 WTE filled Nov 18-April 19: The figures include a rise in agency clinical support worker bookings from 6.8 WTE to 9.4 WTE). Bank recruitment for registered and non-registered nursing roles continues to be prioritised for all areas. The Trust has a neutral vendor agreement for agency staffing which has supported increased supply of clinical support workers at a standardised price under the National Health Service Improvement cap.



*Maple Rehab Unit previously named Lime Walk House

Conclusion

This report for the period November 2018 through to April 2019 has evidenced that there is continuing efforts by ward staff, senior managers and modern matrons to promote safer staffing in-patient areas. Staff have demonstrated that they are able to speak up and raise concerns in relation to safer staffing.

Right Staff

The past six months have brought challenges within in-patient areas due to requirements to staff wards particularly as a consequence of unplanned absences and increased clinical demand. Bollin ward has experienced particular challenges. There was a proactive management approach to address deficits through taking a multi-disciplinary approach in staffing a ward, engaging temporary staff, paying overtime and as a last resort the use of agency staff. The were no concerns relating to seeking additional staff to provide safe care but the challenges at times continues to be the availability of staff. There was cross locality management of staffing to safeguard safe staffing levels. There has been ongoing recruitment into vacancies particularly nursing, this is not unique to the Trust as this forms part of national nursing pressures. The approach to recruit in advance of need is a proactive response to safer staffing with the aim to alleviate pressure.

There remains commitment to attain the right staff and the recruitment of student nurses continues to be proven successful iniative. Additionally the development of new roles and the incorporation of a broader skill mix is evolving and includes the incorporation of pharmacy technicians and registered nurses from other branches. What is evident from a

safer staffing perspective is that the delivery of effective care is not only about the numbers of staff, but also the skill mix of the ward teams and the value of an MDT, in the context of changing clinical demands and priorities. Having the right staff has been a continuous process and requires ongoing monitoring.

Right Skills

The Trust has continued to develop its workforce through the development and expansion of new roles and remains committed to doing so. Key developments have included introducing Nursing Associates now qualified and registered with the NMC. Additionally there are key training posts that will impact on our future skill mix; inclusive of Trainee Nursing Associates, Advanced Practitioner in Training (including AHP) and Consultant in Training post. During the review there has been evidence of multi-disciplinary working to enhance the quality of care to meet the care needs of the population served. Supervision and training remain ongoing staffing requirements to embed skills to enhance care; supervision will form a Quality Improvement Initiative (QI) during 2019.

Right Place & Time

Although clinical areas roster for their own clinical area there is a philosophy of cross unit working to meet the care needs of patients and ensure safe staffing. During the review period there were occasions where staff had to be relocated due to clinical pressures and demand across the organisation, whilst staff fully understood the rationale and requirement to do this at times they also expressed frustration at not being able to always provide continuity within their role.

Recommendations

The report outlines an extensive programme of work in relation to our approach to safer staffing and workforce initiatives to meet the current and future needs of the populations we care for. The Board are asked to note the developments within the report and approve the continued approach to safer staffing.

Section 2 - Improving Access to Psychological Therapies (IAPT)

Overview

The Improving Access to Psychological Therapies (IAPT) programme supports the NHS in implementing National Institute for Health and Clinical Excellence (NICE) guidelines for people with depression and anxiety disorders.

NHS England recommend services employ IAPT trained staff or train their existing staff in the recognised therapy modalities to expand capacity and where services are employing non-IAPT trained staff those staff should be accredited, by the recognised body (i.e. BABCP for CBT therapists) for the modality of therapy they are offering.

The IAPT model is that steps 1 and 2 are provided by low intensity therapy workers trained in cognitive behavioural approaches for people with mild to moderate anxiety and depression. Moving up the stepped approach to level 3, provided by IAPT high intensity therapists trained in Cognitive Behavioural Therapy (CBT).

Right Staff

	Trainee PWPs	Qualified PWPs	Senior PWP	Trainee HITs	Qualified HITs	Qualified Counsellors	Assistant PWPs/HCAs	Total Staffing
South Cheshire and Vale Royal	6	5.74	1	2	9.5	5.3	1	30.54
West Cheshire	4	9.4	1	0	10.9	7.6	0	32.9
South Sefton, Southport & Formby	2	15.49	2	4	11	5.52	0	38.01

Currently the services in West Cheshire and Vale Royal & South Cheshire are lower that the NHSE recommendations for step 2. The current national IAPT model assumes a 60% low intensity work force and a 40% high intensity workforce. To bring South Cheshire & Vale Royal in line with this model we would require an extra 2 whole time equivalent (WTE) qualified Psychological Wellbeing Practitioners (PWPs). Currently we are utilising a higher

percentage of high intensity therapy to meet the demand, this is activity that could be provided by low intensity workforce.

West Cheshire have just recruited 2 trainee PWPs which will bring the service in line with this requirement once they are qualified in 20/21.

Supervision

There are sufficient numbers of supervisors for core PWPs, counsellors, and high intensity therapists (HITs) to meet the NHSE recommendations for IAPT. Within all localities it is identified that there are insufficient supervisors to provide supervision related to Eye Movement Desensitization and Reprocessing Therapy (EMDR). To address this EMDR consultant sessions across the IAPT sites is being purchased to provide the required supervision and a plan has been developed to address this internally in the future. Sufficient number of supervisors to include supervision for counselling for depression is now available as a result of the current trainees qualifying and accessing the Health Education England (HEE) commissioned supervisor course.

Right Skills

Locality	% of PWP Trainee on IAPT approved training	% of IAPT Qualified PWP	% of HIT Trainee on IAPT approved trainee	% of IAPT Qualified HIT	% of Qualified Counsellors with IAPT approved training or commencing training
South Cheshire & Vale Royal	100%	100%	100%	100%	91%
West Cheshire	100%	100%	100%	100%	79%
South Sefton, Southport & Formby	100%	100%	100%	100%	100%

We are assured by reaching 100% compliance for training in accordance with expected standards for all staff groups. It is not mandated that qualified counsellors have IAPT approved training but it is recognised good practice. This is an area of improvement and we

plan to enable our qualified counsellors to access this additional training by the end of the financial year 2019 - 2020.

Right Time / Place

The discussions of individual clinical cases during supervision are prioritised according to clients' needs and a pre-determined schedule. All cases are reviewed within a 2- 4 week period of time; when assessed to be needed supervision is provided for individual clinical cases weekly. The plan is to train a CWP EMDR consultant to provide internal supervision and develop a cascade approach to supervision across the sites. To achieve this we are training 1 EMDR therapist as an EMDR consultant through purchasing external supervision. This requires monitoring to ensure that the supervision standard is met to achieve consultant accreditation.

High intensity activity is currently higher than the national model for step 3 across the IAPT services. Every service offers a stepped care model with all patients being offered a step 2 intervention initially. This enables staff to meet patient need effectively by identifying those with a greater need to continue onto a high intensity programme and enables capacity to be appropriately managed. To ensure we are offering the correct intervention at the right time therapist continually monitor patients improvement through psychometric measure and patients are stepped up to a higher intensity therapy if the patient isn't recovering as expected.

All IAPT services deliver treatment through a range of alternative delivery systems such as telephone, group therapy or 1-1 therapy which is delivered according to the IAPT guidance. All areas offer web based support which is a better use of staff resource to meet patient need.

Recommendations

1. To enable qualified counsellors without IAPT approved training to access courses in the financial year 2019 - 2020.
2. To monitor the provision of internal supervision.

Section 3 - Specialist Mental Health

This section to the safer staffing overview report will seek to provide a position statement with specific reference to the services that fall within the Specialist Mental Health Care Group. It will detail the current position together with the steps currently being undertaken to ensure that services and the workforce are positioned to respond to the *safer staffing* agenda by ensuring *the right staff, the right skills* and *the right place.*

Background

One of the Trust's key priorities is the Transformation of Mental Health Services with key programmes of work focusing upon the:

- Redesign of inpatient services in Central and Eastern Cheshire.
- Development of services outlined within the 5 Year Forward View for Mental Health.
- Transformation of community mental health services as described within the NHS Long Term Plan

Taken in the context of an aging workforce and increasing difficulties in the recruitment to key roles it is imperative that these work programmes take an innovative approach to the development of new roles for both registered and non-registered staff that use the assets and skills of the local community to integrate care delivery. Given the significant changes required to ways of working and staffs' roles, there will be a significant requirement for the skills of Organisational Development as well as a spotlight on the education and training requirements of staff in order to ensure a skilled and motivated workforce.

Looking towards the future, greater emphasis is placed upon ensuring that the Mental Health Services reflect the needs of their population at a Local and Regional level and work in partnership with other agencies to address the wider determinants of health.

Right Skills

The Specialist Mental Health workforce is starting to routinely develop and utilise advanced skills and roles within clinical practice: Particular examples include the development of Non-Medical Prescribers, Advanced Practitioner roles, [although to date these positions are generally held by nurses], and the new Nursing Associate role. Historically, there has been little consistency across the organisation with regard to the development of these roles, particularly the Advanced Practitioner, and how the advanced skills are utilised to their optimum.

The emphasis upon developing *the right skills* has never been greater. Whilst there is an emphasis on enhancing the psychological skills available within Specialist Mental Health services to ensure that there is an increased availability of talking therapies, the significant changes in working practice required to deliver services will undoubtedly require the significant development and strengthening of personal skills together with significant support to enhance the culture of current services.

The increased reliance of technology in everyday working practice as well as digital treatment approaches requires the development of IT skills across the entire workforce. Whilst new kit is being rolled out to teams to support increased mobility, associated protocols and training programmes are yet to be developed but are fundamental in ensuring that the required behaviour change amongst staff is supported.

Attention is starting to move towards the development of psychological skills within the workforce with a specific emphasis on those evidence based interventions for people with a severe mental illness: Psychosis, Bipolar Disorder and Personality Disorder. With investment being made available for both training and backfill, the Specialist Mental Health Care Group are currently engaged in the scoping of current capacity to determine the level of training required across services. To support this, the Care Group has recently invested in training approximately 70 people in Structured Clinical Management and is currently developing a strategy for its implementation and use across the Organisation

<u>Right Staff</u>

The identification of skills required to be delivered has enabled an innovative approach to the development of a multi-disciplinary approach enabling a much broader range of professional backgrounds to be involved, including pharmacy. This approach has also provided an increased resilience with regard to some of the roles that are becoming increasingly difficult to recruit to.

Although very much in its infancy, progress is already being made towards addressing the clinical gaps utilising new roles with the Nursing Associate and new Advanced Practitioner roles are a clear example of how Specialist Mental Health services are seeking to ensure that there is a robust approach to the physical health needs of service users.

<u>Right Time</u>

Proposals for the development of Community Mental Health services reiterate the need for greater integration both within and across services and for earlier intervention. This would

result in the abolition of the divide between primary and secondary care services that are based around Primary Care Networks.

Whilst the Care Group has already piloted more integrated ways of working , for example the Mental Health First approach in Central Cheshire, the proposal for Community Mental Health Services would see this work being accelerated alongside the increased availability of peer/ recovery mentors.

Section 4 - Learning Disability

Overview

There are strengths and challenges facing Learning Disability (LD) services as part of the transforming care programme. From an LD perspective this is principally right as there should be the same opportunities for people with a learning disability to live in the community with the most appropriate care and support to meet their individual needs. It is well evidenced nationally that historically patients with a learning disability that have been admitted to hospital led to significantly protracted lengths of stay and the risk of institutionalisation. Redressing this through the transformation of care programme needs to include repatriating patients back into the community from out of area hospital placements and also identifying those at risk of admission to consider if admission is in their best interest. Established mechanisms are in place through staff knowledge and training to identify those at risk of admission through the Care and Treatment Review (CTR) process; within CWP there is the active use of the Dynamic Support Database (DSD) to identify at risk patients and for timely intervention to negate this where possible. Thus having a community staff team that can dynamically assess risk and provide intervention means that those patients who can remain in the community are getting timely admission avoidance intervention and it is only those with specific care need that cannot be met within a community setting who require admission. Discharge planning is critical with consideration for this starting at the point of admission. Strong assessment processes are essential to ensure that all aspects of care are considered.

In order to meet bespoke care needs there is a need for a skilled workforce who can adjust to the needs identified. A skilled staff group is required that includes the core proficiencies in understanding learning disability and managing complex challenges. This, however, is only a relative requirement. A staff skill with an enhanced knowledge base around physical health and mental health is required given the increased co-morbidities of people with learning disabilities and to reduce health inequalities and increase life expectancy. In order to provide a positive experience for patients patient journey we require a staff team whose skills include patient, carer and family involvement.

The co-morbidities with a learning disability are significant and evidence from the Learning Disability Mortality Review[3] will require proactive and pre-emptive planning by health and partner agencies. From a CWP perspective future planning around the capabilities of

[3] University of Bristol (2018) Learning Disabilities Mortality Review http://www.bristol.ac.uk/sps/leder/

individual staff and also the combination of skill mix, including nursing, medical and Allied Health Professionals (Physiotherapy, Speech and Language and Podiatry) has commenced. This is not just exclusive to health but also considering aligned roles such as transformation workers to identify individual care needs and social workers to ensure arrangement around health and social care needs.

Current Position

In the last 12 months the Learning Disability, Neurodevelopmental and Acquired Brain Injury Care Group (LD, NDD and ABI) has commenced with a trust wide approach to delivering on transforming care. The Care Group is aligned fully with learning disability inpatient services with shared management and governance procedures.

There are 4 Adult Community Learning Disability Health teams across CWP (Wirral, West and Vale, South and East, and Trafford).

Right Staff

Each Community team has a Multi-disciplinary team.

These include:

- Psychiatry
- Administrators
- Community Learning Disability Nursing
- Nurse Specialists including Health Facilitators
- Clinical Support Workers
- Associate Practitioners
- Specialist Physiotherapist
- Specialist Occupational Therapist
- Specialist Speech and Language Therapist
- Clinical Psychologists

These teams are supplemented with trust wide leadership roles:

- Strategic Clinical Director
- Specialist Clinical Director
- Head of Clinical Services
- Head of Operations
- Consultant Occupational Therapist
- Patient and Carer Engagement practitioner

To further develop the roles that work well and identified in the last report (Transition and Autism coordinators), we have joined the NHSI Transition Collaborative. Using Quality Improvement methodology specific standards will be identified for transitions between learning disability Children and Adolescent Mental Health and Adult Community Learning Disability Team.

Right Skills

A key development within the care group maturity requirements is that of workforce planning. The LD, NDD and ABI Care Group workforce plan is a dynamic document that articulates current need and future need to support planning. In order to continue to develop the workforce and respond to the challenges we have invested in the following development opportunities:

- Trainee Advanced Practitioner (Speech and Language Therapy)
- Trainee Advanced Practitioner (Nursing)
- Trainee Advanced Practitioner (Physiotherapy)
- Trainee Nursing Associates
- Quality Improvement Skills

And for the year ahead:

- Approved (Non-medical) Clinician training
- Further Quality Improvement skills training

Continuing professional development is a requirement for all practitioners. Our aim will be to ensure that all development is consistent with professional need and supports the vision and aims of the Care Group. An example of this is following an increase in the use of Court of Protection applications (to support discharges from hospital), alongside our CCG commissioners, relevant training has been accessed.

Right Time

Delivering safer staffing alongside having the right staff and the right skills also requires consideration to an ability to have a timely response to need. This need could be generated through vacancies or population demand. Transforming Care has resulted in teams needing to review their skills to reflect a changing population.

Recruitment of staff at the right time can be a challenge. The care group has recognised this and is supporting through The Centre for Autism, Neurodevelopmental Disorder and Intellectual Disability (CANDDID) a wider plan for ensuring our workforce is both proficient,

accessible and present. This is an academic centre that alongside developing the body of knowledge relevant to the Care group will also develop the access to training for our workforce and the wider community workforce, thus supporting discharges and community resilience.

Centre of Autism Neurodevelopmental Disorder Intellectual Disability (CANDDID) is working in collaboration with universities to both contribute to critical research but also develop academic modules that support the workforce.

We have recognised that where there are disciplines within teams that have small numbers of practitioners and where recruitment is an identified risk, considering this across a wider footprint increases options for maintaining patient safety.

In recognising that learning disability nursing is experiencing a shortage of nurses the Care Group has engaged with recruitment campaigns to support addressing this.

Recommendations

- Continued use of dynamic strategic planning through workforce planning document.
- To monitor the outcomes of the CANDDID approach and determine the need for wider investment to enhance quality of care for people.
- The recruitment of research assistants to support the existing clinical leadership.
- Identify and strengthen core skills and competencies that are generic to the whole of the multi-disciplinary team.

Section 5 - Community CAMHS

Overview

The Children, Young People and Families Care Group has developed and implemented a priority project for Community CAMHS models of care across the Trust footprint. The purpose of the priority project is to ensure models of care across the care group are consistent in the provision of our core offer ensuring unwarranted variation is minimised across all Community CAMHS for Cheshire and Wirral. The priority project is being delivered via the following work streams to ensure the model of care delivered to young people and their families is effective, safe, compassionate and sustainable:

- Operations and workforce;
- Outcomes;
- Data & Reporting;
- Self-Harm;
- Participation & Engagement

A key element of the initial stages of the priority project has included developing an organisational baseline via the operational and workforce work stream. The focus of the work stream is providing the baseline to inform the services current and future skill requirements and opportunities for roles to develop the mental health workforce.

To date the work stream has undertaken a mapping of all CYP CAMHS community services; reviewed the staff whole time equivalents, skill mix, job titles and professional qualifications in each team and is gathering data regarding the pathways in place across CYP services. This baseline is informing the project's steer to standardise and align service operational processes, service structures and the development of clinical pathways across Community CAMHS; ensuring equitable delivery (where possible) informed by CYP and Families feedback on value looks and feels like for them, 'best practice', local and national guidance

Section 6 - Neighbourhood Community Nursing

Overview

The focus of this report is upon the safer staffing requirements of nursing within the Care Community Teams (CCT's) in the Neighbourhood Based Care Group.

Right Staff

The current community nursing establishment is based upon the population size of people aged 65 years and above within identified GP clusters. The development of the Primary Care Networks (PCN), alongside the recognition of varied needs within the populations has provided an opportunity to analyse community nursing staffing in accordance with Primary Care Network populations. This analysis has identified that the current community nursing staffing levels within Ellesmere Port and Princeway Community Care Teams (CCTs) in relation to the PCN general practice populations need to be uplifted. Further understanding is required to determine the skill mix requirements for these teams.

The capacity reporting process has been reviewed allowing reporting of the current status rather than a retrospective position. The Care Community Safer Staffing report (Sitrep) has been developed and provides an overview of the number of clinical available hours, number of planned visits and the number of hours available to provide a response to unplanned patient contact care which requiring on the same day as the request is received. This is reported for community nursing and community therapy within each CCT. The report includes the OPEL status. The Sitrep enables the CCT's to plan and report any additional support required to maintain safer staffing levels.

Right Skills

There is a continued commitment to the trainee advanced practitioner programme. The review of the community matron and the clinical case manager role is being completed. This work will be aligned to the system wide offer with partner providers, in particular the next phase of the Hospital at Home programme.

The CCTs have actively engaged with the community diagnostics programme as part of the Integrated Care Partnership work stream to inform the development of competencies to meet the needs of the population. CCT members from all roles and bands have been taking part in events and workshops based on their local populations.

Right Time & Right Place

There has been no requirement for the use of agency nursing staff since the report submitted in November 2018: Alongside the Sitrep this demonstrates that the establishment is fit for purpose to provide safe and effective care. An emergent theme is the movement of nursing staff to meet the needs of teams; this is being addressed by the review of the community nursing establishment based on the PCN practice populations.

Analysis of the retention rate for band 5 community nurses has been completed. This has enabled the rate of recruitment in advance of need per quarter to be determined. Recruitment in advance of need has been commenced in June 2018. This will reduce the period further the gap between the post holder leaving and the new recruit coming into post. The current recruitment in advance of need is being utilised to address the uplift requirements in Ellesmere Port and Princeway CCTs.

Values based recruitment has been embedded within community nursing and there is currently work underway to align job descriptions to the values based recruitment process.

Recommendations

- Data analysis of activity from the Sitrep will be provided in a consistent manner that enables each team to demonstrate their level of tolerance.
- Deep dive into clinical practice to understand any variances in the response required to meet the needs of the local population.
- To further develop the daily situation report in response to staff feedback.
- Determine the skill mix requirements for Ellesmere Port and Princeway CCTs.

Cheshire and Wirral Partnership NHS Foundation Trust

STANDARDISED SBAR COMMUNICATION

REPORT DETAILS	
Report subject:	Freedom to Speak Up Annual Report 2018-19
Agenda ref. number:	19.20.50
Report to (meeting):	Board of Directors
Action required:	Information and noting
Date of meeting:	31/07/2019
Presented by:	Victoria Peach, Deputy Director of Nursing

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

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

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

The annual Freedom to Speak Up report presented provides assurance to the Trust Board that the creation of a Speak Up Culture, throughout the organisation is continually being strengthened.

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

Cheshire and Wirral Partnership NHS Foundation Trust has had speak up arrangements for any employee to raise a concern that they may have for a number of years. Since the development of the national Freedom to Speak Up (FTSU) programme led by the National Guardian Office, to make the NHS a 'better place to work and a safer place for patients' the Trust has aligned local arrangements to the national agenda.

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

The annual report provides an overview of the:

- Quality improvements taken to fulfil the outcomes of the self-review tool for NHS Trusts and Foundation Trusts.
- Steps taken to build confidence and capability in relation to the Speak Up agenda.
- Analysis of the Speak Up activity for 2018-19.

The Freedom to Speak Up commitments for 2019-20 are detailed within the annual report. The Board of Directors is asked to note the assurances that the Freedom to Speak Up processes are in place, are accessible to all people and that the commitments for 2019-20 will continue to strengthen the development of a robust speak up culture

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

The Board of Directors is asked to note the report.

Who has approved this report for receipt at the above meeting?	Avril Devaney, Gary Flockhart
Contributing authors:	Victoria Peach

Distribution to other people/ groups/ meetings:

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

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

Appendix No.	Appendix title
1	FTSU Annual Report

Cheshire and Wirral Partnership
NHS Foundation Trust

Speaking Up and Raising Concerns

Annual Report

April 2018 – March 2019

Board of Directors' Speaking Up Declaration

Cheshire and Wirral Partnership NHS Foundation Trust (the Trust) are committed to create an open and honest learning culture that is responsive to feedback to continually improve, as such take the responsibility for Speaking Up very seriously. The following declaration of compliance with Speaking Up and Raising Concerns practice is made:

The Trust meets the statutory requirement of NHS England by having Freedom to Speak Up Guardians available to support any employee to raise a concern that they may have.

Speaking up policy and processes have been reviewed; are up to date and in line with recommendations of the National Guardian's Office. All associated polices are reviewed on an annual basis or as guidance develops that requires change.

Our Freedom to Speak Up Guardians have a clear understanding of their roles and responsibilities with sufficient time and support to undertake them.

Executive Director of Nursing, Therapies and Patient Experience, namely Avril Devaney, is the Director Lead for Speaking Up. The Trust has a Non-Executive Director Freedom to Speak Up Champion, Rebecca Burke-Sharples, who provides alternative support to the Freedom to Speak Up Guardians, scrutinises and is able to robustly challenge Speak Up governance.

The Board receives regular reports in relation to Speak Up; alternative months via Board Escalation, triannual through Learning from Experience and an annual report. Report contain details on the number of concerns raised, lessons learned and recommendations for any further necessary action. The Board is assured that Cheshire and Wirral Partnership NHS Foundation Trust adheres to good practice and that appropriate Speak Up arrangements are in place.

If any further information is required, please contact the Chief Executive Officer at Trust Headquarters.

Contents

Introduction

Cheshire and Wirral Partnership NHS Foundation Trust (thereafter referred to as the Trust) are committed to have effective speaking up arrangements for any employee to raise a concern that they may have.

This commitment aligns to the national Freedom to Speak Up (FTSU) programme led by the National Guardian Office, to make the NHS a 'better place to work and a safer place for patients' and is recognised as vitally important to help protect patients and improve the experience of our people.

This annual FTSU report provides assurance to the Trust Board that the creation of a Speak Up Culture, throughout the organisation is continually being strengthened.

Commitment

Our person centred commitment to Freedom to Speak Up is that:

> "We will have the courage to speak up and voice our views. We will always try to improve things to make a lasting difference".

Speaking Up 2018 – 2019

<u>Quality Improvement</u>

In May 2018 NHS Improvement and National Guardian Office published a self-assessment review tool setting out expectations of boards in relation to the Speak Up agenda. The Trust Board completed the in-depth self assessment. Inconjunction with the FTSU Guardians a subsequent quality improvement plan was developed to address the areas where full assurance had not been achieved. This process has enabled the Board to be assured that expectations are being met within the following areas:

- Leaders are knowledgeable about FTSU.
- Leaders have a structured approach to FTSU.
- Leaders actively shape the speaking up culture.
- Leaders are clear about their role and responsibilities.
- Leaders are confident that wider concerns are identified and managed.
- Leaders engage with all relevant stakeholders.
- Leaders are focused on learning and continual improvement.
- Individual responsibilities.

