Controlled Drug Accountable Officer's Annual Report 01 Apr 2023 – 31 Mar 2024

Meeting Title	Board of Directors		
Date	11/12/2024	**Agenda Item**	16
Lead Director	Eddie Roche, Interim Medical Director		
Author(s)	Eddie Roche, Interim Medical Director, Lisa Knight, Lead Pharmacist		

Action required (please select the appropriate box)

To Approve ☐	**To Discuss** ☐	**To Assure** ☒

Purpose

This report from the Trust's Controlled Drugs Accountable Officer (CDAO) covers the period 01 April 2023 to 31 March 2024 and provides assurance that the Trust is compliant with Controlled Drug legislation and that Controlled Drug systems, procedures and incidents are regularly reviewed and actions are taken as necessary to strengthen safety and governance

Executive Summary

This Controlled Drug Annual Report is required, as the Trust Board is accountable for the safe management of controlled drugs via the CDAO

The report outlines that:

- Standard operating procedures are in place and based on best practice surrounding the management and control of Controlled Drugs (CDs)
- CD prescribing is audited, and appropriate challenges are in place
- the handling of CDs within services is audited
- incidents involving CDs are investigated and learning is put in place
- incidents are reported to the regional CDAO via the local intelligence network, of which the Trust is an active member

Strategic (Board Assurance Framework - BAF) and operational Risks and opportunities:

. There are currently no risks on the register that relate to controlled drugs.

Quality/inclusion considerations:

Quality & Equality Impact Assessment completed and attached No.

This report does not fulfil the criteria for completion of a quality impact assessment. An equality impact assessment is not required, because optimising the use of controlled drugs is of equal benefit to all patients, including those in protected groups

Financial/resource implications:

There are no financial implications associated

The Trust Vision – To be a population health focused organisation specialising in supporting people to live independent and healthy lives. The Trust Objectives are:

- Populations – We will support our populations to thrive by optimising wellbeing and independence
- People – We will support our people to create a place they are proud and excited to work
- Place - We will deliver sustainable health and care services within our communities enabling the creation of healthy places

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

Populations - Safe care and support every time	Place - Improve the health of our population and actively contribute to tackle health inequalities	Place - Make most efficient use of resources to ensure value for money

The Trust Social Value Intentions

Does this report align with the Trust social value intentions? Not applicable

If Yes, please select all of the social value themes that apply:

Community engagement and support ☐

Purchasing and investing locally for social benefit ☐

Representative workforce and access to quality work ☐

Increasing wellbeing and health equity ☐

Reducing environmental impact ☐

Board of Directors is asked to consider the following action

To consider this annual report and be assured that controlled drugs are handled safely throughout Trust Services
Report history (Please include details of the last meeting that received this paper, including the title of the meeting, the date, and a summary of the outcome). This provides the audit trail through the governance structure.

Submitted to	**Date**	**Brief summary of outcome**
Quality and Safety Committee	06/11/2024	Committee was assured.

Wirral Community Health and Care NHS Foundation Trust

Controlled Drug Accountable Officer's Annual Report

01 April 2023 - 31 March 2024

Introduction

1. Accountability for the safe management of Controlled Drugs sits with the Trust Board via the Controlled Drugs Accountable Officer (CDAO). The Medical Director is the trusts CDAO. This report from the Trust's CDAO provides assurance that the Trust is compliant with Controlled Drugs legislation and that Controlled Drugs systems, procedures and incidents are regularly reviewed and actions are taken as necessary to strengthen Controlled Drugs safety and governance.

Responsibilities

2. The 2013 Controlled Drugs (Supervision of Management and Use) Regulations outlines the requirement for NHS Trusts to appoint a Controlled Drug Accountable Officer. The Controlled Drug Accountable Officer (CDAO) is a statutory role responsible for ensuring the following:

    - Standard operating procedures are in place, based on current legislation and best practice surrounding the management and use of Controlled Drugs (CDs).
    - Adequate destruction and disposal arrangements are in place for CDs.
    - CDs are used safely and effectively throughout the Trust.
    - The management and use of CDs is audited.
    - Relevant individuals receive appropriate training surrounding the use and handling of CDs.
    - A system is in place to assess and investigate incidents regarding the use and handling of CDs and appropriate action is taken.
    - CD incidents are reported to the regional CDAO via the local intelligence network to which the Trust is an active member.

The following sections describe activity relating to each of these duties.

Standard operating procedures are in place, based on current legislation and best practice surrounding the management and use of Controlled Drugs (CDs).

3. The policy for the Safe Handling and Administration of Medicines (GP11) is applicable to all Trust services that are involved in the handling of medicines. This policy includes sections outlining safe handling of CDs within Trust Services.

   In addition, the Trust has a suite of procedures that outline expected standards for handling of CDs within Community Nursing, GP Out of Hours, Community Dental Service, Community Intermediate Care Centre (CICC), Teletriage, Community Integrated Response Team (CIRT) and the Community Specialist Palliative Care Team.

