Wirral Community Health and Care NHS Foundation Trust

Infection Prevention and Control Board Assurance Framework

Meeting	Board of Directors		
Date	02/12/2020	**Agenda item**	**13**
Lead Director	Paula Simpson, Chief Nurse		
Author(s)	Claire Wedge, Deputy Chief Nurse		

Action required (please tick the appropriate box)

To Approve ☑	**To Discuss** ☐	**To Assure** ☑

Purpose

The purpose of the Infection Prevention and Control Board Assurance Framework is to assure Trust Board that a further comprehensive self-assessment has been conducted to evidence compliance with IPC quality standards incorporating all guidance in response to the Covid-19 pandemic.

The framework has been developed by NHSE/I and is structured around the existing 10 criteria within the Code of Practice on the prevention and control of infection which links directly to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Executive Summary

Board of Directors received assurance following an initial self-assessment against the NHSE/I Infection Prevention and Control Board Assurance Framework in June 2020 at which time three areas of improvement were identified.

Since then actions have been progressed to mitigate all three outstanding areas. This report provides an update to Board of Directors and assurance that all quality standards are met.

Risks and opportunities:
All Covid-19 risks with an impact to quality and safety rated >10 are reviewed weekly by the tactical command group with risks rated >15 escalated to strategic command group.

Quality/inclusion considerations:
Quality Impact Assessment completed and attached No
Equality Impact Assessment completed and attached No
Individualised care delivery is provided by the Trust ensuring compliance with equality and diversity standards for staff and people who use Trust services

Financial/resource implications:
Delivery of high-quality services will support the Trust's financial position, reducing the potential for litigation and regulatory action

Trust Strategic Objectives
Please select the top three Trust Strategic Objectives that this report relates to, from the drop down boxes below.

Our Populations - outstanding, safe care every time	Our Populations – provide more person-centred care	Our Populations - improving services through integration and better coordination

Board of Directors is asked to consider the following action

Board of Directors are asked to be assured by the updated IPC Board Assurance Framework.

Report history		
Submitted to	**Date**	**Brief summary of outcome**
Board of Directors	10/06/2020	Assurance noted

Infection prevention and control board assurance framework

1. Systems are in place to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks posed by their environment and other service users		
Key lines of enquiry	**Evidence**	**Gaps in assurance and mitigating actions**
Systems and processes are in place to ensure: • infection risk is assessed at the front door and this is documented in patient notes • patients with possible or confirmed COVID-19 are not moved unless this is essential to their care or reduces the risk of transmission • compliance with the national guidance around discharge or transfer of COVID-19 positive patients • all staff (clinical and non-clinical) are trained in putting on and removing PPE; know what PPE they should wear for each setting and context; and have access to the PPE that protects them for the appropriate setting and context as per national guidance • national IPC guidance is regularly checked for updates and any changes are effectively communicated to staff in a timely way • changes to guidance are brought to the attention of boards and any risks and mitigating actions are highlighted • risks are reflected in risk registers and	The Trust has been responsive to the requirement to rapidly adapt service provision resulting from the Covid-19 pandemic, to assure the safety of staff, patients and service users. This has resulted in the implementation of consistent triage questions across all services to ensure only essential physical face to face contacts are conducted. Alternative methods of assessment have been developed expanding the Trusts' digital offer via remote consultations. The Trust is a visible leader across the Wirral system ensuring full compliance with all national guidance in relation to the discharge and transfer of Covid-19 positive patients. The Trust has successfully been awarded two contracts within Wirral to lead community swabbing at a local satellite testing centre in addition to testing within Care Homes and testing in the home environment for key workers who are unable to access the satellite centre. Training resources have been developed to ensure the correct process for donning and doffing are implemented throughout Trust services. This includes a range of action cards which provide clear, visual guidance for staff ensuring that the correct PPE is worn as per national guidance. Via the Trust's Covid-19 governance structure, new guidance is efficiently and effectively escalated for review at a daily Tactical command meeting. When required, actions are deferred to the Trusts' Clinical Command, Workforce or Operational groups. Robust, evidence-based processes have been developed to ensure	Full assurance evidenced

the board assurance framework where appropriate • robust IPC risk assessment processes and practices are in place for non COVID-19 infections and pathogens	systems are in place to effectively manage, mitigate and monitor the prevention and control of infection. This is effectively evidenced via the Trust's risk register as required. Risk assessments are pivotal to the Trusts' approach to assuring safety, evidencing decision making to mitigate risk where identified. This is underpinned by a clear escalation process in accordance with the Trust's Covid-19 Command and Control governance structure. This is a continuous process providing a source of internal assurance evidencing that quality standards are maintained. This has been further supported by the development of a bespoke Covid-19 module on the Trusts' Standards Assurance Framework for Excellence (SAFE) system, to evidence compliance with all required IPC standards.	
2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections		
Key lines of enquiry	**Evidence**	**Gaps in assurance and mitigating actions**
Systems and processes are in place to ensure: • designated teams with appropriate training are assigned to care for and treat patients in Covid-19 isolation or cohort areas • designated cleaning teams with appropriate training in required techniques and use of PPE, are assigned to Covid-19 isolation or cohort areas. • decontamination and terminal decontamination of isolation rooms or cohort areas is carried out in line with PHE and other national guidance • increased frequency at least twice daily, of cleaning in area that have higher environmental contamination rates as	Clinical systems and processes have been developed to assure safe working practices adopting the principles of staff cohorting where possible. As a result, where clinically appropriate, high risk vulnerable patients are seen at the beginning of a shift to minimise risk of Covid-19 transmission. Clinical visit allocation is utilised to assure continuity of care whilst minimising the numbers of visiting staff. Where clinically appropriate and safe, suspected and Covid-19 positive patients are visited at the end of a shift pattern. Designated isolation rooms have been identified across all Trust Walk-In Centres for suspected Covid-19 patients. Each area has a Covid-19 PPE Bag which includes the Pathway for managing suspected COVID-19 patients. Isolation rooms are decontaminated by Cheshire and Wirral Partnership	Full assurance evidenced

set out in the PHE and other national guidance • attention to the clearing of toilets/bathrooms, as Covid-19 has frequently been found to contaminate surfaces in these areas • Cleaning is carried out with neutral detergent, a chlorine-based disinfectant, in the form of a solution at a minimum strength of 1,000ppm available chlorine, as per national guidance. If an alternative disinfectant is used, the local infection prevention and control team (IPCT) should be consulted on this to ensure that this is effective against enveloped viruses • Manufacturers' guidance and recommended product 'contact time' must be followed for all cleaning/disinfectant solution/products • As per national guidance: o 'frequently touched' surfaces' eg door/toilet handles, patient call bells, over-bed tables and bed rails, should be decontaminated at least twice daily and when know to be contaminated with secretions, excretions or body fluids o Electronic equipment, eg. Mobile phones, desk phones, tablets, desktops and keyboards should be cleaned at least twice daily o Rooms/area where PPE is removed must be decontaminated, timed to coincide with periods	NHS Foundation Trust (CWP) with Cleaning Staff following local guidance. The Trust has received documented assurance from CWP confirming that their local systems and processes are fully compliant with PHE and other national guidance. Staff have access to the correct cleaning resources to assure safety and to evidence compliance with PHE and national guidance. This includes Clinell Wipes and Bio-Hazard wipes for the decontamination of equipment. The guidance relating to in-patient beds is not currently applicable to the Trust.	

immediately after PPE removal by groups of staff (at least twice daily) o linen from possible and confirmed Covid-19 patients is managed in line with PHE and other national guidance and the appropriate precautions are taken o Single use items are used where possible and according to Single Use Policy o Reusable equipment is appropriately decontaminated in line with local and PHE and other national guidance o Review and ensure good ventilation in admission and waiting areas to minimise opportunistic airborne transmission		
3. Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance		
Key lines of enquiry	**Evidence**	**Gaps in assurance and mitigating actions**
Systems and process are in place to ensure: • arrangements around antimicrobial stewardship are maintained • mandatory reporting requirements are adhered to and boards continue to maintain oversight	The Trust has developed Strategic Principles for Antimicrobial Stewardship, reporting on a Triannual basis to the sub-Board Quality and Safety Committee in accordance with the Trust's robust governance and assurance framework The aims of the strategy are to: • Reduce the need for exposure to antibiotics • Optimise the use of antibiotics • Raise public awareness to encourage self-care and reduce	Full assurance evidenced

	expectations of receiving antibiotics • Work in collaboration with other healthcare partners throughout Wirral	
4. Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/ medical care in a timely fashion		
Key lines of enquiry	**Evidence**	**Gaps in assurance and mitigating actions**
Systems and processes are in place to ensure: • implementation of national guidance on visiting patients in a care setting • areas in which suspected or confirmed Covid-19 patients are being treated are clearly marked with appropriate signage and where appropriate with restricted access • information and guidance on Covid-19 is available on all Trust websites with easy read versions • infection status is communicated to the receiving organisation or department when a possible or confirmed Covid-19 patient needs to be moved	The Trust does not have in-patient beds, however, all standards that are applicable to the Trust can be evidenced to ensure full compliance. Clear signage and literature regarding the Covid-19 pandemic has been developed and is clearly on display for members of the public visiting Trust sites. In addition, the Communications Team ensure that information and guidance regarding Covid-19 is available on the Trusts' website. This includes links to easy read materials from partner organisations, for example Mencap. The Trust has added a bespoke template onto SystmOne to ensure there is safe, secure transfer of internal information relating to infection status. This is communicated to system partners as clinically indicated to assure safety.	Full assurance evidenced
5. Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people		
Key lines of enquiry	**Evidence**	**Gaps in assurance and mitigating actions**
Systems and processes are in place to ensure: • front door areas have appropriate triaging arrangements in place to cohort	The Trust has established robust mechanisms to identify individuals most at risk of developing infections; this is a continuous process to monitor for deteriorating conditions which may increase level of vulnerability.	Full assurance evidenced

patients with possible or confirmed Covid-19 symptoms and to segregate them from non Covid-19 cases to minimise the risk of cross-infection, as per national guidance • mask usage is emphasised for suspected individuals • ideally segregation should be with separate spaces, but there is potential to use screens, eg to protect reception staff • for patients with new-onset symptoms, it is important to achieve isolation and instigation of contract tracing as soon as possible • patients with suspected COVID-19 are tested promptly • patients who test negative but display or go on to develop symptoms of Covid-19 are segregated and promptly re-tested • patients that attend for routine appointments who display symptoms of Covid-19 are managed appropriately	Systems and process have been developed across Trust Walk-in and Urgent Treatment Care Centres to effectively utilise triage to ensure risk of cross-infection is minimised in accordance with national guidance. Trust guidance clearly details that fluid resistant surgical face masks should be considered for all suspected or Covid-19 patients, subject to an assessment of clinical appropriateness. As the provider for the Community Swabbing Service, this Trust has a skilled workforce available to appropriately provide testing to patients as clinically indicated. The Trust has implemented contract tracing mechanisms to support the national test and trace process. In addition, the Trust has participated in a system-wide contact tracing review process, to ensure there is a clear, consistent approach across the local health and care system to rapidly initiate contact tracing as required.	

6. Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection		
Key lines of enquiry	**Evidence**	**Gaps in assurance and mitigating actions**
Systems and processes are in place to ensure: • all staff (clinical and non-clinical) have appropriate training, in line with latest PHE and other guidance, to ensure their personal safety and working environment is safe	The Trust has developed robust systems and processes to ensure compliance with health and safety legislation to assure safety in the work place. Assurance mechanisms include monitoring of mandatory training compliance including IPC Level 1 and Level 2 e-learning and Health and Safety Training.	Full assurance evidenced

• all staff providing patient care are trained in the selection and use of PPE appropriate for the clinical situation and on how to safely don and doff it • a record of staff training is maintained appropriate arrangements are in place that any reuse of PPE in line with the CAS alert is properly monitored and managed • any incidents relating to the re-use of PPE are monitored and appropriate action taken • adherence to PHE national guidance on the use of PPE is regularly audited • staff regularly undertake hand hygiene and observe standard infection control precautions • hand dryers in toilets are associated with greater risk of droplet spread than paper towels. Hands should be dried with soft, absorbent, disposable paper towels from a dispenser which is located close to the sink but beyond the risk of splash contamination, as per national guidance • guidance on hand hygiene, including drying, should be clearly displayed in all public toilet area as well as staff areas • staff understand the requirements for uniform laundering where this is not provided for on site • all staff understand the symptoms of Covid-19 and • take appropriate action in line with PHE and other national guidance, if they or a member of their household displays any of the symptoms	In addition, a Covid-19 clinical audit programme has been established as a rapid assurance mechanism to identify areas for improvement. Audit results are recorded on the Trusts' SAFE system and reviewed monthly at the SAFE steering group and action taken accordingly to mitigate any identified risk. The Covid-19 assurance framework includes CAS alerts which are also recorded centrally on the Trusts' SAFE system, supporting data triangulation. Guidance regarding appropriate use of PPE has been developed and is disseminated to all staff daily via the Trust's e-Covid-19 bulletin. This communication strategy provides a central focus for all staff for key messages and alerts relating to Covid-19. In addition, this is further enhanced via a weekly vlog from the Chief Executive or nominated Executive Director. Hand hygiene posters are displayed throughout public and staff Trust premises. The Trust provides paper towels throughout its premises thereby minimising the risk of droplet transmission. Clear, robust guidance and advice has been provided to all staff via the Covid-19 bulletin and through HR and IPC services in relation to the action required on the presentation of Covid-19 symptoms. The numbers of staff affected are closely monitored by the Workforce group, reporting to the Tactical and Strategic command groups weekly.	

7. Provide or secure adequate isolation facilities		
Key lines of enquiry	**Evidence**	**Gaps in assurance and mitigating actions**
Systems and processes are in place to ensure: • patients with possible or confirmed Covid-19 are isolated in appropriate facilities or designated areas where appropriate • areas used to cohort patients with possible or confirmed COVID-19 are compliant with the environmental requirements set out in the current PHE national guidance • patients with resistant/alert organisms are managed according to local IPC guidance, including ensuring appropriate patient placement	Systems and processes have been developed to ensure that the designated isolation rooms within Trust Walk-In and Urgent Treatment Care Centres are appropriately used for suspected Covid-19 patients. The Trust does not have in-patient beds and therefore the requirement to cohort patients on Trust premises is minimal, however, processes have been established to ensure full compliance with cohorting principles when required.	Full assurance evidenced
8. Secure adequate access to laboratory support as		
Key lines of enquiry	**Evidence**	**Gaps in assurance and mitigating actions**
Systems and processes are in place to ensure: • testing is undertaken by competent and trained individuals • patient and staff Covid-19 testing is undertaken promptly and in line with PHE and other national guidance • screening for other potential infections takes place	The Trust has identified a group of senior staff who have received training in Covid-19 sampling with competencies assessed by external specialists. All staff receive training in swabbing and are supported to achieve the correct technique and competency. A training pack is available to supplement the training, supporting continuous professional development. Robust systems are in place to access laboratories for processing samples.	Full assurance evidenced

9. Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections		
Key lines of enquiry	**Evidence**	**Gaps in assurance and mitigating actions**
Systems and processes are in place to ensure that: • staff are supported in adhering to all IPC policies, including those for other alert organisms • any changes to the PHE national guidance on PPE are quickly identified and effectively communicated to staff • all clinical waste related to confirmed or suspected Covid-19 cases is handled, stored and managed in accordance with current PHE national guidance • PPE stock is appropriately stored and accessible to staff who require it	The Trust has an extensive and robust IPC policy framework to ensure fully adherence to the IPC Code of Practice and Regulation 12 of the Health and Social Care Act 2008 (regulated Activities) Regulations 2014. An IPC clinical audit programme has been developed on the Trust's SAFE system to evidence compliance with the fundamental principles of IPC to prevent and control infections. Audit results are tracked monthly through the Trust's governance system. Changes to PHE national guidance or PPE are escalated in the first instance to the Trust's daily Tactical command group, prior to review at the Clinical command meeting. A predictive methodology has been established to forecast use of PPE; this is reviewed daily at the Tactical command group and weekly by the Strategic command group in accordance with the Trust's Covid-19 command and control structure.	Full assurance evidenced
10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection		
Key lines of enquiry	**Evidence**	**Gaps in assurance and mitigating actions**
Appropriate systems and processes are in place to ensure: • staff in 'at-risk' groups are identified and managed appropriately including ensuring their physical and psychological wellbeing is supported • staff required to wear FFP3 reusable respirators undergo training that is compliant with PHE national guidance	Through the Trust's Command and Control Covid-19 governance structure, appropriate systems and process have been developed to assure the safety of staff in relation to Occupational Health needs. This is primarily led by the Workforce group led by the Deputy Director of HR and OD and the Clinical group led by the Deputy Director of Nursing and Medial Director, reporting to the Tactical command group. A process has been developed to identify 'at-risk' groups, ensuring appropriate management of physical and psychosocial wellbeing. This includes compliance with national guidance in relation to Vitamin D for	Full assurance evidenced

and a record of this training is maintained • consistency in staff allocation is maintained, with reductions in the movement of staff between different areas and the cross-over of care pathways between planned and elective care pathways and urgent and emergency care pathways, as per national guidance • all staff adhere to national guidance on social distancing (2 metres) wherever possible, particularly if not wearing a facemask and in non-clinical areas • consideration is given to staggering staff breaks to limit the density of healthcare workers in specific areas • staff absence and well-being are monitored and staff who are self-isolating are supported and able to access testing • staff that test positive have adequate information and support to aid their recovery and return to work.	BAME staff. The established governance framework supports responsive action in relation to newly released guidance ensuring an appropriate rapid review and assessment of risk to ensure recommendations are made to the Tactical Command group.	

Wirral Community Health and Care NHS Foundation Trust

Mortality Report: Learning from Deaths Framework Quarter 2: 01 July 2020 - 30 September 2020

Meeting	Board of Directors		
Date	02/12/2020	**Agenda item**	**14**
Lead Director	Nick Cross, Medical Director		
Author(s)	Nick Cross, Medical Director		

Action required (please tick the appropriate box)

To Approve ☑	**To Discuss** ☐	**To Assure** ☑

Purpose

The purpose of this paper is to provide assurance to the members of the Quality and Safety Committee in relation to the implementation of the Learning from Deaths framework. It is also seeking approval for the statutory report to be presented to Public Board along with its subsequent publication on the Trust website.

Executive Summary

This quarterly report provides evidence that learning from deaths is firmly embedded as a priority across the Trust, ensuring full adherence to the NQB Learning from deaths framework. It provides anonymised details of the numbers of unexpected deaths which have occurred within the Trust throughout Q2 20/21, along with a summary of thematic learning identified during investigation into these cases. Attached as an appendix is a report detailing this information for purposes of publication of the Trust website.

Risks and opportunities:
Not applicable

Quality/inclusion considerations:
Quality Impact Assessment completed and attached No
Equality Impact Assessment completed and attached No
A QIA and EIA is not applicable in this particular case

Financial/resource implications:
Not applicable

Trust Strategic Objectives
Please select the top three Trust Strategic Objectives that this report relates to, from the drop down boxes below.

Our Populations - outstanding, safe care every time	Our Populations – provide more person-centred care	Our Populations - improving services through integration and better coordination

Board action

The Board of Directors is asked to be assured that 1: processes are in place to meet our statutory obligations surrounding Learning From Deaths 2: that processes are in place to engagement with families and meet our Duty of Candour obligations and 3: to approve the report in Appendix 1 which can be subsequently published on the Trusts website

Report history

Submitted to	Date	Brief summary of outcome
Quality and Safety Committee	25/11/2020	Provided assurance

Wirral Community Health and Care NHS Foundation Trust

Mortality Report: Learning from Deaths
Quarter 2: 01 July 2020 - 30 September 2020

Purpose

1. The purpose of this paper is to provide assurance to the members of the Board of Directors in relation to the implementation of the Learning from Deaths framework.

Executive Summary

2. Wirral Community Health and Care NHS Foundation Trust (WCHC) Board recognises that effective implementation of the Learning from deaths framework (National Quality Board, March 2017), is an integral component of the Trusts' learning culture, driving continuous quality improvement to support the delivery of high-quality sustainable services to patients and service users.

3. In December 2016, the Care Quality Commission (CQC) published its report: Learning, candour and accountability: A review of the way NHS trusts review and investigate the deaths of patients in England. The recommendations of this report were accepted by the Secretary of State and incorporated into a Learning from Deaths framework by the National Quality Board (NQB) in March 2017.

4. The Learning from Deaths framework aims to address the key findings of the CQC report, ensuring a consistent approach to learning from deaths across the NHS, assuring a transparent culture of learning by delivering a commitment to continuous quality improvement, particularly in relation to the care of vulnerable people.

5. The key findings of the CQC report were as follows:

   - Families and carers are not treated consistently well when someone they care about dies.
   - There is variation and inconsistency in the way that trusts become aware of deaths in their care.
   - Trusts are inconsistent in the approach they use to determine when to investigate deaths.
   - The quality of investigations into deaths is variable and generally poor.
   - There are no consistent frameworks that require boards to keep deaths in their care under review and share learning from these.