The Trust Board self assessment identified key areas to be improved upon, which has resulted in: The FTSU Guardians establishing a quality assurance process for cases raised as a concern. Gaining the views and opinions of a diverse range of people through raising the profile of speaking up, inviting people to become FTSU ambassadors and offering training. The FTSU Guardians have specifically focused on engaging with more vulnerable groups such as temporary workers.

The FTSU Guardian role has been undertaken by the two Associate Directors of Nursing and Therapies. Both FTSU Guardians have attended Speaking Up training in 2018 provided by the National Guardian Office. Developing a shared approach has enabled increased access to a FTSU Guardian, providing choice for people, greater independence of the role and a

quality assurance process to be implemented without compromise to individuals' confidentiality.

The FTSU Guardians are well supported to carry out the role: In addition to regular meetings with the Executive Director lead for Speaking Up, both Guardians have met with the Non-Executive Director FTSU Champion, as well as the Chief Executive and Chair to discuss Speaking Up strategy and any associated matters. This has enabled the FTSU Guardians to raise the profile of Speaking Up and ensure senior leaders are aware of the Speaking Up strategy and able to promote the Speaking Up during qualty visits and engagment with people. The FTSU Guardians report in person at board meetings.

Building Confidence and Capability

The Speaking Up policy and processes have been reviewed. The revised policy has been published and is available on the Trust intranet. The importance of Speaking Up and Speaking Up processes have been shared with people in a variety ways; direct via distribution of leaflets; through Trusts communication bulletins; Chief Executive Officer drop in sessions and breakfast with the Chief Executive Officer; board member quality visits; and face to face by FTSU Guardians. Raising the profile of Speaking Up has been in conjunction with in an increased number of concerns being made.

The Trust has recruited Speak Up Ambassadors from wide ranging services across the Trust. The Speak Up Ambassadors are self-nominated people working in any role within the trust who are able to provide support for colleagues in raising concerns, determining the best course of action and advising people of their options. All newly recruited Speak Up Ambassadors have received training and exisiting Speak Up Ambassadors have been offered training.

Feedback mechanisms have been developed to enable direct comment from concluded cases. Alongside the work of organisational development understanding the matters that contribute to related areas hihglighted in the staff survey the information gained has informed the changes to policy and processes; and will continue to do so.

Measuring Progress

One of the challenges for the Trust is reaching all staff regardless of seniority or job role with information regarding the access to FTSU Guardian to enable them to raise any issues or concerns, or challenge any wrongdoing, through this route. It had been recognised that have varying degrees of access to email and some do not have mobile devices supplied by the organisation but do have their own mobile phones. The development of a FTSU App has been an approach to enhance accessibility to the FTSU Guardian. The FTSU App has been accessible to staff through a work or personal device. In the last twelve months no concerns have been raised via the App; concerns have been via email directly to a FTSU Guardian or through the dedicated raising concerns email account, by telephone, escalated through the FTSU Ambassadors or face to face.

People are able to raise concerns to the FTSU Guardian on an anonymous basis; such concerns are considered and investigated accordingly. However, personal evidence and clarification from individuals can be essential to enable a comprehensive investigation. In order to continue to improve the culture regarding raising concerns staff are encouraged to be open with the confidence that the FTSU Guardian will provide confidential support and only use the anonymous route when absolutely necessary.

Learning from concerns is shared within the team, service, care group and organisational wide as appropriate. The Learning from Experience report provides assurance via the Quality Committee on a quarterly basis to trust board and Board Escalation report provides bi-monthly FTSU activity directly to the trust board.

Systems are in place to record and monitor the FTSU activity and the FTSU Guardians report such to the NGO each quarter as required. Success should not be measurable by the number of concerns and issues being raised. However, the trends of reporting can be useful when triangulated with wider data and can support the idenification of early warning that can enable prompt and appropriate intervention and support.

The results from the 2018 National Staff Survey are encouraging with staff responses to three out of four questions being higher than the national average. The FTSU Guardian will continue to work with organisational development to understand the opportunities for further development in those areas that have seen a slight reduction locally compared to 2017 response and for the one area that we did not exceed national average.

Table 1 – Staff Survey Results 2018

Question	National Response	Trust Response			
	2018	2018	2017	2016	2015
If you were concerned about unsafe clinical practice, would you know how to report it?	96%	97%	98%	97%	97%
I would feel secure raising concerns about unsafe clinical practice.	73%	75%	77%	76%	69%
I am confident that my organisation would address my concern.	60%	63%	64%	66%	59%
My organisation treats staff who are involved in an error, near miss or incident fairly.	58%	56%	53%	55%	50%

Analysis of Activity

People are speaking up and raising concerns through the FTSU Guardian route which continues to be utilised across the Trust; the number of concerns raised in 2018 / 2019 has exceeded the previous years.

Table 2 – Total numbers of concerns raised from 2014 / 2015 – 2018 /2019

Year	Total number of FTSU concerns raised
2014 – 2015	7
2015 – 2016	20
2016 – 2017	12
2017 - 2018	23
2018 – 2019	28

This demonstrates that awareness and confidence of staff to utilise the FTSU Guardian continues to grow. Further analysis provides assurance that people raising concerns are from

across the trust; not limited to a particular locality, professional group, level of seniority, and gender or ethnicity. The data demonstrates that those over the age of 35 are most likely to raise a concern via the FTSU Guardian.

Table 3 – Total numbers of concerns raised by locality from 2015 – 2016 to 2018 – 2019.

Locality	**Total 2015 - 2016**	**Total 2016 - 2017**	Q1	Q2	Q3	Q4	**TOTAL 2017-2018**	Q1	Q2	Q3	Q4	**TOTAL 2018-2019**
Central and East	6	5	1	8	5	1	**14**	2	6	1	3	**12**
Wirral	4	2		1		2	**3**			3	1	**4**
West	8	4	2	2		1	**5**	3	2	3	3	**11**
Trust wide	2	1					**1**				1	**1**
TOTAL	20	12	3	11	5	4	**23**	5	8	7	8	**28**

Table 4 – Comparison of 2017 – 2018 and 2018 – 2019 concerns raised by locality

	17-18		**18-19**	
TOTAL	**23**		**28**	
East	**14**	61%	**12**	43%
Wirral	**3**	13%	**4**	14%
West	**5**	22%	**11**	39%
Trust Wide	**1**	4%	**1**	4%

All the concerns raised have been investigated and responded to in a proportionate way by a variety of methods, inclusive of supporting people with specific concerns that could be addressed at supervision or through the line management processes through to commissioning an investigation under dignity at work policy. Scheduled and commissioned reviews have been undertaken to explore some concerns raised with any recommendations being shared with teams and services for further action.

There were four concerns raised anonymously in 2018 / 2019: One such concern was being progressed by HR. One was a patient safety concerns raised directly with the Care Quality Commission (CQC) and followed up by the FTSU Guardian. The FTSU Guardian role is being promoted to encourage staff to report via this route however, in keeping with our Raising and Escalating Concerns policy staff will continue to be encouraged to raise concerns directly with the CQC should they feel this is the most appropriate method.

There has been an increase in the total number of concerns reported to the FTSU Guardian this financial year. The method of collating data has impacted upon the total number in comparison to years prior to 2017 – 2018 when the changes were made.

The FTSU Guardian is accessible to all people working within the Trust, or previously employed by the Trust, regardless of their role. Concerns have been received from a variety

of staff such as nurses, therapists, and clerical staff. People groups considered vulnerable by the NGO criteria have raised concerns this year, such as temporary workers.

There have been a range of concerns raised to the FTSU Guardian; the concerns have been categorised in line with the NGO guidance. Some concerns have been included within multiple categories therefore the total number does not equate to year-end total as above.

Table 4 – Number of concerns raised 2017 – 2018 and 2018 - 2019

	2017-2018					2018-2019				
	Qtr 1	Qtr 2	Qtr 3	Qtr 4	**TOTAL**	Qtr 1	Qtr 2	Qtr 3	Qtr 4	**TOTAL**
Bullying / Harassment				1	1 (4%)	3	6	1	4	14 (44%)
Patient Safety / Quality	1	1	2	1	5 (22%)			1	2	3 (9%)
System / Process				1	1 (4%)	2	1	3	2	8 (25%)
Staff Safety		2			2 (9%)			1		1 (3%)
Leadership / Management Issue	2	10	1	1	14 (61%)		1	4	1	6 (19%)
TOTAL	3	13	3	4		5	8	10	9	

*A speaking up concern can be assigned more than one category; the number of categories exceeds total concerns.

Analysis of the categories of concerns raised by people identifies that in 2018 – 2019 a higher proportion of people spoke up about their perception of bullying and harassment within work. The learning that has been extracted from cases is the importance of developing effective communication between individuals and teams and supporting people to raise concerns as and when they arise.

Speaking Up in 2019 – 2020

The FTSU Guardians will work alongside senior leaders to continue to strengthen, and achieve, a healthy speaking up culture throughout the Trust. The following commitments for 2019 – 2020 are in place:

- The FTSU Guardians will utilise the expectations stated within the self-assessment review tool to review the Trust's position and determine any areas for further improvement.
- Review the use of the FTSU App and gain opinion from people to determine the need for continued availability.
- To promote the importance of strengthening a Speaking Up culture through a variety of methods supported by leaders across the organisation.
- To recruit Speak Up Ambassadors from geographical areas and specialities that currently do not have Speak Up Ambassadors.
- To review the role of the Speak Up Ambassadors, gain feedback to understand if and how the role should be developed.
- To work closely with Equality Lead and develop a shared network approach to strengthen the voice of people with protected characteristics in relation to the Speak Up agenda.
- FTSU Guardians to support the work of organisational development to understand the matters which contribute to related areas highlighted in the staff survey.
- A bespoke eLearning approach will be developed.

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STANDARDISED SBAR COMMUNICATION

REPORT DETAILS	
Report subject:	Medical Workforce Annual Report 2018-2019
Agenda ref. number:	19.20.51
Report to (meeting):	Board of Directors
Action required:	Discussion and Approval
Date of meeting:	31/07/2019
Presented by:	Dr Rachel McLoughlin, Director of Medical Workforce

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*

Each year designated bodies are required to complete an Annual Organisation Audit (AOA) on Appraisal and Revalidation in order to gain an understanding of the progress made during the last year and assure Responsible Officers and Executive Board as well as NHS England, that systems for evaluating doctors fitness to practice are in place, functioning, effective and consistent.

Following the AOA, designated bodies are required to produce a status report and review their organisations developmental needs in this area. PODSC initially receives this report and has approved it for submission to the board. The Chief Executive is asked to receive this status report and complete a statement of compliance for submission to NHS England.

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

There was a slight change to the support team for the Responsible Officer in the last year. Sarah Carroll left her post as Medical Appraisal and Revalidation manager. The process is now supported by the medical staffing team.

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

22 recommendations to revalidate were made to the GMC between 1/4/2018 and 31/03/2019. All recommendations were completed on time.

CWP have 105 doctors for whom Dr Alam is the RO:
82 Consultants, 16 SAS doctors and 7 doctors on temporary/short term contracts or with a prescribed connection with this designated body.

We have 30 medical appraisers, CWP is now able to provide helpful and constructive feedback to these following the introduction of Quality Assurance Panels.

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

The Board of Directors is asked to approve the accompanying report (Appendix 1) and the Chief Executive requested to sign the Statement of Compliance for return to NHS England via the medical staffing team

Who has approved this report for receipt at the above meeting?	Faouzi Alam, Medical Director
Contributing authors:	Rachel McLoughlin, Director of Medical Workforce Mark Cadwallader, HR Manager - Medical Staffing

Distribution to other people/ groups/ meetings:

Version	Name/ group/ meeting	Date issued
1	People and Organisational Development sub-committee	July 2019

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

Appendix No.	Appendix title
1.	Medical Workforce Annual Report 2018-2019
2.	NHS England Statement of Compliance

Medical Workforce Annual Report 2018-2019

This appendix contains a more detailed analysis on:

1. Recommendations made to the GMC regarding CWP's doctors' fitness to practice
2. Arrangements for and outcomes of medical appraisal
3. Arrangements for and outcomes of responding to concerns expressed about doctors
4. A review of last year's action plan
5. A plan of action for the forthcoming year

Dr Alam is the Responsible Officer for the Trust and Dr Rachel McLoughlin is the Director of Medical Workforce. Both are supported by the Medical Staffing Team: Lauren Green, Medical Staffing Officer, Emma Dodd, Administrator and Mark Cadwallader, HR Manager for Medical Staffing.

1. Recommendations to the GMC on Fitness to Practice

At 31 March 2019 CWP had 105 doctors for whom Dr Alam is the RO:
82 consultants, 16 SAS doctors and 7 doctors on temporary /short term contracts or with a prescribed connection with this designated body. This excludes Doctors in Training from Health Education England and GPs doing sessions in CWP where the bulk of their work is within primary care.

The Appraisal Team have developed and distributed a Revalidation Checklist to be completed by all doctors in the trust, to support planning around revalidation, allow early identification of any gaps and measures to address these. Documents will be uploaded to appraisal portfolios annually.
Evidence to support recommendations is reviewed at quarterly Responsible Officer Assurance Group (ROAG) meetings.

22 recommendations to revalidate were made to the GMC between 1/4/2018 and 31/3/2019. All recommendations were completed on time.

2. Appraisal

a. Activity levels of appraisal

Setting a timely appraisal is the responsibility of the individual doctor, supported by early allocation of the appraiser by the Medical Staffing Officer. Ensuring the outputs are completed and signed off within 28 days of the meeting is the joint responsibility of the doctor and appraiser. The appraisal team monitor the process and issue prompts along the way.

In 2018-19 104 doctors were appraised and the outputs (the appraisal summary, PDP and appraiser assurances) signed off.

8 doctors had a delayed, incomplete or missed appraisal approved by the RO. The majority of these were due to long term sick, maternity leave and service pressures.

One doctor had an unapproved, incomplete or missed appraisal. This doctor completed his appraisal on the 29th March but was unable to submit the outputs within the required timeframe. The appraisal has now been completed.

The criteria for the categorisation of appraisal was very slightly amended for 2018-2019 by NHS England. Category 1B has been removed and all are now classified as 1A. The comparison below now includes all 1A/1B as one figure:

1.4.17 - 31.3.18 criteria	**2015-16**	**2016-17**	**2017-18**	**2018-19**
Category 1A - Appraisal meeting took place in the 3 months preceding the agreed appraisal due date, the outputs of appraisal have been agreed and signed-off by the appraiser and the doctor within 28 days of the appraisal meeting, and the entire process occurred between 1 April and 31 March.	33	75	57	92
Category 1B - The appraisal meeting took place between 1 April and 31 March, the outputs were agreed & signed-off by the appraiser and the doctor, but one or more of the following apply: - the appraisal did not take place in the window of three months preceding the appraisal due date; - the outputs of appraisal have been agreed and signed-off by the appraiser and the doctor between 1 April and 28 April of the following appraisal year; - the outputs of appraisal have been agreed and signed-off by the appraiser and the doctor more than 28 days after the appraisal meeting. However, in the judgement of the responsible officer the appraisal was satisfactorily completed.	40	26	46	N/A
Category 2 - the appraisal has not been completed as a 1a) or 1B) but the responsible officer has given approval to the postponement or cancellation of the appraisal.	10	6	4	12
Category 3 - the appraisal has not been completed according to the parameters above and the responsible officer has not given approval to the postponement or cancellation of the appraisal.	0	0	1	1

There has been an increase in the number of Category 2 appraisals. We believe this is due to a number of factors, including long term sickness and maternity leave. Another factor has been the impact of medical workforce pressures on the time available for appraisal preparation, with some doctors taking on extra duties over the appraisal year. At the Appraisal Leads Network discussion has focused on the importance of meaningful conversations and quality outputs being preferable to rushed meetings and poor documentation, and this is what we have prioritised. We will continue to monitor the appraisal process to ensure that the vast majority of appraisals fall into Category 1A in the coming year.

Our experience from previous years, supported by data, continues to identify a very small number of practitioners who appear to struggle with the organisational tasks associated with appraisal. We have developed checklists to simplify and clarify the evidence required within portfolios. In addition to providing training for new appraisers, and those new to the trust appraisal process, we have also provided "refresher" training for doctors who we identify may benefit from this. Where required, Clinical Directors work with the Appraisal team and Director of Medical Workforce to provide proactive support to clinicians they line manage.

b. Appraisers

Two medical appraiser training sessions took place during the appraisal year. We now have 30 appraisers, allowing us to share the number of appraisals more evenly. Appraisers should see 4-5 doctors a year and each appraisal takes approximately 5 hours in total (pre-reading the supporting evidence, the appraisal meeting itself and the documentation of outputs.)

The Medical Appraiser Peer Group is led by the Director of Medical Workforce and the minutes feed into the People and Organisational Development Sub-Committee. Appraisers are required to attend an update session at least once a year. The purpose of the group is to provide peer support to appraisers, share good practice, discuss any issues and concerns and provide updates and feedback from the NHS England North West appraiser network events. In recognition of the time demands on all doctors, during the past appraisal year we offered an increased number of update sessions, based in different localities across the trust. Feedback following this indicates that appraisers appreciate having more choice regarding potential dates, but are happy for the sessions to be held centrally.

c. Quality Assurance of Appraisal

Assurance around the quality of information gathered for appraisal:

The appraisal team continue to source and upload governance information to doctors' electronic portfolios. We are aware this is an extra burden on the departments who provide it and are grateful for their on-going support.

We continue to review the information required for appraisal, consistent with national guidance, particularly the Pearson Review (2017) which recommended medical appraisal should be a process which is supportive, adds value and is not overly burdensome for doctors.

At the medical appraisal training sessions we have continued to stress the benefits and satisfaction a well-planned appraisal can bring. A skilful, enquiring appraiser is essential, as is the doctor's provision of thoughtful reflections on his/her performance, challenges and aspirations.

Random review of portfolios is carried out prior to some appraisal meetings.

Assurances around the quality of the appraisal discussion and the appraisal summary:

This year we will pilot a new process to allow benchmarking of information contained within appraisal summaries, using the NHSE Quality Assurance (QA) tool. Approximately 30 percent of appraisal outputs will be chosen for a detailed review each year, by a panel comprising of a number of appraisers, the Director of Medical Workforce (DoMW) and HR Manager for Medical Staffing. All appraisers will receive written feedback from the DoMW highlighting the key themes, their attendance at the appraiser peer group meetings and feedback from the doctors they have met with. 30% of appraisers will also receive tailored feedback. This will be a rolling process, which will allow all appraisers to receive tailored feedback over a 3 year cycle.

The importance of appraisers mentioning "revalidation-readiness" in appraisal outputs, including any gaps and plans to address these, has been discussed at the Medical Appraiser Peer Group.

Audit of timelines of process of appraisal – maintained by the Appraisal Team.

An increasing number of doctors are seeing the advantage of meeting with a colleague outside of their own psychiatry specialty. (Doctors cannot have more than 3 consecutive appraisals with one appraiser.) This brings a completely different perspective to the appraisal discussion and mostly it has been welcomed, after some initial hesitancy.

Acknowledgement of work outside of CWP is also more consistently discussed. The need for appraisal to reflect the whole scope of practice has been highlighted during training and Appraiser Peer Group meetings, with an emphasis on the provision of evidence to support these activities.

d. New developments during 2018-19

1. This year we have introduced some new processes to benchmark and provide assurance regarding appraisal outputs and revalidation recommendations. Evidence to support revalidation recommendations is now discussed on a quarterly basis at Responsible Officer Assurance (ROAG) meetings, attended by the RO, DoMW and Medical Staffing/Appraisal Manager.
2. Evidence provided through appraisal summaries is now reviewed by a Quality Assurance (QA) panel process. The first panel met during May 2019. The panel reviewed a selection of appraisal summaries, using the NHSE QA structure as a guide, to provide individual feedback and highlight any key themes. Over a 3 year cycle it is expected that all appraisers will receive personalised feedback.
3. The appraisal team has also met with a peer network of Trusts in the region to benchmark and shape appraisal processes. As part of this work we have agreed a future plan for peer review audits. It's anticipated that CWP will join a peer review during 2020 with a partner organisation. Feedback and learning will be shared across the group to shape the development of appraisal and revalidation processes.
4. The Medical Appraisal Policy has been reviewed with increased emphasis on the importance of early identification of difficulties in providing sufficient data and the postponement of face to face meetings to allow this to be addressed. This has been explored with appraisers through the Medical Appraisers group.

e. Completion of 2018-19 action plan

Recommendation	Action	Responsibility	Timeframe	Outcome
Establish a QA panel to benchmark and quality assure appraisal output	Panel to meet annually to mark appraisal outputs	DoMW MARM	May/June 2019	Initial panel took place in May 2019.

	from a selection of appraisers against QA tool & feedback to them.			
Implementation of Responsible Officer Action Group (ROAG) to consider the appraisal outputs over the previous 5 years for doctors due a revalidation recommendation in the forthcoming year.	Set up system to record and highlight data over 5 year period Set up meetings of RO, DoMW & MARM in time to examine evidence and make recommendations to GMC	MARM MARM	January 2019	Quarterly meeting dates arranged. Key themes/issues from meetings identified.
Increased collaboration with neighbouring trusts to share best practice with periodic audits. MC, MCT & NWB	Liaison with other trusts & consideration of all audit recommendations for implementation in CWP	DoMW, MARM	March 2019	Sharing of best practice, adaptation of processes, calibration.

f. Medical recruitment

Recruiting Consultants continues to be difficult and at the time of reporting, psychiatry of old age is a particularly challenging area. CWP continues to link in with Resourcing and other Trusts in the North West to think about what, if any, additional strategies could be put in place to attract doctors. Where possible, medical cover has been reconfigured and funding used differently to try fill existing medical vacancies eg consultant funding used to support and develop SAS doctors in locum consultant posts; part time consultant funding used to create full time staff grade cover where there was known interest. Options to manage medical workforce pressures are reviewed on a monthly basis by the Medical Staffing Group and new IT processes are being developed to map the workforce and assist planning.

g. Appraisal action plan for 2019-20

Recommendation	Action	Responsibility	Timeframe	Outcome
Effective use of IT to map medical workforce	Establish a live database to allow workforce information to be updated and used to plan ahead	MST	May/June 2019	Awaiting information to be put on Sharepoint and system to go 'live'
Documentation to support appraisal discussions with doctors who complete a low volume of NHS clinical work.	Adapt a reflective template to be used at appraisal with a focus on maintaining skills to continue to practise safely e.g through CPD/ benchmarking and links with peers,	DoMW	During 2019/2020	Review template with appraisers and pilot use.

	identification of any gaps/areas of concern and plans to address these.			
DoMW and CD annual meetings to review progress/highlight any medical workforce issues	To provide more pro-active support to CDs in their medical management role.	DoMW	During 2019/2020	Support around job planning, early identification and support regarding difficulties.
Implement electronic leave process for medical workforce	To ensure all annual leave requests are made electronically	MST	During 2019	Clarity regarding "on the ground" workforce numbers and more effective leave planning.

3. Concerns Involving Doctors

There has been one formal investigation undertaken within CWP during the last year. This investigation was in conjunction with the Lead Employer of junior doctors.

During the year, CWP have remained committed to ensuring Clinical Directors deal more appropriately with local concerns about a doctor's practice at the earliest possible opportunity, implementing an action plan if appropriate and confirming discussions and agreements in writing to the doctor. This is intended to prevent minor concerns escalating and will also ensure the supporting evidence is there if more formal action needs to be taken in future.

Quarterly meetings with the GMC Employer Liaison Service have continued. They allow helpful, informal discussions with a GMC colleague and the sharing of information in both directions.

3 CWP Consultant received external training in MHPS (Maintaining High Professional Standards) and are now trained investigators.

DR FAOUZI ALAM
Responsible Officer
2nd July 2019

NHS
Cheshire and Wirral Partnership
NHS Foundation Trust

STANDARDISED SBAR COMMUNICATION

REPORT DETAILS	
Report subject:	Infection Prevention and Control Annual Report
Agenda ref. number:	19.20.52
Report to (meeting):	Board of Directors
Action required:	Discussion and Approval
Date of meeting:	31/07/2019
Presented by:	Vic Peach, Director of Infection, Prevention and Control

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

Which 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 purpose and content of this annual report is to provide an overview of the Infection Prevention and Control (IPC) activities from April 2018 to 31st March 2019. The report will highlight service achievements, compliance and progress made against the priorities outlined in the Infection Prevention and Control Sub Committee (IPCSC) work programme.