   The procedures incorporate best practice as outlined by NICE guidance NG46, Controlled Drugs: Safe Use and Management 2016. This guidance outlines expected standards for storing, transporting, disposal, prescribing, supply and administration of CDs.

   All the guidance documents are in date.

   A full list of Trust procedures relating to CDs can be found in Appendix 1

Current legislation surrounding safe handling of CDs is considered and incorporated into Trust guidance where applicable.

4. The Trust is required to comply with current legislation surrounding safe use and handling of CDs.

   The Controlled Drugs (Supervision of Management and Use) Regulations 2013, outlines how CDs should be handled throughout the organisation. (NICE Guidance NG46, Controlled Drugs: Safe Use and Management 2016 is in line with these regulations.)

   There were no changes in legislation during the reporting period that required amendment to Trust policies or procedures.

Adequate destruction and disposal arrangements are in place for CDs

5. The Trust has two current procedures specifically for disposal of CDs:

   MMSOP28 - Standard Operating Procedure for Witnessing the Destruction of Controlled Drugs within Community Trust Services.

   MMSOP17 - Destruction of Patients' Own Controlled Drugs in the Community.

   In addition, MMSOP56 - Safe Handling and Administration of Medicines within Community Intermediate Care Centre includes specific guidance on disposal of patients' own CDs that are no longer required and have not been returned to the patient on discharge.

   MMSOP59- Safe Handling and Administration of Medicines within Urgent Community Response and Wirral Frailty Ward also includes a section on CDs, instructing practitioners to

never remove CDs from patient's homes and only in exceptional justifiable circumstances to destroy CDs in line with MMSOP17.

Guidance for removal and destruction of illicit substances, is included in the Trust' security management policy HS18.

These procedures provide staff with guidance which, when followed, ensures CDs are denatured prior to appropriate destruction. The procedures are compliant with current legislation and best practice.

The Management and use of CDs is Audited to support the safe use of CDs

6. In June 2018 the government published the findings of investigations into the earlier than expected deaths of patients within a community hospital in Hampshire, "The Gosport Independent Panel". The report identified that patients had received inappropriately high doses of opioids delivered via syringe driver. Since the publication of this report, the CQC has required healthcare organisations to evidence that their patients only receive appropriate opioid dosing, titrated to each individual patient's needs.

7. Opioid medication administered within community nursing is typically prescribed by the patients' GP, or sometimes, by a hospital clinician. Community nurses are responsible for reporting inappropriate dosing and titrating doses to individual patient needs.

8. A member of the specialist palliative care team performed a retrospective review of 40 patient records of patients who received end of life care via community nursing during 2023. Records were scrutinised to identify if initial doses were appropriate and if escalating doses were within the recommended maximum of up to the equivalent of 30% of the previous daily dose. The audit is currently in draft, preliminary findings show that patients received dosing in line with guidance. No major concerns were identified; however, the auditor noted some minor areas for improvement which will be fed back to the nursing teams for learning.

9. A member of the Medicines Management Team conducted face-to-face audits of the handling of CDs within services that hold stocks of CDs. In addition, the in-patient wards at CICC were audited. The audits identified that services generally followed agreed procedures, completion of the few actions identified were monitored via the Medicines Governance Meeting. Where there was any deviation from process, this has been positively managed with the support of the service staff.

10. Controlled Drug prescribing continued to be audited by reviewing ePACT prescribing data. Controlled Drug prescribing data for the Trust was presented each quarter at the Medicines Governance Group. Most Controlled Drug prescribing occurred within GP Out of Hours and the Urgent Treatment Centre. Trust procedure dictate that quantities should be sufficient only to allow the patient time to obtain further supplies from their own GP. ePACT data was therefore reviewed to identify large quantities of prescribing. Any larger than expected quantities were challenged and fed back to the prescriber via line management.

11. During the reporting period scrutiny of ePACT data identified unusual prescribing of some Controlled Drugs, after escalation to the NHSBSA it was found that these Controlled Drugs

were incorrectly attributed to the Trust. Details of incorrectly attributed medication was reported in the medicines' optimisation annual report for 2023 2024.

12. The quantity of CDs prescribed within the Trust was also compared to the prescribing of CDs in other community trusts by utilising CD benchmarking data. It was noted that the Trust is not an outlier for the prescribing of Controlled Drugs.

13. ePACT data does not include data from individual consultations, therefore to scrutinise the Controlled Drug prescribing data further, from January 2024 bi-monthly audits of SystmOne records have been undertaken to ensure appropriate quantities were prescribed and the prescribing was appropriate for the indication. In January 2024, all prescriptions for Diazepam 2mg tablets were audited. 7 patients were identified as being prescribed Diazepam 2mg tablets, all indications recorded were appropriate. In March 2024, co-codamol prescribing was audited, there were a small number of records of prescribers issuing greater than the required number of days of treatment. Where this occurred, this was fed back to prescribers via line management.