6. This quarterly report provides evidence that learning from deaths is firmly embedded as a priority across the Trust, ensuring full adherence to the NQB Learning from deaths framework.

7. WCHC compliance with the NQB framework has been self-assessed by an internal review of the Board Leadership requirements as outlined in the National Guidance on Learning from Deaths (NQB, March 2017). The RAG rating for this process has been included in the inaugural Learning from Deaths report.

WCHC Learning from deaths governance framework

8. All reported deaths are discussed at the weekly Clinical Risk Management Group (CRMG). Further investigations are commissioned on the basis of the events surrounding the death and on the results of the Mortality Screening Tool. The principles around Duty of Candour are also overseen within this group.

9. Pending investigations are monitored against progress and timelines and expediated where necessary. Any reports (ie Root Cause Analysis - RCA) and associated action plans are quality assured at CRMG. This includes cases which are under investigation by the coroner.

10. Lessons learnt and learning themes from Learning from Deaths cases are reviewed at the Trust's quarterly Mortality Review Group which is chaired by the Executive Medical Director who is responsible for the Learning from Deaths agenda.

11. Minutes from the Mortality Review Group are submitted to the Standards Assurance Framework for Excellence (SAFE) Steering Group, which in turn reports directly to the Quality and Safety Committee and finally to the Board.

12. A report is produced which summarises the details of the deaths which have occurred within the preceding quarter, along with details of any thematic learning. This is ratified by the Quality and Safety Committee prior to being presented to Public Board, again on a quarterly basis.

13. In accordance with the Learning from Deaths framework, the Trust ratified and published a Learning from Deaths Policy during September 2017.

14. The policy provides a framework for how the Trust will evaluate those deaths that from part of our mortality review process, the criteria for review and quarterly and annual reporting mechanisms.

15. The Trust's Datix incident reporting system has been aligned to the Learning from Deaths Policy to ensure prompt communication to the Executive Medical Director, Director and Deputy Director of Nursing for all reported unexpected deaths. This includes integrating the Mortality Screening Tool with Datix.

16. The Incident Management Policy - GP08 has been updated during January 2018 and cross references the newly implemented Learning from Deaths Policy, ensuring a consistent approach to implementation. The revised policy contains arrangements for staff to follow in the event of an unexpected death of an adult and in the event of an unexpected death of a child.

17. The Trust continues to work with our system partners to devise systems whereby Learning from Deaths can take place in a consistent way across all major health and social care providers.

18. The Learning from Deaths report is based on the template devised by the National Quality Board. This report will be published on the Trust's website in keeping with our statutory obligations.

Bereaved Families

19. Families will be treated as equal partners following a bereavement and will always receive a clear, honest, compassionate and sensitive response in a supportive environment and receive a high standard of bereavement care which respects confidentiality, values, culture and beliefs, including being offered appropriate support.

20. Families are informed of their right to raise concerns about the quality of care provided to their loved one and their views help to inform decisions about whether a review or investigation is needed.

21. Families will receive timely, responsive contact and support in all aspects of an investigation process, in line with duty of candour and with a single point of contact and liaison.

22. Families are partners in an investigation to the extent, and at whichever stages, that they wish to be involved and voice their experiences of the death of their loved one, as they offer a unique and equally valid source of information and evidence that can better inform investigations; bereaved families and carers who have experienced the investigation process help us to embed the learning to continually improve patient safety.

Q2 2020/21 WCHC Reported deaths (Datix incident reporting)

23. During Q2 there were a total of 17 reported deaths within scope.

24. During Q2 1 death met the criteria for StEIS reporting.

Recording data on Structured Judgement Reviews:		
Total Number of Deaths in scope	17	
July (7) W36729 – T2A, 72 hour review revealed external learning for care homes W36783 – STAR, suspected COVID, no learning for the Trust W36899 – 0-19 Cheshire East, Neonatal death, SuDIC policies followed, no learning for the trust W36896 – STAR, no learning for the Trust W36898 – T2A, Covid +, Rapid learning review revealed learning for the Trust W36916 – ICCT (Wallasey), no learning for the Trust W36929 – 0-19 Cheshire East – StEiS, SuDIC processes followed, no learning for the Trust August (5) W37130 – STAR – No learning for the Trust W37216 – ICCT (Wallasey) – 72 hour review revealed learning for the Trust W37239 – T2A – No learning for the Trust W37470 – T2A – Rapid learning review revealed learning for the Trust W37556 – STAR – no learning for the Trust September (5) W37566 – 0-19 Cheshire east, SuDIC process followed, no learning for the Trust W37645 – IMC (Birkenhead), no learning for the Trust W37894 – ICCT (Birkenhead), no learning for the Trust W37937 – 0-19, Not in receipt of care from the Trust, SuDIC processes followed, no learning W38004 – ICCT (Wallasey) – 72 hour review reveal some learning for Care homes There are no outstanding cases from previous quarters		
Total Number of Deaths considered to have more than 50% chance of being avoidable	0	
Recording data on LeDeR reviews: - Please note that these are undertaken by the mental health trust		
Total Number of Deaths in scope	0	
Total Deaths reviewed through LeDeR methodology	0	
Total Number of deaths considered to have been potentially avoidable	0	
Recording data on SUDIC reviews:		
Total Number of Child Deaths	4	
Total Deaths reviewed through SUDIC methodology	4	

Summary of Thematic Learning

25. Each unexpected death reported during Q2 has been analysed and investigated as appropriate, to identify any relevant learning points for the Trust and the wider health and social care system.

26. Of the 17 cases reported, after investigation, 5 identified lessons which the Trust and system partners could learn from.

27. Themes from the learning included:

External Learning for Care Providers

Understanding the difference between verification and certification of death by care homes

This was identified as an issue and raised within the Care Home Manager's Forum. If training is required, then the Trust will try to facilitate this if needed.

Communication of DNACPR information

It was identified that in some circumstances the DNACPR form has not been visible within care home notes and this has resulted in inappropriate resuscitation attempts. This external learning has been raised at the Care Home Manager's forum to highlight the importance of having correct systems and processes in place.

Internal Service Specific Trust Learning

Recognition of the deteriorating patient

An action plan is in place and being actively monitored specifically focusing on:

- NEWS2 and RESTORE2 risk stratification scoring system among both Trust and care home staff
- Sepsis training with T2A staff
- Improved data capture on SystmOne
- Escalation pathways in the event of a deterioration

Training need assessment

It was identified that there is a training need for some therapists working within T2A teams, which focusses on pain assessment and safeguarding training. As a result, there is an action plan in place to address these issues which is being actively monitored.

Recommendations

28. The Board of Directors is asked to be assured that quality governance systems are in place to ensure continuous monitoring and learning from deaths in accordance with Trust policy.

29. The Board of Directors is asked to be assured the Trust is actively involved in supporting the system-wide development of processes reporting and learning from deaths.

Dr Nick Cross
Executive Medical Director

19 November 2020

Appendix 1

Learning from Deaths Q2 20/21 Report

The following data represents the high-level reporting of deaths which occurred within our services over the period of Quarter 2 2020/21.

A more detailed report has been ratified and approved by the Quality and Safety Committee as per the Learning from Deaths Policy.

There were 17 deaths reported within scope during this period and all have been reviewed in accordance with Trust policy. Duty of Candour was met in all cases where this was appropriate.

None of the deaths were deemed attributable to the care received by our Trust.

Themes from the learning included:

External Learning for Care Providers

Understanding the difference between verification and certification of death by care homes

This was identified and raised within the Care Home Manager's Forum. If training is required, then the Trust will try to facilitate this if needed.

Communication of DNACPR information

It was identified that in some circumstances the DNACPR form has not been visible within care home notes.

The Trust is working closely with care providers to address both of these issues.

Internal Service Specific Trust Learning

Recognition of the deteriorating patient

The Trust is committed to ensure that staff training and awareness of this importance aspect of care is embedded within our services and teams along with access to appropriate escalation pathways in the event that they are required.

Training need assessment

As a Trust, we continually assess the training requirements of our workforce, to ensure they are armed with the best skills to support the people we serve. As a result of our learning, the Trust is expanding its training for some specific teams (for example, pain assessments).

There were 4 child deaths, all of which were appropriately reported, scrutinised and followed the SUDIC process. There was no learning for the Trust as a result of the investigative process.

We continue to promote shared learning across the health and care sectors.

Dr Nick Cross
Executive Medical Director, Wirral Community Health and Care NHS Foundation Trust

19 November 2020

Wirral Community Health and Care NHS Foundation Trust

Draft Quality Account 2019/20

Meeting	Board of Directors		
Date	02/12/2020	**Agenda item**	**15**
Lead Director	Paula Simpson, Chief Nurse		
Author(s)	Alison Nugent, Quality Improvement Practitioner Claire Wedge, Deputy Chief Nurse		

Action required (please tick the appropriate box)

To Approve ☑	**To Discuss** ☐	**To Assure** ☐

Purpose

The purpose of this report is to request approval for the Draft Quality Account 2019/20 prior to final publication on 15 December 2020.

Executive Summary

All providers of NHS services in England have a statutory duty to produce an audited annual report to the public about the quality of services they deliver.

Quality Accounts aim to increase public accountability and drive quality improvements within NHS organisations.

As a result of the Covid-19 pandemic, the requirement to have an independent audit of quality metrics has been relaxed nationally and the trust has therefore prepared a Quality Account 2019/20 for the year using the same high standards as in previous years.

The report provides a reflection on quality successes achieved during the reporting year and includes identify agreed quality priorities for the coming year – 2020 / 2021.

Risks and opportunities:
No risks identified

Quality/inclusion considerations:
Quality Impact Assessment completed and attached No
Equality Impact Assessment completed and attached No
No impact assessments have been undertaken.

Financial/resource implications:
No financial or resource implications identified

Trust Strategic Objectives
Please select the top three Trust Strategic Objectives that this report relates to, from the drop down boxes below.

Our Populations - outstanding, safe care every time	Our Populations – provide more person-centred care	Our Populations - improving services through integration and better coordination

Board of Directors is asked to consider the following action

Board of Directors is asked to approve the final draft of the Quality Account 2019/20 prior to publication on 15 December 2020

Report history		
Submitted to	**Date**	**Brief summary of outcome**
Quality and Safety Committee	27/11/2019	Report ratified with a few minor amendments

NHS

Wirral Community Health and Care

NHS Foundation Trust

Annual Quality Account | 2019/20

Table of Contents 2019 / 2020

Part 1: Introduction

Wirral Community Health and Care NHS Foundation Trust: At the heart of the community

Welcome to Wirral Community Health and Care NHS Foundation Trust Quality Account which covers the period April 2019 to March 2020. All providers of NHS services in England have a statutory duty to produce an audited annual report to the public about the quality of services they deliver. Quality Accounts aim to increase public accountability and drive quality improvements within NHS organisations.

As a result of the Covid-19 pandemic, the requirement to have an independent audit of quality metrics has been relaxed nationally and the trust has therefore prepared a Quality Account for the year using the same high standards as in previous years.

Wirral Community Health and Care NHS Foundation Trust provides high quality primary and community services including adult social care and public health services to the population of Wirral and parts of Cheshire.

Wirral Community Health and Care NHS Foundation Trust is one of a handful of places in England to have made significant progress towards truly integrated health and social care provision; of which we are very proud.

We are registered with the Care Quality Commission (CQC) without conditions, and play a key role in the local health and social care economy working in partnership to provide high quality, integrated care to the communities we serve.

Our expert teams provide a diverse range of community health and statutory social care services, seeing and treating people right through their lives both at home and close to home. We have an excellent clinical reputation employing over 1,500 members of staff, 90% of who are in patient-facing roles, working directly with individuals and their families. Our workforce represents over 70% of the costs of the organisation, and is the most important and valued resource we have.

In 2019 / 2020, our services collectively delivered close to 1 million face to face contacts in many settings: clinics, health centres, GP surgeries, schools and people's homes.

We serve a Wirral population of around 323,000 residents. It is very likely that most will come into contact with our services at some point either as a patient, carer, service user or relative of a patient or as one of our members or volunteers.
Not unlike most places in the country, the local health and social care economy is faced with the challenge of meeting rising demand, within finite resources. This is driving the growth in provision of community health services ensuring we play a vital part in enabling people to live healthier, more active and independent lives, reducing unnecessary hospital admissions

Quality Account

Statement on Quality from the Chief Executive and declaration

I am happy to introduce the Quality Account for Wirral Community Health and Care NHS Foundation Trust. The Quality Account gives us an opportunity to reflect on our many quality achievements and successes over the year and also enables us to identify areas where we want to focus attention on the agreed quality priorities for the coming year – 2020 / 2021.

As the main provider of community health and adult social care services across Wirral and the provider of 0-19 services across Cheshire East, we are committed to ensuring continuous quality improvements to the services we provide. Quality is at the heart of our agenda with our vision being to be the outstanding provider of high quality, integrated care to the communities we serve. Quality and efficiency are two sides of the same coin; high quality care means we get it right the first time; it means using the full talents of all professionals, and it means working with service users, patients and carers as partners in their own care.

The Trust has continued in its aim to provide safe, effective and person centred care to the people who use our services throughout the year. The high quality care our staff deliver, is driven by an organisational culture that embraces the Trust's values.

This report reflects our commitment to providing the best possible standards of clinical care and professional practice. It shows how we listen to patients, service users, staff and partners and how we work with them to deliver services that meets the needs and expectations of the people who use them.

We aim to be an outstanding organisation recognised for the consistent delivery of high quality care and support across all services, maximising patient safety and experience.

Our staff continue to develop innovations that are transforming the delivery of integrated community services, ensuring their sustainability. We are determined to maintain our financial stability and see 'quality' as both a clinical, professional and business priority. We have been changing the way we deliver services, making sure we continue to deliver care efficiently and working with our staff to embed technological solutions that give us more time to provide care to our populations.

We continuously strive to improve the provision of high quality community health and social care to older people, adults and children across Wirral and across children's services within Cheshire East in a seamless and integrated way.

On behalf of the Trust Board, I would like to thank all staff and volunteers for their dedication, energy and passion for quality care, in what has been another successful year improving quality across all services.

I confirm on behalf of the Trust Board that, to the best of my knowledge and belief, the information contained in the Quality Account represents our performance in 2019 / 2020 and our priorities for continuously improving quality in 2020 / 2021

Mark Greatrex, Interim Chief Executive, December 2020

Staff awards at a glance

2019 / 2020

The Trust has an annual HEART Awards ceremony that recognises the fantastic achievements and commitment of our staff. Due to the Covid-19 pandemic the usual event could not be hosted, and with no event possible for the foreseeable future it seemed such a shame for our winners to have to wait until next year to find out whether they had won. A plan was devised by the Trust communications team to hold the event virtually.

Initially the plan to present the Heart Awards in this way had started as an idea, a simple *'what if',* which eventually led to asking Roger Johnson, Presenter of BBC North West Tonight, if he would kindly compere the virtual event and to our delight, he agreed. What's more is that he filmed his presentations in the BBC North West studios, a fantastic and fitting surprise.

The prevailing power of technology allowed the Trust to present the awards to the winners live – seamlessly going from pre-recorded video of Roger in the studio, to Chairman Michael Brown, the nomination videos, live streaming, and then back to pre-recorded video once again. This allowed staff across the Trust to tune into the event while it was happening, whether they were in the office, shielding at home, or even out in the community watching on their mobile phone!

The winners from 2019 were:

Exceptional Care Category – Celebrating those individuals and teams who have demonstrated excellence in how they provide person centred care.

Winner - Cherish Cadelina from Access and Intermediate Care

Cherish is an enthusiastic, caring and compassionate nurse. She goes above and beyond for the patients she supports, facilitating safe and timely discharge from hospital. Cherish works closely with patients' and families to provide information, clinical support and undertake assessments to ensure the most appropriate placements are found to meet the needs of the individual. She is a credit to her profession and to our Trust.

Outstanding Achievement Category– Who has gone the extra mile to achieve something amazing, or made a significant personal contribution over and above what would be expected over a period of time.

There were two winners for this category

Winner – Fiona Campbell from 0-19 Health and Wellbeing

Fiona is the Professional Development Lead in Cheshire East (CE) with a role that encompasses so much. She led on the CE staff flu campaign, writing a poem encouraging staff uptake of the vaccine which was set to music and rapped! She also put together the training for staff involved in the school age fluenz campaign as well as a competency based programme for unqualified staff. To add to this Fiona also led on School Health Input to the 'Crucial Crew' events for all Year 6 Children around healthy eating, devising the session content and resources.

Winner - Padraig O'Dea – Integrated Gateway

Padraig is the Professional Lead for the Integrated Gateway team and has a real 'can do attitude'. He has been instrumental in setting up Continuing Professional Development sessions showing initiative, creativity, drive and enthusiasm. His innovative approach gives practitioners a safe space to grow, learn and develop. Staff are given the opportunity to express concerns, ask questions and share best practice. Paddy is a role model to his peers and a true ambassador for the Trust.

Innovation Category – This award showcases the innovations that have brought about demonstrable improvement for the Trust and the people we serve

Winner – Wirral and West Cheshire Wheelchair Service

The team has had huge success in their innovative approach to personal wheelchair budgets across Wirral and West Cheshire. They are now mentoring other wheelchair providers and commissioners in developing and implementing their local offer. Personal wheelchair budgets offer users more choice to better meet their assessed needs and any specific requirements they identify. Since April 2019, this has made a difference to the lives of more than 400 people. The team support other wheelchair providers in implementing changes to personal wheelchair budgets and assist NHS England in the delivery of regional and national masterclasses.

Excellence in Partnership Category – This award is for an individual or team who has demonstrated excellent working partnership working internally and / or externally.

Winner – Healthier South Wirral Primary Care Network

GP practices and our community teams began working together in 2018 to build relationships, improve health outcomes as well as staff satisfaction with system-wide quality improvements. This was strengthened in 2019 with the launch of Primary Care Networks. A series of staff workshops, education sessions, patient engagement events and shadowing opportunities were planned and delivered. This helped people understand each other's roles, working together to improve care for the people of South Wirral. Using a Multi-disciplinary team approach has led to effective information sharing and involving the right people has produced better health outcomes

Quality Improvement Category – This award is for an individual or team who can evidence delivery of quality improvement which has shown a tangible improvement to the experience, safety and / or outcomes of the people we care for.

Winner – The Standard Assurance Framework for Excellence (SAFE) Team – Emma Carvell, Mel Johnston and Janet Kane

Initially built to help clinical services record evidence for future Care Quality Commission (CQC) inspections, the SAFE system has become so much more. The team have developed a bespoke system based on feedback from staff. It has given teams the chance to reflect on their services being safe, caring, responsive, effective and well-led. It identifies where quality improvements can be made, improving experience, safety and better outcomes for service users. The SAFE team are proactive and approachable and encourage the sharing of best practice which has led to quality improvements across the Trust.

Volunteer of the Year Category – All volunteers are amazing but do you know of an exceptional volunteer or work placement who you feel deserves this award for their hard work

Eileen and Spartacus (Pets as Therapy Dog), have worked closely with Quality & Governance to co-ordinate therapy sessions across the Trust. This 'pawfect' pair visit teams and their service users bringing joy and reassurance wherever they go. They have made a big difference to the health and wellbeing of our staff and service users, particularly our young people. Eileen is professional, caring and selfless and the feedback we receive is genuinely uplifting.

Inspirational Leader Category – The support of colleagues and our managers is so important in our daily work. Have you been inspired and motivated by the actions of another member of staff?

Winner – Gilbert Ngatia – Head of Community Nursing

10 years' experience as a Senior Community Nurse has enabled Gilbert to lead improvements across all our nursing teams. Gilbert leads with credibility, authenticity, courage and a passion for supporting staff. He displays commitment, inspiration and dedication, balancing decision making which has had a positive impact on patient outcomes and staff wellbeing. He has launched several new initiatives making the service more responsive and innovative. He is approachable, caring and engaging, empowering staff to find solutions and become part of the decision making process

People's Heart Award Category – The People's Heart Award gives the public the opportunity to recognise our staff for their exceptional health and care services and a great person-centred experience.

Winner – Sheila Nugent – Macmillan Clinical Nurse Specialist, Specialist Palliative Care Team

Sheila was nominated for her excellent nursing skills, her unwavering standards and positive presence. Described as a 'guiding light', Sheila made sure that the person in her care was able to spend his final days at home, with the people most dear to him. Through Sheila's expert guidance and care, his symptoms became more controlled and she boosted his confidence, making it easier for him to talk about his condition. She promised to stay with him to the end of his journey, insisting on only the best from every service involved.

Part 2.1 Priorities for improvement and statements of assurance from the board

Progress made during 2019 / 2020

Progress made during 2019 / 2020

Annually, the Trust identifies three quality goals aligned to the recognised pillars of quality:

- Patient Safety
- Person Centred Care
- Clinical Effectiveness

Quality goals are subjected to a consultation and approval process with external partners as well as senior leaders, Trust Board and our Council of Governors.