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

High standards of infection prevention and control are crucial to reduce and help prevent infection and infection risks, in all health care facilities across Cheshire and Wirral Partnership NHS Foundation Trust (CWP). To support this, the IPC Integrated Service, which consists of the CWP Infection Prevention and Control Team (IPCT) and Cheshire West and Chester (CWaC) IPCT colleagues, continues to work hard to prevent all avoidable infections and reduce the risk of resistant organisms across our Health & Social Care footprint.

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

Infection prevention and control remains a priority for CWP. The IPCSC and IPCT continue to maintain and improve on the application, conservation and development of IPC standards. The Trust is committed to working towards excellence in IPC practice to help prevent avoidable infections in our patients including wound and urinary tract infections. When infection does occur, this is recognised early and treated appropriately in line with local antimicrobial guidance. AMR remains a high priority within the Trust and antimicrobial stewardship represents an organisational and system-wide approach to promoting and monitoring the prudent use of antimicrobials.

This report highlights the partnership working and continuous improvements within IPC during 2018/19 and the key priorities for 2019/20.

Work Priorities for 2019/20

- Maintain compliance and assurances with the Health and Social care Act (2015)
- Promote hand hygiene week in May 2019
- Deliver a quality IPC Education event to CWP staff in November 2019
- Actively support the staff influenza campaign to achieve 80% uptake in face to face staff
- Undertake a Trustwide mattress audit
- Improve compliance to anti-microbial prescribing using Quality Improvement Methodology
- Develop health economy wide infection prevention and control group across West Cheshire and align IPC with the 10 year NHS Plan.

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

The Board is asked to approve the Infection Prevention and Control Annual Report for 2018/19 and the work priorities for 2019/20.

Who has approved this report for receipt at the above meeting?	Infection Prevention and Control Sub Committtee
Contributing authors:	Julie Spendlove; Helen Davies; Jen Adams: Lesley Irwin; Dan Allmark; David Pearson

Distribution to other people/ groups/ meetings:

Version	Name/ group/ meeting	Date issued
Final	Infection prevention and Control Sub Committee	April 2019

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

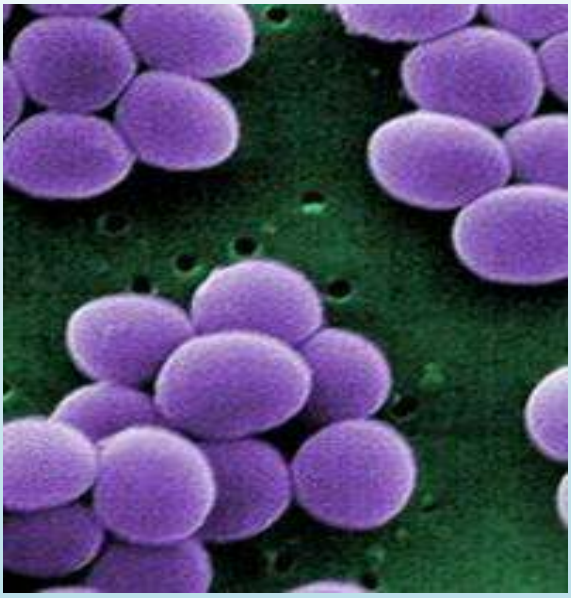
Appendix No.	Appendix title

Cheshire and Wirral Partnership
NHS Foundation Trust

Infection Prevention and Control

ANNUAL REPORT

2018 - 2019



CONTENTS

1. Introduction

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High standards of infection prevention and control are crucial to reduce and help prevent infection and infection risks, in all health care facilities across Cheshire and Wirral Partnership NHS Foundation Trust (CWP). To support this, the IPC Integrated Service, which consists of the CWP Infection Prevention and Control Team (IPCT) and Cheshire West and Chester (CWaC) IPCT colleagues, continues to work hard to prevent all avoidable infections and reduce the risk of resistant organisms across our Health & Social Care footprint.

The team use the CWP values in all areas of their work on a daily basis.

We encourage communication with our staff by being visible in the localities, having link practitioners, providing newsletters and attending key meetings.

We provide person – centred care.

We have the courage to challenge ANY behaviour that puts our services user, carers, visitors or staff at risk.

We are dedicated to maintaining competences required in relation to preventative IPC practice.

We are compassionate in all our contact with patients, carers and colleagues.

We are committed to preventing ANY avoidable infection.

Below is a brief summary of the IPCT highlights and achievements, and how we continue to raise the profile of both CWP and the IPC Integrated Service.

- **No** preventable Methicillin Resistant Staphylococcus Aureus (MRSA) bacteraemia infections within our provider services
- **No** preventable Clostridium Difficile Toxin (CDT) infections within our services
- **Successful** roll out and implementation of safety devices across the whole Trust. CWP is now fully compliant with Health and Safety (Sharps Instruments in Healthcare) Regulations 2013.
- **Collaborative** working with Public Health England (PHE) on local Public Health issues and antimicrobial stewardship.
- **Achieving** a zero number of identified cross infection cases in service users or staff (excluding small round structured virus outbreaks or influenza)
- **National** conference speakers and poster presentations for SEVENTH consecutive year
- **National** Education Professional and Development Committee secretary role for the Infection Prevention Society (IPS)
- **Active** members of national Mental Health IPS Special Interest Group

- **North West** IPS Deputy Communications Officer role
- **Regional** conference speakers at regional conferences,
- **North** West IPS and PHE meetings hosted at CWP, raising our profile for IPC
- **Ongoing** succession planning and developmental opportunities within the team including tissue viability, sepsis awareness, tuberculosis.
- **Innovative** role out of sepsis awareness across the Trust completed
- **Successful** IPC study days both internal in November 2018 (CWP) and external in March 2018 (CWAC).

2. Summary of Director of Infection Prevention and Control (DIPC) reports to the Board of Directors (BoD)

In addition to the annual report the DIPC delivers two half yearly reports produced by the Nurse Consultant and Lead Nurse. During 2018/19, the Board of Directors received concise reports in accordance with the business cycle, which also highlighted areas of good practice and areas requiring development. The approval and any recommendations from the Board are communicated directly to the DIPC.

3. Care Quality Commission (CQC)

The CQC assess IPC standards against the Health and Social Care Act 2008: Code of Practice for health and adult social care on the prevention and control of infections and related guidance (Department of Health, 2015). During the CQC visit to the Trust in 2018 there were no major concerns identified within IPC. The IPC assurance framework for 2018/19 demonstrates full compliance with the Code of Practice standards and this includes Water Safety and Antimicrobial Stewardship.

4. Infection Prevention and Control (IPC) governance

The IPCT continues to have a high profile within Clinical Services and Support Services across the CWP footprint.

4.1 Infection Prevention and Control subcommittee (IPCSC)

The IPCSC reports directly to the Quality Committee (QC), and is chaired by the DIPC or Nurse Consultant. Meetings take place four times per year, the meetings are well attended and all CWP services and care groups are represented. Assurance reports are provided bi-annually inclusive of this annual report.

4.2 The IPC Integrated Service

The structure of the IPC team enables an efficient service and response across the care groups and all CWP teams within mental health, learning disabilities and harm reduction services. The DIPC has overall accountability for the IPCT, which is led by the Nurse Consultant and supported by a lead nurse, a specialist nurse and two IPC nurses. The team no longer provide a tissue viability service. In line with the Five Year Forward View, the team is working alongside the newly formed Care Groups. This will continue to evolve and include the Integrated Care Partnership during 2019-20.

5. CWP's commitment to IPC 2016 -2020

This document is a working strategy until 2020. The commitment supports the person centred framework and the on-going IPC achievements to reduce and prevent avoidable healthcare-associated infections. The Board of Directors receives regular progress reports on the initiatives that are in place. The key objectives and plans for monitoring improvement are highlighted within the commitment and this is supported by the IPCSC work programme and assurance framework.

This commitment supports effective and meaningful infection prevention and control practice of all employees within CWP. It also ensures that effective measures for prevention and control of infection are integrated into the trust core business, planning and delivery.

5.1 IPC Link Groups

Modern Matrons and IPC link practitioners throughout CWP are supported by the IPCT to deliver the IPC agenda locally. IPC link practitioner groups are well established in each locality. These groups meet on a quarterly basis and provide an excellent opportunity to cascade and disseminate key IPC guidance and updates to operational staff. An education element is also incorporated to promote continuing professional development (CPD). Updates, in between the quarterly meetings, are provided via monthly newsletters and newsfeeds.

The IPCT held their 15th annual IPC study day in November 2018 with in excess of 40 members of staff, including link practitioners, attending from a wide variety of CWP services. As in previous years this event provided an excellent stage for learning and networking with colleagues. The IPCT were able to secure the support of several speakers to provide an engaging and thought-provoking event, and look forward to facilitating this event again in November 2019. The topics presented provided a wide a varied overview of topics relevant to the current IPC agenda.

5.2 Refurbishments and New Builds

The IPCT provide advice and support during refurbishments and new builds across the trust, including advice for primary care premises to ensure compliance with national guidance and the audit programme. The IPCT continue to work in collaboration and partnership with CWP Estates in relation to any plans and works carried out within CWP, ensuring compliance with Hospital Building Note 00-09.

5.3 Safe systems to prevent needle stick and exposure incidents

The team review all incidents to reduce risk and promote good practice in relation to needle stick injuries (NSI) and have provided training and posters to all staff to support safer processes. Exposure incidents are potentially high risk, and preventative training and resources are ongoing.

5.4 Inoculation Incidents – including Needlestick injuries, bites and scratches 2017-2018

	East	PH West	West	Wirral	Total
2018 / 19	5	5	7	2	19
2017 / 18	9	14	10	5	38
2016 / 17	9	12	8	1	30
2015 / 16	4	5	16	7	32

These figures are represented below per care group.

Central & East Clinical Services	**5**
Specialist MH - Bed Based - Central & East	2
Specialist MH - Place Based - Central & East	3
West Clinical Services	**12**
Adult Mental Health Services West	1
Children, Young People & Families - West CAMHS	2
Neighbourhood - Integrated teams - West	3
Neighbourhood Based Services - West	1
Physical Health Services West	1
Specialist MH - Bed Based - West	2
Specialist MH - Place Based - West	2
Wirral Clinical Services	**2**

Specialist MH - Bed Based - Wirral	1
Specialist MH - Place Based - Wirral	1
Grand Total	**19**

There has been a significant decrease (50%) in the number of inoculation incidents across the Trust since the implementation of safety devices during 2018/2019.

The joint programme involving IPCT, Health and Safety and Procurement, has achieved full compliance to the use of safety devices where applicable and all non-safety devices have now been removed from clinical areas. This has excluded podiatry as the current safety devices sharps available are not practicable. A rolling programme to review suitable safety products as they come to market will be in place for podiatry. The Infection Prevention and Control Sub – Committee will receive quarterly progress reports.

5.5 Outbreaks

All IPC incidents and outbreaks are routinely reported to the IPCSC and QC, ensuring relevant information and good practice is shared and action plans developed where required. A focus of the IPCT is to prevent outbreaks and if they do occur, to reduce the impact of the outbreak on service users and staff. This is achieved by monitoring environmental cleaning standards, hand hygiene and by ensuring staff can identify a potential outbreak which is addressed during Essential Learning.

	East	West	Wirral
Number of outbreaks	1	2	0
Outbreak cause	Diarrhoea	Confirmed Influenza A and Confirmed Norovirus	NA
Average number of patients affected per ward	3	6	NA
Average number of staff affected per ward	0	1	NA
Average number of days ward closed	3	9	NA

In order to learn from experience, post-outbreak meetings are held for CWP inpatient areas within 5 working days of the end of an outbreak. These meetings include IPC Nurse, ward manager, modern matron, clinical lead and facilities manager where appropriate. Learning from these outbreaks is given as feedback to the teams and used with in future training.

5.6. Hand Decontamination

IPCT continues to actively promote hand hygiene, via observational activities in the workplace, trust induction, Essential 1 Learning and at all other events and opportunities.

The IPCT continue to work closely with colleagues from the Facilities Department and the main Trust supplier for hand hygiene products to ensure cost effective and appropriate hand hygiene facilities are accessible to all CWP staff, patients and visitors.

6. Education

6.1 Induction and Essential Learning (EE1)

The IPC team have facilitated 12 Induction sessions during 2018-2019 and 74 EE1 sessions (Essential Education). This has resulted in 2681 staff (clinical and non-clinical) having received IPC and hand decontamination training. Overall 81% of clinical staff (including domestic staff) received IPC training in year and 85% of non-clinical staff received training giving a CWP compliance rate of 80%. This remains slightly below the expected compliance rate for mandatory training but is an improvement of 2% on last years figures; care groups and services will be providing assurance to future Infection Prevention and Control sub-committee regarding local strategies for improvement.

The team strive to improve compliance by providing extra sessions, targeting low compliance areas and attending key clinical meetings. Throughout the period of this report, the IPC sessions consistently scores “good” or “excellent” in feedback from participants.

During 2018-19 the IPC team have been working closely with CWP Education to ensure we are offering the right training to the right staff to improve overall compliance. As a result, from April 2019, non-clinical staff now complete e-learning triennially; patient facing clinical staff will undertake annual face to face training in IPC and patient facing staff who do not undertake personal care or invasive procedures with a patient can complete their annual IPC mandatory training via e-learning.

6.2 Continuing Professional Development of the IPC team during 2018 - 2018

In addition to the completion of organisational training requirements, the IPC team attends relevant local, national workshops and conferences, including national and regional Infection Prevention Society (IPS) conferences.

All IPCT members hold recognised infection prevention and control qualifications at BSc level and the lead and specialist nurses are all in the process of completing their MSc programmes.

One member of the team has successfully completed the non-medical prescribing course which will support his role as TB nurse.

Two staff have undertaken the Succeed course in-house – one has completed and the other is in progress.

Several members of the team have a keen interest in Quality Improvement and a member of the team has recently completed the in-house Quality Improvement Course and will be applying quality improvement methodology into a project around anti-microbial stewardship

A further member of the team has completed a university module in Tissue Viability.

One of the IPCT secretaries is nearing the completion of a NVQ in Business and Admin Management.

7. IPC Audits

During the period this report covers, the team carried out audits on all inpatient clinical areas, community based clinics across all localities, health centres, and two GP practices**.** All inpatient areas have achieved above the compliance score of 93% during 2018/19.

Support visits were made to all Children Centres including both hub and link sites, in preparation for them to be added to the audit programme in 2019/20.

In Central and East 14 out of 16 areas inpatient and community audited scored between 93 – 100%, which is a pass. Of those areas that did not pass there were some environmental concerns that are being addressed with facilities and the team are working with the services around access to spillage kits and appropriate use of sharps bins.

On the Wirral, 10 out of 11 areas passed with scores between 93-100% and one clinic area failed with a score of 92% due to there being no hand hygiene facilities at the entrance to the building, IPC are currently liaising with Estates and Facilities to have a hand sanitiser dispenser installed.

West Mental Health and Learning Disability services, 14 areas were audited and 14 passed with scores between 93-100%. This is a significant improvement from last years report.

Within the Physical Health West, 13 clinical areas were audited including 2 GP practices. 8 passed with scores between 94 – 98%. The majority of IPC concerns in those that did not pass are environmental and concerns raised are being addressed with service leads. One clinic, Lache has since undergone a refurbishment so compliance is expected to have improved at next audit.

Results and action schedules are reported back to the ward manager, modern matron, service leads, estates and facilities managers. Where areas of good practice are noted and appropriate actions regarding areas of concern are highlighted, an update of feedback regarding progress of the actions is requested within one calendar month. Audit scores are reviewed and discussed at IPCSC and documented on the risk register if necessary. Improvement requirements will be reviewed within three months of the audit by the IPCT.

8. Service User Involvement

IPC nurses are involved In the Recovery Colleges by presenting sessions that aim to show how the principles of IPC can be used to maintain aspects of personal health.

9. Health Care Associated Infection (HCAI)

During 2018 – 2019 there were no cases of Clostridium Difficile Infection or MRSA Blood Stream Infections within CWP.

9.1 Quality Premium - Gram Negative Blood Stream Infections (GNBSI)

There is a national ambition to reduce healthcare associated gram-negative blood stream infections by 50% by March 2021. This is supported by the Quality Premium for Clinical Commissioning Groups (CCG), which has also set a reduction ambition of 10% in all E. Coli blood stream infections reported at CCG level, by 2019/20.

Following the development of an improvement plan, work has developed across key areas that could result in this type of infection, including; catheter care, appropriate management and treatment of patients presenting with a urinary tract infection; appropriate antimicrobial prescribing; PICC line management and chronic wound care management. Implementation of this action plan has resulted in a full review and update of a Catheter Care Pathway in the community. This piece of work has now concluded.

Nationally, the ambition is proving difficult to achieve and the focus appears to be moving towards public health interventions including lifestyle and wellbeing, to help prevent infections occurring. A Health Economy Infection Prevention and Control group has been set up and meets for the first time at the end of April 2019. This will bring together practitioners from across the health economy including CWP, Primary Care, Health and Social care and Public Health. The purpose of this group will be to work together to improve communication between different healthcare groups in order to improve patient outcomes relating to avoidable infections.

10. Surveillance and Zero harm

The key items for community services are the surveillance and identified risks associated with Pressure Ulcers, Wounds, Urinary Catheters, PICC and Hickman lines.

The Care Community Teams hold their own database of patients with Urinary and Suprapubic Catheters in the community, where patients are under the care of the Care Community Teams. The IPCT offers advice and guidance where appropriate and supports the teams to consider the suitability of the catheterisation and to consider a trial without catheter. The nursing teams are advised to use the 10 week catheter pathway, which has recently been updated in line with national guidance and support from the Community Continence & Urology Service.

Aseptic Technique training is provided via an e-learning package and the policy has recently been updated.

The IPC nurses continue to be visible across the Trust and are becoming accustomed to working within the Care Groups to provide information, advice and guidance as and when required. They have had numerous face to face interactions with staff and service users throughout the year and approximately 250 telephone contacts across the Trust.

For inpatient settings the IPCT continue to monitor MRSA screening of service users admitted to a mental health unit from another healthcare provider and service users with an invasive device e.g. catheter or wound/breaks in the skin as well as offering IPC advice and support to staff looking after patients with invasive devices and wounds as part of ongoing surveillance.

10.1 Catheter Associated Urinary Tract Infection (CAUTI)

The IPCT continue to support the Trust response to the implementation of NICE guidance EPIC 3 (2014) and CQC requirements with regards to Catheter Associated Urinary Tract Infections. This has included the continuing monitoring of all catheterised patients in the community setting with CWP input, on average 250 patients, and offering support through, training, zero harm meetings, link meetings, study days, communications (newsfeeds/newsletters), and updating the 10 week catheter pathway in line with new/updated guidance.

10.2 Skin-Tunnelled Central Catheter (Hickman) and Peripherally Inserted Central Line (PICCs)

The IPC service have worked collaboratively with other healthcare providers across the Western Cheshire footprint on the development of guidance and competencies to support these devices, based on national guidance including NICE and EPIC 3. Patient information leaflets are available and in use, providing support and advice to both patients and carers. The IPCT continue to ensure best practice is in place in relation to these devices and the prevention of infection.

11. Sepsis

In the United Kingdom, there are more than 250,000 episodes of sepsis annually. Updated figures suggest that of these there are at least 52,000 deaths as a result. Sepsis costs the NHS between £1.25 and £2 billion annually. Urgent basic care can make a real difference between survival and death. Evidence shows that early intervention saves lives and can also reduce the length of hospital stay for patients.
There has been a roll out of a Sepsis Care Improvement Programme Trust wide, that was initiated 2 years ago and implemented using Quality Improvement Methodology.

The key aims for the Sepsis Care Improvement Programme (SCIP) included:

- Minimising delay for CWP patients with signs of sepsis in accessing acute care, by having a high level of awareness and a simple but effective process that enables the recognition of the early signs of sepsis.
- Improved awareness of sepsis across all of our services through a programme of education for all patient facing staff.

Following completion of the Pilot Programme in January 2018, there has now been a successful roll out across inpatient services and GP out of Hours services. The pilot programme ran for three months,

concluding on 8th January 2018. A period of evaluation was completed and final changes were made to the pathways and education package based on feedback.

Work has been completed with our community based colleagues with the launch of 'Sepsis in the Community' which was launched in February 2018. Community staff are invited to access the e-learning package and have also commenced use of a Community Sepsis Screening & Action Tool to assist in their decision making processes.

Sepsis information continues to be included in mandatory EE1 IPC Training and during Trust Induction. Additional Sepsis resources have been purchased, and some resources are made available at training events facilitated and/or supported by the IPC Team.

Initial meetings held with both the 0-19 Starting Well Service and the Health Facilitators, in order to look at the requirements of these services, as the tools and pathways will differ from what is required by the services already involved in the roll out. The tools and pathways are nearing completion, and there will be a further set of meetings to discuss and plan the roll out into the 0-19 Starting Well services and also the community mental health and learning disability services. There will be additions made to the existing e-learning programme based on these requirements, and staff from these teams/services will be encouraged to complete the training.

To maintain Sepsis as an important topic, staff receive relevant information via IPC Newsletters and the Newsfeed that is sent regularly to all IPC Link staff. There will be an IPC information board that will include Sepsis Awareness, in the market Place at Trust Induction from June 2019.

11.1 Sepsis Success Stories

Staff are encouraged to share their success stories where they have suspected sepsis and used the pathways and triage tools to support their decision making. This then allows for an acknowledgement process where the staff member meets with the lead co-ordinator for the sepsis awareness campaign to receive a Sepsis Trust pin badge and sepsis pen. Success stories and photographs are then shared via newsletters, newsfeeds and the IPC intranet page. Staff have, to date, suspected sepsis in both community and in-patient settings and initiated early and appropriate transfers to acute settings for ongoing, timely treatment for sepsis.

12. Influenza Immunisation Activity

Members of the IPCT completed training to support the annual staff influenza vaccination campaign during 2018/19. The team has worked in partnership with the Workforce Wellbeing team to deliver the vaccine across all localities**.** CWP reached a total of 60% of face to face staff vaccinated, which was unfortunately a decrease in 12% on the previous year.

End of Campaign Staff Uptake Position

Patient Facing	Vaccinated	Headcount	Staff Uptake Rate
Patient Facing	**1664**	**2773**	**60.01%**
All Doctors	93	125	74.40%
All Other Professionally Qualified Clinical Staff	396	614	64.50%
Qualified Nurses	673	1096	61.41%
Support to Clinical Staff - With Direct Patient Care	502	938	53.52%
Non-Patient Facing	**435**	**686**	**63.41%**
NHS Infrastructure Support	179	276	64.86%

Support to Clinical Staff - No Direct Patient Care	256	410	62.44%
Grand Total	**2099**	**3459**	**60.68%**

For 2019/20, the national CQUIN targets for Health & Wellbeing of Staff in the NHS continue and the flu immunisation target for all Trusts will be 80% of all face to face staff to be vaccinated for flu by the end of February 2020. Planning for the 2019/2020 campaign has begun and the IPCT will continue to support the Workforce Wellbeing team in their delivery and will also support with the immunisation update training.

13. Antimicrobial Resistance (AMR) Strategy and CWP work

AMR has risen over the last 40 years and the inappropriate use of antimicrobials is a key contributor. The consequences of AMR include increased treatment failure for common infections and decreased treatment options where antibiotics are vital. Antimicrobial stewardship is crucial in combating AMR and is an important element of newly published documents to include: The NHS Long Term Plan; Contained and controlled: The UK's 20 year vision for antimicrobial resistance; Tackling antimicrobial resistance 2019-2024:The UK's five-year national action plan all published in January 2019.

By 2040, the government's vision is of a world in which antimicrobial resistance is effectively contained, controlled and mitigated. There are approximately 700,000 deaths around the world each year as a result of antimicrobial resistance. At least 20% of all antibiotic prescriptions in primary care are inappropriate and if no action is taken there will be 10 million deaths by 2050.

The Five year national action plan focuses on 3 key areas:

- Reducing need for and unintentional exposure to antimicrobials
- Optimising use of antimicrobials
- Investing in innovation, supply and access to tackle AMR

AMR remains a high priority within the Trust and antimicrobial stewardship represents an organisational and system-wide approach to promoting and monitoring the prudent use of antimicrobials by ensuring:

- Good infection prevention and control measures
- Quick and appropriate diagnosis of infection
- Appropriate use of antimicrobials
- Optimising therapy for individual patients;
- Minimising the development of resistance at patient and community levels

The IPCT are working collaboratively with the Trusts Pharmacy Department to ensure the Trusts prescribers are aware of local antibiotic guidelines and formulary and that they adhere to that formulary unless it is clinically indicated otherwise. During the period of 2018/19 there have been some areas of non-compliance to formulary. The IPC and Pharmacy teams are developing an action plan using a Quality Improvement methodology to improve engagement with prescribers and increase compliance to antimicrobial prescribing during 2019/20.