14. The Medicines Management Team completed an annual CD LIN Assurance framework self-assessment January 2024. The framework allowed organisations to reflect on their arrangements for CDs, following the self-assessment an action was identified to update the overarching policy for handling medicines to include a requirement for the Trust to share their CDAO's contact details with the NHS England CD Accountable Officer when the policy is next updated.

Relevant individuals receive appropriate training surrounding the use and handling of CDs

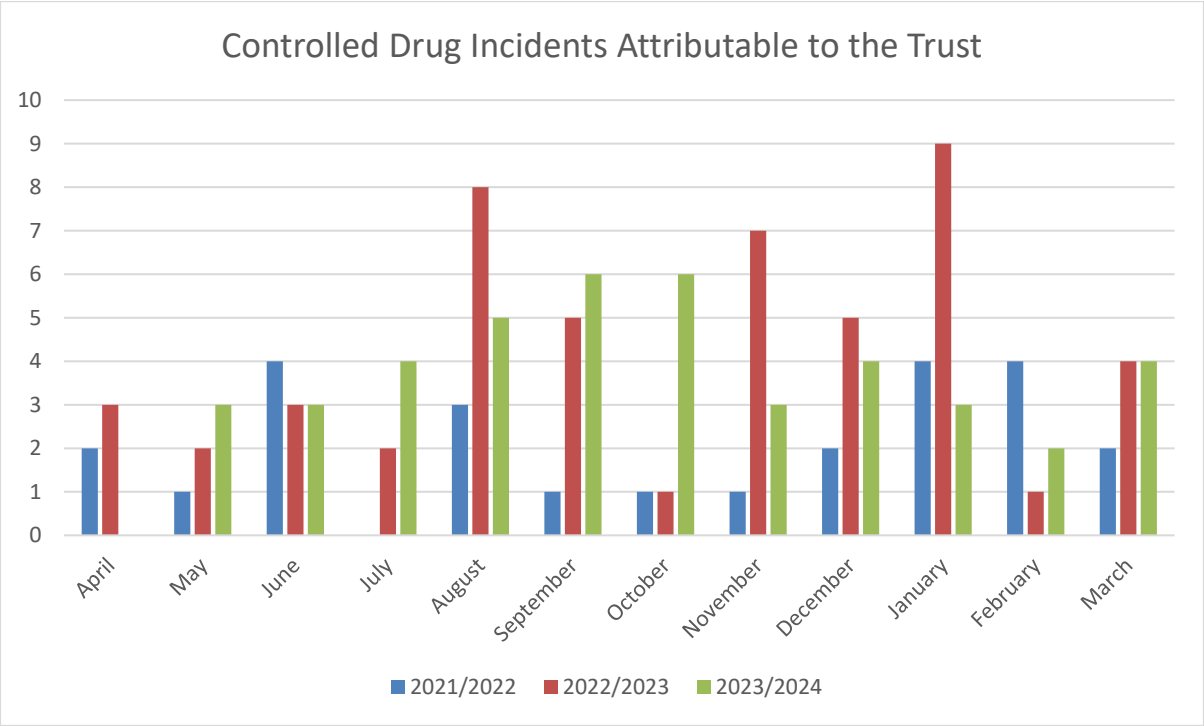
15. Community Nurses when joining the Trust attended end of life training, regular updates on palliative care were also available to staff. Nursing staff were trained to convert oral doses of opioids to equivalent subcutaneous doses and were therefore able to challenge inappropriate dosing. In addition, handling of Controlled Drugs was incorporated into mandatory refresher Medicines Management training for community nurses.

16. The Trust's CDAO and/or a pharmacist from the Trust's Medicines Management Team attended Mersey Regional Local Intelligence Network (LIN) meetings. These meeting are a forum for different health care providers to meet and discuss Controlled Drug incidents with a view to implement lessons learnt throughout the region. The Trust was therefore kept up to date with current best practice surrounding the handling of CDs.

A system is in place to assess and investigate incidents regarding the use and handling of CDs and appropriate action is taken

17. All medication incidents including Controlled Drug incidents were monitored via the Medicines Governance Meeting, any outstanding actions following investigations were also monitored via this group.

The graph below indicates the number of Controlled Drug incidents reported as being attributed to Trust Services during 2023-2024. Incidents reported 2022-2023 and 2021-2022 are included for comparison.



18. There was a total of 43 Controlled Drug incidents reported during 2023/2024 (compared with 50 reported 2022/2023, and 25 reported 2021/2022). All the reported CD incidents were low or no harm. The most common theme reported were incidents involved documentation errors with no actual loss of Controlled Drugs. There were also 5 incidents reported over the period where there were minor dosing errors, none of these incidents caused patient harm. Learning was in all incidents fed back to the team and where appropriate included in the Medicines Management Bulletin for organisational wide learning.