Patient Safety	Person Centred Care	Clinical Effectiveness
We will reduce avoidable pressure ulcers by one third based on 2018 / 2019 performance, with an ambition to achieve zero	We will carry our 12 shadowing events, to look and listen to what happens along a person's care pathway, to see what is working well and what needs to be improved	We will develop a Quality Improvement network to evaluate impact of quality improvements undertaken across the Trust
We will improve our response times for social care assessments across all neighbourhood teams	The organisation will maximise the Trust's Your Voice Group to embed a consistent approach to service users engagement and feedback across all services	We will implement a consistent framework for clinical, professional and managerial supervision across the Trust, strengthening support mechanisms for staff
We will increase reported incidents by 10% or more above the 2018 / 2019 levels	We will undertake four co-produced "Always Events" with patients/service users to learn from person-centred perspectives	We will implement a validated Patient Reported Outcome Measures for Palliative patients to improve the quality of their end of life care

Our Patient Safety Priorities for 2019 / 2020 were:

Quality Ambition: There will be no avoidable injury or harm to people from the health and care they receive, and an appropriate, clean and safe environment will be provided for the delivery of healthcare services at all times
Quality Goal
We will reduce avoidable pressure ulcers by one third based on 2018 / 2019 performance, with an ambition to achieve zero
We will improve our response times for social care assessments across all neighbourhood teams
We will increase reported incidents by 10% or more above the 2018 / 2019 levels

The improvement interventions that will enable us to reach our ambitions are:

- The continued implementation of a workable pressure ulcer prevention action plan
- Develop robust mechanisms in our Standards Assurance Framework for Excellence (SAFE) to monitor compliance with our social care improvement goal
- Develop incident reporting dashboards in the Trust's Information Gateway with a clear focus on quality and timely feedback to staff who report incidents enhancing ownership at team level and improving staff experience

Our Person Centred Priorities for 2019 /2020 were:

Quality Ambition: Mutually beneficial partnerships between people, their families and those delivering health and care services which respect individual needs and values and which demonstrate compassion, continuity, clear communication and shared decision making.
Quality Goal
We will carry out 12 shadowing events, to look and listen to what happens along a person's care pathway, to see what is working well and what needs to be improved
The organisation will maximise the Trust's Your Voice Group to embed a consistent approach to service users engagement and feedback across all services
We will undertake four co-produced "Always Events" with patients/service users to learn from person-centred perspectives

The improvement interventions that will enable us to reach our ambitions are:

- Embed standard requirements for clinical / professional quality leads within health and social care services, including leadership for service user engagement and co-design
- Develop our Standards Assurance Framework for Excellence (SAFE) reporting to support monitoring of progress against person centred care goals
- Always Events will be co-produced with patients/service users to ensure changes are happening in areas which really matter to them

Our Clinical Effectiveness Priorities for 2019 / 2020 were:

Quality Ambition: The most appropriate treatments, intervention, support and services will be provided at the right time close to home and wasteful or harmful variation will be eradicated
Quality Goal
We will develop a Quality Improvement network to evaluate impact of quality improvements undertaken across the Trust
We will implement a consistent framework for clinical and managerial supervision across the Trust, strengthening support mechanisms for staff
We will implement a validated Patient Reported Outcome Measures for Palliative patients to improve the quality of their end of life care

The improvement interventions that will enable us to reach our ambitions are:

- Embed a Quality Improvement network across the Trust
- Develop clinical and professional leadership forums
- Develop a consistent clinical and managerial supervision framework for staff
- Introduce a series of Patient Reported Outcome Measures (PROMS)

Patient Safety: We protect people from avoidable harm

Progress made during 2019 / 2020

1: Pressure Ulcers

We will reduce avoidable pressure ulcers by one third based on 2018 / 2019 performance, with an ambition to achieve zero

This priority was successfully achieved during 2019 / 2020

During 2019 / 2020 the Trust identified a total of six community Trust acquired pressure ulcers that could have been categorised at 'avoidable'. This compares to 15 during 2018 /2019, evidencing a 60% reduction in avoidable pressure ulcer development.

Community Nursing

Reducing the development of avoidable community acquired grade / category 3, 4 and unstageable pressure ulcers is a strategic priority to evidence the delivery of high quality, safe, harm free care.

All community acquired pressure ulcers of grade 3 and above were reviewed by the Trust's Pressure Ulcer Multi-Disciplinary Review group during 2019 / 2020. Outcomes and identified learning from each review was submitted to Wirral Clinical Commissioning Group (CCG) in accordance with our clinical governance assurance framework. Pressure ulcer prevention remains an organisational priority. The Division implemented the 'ASSKIN' framework and each community nursing base has posters and stickers.

Integrated Children's Division

The Division developed a patient advice leaflet for children and families to help reduce avoidable pressure ulcers for children. The leaflet was approved via the Division INVOLVE / Trust Your Voice Group.

Adult and Community Division

A patient engagement survey was undertaken within the Wheelchair Service for 'at risk' patients to determine they're awareness of pressure ulcers to promote self-care. The Divisions patient information leaflet was updated.

Urgent and Primary Care Division

The walk-in-centres / urgent treatment centre and GP out of hours do not hold a caseload. Staff are encouraged to escalate any concerns they may have with a patient's skin integrity to the community nursing teams / GP.

2: Adult Social Care

We will improve our response times for social care assessments across all neighbourhood teams with a target of 28 days

This priority was partially achieved during 2019 / 2020

Adult Social Care response times for social care assessments improved across all neighbourhood teams during 2019 / 2020.

Collectively, the total improvement against the 28 day target was 79.2%. The service successfully completed 698 assessments within the Trust's internal target of 28 days, narrowly missing the Trust's internal standard of 80% by five assessments. As a result, this quality goal has been classified as partially achieved.

This was a two year priority and has been reported monthly to the Standards Assurance Framework for Excellence (SAFE) Steering group and to the Trust Oversight and Management Board.

Promoting wellbeing and supporting people to be independent, is at the heart of our services. We recognise the importance of ensuring assessments are completed in a timely and proportionate manner. This priority will ensure that our assessments are strength based, person-centred and focus on supporting individuals to access community based services.

3: Incident Reporting

We will increase reported incidents by 10% or more above the 2018 / 2019 levels

This priority was successfully achieved during 2019 / 2020

Overall incident reporting improved by 20% when compared to the previous annual period.

The greatest improvements in reporting were identified across low and no harm incidents, which evidences a learning culture, maximising learning opportunities to prevent more serious harm.

During 2019 / 2020, 93% of reported incidents were coded as resulting in no or low harm, compared to 84% for the previous reporting year.

Three Divisions carried out a survey to better understand the challenges and barriers to staff reporting incidents.

Community Nursing held a medication summit which highlighted themes and trends and raised the importance of reporting incidents.

Datix (Trust incident reporting system) champions were identified in each Division to support the wider increase in reporting incidents and supporting staff in completing Datix effectively. Risk and Governance Manager monitored monthly numbers of incidents and an email sent to each Division.

Datix is web-based patient safety software for healthcare risk management applications which are available through a variety of integrated software modules. Datix is a secure system and access is restricted to personal information on a ‘need to know’ bases to protect confidentiality.

Patient Experience

Progress made during 2019 / 2020

1: Shadowing Events

We will carry out 12 shadowing events; to look and listen to what happens along a person's care pathway, to see what is working well and what needs to improve

This priority was successfully achieved during 2019 / 2020

Wirral Community Health and Care NHS Foundation Trust is committed to providing the best possible standards of clinical care. We listen to patients, service users, staff and partners and work with them to deliver services that meet the needs and expectations of the people who use them.

Each Division undertook 3 shadowing events:

Integrated Children's Division:

- Attention Deficit Hyperactivity Disorder Pathway Service
- 0 – 19 Cheshire East Health Visiting
- Speech and Language Service

Urgent and Primary Care Division

- Dental Service
- Sexual Health Service
- Walk-in-Centre

Adult Community Division

- Adult Social Care
- Dietetics Service
- Speech and Language Service

Community Nursing

- Bladder and Bowel Service – Bowel clinic
- Bladder and Bowel Service – Catheter clinic
- Community Nursing Team – Intravenous therapy clinic

2: Engagement Events

The organisation will maximise the Trust's Your Voice Group to embed a consistent approach to service user's engagement and feedback across all services

This priority was successfully achieved during 2019 / 2020

During 2019-20, the 'Your Voice' group continued to meet with the expanded membership that included governors and more members. The Your Voice Group met bi-monthly and provided a voice to help drive and improve the experiences of people and their families who access Trust services. Members shared an understanding of common issues affecting local people in relation to services provided by the Trust.

The Your Voice Group reflects the communities the Trust serves. It is made up of:

- Public members of the Trust
- Public governors
- Trust staff including the Director of Corporate Affairs who Chairs the group

The agreed terms of reference of the group include the following:

- To improve the experience of patients and service users receiving care from the Trust
- To share patient, service user and public feedback intelligence with the group including compliments, concerns and learning from complaints and the Trust's position in relation to the national Friends and Family (FFT) score
- To report to the group on the patient and service user experience aspects of the Trust's annual quality goals
- To input into the development of new quality goals (following governor input)
- To contribute and share views on service redesign and key projects
- To develop and implement the Trust's Membership Strategy

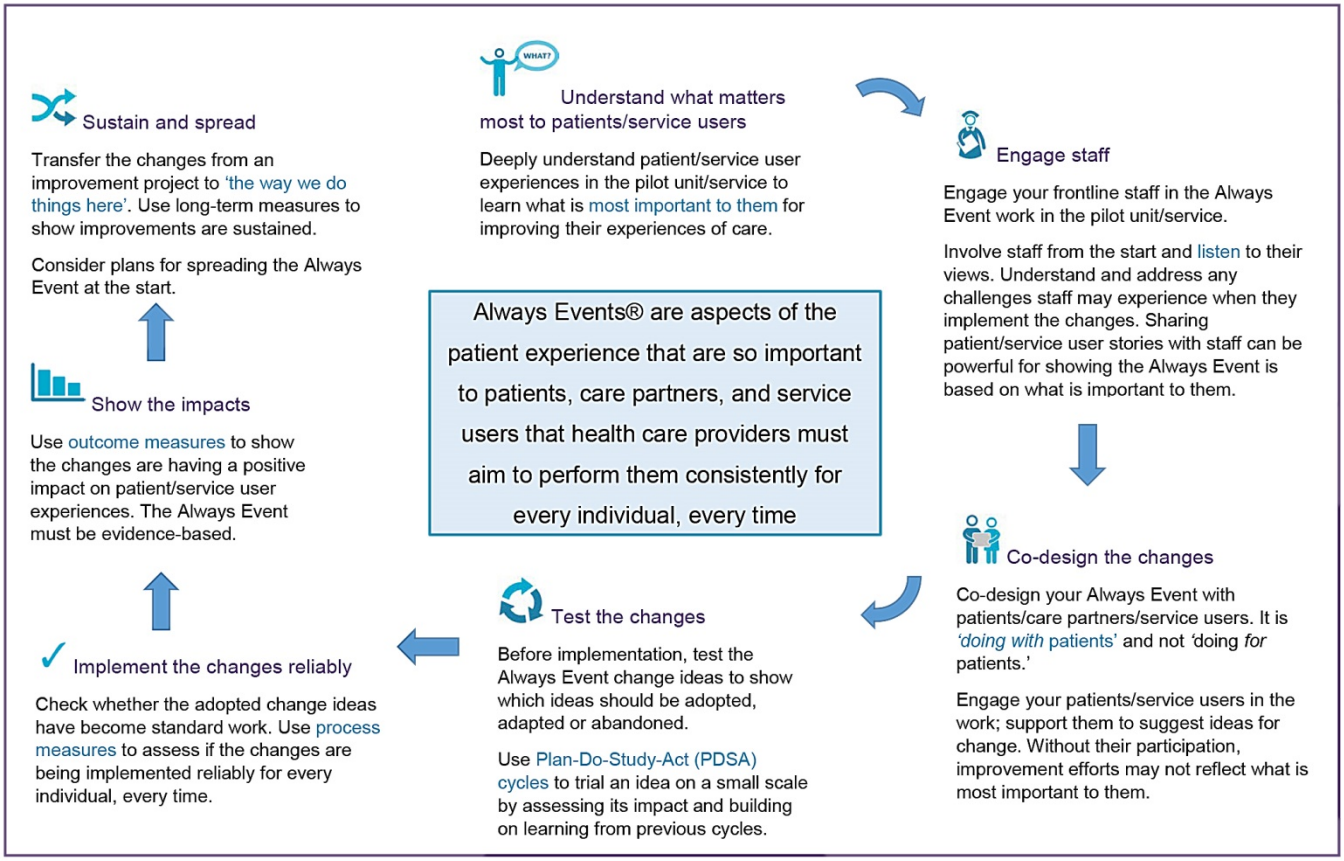
During 2019 / 2020 the members of the Your Voice group supported the Trust with the introduction of the PLACE framework to review buildings across the Trust estate, provided feedback on the Trust's new public website and contributed to the development of a series of patient information leaflets including Community Nursing, complaints and Hand Hygiene.

The group also met with the Trust's INVOLVE young people's group to discuss the issues facing young people and how Trust services support and interact with them.

3: Always Events

We will undertake four co-produced "Always Events" with patients/service users to learn from person-centred perspectives

This priority was successfully achieved during 2019 / 2020 with the completion of 5 co-produced Always Events



Always Events are aspects of the patient experience that are so important to patients, their care partners and service users that health care providers must aim to perform them consistently for every individual, every time.

An Always Event must meet four criteria:

Important: Service users and family members have identified the event as fundamental to improving their experience of care, and they predict that the event will have a meaningful impact when successfully implemented

Evidence-based: The event is known to contribute to the optimal care of and respect for service users (either through research or quality improvement measurement over time)

Measurable: The event is specific enough that it is possible to determine whether or not the process or behaviours occur reliably. This requirement is necessary to ensure that Always Events are not merely aspirational, but also quantifiable

Affordable and Sustainable: The event should be achievable and sustainable without substantial renovations, capital expenditures, or the purchase of new equipment or technology. Focus on improving the care experience through improvements in relationship-based care and in care processes.

Five services across the Trust undertook an Always Event and action plans were completed if appropriate

Always Events

Service	Always Event Aim Statement	Outcome
Adult Community – Community Cardiology	By March 31st 2020, we will introduce four new talks to the cardiac rehabilitation education programme for patients to increase the breadth of information given.	The aim statement was achieved
Integrated Children's Division	By March 31st 2020, we will introduce a dad's health group to enable them to develop and improve services for fathers.	The aim statement was achieved
Bladder and Bowel Service	By March 31st 2020, we will increase response times from clinicians to patients with an indwelling catheter	The aim statement was achieved
Urgent and Primary Care: Wirral Sexual Health	By March 31st 2020, we will improve accessibility to Sexual Health Wirral clinics – increasing choice and reducing waste	The aim statement was achieved
Urgent and Primary Care: Dental Service	By March 31st 2020, we will introduce information leaflets and other patient literature using easy read and symbol formats for patients with additional needs	The aim statement was achieved

Clinical Effectiveness

Progress made during 2019 / 2020

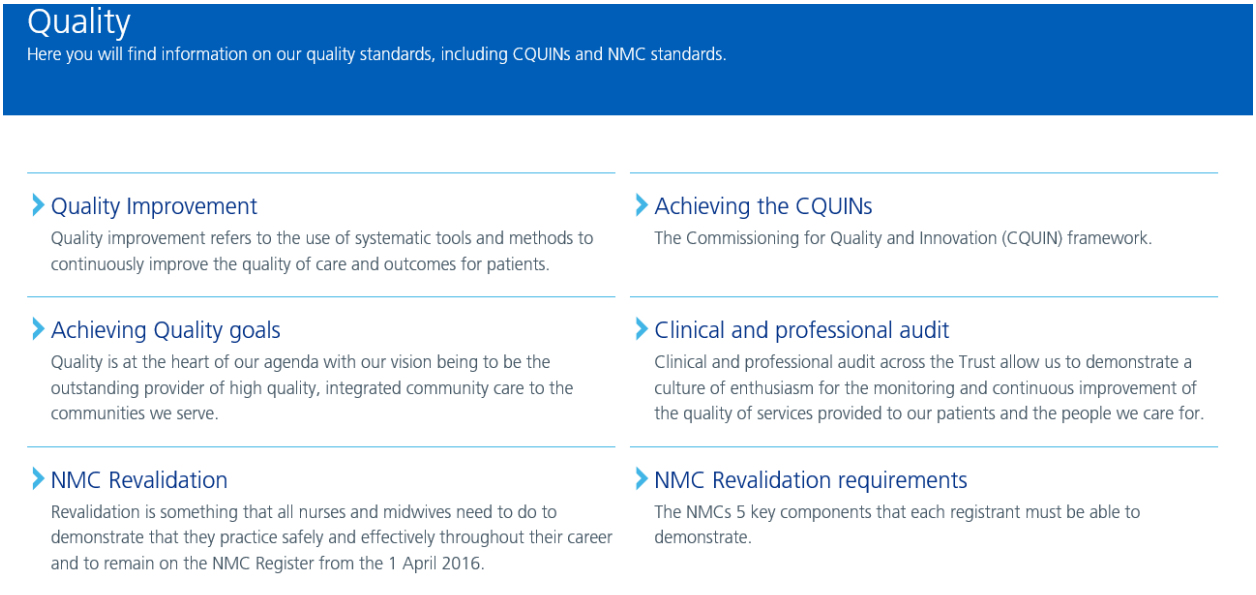
1: Quality Improvement (QI) Network

We will develop a QI network to evaluate impact of quality improvements undertaken across the Trust

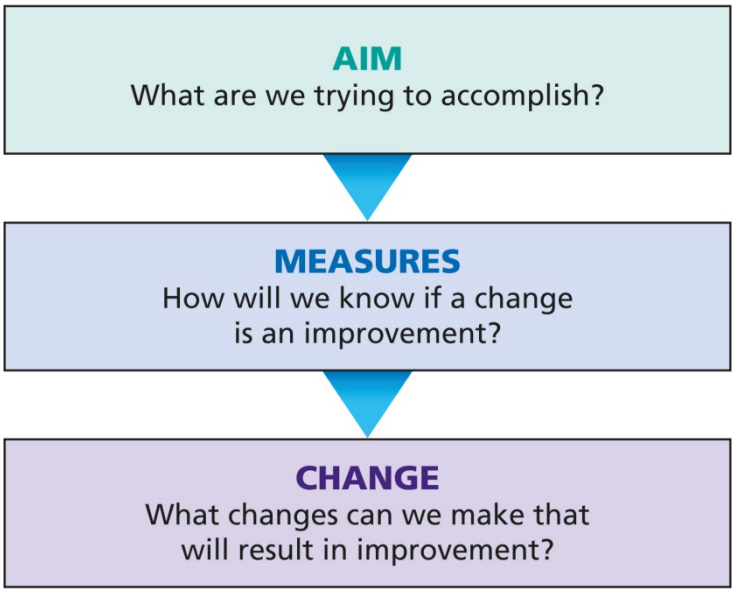
This priority was successfully achieved during 2019 / 2020

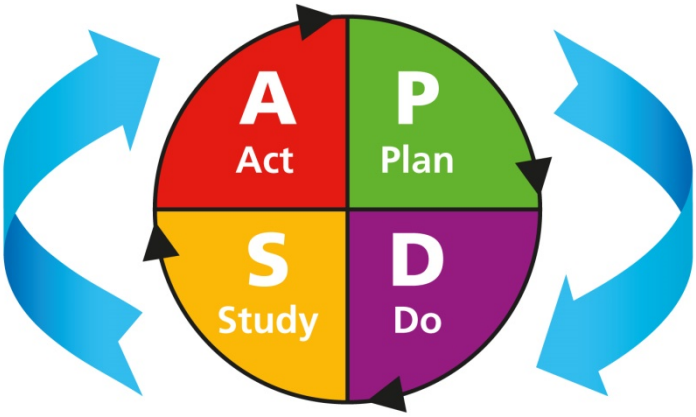
The Trust aims to cultivate a passion for continuous quality improvements across the organisation and it is our ambition to build on the strong foundation of quality improvement established since 2017 and to further embed a quality improvement infrastructure throughout the organisation. By developing our close working relationships with Advancing Quality Alliance (AQuA) we have already developed a cohort of staff, trained in Quality Improvement techniques. Strategically we will continue to grow this cadre and empower them to become ambassadors for transformation, the underlying principle of which is to improve the quality of the system within which staff work and achieve excellent outcomes for patients through staff and service user engagement / involvement.

The Trust has a dedicated section on Staff Zone (see below) where staff can access all information relating to quality



The Trust uses the Institute for Healthcare Improvement Model for Improvement as the framework for driving continuous improvement. It is essentially a method for structuring an improvement project.





A screensaver was visible on all Trust computers / laptops week beginning 24th January 2020 to promote the excellent work undertaken during 2018 / 2019

A celebration event was planned for Wednesday 6th May 2020 to celebrate all the excellent work that had been achieved throughout the year, however due to Covid-19 pandemic this had to be postponed.