Towards the end of 2018, the IPCT and pharmacy department worked closely to promote the European Antibiotic Awareness campaign across the organisation to all staff including prescribers, in the form of posters, leaflets, screensavers and stands in each of the inpatient areas. The campaign aim has been to motivate people to change their behaviour relating to the use of antibiotics, without deterring those who need antibiotics. The event was promoted on the Trust intranet, twitter and Facebook page, the IPC twitter account as well as in newsletters, newsfeeds and CWP essential.

Within CWP, we continue to raise awareness and knowledge amongst our staff through education and training, to help promote these key messages, both internally with their patients but also for themselves and their families. The IPCT work closely with the medicines management teams across the Trust in the monitoring of prescribing to improve compliance in line with the current antimicrobial formulary.

13.1 Inpatient Services antibiotic audit 2018/19

Antibiotic prescribing on the inpatient wards is audited and compliance to prescribing reported quarterly into the IPCSC and Medicines Management Group. The most common infections treated on the CWP inpatient wards are urinary tract infections, respiratory infections and skin infections. Prescribers should prescribe according to the West Cheshire CCG (WCCCG) Antimicrobial Prescribing Guidelines.

April 2018 - March 2019		Wirral	West	East	Total	% audit compliance
Total number of prescriptions issued		74	150	105	329	
Allergies documented on medication chart	Yes	74	149	102	325	99%
	No	0	1	3	4	
Indication of prescription Noted	Yes	63	128	85	276	84%
	No	11	22	20	53	
Follows antimicrobial formulary/micro advice	Formulary	42	90	71	203	62%
	Sensitivities	2	11	9	22	7%
	Microbiology Advice	2	3	1	6	2%
	Commenced by other provider	16	35	16	67	20%
	Not completed	3	2	1	6	2%
	Other	9	9	7	25	7%
Indication of stop date on medication chart	Yes	42	130	59	231	61%
	No	32	20	46	98	
Indication of length of course on medication chart	Yes	64	138	84	286	76%
	No	10	12	21	43	
Indication of long term prophylaxis on medication chart	Yes	2	5	8	15	6%
	No	66	134	90	290	
	Not completed	6	9	7	22	
Indication of stop date on care notes	Yes	17	59	18	94	28%
	No	55	91	84	230	
	Not completed	2	0	3	5	
Indication of length of course on care notes	Yes	42	92	50	184	49%
	No	31	58	55	144	
	Not completed	1	0	0	1	
Indication of long term prophylaxis on care notes	Yes	1	0	0	1	1%
	No	71	99	61	231	
	Not completed	2	14	3	19	
Not completed figures have not been included in the % as this data was only available for Q4						

329 antibiotic forms were collected during 2018/19. 262 prescriptions were written by CWP medical staff and 67 from other providers prior to admission.

203 of these prescriptions complied with the WCCCG guidelines; 22 were prescribed according to sensitivities following laboratory culture and 5 on the advice of a microbiologist. This demonstrates an actual compliance rate for CWP in-patient medical prescribers, prescribing correctly to guideline formulary, as 93%.

The indication fields should be completed on the prescription chart; the above data identifies areas for record keeping improvements as not all fields have been completed. This data is co-owned with the medicines management group who take action in relation to prescribing standards.

There has been a 2% improvement in prescribing to formulary since 2017/18; further collaborative work will continue and include the development of an action plan using a Quality Improvement methodology to improve engagement with prescribers and increase compliance to antimicrobial prescribing during 2019/20.

The focus for antimicrobial stewardship will be around the prevention of infection therefore reducing the need for antibiotics and also raising awareness and recognition of infection so antimicrobials are only prescribed when necessary.

13.2 West Physical Health antibiotic prescribing 2017/18

Antibiotic prescribing activity in CWP West Physical Health is primary care based and as such is a different healthcare setting to secondary care mental health. Prescribers follow current NHS West Cheshire CCG antibiotic guidelines. Prescribing is reviewed using online ePACT data from the NHS Business Services Authority (NHSBSA). The prescribers are:

- The Urgent Treatment Centre (UTC) (Out of Hours service) – A mix of medical (GP) and nurse independent non- medical prescribers (NMP)

- Community Matrons – independent non-medical prescribers (NMP) based in the community.

The UTC antibiotic benchmarking is currently measured against one local and two national measures:

- Local: compliance with NHS West Cheshire CCG antibiotic formulary

- National: compliance with recommendations to keep prescribing of Cephalosporins, Quinolones and Co-amoxiclav as low as possible to prevent development of C.difficile infection, and antibiotic resistance in line with national targets

- National: work on the Bloodstream Infections Quality Premium to reduce inappropriate antibiotic prescribing for urinary tract infections (UTIs) in primary care by achieving a 10% (or greater) reduction in the Trimethoprim : Nitrofurantoin prescribing ratio

CWP has maintained a 99% compliance with formulary.

Cephalosporin, Quinolone and Co-amoxiclav prescribing for UTC has achieved 9.1% (GPs have averaged 9.9%, while the NMPs averaged 3.35%). The quality premium is 10%.

The Trimethoprim: Nitrofurantoin ratio for UTC is 0.33 (GPs is 0.0.32 and 0.36 for the NMPs). This is well below the West Cheshire CCG baseline of 0.951, which in turn is well below national average.

This data is taken from NHSBSA epact data which measures volume of prescribing. Audits of prescribing of Cephalsporins, Quinolones and Co-amoxiclav, and Trimethoprim and Nitrofurantoin against individual patients' Adastra records have recently been undertaken. The results of these audits will be presented at the next IPCSC.

14. Estates Department Report

Estates department activity is essential in delivering the IPC agenda, and is delivered under the principles outlined in two main documents:

1. Health Building Note 00-09 and covers the importance of a clean, safe environment for all aspects of Healthcare.

2. The Department of Health (DH) Health Technical Memorandum (HTM) 04-01 (2016), Safe water in healthcare premises.

The Estates department manages Water Safety to HTM 04-01 with the implementation of a Water Safety Plan, Operations Manual, and a Water Safety Group.

For CWP this Water Safety Group is covered via our monthly Statutory Standards Departmental meetings where Legionella is discussed and reviewed and the quarterly Infection Prevention and Control Sub Committee meeting (IPCSC). Both meetings consist of a variety of personal with a range of competencies. We also engage with an independent Water Safety Authorising Engineer who gives expertise and guidance to our policies and procedures.

14.1 Legionella compliance with legislation

The control of legionella is covered by the legal requirements of the Health & Safety at Work Act 1974 concerning risks from exposure to legionella and guidance on compliance with the relevant parts of the Management of Health and Safety at Work Regulations 1999.

Legionella is managed and controlled by the estates department, which continues to employ the services of ZetaSafe Ltd, who provide professional monitoring software for statutory legionella temperature monitoring. The department also employs various contractors to undertake legionella risk assessments on Trust properties where required. There is a three monthly review of test results, control measures and procedures to ensure compliance with current legislation and these results are published at the Infection Prevention Control Sub Committee.

Estates Operational Service continually undertake statutory legionella temperature monitoring tests throughout the Trust estate, during April 18' – March 19' a total of 16,966 temperature tests were undertaken. The annual test result report records an overall compliance level of 94.04% which is above the department's target of 90%. Tests recorded not meeting the required standard was 5.96% and therefore automatically triggered remedial work to ensure compliance moving forward.

14.2 Capital programme Works

Whilst the capital programme only includes limited projects, specifically aimed at addressing IPC, all new build and major refurbishment projects are designed in full accordance with the latest Building Regulations, and British Standards together with the latest HTM guidance specifically in relation to Infection Prevention and Control and with consideration to the IPC audits.

All projects, both new builds and refurbishment, include advice from the IPC team which reflects the latest Health Building Note 00-09 (Department of Health, 2013) which states 'the infection prevention and control (IPC) team should be consulted throughout every stage of a capital project and their views taken into account.'

During the financial year 18/19 the following finances were invested in the built environment:

- Capital Programme 17/18 = £2.01m
- Environmental /IPC/ Place Work Plan – Funded from Revenue = £36k

Note: This is significantly lower than previous years due to in year cost pressure associated with the redevelopment of Coronation Road Workplace Hub.

The main IPC achievements in 2017/18 were:

- Environmental upgrade of Eastway

- Completion of 8 bed extension to Bowmere
- Commencement of environmental upgrade of Brooklands ward
- Commencement of refurbishment of Cherrybank
- Minor decoration and flooring works informed by IPC audits and environmental work plan.

Estates service have also agreed a recurring planned replacement programme for ward based washing machines, dryers , dishwashers and EBME equipment in order to enable finance to plan for this recurring expenditure and avoid periods of downtime when these facilities are unavailable to wards due to breakdown.

14.3 Physical Health West capital and operational revenue programme

In response to CWP IPC audits of Physical Health West properties, a further £50k was invested from the minor works budget to address specific action points.

15. Facilities Service and Waste Report

CWP operational cleaning services are led via the Estates & Facilities services structure and the Facilities management team are responsible for implementing the trusts cleaning strategy.

The Facilities Management (FM) function has teams in each locality that report through a structure of managers and supervisory staff members, who are responsible for the co-ordination of services and monitoring of standards in all trust areas in line with National Standards of Cleanliness (2007). NHS Improvement have advised that Cleaning standards are under review including changing the number of factors monitored and timescales this was due to be done by Q4 however a full report has not yet been released to trusts. Once the new standards are released CWP facilities management will review the cleaning and decontamination policy.

CWP Facilities services are predominantly provided in-house, this helps to ensure that services provided by the FM team are linked to the needs of Care Groups. There are a number of locations within CWP that are outsourced. This is only where operationally and commercially practical and there are robust monitoring systems in place to ensure the quality of service provided is the same as the in house team. Within 2019 there will be a full review of our outsourced services to ensure they meet the needs of the Care Groups and also ensure they are commercially viable given the changes to living wage.

15.1 Monitoring Arrangements for CWP in house cleaning service

Within 2018 – 2019 the EFM service had looked to improve the evidence based assurance on the standards of internal environment and cleanliness within CWP's inpatient areas and clinical areas - including community premises. We have found that there is gaps in the provision of monitoring that we provide mainly that it is just a snap shot in time and doesn't provide any real assurance of standards more reassurance, therefore we have instructed a full review with the change to meet the new cleaning standards and also ensure that real time monitoring is conducted by key staff members from both the IPC and Facilities service.

Current systems for ensuring that CWP's internal environments continue to meet the required standards are not fully fit for purpose; as a result the following actions/amendments are being implemented as a result of the review.

- CWP Facilities team are now accredited members of the British Institute of Cleaning science, we have adopted there full training package and are in the process of rolling out the Cleaning proficiency certificate for all Domestic staff members within CWP. This will improve the base

level of qualification for all staff and ensure a consistent approach to training and assessment of ability is done trust wide.

- CWP Facilities management have reviewed the cleaning monitoring software provided my Micad C4C and have found that it no longer meets the needs of the service, therefore within 2019 the FM team will be looking to change our Audit tool and align with IPC team better to ensure that real time monitoring and auditable response times are provided, linked to appropriate standards.

- Unfortunately the creation of Dashboard of compliance for cleaning standards has not been achieved within 2018, this was due to the notification of change from NHS improvement on the National cleaning standards and the internal review identifying the need to integrate both IPC audits and facilities audits to increase levels of assurance.

- We have completed a full review of Domestic job descriptions with the removal of the band 1 role from agenda for change to ensure that the Support team assistant – Domestic role meets the needs of the service.

To monitor compliance in relation to cleaning standards, CWP operate a monitoring system that covers all current factors (49) as set out in the National Standards of Cleanliness 2007 approved code of practice.

The overall targets and achievements for cleanliness for all CWP areas for period 2018 - 2019 are listed below (again based on NSC risk ratings):

RISK LEVEL	TARGET RESULT (as set out by National Patient safety agency)	CWP Result
High Risk	95%	97.9%
Significant Risk	85%	91.7%
Low Risk	75%	99.30%

This information is taken from an average of all paper audits completed within 2018-2019

The Facilities management team cleanliness monitoring is supported by monthly Modern Matron walk-rounds that are attended by a senior member of the FM team to undertake a joined up approach with clinical services and address any issues patients or clinicians have with the Facilities services including the environment, this is then actioned by the relevant departments. We have amended these to include IPC nurses to every other visit to increase the support available ensuring the multi-disciplinary team are linking with key individuals within care group operational nursing teams.

CWP FM attends all inpatient IPC audits. Areas for action are addressed mostly at the time of audit all other actions are done immediately following the inspection. The facilities team continue to have a good working relationship with all members of the IPC team, taking collaborative approach to ensuring CWP's environments meet all required standards.

It is recognised that CWP have maintained assurance on cleaning standards using the current system however can be further improvement with the introduction of technology and continued integration with the IPC audit findings will ensure actual assurance that standards are being achieved to the required levels.

Important Note:

As stated in previous annual report CWP FM recognised the need for a Deep clean team however this needed to be found from within the existing structure, we have managed as part of the east re-design to fund a 20 hour dedicated resource for east on deep cleaning and to support the cleaning schedule appropriately. We are still working to restructure our cleaning teams within the Wirral and West areas to provide the same level of service. This will be an ongoing action for facilities to provide.

The investments made within improved cleaning equipment using the latest cleaning equipment has been valuable in ensuring an improved standard as can be seen from our PLACE results. Further investment is required on cleaning equipment and technology to ensure that CWP premises are at the required standard, we will be working with our finance colleagues to produce a formal investment plan in cleaning equipment for each ward to maintain and ultimately improve standards

15.2 Waste Management

CWP facilities team are currently undertaking a full review of all waste management services to ensure that they are fully compliant with all appropriate legislation; this will be done in conjunction with our in house IPC team.

The continued programme of central recycling points are situated in high concentration staff areas across CWP continues to be successful, working with CWP Estates project teams to ensure that these strategies are factored as part of redesign of buildings is helpful and ensures there success this has been evident within 2018 – 2019 at Coronation road site.

The WARPIT reuse portal project for surplus assets has had another successful year with over 600 staff members claiming items for their teams and services. The review being conducted by Facilities will ensure to include WARPIT to ensure that all opportunities to support reuse of equipment and assets of the organisation is done where appropriate to support the trusts sustainable development management plan.

15.3 Waste auditing

The CWP Waste audit system is designed to assess compliance with the requirements of Department of Health guidance document Safe Management of Healthcare Waste and to also ensure that waste segregation standards meet the requirements for waste handling and storage.

The home patient referral guidance on Community Clinical waste that was instigated within 2017 to improve the process for district nursing teams referring patents for home collections has been a success and will continue to be monitored to ensure it is fit for purpose and ensuring prompt action for patients requiring this service.

A programme of 6 monthly waste audits is undertaken twice yearly by Domestic community supervisors. The Waste audits submitted by Facilities domestic supervisors are underpinned by a Waste Audit Schedule maintained by the Waste Manager which also notes any issues or incidents and solutions or outcomes. The waste audit tool covers; Waste provision overview; Segregation procedure; Types of waste produced; Personal protective equipment; Bin sizes and condition; Storage.

Waste audits form part of the planned programme of waste management and any issues or outstanding actions is followed up by the Waste Manager or members of Trust Facilities team. The Infection prevention and Control Team are included in any communications and any issues raised we work together to ensure that these are resolved as quickly as possible minimising any disruption to clinical service.

Where appropriate a full pre- acceptance waste audit is carried out by the Waste Manager to assess all types of waste and disposal methods. Thereafter audits are completed as part of the cleanliness monitoring by domestic supervisors at all sites.

- Summary of issues identified on waste audits 2018
- Inappropriate waste disposal – including following up of DATIX reports for disposal of sharps
- Sharps bins temporary aperture closure not in use leaving bin open, this is included on Modern Matron audit checklist now to ensure compliance
- Storage of items in non-appropriate non patient areas (Waste holds)
- Unlocked bins in outside areas
- Waste Compounds not secured
- Contractor issues- missed collections and non-delivery of sharps bins / including missed home collections

All of the issues stated above have been rectified where appropriate and any actions required are being addressed including reviewing supplier arrangements to ensure improvements and the introduction of key performance indicators on waste providers. There is a need to improve CWP waste management policy and this will be done within 2019.

16 Patient-led Assessment of the Care Environment (PLACE) 2018

Patient-Led Assessments of the Care Environment (PLACE) are a self-assessment of non-clinical services which contribute to healthcare delivered in both the NHS and independent / private healthcare sector in England. PLACE is reported directly to the Department of Health and results are calculated nationally and broken down into organisations, and formulate part of the Model Hospital matrix as outlined in Lord Carter's report to central government.

In 2018 Cheshire and Wirral Partnership participated in the Patient-Led Assessment of the Care Environment (PLACE) inspections. These assessments were led by the facilities management team; all assessments were concluded by the end of May 2018, all NHS organisations are given a window in which to carry out an assessment of all sites, these dates were provided by NHS Improvement and were unannounced to the wards until day of inspection.

There has been an improvement in the majority of areas of inspection within Cheshire & Wirral Partnership. There has been a slight reduction in scoring under the condition maintenance and appearance compared with 2017, this is due to issues identified within the East Cheshire locality, to which CWP are currently working with commissioners to resolve (highlighted in red below).

Overall CWP is performing above national average in all areas of the assessment criteria. This is down to the hard work input by the Facilities and Estates teams across the organisation. The scoring also demonstrates the good working relationship the support services team have with clinical services. PLACE is a useful tool to help gauge how the investment the Trust has put into wards is perceived by patient representatives, as well as external organisations with an interest in healthcare (Healthwatch).

Site Name	Cleaning Score %	Food Score %	Org Food Score %	Ward Food Score %	Privacy Dignity Score %	Building condition Score %	Dementia Score %	Disability Score %
Bowmere Hospital	99.93%	97.29%	94.71%	100.00%	98.24%	99.63%	97.74%	96.25%
Lime Walk House	99.57%	96.96%	93.86%	100.00%	98.08%	95.29%	N/A	93.03%
Greenways	100.00%	95.91%	93.86%	100.00%	94.70%	100.00%	N/A	100.00%

Springview Unit	100.00%	96.23%	93.86%	100.00%	100.00%	97.63%	85.82%	92.54%
Millbrook	99.13%	95.72%	93.86%	100.00%	93.09%	85.42%	94.89%	98.63%
Soss Moss Site	99.66%	96.23%	93.86%	100.00%	100.00%	100.00%	N/A	100.00%
Eastway	100.00%	94.33%	92.61%	100.00%	100.00%	98.12%	N/A	94.88%
Ancora House	100.00%	96.23%	93.86%	100.00%	100.00%	100.00%	N/A	100.00%

Overall the 2018 PLACE inspection programme has been very successful, the assessments completed help to provide assurance to Cheshire & Wirral Partnership Board of directors, commissioners and general public that the standards of the environment and Facilities services provided are meeting the needs of service users. These assessments also demonstrates the hard work that the Facilities and Estates team, in conjunction with clinical services, provide in improving the environment for service users to ensure it is safe and effective.

17. Conclusion

Infection prevention and control remains a priority for CWP. The IPCSC and IPCT continue to maintain and improve on the application, conservation and development of IPC standards. The Trust is committed to working towards excellence in IPC practice to help prevent avoidable infections in our patients including wound and urinary tract infections. When infection does occur, this is recognised early and treated appropriately in line with local antimicrobial guidance. AMR remains a high priority within the Trust and antimicrobial stewardship represents an organisational and system-wide approach to promoting and monitoring the prudent use of antimicrobials.

This report highlights the partnership working and continuous improvements within IPC during 2018/19 and the key priorities for 2019/20.

18. Work Priorities for 2019/20

- Maintain compliance and assurances with the Health and Social care Act (2015)
- Promote hand hygiene week in May 2019
- Deliver a quality IPC Education event to CWP staff in November 2019
- Actively support the staff influenza campaign to achieve 80% uptake in face to face staff
- Undertake a Trustwide mattress audit
- Improve compliance to anti-microbial prescribing using Quality Improvement Methodology
- Develop health economy wide infection prevention and control group across West Cheshire and align IPC with the 10 year NHS Plan.

19. Recommendations

The Board is asked to approve the Infection Prevention and Control Annual Report for 2018/19 and the work priorities for 2019/20.

20. Appendices

Appendix 1

Glossary

Antibiotic Formulary
A list of approved antibiotics based on evaluations of efficacy, safety, and cost-effectiveness of drugs based on population trends

Antimicrobials
Antimicrobials are substances which are used in the treatment of infection caused by bacteria, fungi or viruses

Aseptic Non Touch Technique
Aseptic Non Touch Technique or ANTT is a tool used to prevent infections in healthcare settings

Assurance Framework
A system for informing their parties that a process of due diligence is in place to assure safety and quality exists within that setting

Audit
Audit is a quality improvement process that aims to improve service user care and outcomes by carrying out a systematic review and implementing change. This is not necessarily complex and in its simplest form shows compliance with a single protocol. Its value is in showing improvement or maintenance of a high standard. Once an audit has been completed and actions taken, repeating the audit will complete the audit cycle

Benchmark
A standard or point of reference against which, things may be compared

Best Practice
A best practice is a method or technique that has consistently shown results superior to those achieved with other means, and that is used as a benchmark

Board
A Board (of Directors) is the executive body responsible for the operational management and conduct of an NHS Foundation Trust. It includes a non-executive chairman, non-executive directors, the chief executive and other executive directors. The Chairman and non-executive directors are in the majority on the Board

Clostridium Difficile Toxin
This is a type of infectious diarrhoea caused by the bacteria Clostridium difficile

CareNotes
The main clinical electronic care record, used within CWP

Carers
Person who provides a substantial amount of care on a regular basis, and is not employed to do so by an agency or organisation. Carers are usually friends or relatives looking after someone at home who is elderly, ill or disabled

Catheter Associated Urinary Tract Infection – CAUTI
Catheter associated urinary tract infections comprise a large proportion of healthcare associated infections and can occur whether a person has either a short-term or a long term catheter

Clinical Commissioning Group – CCG
Clinical Commissioning Groups are groups of GP's that are responsible for designing and commissioning / buying local health and are services in England

Care Quality Commission – CQC
The Care Quality Commission is the independent regulator of health and social care in England. It regulates health and adult social care services, whether provided by the NHS, local authorities, private companies or voluntary organisations

Colonisation
Where an organism is present on, or within a person's body but without signs or symptom of disease

CPE - Carbapenemase-producing Enterobacteriaceae
Carbapenems are one of the most powerful types of antibiotics. Carbapenemases are enzymes (chemicals), made by some strains of these bacteria, which allow them to destroy carbapenem antibiotics and so the bacteria are said to be resistant to the antibiotics

Cross Infection
Cross infection is the transfer of harmful microorganisms. Bacteria and viruses are among the most common. The spread of infections can occur between people, pieces of equipment, or within the body

CSU
Clinical Support Unit which supports the CCG's

CWP footprint
This is the geographical areas that CWP provide healthcare to its populations

CWaC
Cheshire West & Chester local authority

DATIX
An electronic record for reporting incidents

Decolonisation
A method to temporarily or permanently eradicate the body from an organism that is colonising either skin or tissue

Decontamination
The combination of processes (including cleaning, disinfection and sterilisation) used to make a reusable item safe for further use on service users and for handling by staff

DH
Department of Health

DIPC - Director of Infection Prevention and Control
An individual with overall responsibility for infection control and accountable to the registered provider in NHS provider organisations

EE1
Essential learning which is Mandatory

ESBL
Extended Spectrum Beta Lactamase
HCAI
Health Care Associated Infection

Health and Social Care Act 2008 - The Health and Social Care Act 2008: code of practice on the prevention and control of infections and related guidance.
The guidance and standards used as Part of Regulation 12 and 15 in relation to the CQC standards health providers are assessed against

Healthcare
Healthcare includes all forms of care provided for individuals, whether relating to physical or mental health

Infection
Where the body is invaded, by a harmful organism (pathogen), which causes disease or illness

IPC link practitioners
The Infection Prevention and Control Link Practitioner (IPCLP) will act as a resource and role model in their designated area of work and will liaise with the Trust's Infection Prevention and Control Team (IPCT). The role will help to create and maintain an environment that is safe for service users, visitors and staff

IPCIS
Infection Prevention and Control Integrated Service

IPCN (S)
Infection Prevention and Control Nurse (Specialist)

IPCSC
Infection Prevention and Control Sub Committee

IPCT
Infection Prevention and Control Team

IPS
Infection Prevention Society

LD
Learning disabilities

MDG

Medical Devices Group.