CD incidents are reported to the regional CDAO via the local intelligence network (LIN) to which the Trust is an active member

19. The criteria for reporting incidents to CD LIN changed in December 2022. Incidents and concerns were only be reported if the following criteria was met:
    - Real or perceived staff diversion of CDs
    - Real or perceived staff substance misuse of CDs
    - Patients with drug seeking behaviours that might require an NHSE alert to be issued to health and care settings.
    - Severe harm issues

There were no reported CD incidents during 2023 2024 that met the reporting criteria for LIN, however following the publication of the 2022 2023 CD annual report, one incident was reported retrospectively. This incident was included in the 2022 2023 annual CD report.

Thematic learning relating to the management of Controlled Drugs across Cheshire and Mersey was distributed via the LIN, so that Trusts could be made aware of possible issues and learn lessons from other trusts incidents or errors. Any learning of relevance to the Trust was distributed internally to WCHC clinical services.

National Recommendations from the CQC

20. The Safe Management of Controlled Drugs Annual Update 2023 was published by CQC July 2024. Our oversight activity in 2023 - Care Quality Commission (cqc.org.uk).

21. The update highlighted legislative changes during 2023-2024

- Nitrous oxide rescheduling to a schedule 5 Controlled Drug under the Misuse of Drugs Regulations 2001- this change was highlighted to staff via the Medicines Management Bulletin November 2023 for information. The legislation surrounds the possession of nitrous oxide for illicit use and not the medical use. Trust procedures for use of nitrous oxide were therefore unaffected.

- Rescheduling of codeine linctus from a P Medicine, that could be purchased from a pharmacy to a prescription only medicine (POM). This change was highlighted to staff via the Medicines Management bulletin March 2024.

Learning from national incidents

Alfentanil Medication Errors

22. There are two strengths of alfentanil ampoules available, 500 micrograms per ml (1mg in 2ml) and 5mg per ml. The higher strength preparation being used more commonly in intensive care settings. CQC were made aware of incidents where the higher strength product was selected in error. One of the recommendations was to make practitioners aware of the two strengths of alfentanil. Lack of awareness is more likely in services that do not usually handle the higher strength preparation. An article was placed in the September 2024 issue of the Medicines Management Bulletin to raise awareness of the higher strength Alfentanil.

Safe storage of prescription stationary

23. CQC identified problems when prescription stationary is received into a main office, and not logged or stored securely and not tracked when sent to prescribers- Concerns of this nature are not likely to occur within the Trust as the Medicines Management Team take direct responsibility for ordering, receipt, logging, storage and distribution of prescription forms to prescribers and services.

Keeping CDs after someone has died.

24. When a person dies, it is usual practice to keep any medication the person was prescribed for up to 7 days in case they are required by the coroner. CQC reported concerns raised surrounding the risks associated with leaving bereaved families to keep medicines that may be used for self-harm. CQC recommended organisations have clear professional guidelines- The Trust already has a procedure in place for disposal (denaturing) of Controlled Drugs in

patients' homes, MMSOP17. This procedure authorises the disposal of Controlled Drugs where the attending practitioners have identified a risk of diversion or misuse of the Controlled Drugs.

Incorrect use of Controlled Drug Disposal Kits

25. Nationally, CQC identified that some organisations were not using the CD disposal kits using resins correctly and therefore some medicines were available to be extracted. An audit of the use of Controlled Drug disposal kits will now form part of the 2024/2025 audit programme.

Electronic Controlled Drug registers

26. CQC identified how auditors had difficulty in accessing electronic Controlled Drug registers within some of the trusts they visited. There are currently no electronic Controlled Drug registers within the Trust, however there is currently joint planning for the Trust's urgent and primary care services to integrate with WUTH's emergency department. The question as to whether the unit will use electronic registers will be included in the communications with WUTH. This will ensure appropriate planning and training can be put in place.

Conclusion

27. This report provides an overview of how the Trust has engaged fully with the local healthcare community and the Mersey Regional Local Intelligence Network and carefully considered national learning from CQC inspections, ensuring the governance arrangements surrounding the handling of Controlled Drugs comply with best practice.

Eddie Roche- Interim Medical Director & Trust CDAO

Lisa Knight - Lead Pharmacist

October 2024

References

Our oversight activity in 2023 - Care Quality Commission (cqc.org.uk)

The Gosport Independent Panel

Appendix 1

STANDARD OPERATING PROCEDURES (SOPS) AND POLICIES OUTLINING HANDLING OF CONTROLLED DRUGS

The following procedures and policies are available to all staff via the Staff Zone of the Wirral Community NHS Foundation Trust's website

General Policies:

- GP11 Policy for the Safe Handling and Administration of Medicines is applicable to all trust services who are involved in the handling of medicines. The policy includes sections on the following:

    - Administration of Controlled Drugs
    - Disposal of Controlled Drugs
    - Ordering Controlled Drugs from Wirral University Teaching Hospital
    - Receipt of Controlled Drugs
    - Storage of Controlled Drugs
    - Controlled Drugs stock reconciliation
    - Procedure for missing Controlled Drugs