2: Supervision

We will implement a consistent framework for clinical and managerial supervision across the Trust, strengthening support mechanisms for staff

This priority was successfully achieved during 2019 / 2020

The Care Quality Commission (CQC) sets out guidance for 'Supporting Effective Clinical Supervision', and it is also a key requirement detailed within the Local Government Association (LGA) Standards for Employers of Social Workers.

The NHS Constitution makes a pledge to all staff that it 'commits to providing support and opportunities for staff to maintain their health, well-being and safety'

Supervision provides a safe environment for critical reflection, challenge and professional support that operates alongside the Trusts appraisal process. It includes time for reflection on practice issues that arise and can help staff to do their jobs more effectively. It enables staff to develop their capacity to use their experiences to review practice, receive feedback, build emotional resilience and think reflectively.

- A supervision log was developed and circulated to all clinical services to record supervision sessions
- The management supervision procedure was launched in July 2019
- The annual audit for clinical and professional supervision – including the quality of supervision sessions – was undertaken and results shared

As a result of the dedicated focus on implementing a consistent framework for supervision across the Trust, an opportunity was identified to enhance the approach to recording supervision, by centralising on the Electronic Staff Record (ESR).

As a result, a pilot is currently being undertaken to record supervision sessions on ESR. This will support effective triangulation of supervision with multiple quality and workforce metrics, to maximise support mechanisms to our staff.

3: Patient Reported Outcome Measures (PROMS)

We will implement a validated Patient Reported Outcome Measure for palliative patients to improve the quality of their end of life

This priority was successfully achieved during 2019 / 2020

Patient reported outcome measures are defined as standardised, validated questionnaires completed by patients to measure their perception of their functional well-being and health status. Patients rate their health by scoring the severity or difficulty in completing certain tasks or routine activities

The Trust chose to implement the Integrated Palliative Care Outcome Measure (IPOS) for community nursing teams as this was already in use by the Integrated Palliative Care Team within the Trust. The IPOS is a more streamlined measure which is brief, yet which still captures end of life care patient's most important concerns – both in relation to symptoms, but also extending to information needs, practical concerns, anxiety or low mood, family anxieties and overall feeling of being at peace.
The IPOS template has been built on the Trust electronic patient record. The Patient and Carer Assessment was reviewed and the IPOS incorporated into the document.

NHS Staff Survey

Summary of performance – results from the NHS staff survey

2019 / 2020 was the ninth survey since the trust was established in 2011. The findings provide an opportunity for Trusts to improve working conditions and practices and to monitor their pledges to staff.

The survey method was mixed using paper based and electronic surveys. The overall final response rate was 52% which was an improvement on the previous response. The community average is 58%.

There have been significant changes in the reporting process and the survey has been split into 11 themes:

	Equality, diversity & inclusion	Health & wellbeing	Immediate managers	Morale	Quality of appraisals	Quality of care	Safe environment - Bullying & harassment	Safe environment - Violence	Safety culture	Staff engagement	Team working
Best	9.6	6.7	7.6	6.7	6.3	8.0	8.7	9.9	7.4	7.5	7.5
Your org	9.5	5.8	7.4	6.2	5.6	7.2	8.6	9.9	7.0	7.1	7.0
Average	9.4	6.0	7.2	6.3	5.8	7.4	8.4	9.7	7.0	7.2	7.0
Worst	8.8	5.4	6.9	5.9	5.2	7.1	7.6	9.6	6.5	6.6	6.6
Responses	825	827	831	823	790	708	825	826	828	834	822

We improved our performance in 8 themes and maintained performance in 3 which is a great achievement and shows a better position than the previous year.

We showed above average performance in 4 themes, average in 2 and below average in 5 when comparing to other community trusts.

These results are shared with our trade union staff side colleagues (JUSS) and our Staff Council.

Future priorities and targets

In response to the 2019 staff survey results there will be actions concerning the following themes which did not see an improvement from the 2018 scores:

- Staff engagement – to explore further the low scores for the questions on morale, involving staff in decisions and senior manager communications to then identify areas for action and teams / departments requiring support

- Health and wellbeing – providing a clearly articulated wellbeing offer, asking staff want they want to see to improve their health and wellbeing at work and publicising staff benefits. Wellbeing champions will seek feedback on initiatives that would improve satisfaction levels

- Quality of care and support – examining through focus groups why we scored low in the areas of staff not being satisfied with the care they give to patients, why they feel their role does not make a difference and not being able to give the care they desire. We will also review the scores on the feedback from incidents

- Quality of Appraisals – clear focus on improvement and development in appraisals and have a clearly articulated offer on all the development opportunities across the trust

- We will use the new 2020 Pulse survey to engage with staff and focus on a theme per quarter. This is to improve continual feedback on progress and ensure a regular dialogue throughout the year.

- Divisional action plans will be developed following a review of their results and determine specific actions to address any areas of concern. For any services / departments that are showing below the Trust average for 8 or more of the 11 themes there will also be tailored actions developed

The action plans will be taken into consideration as part of the new People Strategy Delivery Plans 2020 / 2021 to ensure that they are incorporated into the Trust's wider strategy concerning staff experience and development.

Monitoring of the action plans and progress will be at committee level through Education and Workforce Committee, at senior operational level at Oversight and Management Board and at divisional level through Quality Performance Experience and Risk (QPER) meeting structures.

Priorities for improvement

2020 / 2021

As a result of the Covid-19 pandemic, quality goals were temporarily paused during quarters 1 and 2 of 2020/21 to ensure Trust services could be responsive to priorities resulting from the pandemic.

The priorities below will be progressed during quarters 3 and 4 of 2020/21:

- Population health management; reducing inequalities
- Maximising the health and wellbeing of our staff
- Improving discharge pathways.

Quality goals aligned to safety, experience and effectiveness have been developed and are listed below.

QUALITY GOALS 2020-21
Insight – Involvement – Improvement

Priority	Safety	Experience	Effectiveness
Population health management: Reducing inequalities	**We will:** Use population health data along with other data sources to identify key priorities to keep people safe.	**We will:** Use a range of feedback from identified groups utilising population health data to improve access and experience of services.	**We will:** Implement a Wirral Covid Virtual ward targeting groups with higher risk factors based on population health analysis.
Maximising health and wellbeing of our staff	**We will:** Prioritise the Psychological Safety of our staff by enhancing our learning from incidents framework.	**We will:** Develop clear Infection, Prevention and Control guidance for staff.	**We will:** Ensure that staff always have access to the correct Personal Protective Equipment (PPE) in-line with national guidance.
Improving discharge pathways	**We will:** Establish a system-wide quality and safety forum to improve safety across discharge pathways.	**We will:** Improve the transfer of care documentation to maximise people's experience of the discharge process.	**We will:** Develop additional rehabilitation bed capacity within Wirral.

We are the NHS
We are a team. We work flexibly. We are always learning. We are safe and healthy. We each have a voice that counts. We are recognised and rewarded. We are compassionate and inclusive.

Safety

Priorities for improvement 2020/21

Priority 1:

We will use population health data along with other data sources to identify key priorities to keep people safe

Why have we chosen this priority?

Population health aims to improve physical and mental health outcomes, promote wellbeing and reduce health inequalities across an entire population.

This includes focusing on the wider determinants of health, which have a significant impact on health outcomes; this has been increasingly evident during the Covid-19 pandemic.

Population health management is vital in assisting with understanding our current and predicting our future health and care needs. This supports health and care services to take action in tailoring better care and support with individuals, design more joined up, connected and sustainable health and care services, and make better use of public resources.

It is important that population health management is seen as a partnership approach across the NHS, social care and other public services including: councils, the public, schools, fire service, voluntary sector, housing associations and police.

Priority 2:

We will prioritise the psychological safety of our staff by enhancing our learning from incidents framework

Why have we chosen this priority?

The Trust is committed to supporting staff wellbeing, including psychological safety.

Psychological safety is increasingly being recognised as a vital component of open, transparent learning organisations, with a strong ethos of candour, where staff feel supported to report incidents.

The principles of psychological safety create an environment in which learning and change can be embraced, with high levels of confidence that there are effective mechanisms to embed continuous cycles of improvement within an organisational just culture that considers human factors and actively seeks feedback from staff.

Priority 3:

We will establish a system-wide quality and safety forum to improve safety across discharge pathways

Why have we chosen this priority?

Throughout the Covid-19 pandemic, the Trust's Clinical Risk Management group has continued to meet on a weekly basis to review incident themes and trends. National changes to discharge processes resulting from the pandemic have highlighted the increasing need to assure safety across discharge pathways.

The Trust recognise that collective, system-wide partnership working will be the most effective approach to reviewing multiple data sources to identify themes and trends to improve discharge processes and outcomes for individuals. Establishing a system-wide quality and safety forum will provide an effective governance framework to support continuous quality improvement in respect of discharges.

Experience

Priorities for improvement 2020/21

Priority 1:

We will use a range of feedback from identified groups utilising population health data to improve access and experience of services

Why have we chosen this priority?

As previously documented, population health aims to improve physical and mental health outcomes, promote wellbeing and reduce health inequalities across an entire population.

To ensure services truly reflect the needs of our communities it is vital that we provide a platform to effectively hear a broad and diverse range of feedback from our local population.

Feedback mechanisms will be developed to gain a deeper understanding of community services, resulting in identification of key priorities to improve access and experience.

Priority 2:

We will develop clear Infection, Prevention and Control (IPC) guidance for staff

Why have we chosen this priority?

This priority builds on the principles of psychological safety during the Covid-19 pandemic, where understandably there may be heightened concerns regarding IPC from staff and people who use our services.

The Trust will continue to be responsive to the pandemic, developing clear IPC guidance for staff that continues to reflect national standards and best practice guidance to assure safety.

Priority 3:

We will improve the transfer of care documentation to maximise people's experience of the discharge process

Why have we chosen this priority?

There is an increasing requirement to assure safety when people are being transferred between service providers, based on effective communication to ensure seamless transitions of care.

Focussing on improving the transfer of care documentation with system-partners, will ensure that there is a consistent, expected standard of documented communication to maximise people's experiences of the discharge process. This is increasingly important during the fast pace of change resulting from the Covid-19 pandemic.

Effectiveness

Priorities for improvement 2020/21

Priority 1:

We will implement a Wirral Covid Virtual ward targeting groups with higher risk factors based on population health analysis

Why have we chosen this priority?

To ensure the Trust are continuously providing high quality responsive services that meet the changing needs of the local population, we are committed to implementing a Covid virtual ward to keep people safely at home for as long as possible during the pandemic.

The virtual ward provides an enhanced package of remote monitoring for people who are at risk of future deterioration or admission to hospital as a result of Covid-19 due to pre-existing risk factors.

Targeted intervention based on population health analysis will support an enhance package of remote monitoring and support at home, overseen by a multidisciplinary team.

Outcome measures will be established to track and monitor the impact of this intervention.

Priority 2:

We will ensure that staff always have access to the correct Personal Protective Equipment (PPE) in-line with national guidance

Why have we chosen this priority?

The pandemic has highlighted the importance of utilising the correct PPE as a vital protective mechanism for staff.

The Trust are committed to ensuring staff always have access to the correct PPE, supported by clear guidance to support health and well-being and psychological safety.

Priority 3:

We will develop additional rehabilitation bed capacity within Wirral

Why have we chosen this priority?

The pandemic has highlighted the importance of providing high quality services within the community to minimise bed pressures within hospital environments.

To support the Wirral system, the Trust will develop additional rehabilitation bed capacity to ensure people are effectively supported to receive the right care at the right time, maximising personal goals to support independence.

How will we monitor, measure and report our identified priorities?

The Trust quality goals will be monitored using multiple data sources which will vary subject to each priority. Where appropriate, data will support agreed quality metrics to measure population health outcomes, based on the use of broad system-wide qualitative and quantitative data sources from across the health and care system. In addition, the Trust's patient safety incident reporting system: Datix will be used to capture incidents and feedback regarding our services.

Data will be triangulated in accordance with the Trust's clinical governance assurance framework, which includes the following:

- Divisional Quality Performance Experience sand Risk (QPER) Group
- Standards Assurance Framework for Excellence (SAFE) Group
- Oversight and Management Board
- Quality and Safety Committee
- Trust Board

2.2 Statements of assurance from the Board

Review of services

1. During 2019 / 2020, Wirral Community Health and Care NHS Foundation Trust provided and / or sub-contracted 33 relevant health services.

1.1 Wirral Community Health and Care NHS Foundation Trust has reviewed all the data available to them on the quality of care in 33 of these relevant health services.

1.2 The income generated by the relevant health services reviewed in 2019 / 2020 represents £55.9m of the total income generated from the provision of relevant health services by Wirral Community Health and Care NHS Foundation Trust for 2019 / 2020.

Participation in clinical audit

National Clinical Audit

2. During 2019 / 2020, 2 national clinical audit and 0 national confidential enquiries covered relevant health services that Wirral Community Health and Care NHS Foundation Trust provides.

2.1 During that period, Wirral Community Health and Care NHS Foundation Trust participated in 100% of national clinical audits and 0% national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

2.2 The national clinical audits and national confidential enquires that Wirral Community Health and Care NHS Foundation Trust was eligible to participate in during 2019 / 2020 is as follows:

- BASHH Chlamydia – online submission to BASHH
- National Audit for Cardiac Rehabilitation

2.3 The national clinical audits and national confidential enquiries that Wirral Community Health and Care NHS Foundation Trust participated in during 2019 / 2020 is as follows:

- BASHH Chlamydia – online submission to BASHH
- National Audit for Cardiac Rehabilitation

2.4 The national clinical audits and national confidential enquiries that Wirral Community Health and Care NHS Foundation Trust participated in, and for which data collection was completed during 01 April 2019 – 31 March 2020, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

National Clinical Audit	Number of cases submitted (%) of the number of registered cases
Sexual Health - BASHH Chlamydia - online submission to BASHH	Figures are sent directly to BASHH from the laboratory not the Trust
National Audit for Cardiac Rehabilitation	100%

2.5 – 2.6

These sections are not applicable to the Trust, as there have been zero national clinical audit reports published during the reporting period in which the Trust has participated.

2.7– 2.8 Local Clinical Audits

The reports of 27 local clinical audits were reviewed by the provider in 2019 / 2020 and Wirral Community Health and Care NHS Foundation Trust intends to take the following actions to improve the quality of health and social care provided.

Adult Community Division

Community Nursing: Compliance with Trust Standing Operating Procedure and Clinical Protocol for the Management of Wounds (Pressure Ulcers)

Standard: Wirral Community Health and Care NHS Foundation Trust: Standard Operating Procedure Pressure Ulcer Prevention and Management

Aim:

To ensure compliance with Trust Policy for the management of pressure ulcers

Areas of Good Practice:

100% of records had evidence that:

- Pressure ulcer graded using European Pressure Ulcer Advisory Panel (EPUAP)
- Site of pressure ulcer recorded on wound assessment template
- Wound swab taken if signs of clinical infection

98% of records had evidence that:

- Tissue type was documented
- Monthly photograph taken

Priority Areas for Improvement:

Priority improvements are required for standards that were 69% or lower:

- Pain documented at every visit
- Urinalysis screening for diabetes undertaken

Community Nursing: Compliance with Trust Clinical Procedure for Leg Ulcer Management

Standard: Wirral Community Health and Care NHS Foundation Trust: Clinical Procedure for Leg Ulcer Management CP98 (2018)

Aim:

To ensure compliance with Trust Clinical Procedure for the management of leg ulcers

Areas of Good Practice:

96% of records had evidence of verbal consent obtained from patient for examination
93% of records had evidence of a MUST completed
91% of records had evidence of:

- Examination of both legs (including eczema, varicose veins etc)
- Surrounding skin examined

Priority Areas for Improvement:

Priority improvements are required for standards that were 69% or lower:

- Depth of wound recorded at first presentation
- Length of wound recorded at first presentation
- Width of wound recorded at first presentation
- Photographic evidence of wound
- Photographic evidence of wound monthly thereafter
- Length of wound reassessed weekly
- Width of wound reassessed weekly
- Depth of wound reassessed weekly
- Pain documented on initial assessment
- Pain assessed at every visit
- Patient information leaflet offered
- Urinalysis screening for diabetes

Community Nursing: Compliance with NICE guidance and trust policy for management End of Life Care

Standard: Wirral Community NHS Foundation Trust: CP05 Clinical protocol for End of Life Care for adults (2016) NICE: Quality Standard 13 / 144 (2017)

Aim:

To ensure compliance with Trust and NICE guidance for the management of end of life care patients

Areas of Good Practice:

100% of records had evidence of shared decision making
98% of records had evidence of symptom score recorded on initial assessment
90% of records had evidence of patient pain assessed and recorded at each visit on the patient and carer assessment (PACA)

Priority Areas for Improvement:

Priority improvements are required for standards that were 69% or lower:

- Insight score recorded on initial assessment
- Patient offered their Preferred Priorities for Care (PPC) document or rationale documented
- Do Not Attempt Cardio-Pulmonary Resuscitation (DNACPR) Form is present in the patient record
- Evidence of palliative care communication handover form
- Informal carer offered an assessment (declined to be recorded in record) where appropriate

Rehabilitation at Home: Use of the Therapy Outcome Measure (TOM)

Standard: Therapy Outcome Measures

Aim:

To evaluate the use of 'The Therapy Outcome Measure' in the Rehabilitation at Home service

Areas of Good Practice:

86% of patients showed an improvement in at least one domain
62% of patients showed an improvement in two or more domains

Of those that showed an improvement **91%** of patients showed an improvement in 2 or more domains
Of those that showed an improvement **74%** of patients showed an improvement in 3 or more domains

68% of patients showed an improvement in 'activity'
59% of patients showed an improvement in 'participation'
62% of patients showed an improvement in 'wellbeing'
24% of patients showed an improvement in 'impairment'

Priority Areas for Improvement:

No priority areas for improvement were identified

Bladder and Bowel Service: Quality of Life Score

Standard: ICIQ-UI Female IPSS / International prostate score Male

Aim:

To audit the Quality of Life Score on initial assessment and review

Areas of Good Practice:

100% (24/24) of patients had a Wirral Bowel Dysfunction Assessment or Bowel Assessment: Integrated Continence
88% (21/24) of patients had a Bristol Stool Chart scale recorded.
72% (18/25) of patients had a quality of life score recorded.

Priority Areas for Improvement:

No priority areas for improvement were identified

Adult Dietetics: Compliance with NICE Quality Standard for Coeliac Disease

Standard: NICE: Coeliac Disease Quality Standard 134 (2016)

Aim:

To ensure compliance with NICE Quality Standard for coeliac disease

Areas of Good Practice:

100% of records had evidence that:

- Type 1 diabetes and irritable bowel syndrome patients were recommended to have a serological test for Coeliac disease by the Dietician in their clinic / group setting
- Type 1 diabetes and irritable bowel syndrome patients recommended to have a serological test for Coeliac disease, did the Dietician include this recommendation in the patient letter to GPs
- Information on which types of food contain gluten and suitable alternatives, including gluten-free substitutes
- Information on what types of food are naturally gluten free
- The patient was advised how to manage social situations, eating out and travelling away from home, including travel aboard

Priority Areas for Improvement:

Priority improvements are required for standards that were 69% or lower:

- Coeliac disease patients to be offered an annual review

Podiatry: Compliance with Trust Clinical Procedure for Annual Diabetic Foot Screening

Standard: Wirral Community Health and Care NHS Foundation Trust: Clinical Procedure for Annual Diabetic Foot Screening: CP12 (2019)

Aim:

To ensure compliance with Trust procedure for patients attending podiatry service for annual diabetic foot screening

Areas of Good Practice:

100% of records had evidence that:

- Patient 'at risk' category was documented
- Patient re-screened annually in line with revised Trust and NICE guidance
- Patients current foot care arrangements documented
- Valid consent gained and documented
- Clinical history recorded
- Vascular assessment documented
- Neurological assessment documented
- Clinical outcome was reported to GP within KPI target

Priority Areas for Improvement:

No priority areas for improvement were identified

Integrated Children's Division

0-19 Service: Compliance with Trust Standard Operating Procedure for Blood Spot Screening

Standard: Wirral Community Health and Care NHS Foundation Trust: Standard Operating Procedure for Blood Spot Screening (ICD-SOP-001)

Aim:

To ensure compliance with Trust blood spot procedure for children under one year old

Areas of Good Practice:

100% of records had evidence that:

- The blood spot screening result was attached / scanned onto SystmOne
- If positive or repeat test required, appropriate action was taken

Priority Areas for Improvement:

No priority areas for improvement were identified

Urgent and Primary Care Division

Sexual Health: Compliance with NICE Quality Standard for service users at risk of a sexually transmitted disease

Standard: NICE Guidance Quality Standard 178 (2019)

Aim:

To ensure compliance with NICE guidance quality standard 178

Areas of Good Practice:

100% of records had evidence that:

- Service user asked about sexual history at key points of contact
- A documented discussion about prevention and testing for a sexually transmitted disease took place
- Service user who contacted the service about a sexually transmitted infection was offered an appointment within 2 working days
- Service user diagnosed with a sexually transmitted infection is supported to notify their partners

Priority Areas for Improvement:

No priority areas for improvement were identified

Sexual Health: Quality of Risk Assessments and Screening Tools

Standard: Care Quality Commission Key Lines of Enquiry

Aim:

To ensure compliance with CQC key lines of enquiry (S3).