MH
Mental Health

MMG
Medicines Management Group

MRSA
Meticillin Resistant Staphylococcus Aureus

MRSA Bacteraemia
Meticillin Resistant Staphylococcus Aureus infection which enters the patients' bloodstream

Multi Resistant Organisms
Organisms that have a resistance to several groups of antibiotics, typically oral

NSC
National Standards of Cleanliness

Patient, also called Service User

PH
Physical Health

PHE
Public Health England

PLACE
Patient Led Assessment of the Care Environment

Post Exposure Prophylaxis – PEP
Treatment following exposure to prevent further infections or symptoms

Post Infection Review – PIR
A process which allows organisations to understand areas requiring improvement in the patient care pathway, and more importantly, identifies and targets actions to minimise the chance of recurrence for future patients for MRSA Bacteraemia

Root Cause Analysis - RCA
A process which allows organisations to understand areas requiring improvement in the patient care pathway, and more importantly, identifies and targets actions to minimise the chance of recurrence for future patients for Clostridium Difficle Toxin Positive cases

Safety Metrics
A measurement of practice to give assurance and identify gaps

Service User
Anyone who uses, requests, applies for or benefits from health or local authority services

Standard Operating Procedure (SOP)

Standard operating procedures (SOPs) are written instructions intended to document how to perform a routine activity. Many Trusts rely on standard operating procedures to help ensure consistency and quality in their products.

Surveillance
Infection surveillance is the continuous, systematic collection, analysis and interpretation of health-related data needed for the planning, implementation, and evaluation of infection prevention and control practice. Such surveillance can serve as an early warning system for impending multi resistance or increase in emergence of newer organisms, and allow the team to respond appropriately supporting the health care structure for our population

Trajectory/Ambition
A figure dictated by Gov.uk in relation to HCAI performance

UTI's – Urinary Tract Infection
An infection of the Urinary Tract that can be upper or lower and complicated or uncomplicated causing symptoms**.**

NHS
Cheshire and Wirral Partnership
NHS Foundation Trust

STANDARDISED SBAR COMMUNICATION

REPORT DETAILS	
Report subject:	Medicines Management & Optimisation Annual Report 2018-19
Agenda ref. number:	19.20.53
Report to (meeting):	Board of Directors
Action required:	Discussion and Approval
Date of meeting:	17/07/2019
Presented by:	Chief Pharmacist & Associate Director of Medicines Management

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

Which 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 Medicines Management Annual Report for 2018 – 19 describes the progress with the Trust's journey towards improved medicines optimisation as well as providing assurance with the framework for medicines governance across the Trust.

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

This report provides a summary of the activity and progress that has been made by the Medicines Management Group (MMG) and the Pharmacy Team against the group's annual business cycle and the pharmacy team's quality improvement priorities.

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

The progress, achievements and challenges over 2018 – 19 relating to Medicines Optimisation have been highlighted and assurance is provided of the underpinning mechanisms across the Trust to provide high quality, effective and safe services relating to medicines.

A big focus of our work over the year has been through enabling those that use our services be the best they can be through increased knowledge about their treatment and signposting to other pharmacy support services in their local communities. Innovation of the workforce through scoping out new ways of working and delivering a patient centred service has also been key and is aligned with the recommendations of the 10 year NHS plan and the Carter recommendations for mental health and community services. Further development of the pharmacy workforce as a key player in multidisciplinary teams is anticipated to be a key feature during 2019-20. Our vision for how this will be implemented over the next five years will be captured in the revised medicines management strategy.

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

Board of Directors is asked to discuss and approve the Annual Report.

Who has approved this report for receipt at the above meeting?	Dr A. Sivananthan, Medical Director Quality, Compliance & Assurance
Contributing authors:	Jasmeen Islam, Hazel Sharp, Julie Orton, Lesley Irvin, Other members of the Pharmacy Team & MMG membership.

Distribution to other people/ groups/ meetings:

Version	Name/ group/ meeting	Date issued
1	MMG Quality Committee	21/06/19

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

Appendix No.	Appendix title
1	Medicines Management & Optimisation Annual Report 2018-19

Cheshire and Wirral Partnership
NHS Foundation Trust

Medicines Management and Optimisation Annual Report 2018-19

Pharmacy Team, Cheshire & Wirral Partnership NHS Foundation Trust in Collaboration with the Medicines Management Group June 2019

Executive Sponsor: Dr Anushta Sivananthan, Medical Director

Table of Contents

Executive Summary

This report provides the Board with assurance for the delivery of the medicines optimisation work plan over 2018-19, allowing for the safe and effective use of medicines within the Trust.

The report highlights the progress we have made over 2018-19 towards effective Medicines Optimisation, aligned with CWP's Forward View, the Carter recommendations of productivity and efficiency and the NHS 10 year plan. Key achievements are outlined as:

- Quality Improvement approaches to medicines optimisation
- Assurance for statutory obligations including controlled drugs and rapid tranquillisation
- Medicines Management Group outputs
- Transfer of care to community pharmacy through integrated working
- Medicines safety assurance
- Innovation across the workforce and development of new roles
- Medicine education and support to patients and colleagues

Optimising medicines by enabling those that use our services be the best they can be through increased knowledge about their treatment and signposting to other pharmacy support services in their local communities has been a big focus of our work over the year. Innovation of the workforce through scoping out new ways of working and delivering a patient centred service has also been key and is aligned with the recommendations of the 10 year NHS plan and the Carter recommendations for mental health services. Further development of the pharmacy workforce as a key player in multidisciplinary teams is anticipated to be a key feature during 2019-20. Our vision for how this will be implemented over the next five years will be captured in the revised medicines management strategy.

Much has been achieved over 2018-19 and there is much more to do over the coming years to continue to build on previous years' high standards in pharmaceutical care, including the continuous strive for excellent patient care, innovation and value from medicines.

Fiona Couper,
Chief Pharmacist & Associate Director for Medicines Management

1. Notable Achievements

Work led by the Pharmacy Team for NHSE Commissioned STOMP-LD (Stopping Overmedication of people with a Learning Disability, Autism or both) was shared at the NHSE Transforming Care Operational Group in Leeds and at the NHSE Physical Health Good practice Showcasing event in Warrington in October 2018. It was also included in the CWP Big Book of Best Practice 2018/19

We support STOMP

Stopping over-medication of people with a learning disability, autism or both

Following previous successful postgraduate diploma teaching, we secured a long-term tenure with Liverpool John Moore's University for a Mental Health Teacher Practitioner post. The 0.4WTE role which began in February will involve delivering specialist mental health lectures and workshops, facilitating a specialist mental health pathway and placements for 3rd year undergraduates and development of a 20 credit on-line self-directed study package in psychiatric pharmacy. Bi-annual delivery of weekend psychiatry study days, as part of the clinical diploma for post graduates will also continue. The aim is to raise the profile of the pharmacists' role in mental health and CWP as a potential employer. Additional bi-annual delivery of weekend psychiatry study days, as part of clinical diploma for post graduates. Pharmacists have requested unit visits following delivery of study days due to increased interest in psychiatry."

The Pharmacy Team secured a place on the NHS England Clinical Entrepreneur Programme for 2018-19 following significant national competition, of which both Pharmacy and mental health representation is a minority; this training programme is referenced in the NHS Ten Year Plan.

NHS England Clinical Entrepreneur Programme

This team member was selected as a nominated clinical assessor for applications across the UK for the category of mental health innovation for a joint initiative between the UK Space Agency, NHS England and the European Space Agency to turn technology originally designed for space into medical applications worth £4.5 million.

In May 2018, a senior member of the Pharmacy team was selected to be a moderator for the NHS England Care Home Medicines Optimisations Applications for the Northern Region.

In June 2018, one of the Clinical Pharmacists was shortlisted for 'Excellence in Patient Care' at the CWP Recognition Awards. The prestigious recognition for 'Outstanding Contribution to Leadership' was awarded to a senior member of the Pharmacy Team.

Funding was secured for four pharmacist places on the Aston post-graduate pharmacy psychiatry diplomas/certificates, six technician places on the Bradford Pharmacy Clinical Professional Diploma Level 4 and one data scientist apprenticeship for our physical health technician.

2. Quality Improvement and Medicines Optimisation

2.1 Quality Improvement Charter 2018-19

In January 2018, the Pharmacy Team developed a Quality Improvement (QI) Charter as part of the QI Faculty across CWP. Please see Appendix 1.

Our quality improvement priority areas for 2018-19 were refreshed and updated based on our 3 year plan around quality improvement for medicines Optimisation.

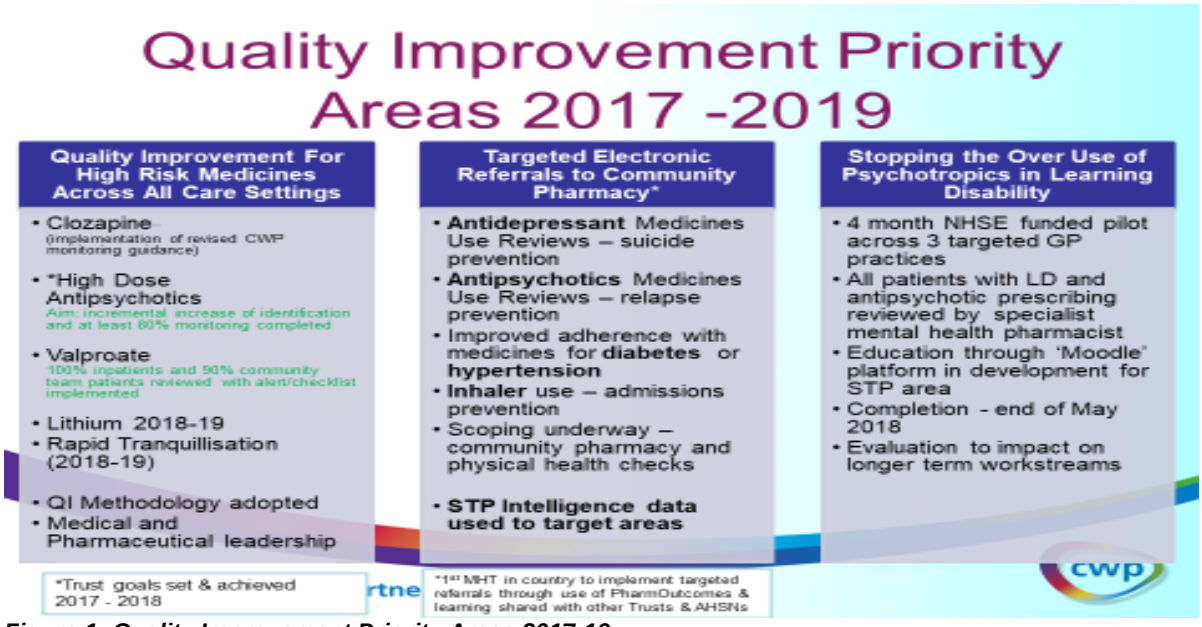


Figure 1: Quality Improvement Priority Areas 2017-19

We build on the work undertaken over 2016-17 and 2017-18 to reduce risk of patient harm from the use of high risk medicines used across our services:

This included the following medicines:

- Valproate – to reduce risks of teratogenicity in the offspring of females at risk of child-bearing potential
- High Dose Antipsychotic Therapy – to reduce risks of patient harm and in line with Royal College of Psychiatry recommendations and local prescribing guidance
- Clozapine optimisation – to reduce risk of harm as well as ensure sufficient uptake for the treatment resistant schizophrenia

Benchmarking against Quality Standards Nationally:

- We benchmarked ourselves against Nationally agreed standards for Pharmacy and Medicines Optimisation standards for Mental Health and Community Services as published by the Royal Pharmaceutical Society[1] and the CQC self-assessment for medicines[2] and used this to plan continued improvement over 2018/19
- We reviewed the Carter Report entitled "*NHS Operational Productivity: Unwarranted variations – Mental Health Services, Community Health Services.*" (May 2018)[3] against our current position and suggested quality improvement recommendations based on the recommendation that Trusts *should develop*

plans to ensure their pharmacists and other pharmacy staff spend more time with patients and on medicines optimisation.

- We implemented the action plan relating to the findings of the CQC well–led inspection in relation to medicine gaps conducted during August-September 2018.

Made the best possible use of the Pharmacy Professional workforce and the value to CWP and Patients who use our services by:

- Continuing to deliver and roll out Electronic Referrals to Community Pharmacy for patients identified post discharge as well as in the community
- Continuously use data monitoring to drive improvement and monitor progress
- Continuing to engage teams to identify patients who would are likely to have improved health outcomes as a result of a referral to a pharmacist
- Continued our close working relationships with our Primary Care colleagues

2.2 Support to Care Groups

Senior members of the Pharmacy team regularly attended all four Care Group meetings to provide advice and proactive input on medicines related issues. One area of concern that was identified by the care groups was consistency of pharmacy support across all teams. A self-assessment exercise was therefore carried out by the pharmacy team using national benchmark standards.

2.2.1 Self-Assessment against RPS and CQC Standards

In April 2018 the Pharmacy Team undertook a self-assessment against the RPS and CQC standards for medicines optimisation. The self-assessment has provided the evidence of the gap in pharmaceutical care provision across our community team settings. The findings of the self-assessment were presented to the Quality Committee in May 2018. The key findings are illustrated in the below spider diagrams.

Royal Pharmaceutical Standards – Self-Assessment

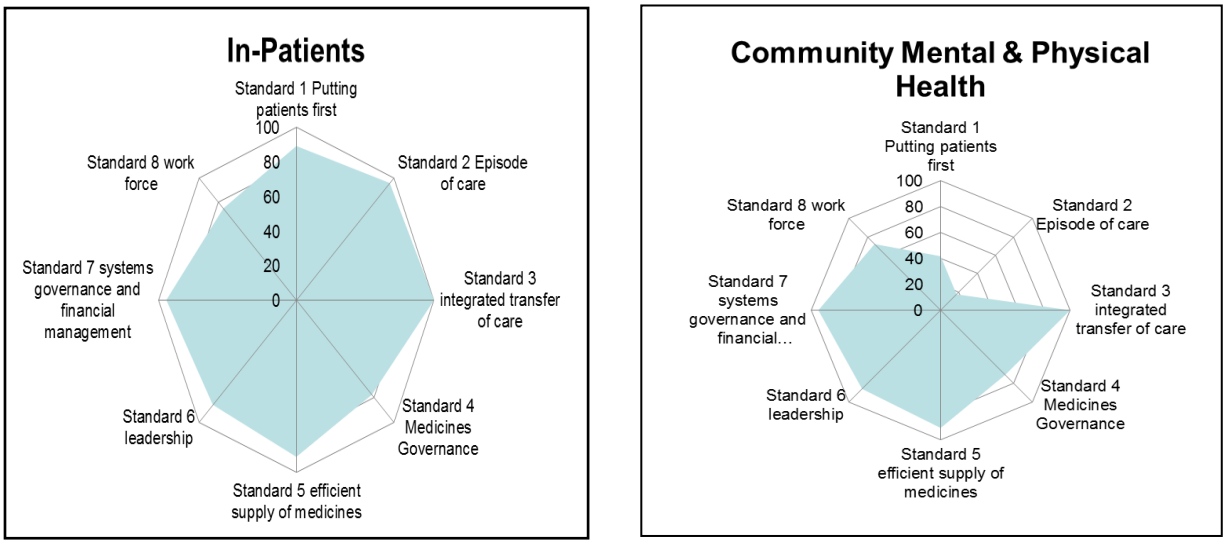


Figure 2: RPS Self -Assessment Tool

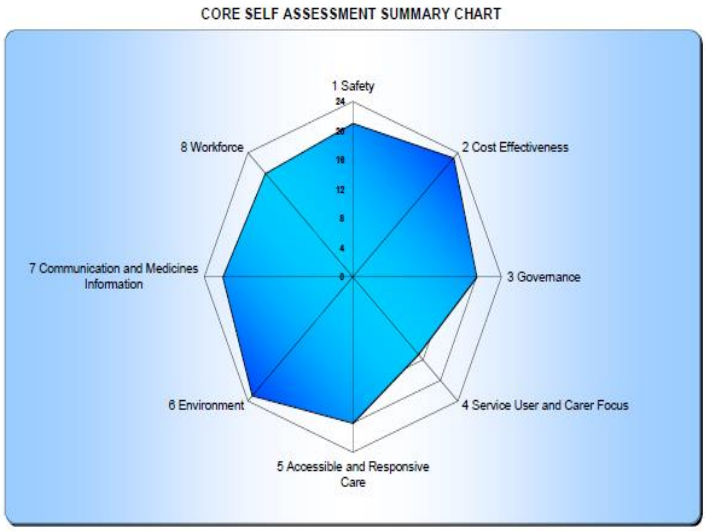


Figure 3: CQC Self-Assessment Tool

We concluded that:

Synergism between RPS and CQC Indicators existed, highlighting assurance for medicines management in:

- Safe, effective, responsive and caring services
- Leadership and governance

Identified gaps in standards were:

- Pharmacy workforce in our community settings leading to reduced responsiveness to service user & carer needs for medicines optimisation.

In May 2018, the Pharmacy Team received the Specialist Mental Health Care Group full support to present a proposal for enhanced Pharmaceutical care into Community Mental Health Teams to support nursing and medical workforce challenges as well as the current service delivery gap in pharmaceutical care provision. The evidence was subsequently presented to Quality Committee and as a result of this the implementation plan for proof of concept pilots across Wirral and West Cheshire Community Mental Health Teams commenced. The pilots commenced in March 2019 following backfill arrangements to reduce inpatient services risk. Evaluation will take place in July 2019. A paper will subsequently be presented to Quality Committee in September based on these findings with recommendations on new roles for pharmacy staff in community teams.

2.3 Pharmacy Interventions and Multi-disciplinary Team (MDT) Working

The clinical pharmacy team are an integral component of inpatient MDTs and undertake pharmaceutical interventions which are recorded in the CareNotes clinical system. The top three specific categories of interventions made in 2018/19 were:

- Medicines education(patient counselling)
- Choice of Therapy
- Advising on Adverse Drug Reactions/Side Effects

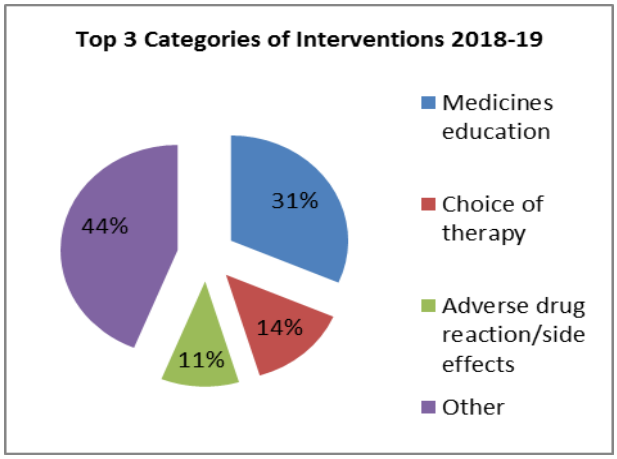


Figure 4: Type of Intervention

Interventions in the 'other' category equated to 44% of all interventions made; this includes antibiotic prescribing, compliance assessment/discharge planning, dose adjustment and titration/switching recommendations, drug interactions, formulation choices, medicines reconciliation, monitoring - TDM / physical health checks and prescribing Issues. A deep dive review is to be carried out on this category such that we can identify more meaningful sub-categories to report on.

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

2.4 Place Based Approaches to Medicines Optimisation

Work continued with our primary and secondary colleagues in the three geographical locations and wider for improved medicines optimisation, providing pharmaceutical leadership for medicines optimisation in mental health across our footprint including the following:

i. Continued membership of the Cheshire Area Prescribing Committee and the West Cheshire Medicines Strategy Group
ii. Newly introduced members of the Pan Mersey Area Prescribing Committee reflecting the Wirral CCG Medicines Decision processes
iii. Continued proactive input into the Healthy Wirral Medicines Optimisation Group, where we lead the mental health medicines work stream
iv. Proactive members of the Cheshire & Merseyside Local Professional Network for Pharmacy (NHS England) with a CWP mental health standing item on the agenda
v. Proactive attendance at the North West Chief Pharmacists Network Meeting and the Northern Mental Health Chief Pharmacists Meeting allowing for shared learning across places of care
vi. Specialist Mental Health Pharmacist in-reach into Wirral University Teaching Hospital NHS FT was agreed over 2018-19 to commence in May 2019.
vii. It was agreed with all our Medicines Optimisation Lead Commissioners that priorities for Mental Health Medicines Optimisation across the system would reflect the Trust QI Charter for Medicines including priorities for electronic referrals to community pharmacy, clozapine, high dose antipsychotic therapy and valproate.

2.5 Prescribing Observatory for Mental Health

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

The following audits were undertaken during 2018-19:

- Prescribing Clozapine
- Assessment of the side effects of depot antipsychotics
- Monitoring of patients prescribed lithium

The Trust has received the audit results for the following audits during 2018-19:

- Monitoring of patients prescribed lithium
- Prescribing valproate for bipolar disorder

The learning, action plans and results of the audits disseminated to clinical teams and presented at Clinical Practice and Standards Sub-Committee / Medicines Management Group.

2.6 Referral to Community Pharmacy through 'PharmOutcomes' Digital Platform

Figure 5: Jennifer Southern, Senior Clinical Pharmacist, presenting at CMHP 2019 Conference

As part of the Transfer of Care Around Medicines initiative, engaging with the North West Coast Innovation Agency and NHS England local team, the Pharmacy team have sustained the Referral to Community Pharmacy Scheme for patients under the care of CWP over 2018-19 using a Quality Improvement Approach and incremental adjustments to the initial methodology.

In October 2018, we presented our learnings as the first Mental Health Trust in the UK to use PharmOutcomes for referrals to Community Pharmacy at the National Pharmacy Show, Innovation Theatre. We also presented at the 9th Annual International CMHP Psychiatric Pharmacy Conference.

Both these fora raised interest from other parts of the country, following which an article was published in the *National Pharmacy Magazine* at the end of March 2019 notably in the role for clozapine safety.

In February 2019, we submitted 5 entries to the National Health Service Journal Awards for the categories of. The Trust has subsequently been shortlisted in all categories as Finalists for the Awards.

Figure 6: Pharmacy and Clozapine Team members cited in National 'Pharmacy Magazine'

2.7 STOMP – Stopping over medication of people with a learning disability (LD), autism or both

Following on from events at Winterbourne View Hospital; NHS England commissioned three reports into the use of antipsychotic medication in people with learning disability, autism or both. CWP was given funding to undertake two task and finish functions:

- Enable dedicated and expert clinical pharmacist time to identify and review individuals with a Learning Disability who are being prescribed antipsychotics
- Undertake a series of GP education events around STOMP

In total, 126 patients were reviewed across 5 practices. In total, 37 recommendations were made to review or change medication based on the available information. This CWP project built on the NHS England STOMP initiative by engaging with GP practices and medicines optimisation teams to identify patients who had a diagnosis of LD without the co-morbidity of mental ill-health. Of this cohort, the project identified any patients prescribed antipsychotics who were not currently under the care of CWP. Particular attention was paid to any treatment of challenging behaviour with antipsychotic medication.

3. Governance

3.1 Medicines Management Group (MMG)

The MMG is the regulatory meeting in the Trust's integrated governance structure that is accountable for the safe and effective use of medicines and their associated policies and procedures.

The MMG has met 6 times over the year and all six meetings were quorate.

The Terms of Reference of the group were revised to reflect the change to Care Groups.

Figure 7: MMG in Action

3.2 Care Pathways

Care pathways were developed and ratified at the Medicines Management Group including:

- Antidepressant Treatment Pathway for Moderate – Severe Depression in Adults,
- Revised Antimicrobial Guidance,
- Updated Rapid Tranquillisation Policy,
- Prescription generation for Adult ADHD prescribing,
- Treatment of hypoglycaemia for use across inpatient services.

3.3 CQC feedback from Well-led Inspection

The CQC visited the Trust in August – September 2018.

Positive aspects of the report highlighted the following good practice points in relation to medicines across the Trust:

"**Medication was monitored by a pharmacist and national guidance was followed in the administration and prescribing of medication"**

"The service provided lots of information regarding medication and mental health problems"

"Staff followed national guidance in the routine prescribing of medication for children and young people and the care and treatment of patients with eating disorders"

"Managers took immediate action on the gaps in auditing around seclusion and rapid tranquilisation which we identified"

"There was information across the service regarding medication and treatment that was available to patients"

However further improvement work was required about the embedding of NICE guidance about Rapid Tranquilisation and post administration physical health monitoring. This is underway across our care groups.

The CQC recently published a report entitled "*Medicines in health and adult social care – learning from risks and sharing good practice for better outcomes.*"[4] This report details findings from inspections about the risks from medicines in various healthcare settings and details actions for ensuring medicine safety. There are 5 specific actions for mental health care providers:

(i) Strengthening procedures for rapid tranquillisation; to include staff training on the need for it, delivering it safely and monitoring physical health appropriately.
(ii) Improving prescribing and monitoring of high dose antipsychotics,
(iii) Challenge prescribing and administration that is not aligned to national guidance or a person's consent to treatment,
(iv) Good monitoring of physical health, side effects and effectiveness of prescribed medicines,
(v) Enhanced recognition of medicine safety and the role of the medicine safety officer at Board level.