Community Nursing Procedures:

- MMSOP04 Standard Operating Procedure for McKinley Syringe Driver for Administration of Palliative Care Medicines

- MMSOP09 Standard Operating Procedure for Transport of Prescribed Controlled Drugs

- MMSOP17 Standard Operating Procedure for Destruction of Patients' Own Controlled Drugs in the Community

- MMSOP18 Standard Operating Procedure for Administration of Opioid Medicines

GP Out of Hours

- MMSOP34 Standard Operating Procedure for the Management of Controlled Drugs within Primary Care Division

- SOP10 GP Out of Hours Prescribing Policy (This procedure outlines appropriate prescribing of Controlled Drugs within GP Out of Hours)

Specialist Palliative Care Team

- MMCP07 Clinical Protocol for Providing Specialist Palliative Care Medicines Advice from the Integrated Specialist Palliative Care Team

- MMCP13 Clinical Protocol for Non-Medical Prescribing within Palliative Care

Community Dental Services

- MMSOP21 Standard Operating Procedure for the Administration of Intravenous Midazolam for Conscious Sedation.

- MMSOP41 Procedure for the Administration of Oral, Buccal or Intranasal Midazolam for Premedication prior to Dental Conscious Sedation

- MMSOP37 Standard Operating Procedure for the safe and secure management of Midazolam within Community Dental Services

Community Integrated Care Centre (CICC)

- MMSOP56 Standard Operating Procedure for safe handling and administration of medicines within Community Intermediate Care Centre. This procedure includes a section on the management of Controlled Drugs within the centre. All Controlled Drugs are prescribed for individual patients, there are no stock Controlled Drugs held on the unit.

Community Intermediate Response Team (CIRT)

- MMSOP59 Standard Operating Procedure for safe handling and administration of medicines within Community Intermediate Response Team (CIRT). This procedure includes a section on CDs highlighting the fact that CDs must never be removed from patient's homes.

Trust Wide

- MMSOP28 Standard Operating Procedure for witnessing the destruction of Controlled Drugs within Community Trust Services

- MMSOP120 Remote Prescribing Policy

Mortality Report: Learning from Deaths Framework Quarter 2: 01 July 2024 – 30 Sept 2024

Meeting Title	Board of Directors		
Date	11/12/2024	**Agenda Item**	17
Lead Director	Eddie Roche, Interim Medical Director		
Author(s)	Eddie Roche, Interim Medical Director		

Action required (please select the appropriate box)

To Approve ☒	**To Discuss** ☐	**To Assure** ☒

Purpose

The purpose of this paper is to assure the Board of Directors of quality governance systems regarding learning from deaths and to seek approval in relation to the publication of the learning from deaths appendix on the Trust website.

Executive Summary

This quarterly report provides evidence that learning from deaths is 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 2024/25, along with a summary of any thematic learning identified during investigation into these cases.

All deaths reported to the Trust in Q2 2024/25 have flowed through the Trusts governance processes. There are no deaths that were attributable to the care delivery provided by our Trust. Attached as an appendix, is a Q2 summary report for publication on the Trust website

Strategic (Board Assurance Framework - BAF) and operational Risks and opportunities:

Not applicable.

Quality/inclusion considerations:

Quality & Equality Impact Assessment completed and attached No.

The contents of the report do not relate to quality and inclusion matters.

Financial/resource implications:

There are no finance and resource implications

The Trust Vision – To be a population health focused organisation specialising in supporting people to live independent and healthy lives. The Trust Objectives are:

- Populations – We will support our populations to thrive by optimising wellbeing and independence
- People – We will support our people to create a place they are proud and excited to work
- Place - We will deliver sustainable health and care services within our communities enabling the creation of healthy places

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

Populations - Safe care and support every time	Place - Improve the health of our population and actively contribute to tackle health inequalities	People - Improve the wellbeing of our employees

The Trust Social Value Intentions

Does this report align with the Trust social value intentions? Yes.

If Yes, please select all of the social value themes that apply:

Community engagement and support ☐

Purchasing and investing locally for social benefit ☐

Representative workforce and access to quality work ☐

Increasing wellbeing and health equity ☒

Reducing environmental impact ☐

Board of Directors is asked to consider the following action

To be assured by the report and approve Appendix 1 to be published on the public facing website

Report history (Please include details of the last meeting that received this paper, including the title of the meeting, the date, and a summary of the outcome). This provides the audit trail through the governance structure.		
Submitted to	**Date**	**Brief summary of outcome**
Quality and Safety Committee	06/11/2024	Committee assured and approved

Wirral Community Health and Care NHS Foundation Trust

Mortality Report: Learning from Deaths
Quarter 2: 01 July 2024 – 30 September 2024

Purpose

1. 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.

Executive Summary

2. During Q2 there were a total of 8 reported deaths none of which were within scope for reporting. This includes a total of 5 child deaths all of which were reviewed using SUDIC methodology.