Areas of Good Practice:

100% of records had evidence of:

- Demographics check
- Safeguarding proforma completed
- Appropriate examination performed
- Tests taken and documented
- Diagnosis shared with patient and explanation given
- Relevant guidelines followed
- Documents follow up and safety advice given

96% of records had evidence of:

- History taking
- Relevant sexual history
- Other relevant medical history

- History of contraception
- Consent documented

Priority Areas for Improvement:

No priority areas for improvement were identified

GPOOH: Compliance with NICE guidance for the Management of Patients in the Last Days of Life

Standard: NICE: Care of dying adults in last days of life: Quality Standard 13/144 (2017) NG:31 (2015)

Aim:

To ensure compliance with NICE guidance, and nationally identified quality improvement priorities in GPOOH for the management of patients in the last days of life

Areas of Good Practice:

Standards where GPOOH is responsible for baseline collection or updating, and has control over:

100% of records had evidence that:
- Current clinical signs and symptoms were documented
- Appropriate medical history documented
- Safety netting advice documented
- Appropriate information transfer at end of OOH consultation

98% of records had evidence of an assessment and appropriate management of pain was documented
93% of records had evidence that investigations were avoided that were unlikely to affect care in the last few days of life, unless there was a clinical need to do so
91% of records had evidence that patient levels of hydration were assessed

Priority Areas for Improvement:

Priority improvements are required for standards that were 69% or lower:
- Patient had risk and benefits of hydration discussed

Dental: Intraoral Radiograph Quality Assurance

Standard: Faculty of General Dental Practice (FGDP) Selection Criteria for Dental Radiograph Standards 3rd Edition (2018)
Department Protocol for Radiography, Radiology and Quality Assurance

Aim:

To ensure compliance with FGDP Selection Criteria for Dental Radiography Standards (3rd edition, 2018) and Departmental Protocol for Radiography, Radiology and Quality Assurance

Areas of Good Practice:

April – September 2018:

- **87%** of radiographs were graded as excellent. This exceeds the FGDP target of more than 70% of radiographs being in this category

October 2018-March 2019:

- **77%** of radiographs were graded as excellent. This exceeds the FGDP target of more than 70% of radiographs being in this category

Priority Areas for Improvement:

No priority areas for improvement were identified

Dental: OPT Radiograph Quality Assurance

Standard: Faculty of General Dental Practice Selection Criteria for Dental Radiograph Standards 3rd Edition (2018)
Department Protocol for Radiography, Radiology and Quality Assurance

Aim:

To ensure compliance with FGDP Selection Criteria for Dental Radiography Standards (3rd edition, 2018) and Departmental Protocol for Radiography, Radiology and Quality Assurance

Areas of Good Practice:

April – September 2018:

- **90%** of radiographs were graded as excellent. This exceeds the FGDP target of more than 70% of radiographs being in this category

October 2018-March 2019:

- **92%** of radiographs were graded as excellent. This exceeds the FGDP target of more than 70% of radiographs being in this category

Dental: Compliance with Record Keeping Dental Standards

Standard: FGDP Clinical Examination and Record Keeping Standards (2016)
Wirral Community Health and Care NHS Foundation Trust: Managing the Quality of Care Records Policy (GP06, 2020)

Aim:

- To ensure compliance with dental record keeping standards.

Areas of Good Practice:

100% of records had evidence:

- That for patients aged 3 and above, fluoride varnish was applied as part of most recent course of treatment or rationale documented
- That patients risk for dental caries was recorded
- Fluoride toothpaste was prescribed at the appropriate strength (<16 years 2800ppm, 16+ 2800 or 5000ppm)

Priority Areas for Improvement:

No priority areas for improvement were identified

Dental: Flumazenil use during IV Midazolam Sedation Sessions

Standard: National Patient Safety Agency

Aim:

Aim
To comply with national patient safety agency guidance relating to IV sedation

Areas of Good Practice:

- In all cases where flumazenil was used its use was indicated for a specific clinical reason which was documented accordingly
- All incidences of flumazenil use were recorded in the patient's records
- The reason for flumazenil use is now being recorded within the patient dental record as standard. This is an improvement on last year's score
- The rate of reversal is within accepted levels of Gold Standard set at 5%. This is an improvement on last year's score

Priority Areas for Improvement:

No priority areas for improvement were identified

Dental: Compliance with SAAD Quality Assurance Programme for Implementing National Standards in Conscious Sedation for Dentistry in the UK (premises)

Standard: Society for the Advancement of Anaesthesia in Dentistry (SAAD): Safe Sedation Practice Scheme: (2017)

Aim:

- To ensure compliance with the SAAD Quality Assurance Programme for Implementing National Standards in Conscious Sedation for Dentistry in the UK for premises

Areas of Good Practice:

- The premises are clinically fit for purpose and fulfil legislative and regulatory requirements (lighting, heating, ventilation and safe access)
- Waiting room, surgery and recovery room of adequate size for management of emergencies
- Adequate access for emergency services
- Separate area for patient recovery and waiting room
- Privacy assured in surgery
- Individual privacy assured in recovery area
- Patient confidentiality and privacy maintained throughout the patient journey

Priority Areas for Improvement:

No priority areas for improvement were identified

Dental: Compliance with SAAD Quality Assurance Programme for Implementing National Standards in Conscious Sedation for Dentistry in the UK (personnel)

Standard: Society for the Advancement of Anaesthesia in Dentistry (SAAD): Safe Sedation Practice Scheme: (2017)

Aim:

To ensure compliance with the SAAD Quality Assurance Programme for Implementing National Standards in Conscious Sedation for Dentistry in the UK for personnel

Areas of Good Practice:

- Provision of sedation / suitable accredited sedation qualification
- Evidence of a sedation log
- Sedation relevant CPD equating to 12 hours over 5 years
- Regular activity to maintain skills

Priority Areas for Improvement:

No priority areas for improvement were identified

Dental: Compliance with guidance on antimicrobial prescribing for General Dental Practitioners (GDP)

Standard: Faculty of General Dental Practice (2012) Antimicrobial Prescribing for GDPs Updated 2016

Aim:

To ensure compliance with Faculty of General Dental Practice (2012) Antimicrobial Prescribing for GDPs (updated 2016) and local procedures for antimicrobial prescribing regarding completion of the antibiotic custom screen

Areas of Good Practice:

100% of custom screen had evidence of:

- A drug name prescribed
- Drug form e.g. tablets / capsule / suspension
- Drug dose recorded
- Frequency of dose recorded

93% of custom screen had evidence of prescription number recorded on custom screen
90% of custom screen had evidence of diagnosis recorded

Priority Areas for Improvement:

Priority improvements are required for standards that were 69% or lower:

- Patients temperature recorded on custom screen, or reason why this was not taken given
- For patients of child bearing age custom screen to indicate warning about oral contraceptive interaction

Dental: Compliance with NICE guidance for recall intervals for dental checks

Standard: NICE (2004) Dental checks: intervals between oral health reviews CG19: (Reviewed 2018)

Aim:

- To ensure compliance with NICE guidance relating to dental checks: intervals between oral health reviews

Areas of Good Practice:

100% of records had evidence that:

- Patient's risk of oral disease recorded
- For adult patients (18 years and older) suggested recall interval was no more than 24 months

97% of records had evidence that:

- Recall interval recorded on SOEL health match recall interval recorded on paper record for most recent course of treatment

96% of records had evidence that:

- Patients recall interval was recorded on SOEL health

Priority Areas for Improvement:

Priority improvements are required for standards that were 69% or lower:

- If recall interval assigned is not appropriate for level of risk of oral disease reason why not recorded

DVT Service: Quality of initial assessment and documentation of patients found to have a positive diagnosis of Deep Vein Thrombosis (DVT)

Standard: NICE: Venous Thromboembolic disease: Diagnosis, management and thrombophilia testing (2015): CG144

Aim:

To ensure compliance with NICE guidance for patients with venous thromboembolism and quality of initial assessment and documentation of patients found to have a positive diagnosis of DVT

Areas of Good Practice:

100% of records had evidence that:

- Patient's past medical history was recorded, e.g. VTE history / family history / Patient's history of symptoms recorded

Documented evidence that the patient had a discussion about:

- Chest pain
- Dyspnoea
- A full set of baseline observations was recorded
- The Wells score was recorded
- If there was a differential diagnosis, treatment was given
- The examination findings were documented
- Patient's weight was documented

The following was recorded:

- Dose of treatment given / Batch number of medication / Expiry date
- Documented evidence that a patient information leaflet was offered / safety netting advice given

Priority Areas for Improvement:

No priority areas for improvement were identified

DVT: Audit of Clinical Outcomes of patients diagnosed with positive Deep Vein Thrombosis

Standard: NICE (2015) Venous thromboembolic diseases: CG144
NICE (2016) Venous thromboembolism in Adults:QS29

Aim:

To ensure compliance with NICE guidance for the management of patients with a positive diagnosis of DVT

Areas of Good Practice:

100% of records had evidence that:

- Patients with unprovoked DVT who aren't diagnosed with cancer had a letter sent to GP to consider investigations for cancer
- Patient with provoked DVT were not offered thrombophilia testing
- Patient with active cancer and confirmed proximal DVT were offered anticoagulation with low molecular weight heparin
- Patients with cancer and diagnosed with DVT were advised to have a review by their GP after 6 months of treatment to discuss the risks and benefits of continuing anticoagulation therapy
- Consent was documented
- Patient was offered choice of treatment where clinically safe with clear documentation of drug of choice
- Patient commenced on anticoagulation received drug counselling
- Patient had a documented Wells score
- Patient had documentation if they had recent risk factors of lower limb immobilisation or hospital admission

Priority Areas for Improvement:

No priority areas for improvement were identified

Walk in Centres: Compliance with NICE Guidance for acute sore throat in children and young people

Standard: NICE: Sore throat (acute): Antimicrobial prescribing: NG84 (2018)

Aim:

To ensure compliance with NICE Guidance for children and young people relating to sore throat: Antimicrobial prescribing

Areas of Good Practice:

100% of records had evidence of:

- Child or young person's past medical history recorded
- Child or young person's medication history recorded
- Full set of observations recorded
    - Temperature
    - Pulse rate

    - Respiratory rate
    - 02 saturations
    - Capillary refill
- Child or young person's throat examined and recorded
- Child or young person's lymphadenopathy recorded
- Treatment supplied in line with the PGD
- Child or young person's had discharge advice and safety netting recorded

Priority Areas for Improvement:

Priority improvements are required for standards that were 69% or lower:

- Evidence of the batch number of the medication recorded
- Evidence of the expiry date of the medication recorded
- The centor criteria score recorded for child or young person

Adult Social Care

Adult Social Care: Compliance with Assessment, Eligibility and Review Policy (including Carers Assessment)

Standard: Wirral Borough Council / Wirral Community NHS Health and Care Foundation Trust: Assessment, Eligibility and Review Policy (2015)

Aim:

To ensure compliance with Trust policy on assessment, eligibility and review policy

Areas of Good Practice:

98% of records had evidence that the assessment includes enough information proportionate to needs identified
96% of records had evidence that the support plan was person centred
90% of records had evidence that the assessment identifies any impact on the person's wellbeing

Priority Areas for Improvement:

Priority improvements are required for standards that were 69% or lower:

- Further enhance the adoption of a strength based approach in the assessment and support planning process
- Develop a consistent approach to contingency planning within the support planning process
- Ensure a consistent approach for the completion of carers assessments

Integrated Co-ordinated Care Team / Integrated Discharge Team: Assessment for Financial Management and Charging Advice

Standard: The Care Act 2014

Aim:

To ensure compliance with statutory responsibilities in the Care Act 2014 and agreed local processes and procedures

Areas of Good Practice:

- **100%** of records had evidence where criteria was met, a referral was made to Wirral Borough Council's Financial Protection Team (where applicable)
- **96%** of records had evidence that each assessment completed documented evidenced discussion and recording of any issues pertaining to financial management, including self-management, Lasting Power of Attorney, saving ownership of property
- **92%** of records had evidence a financial assessment has been completed / triggered

Priority Areas for Improvement:

No priority areas for improvement were identified

Adult Social Care: Compliance with statutory responsibilities / best practice for transitions

Standard: Wirral Community NHS Foundation Trust/Wirral Council: Transition Policy 2016

Aim:

To ensure compliance with Trust policy and NICE guidance relating to transition of young person

Areas of Good Practice:

100% of records had evidence that:

- The young person was involved in how transition was planned, implemented and reviewed and this is evidenced in the documentation
- A care plan in place, developed in partnership with the young person and their carer's, evident in the records
- Evidence the care plan is person centred and promotes independence
- A named adult worker was allocated and the case co-worked once the young person reached 17½ years of age
- An assessment completed within 28 days and sent to adult social care manager for approval and authorisation, with Liquid Logic updated

90% of records had evidence that:

- The young person and their family were provided with information about:
    - What to expect from adult services
    - What support is available to them from statutory and non-statutory services
    - How to access support when required

Priority Areas for Improvement:

Priority improvements are required for standards that were 69% or lower:

- The young person to be asked how they would like their parents / carers to be involved once they have moved to adult services (taking their capacity into consideration, evident in the records

Trust Wide Audits

Trust-wide: Record Keeping: Clinical and Social Care Audit Results

Standard: Wirral Community Health and Care NHS Foundation Trust: Managing the Quality of Care Records Policy: (2020) GP06 / Wirral Council Case Recording Procedure (2017)

Aim:

To audit compliance with Wirral Community Health and Care NHS Foundation Trust 'Managing the Quality of Care Records Policy' and Wirral Borough Council Case recording procedure across clinical and professional services.

Areas of Good Practice:

100% of records had evidence:

- All of the entries belonged to the correct patient
- All recorded entries were free from offensive or subjective statements
- Text on the scanned document was legible
- That for numbered multiple paged document: All of the pages had been scanned

99% of records had evidence:

- A personalised care plan in place
- The scanned document was attached to the correct patient record
- All of the images on the scanned document were clear

Priority Areas for Improvement:

Electronic Records for Professional standards:

Priority improvements required for standards scoring 69% or lower for electronic professional standards records:

- Where abbreviations are used, a definition is provided of the abbreviation where it is first recorded

Paper Records:
Priority improvements required for standards scoring 69% or lower for paper records:

- Alterations / additions are timed

Trust-wide: Clinical and Social Care Supervision Audit including Preceptorship

Standard: Clinical Protocol for Supervision and Preceptorship: CP95 (2018)

Aim:

To measure standards set by the Care Quality Commission (Outcome 14 Supporting Workers) and Wirral Community Health and Care NHS Foundation Trust Clinical Protocol for Supervision and Preceptorship.

Areas of Good Practice:

Social Care Supervision:

- **97%** of social care staff felt the session enabled them to reflect on their practice / and to seek / receive advice and support from their supervisor
- **91%** of social care staff stated that a minimum of 2 casework records were reviewed / discussed at each session

Quality of Supervision:

- **92%** of staff felt that they were supported to engage in effective reflection to learn and develop
- **95%** of staff felt heard and engaged throughout their supervision sessions

Safeguarding:

- **100%** of action plans are clear with outcomes discussed at subsequent supervisions

Priority Areas for Improvement:

Priority improvements are required for standards that were 69% or lower:

- New starters to have a preceptorship contract
- Staff to have a signed clinical supervision contract
- Staff to complete a written record for each clinical supervision session

Participation in Clinical Research

3 The number of patients receiving relevant health services provided or sub-contracted by Wirral Community Health and Care NHS Foundation Trust in 2019 / 2020 that were recruited during that period to participate in research approved by a research ethics committee was zero.

Commissioning for Quality and Innovation Payment Framework (CQUIN)

The Commissioning for Quality and Innovation (CQUIN) framework supports improvements in the quality of services and the creation of new, improved pathways of care.

4 4.2 (a) A proportion of Wirral Community Health and Care NHS Foundation Trust income in 2019 / 2020 was conditional on achieving quality improvement and innovation goals agreed between Wirral Community Health and Care NHS Foundation Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework.

Further details of the agreed goals for 2019 / 2020 and for the following 12-month period are available electronically at: www.wirralct.nhs.uk

The total income conditional on achieving quality improvement and innovation goals during, 2017 / 2018, 2018 / 2019 and 2019 / 2020 was as follows

- 2017/2018: £1.039m
- 2018/2019: £1.000m
- 2019/2020: £0.493m

Care Quality Commission Registration

5 5.1 Wirral Community Health and Care NHS Foundation Trust is required to register with the Care Quality Commission (CQC) and its current registration is 'Requires Improvement'. Wirral Community Health and Care NHS Foundation Trust has no conditions on registration and the Care Quality Commission has not taken enforcement action against the Trust during 2019 / 2020.

The Trust was inspected by the CQC in 2018. In March 2020 the CQC issued the Routine Provider Information Request (RPIR) to the Trust for submission, but this process was postponed due to the COVID-19 pandemic and the response of the Trust to the national Level 4 incident. We look forward to resuming the CQC inspection process as soon as possible and the opportunity this will provide to demonstrate the significant improvements the Trust has made.

7 7.1 Wirral Community Health and Care NHS Foundation Trust has not participated in any special reviews or investigations by the CQC during the reporting period.

Review of adult social care 2019

Senior colleagues from a number of local authorities (Council) and Trusts undertook a review of Adult Social Care. The review focused on three key areas:

- Front line practice and current arrangements
- Adopting a strength based approach
- Maintaining the Professional Status of social work

Findings:

- Recognition of the integration success and the positive impact it's having for people using our services and our workforce
- The benefits of working in a Multi-Disciplinary Team (MDT), enabling a more positive joint working at neighbourhood level and the Wirral system
- An increase in training and development opportunities for staff since transferring (including specialist training) into the NHS
- Easier problem solving across health and social care, with an improved understanding of safeguarding from the perspective of other professionals and organisations

- Increased understanding and a deeper respect for the Social Work profession and its legal position
- Many managers and staff identifying good examples to work in a strengths based approach and to improve the outcomes for individuals
- High level of senior management engagement with frontline teams
- Social Workers feeling part of a team and part of the Trust and contributing to our cultural aspirations

Secondary User Service

8 8.1 Wirral Community Health and Care NHS Foundation Trust submitted records during 2019 / 2020 to the Secondary User Service for inclusion in the Hospital Episode Statistics which are included in the latest published data.

The percentage of records in the published data which included the patient's valid NHS number was:

- Not applicable for admitted patient care
- Not applicable for outpatient care; and
- 99.2% for accident and emergency care

The percentage of records in the published data which included the patient's valid General Medical Practice Code was:

- Not applicable for admitted patient care
- Not applicable for outpatient care; and
- 97.2% for accident and emergency care

Data Security and Protection Toolkit Attainment Level

9 Wirral Community Health and Care NHS Foundation Trust's Data Security and Protection Toolkit overall score for April 2019 – March 2020 was graded Substantial Assurance

Payment by Results clinical coding audit / Data Quality

10.1 Wirral Community Health and Care NHS Foundation Trust were not subject to the Payment by Results clinical coding audit during 2019 / 2020 by NHS Improvement.

Learning from Deaths

27.1 During 2019 / 2020, 75 of Wirral Community Health and Care NHS Foundation Trust patients died. This comprised the following number of deaths which occurred in each quarter of that reporting period:

- 18 in first quarter – none were attributable to the Trust

- 16 in the second quarter – none were attributable to the Trust
- 20 in the third quarter – none were attributable to the Trust
- 21 in the fourth quarter – none were attributable to the Trust

27.2 By 31 March 2020, 75 case record reviews and 51 investigations have been carried out in relation to 75 of the deaths included in item 27.1.

In 51 cases a death was subjected to both a case record review and an investigation. The number of deaths in each quarter for which a case record review or an investigation was carried out was:

- 11 in the first quarter
- 13 in the second quarter
- 14 in the third quarter
- 13 in the fourth quarter

27.3 0 representing 0% of the patient deaths during the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient.

These numbers have been estimated using the Trust's mortality review screening tool, which are recorded centrally on the Trust's Datix incident reporting system. Each completed review tool is progressed through the Trust's mortality review group chaired by the Medical Director.

Learning from deaths – case record reviews and investigations

27.4 The Trust's Learning from Patient Deaths Policy provides a framework for how the Trust will evaluate those deaths that form part of our mortality review process, the criteria for review and quarterly and annual reporting mechanisms.

The Trust's Datix incident reporting system is aligned to the Learning from Patient Deaths Policy to ensure prompt communication to the Medical Director, Deputy Chief Nurse and Chief Operating Officer for all unexpected deaths.