All five of these actions are part of our quality improvement priorities work plan and will be incorporated into the revised medicines strategy.

3.4 Named Patient Requests

Throughout the year, MMG have received a total of 231 named patient requests, 219 of which have been approved for use. The majority (61%) of requests were for atypical depots due to non-compliance with oral medication.

Locality	Antipsychotics	Other (eg:antidepressants/anxiolytics)
East	82	30
West	24	9
Wirral	54	32
Total	160	71

Figure 8: Named Patient Request Breakdown

3.5 Trust Assurance for Controlled Drugs

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

3.6 Medicines Safety - Incident Reporting

3.6.1 Incident Reporting of Medication Errors

Figure 9 below shows the context of this year's medicines-related incidents, within the previous five years of data. The number of reported incidents has fallen from 2017/18. This is due to a reduction in non patient safety incidents, The proportion of moderate / serious incidents has continued to **decrease** over the years. This is in line with the overall pattern of increased low level harm incident reporting for the Trust indicating a positive safety culture.

Year/Severity	A	B	C	D	E	Total
2014/15	0	0	45	109	276	**430**
2015/16	0	0	50	126	342	**518**
2016/17	0	0	27	98	392	**517**
2017/18	0	0	20	85	304	**409**
2018/19	0	3	7	63	253	**326**
Totals	**0**	**3**	**149**	**481**	**1567**	**2200**

Figure 9: Five year trend of medication incidents by severity: April 2014 – March 2019

3.6.2 Patient Safety Incidents

The highest number of reported incidents relates to the administration of medicines n=152 (n=154 in 2017/18).

There were 53 prescribing incidents reported in 2018/19 compared to 72 in 2017/18. 64% of prescribing incidents are related to prescribing of incorrect dose (13), omissions (10), frequency (5) and incorrect drug (6).

3.6.3 Non-patient safety incidents

Controlled drug discrepancies comprise 43% of non-patient safety incidents and loss of prescriptions, charts or medications comprise 27% of the total. None of these incidents impacted on patient care.

Controlled drug discrepancies	39
Loss of prescription or pad/drug chart lost/missing medication	24
Non-adherence to policies	9

Failure to monitor medication fridge/room temperature/ breakdown	6
Medication not transferred when patient moves ward/hospital or discharged	6
Miscellaneous	5

Figure 10: Table showing breakdown of non-patient safety incidents 2018/19

3.7 Patient Group Directions (PGDs)

The PGD subgroup of MMG meets every 2 months and undertakes a programme of work to review and update PGDs in line with an agreed schedule in the business cycle. Figure 11 below illustrates the PGDs that were approved during the year.

PGD	Detail
Seasonal Flu	1. Supply and administration of intramuscular inactivated influenza vaccine. 2. Supply and administration of live attenuated influenza vaccine nasal spray suspension (Fluenz Tetra®▼)
MenACWY Risk Groups v2	Administration of meningococcal group A, C, W, and Y conjugate vaccine (MenACWY) to individuals with an underlying medical condition which puts them at increased risk from *Neisseria meningitidis.*
Fucidin (fusidic acid) 2% cream v3	For supply as treatment of primary and secondary skin infection in homeless people
Ciprofloxacin use in meningitis v2	Administration of ciprofloxacin tablets or liquid for management of clusters of meningococcal disease when two or more cases are reported in a congregate setting.
Corticosteroid Injection Therapy v5	Corticosteroid and local anaesthetic injection therapy for Peripheral Intra or Peri-articular Lesions in patients aged 18 years or over for the treatment of musculoskeletal conditions.
Shingles v8	Administration of shingles (herpes zoster, live) for the prevention of herpes zoster ('zoster' or shingles) and herpes zoster-related post-herpetic neuralgia (PHN)
PPV (Pneumonia) v2	For the national immunisation programme for active protection against pneumococcal disease
HPV v2	Administration of human papillomavirus vaccine [Types 6, 11, 16, 18] (Recombinant, adsorbed) (HPV) to females from 12 years of age or from school year 8 in accordance with the national immunisation programme

Figure 11: PGDs approved during 2018/19

3.8 Antimicrobial Resistance (AMR) Strategy

3.8.1 Context

This section should be read in conjunction with the Infection Prevention and Control (IPCT) Annual Report 2018/19.

Tackling antimicrobial resistance 2019-2024: The UK's five-year national action plan, published in January 2019, focuses on 3 key areas:

- Reducing need for and unintentional exposure to antimicrobials
- Optimising use of antimicrobials
- Investing in innovation, supply and access to tackle AMR

During the period of 2018/19 there have been some areas of non-compliance to formulary. The IPC and Pharmacy teams are developing an action plan using a Quality Improvement methodology to improve engagement with prescribers and increase compliance to antimicrobial prescribing during 2019/20.

In November 2018, the pharmacy and IPC teams promoted the European Antibiotic Awareness campaign across the organisation to all staff, with the aim of motivating people to change their behaviour to always using antimicrobials appropriately.

3.8.2 Inpatient Services Antibiotic Audit 2018/19

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

- 329 antibiotic forms were collected during 2018/19. 262 prescriptions were written by CWP medical staff and 67 from other providers prior to admission.
- 203 of these prescriptions complied with the guidelines; 22 were prescribed according to sensitivities following laboratory culture and 5 on the advice of a microbiologist. This demonstrates a compliance rate of 92% for CWP medical prescribers.

3.8.3 West Cheshire Physical Health Services Antibiotic Prescribing

- 100% of antibiotics prescribed in GPOOH are on the antibiotic formulary. For cephalosporins, quinolones and co-amoxiclav prescribing rates averaged 11.23% (11.7% for GPs and 4.4% for NMPs) against a quality standard of 10%.
- A snapshot audit of prescribing compliance with formulary recommendations was conducted by retrospectively reviewing patient records over a 7 day period in March 2019 for appropriate prescribing for urinary tract infections (UTIs), and for use of cephalosporins, quinolones and co-amoxiclav. The results showed appropriate choices for UTI prescribing however prescribing of the other antibiotics was non-formulary in 62% of cases. Further audits are planned and an action plan devised around improving formulary adherence by the GPs.
- Antibiotics are not routinely prescribed by NMPs in community clinics.

3.8.4 Westminster and Willaston Surgeries

NHS England AMR CCG Improvement & Assessment Framework provides two indicators for antibiotic prescribing in primary care:

- A target level for total number of antibiotics prescribed Both Westminster and Willaston surgeries are slightly higher than the target level
- The prescribing of co-amoxiclav, cephalosporin and quinolone antibiotics needs to be less than 10% of the total antibiotic prescribing.
  Westminster is 2.88% above the target whilst, Willaston is 0.67% within target.

To note; the West Cheshire CCG average for GP prescribing of antibiotics is above 10%.

3.9 Flu planning

The Flu planning group was chaired by the Chief Pharmacist for the 2018/19 campaign with the aim of having clinically lead leadership for the campaign. The pharmacy physical health team ensured that robust governance processes were in place for the vaccines including adherence to PGDs, correct storage and cold chain processes, and timely support with any problems. The campaign focussed on engaging staff in a patient centred approach of encouraging staff to have the vaccine through a multitude of patient/carer stories of experiencing 'flu and the impact it had on loved ones. Uptake in patient facing areas was 60.01% and in non-patient facing areas 63.4% giving an overall uptake for the Trust of 60.68%.

3.10 NICE Update

During the last year, NICE has updated guidance in respect of the use of Donepezil, galantamine, rivastigmine and memantine for the treatment of Alzheimer's disease (TA217) and work was undertaken internally to ensure compliance.

4. Innovation and Workforce

4.1 Non-Medical Prescribing Roles

The pharmacy team is aiming to have one pharmacist per year trained as a non-medical prescriber. At the point of writing one pharmacist is fully qualified to prescribe, a further pharmacist is currently awaiting registration and a third pharmacist is expected to complete the training in September 2019.

4.2 Gateway Pilot

In 2018 the pharmacy team participated in a 3 month pilot project with the Gateway Team in Winsford, providing 2 sessions per week of pharmacist input. During this time the pharmacist received 80 referrals and was able to action 75 of those 80 referrals without the need for a further referral to a consultant. The project showed the value of pharmacist input by providing prompt medication advice to all members of the team and local GPs and saving consultant time.

Feedback was very positive and included the quotes:

Prompt medication advice, resulting in reduced waiting times for patients as often no consultant appointment needed

Attention to detail and clarity in well-considered advice to our queries and GP requests

4.3 Medicines Administration PharmacyTechnician

A pilot project to train a pharmacy technician to safely administer medicines on Croft ward commenced in July 2018 for six months. The role was predominantly developed to incorporate the morning medication round in order to release nursing time to undertake more patient focussed tasks. On Croft ward, medication rounds can take longer than other wards due to the complex needs of the patients and associated polypharmacy.

The results of the pilot were presented to CPSSC in February 2019. The pilot demonstrated the following outcomes over the six month period:

Released nursing time	Average of 9 hours per day
Reduction in omitted doses of medicines	12%
Medicine cost saving	20%

Figure 12: Pilot Findings from Croft Ward

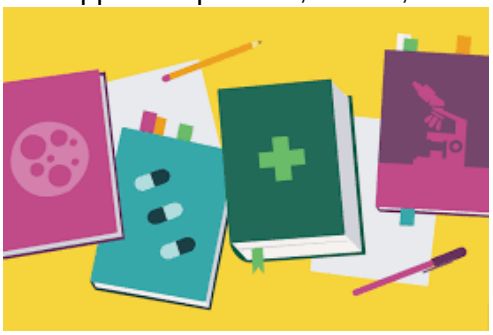
Other benefits include helping patients to self-manage; increased medication related interventions, greater stock control and reduced dispensary workload.

In conclusion, this novel role releases nursing staff time to undertake more patient-centred nursing duties whilst simultaneously reducing medication spend. In addition, the specialist knowledge of the pharmacy technician at the point of medicine administration had a positive impact on medicines optimisation for patients in hospital, providing more effective administration of medicines and contributing to the wider patient safety agenda.

5. Education Provided to Other Teams/Patients

5.1 Education Support across Mental Health and Physical Health Services

Each year the pharmacy team provides education and support to patients, carers, clinical staff and trainee health professionals. Below is a summary of key examples of this from the year:



- Supported pre-registration pharmacists from neighbouring acute trusts for week long placements. Positive feedback was received from the eleven trainees.
- The East pharmacy team hosted on-site teaching sessions for pharmacy students from Manchester University. On this occasion the team provided 3 sessions for nine students. Feedback was extremely positive and included the quote '*It was an area that I was previously interested in and this has definitely given me more insight*.'
- Provided medicines management training sessions, including rapid tranquillisation, at the trust-wide junior doctors' induction.
- One of the West team pharmacists delivered a clozapine teaching session at the Countess of Chester Hospital.

- Facilitated a thirty minute session on rapid tranquillisation medication at the Prevention Management of Violence and Aggression course.

- The East team have worked alongside the Recovery College to provide two 3 hour sessions on “Understanding Medicines” in Crewe and Macclesfield. Similarly, the Wirral team have been working with the Wellness and Recovery team to facilitate bi-annual sessions at the Stein Centre.

- A smoking cessation session was delivered to CAMHs unit by a pharmacist and technician.

- In Wirral, the Clinical Pharmacists presented a medication education session ‘Understanding your medicines’ for the ‘Education For Wellbeing Course’ for service users, which is held three times a year.

- Ad-hoc requests facilitated this year included a 2 hour session on the nurse preceptorship course and organisation of the May 2019 Grand Round.

- The physical health pharmacist and technician have delivered training on inhaler technique to Health Facilitators, and medicinal maths as part of the insulin administration training for non-registered practitioners.

- Regular talks were delivered on “back pain management” for patients of the MSK service in Ellesmere Port.

5.2 Education Support across Westminster and Willaston Surgeries

- The pharmacist from Well Pharmacy (adjacent to the surgery) holds a Medication Review clinic once a fortnight for patients with chronic and long term conditions at Westminster Surgery. He continues to work with the practice to ensure all frail elderly patients have an annual medication review, and all patients admitted to hospital for a respiratory condition have an inhaler check on discharge. This is supervised by the Pharmacy team.

- Pharmacy team is supporting Willaston surgery to help rationalise antibiotic prescribing by engaging with the Patient Participation Group as well as prescribers. Sourcing a practice Pharmacist for Willaston Surgery is currently in progress.

6. Other work

6.1 Progress Towards ePMA

The Trust has reviewed all its Electronic patient Record (EPR) systems in terms of their future deliverability and interoperability with other systems. ePMA is a consideration of this work as it is currently one of our main paper systems. The Board has approved the review and replacement of the main EPR system for MH/LD services. Any review will build in an ePMA solution as part of its criteria.

6.2 Change in Medicine Supplier

A competitive tender process was undertaken following the expiry of CWP's previous pharmacy contractor. The contract award was made to a new supplier, Rowlands Pharmacy. The new service was implemented in May 2019

6.3 Integrated Care and Emerging Pharmacy Roles

The changing NHS landscape and new emerging models of integrated care have resulted in the Senior Pharmacy leadership team engaging and leading work in mental health medicines optimisation.

6.4 Refresh of the Medicines Management Strategy and Priorities

The strategy is being refreshed to include the Carter recommendations, the priorities from the NHS 10 year plan and feedback from patient/service user engagement. The new strategy will be presented to CWP's Board in September

7. Recommendations

The Board of Directors is requested to:

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

8. References

1. Professional Standards for Hospital Pharmacy Services For providers of pharmacy services in or to acute hospital, mental health, private, community service, prison, hospice and ambulance settings Version 3 | December 2017 https://www.rpharms.com/Portals/0/RPS%20document%20library/Open%20access/Professional%20standards/Professional%20standards%20for%20Hospital%20pharmacy/Hospital%20Standards-2017.pdf?ver=2017-12-21-132808-697
2. CQC indicators for medicines
3. *NHS Operational Productivity: Unwarranted variations – Mental Health Services, Community Health Services.* May 2018.
4. Medicines in health and adult social care, June 2019. https://www.cqc.org.uk/sites/default/files/20190605_medicines_in_health_and_adult_social_care_report.pdf

Appendix 1: Pharmacy Quality Improvement Charter

Quality Improvement Charter 2018/19 Pharmacy Department

This charter describes the Pharmacy Department's contributions to enabling CWP to deliver and implement Phase 1 of the Quality Improvement Strategy for 2018/19. This includes the support that will be offered to clinical teams and to other clinical support teams to ensure that the whole organisation's operating principle is Quality Improvement. This charter will be updated annually.

Our improvement advisors are Jasmeen Islam & Julie Orton

This is our point of contact who has expert knowledge of Quality Improvement. Jasmeen & Julie will ensure that within our team, and in our interactions with other clinical support teams and clinical services, that there is a common language and approach.

OUR OFFER	We will adopt a QI approach into medicines optimisation across the Trust and share learning and feedback in line with continuous improvement methodologies. Medicines remain the most commonly used therapeutic intervention in the NHS o However half of prescribed medicines are not taken as intended; this can lead to avoidable relapse and admission to hospital o Hospital pharmacy services and the optimisation of medicines are intrinsically linked. A quality Improvement plan will support an outcomes based approach to medicines opimisation It is likely that plans may evolve during the course of the year in light of National Priorities for Medicines Optimisation (eg. Carter Review due May 2018) To ensure that we release an optimal offer in support of CWP's QI Ambition: • We will continuously challenge the way we operate to facilitate continuous quality improvement. • We will always work in a multi-disciplinary way to ensure effective use of collective assets across the organisation. • We will raise the profile of a Quality Improvement approach to Medicines Optimisation both internally within the organisation as well as with our external partners • We will work with teams to help understand their issues in relation to safety and quality relating to medicines, identify means to improve and seek ideas from across teams, and help to share best practice (internally and externally where appropriate) wherever we find it. • We will liaise with colleagues across wider networks in order to obtain intelligence about developments locally and nationally relating to Quality Improvement in Medicines Optimisation across our services

OUR PLANS	1. We plan to build on the work undertaken over 2016-17 and 2017-18 to reduce risk of patient harm from the use of high risk medicines used across our services: - This will include the following medicines: • Valproate – to reduce risks of teratogenicity in the offspring of females at risk of child-bearing potential • High Dose Antipsychotic Therapy – to reduce risks of patient harm and in line with RCPsych Recommendations and local prescribing guidance • Clozapine optimisation – to reduce risk of harm as well as ensure sufficient uptake for the treatment resistant schizophrenia - We will support teams to deliver against agreed metrics for these indictors and provide ongoing communication on progress against achievement towards these areas - taking the views and considerations of front line clinicians of ideas for quality improvement in these areas this will allow for greater ownership and engagement - The POMH Steering Group, Medicines Management Group and PSESC will oversee progress with these indicators - The best use of the available clinical system will be employed to embed the infrastructure on systems to improve prescribing, monitoring and consent in these areas by working closely with the IT and Data Reporting Teams - We will aim to obtain feedback and involve patients where we can on the development of strategies relating to these indicators - The development of a Medicines Optimisation dashboard will make the best use of data to drive quality improvement in these areas 2. Benchmarking against Quality Standards Nationally - We will benchmark ourselves against Nationally agreed standards for Pharmacy and Medicines Optimisation standards for Mental Health and Community Services as published by the Royal Pharmaceutical Society and use this to plan improvement over 2018/19 - We will review the Carter Report for Pharmacy Services for Mental Health and Community Services to review current position and any quality improvement recommendations that are derived from this (expected report due May 2018) and use this to plan improvement over 2018/19 - We will revise and implement the action plan relating to CQC outcomes following both the 2015 inspection and the 2017 well-led pilot 3. We will make the best possible use of the Pharmacy Professional workforce and the value to CWP and Patients who use our services by - Continue to deliver and roll out Electronic Care to Community Pharmacy (ETCP) for patients identified post discharge as well as in the community - Continuously use data monitoring to drive improvement and monitor progress - Continue to engage teams to identify patients who would are likely to have improved health outcomes as a result of a referral - We will add information obtained to the Quality Improvement Dashboard for Medicines Optimisation - Continue our close working relationships with our Primary Care colleagues 4. We will refresh our Strategic Plans for the Medicines Optimisation incorporate the Quality Improvement agenda over 2018/19, in consultation with a range of partners.
OUR DELIVERY	We will deliver Our Plans for 2018/19 as per our commitment detailed above. • We will discuss the strategic improvement projects that are formally identified for 2018/19 with key stakeholders and the CWP Care Groups and Governance Forums and ensure that our offer and our plans are aligned

OUR COMMITMENT	We will ensure Pharmacy Team attendance at QI Faculty meetings and commit to delivering agreed actions • We will routinely contribute to the QI Report, twitter, and other media. • We will openly share change ideas with our QI Faculty colleagues. • We will be person-centred in all of our ways of working • We will use information and intelligence from a wide range of sources and share them as appropriate with the QI Faculty • We commit to matrix working and a collaborative approach across CWP for the benefit of Quality Improvement. We commit to continuing to make medicines optimisation everyone's business so that silo working is avoided, ensuring continuous medical and nursing engagement.

Appendix 2: Contributing Authors

Fiona Couper	Chief Pharmacist & Associate Director of Medicines Management
Jasmeen Islam	Deputy Chief Pharmacist
Hazel Sharp	Deputy Chief Pharmacist
Julie Orton	Medicines Safety Pharmacist
Nina Geiger	Senior Clinical Pharmacist
Bethan Thorpe	Senior Clinical Pharmacist
Jennifer Southern	Senior Clinical Pharmacist
Rebecca Hellier	Clinical Pharmacist
Lesley Irvin	Senior Clinical Pharmacist – Physical Health
Ian Winton	Pharmacy Technician
Jo Campbell	Personal Assistant
Lisa Bellis	Pharmacy Business Information Officer
Julie Spendlove	Head of Infection Prevention and Control
Tracey Collins	Head of Effective Services

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STANDARDISED SBAR COMMUNICATION

REPORT DETAILS	
Report subject:	Data Protection Annual Board Report 2018/19
Agenda ref. number:	19.20.54
Report to (meeting):	Board of Directors
Action required:	Information and Noting
Date of meeting:	31/07/2019
Presented by:	Dr Faouzi Alam, Medical Director & Caldicott Guardian

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

Which 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
Strategic risk register number 7, potential clinical, operational and financial risks associated with services being delivered to or by CWP for which there is no assurance of adequate contractual documentation being in place.	

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 brief the Board of Directors on progress with new data protection legislation implementation. The General Data Protection Regulation 2016 (GDPR) became directly applicable as law in the UK from 25 May 2018. The UK Data Protection Act 2018 (DPA18), which relates to crime and taxation in the UK which GDPR does not cover, also came into force on the same date. Implementation of the new data protection legislation action plan is overseen by the Trust's Information Governance & Data Protection Sub-Committee (IG & DP SC). Any variance or risk is escalated to the Trust's Operational Committee.

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

The Trust's GDPR group, as a sub-group of the IG & DP SC, managed preparations for the new legislation. The work has been methodical and incorporated into scheduled reviews of policies, procedures and fair processing notices. Updated position papers were submitted to the Board of Directors on 28/03/18 and 25/07/18. Organisations (data controllers) must be able to demonstrate compliance with the legislation and in particular that they have appropriate technical and organisational measures in place.

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

Significant progress for GDPR compliance has been made by CWP during 2018/19. The Trust's GDPR group action plan (see Appendix 1) was significantly revised with clear ownership assigned and delivery time frames added. Completed actions include:

1) Privacy notices. The public privacy notice was reviewed and published prior to 25 May 2018. The staff privacy notice was created and distributed to staff with April payslips.

2) Data Protection Impact Assessment. The DPIA, which is required for all new systems or significant projects involving the use of personally identifiable data, has been updated and now includes a risk matrix.

3) Data Protection Officer. The role of Data Protection Officer (DPO) sits with the Records & Information Governance Manager which has been publicised within the privacy notices.

4) Roll out across the organisation. Several communications to staff took place in the weeks leading up to 25 May 2018 to advise of the key changes within the new data protection legislation.

5) Significant review of the Information Asset Register. Data flow mapping information for all areas of the Trust has been incorporated into the information asset register including the GDPR requirement to log the legal basis for processing data.

6) Review of all contracts to ensure GDPR compliance. In April 2018 the contracts team communicated with clinical providers, and the procurement team communicated with non-clinical providers to advise that contract variations to incorporate GDPR were required. As a central repository of contracts was not in place, a risk in scope was recorded by the Operational Committee of potential clinical, operational and financial risks associated with services being delivered to or by CWP for which there was no assurance of adequate contractual documentation being in place. The contracts, procurement and finance teams have worked collaboratively to identify those recurrent payments being made where person identifiable information may be accessed, but which potentially do not have contract documentation in place. Letters have been sent to all providers resulting in risks associated with GDPR requirements being mitigated and the risk on the strategic risk register has now been archived.

The above actions demonstrate that the Trust made excellent progress with implementing the new data protection legislation during 2018/19.

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

That the Board notes the GDPR Annual Board Report 2018/19

Who has approved this report for receipt at the above meeting?	Dr Faouzi Alam, Medical Director, Effectiveness, Medical Education and Medical Workforce
Contributing authors:	Gill Monteith, Information Governance Manager/Data Protection Officer

Distribution to other people/ groups/ meetings:

Version	Name/ group/ meeting	Date issued
1	Information Governance & Data Protection Sub-Committee	13/03/2019

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

Appendix No.	Appendix title
1	GDPR Action Plan v15

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STANDARDISED SBAR COMMUNICATION

REPORT DETAILS	
Report subject:	People Strategy 2019-2022
Agenda ref. number:	19.20.55
Report to (meeting):	Board of Directors
Action required:	Discussion and Approval
Date of meeting:	31/07/2019
Presented by:	David Harris, Director of People and OD

Which strategic objectives this report provides information about:	
Deliver high quality, integrated and innovative services that improve outcomes	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 purpose of this report is to introduce to Trust Board the attached presentation on the CWP People Strategy 2019-2022. The attached presentation contains a greater level of detail than will be presented during the meeting on the 31st July 2019. The intention for that session is to highlight the main themes of the NHS Interim People Plan and key aspects in the development and content of the CWP People Strategy and then to allow time for Board members to provide comments and ask questions on the full information attached. Also contained within the presentation is an outline of the proposed revised approach to people planning.

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

The attached presentation sets out the core content of the proposed CWP People Strategy for 2019-2022. The strategy has been designed to align with the key priorities set out in the NHS Interim People Plan, the Cheshire and Merseyside Health Care Partnership people priorities and emerging people plans for Healthy Wirral, Cheshire West ICP and Cheshire East ICP. It has been substantially informed by the extended Board Seminar held on 24th April and by other meetings with senior clinicians and operational

leads. It has been submitted for comment to the Operational Committee and People and OD Sub Committee.