3. During Q2 there were 0 deaths which met the criteria for StEIS reporting.

4. Each unexpected death reported during Q2 has been analysed and investigated appropriately, to identify if care provided by the Trust resulted in harm or contributed to the death, and if any relevant learning exists for the Trust and the wider health and social care system.

5. Of the total deaths reported in Q2, after investigation, none of these were within scope of this report as none of the deaths had been caused by gaps or omissions in the provision of NHS care.

Background

6. 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.

7. The National Quality Board (NQB) Learning from Deaths framework (2017) exists with the specific aim 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.

8. 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 system partners 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.

9. 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.

10. Since 2017 the focus on learning from preventable deaths and unexpected deaths has continued to strengthen and the NHSE developed the Patient Safety Strategy in 2019 which

describes how the NHS will continuously improve patient safety, building on the foundations of a safer culture and safer systems.

11. The National Safety Strategy has been pivotal introducing a Patient Safety syllabus, Patient Safety Specialists, and Patient Safety Partners. All of which have been embedded within the governance of the Trust.

12. Patient Safety and Incident Reporting Framework (PSIRF) is embedded within our Trust. It sets out the NHS approach for effective systems and processes for responding to patient safety incidents for the purpose of learning and improving patient safety. This is embedded within our Clinical Risk Management group and Mortality Review group.

13. Learning From Patient Safety Events (LFPSE) is designed to capture events where:

    - A patient was harmed or could have been harmed
    - there has been a poor outcome, but it is not yet clear whether an incident contributed or not
    - risks to patient safety in the future have been identified
    - good care has been delivered that could be learned from to improve patient safety.

14. LFPSE is being rolled out nationally and is being fully adopted by the Trust.

WCHC Learning from deaths governance framework

Policies

15. In accordance with the Learning from Deaths framework, the Trust ratified and published a Learning from Deaths Policy during September 2017, and which is subject to regular review.

16. The 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.

17. The Incident Management Policy - GP08 has been updated and cross references the 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.

18. 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, Chief Nurse and Deputy Chief Nurse for all reported unexpected deaths.

Process

19. All reported deaths which have occurred in a place where we are commissioned to deliver services, are discussed at both the Quality and Governance Safety Incident Review Group (SIRG) and at the fortnightly Clinical Risk Management Group (CRMG). Further investigations are commissioned based on the events surrounding the death and the results of the Mortality Screening Tool. The principles around Duty of Candour are also overseen within this group.

20. The Mortality Screening Tool considers whether a variety of factors were present. Examples include:
    - Receipt of an End-of-Life advance care plan (PACA)
    - Presence of a DNACPR form
    - Association with failed visits
    - Association with rescheduled visits
    - Concerns raised by any party regarding the care provided prior to death
    - The involvement of other services involved prior to death
    - Medical Cause of death (if known)

21. Commissioned investigations are monitored at CRMG against progress and timelines. Any investigation reports and associated action plans are approved at CRMG. This includes cases which are under investigation by the coroner.

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

23. Minutes from the Mortality Review Group are submitted to the Quality and Safety Committee and to the Board by exception.

24. A report is produced which summarises the details of the unexpected 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.

25. 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. This includes working with the UK Health Security Agency and the Local Authority to analyse the effect of COVID-19 by utilising a population-based approach to identify areas of inequality and its association with deaths due to this disease.

26. 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.

Child Deaths

27. Given the extensive geography that WCHC delivers Children and Young People's services, there are now robust processes in place which enable every unexpected child death to be identified within all the places we deliver care. This includes Wirral, East Cheshire, St Helens & Knowsley.

28. The membership of the Mortality Review Group includes the Trust's Child Death Overview Panel (CDOP) representative and the Trust's Head of Safeguarding enabling, the visibility of any thematic learning across the whole of Cheshire and Mersey. The membership is regularly reviewed to ensure it contains a variety of skills and knowledge to maximise the identification of learning.

29. The Trust has links with each Place-based Child Death governance structures, which facilitates the identification of themes over a large geography and then uses this data to reflect on how WCHC can continuously improve the delivery of its Children and Young People services. Services.

30. The Trusts Named CDOP representative is an active participant of the multi-agency Place-based Sudden Unexpected Death in Childhood (SUDIC) meetings and feeds any intelligence and learning into the Mortality Review Group. When our representative has any concerns then these are escalated and raised with system partners.

31. The Mortality Review Group will receive the Child Deaths Annual reports when they become available.

Bereaved Families

32. 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.

33. 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.

34. 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.

35. 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.

National Medical Examiner Updates

36. Medical Examiner officers at hospital trusts now provide independent scrutiny of almost all non-coronial deaths occurring in hospitals. All deaths in England and Wales are independently reviewed either by a Medical Examiner or a coroner. Medical Examiners provide an important safeguard.