Actions taken as a result from learning from deaths

27.5 Through review and analysis of reported incidents, the Trust has identified the benefit of a whole system approach to learning from deaths. As a result the Medical Director is actively engaging with providers across the Wirral health and social care economy to ensure shared learning opportunities are identified and appropriately disseminated to support collaborative working to continuously improve the quality of care provided.

Assessing the impact of the quality improvement actions taken to learn from deaths

27.6 The impact of the system-wide approach to learning from deaths is assessed and monitored at the Trust's mortality review group. The group will continue to closely monitor the impact of implementing a system-wide approach to learning from deaths during 2020 / 2021.

27.7 0 case record reviews and 0 investigations completed after 01 April 2019 which related to deaths which took place before the start of the reporting period.

27.8 0 representing 0% of the patient deaths before the reporting period, are judged to be more likely than not to have been due to problems in the care provided to the patient.

This number has been estimated using the case record review and investigation process.

27.9 0 representing 0% of the patient deaths during 2019 / 2020 are judged to be more likely than not to have been due to problems in the care provided to the patient.

COVID-19 Context

27.10 During the COVID-19 pandemic there has been an increased number of total deaths reported within the community and the hospital environments. All death statistics are collated by Public Health England and disseminated on a monthly basis to key health and care stakeholders. As a Trust, we analyse this data to determine how services can be improved whilst addressing widening health inequalities as a consequence of the pandemic.

27.11 Therefore, excess death numbers associated with Covid-19, occurring on Wirral during the pandemic have been captured within the mortality figures of other organisations. These will, where appropriate, be subject to those organisations own Learning from Deaths processes

2.3 Reporting against core indicators

Since 2012 / 2013 NHS Foundation Trusts have been required to report performance against a core set of indicators using data made available to the Trust by NHS Digital.

Domain 5: Treating and caring for people in a safe environment and protecting them from avoidable harm:

The number of patient safety incidents reported within the Trust during the reporting period:

Year	Total Patient Safety Incidents	Incidents coded as severe harm or death
2019/2020	4799	85 (1.77%)
2018/2019	4045	50 (1.24%)
2017/2018	3785	48 (1.27%)
2016/2017	3550	49 (1.38%)

Wirral Community Health and Care NHS Foundation Trust considers that this data is as described for the following reasons:

- The Trust has an open, honest and transparent culture of learning from experience and actively promotes the reporting of patient safety incidents.

- Staff are encouraged to report all incidents to maximise learning, ensuring a culture of continuous quality improvement. This benefits services directly provided by the Trust, and broader system wide learning across the health and social care economy.

Friends and Family Test Score

The Friends and Family Test (FFT) is an important feedback tool that supports the fundamental principle that people who use NHS services should have the opportunity to provide feedback on their experience.

The friends and family question is incorporated into the Trusts' your experience questionnaires, feedback cards, and our online form. Anyone who contacts the 'your experience service' by telephone will also be asked the question:

'How likely are you to recommend our services to friends and family if they needed similar care or treatment?'

The table below shows monthly percentage of respondents who would recommend our services for care or treatment and the total number of responses:

Month / Year	% of those who would recommend our services for care or treatment	Total Number of responses
April 2019	95%	347
May 2019	98%	359
June 2019	96%	471
July 2019	96%	562
August 2019	96%	337
September 2019	96%	427
October 2019	97%	446
November 2019	97%	386
December 2019	98%	500
January 2020	98%	623
February 2020	98%	225
March 2020	97%	262

Part 3: Other Information

Performance in 2019 /2020

3.1 Quality of care provided by Wirral Community Health and Care NHS Foundation Trust

The Trust Board recognises that quality is an integral part of its business strategy and quality has been placed as the driving force of the organisation's culture.

Maintaining and improving quality and patient safety standards and processes in a dispersed community organisation is a challenge that is met through rigorous leadership, high professional standards and low tolerance on non-compliance.

Quality Strategy Themes

Our Quality Strategy outlines our ambition for quality and commits the Trust to ensuring that quality forms an integral part of our philosophy, practices and business plans with responsibility for driving the quality agenda embraced at all levels of the organisation.

Our Quality Strategy is built around three local priorities:

- Person centred care
- Outstanding Safe Care Every Time
- Effective Care Every Time

Always Events

Adult Bladder and Bowel Service

Aim Statement: To improve the journey for patients with a catheter on discharge from hospital

The bladder and bowel service held a patient focus group for patients with an indwelling catheter for management of bladder dysfunction to gain their feedback. Comments from the focus group demonstrated that the pathway on discharge from hospital needed to be revised to improve communication, integration and quality of care for patients.

The pathway would ensure an effective triage and sign posting enabling patients to be seen by the right person at the right time:

- All referrals from hospital for patients with a catheter would be shared with the adult bladder and bowel service
- All patients would be contacted to ensure they understood how to self-care and manage their catheter
- All patients will be asked if they have appropriate supplies
- All patients will be triaged effectively for community nursing, mobile catheter clinics or trial without catheter service

The new pathway improves the transition for the patient between secondary and primary care. It also improves communication and offers timely information for the patient ensuring the patient is seen by the right person at the right time but also educated and supported regarding the catheter and self-care needs.

Once the revised pathway was fully implemented, data revealed that 100% of referrals were triaged effectively offering person centred care and an improved journey for all those referred to the service

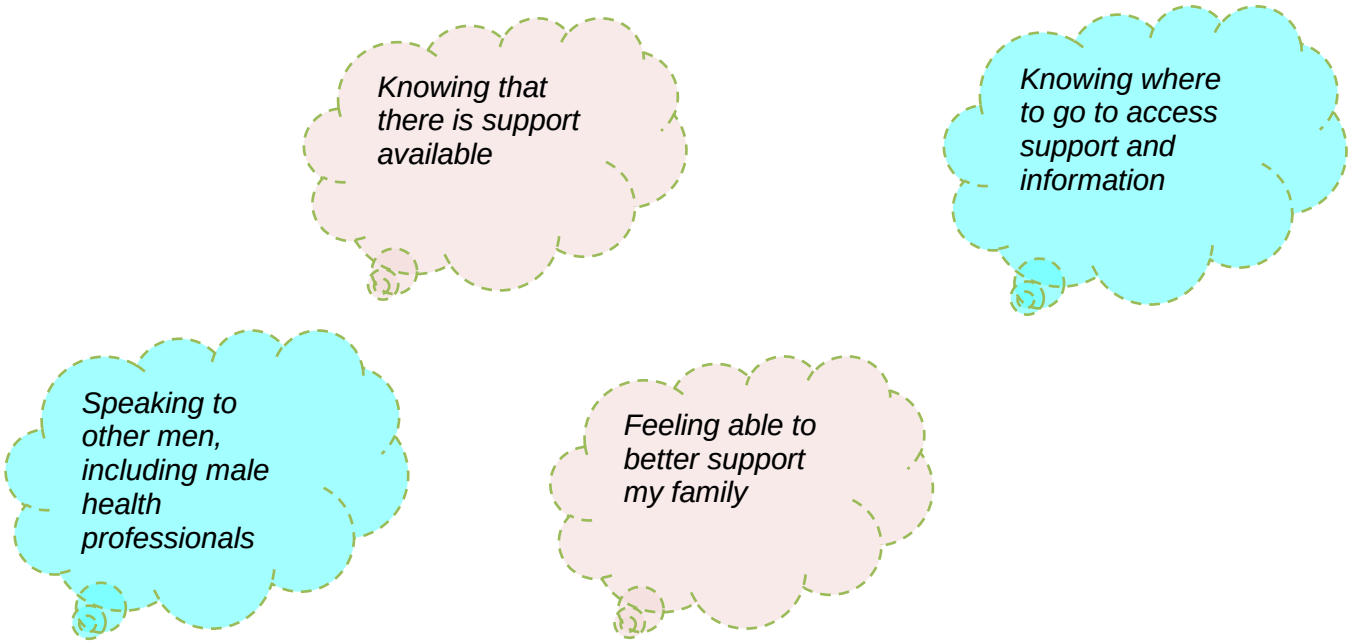
0 – 19 Service

Aim Statement: To introduce a dad's health group

The 0 – 19 service wanted to understand father's experiences of care provided by the service and work with them to design a service that they would want to access

The service identified a small cohort of fathers who supported them by taking part in a focus group. They helped develop a questionnaire which is now part of the health visitor contacts

Feedback from the focus group included:



The focus group also supported the service in co-designing and developing several quality improvements and change ideas. Detail of successful changes as a results of the always event

- Men's health group to start in a local Children's Centre
- Men's health questionnaire devised
- Men's health resources identified and will be added to patient facing website
- Plan to review number of father's registered on SystmOne (electronic patient health record)

Aim Statement: Improved accessibility to Sexual Health Wirral clinics – increasing choice and reducing waste

The main objectives of the Always Event for Sexual Health Wirral were:

- Offer increase choice to patients / service users
- Respond to overwhelming patient feedback requesting increased walk and wait session
- Continue to offer pre-booked appointments for those who prefer a planned approach
- Reduce wasted clinical time following peaks in do not attend (DNA) rates
- Protect pre-booked appointments to Wirral residents whilst offering wider walk in care to anybody (all areas) as per NICE recommendations and contractual agreements
- Reach full capacity meaning more patients with routine needs can be seen

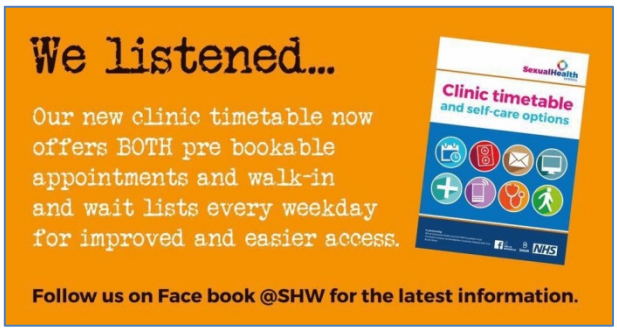
To help combat our DNA rates for pre-booked appointments (resulting in wasted protected clinical time) whilst also reducing the pressure of high demand at walk in and wait clinics, in August 2019 we looked at the potential of re-modelling of our 8am – 8pm, 5 days a week service. We included staff in these discussions to welcome thoughts and ideas and we also looked at the design of neighbouring Sexual Health services.

The outcome of this development project saw us adopt the plan of a new service model; to run 8am – 8pm walk in and wait clinics every weekday with 1 of 3 clinical streams protected for pre booked appointments - available to book online or via tele-booking. This would ensure those who required a more structured pre-planned approach to care could still access our service in this way.

Communication and promotion

The service used its Facebook pages and social media platforms to promote the new model. The redesign of the timetable was shared widely and feedback was really positive.

Example of communication and public messages / social media and redesign of our service timetable:



Feedback from Patients:

I still prefer booking ahead as I have to arrange my availability around childcare and my partner's shifts but it's good to know that I could walk in if my problem was more urgent

It is much easier now that you have walk in clinics every day – all day. I can choose what day is best for me and just turn up. I don't mind waiting to be seen

Feedback from Staff:

If I have an appointment list and I have a couple of DNAs, I can just pick up off the walk in clinic to help reduce the waiting times, use my time more effectively. When we had appointment clinics separate to walk in, that time would have been wasted waiting for my next patient which may have been half an hour later

The clinic flows better, because walk in is open longer we don't get that same rush of patients in a short 3 hour window – patients are more spread out

Dental Service

Aim Statement: To introduce information leaflets and other patient literature using easy read and symbol formats for patients with additional needs

By purchasing a software programme called 'Widgit', the service was able to produce easy read / pictorial leaflets for their patients, both children and adults, who find reading text difficult for a variety of reasons, including learning needs and low literacy skills. By adding symbols to their existing information leaflets they were able to engage and communicate more clearly with patients.

The aim of the innovation was to:

- Produce a range of Easy Read Patient Information Leaflets to use across all client groups attending for specialist dental treatment
- Produce written information in an easy read format in which straightforward words and phrases are used supported by pictures, diagrams, symbols and / or photographs to aid understanding and to illustrate the text
- Ensure effective communication at all times meeting Accessible Information Standards

Community Cardiology

Aim Statement: By March 31st 2020, we will introduce four new talks to the cardiac rehabilitation education programme for patients to increase the breadth of information given.

The main objective of the Always Event was to ensure that patients always have the most up to date, evidenced based information to enable them to manage their condition.

Community Cardiology held a service development day to discuss current provision of the educational talks. Staff felt the existing talks needed updating to include some new treatments and information.

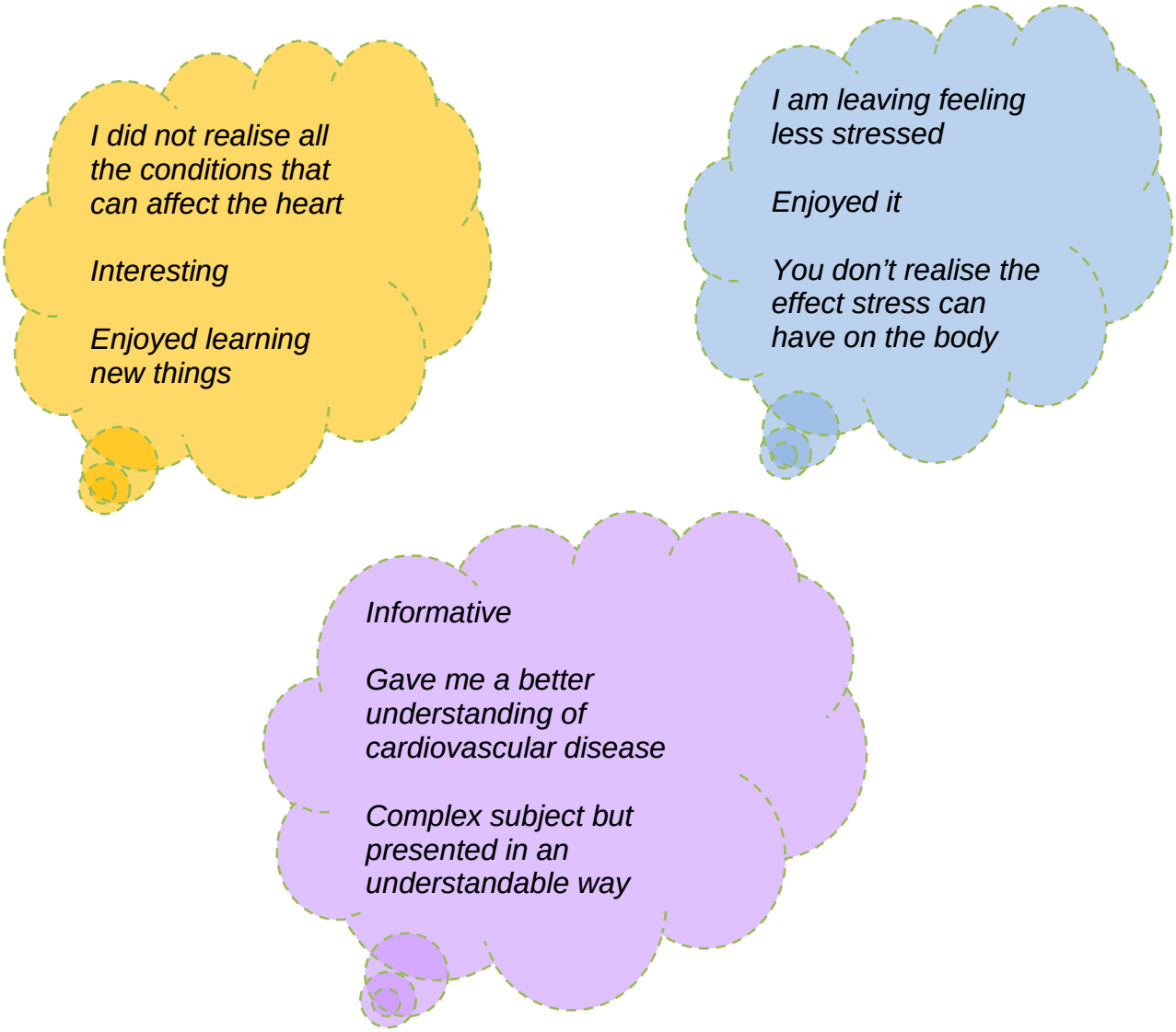
The talks incorporate information to ensure patients learn about their condition, medications and risk factors but also make sure they understand the government guidelines and learn how to reduce their cardiovascular risk. It also gives the patients confidence in managing their condition and gives them tools to have a better quality of life.

Patient feedback was reviewed from the following educational talks:

- Cardiovascular disease and heart
- Cardiac conditions
- Risk factors
- Managing your medicines
- Heart failure explained
- Healthy mind, healthy heart
- Stress and your heart health
- Exercise for a healthy heart
- Healthy eating
- Basic Life Support (new)
- Getting back on track (new)

- Weight management (new)
- Atrial Fibrillation and Stroke (new)

Feedback from patients following the educational talks:



Service Innovation

The Trust has an innovation fund which was established in 2014 / 2015 and was designed to support and introduce service transformation opportunities, driven by a culture of staff engagement and ownership.

A robust process for staff innovation applications has been developed and the projects must set out an innovative approach that makes a significant contribution to the evidence base for delivering high quality care.

All innovation proposals must meet the essential requirements of the scheme and address at least three of the specific CQC themes.

Three innovation applications were considered during 2019 / 2020

Community Nursing - Implementation of Veinlite scanner within community nursing to aid cannulation and venepuncture for housebound patients

This innovation was granted Trust innovation funds

Infusion therapy is now an integral part of professional practice for many healthcare professionals. It ranges from peripheral cannulation to caring for patients with multiple parenteral and haemodynamic therapies.

Infusion therapies may be a result of an emergency or planned care and will be dependent on the clinical needs of the patient, with therapy ranging from a few days to a number of weeks and months.

The introduction of a digital vein scanner will improve service delivery and patient related outcomes and experience by allowing clear vision of the veins, therefore reducing the need for multiple attempts of an invasive procedure which can cause discomfort to the patient.

The aim of the innovation was to:

- Improve clinical effectiveness of cannulation and venepuncture
- Improve patient experience and satisfaction
- Reduce requirement for calls to Outpatient Parenteral Antibiotic Therapy (OPAT) Service / GP Out of Hours to cannulate patients
- Reduce delays in treatment and missed doses of medication
- Reduce patient safety incidences (e.g. extravasation), reduce increased risk of infection and reduce the need for multiple invasive procedures

Community Cardiology - Reducing the secondary Cardiovascular Disease (CVD) risk through Point of Care Testing (POCT) of Cholesterol levels within Cardiovascular Rehabilitation.

This innovation was granted charitable funds. This innovation is to continue during 2020 / 2021.

Most patients have their full Lipid (cholesterol) profile when they are an inpatient following their cardiac event. Patients are prescribed Lipid lowering medication. The project will empower patients to know their cholesterol levels and what that means for their Cardiovascular Disease risk. Knowing that they are going to be retested at 12 weeks and then 12 months will aim to help motivate them to maintain lifestyle changes and comply with cholesterol lowering treatments.

The aim of the innovation was to:

- To be able to assess the cholesterol control and effectiveness of medical and lifestyle management of patients referred to Cardiovascular Rehabilitation following an emergency admission resulting in a Primary Percutaneous Cardiac Intervention following a heart attack
- Use the information to support patients in reducing their CVD risk
- Further develop the role of the non-medical prescribers in CVD Rehabilitation to achieve medical optimisation of cardio protective therapies

Two innovations which were approved in 2018 / 2019 were 2 year projects

Children's Speech and Language Therapy - Hanen Training

The innovation was granted innovation funding in 2018 / 2019

The service are committed to providing highest quality, evidence based care that has a positive outcomes for children and their families. The Hanen programme provides a proven teaching methodology and coaching framework for effectively engaging parents in their child's early language intervention. The service uses strategies with children to develop their language skills for 30 minutes a week but wanted to empower parents to develop their child's skills all the time.