The proposed revised approach to people planning has been developed by People and OD Business Partners in collaboration with Care Group colleagues.

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

The main strategic aim and strategic priorities for the CWP People Strategy 2019-2022 were agreed at the extended Board Seminar held on the 24th April 2019:

Strategic Aim: to help our people be the best they can be

Strategic priorities: Contribution
Development
Wellbeing
Policies, processes and systems

The areas of focus and specific deliverables that arise from these priorities have been through a number of iterations to ensure that the content aligns with national, regional and local people priorities and meets the expectations of NHSI/NHSE and the CQC. Particular attention has been given to Year 1 deliverables and the extent to which they are necessary for completion this year and realistically achievable within existing capability (capacity and competence).

Once agreed, a Word document version will be produced (including a more detailed introductory narrative) and the year 1 deliverables will be translated into a delivery plan with milestones and owners, which will be monitored by the People and OD Sub Committee (PODSC).

Key indicators have been identified and are set out in the presentation. These will be incorporated into the revised Trust approach to reporting. Further work is required to confirm the business reporting cycle. It is intended that this can be completed once the delivery plan has been produced and the recommended review of PODSC (including consideration of it being made a sub-committee of the Board) is completed.

It is anticipated that an adaptive approach will be taken with the People Strategy, ensuring that it is continually reviewed at PODSC in the light of emerging needs and context. As should it should be considered "a living document".

In respect of people planning, the proposed approach will be used to create a more detailed, populated plan which will be presented to a future meeting of Trust Board.

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

The Board of Directors is recommended to:
1. note and comment on the content of the presentation of the CWP People Strategy for 2019-2022;
2. note and comment on the proposed revised people planning approach;
3. approve the proposed strategy and people planning approach, subject to the above.

Who has approved this report for receipt at the above meeting?	David Harris, Director of People and OD
Contributing authors:	

Distribution to other people/ groups/ meetings:

Version	Name/ group/ meeting	Date issued
Version 9	Operational Committee	17.7.19
Version 9	People and OD Sub Committee	18.7.19

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

Appendix No.	Appendix title
1	PowerPoint presentation of CWP People Strategy 2019-2022 and proposed revised people planning approach.

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Helping our people to be the best they can be

People Strategy 2019 - 2022

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Cheshire and Wirral Partnership
NHS Foundation Trust

Agenda

- Context and background
- People Strategy
- Governance
- People Planning

Helping people to be
the best they can be

Context and background

- National - NHS Long Term Plan published in January 2019
  NHS Interim People Plan published 3rd June 2019
  NHSI Letter to Chairs and CEOs – 23rd May 2019
  CQC domains
  NHSI Patient Experience Improvement Framework 2018

- System - Cheshire and Merseyside Health and Care Partnership
  Healthy Wirral, Cheshire West ICP, Cheshire East ICP

- CWP - CWP Forward View
  CWP Operational Plan 2019-2020
  Person-Centred Framework
  Aligning Capability model and approach
  Quality Improvement Strategy
  Equality, Diversity and Inclusion Reports
  Staff Survey 2018
  Board Seminar on 24th April 2019
  Various CELF and Senior Leadership events

NHS Interim People Plan

Briefing for board members

Introduction

The Interim People Plan for the NHS has been developed over the last few months and sets an agenda to tackle the range of workforce challenges in the NHS with a particular focus on the actions for this year.

Baroness Harding has described the interim plan as follows:

“This interim People Plan doesn’t answer all the questions we know need answering, nor does it set out a detailed 5 -10 year roadmap.

“It does, however, set out our vision for our people and the urgent actions we all need to take this year, both to make immediate improvements but also to build a plan for our people that is fully integrated with those for financial and operational delivery.”

Background

- Workforce supply is acknowledged as the biggest challenge facing the NHS but the plan is clear that the quality of staff experience must be improved or those extra people will not stay, or come at all.
- The NHS Interim People Plan has been developed with involvement from NHS Employers and a wide range of other stakeholders to set out an initial approach to tackling the range of workforce challenges.
- The substantive People Plan will be published following the Spending Review. Key financial commitments will be decided as part of the Spending Review.
- NHS organisations will be expected to undertake initial actions and further action following the publication of the final People Plan.

Key themes

- Making the NHS the best place to work
- Improving NHS leadership culture
- Addressing workforce shortages
- Delivering 21st century care
- Developing a new operating model for workforce.

Making the NHS the best place to work

- The plan acknowledges that people working in the NHS report ‘growing pressure, frustration…, and rising levels of bullying and harassment’.
- Black, Asian and Minority Ethnic (BAME) staff report the poorest workplace experiences.
- Sickness absence runs 2 percentage points higher than the rest of the economy.
- 1 in 11 staff leave the NHS permanently each year.

Making the NHS the best place to work

- NHS organisations will be asked to develop their approach to making their organisation the best place to work.

- They will also be asked to contribute ideas to the development of a new offer for staff setting out the support they can expect from the NHS as a modern employer.

- There will be a summer of conversation led by the new chief people officer to develop this offer to staff.

Making the NHS the best place to work

This offer would cover:

- creating a healthy inclusive and compassionate culture (including ensuring equality, diversity and inclusion; tackling bullying and reducing violence)
- enabling great development and fulfilling careers (including CPD and ensuring recognition of qualifications between employers)
- ensuring everyone feels they have a voice, control and influence (including freedom to speak up, health and wellbeing and flexible working).

A balanced scorecard will be developed to assess organisations in these areas via the NHS Oversight Framework and the CQC Inspection Framework (Well Led Assessment).

Pensions

- As part of the theme of making NHS the best place to work, there is an acknowledgement of the impact of the current pension taxation policy on staff retention, particularly in relation to senior clinicians.

- Accordingly, the government is bringing forward a consultation on a proposal for new pension flexibility for senior clinicians.

- The proposal would give senior clinicians the option to halve the rate at which their NHS pension grows, in exchange for halving their contributions to the scheme.

- This consultation is expected to take place over the summer, and it may lead to changes from April 2020.

Improving leadership and culture

The plan says NHS leaders should have:

- 'a compassionate inclusive culture' including senior leaders, clinical and non-clinical roles and the 'vital middle manager layer.'
- It should have a greater focus on collaborative talent management and a range of measures for greater board assurance.

NHS England/Improvement will work to develop an agreed set of competencies for senior leadership roles and will engage widely on options for assuring leadership (which will enable a response to the Kerr and Kark reviews).

They will agree a new compact setting out the 'gives and gets' to shape the development of senior leaders.

Leadership priority areas

- System leadership
- Quality improvement
- Talent management
- Equality, diversity and inclusion

These leadership challenges apply just as much to the national NHS arms-length bodies, which have an equally important role to play in fostering a new leadership culture.

Addressing workforce shortages

The plan includes measures to improve workforce supply and retention across the NHS clinical workforce. There will be a focus on nursing in terms of immediate actions which include:

- NHS England/Improvement expanding its retention support programme with a focus on the most challenged areas
- increasing clinical placements by 25% to 5,000 by September 2019
- developing a new return to practice scheme in conjunction with Mumsnet
- better coordination of international recruitment with a national procurement framework for lead agencies.

Addressing workforce shortages

The final People Plan, which is scheduled for release later this year, will cover:

- entry routes into the profession building on the nurse apprenticeship and nurse associate routes

- the development of a 'blended learning nursing degree' programme working with higher education providers

- greater focus on primary and community nursing.

Subject to resources being allocated within the spending review, the aim would be to achieve a phased restoration of previous CPD funding levels over five years.

Delivering 21st century care

In order to deliver the vision of care set out in the NHS Long Term Plan, the report calls for a reshaping of the NHS workforce. It specifically calls for:

- a transformed workforce with a more varied and richer skill mix, new types of roles and different ways of working

- the scaling up of new roles via multi-professional credentialing and more effective use of the apprenticeship levy.

There will be further detailed planning work across all major NHS workforce care groups and discussion with the service over future needs before the final plan.

Delivering 21st century care

On nursing, the plan calls for further expansion of the nursing associate role to reach 7,500 nursing associates by the end of 2019.

On medical workforce, it pledges an expansion of doctors in primary care by 5,000, further roll out of medical credentialing and support for shortage areas and for the development of more generalist roles.

There will also be action to expand AHP, scientific and other roles as well further develop multi-professional team working starting in primary care networks.

A new programme entitled *Releasing Time to Care,* which has a focus on using technology to support better deployment of staff time and increase productivity, will be launched.

A new operating model for workforce

The interim plan accepts that the workforce planning model in the NHS needs to change.

It argues that functions should be undertaken at the best level to meet the needs of the services. It commits to devolution of responsibility to the Integrated Care Systems (ICSs) as over time they will 'take on greater responsibility for people planning and transformation activities, in line with their developing maturity.'

A newly developed ICS workforce ‘maturity framework’ will be used to assess the readiness of ICS to take on responsibilities including workforce planning.

Developing the final People Plan

This interim plan will be followed by work over the summer with a range of stakeholders to help develop a fully-costed final plan.

The aim is to publish a full, five-year plan later this year, following the Spending Review and the development of five-year STP/ICS plans.

The final plan will include:

- measures to embed culture change and develop leadership capability
- more detail on changes to professional education and on investment in CPD
- more detail on additional staff needed.

Developing the final People Plan

- The final plan will be developed via National People Board (to be chaired by the CPO, Prerana Issar) and an advisory board (to be chaired by Baroness Harding).

- The way of working will reflect that established in the last phase with working groups chaired by senior leaders including chief executives drawn from the service (Navina Evans, Rob Webster, Julian Hartley).

- The plan will seek investment from the CSR, but is clear that there must be a focus on the things that are in the control of the NHS.

NHS Interim People Plan – responsibilities for local organisations

- An employee's primary experience of work will be set by their line manager, the culture of the department and the organisation, and the organisation's policies and procedures. To be successful, all organisations need a clear purpose and vision, and their people need to be able to work to a set of clear values, be engaged in the success of the organisation, and have the tools and knowledge to be able to improve the work they do.

- To plan our workforce effectively we need a single, timelier workforce dataset available at national, regional, ICS and organisational level and capable of being interrogated and analysed through these different lenses. We must also take steps to address the gaps in our workforce data, beginning with primary care. This will remain a focus for 2019/20 and beyond.

NHS Interim People Plan – responsibilities for local organisations

The following activities will remain important for all NHS organisations:

- Developing and sustaining a clear vision for the organisation aligned to the overall ambition of the ICS
- Developing and embedding local values, derived from the NHS Constitution
- Building an inclusive, compassionate and improvement-focused culture where all people are able to do their best work
- Recruiting and retaining their people
- Taking accountability for the wellbeing of their people and advancing equality of opportunity
- Developing and implementing organisational people plans and contributing to ICS people plans.

Cheshire and Merseyside Health and Care Partnership People Priorities

6 priorities:

- Sustainable supply of staff
- Up-skilling and re-skilling staff to work in an integrated system with different competencies / new roles
- Promoting staff health and wellbeing
- New ways of working and digitalisation
- Multiple models of employment and engagement
- Leadership and talent management

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Healthy Wirral, Cheshire West, Cheshire East ICPs People Priorities

- Relationships and behaviours
- Care Community / Neighbourhoods development
- Leadership and Management Development
- Recruitment and Retention
- Career Progression within system / talent management and succession planning
- New roles (including apprenticeships)
- Wellbeing
- Shared resources and expertise (links to Lord Carter work)

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Staff Survey 2018

Findings of Board presented to 27th March 2019 and the following priorities were agreed:

- Further build upon work to Improve senior manager visibility and engaging staff in decision making and shaping service plans
- Teams to receive feedback to inform decision making
- Improving team effectiveness through implementation of QI Strategy
- Improving access to resources and materials to support staff in undertaking their work
- Raise awareness of the importance for reporting concerns / incidents and ensure all staff are aware of the process
- Improve quality of supervision and appraisal process
- Create more opportunities for flexible working
- Undertake a deep-dive to build upon the data identified within 2018 staff survey and make recommendations to address gap between White Staff and BAME staff experience

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24th April Board Seminar

- Board and senior leaders from Care Groups reviewed the People agenda, specifically the successes, challenges and opportunities

- Four strategic People Priorities were agreed:
    - Contribution
    - Development
    - Wellbeing
    - Policies, Processes and Systems

- Initiatives and actions were identified for each of these priorities, including desired outcomes and assurance requirements.

- There were some gaps on the cards but the conversation was great!

- The suggestions have been incorporated into the draft People Strategy

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Extended Execs/CELF Events

- The outputs from a number of different sessions involving Executive Directors and people from senior clinical and operational roles were brought together at an event on Friday 19th July 2019.
- The day focused on many of the issues discussed at the Board Seminar on 26th June 2019 with an emphasis on:
    - common purpose
    - values, beliefs and behaviours
    - the role of a CWP leader and CWP manager
    - the need for confident conversations throughout the organisation
    - responsibility and accountability

- These themes are reflected in the People Strategy and will form part of the introductory narrative for the Word document version.
- A further session is planned for September.

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Aligning the People Strategy

Trust Vision

- To lead in partnership to improve health and wellbeing by providing high quality care

Trust Strategic Objective

- Be a model employer and have a caring, competent and motivated workforce

People Strategy

- To help our people be the best they can be

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Strategic Aim	Strategic Priority	Areas of Focus
To help our people be the best they can be	Contribution	
	Development	
	Wellbeing	
	Policies, Processes & Systems	

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Strategic Priority	Areas of Focus
Contribution - To ensure we each have the capability (capacity, confidence and competence) to make our own unique contribution.	People Planning
	Attraction, Recruitment and Selection
	Resourcing Approach
	Confident Conversations
	Talent Management
	Volunteering

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People Planning - Develop and improve the way we deploy our people through more effective planning.		
Year 1 • Q3 - Implement new, iterative and adaptive approach to People Planning • Q3 - Strengthen role of PPG and implement quarterly-cycle of planning updates • Q4 - Build on current joint commissioning of apprenticeship programmes with providers in order to develop new and existing roles	**Year 2** • Implement competency-based People Planning; better connect People Planning, Service Planning and Financial Planning • Maximise use of the levy in 2020-2021 • Work with partners to develop system/place-based roles and apprenticeships	**Year 3** • Embed Competency based people planning • Maximise use of the levy 2021- 2022

Attraction, Recruitment and Selection - Develop and improve the way we widen participation for the future workforce recognising that everyone has a unique contribution.		
Year 1 • Q1-4 Roll out of Values Based Recruitment • Q1-4 Promote and develop Facebook recruitment page • Q2-Q4 Develop approach and recruit to Medical MSc programme for Junior Drs working with Medical Staffing leads • Q3 Introduce New Starter survey monkey	**Year 2** • Embed Values Based Recruitment in relevant Education CWP courses for managers and provide additional courses throughout the year • Review new starter arrangements and tie in with feedback from Equality, Diversity and Inclusion (ED&I) networks	**Year 3** • Review Values Based Recruitment in relevant Education CWP courses for managers and provide additional courses throughout the year

Attraction, Recruitment and Selection – Continued…		
Year 1 • Q3-4 re-focus on WRES, WDES and Gender Pay Gap Report activities to improve attraction, recruitment and selection • Q2-4 Enhance options for flexible working by introducing revised policies and processes	**Year 2**	**Year 3**

Resourcing Approach - Continually review our arrangements to ensure they proactively enable clinical care and are efficient, cost effective and ensure Trust compliance with regulators.		
Year 1 • Q1-4 Implement "recruitment in advance of need" for clinical roles including students • Q2-4 Continue involvement in collaborative bank and agency work • Q4 Extend use of internal bank staff system to all staff groups	**Year 2** • Continue to work with partners on system attraction activities • Work with partners to develop further collaborative bank • Work with partners regarding regional approach to agency charge rates and compliance	**Year 3** • Work with partners to develop system/place-based recruitment

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Confident Conversations - Create a culture of confident conversations that enables our people to be have their voice heard and involves them in contributing to improving CWP's plans and services		
Year 1 • Q1 Launch senior leader shadowing programme • Q2-3 Launch 'Staff App.' • Q2-4 Introduce revised policy, process and forms for supervision and appraisal with a focus on strengths and quality of conversation • Q4 Align appraisal to pay progression by utilising the appraisal module within ESR as part of manager self-service rollout • Q3-Q4 Run 2019 Staff Survey	**Year 2** • Implement and evaluate electronic solution to monitor the quality of conversations in staff appraisals • Embed 2019 Staff Survey action planning across the organisation	**Year 3**

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Confident Conversations – Continued…

Year 1	Year 2	Year 3
• Q3-4 Embed the use of mediators within the organisation • Q3 – Q4 Embed and review exit surveys • Q2-4 Implement and embed a CWP change approach that sets out standards for implementing workplace change • Q4 Relaunch Coaching and Mentoring Programme • Q4 Strengthen ‘key message cascade’ offer to aid managers with team communications (including temporary staff)	Review the impact of mediators	

Talent Management - Harness the talent of our people (including volunteers) by providing opportunities to experience new challenges and contribute to improving CWP's plans and services		
Year 1 • Q4 Produce Talent Management Strategy aligned to regional Talent for Care plans	**Year 2** • Launch Talent Management Strategy Launch and evaluate cycle one of Harnessing Talent programme	**Year 3** • Review and embed Harnessing Talent programme

Volunteering - Offer CWP staff the ability to get involved in volunteering opportunities, taking time as "volunteering days" each year		
Year 1 • Q2-4 Develop staff volunteering programme, learning from successful implementation in other Trusts	**Year 2** • Evaluate and embed staff volunteering programme	**Year 3**

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Strategic Priority	Areas of Focus
Development - To ensure we each develop the competence (knowledge , skills, behaviours) we need to deliver outstanding, person-centred care	Leaders and Managers
	QI Capability
	Education
	OD Capability

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Leaders and Managers - Develop confident and competent leaders and managers at all levels in the organisation.		
Year 1 • Q2 Produce description and profile of a CWP manager and CWP leader • Q4 Review management and leadership development programme • Q4 Develop managers to be able to support volunteers and people with lived experience to join the NHS • Q2-4 Deliver Board development programme	**Year 2** • Embed refreshed management and leadership development programme • Align talent management and management development programmes to support succession planning • Review and embed Board development programme	**Year 3** • Review and refresh management development programme • Review and refresh Board development programme

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QI Capability – Develop capability in QI across and enable our people to make quality improvement a fundamental aspect of their role.		
Year 1 • Q2 Design and deliver QI curriculum • Q3-4 Embed QI into appraisal and supervision process • Q4 Further develop Virtual Academy for hosting QI information	**Year 2** • Review and deliver QI curriculum • Implement a programme of QI development for those selected to participate in Harnessing Talent programme	**Year 3** • Review and deliver QI curriculum

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Education – Develop our people to be the best they can be through person-centred interventions.		
Year 1 • Q3 Define pathways for employability programmes e.g. Pre-employment and Traineeships routes into CWP (funding dependant) • Q4 Ensure the HEE requirements for our students (Nurses/AHP/Medics etc.) are reviewed and action plans completed • Q4 Update Simulation Based Education programmes	**Year 2** • Deliver new programmes for: Trauma Informed Care Sexual Safety New clinical systems Simulation Based Education • Refresh person centred mandatory training using QI methodology • Build on current joint commissioning of apprenticeship programmes with providers in order to develop new and existing roles • Continue to develop CWP Virtual Academy	**Year 3** • Refresh person-centred mandatory training using QI methodology

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Education – Continued…		
Year 1 • Q4 Develop bespoke programmes for specific staff to address clinical needs • Q4 Deliver the outputs of the agreed Mandatory Training review i.e. One Stop Workshops across the Trust • Q4 Launch CWP Virtual Academy as the learning platform for all staff and to host the updated mandatory training	**Year 2** • Ensure we maximise the levy for 2020-2021 • Work with partners to develop system/place-based roles and apprenticeships	**Year 3** • Ensure we maximise the levy for 2021-2022

OD Capability – Develop organisational development capability across CWP and local systems to enable effective transformation.		
Year 1 • Q1-4 Provide OD, Education and Wellbeing support to enable transformation of East Cheshire SMH services • Q1-4 Provide OD interventions to support development of integrated care teams in West Cheshire • Q2-4 Provide OD support to IT- enabled Transformation programme	**Year 2** • Build OD capability into management/ leadership development programme • Continue to provide OD support to IT-enabled Transformation programme • Provide OD support to community mental health services	**Year 3**

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Strategic Priority	Areas of Focus
Wellbeing - To create a workplace which helps each of us to enjoy positive physical and mental well-being and so be the best we can be.	Wellbeing Strategy Wellbeing Services Recognition and Reward

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Workforce Wellbeing Strategy – Develop and deliver an innovative, person centred, evidence based strategy that empowers people to improve their health and wellbeing.		
Year 1 • Q1-3 Develop new models of working within Psychological Wellbeing Pathway • Q2-4 Produce and launch 'Thriving at Work' Action Plan	**Year 2** • Review all Wellbeing pathways using QI approach • Review 'Thriving at Work' Action Plan'	**Year 3**

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Workforce Wellbeing Strategy – Continued…

Year 1	Year 2	Year 3
• Q2-4 Implement and embed a Wellbeing Coaching approach including building a network of lived experience staff • Q2-4 Continue to roll out Later Life Transitions Programme including legacy work within other NHS Trusts and a co-produced Recovery College version for people who access our services	• Continue building and review Lived Experience Network • Review and evaluate legacy programme	

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Workforce Wellbeing Strategy – Continued…

Year 1	Year 2	Year 3
• Q3 Produce options for the use of an Employee Assistance Programme (EAP) • Q3-4 Scope out a programme of Mental Health First Aid for staff • Q3-4 Deliver 2019/20 Flu Campaign • Q4 Produce a plan to address the recommendations in the Health Education England NHS Staff and Learners Mental Wellbeing Commission report	• Make decision re: EAP • Identify funding and implement training for Mental Health First Aid • Evaluate previous year's Flu campaign	

Workforce Wellbeing Service - Continue to build an innovative, adaptive, responsive Workforce Wellbeing Service.		
Year 1 • Q2-3 Carry out full cost benefits analysis of external contracts • Q2-4 Review current service model • Q2 - 4 Review software solutions including text technology • Q3-4 Conduct a deep dive into DNA rates	**Year 2**	**Year 3**

Recognition and Reward - Develop multiple ways to recognise and celebrate the dedication and achievements of our people.		
Year 1 • Q1 Deliver the annual Recognition Awards • Q2 Evaluate the 3rd annual Recognition Awards and make recommendations for 2020 awards • Q2 Evaluate the rollout of recognition cards and provide recommendations on further rollout	**Year 2** • Deliver Annual Recognition Awards • Produce and implement CWP Recognition strategy	**Year 3** • Deliver Annual Recognition Awards • Review CWP Recognition strategy

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Strategic Priority	Areas of Focus
Policies, Processes and Systems - To provide policies, processes and systems that help (not hinder) each of us to deliver outstanding, person-centred care.	HR policies and processes People Information People Systems

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HR Policies and Processes - Review HR policies and procedures with a person-centred, values-based lens with a focus on resolution.		
Year 1 • Q2-4 Review the Trust's dignity at work and grievance procedures with a QI approach to develop a single resolution procedure which focuses on the constructive resolution of workforce disputes • Q2-4 Review the Trust's disciplinary policy and procedures to ensure they focus on resolution and comply with NHSI recommendations 'learning lessons to improve our people practices'.	**Year 2** • Revise the Job Descriptions Library • Embed and review the revised approach to conflict resolution	**Year 3**

HR Policies and Processes - Review HR policies and procedures with a person-centred, values-based lens with a focus on resolution.		
Year 1 • Q2-3 Develop and provide regular reports to Board regarding investigations and disciplinary procedures to provide assurance that our people's wellbeing is being appropriately addressed. • Q2-3 Revise the Trust's Pay Progression Policy, ensuring that it meets the requirements of the Agenda for Change Framework	**Year 2** • Revise management development programme to ensure it addresses competence needs required by shift to resolution-focused HR policies and processes	**Year 3**

People Information - Provide timely and accurate information about our people to ensure they are supported to be the best that they can be and to support service planning.		
Year 1 • Q3 Develop Medical Staffing Dashboard • Q3 Develop activity and performance reports for e-expenses • Q3-4 Develop BI reporting within Information and Reporting section of the team	**Year 2** • Explore the introduction of one page profiles for all staff specifically in relation to WDES.	**Year 3**

People Information – Continued…		
Year 1 • Q2-3 improve ER activity recording and reporting • Q2-4 Complete reconciliation of Financial and ESR pay costing information and build processes to ensure alignment is maintained • Q3 Procure payroll provision April 2020 onwards	**Year 2** • Explore options for setting up establishment Control in ESR	**Year 3**

People Information – Continued…

Year 1	Year 2	Year 3
• Q4 Review and consult re structure of PI team for Year 2 • Q4 Re-develop appraisal and supervision reporting aligned to new policy and capture methods • Q4 Develop activity and performance reports for ESR MSS	• Implement new team structure (if applicable) • Mobilise and embed new team structure	