37. The Department for Health and Social Care (DHSC) published details of the death certification reforms and are now in place since April 2024. Primary legislation was commenced on 1 October 2023. The new death certification process requires all deaths in England and Wales to be independently reviewed either by a medical examiner or a coroner.

38. DHSC's document notes that:

39. NHS trusts hosting a medical examiner should provide adequate support and ensure the independence of medical examiners is respected. The host in Wirral is Wirral University Teaching Trust.

40. All other healthcare providers including GP practices should set up processes to start referring deaths to medical examiner offices if they have not already done so. Our trust has liaised with the Medical Examiner's office in Wirral and we have created agile and secure access for medical records to allow the Medical Examiner to fulfil their role.

Q2 2024/25 WCHC Reported deaths (Datix incident reporting)

41. During Q2 there were a total of 8 reported deaths none of which were within scope for reporting. This includes 5 child deaths.

42. During Q2 there were 0 deaths which met the criteria for StEIS reporting.

Structured Judgement Reviews:	
Total Number of Deaths in scope	8
There are no outstanding cases from the previous quarter (Q1)	
Total Number of Deaths considered to have more than 50% chance of being avoidable	0
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
SUDIC reviews:	
Total Number of Child Deaths	5
Total Deaths reviewed through SUDIC methodology	5

Summary of Thematic Learning for Q2

43. Each unexpected death reported during Q2 has been analysed and investigated appropriately, to identify if care provided by the Trust resulted in harm or contributed to the death, and if any relevant learning exists for the Trust and the wider health and social care system.

44. Of the total deaths reported in Q2, after investigation, none of these were within scope of this report as none of the deaths had been caused by gaps or omissions in the provision of NHS care.

45. There were no trends or themes identified during the review of deaths.

Trend Analysis

Adult incidents coded as Unexpected Death, per service area – Q2 2025/25

	July 2024	Aug 2024	Sept 2024	Total Q2
Community Night Nursing	1	0	0	1
Community Nursing Birkenhead	0	1	0	1
GP OOH	0	0	1	1
Total	1	1	1	3

Child incidents coded as Unexpected Death, per service area – Q2 2024/25

Area	July 2024	Aug 2024	Sept 2024	Total Q2
Wirral 0 -19	1	1	0	2
Cheshire East	1	0	1	2
St. Helens 0 -19	1	0	0	1
Knowlsey 0 -25	0	0	0	0
Total	3	1	1	5

Adult and Child incidents coded as unexpected death – current year from April 2024

Incidents Coded as Unexpected Death (this financial year)

	Apr 2024	May 2024	Jun 2024	Jul 2024	Aug 2024	Sep 2024	Total
Community Nursing Birkenhead	1	0	0	0	1	0	2
Community Nursing Night Service	0	0	0	1	0	0	1
Community Dental	0	0	1	0	0	0	1
Community Integrated Response Team	0	0	1	0	0	0	1
Community Intermediate Care Centre	1	0	0	0	0	0	1
GP Out of Hours	0	0	0	0	0	1	1
Safeguarding Children	2	0	3	3	1	1	10
Total	4	0	5	4	2	2	17

Further discussion and actions from the Mortality Review Group Q2 2024/2025

- The group discussed the evolution of Marthas Rule which relates to a ruling imposed that NHS trust should have access to a 24/7 critical care outreach team, and that all patients, and families of patients, also can access these services themselves. Furthermore, trusts must have in place, a system to gather information from patients and their families relating to the patient's condition, at least daily.

- Marthas Rule is currently being rolled out in a phased approach across relevant acute hospital trusts since April 2024 with wider roll out in 2025/26. It is anticipated that the coverage of trusts will include community and mental healthcare trusts in due course, although there is no defined plan or timeline for this. WCHC FT is aware of the rule and is considering how it could apply, and how we would operationalise the ruling.

- The group discussed the ongoing development of the Medical Examiner role in reviewing deaths in Wirral.

- The group discussed the regional Child Death Overview Panel (CDOP) report 2023/2024, a deep dive into each child death reported in the year (excluding stillbirths and planned terminations of pregnancy). This had some interesting data relating an increase in the modifiable risk factors compared to previous year of, smoking in the household, smoking in pregnancy, substance misuse, unsafe sleep, reduced engagement with healthcare services and neglect. The report is being reviewed in more detail by the Safeguarding Assurance Group and by the leads for our 0-19 services. External review also is done via the CDOP.

Recommendations for Quality and Safety Committee

46. The Quality and Safety Committee 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.

47. The Quality and Safety Committee is asked to be assured the Trust is actively involved in supporting the system-wide development of processes reporting and learning from deaths.

51. The Quality and Safety Committee is asked to approve Appendix 1 to proceed through to Public Board

Dr Eddie Roche

Interim Executive Medical Director

23/10/2024

Appendix 1

Learning from Deaths Q2 24/25 Report

The following data represents the high-level reporting of deaths which occurred within our services over the period of Quarter 2 2024/25.