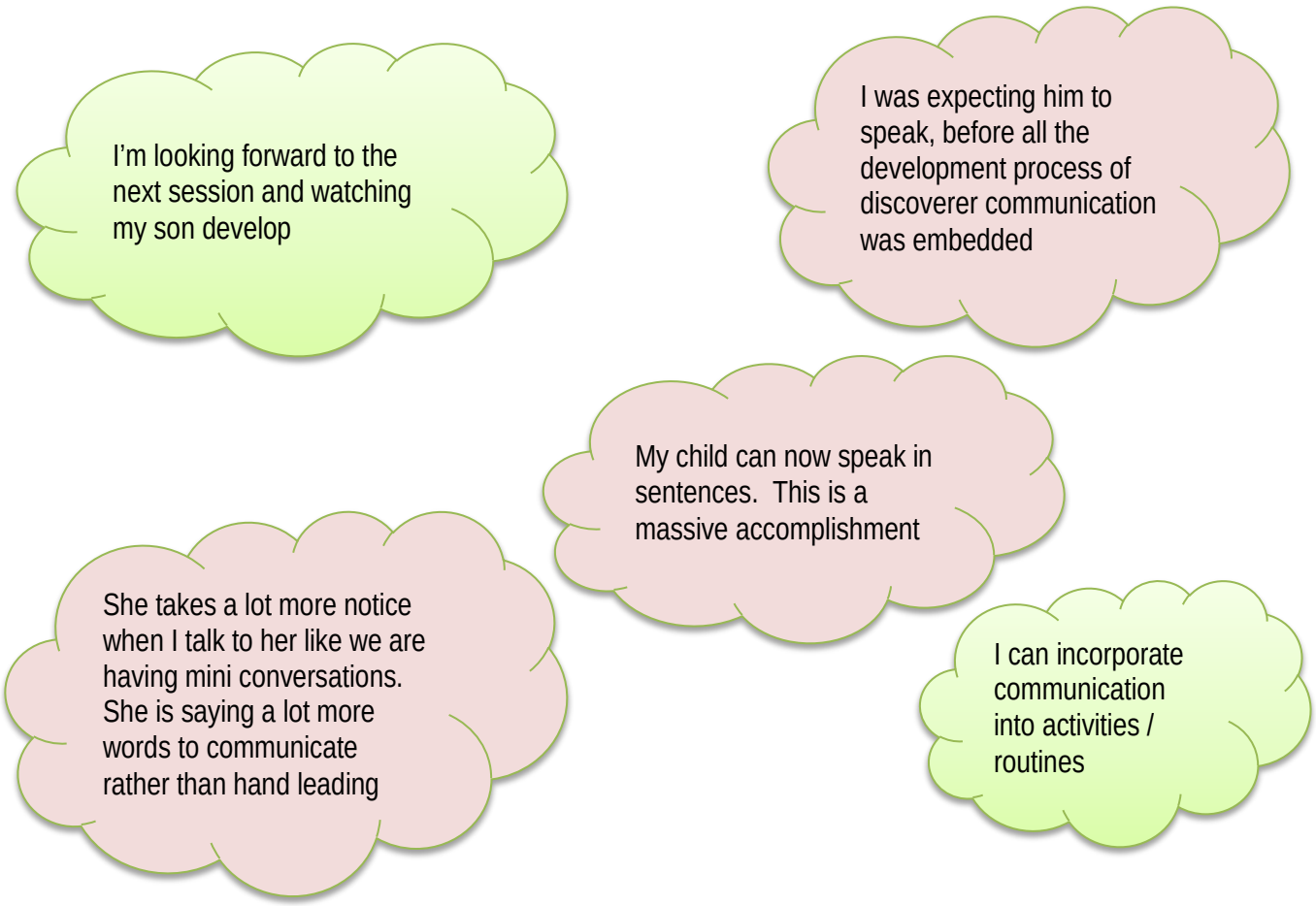
By enabling parents to provide the best possible language learning environment in their own home, their children will enter school with better language skills and are therefore likely to do better throughout school. Once the therapists were trained, they commenced running the programme immediately and the number of children and families they can support increased.

The aim of the innovation was to:

- Increase the amount of therapists trained in It Takes Two to Talk'® - The Hanen Program® for Parents of Children with Language Delays within the department so that programmes can be offered where there is an identified need.

- We aim to empower parents to support their child's language development at home

Feedback from families who have attended the course include:



0-19 Service Senior Health and Wellbeing Advisor

The innovation was granted innovation funding in 2018 / 2019

The Health Promotion Team (Fit Club) within the 0-19 service works with overweight children across Wirral who have been identified above the 98th centile. Many of these young people have low confidence levels and anxiety around physical activity and are put off by traditional school or community based sports.

The senior health and wellbeing advisor is committed to providing quality physical activity sessions for children and young people who are above a healthy weight and who may not like traditional forms of exercise. By using an external coach, the service was able to signpost clients to the sessions at no cost to the Trust.

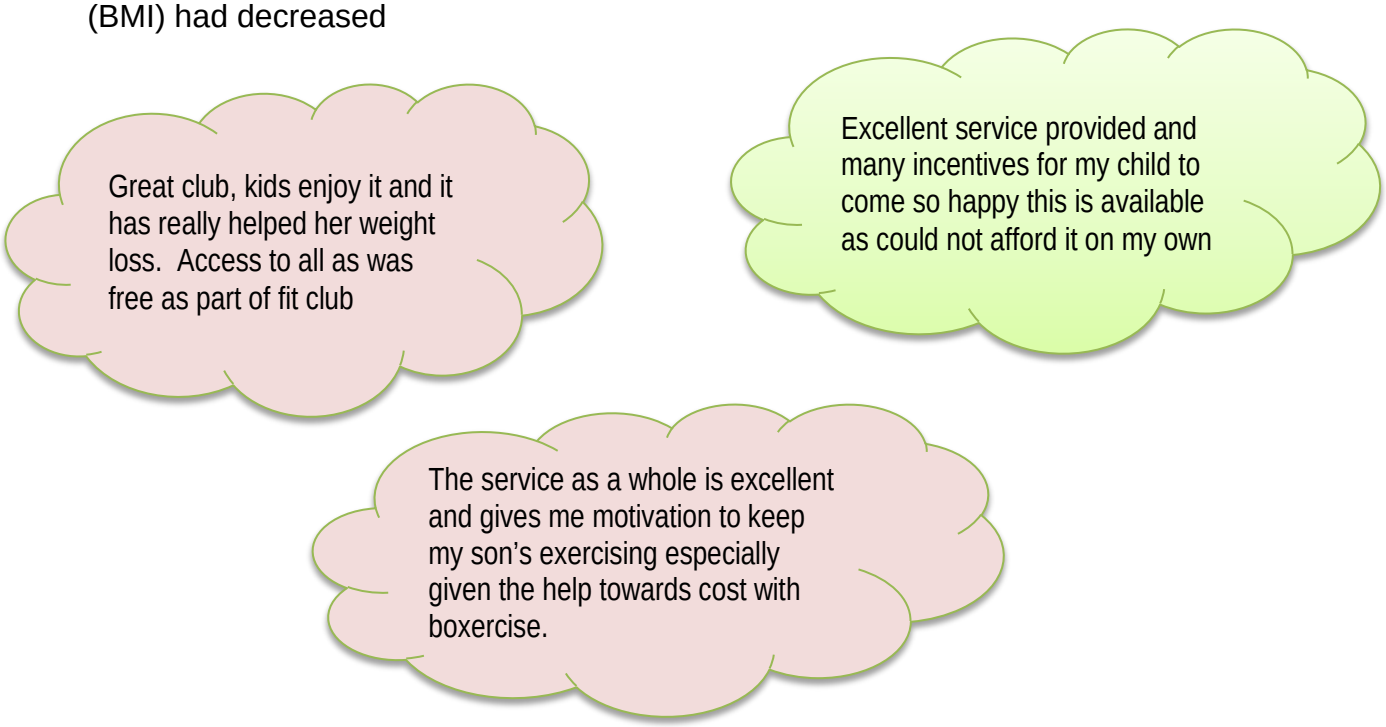
The funding has allowed the service to provide a greater service to clients in a comfortable, safe environment where they are less likely to meet people from school as they might do if they attended a sports centre.

The aim of the innovation was:

- To provide a quality physical activity session to children and young people who are above a healthy weight and who may not like traditional forms of exercise.
- To deliver two exercise sessions a week for a younger vs older age group.
- To monitor the impact of these sessions on emotional health and wellbeing measures, improved BMI (Body Mass Index) and attendance rates

Some of the outcomes following the project are:

- Of the 26 children who completed the boxercise programme, 66% of children's Body Mass Index (BMI) had decreased
- Of the 17 children who completed the circuit programme, 76% of children's Body Mass Index (BMI) had decreased




What is Fit Club?
We are a confidential NHS service offering a FREE tailored, 1 to 1, personalised or group support plan for children who are above a healthy weight.
Our inclusive, young people friendly service can really help your child reduce or maintain their BMI. We have an 80% success rate in reducing or maintaining BMI. We work with parents and carers, and can arrange to see your child in a health centre, school or at home.
Our team
We are a team of registered nurses, childcare practitioners and qualified health trainers.
How it works
Working on a 1 to 1 basis with one of our health professionals your child will be given a tailor made plan just for them. During this initial comprehensive health assessment we take a note of your child's BMI and lifestyle and they will be seen over a 6 month period, depending on their identified needs.

Sessions cover...

- diet, nutrition, portion size and physical activity
- signposting to activities that you can take part in based in your local community
- access to other NHS services that could be of potential benefit to your child, eg Speech and Language Therapy, Child Continence Service

We aim to make the service as convenient as possible by offering a variety of time slots that suit you and your child's needs.

Accessing Fit Club

Although Fit Club is **FREE** your child will still need a referral to access the service. Ask your GP, School Nurse, Paediatrician or other healthcare professional to refer your child.

If you have any questions about our service please feel free to contact us on: **0151 643 5403.**

If you would like this information in another format, please contact the Your Experience Team on freephone 0800 694 5530. Alternatively you can email wcnt.yourexperience@nhs.net

Individual staff / teams / services who were nominated for external awards during 2019 / 2020

During 2019 / 2020 the Trust was recognised for its success in improving services through better integration and coordination, in line with our goals and some examples of our successful awards are provided below.

- The Tele-triage Service won the Empowerment Award at the inaugural Cheshire and Merseyside Digit@LL Awards 2019. The service was selected from a large number of nominations for transforming healthcare within nursing and residential homes, enabling better outcomes for patients and reducing the pressure on A&E. Through the use of iPads and Skype, the Tele-triage Service provides healthcare advice to care home staff, helping to manage any health concerns they have about their residents and thereby aiming to reduce unnecessary hospital admissions

- The Tele-triage Service was also announced as Transformation Award finalists in North West Coast Research and Innovation Awards 2019

- Integrated Children's Division were awarded Level 1 'Always Event®' from NHS England and Institute for Healthcare Improvement. Always Event® is a co-production quality improvement methodology which seeks to understand what really matters to patients, people who use services, their families and carers and then co-design changes to improve experience of care

- Business Information Team won 'ISD Innovation award for Collaboration' for a project on a 'High Intensity User Dashboard'. It was won in conjunction with Wirral Health and Care Commissioning and Wirral University Teaching Hospital

- The Trust received an Innovation Award for the Standards Assurance Framework for Excellence (SAFE) system at In Phase's annual user conference. SAFE is the Trust's quality assurance system to support the monitoring of CQC standards

- Leasowe Personal Dental Service have retained their British Dental Good Practice Award. Good Practice is a quality assurance programme that allows its members to communicate to patients an ongoing commitment to working to standards of good practice on professional and legal responsibilities

- Our 0-19 service was shortlisted for a Nursing Times Award 2019 in the Child and Adolescence Services category recognising innovation and evidence of improved outcomes of care that involves families and / or empowers adolescents

- Community Nurse Manager application to be Queen's Nurse was approved. A Queen's Nurse is someone who is committed to high standards of practice and patient-centred care. They are trusted and valued by the people they serve and respected and admired by their peers. They are enthusiastic and passionate about the care they provide

Learning from Incident Reporting

Performance in 2019 / 2020

The Trust is committed to delivering high quality, clinical care free from avoidable harm, ensuring patient safety. When patient safety incidents do occur, they are managed in an open and transparent manner, in accordance with the Duty of Candour, ensuring a culture of continuous improvement as a result of learning from experience.

Shared learning is communicated using a variety of methods, which can include:

- Shared learning by listening to patient stories and learning from patient experience
- Shared learning with the relevant teams to promote continuous quality improvements
- Reporting learning to commissioners as part of the quality contract monitoring
- Significant clinical incidents may be shared via the patient safety bulletin
- Significant medication incidents are shared via the Medicines Management bulletin
- Local procedures and policies are updated when significant learning needs to be incorporated for all staff to promote harm free care and to promote staff safety

Never Events

During the 2019 / 2020 reporting period the Trust had 0 never events

Clinical Effectiveness

Progress made during 2019 / 2020

Quality Improvements

During 2019 / 2020, services within the Trust undertook a range of quality improvements using the Model for Improvement Plan, Do, Study, Act (PDSA) cycle to improve patient safety, patient experience and clinical effectiveness.

Key achievements include:

1. **Community Nursing - Improvement in the monitoring of patient blood levels appropriate to the IV antibiotics being administered**

Goal One: Number of incidents reported by WUTH/OPAT in relation to incorrect blood monitoring

Goal Two: Reasons for errors with blood monitoring and collection

Goal Three: Use of the blood monitoring care plan

Goal Four: Re-admissions to hospital

This Quality Improvement was not completed before 31 March 2020 due to Covid-19 pandemic

2. **Community Nursing - Improvement in the clinical management of patients with diabetes**

Goal One: To seek an improvement in the clinical management of patients with Diabetes

- All 19 patients audited saw a reduction in the number of visits
- The number of visits reduced from 280 to 56, resulting in a **reduction of 224 visits** was achieved

Goal Two: To demonstrate via case study the role of the Diabetes Specialist Nurse in complex discharge of diabetic patients

- 2 case studies documented the important role a diabetes specialist plays in the discharge of complex diabetic patients

Goal Three: To calculate time released to care

- A total of **37 hours 33 minutes of time** was released to care based on a 10 minute appointment
- A total of **74 hours 40 minutes of time** was released to care based on a 20 minute appointment (which allows for travel time)

3. Bladder and Bowel Service - Improving Quality of Life for patients' with continence problems

Goal One: To reduce the number of patients with a catheter by identifying those suitable for a trial without catheter (TWOC) or an alternative management plan

- Achieved by performing a catheter review of all patients including those who experience multiple unplanned catheterisations due to complications associated with the catheter

Goal Two: To reduce the use of catheter maintenance solutions which are currently used for the prevention of catheter blocking and by-passing

Achieved as part of the catheter review with the aim of discontinuing its use. The use of FarcoFill and open tip catheters will be considered as an alternative for the management of problematic catheters. It is anticipated that this will reduce the catheter related workload for community nursing team and the night service

Goal Three: To conduct a review of the patient's catheter product prescription and stock levels

- For those patients who are prescribed catheter products that are not on the Trust Formulary their prescription will be changed. It is anticipated that this will have a positive impact on the prescribing budget

Goal Four: To demonstrate via case study the importance of the Bladder and Bowel service in enhancing the quality of life for patients with an indwelling catheter

- The two patient case studies identify when an invasive device is managed by the Bladder and Bowel service, this often resulted in a reduction in crisis calls

Goal Five: The pilot aims to reduce community nursing workload including crisis calls associated with problematic catheters

- **56%** of patients (5/9) who were identified for a Trail Without Catheter (TWOC) are now catheter free following successful TWOC

4. Rehabilitation at Home - Quality of Triage Process

Goal One: Introduce SBAR tool to triage process

- A triage template is available on patient electronic records which includes the Situation, Background, Assessment, Recommendations (SBAR) tool to record key facts relating to the patient

Goal Two: Each staff member to review 5 patient referrals

- 5 staff members reviewed 5 patient records using the SBAR tool

Goal Three: To undertake a brainstorming session to evaluate results

- To continue using SBAR within the service
- Team leaders to discuss more complex referrals as and when required, to ensure appropriate triage

5. Wheelchair Service - Co-production of personalised wheelchair pathway

Goal One: Introduce standardised list for staff to ensure all patients receive same budget offering

- **100%** of patients were offered a personal wheelchair budget in clinic
- **100%** of patients received a personalised assessment where they were supported to identify the health and wellbeing outcomes they wished to achieve

Goal Two: Each patient to receive a personal support plan which captures their health and wellbeing outcomes

- **100%** of patients agreed a personal support plan which captured their health and wellbeing outcomes

Goal Three: All eligible patients with a mixture of budgets are offered a choice of Notional, Notional Plus or 3rd party budget to fund their prescribed wheelchair

- **100%** of patients received information prior to assessment about the money available in their personal wheelchair budget and the options available to them locally to use it

- **100%** of patients received information about the repair and maintenance of wheelchairs (3rd party wheelchairs), if the option to purchase a wheelchair outside of the NHS commissioned service is taken

Goal Four: To obtain patient experience of choosing a personal wheelchair budget

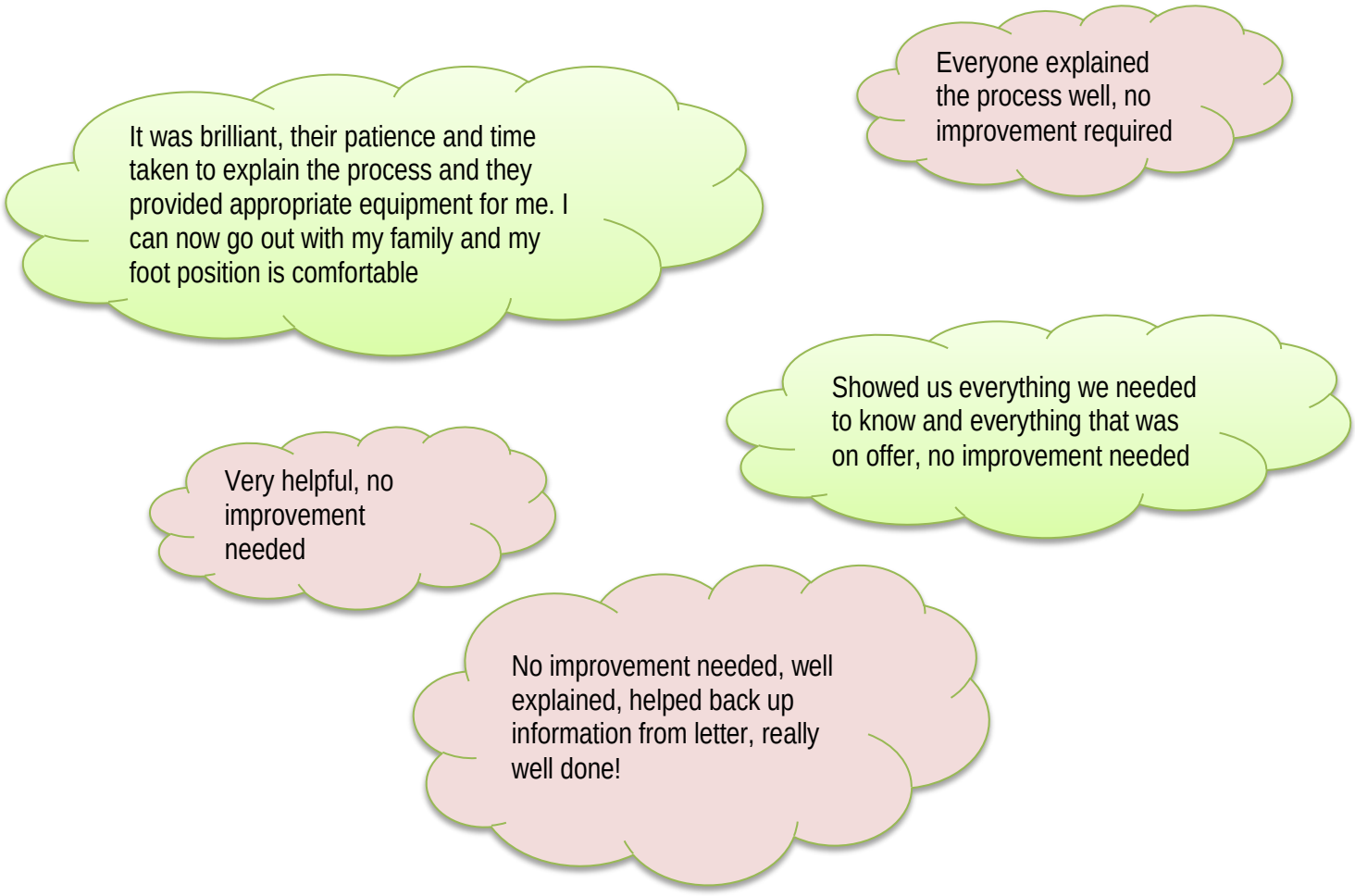
17 personal wheelchair budget questionnaires were collated with the following results:

- **94%** (16/17) of users were happy with the level of information provided before they attended for their appointment
- **88%** (15/17) of users could understand the written information given to them prior to attending their appointment
- **100%** (17/17) of users felt that staff explained their options
- **100%** (17/17) of users felt that after staff explained their options, they understood what was explained to them
- **100%** (17/17) of users felt involved in their decision making
- **100%** (17/17) of users felt that they had enough time to ask questions
- **94%** (16/17) of users felt they had enough choice as to the type of wheelchair

The wheelchair service contacted the user after one month by telephone to obtain further feedback after the user had been using the wheelchair:

- **100%** (17/17) of users felt that their wheelchair helped them do what they stated in their health and wellbeing outcomes, which were completed at their original appointments
- **94%** (16/17) of users felt that they had made the right decision on their wheelchair

Service users were asked 'how could it be better'



6. Community Cardiology – Education talk review to improve patient experience

Goal One: To introduce four new talks to the cardiac rehabilitation education programme to increase the breadth of information given to patients

- In April 2019, four new talks were introduced

Goal Two: To redesign the current educational talks the service offers to ensure the most up to date information is being delivered