People Systems – Develop the confidence and competence of our people with systems and tools to ensure they have access to information that they need when they need it.		
Year 1 • Q2-4 Embed e-expenses including further training • Q2 – Q4 Develop and deliver Staff Experience Report (including Stay and Exit Interviews) • Q1-3 Deploy ESR Manager Self Service to all CWP Budget Holders, • Q3-Q4 Roll out ESR Employee Self Service with full access	**Year 2** • Roll out of e-roster for all clinical and medical staff	**Year 3** • Roll out of e-roster for all staff

People Systems – Continued…

Year 1	Year 2	Year 3
• Q3 Roll out Employee On-line to bank staff (Temp Staffing and PI) • Q4 Review value for money of Attendance Line • Q4 Support continued training and embedding of MSS	• Deliver smartcard support to enable the e-Referral project	

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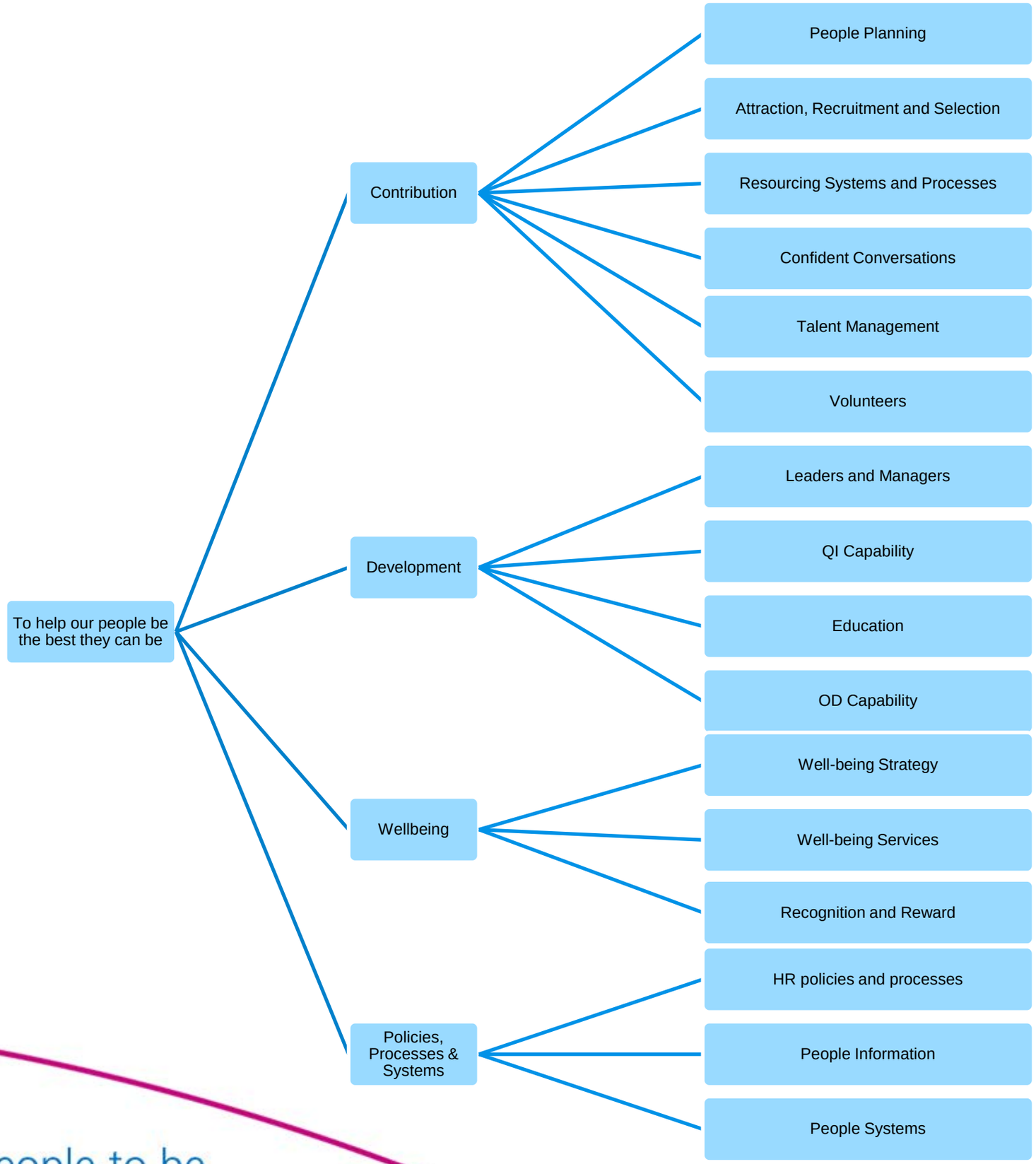

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Governance

- Key Indicators:
    - Vacancies
    - Turnover
    - Sick Absence
    - Appraisal and Supervision (quantity and quality)
    - Mandatory Training
    - WRES and WDES data
    - Gender Pay Gap
    - Staff Experience Report (including Staff Friends and Family)
    - Staff Survey
    - New Starter/Exit interviews

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Governance

- It is proposed that a review of People and OD Sub-Committee (PODSC) be carried out in relation to whether it should be a committee of the Board rather than report to Ops Committee.
- September meeting of PODSC will be focused on turning People Strategy into a delivery plan, revised risks and business cycle for reporting.
- The above will inform the reporting cycle for Board which could include:
  - Appraisals and Supervision (with focus on quality)
  - Wellbeing (not just absence)
  - Recruitment and Retention (including vacancy rates and fill rates)
  - Employee Relations (formal vs local resolution)
  - Streamlined, person centred policies, procedures and systems
  - Staff Survey
  - Friends and Family Test
  - Equality, Diversity and Inclusion (WRES, WDES and Gender Pay Gap)
  - Deep Dive topics (as appropriate)
  - National and regional benchmark data
  - Inspection results and action plans (audit, CQC, Ofsted etc.)

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CWP People Planning approach

- People planning should be adaptive and iterative; reactive and proactive
- People planning should be driven by need and informed by timely and accurate information
- Should focus on the overall capability (capacity and competence) required to deliver the model of care and pathways rather than just numbers of staff
- Should consider the mix of all roles available that could deliver the capability required (including new roles)
- Is still likely to be our “best informed guess”

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NHSI – what a good people plan should do:

- be constructed from robust plans focused at clinical service-line level
- take account of financial restraints, minimise or negate the need for expensive agency staff
- inform and be informed by an organisation's clinical strategy, business and efficiency plans
- encourage leaders, managers and staff to work collectively on the workforce planning process, which should be informed by comprehensive staff engagement
- set the standard for expected staffing levels – encouraging transparency and enabling staffing decisions to be based on evidence
- be formulated by multidisciplinary teams and consider the whole service
- promote a proactive rather than reactive approach to staffing because workforce planning is a continuous process and should be continually monitored and reviewed.

For CWP:

- Inform career/engagement, attraction, recruitment and Education strategies.
- Support returns to NHSI and bids for new initiatives. Allow us to influence regional initiatives.

Short-term, Medium-term, Long-term

Workforce planning

	Horizon 1: Short-term – operational	Horizon 2: Medium-term – tactical	Horizon 3: Long-term – strategic
	Less than one year	One year (upcoming budget year)	2–5 years
Typical questions	• How do we best deploy existing workforce and fill gaps caused by natural workforce evolution?	• What people are needed in the coming year to accomplish our strategy?	• What people are needed to accomplish long-term business strategies? • Where and when will these people be needed? • What skills/ qualifications/ competencies will they need?
Typical activities/ methodology	• Driven by headcount projections • Results in rota scheduling within day-to-day management	• Conducted within an annual budgeting process • Focus on training and professional development • Individual, small-scale recruitment and effective performance management	• Prioritising workforce planning within long-term business planning process

Strategic workforce planning is:

- Long-term-oriented
- Integrated with the organisation's strategic-planning processes
- Focused on the quality and size of workforce

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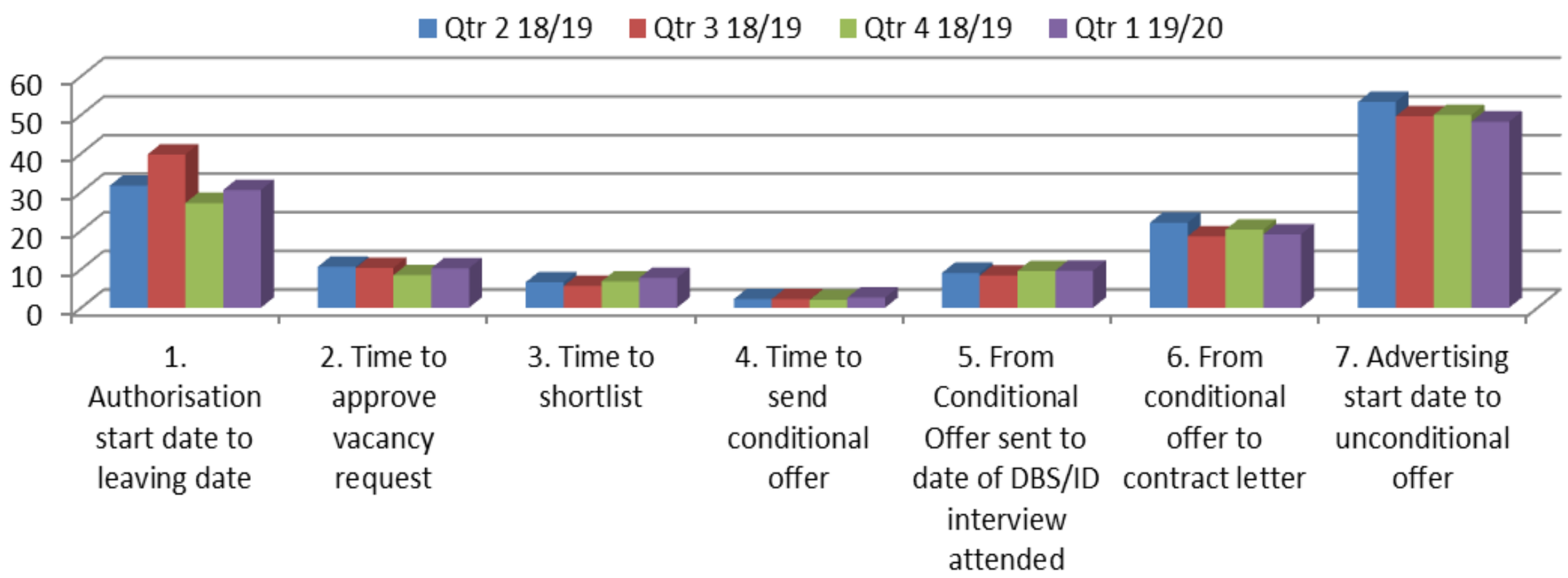
Time to Hire



Short term:

- Ensure that all stages of recruitment are followed as efficiently and effectively as possible
- Rolling recruitment at events for Springview and Bowmere to reduce time taken by each ward to recruit individually
- Recruiting in advance of need for Springview and Bowmere to reduce the time to hire once a vacancy arises (includes student recruitment)
- Roll out of values based recruitment selection techniques to support rolling recruitment in advance of need, retention and patient care
- Continue widening participation work

Short term continued:

Data

- Vacancy data is produced from the finance ledger and work is on-going to reconcile with recruitment activity and ESR data
- Roll out of manager self service to result in improved reporting due to real time system changes
- Improved reporting access from ESR for both People Information and also manager driven
- Working with Finance to manage recruiting in advance of need
- Improved reporting from Healthroster

NHSI compliance

- Any redesign or introduction of new roles will be considered a service change and must have a QIA and will be considered at PPG
- Board review of workforce metrics
- Have responded regarding benchmarking for e-roster and e-job planning in readiness for future developments
- Workshops held with clinical services and medics regarding medium and longer term planning

Medium and Long Term:

Approach

POD Business Partners working with Care Groups to develop plans by:

- Identifying the future shape and scope of change
- Identifying resources affected by the change (excluding workforce)
- Identifying the general staffing implications of the changes
- Forecast demand
- Action Plan

Data

- Staff group profile (headcount or FTE or both, and may be expressed in numbers or %)
- Length of service profile (complete for current staff and leavers)
- Leavers, Starters, and turnover rates for the last 12 months
- Starters analysis
- Leavers analysis – reason for leaving
- Leavers analysis – Destination on Leaving
- Vacancy and absence analysis

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Medium and Long Term Continued:

- Medium and long term planning to be collated at Care Group level and reported to PPG – financial challenge at both stages
- Quarterly collation of establishment and staff in post with planning figures – reconciliation with NHSI reporting from Finance
- Mandatory reporting to be drawn from quarterly reports as required with sign off from Heads of Operations and Associate Directors before Execs
- Quarterly reports to form basis of planning work with partner organisations
- Maintain contact with HEE and WRAPT in terms of projects and regional work

NHSI Compliance:

- Plans developed collectively with all our people and from robust plans at clinical service-line level taking account of financial restraints
- Proactive rather than reactive planning informed by clinical and business strategies and efficiency plans
- Continuous and iterative
- Widen scope of electronic rostering and e-job planning across CWP in line with NHSI guidance
- Ensure ESR data and finance ledgers are reconciled (or establishment control moves to ESR)

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Sustainability of Services

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

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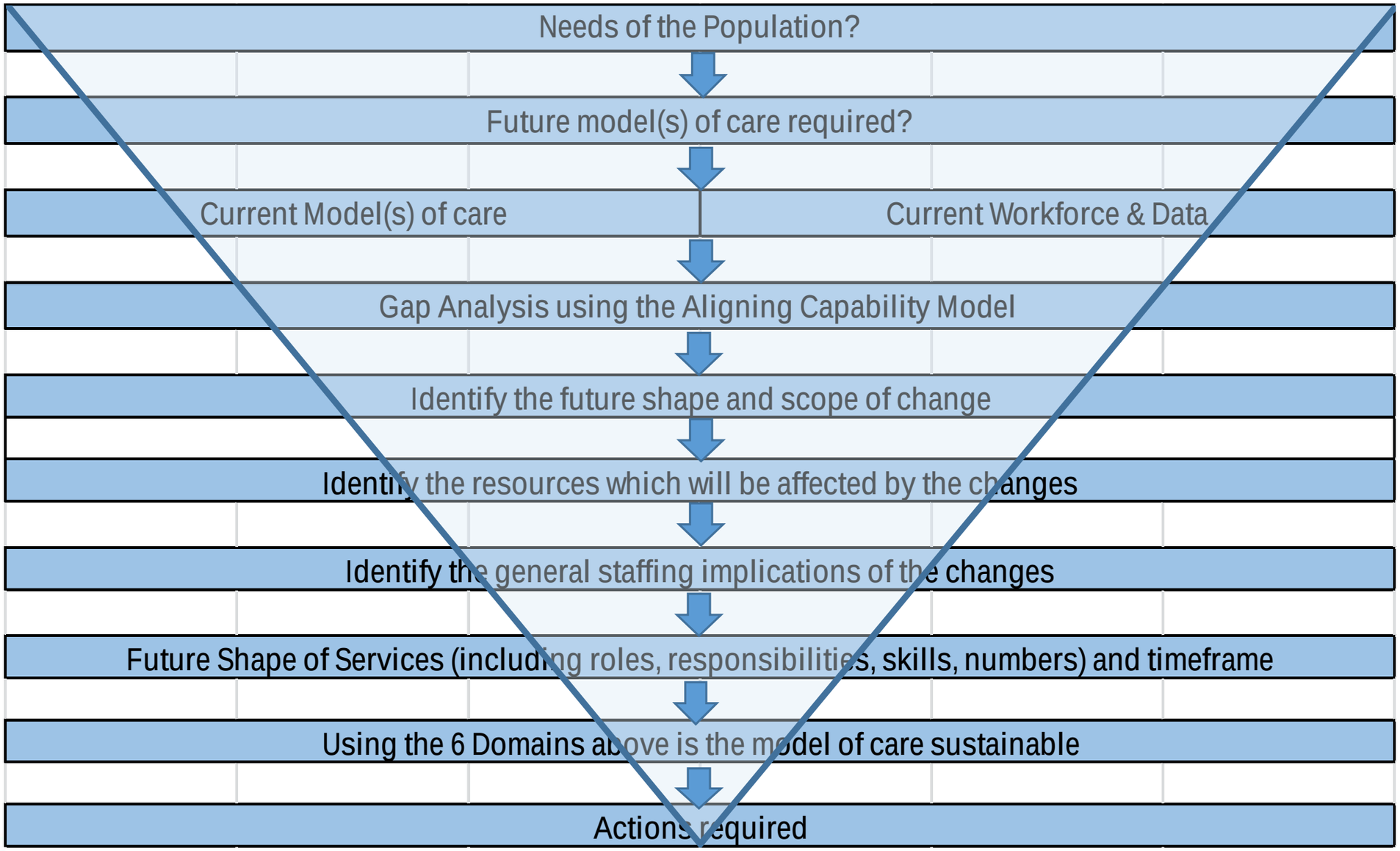
Sustainability of Services



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People Planning – Develop and improve the way we deploy our people through more effective planning

- Data reconciliation
- Planning cycle
- New roles and competency based planning
- E-job planning and E-roster
- People Planning Group
- Attraction, selection and recruitment

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STANDARDISED SBAR COMMUNICATION

REPORT DETAILS	
Report subject:	Learning lessons to improve our people practices
Agenda ref. number:	19/20/55b
Report to (meeting):	Board of Directors
Action required:	Information and noting
Date of meeting:	31/07/2019
Presented by:	David Harris, Director of People and OD

Which strategic objectives this report provides information about:	
Deliver high quality, integrated and innovative services that improve outcomes	Yes
Ensure meaningful involvement of service users, carers, staff and the wider community	Yes
Be a model employer and have a caring, competent and motivated workforce	Yes
Maintain and develop robust partnerships with existing and potential new stakeholders	No
Improve quality of information to improve service delivery, evaluation and planning	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	Yes

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	Yes

CWP Quality Framework:		
Patient Safety	Safe	Yes
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*

This report provides a summary of an initial high level assessment undertaken of our current investigation and disciplinary processes against a set of recommendations issued by NHS Improvement. A more detailed assessment and action plan will be developed to ensure that any areas for improvement are addressed.

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

In May 2019, NHS Improvement issued a letter to all NHS Trust and Foundation Trust Chairs and Chief Executives (see appendix 1) requesting that investigation and disciplinary processes be reviewed against a set of recommendations and that any improvements be identified. This follows an inquiry after the death of a member of staff in a London Trust who had been subject to disciplinary proceedings and whose treatment led to his committing suicide.

It is likely that in the future that consideration and assessment of the health of organisational culture, including aspects of the management of workplace issues, will be given more prominence in the 'well-led' assessment domain.

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

The initial, high-level assessment of the Trust's investigation and disciplinary processes is set out in appendix 2. This was undertaken by the Head of HR based on the HR Operations team's knowledge and understanding of current policy and processes. However, wider views will be sought with a more evidence based approach, which will then inform the subsequent action plan.

The assessment identifies both areas of good practice and areas for improvement:

Areas of good practice:

- A robust policy based on best practice
- Objectivity and independence maintained throughout
- Good decision making relating to the implementation of decision making of suspensions/exclusions

Areas for improvement :

- Ensuring people are fully trained, particularly in relating to panel members
- Assigning sufficient resources for those undertaking investigations and disciplinary hearings
- Maintaining regular, clear and compassionate communications with people involved in investigations
- Board level oversight – establishing regular reporting

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

The Board is asked to note the contents of this initial, high level assessment and the intention to carry out a more detailed assessment in order to deliver an improvement action plan, which will be overseen by the People and OD Sub-Committee.

Who has approved this report for receipt at the above meeting?	David Harris, Director of People and OD
Contributing authors:	Chris Sheldon, Head of HR

Distribution to other people/ groups/ meetings:

Version	Name/ group/ meeting	Date issued
1	People and OD Sub-Committee	18 July 2019

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

Appendix No.	Appendix title
1	Letter to NHS Foundation Trusts' learning lessons to improve our people practices'
2	Initial assessment of disciplinary policy and processes against NHSI recommendations

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STANDARDISED SBAR COMMUNICATION

REPORT DETAILS	
Report subject:	Quality improvement strategy – Progress with implementation
Agenda ref. number:	19.20.56
Report to (meeting):	Board of Directors (meeting in public)
Action required:	Discussion and Approval
Date of meeting:	31/07/2019
Presented by:	Katherine Evans, Head of Quality Assurance and Improvement

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

Which 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
n/a	

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

REPORT BRIEFING

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

The purpose of this report is to provide assurance to the Board of Directors of progress with the implementation of the Trust's quality improvement strategy, including forward planning for and progress with building sustainable quality improvement capability. The Quality Committee, as the designated committee of the Board for quality, endorsed the implementation plan for 2019/20 at its meeting on 3 July 2019.

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

Official launch of the quality improvement strategy was 1 April 2018, with a delivery plan setting out 2018/19 activity which was overseen by the quality improvement faculty. For 2019/20, co-ordinators of a building sustainable improvement group have agreed a delivery plan and identified key performance indicators to demonstrate return on investment. These will be complemented by outcomes achieved by staff undertaking quality improvement projects as part of an educational programme to build their quality improvement capability. A further monitoring meeting for the quality improvement faculty has been arranged for 2 August 2019, before further reporting to Quality Committee in September 2019.

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

Building sustainable quality improvement capability

A mindset shift is required in order to apply quality improvement effectively on a Trustwide scale. As quality improvement methodologies focus on improving efficiency and reducing burden, developing knowledge and skills in this area will reduce workforce pressures and identify areas of continuous improvement.

A competency framework setting out the operational detail of the five levels of quality improvement capability (approved by the Board when it approved the strategy in 2018/19) has been developed – levels 1, 2, 3, 4a and 4b. This will enable CWP to train the CWP workforce at pace and scale as per the so-called 'dosing model'. A second cohort has successfully completed the level 4a expert training, co-delivered by NTW and our newly trained quality improved experts from cohort one. CWP now benefits from a total of 30 trained quality improvement experts, who are already using their newly acquired skills to support a number of projects and demonstrating a return on investment – for example value stream mapping of complaints and incidents processes reducing burden on clinical and clinical support teams.

Dates for the level 3 (Band 8A and above) training have been set, the first three cohorts will be co-delivered by Dr Anushta Sivananthan (executive lead for quality) and identified CWP quality improvement experts. The level 3 course is mandatory for senior managers and is instrumental to the quality improvement strategic ambition of building sustainable quality improvement capability. The course will focus on teaching colleagues to 'know how and support others' and on integrating their learning back to their place of work. They will complete project work and will be able to report on outcomes that this achieves.

Alignment of organisation-wide programmes

The quality improvement strategy is a high level framework which sets out our ambition to deliver the best outcomes for the population we serve. To do this, we need to underpin this strategy by developing systematic, organisation-wide programmes (and wherever possible, whole health care system-wide programmes) to ensure that continuous improvement happens at scale and as part of our every-day way of working. The quality improvement strategy is therefore not standalone and is not the only way in which we will seek to improve quality. Each of our other supporting Trust strategies and frameworks also have a strong focus on quality improvement. A particular organisation-wide programme is the ambition to become a trauma informed organisation; this is currently being led by the Associate Director of Nursing & Therapies for Mental Health. The delivery plan for quality improvement will embed a positive behaviour support model, underpinned by our person-centred framework to support this ambition and also this will support of the aspiration set in our quality improvement strategy to achieve Outstanding for Well-led by the end of 2021.

Co-ordination of QI

The quality improvement hub is currently managed by the quality support team in Safe Services. Using existing resources, this is currently being developed into a quality improvement co-ordination function, supported by other clinical support service colleagues who will continue their input into the quality improvement infrastructure via the quality improvement faculty. A small, central co-ordination team will act as a single point of access for staff and will support the ongoing development of quality improvement capability and provide structured oversight of quality improvement activity, whilst continuing to guide the maintenance and development of the quality improvement hub and greater usage of 'Life QI'. Life QI is a web platform that supports and manages quality improvement work, making it easy for teams to run quality improvement projects and for organisations to report on quality improvement activity. The latter (in addition to ongoing promotion via the quality improvement extranet and twitter handle) will make it easier to report outcomes/ return on investment to the Board, such as those projects being led by/ supported by our quality improvement experts and the projects that will be undertaken by the Band 8A+ managers.

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

The Board is asked to make note and **endorse** the forward proposals for delivering the QI strategy.

Who has approved this report for receipt at the above meeting?	Board business cycle requirement
Contributing authors:	QI Faculty

Distribution to other people/ groups/ meetings:

Version	Name/ group/ meeting	Date issued
1	Board of Directors	24/07/2019

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

Appendix No.	Appendix title
n/a	n/a