- Existing talks updated to include some new treatments and information
- On review, staff felt some of the information was misplaced in some talks and would be better suited to another

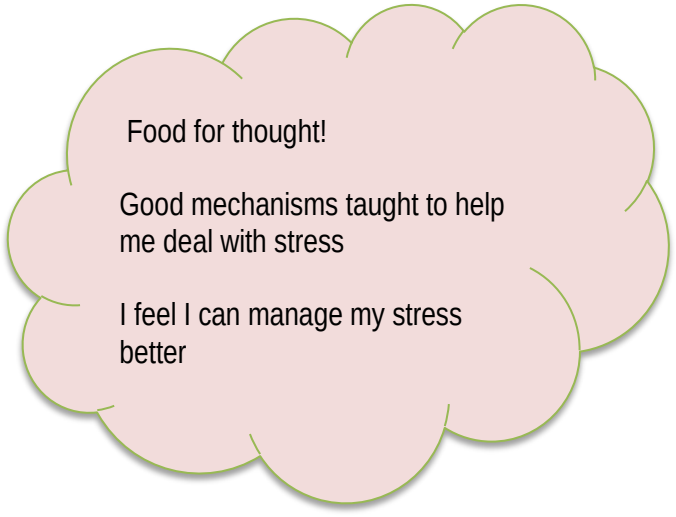
Goal Three: To measure patients HAD anxiety and depression score pre and post attendance at cardiac rehabilitation talks

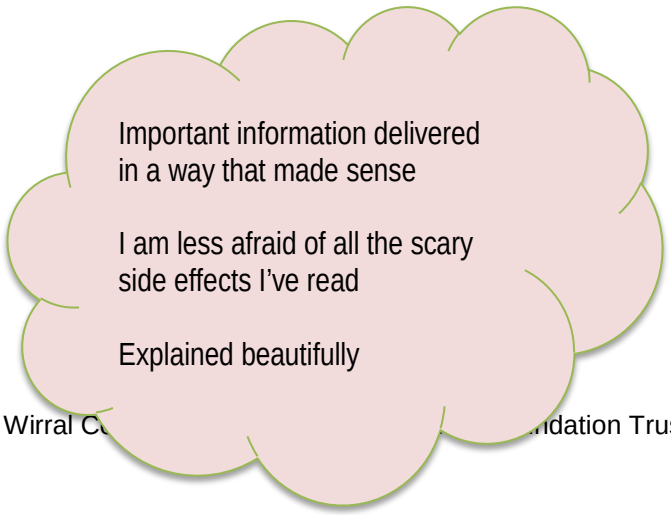
- 4 patients anxiety score reduced, with 2 patients remaining the same
- 6 patients depression score reduced, with 1 patient staying the same

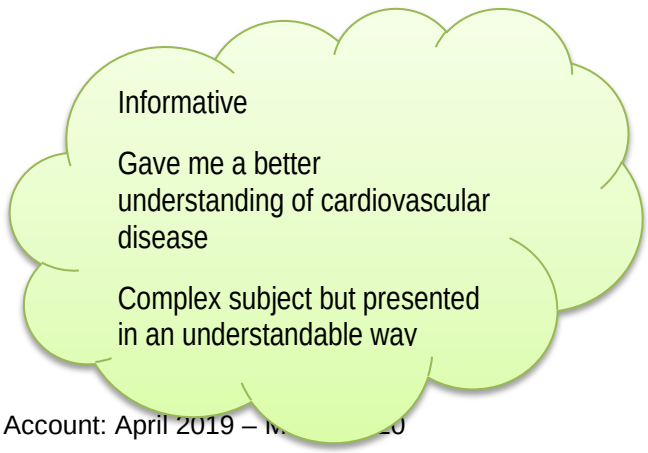
Goal Four: To review patient feedback from patients who attended an education talk

Patient feedback was reviewed from the following education talks:

- Cardiovascular disease and heart
- Cardiac conditions
- Risk factors
- Managing your medicines
- Heart failure explained
- Basic life support
- Getting back on track
- Healthy mind, healthy heart
- Stress and your heart health
- Exercise for a healthy heart
- Heathy eating
- Weight management
- Atrial Fibrillation and stroke







7. Paediatric Speech and Language Service - Clinical pathway for children with social communication issues

Added to annual programme for 2020 / 2021 as Quality Improvement was more extensive than originally thought

8. Paediatric Dietetics - Introduction of Therapy Outcome Measures (TOMs)

Goal One: To measure the impact of pre and post interventions for children attending paediatric dietetics

TOM Core Scale

Identify descriptor that is "bestfit". The patient/client does not have to have each feature mentioned. Use 0.5 to indicate if the patient/client is slightly better or worse that a descriptor and as appropriate to age.

Impairment

0 The most severe presentation of this impairment

1 Severe presentation of this impairment

2 Severe/moderate presentation

3 Moderate presentation

4 Just below normal / mild impairment

5 No impairment

- **96%** of children showed an improvement in 'impairment'

Activity

0 Total dependent / unable to function

1 Assists / cooperates but burden of task / achievement falls on professional or caregiver

2 Can undertake some part of task but needs a high level of support to complete

3 Can undertake take / function in familiar situation but requires some verbal / physical assistance

4 Requires some minor assistance occasionally or extra time to complete task

5 Independent / able to function

- **87%** of children showed an improvement in 'activity'

Participation

0 No autonomy, isolated, no social / family life

1 Very limited choices, contact mainly with professional, no social or family role, little control over life

2 Some integration, value and autonomy in one setting

3 Integrated, valued and autonomous in limited number of settings
4 OPccasionally some restriction in autonomy, integration or role

5 Integrated, valued, occupies appropriate role

- **92%** of children showed an improvement in 'participation'

Wellbeing / Distress

0 Severe constant: High and constant levels of distress/upset/concern/frustration/anger/ embarrassment/withdrawal/severe depression/ or apathy. Unable to express or control emotions appropriately.

1 Frequently severe: Moderate distress/upset/concern/frustration/anger/embarrassment/ withdrawal/severe depression or apathy. Becomes concerned easily, requires constant reassurance/support, needs clear/tight limits and structure, loses emotional control easily.

2 Moderate consistent: Distress/upset/concern/frustration/anger/distress/embarrassment/ withdrawal/severe depression/apathy in unfamiliar situations. Frequent emotional encouragement and support required.

3 Moderate frequent: Distress/upset/concern/frustration/anger/embarrassment/ withdrawal/severe depression/apathy. Controls emotions with assistance, emotionally dependent on some occasions, vulnerable to change in routine, etc., spontaneously
uses methods to assist emotional control.

4 Mild occasional: Distress/upset/concern/frustration/anger/distress/embarrassment/ withdrawal/severe depression/apathy. Able to control feelings in most situations, generally well adjusted/stable (most of the time/most situations), occasional emotional support/encouragement needed.

5 Not inappropriate: Distress/upset/concern/frustration/anger/embarrassment/withdrawal/ severe depression/apathy. Well adjusted, stable and able to cope emotionally with most situations, good insight, accepts and understands own limitations.

100% of children showed an improvement in 'wellbeing'
Wellbeing / Distress questions are applied to the carer, which is particularly relevant to paediatric patients

Goal Two: To demonstrate that the paediatric dietetic service input has an impact for a complete episode of care

100% of children showed an improvement in 4 or more domains – **32%** in 4 domains and **68%** in all 5 domains

Goal Three: To obtain staff experience using TOMs

Comments were collected from all 4 team members employed at the time of the pilot, and themes were grouped.

Anecdotally all staff reported the TOMs were quick and easy to use, but felt that they would need more practice and a longer trial period to reduce inter-observer variability.

Staff also commented on the subjective nature of TOM's assessment and therefore the potential for misuse.

9. Special School Nursing - Introduction of Situation, Background, Assessment and Recommendation (SBAR) tool for handover

Goal One: Research use of SBAR for handover tool

- NHS Improvement: ACT Academy SBAR documentation reviewed

Goal Two: Staff thoughts and feedback prior to introduction of SBAR / after trial period of SBAR

- A staff questionnaire was circulated to school nurses to obtain some baseline data relting to current staff handover process

Goal Three: Trial use of SBAR for a period of 4 months / alterations of the tool if needed

- Pilot undertaken of staff completing SBAR at handover
- Handover guidance distributed to staff
- SBAR template reviewed and updated following feedback / audit of completed SBARs

Goal Four: Review of SBAR and monitor compliance

An audit was undertaken of 20 completed SBARs:

- **85%** of SBARs were clear and expectations of practitioner concise

Goal Five: Staff education pre pilot of SBAR tool

- A presentation entitled 'How we communicate with each other' was presented to all school nurses

10. Paediatric Continence - To improve the referral pathway for continence assessment

Goal One: To develop a referral pathway into children's continence service

- A referral pathway and criteria has been developed

Goal Two: To review all assessment documentation (baseline tools) for health visitors and school nursing staff and upload to SystmOne (patient electronic health record)

- All assessment documentation has been reviewed and uploaded to SystmOne

Goal Three: To ensure a wide range of literature available to parents/carers

- **8** patient information leaflets are available for distribution to parents / carers. These are now available on our website for families

Goal Four: To collect data to monitor referral levels to the continence service

95 referrals were made from July 2019 to end March 2020:

- Health visiting 31 total for 9 months Average **3.4** per month
- School nursing 64 total for 9 months Average **7.1** per month

The overall average of referrals made for school nursing and health visiting is **5.3 per month**

11. Ophthalmology - Glaucoma Awareness

Goal One: To ensure information complies with Accessible Information Standards (AIS) instruction on drops

- Leaflet to be designed by communications team and approved at Trust Your Voice Group to ensure all AIS standards are adhered to

Goal Two: To measure patient's level of understanding of glaucoma

A patient questionnaire was developed to gain patient feedback on their understanding of their condition

	Yes	No	Unsure
Was it explained to you what Glaucoma is?			
Are you able to put drops in yourself or do you have a carer who supports you?			
Do you know how often you should put eye drops in?			
Do you know how many drops to put in each time?			
Do you know why we are doing various tests on your eyes?			
Are you aware of your follow up appointment?			
Would you find a patient information leaflet on Glaucoma useful?			

- A patient experience questionnaire was distributed to patients for feedback
- **60%** of patients felt an explanation about glaucoma was given

Goal Three: To gain patient feedback on eye drop use

A questionnaire was distributed to patients:

- **87%** of patients were able to put drops in themselves or had a carer to support them
- **47%** of patients knew how often they should put eye drops in
- **50%** of patients knew how many drops to put in each time
- **73%** of patients would find a patient information leaflet on glaucoma useful

Goal Four: To introduce a patient information leaflet for eye drop use

- A patient information leaflet to be developed for eye drop use. To be approved at Trust Your Voice group before launch

12. Walk-in-Centres – Improvement in Triage times in Walk in Centres

Goal One: To seek a measureable improvement in Triage times for patients presenting to walk in centres

- The average for October 2019 was 38.27% compared to **March 2020** of **72.07%**
- The **highest percentage of 93%** was achieved in **March 2020**
- A business case was written to support the walk in centres with the target of 15 minute triage
- In January 2020 the location of the shift manager changed to allow an overview of the 3 walk in centre sites
- A daily Safety Huddle is undertaken which raises awareness of the 15 minute national triage target for urgent treatment centres
- Business Intelligence collect performance data on 15 minute national triage target and distribute
- From February 2020 the Centre Manager worked differently to allow for the operations and nursing teams to work closer together to support the 15 minute triage
- During March 2020 the Urgent Treatment Centre Lead Nurse worked in a predominantly supervisory capacity with a focus on reducing triage times

CQUINS

Performance in 2019 / 2020

During 2019 / 2020 the Trust participated in the following CQUINS:

National CQUINS

1. Staff Flu Vaccinations – Fully achieved

The aim of the staff flu vaccination CQUIN for 2019 / 2020 was to immunise 80% of reportable staff. As a Trust we achieved 82%

Local CQUINS

1. Human Factors learning in Serious Incident Management – Fully achieved

The aim of this CQUIN was to examine incident themes where situational awareness has been reported as a contributing factor. Using Human Factor theory and practices will enable stronger and more consistent learning to be identified and addressed.

2. Culture of Care Barometer **–** Fully achieved

The aim of this CQUIN was to highlight specific issues within the care environment and or highlight early warning signs of cultural issues which could impact on patient care. This CQUIN will support the development and delivery of action plans to address the survey findings.

3. Developing an IPC back to basics programme – Fully achieved

The aim of this CQUIN was to raise the standard of infection prevention and control across the NHS aiming to:

- Reduce health care associated infections
- Break the chain of infection
- Essential steps and SAFE
- Recognise the importance of hand hygiene in health care
- Improve patient harm free care

Quarter 4 reports were stepped down due to Covid-19, however due to the excellent work completed during Quarter 1 – Quarter 3, payment was still received by the Trust

Freedom to Speak Up

Our ‘Freedom to Speak Up’ team is led by our Freedom to Speak Up (FTSU) Guardian. The Guardian provides independent and impartial advice to staff and can be contacted by any member of staff if they feel that the matter is serious enough or that it hasn’t been resolved properly.

The Guardian is supported by our Freedom to Speak Up Champions who play an important role in encouraging staff to raise concerns at the earliest reasonable opportunity. They act as ambassadors for the Speaking Up Policy and they receive training to support them in their role.

Our Freedom to Speak Up champions support an open and transparent place to work, where all colleagues are actively encouraged and enabled to speak up safely. They have a key role in helping to increase awareness of raising concerns, as well as providing confidential advice and support to staff in relation to concerns they have about patient safety and/or the way concerns are handled

The role will have a direct impact on continuously improving safety and quality for our service users, carers and families, as well as enhancing the experience of our staff.

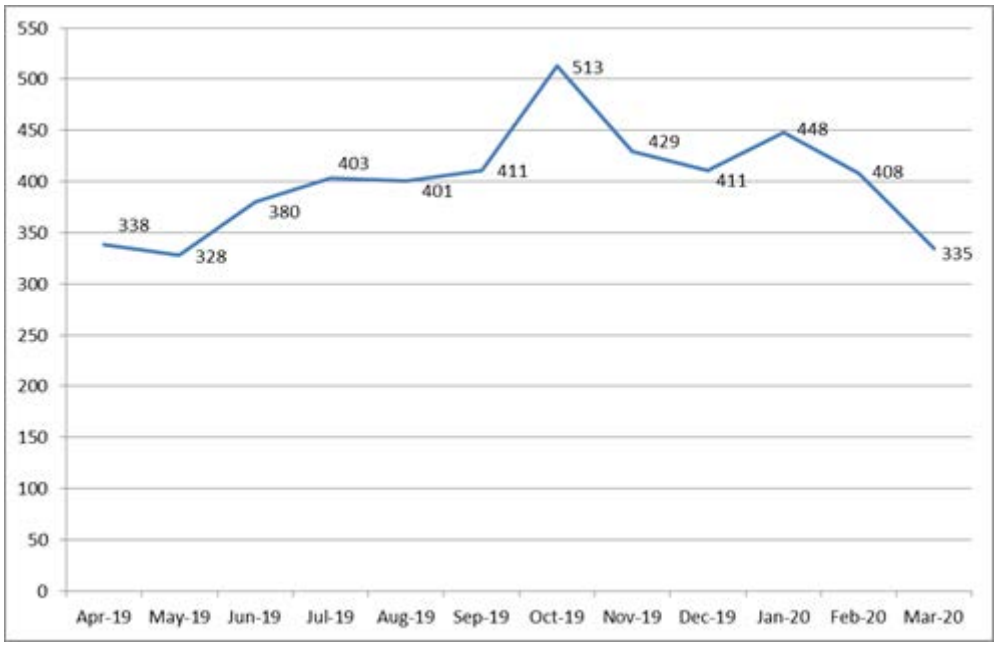
Champion Responsibilities:

- Advising employees of the options available to them, relevant trust policies and who to contact
- Offering support and advice to those who want to raise concerns
- Being an FTSU ambassador, raising awareness amongst staff
- Encouraging staff to raise concerns at the earliest opportunity
- Instilling confidence that concerns will be listened to and addressed
- Helping ensure the voice of staff is heard at a senior level
- When receiving information that has legal implications for the trust, or implications in line with professional codes, reporting the outcome in a timely manner to a senior line manager

Champion qualities and attributes:

- Passionate about creating a culture of openness and honesty
- Believe and trust our values and behaviours
- Demonstrate excellent communication skills
- Show empathy and compassion to others
- Have personal resilience
- Patient and staff advocate

Patient Safety Incidents 1st April 19 – 31st March 20



Patient Safety Incidents Severe Harm or Death as an Actual Degree of Harm

	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Total
Severe (Permanent or long term harm caused)	0	0	2	0	0	0	0	0	1	1	0	0	4
Death	8	5	6	3	6	6	9	7	11	7	3	10	81
Total	8	5	8	3	6	6	9	7	12	8	3	10	85

3.2 Performance against relevant indicators and thresholds in the Risk Assessment and Single Oversight Frameworks

In accordance with the quality report for foundation trusts 2017 /2018 guidance, the following indicators appear in both the Risk Assessment Framework and the Single Oversight Framework, and have been identified as being applicable to the trust.

Maximum time of 18 weeks from point of referral to treatment (RTT) in aggregate – patients on an incomplete pathway:

	19/20	18/19	17/18	16/17	15/16	14/15
Maximum time of 18 weeks from point of referral to treatment (RTT) in aggregate – patients on an incomplete pathway	100%	100%	100%	100%	100%	N/A

A&E: maximum waiting time of four hours from arrival to admission/ transfer/ discharge:

	19/20	18/19	17/18	16/17	15/16	14/15
A&E Maximum waiting time of four hours from arrival to admission/transfer/discharge	99.65%	99.77%	99.19%	99.16%	99.57%	99.72%

Annex 1:

Statements from commissioners, local Healthwatch organisations and overview and scrutiny committees

Statement from NHS Wirral Clinical Commissioning Group

Quality Account 2019/20

NHS Wirral Clinical Commissioning Group (CCG) is committed to commissioning high quality services from Wirral Community, Health and Care NHS Foundation Trust. We take seriously our responsibility to ensure that patients' needs are met by the provision of safe, high quality services and the views and expectations of patients and the public are listened and acted upon.

We welcome the opportunity to comment on this account and believe it reflects accurately quality performance in 2019/20 and sets out forthcoming priorities for 2020/21.

We acknowledge that the trust has continued progression against quality priorities and achieved most of the targets set out in the 2018/19 quality accounts.

With regard to the patient safety pillar the trust has achieved a 60% reduction of avoidable pressure ulcers for patients care for by the trust during 2019/20. This has been achieved by the implementation of a number of measures and good practices that the Trust has in place.

We note that the Trust has not achieved their standard met of 80% in relation to response times for Social Care assessments; however this was by less than 1% against a 2 year priority, which we are confident will be achieved next year.

The reporting of incidents is an indicator of an organisation willing to learn lessons in order to become safer. It is pleasing to see that the Trust did exceed their priority in increasing their reporting by 20%.
In relation to the Patient Experience pillar the trust again achieved against all of the priorities set. The five always events are notable due to the engagement that took place with service users which has led to improvements within those services.

The pillar of clinical effectiveness has also been achieved across the three identified areas. The establishment of a Quality Improvement Network is of note as this will ensure that the Trust has a culture of Quality Improvement which is sustainable in the future.

It is pleasing to see the intended improvement following the staff survey results for 2020/21 and the CCG is in agreement that this is an area of priority.

NHS Wirral CCG will continue to work in partnership with the Trust to assure the quality of services commissioned for the population it serves over the forthcoming year.

Dr Paula Cowan, Chair NHS Wirral CCG

Annex 2:

Statement of directors' responsibilities for the quality account

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare Quality Accounts for each financial year.

NHS Improvement has issued guidance to NHS Foundation Trust Boards on the form and content of annual Quality Reports (which incorporate the above legal requirements), and on the arrangements that NHS foundation trust boards should put in place to support the data quality for the preparation of the Quality Report.

In preparing the Quality Report, directors are required to take steps to satisfy themselves that:

The content of the Quality Report meets the requirements set out in the NHS foundation trust annual reporting manual 2017/18 and supporting guidance

The source of the Quality Report is not inconsistent with internal and external sources of information including:

- board minutes and papers for the period 1 April 2019 to 30 May 2020
- papers relating to quality reported to the board over the period 1 April 2019 to 30 May 2020
- feedback from commissioners dated 13/11/2020
- feedback from local Healthwatch organisations dated
- feedback from Overview and Scrutiny Committee dated
- the national staff survey

- the Quality Account represents a balanced picture of the NHS foundation trust's performance over the period covered
- the performance information reported in the Quality Account is reliable and accurate
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Account, and these controls are subject to review to confirm that they are working effectively in practice
- the data underpinning the measures of performance reported in the Quality Account is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review and
- the Quality Account has been prepared in accordance with NHS Improvement's annual reporting manual and supporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the Quality Account.

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Account.

By order of the board

December 2020	Professor Michael Brown, Chairman
December 2020	Mark Greatrex, Interim Chief Executive