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

There were 8 deaths reported to the Trust and all have been reviewed in accordance with Trust policy. On this occasion, none of the deaths were within scope of this report during this period. This is because the deaths were not associated with any care delivered or harm caused by services provided by the Trust. Duty of Candour was not applicable to any of these cases.

There were 3 adult and 5 child deaths reported during this quarter, which followed the appropriate investigation processes.

We continue to promote shared learning across the health sectors and work collaboratively with our system partners to improve care within all the communities in which we provide services, focusing on addressing health inequalities on a population-based approach.

Dr Eddie Roche

Interim Executive Medical Director
Wirral Community Health and Care NHS Foundation Trust

23 October 2024

Safe Staffing Report Quarters 1 and 2 2024-2025

Meeting Title	Board of Directors		
Date	11/12/2024	**Agenda Item**	18
Lead Director	Paula Simpson, Chief Nurse		
Author(s)	Claire Wedge, Deputy Chief Nurse, Carla Burns, Deputy Director of HR&OD, Martin Godfrey, Head of HR (Workforce Planning & Resources)		

Action required (please select the appropriate box)

To Approve ☐	**To Discuss** ☐	**To Assure** ☒

Purpose

This report provides the Board with an overview of the Trust and CICC Wards Safe Staffing information and data for Quarters 1 & 2 2024.

The report is to provide assurance to the Committee in relation to compliance with the Care Quality Commission Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 18 for safe staffing levels at the Trust's Community Intermediate Care Centre (CICC)

Executive Summary

This report details the following:

- principles of safe staffing
- safe staffing model
- update regarding six monthly review Trust-wide safe staffing
- Q1 & 2 safe staffing analysis – CICC
- Q1 & 2 safety analysis aligned to safe staffing analysis – CICC

The safe staffing model outlined supports professional judgement by maximising use of available staffing resource, implementing a holistic multidisciplinary team model which

includes the use of therapies staff. The report shows the “required” versus actual CHPPD for the wards.

In addition, the report provides a summary of the requirements of the regulatory framework for the provision of safe staffing, an overview of the baseline staffing model for CICC, a breakdown of the different staffing types (substantive, bank and agency) as well as a triangulation with patient safety data including incidents and complaints data.

Fluctuations and variation are identified within the report between wards in relation to actual and required CHPPD, however, this reflects a positive position on required versus actual.

The safety systems and mitigations in place at CICC have been effective in minimising impact to patient safety; this will continue to be monitored through the Trust’s governance framework. Mitigations continue to include utilisation of the available clinical and professional resource at CICC, including therapy staff.

Strategic (Board Assurance Framework - BAF) and operational Risks and opportunities:

BAF Risks linked to this report include: - ID01 - Failure to deliver services safely and responsively to inclusively meet the needs of the population; - ID07 - Our people do not feel looked after, their employee experience is poor, and their health and wellbeing is not prioritised; - ID10 - We are not able to attract, grow and develop our talent sufficiently to ensure the right numbers of engaged, motivated and skilled staff to meet activity and operational demand levels.

Quality/inclusion considerations:

Quality & Equality Impact Assessment completed and attached No.

Not applicable to this style of report.

Financial/resource implications:

Not applicable to this report

The Trust Vision – To be a population health focused organisation specialising in supporting people to live independent and healthy lives. The Trust Objectives are:

- Populations – We will support our populations to thrive by optimising wellbeing and independence
- People – We will support our people to create a place they are proud and excited to work
- Place - We will deliver sustainable health and care services within our communities enabling the creation of healthy places

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

Populations - Safe care and support every time	People - Grow, develop and realise employee potential	Place - Make most efficient use of resources to ensure value for money

The Trust Social Value Intentions

Does this report align with the Trust social value intentions? Not applicable

If Yes, please select all of the social value themes that apply:

Community engagement and support ☐

Purchasing and investing locally for social benefit ☐

Representative workforce and access to quality work ☒

Increasing wellbeing and health equity ☒

Reducing environmental impact ☐

Board of Directors is asked to consider the following action

The Board of Directors are asked to be assured by the Safe Staffing analysis and described mitigations.

Report history (Please include details of the last meeting that received this paper, including the title of the meeting, the date, and a summary of the outcome). This provides the audit trail through the governance structure.

Submitted to	Date	Brief summary of outcome

Compassion | Open | Trust

NHS
Wirral Community Health and Care
NHS Foundation Trust

Safe Staffing: Community Intermediate Care Centre (CICC)
Quarter 1 & 2: April – Sept 2024

Board of Directors

Date: 11/12/24

Contents

Purpose

The purpose of this report is to:

- Provide assurance to Wirral Community Health and Care NHS Foundation People and Culture Committee in relation to compliance with the Care Quality Commission Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 18 for safe staffing levels at the Trust's Community Intermediate Care Centre (CICC)
- This report focusses on ward-based Care Hours Per Patient Day (CHPPD) and analysis of incident reporting for Quarter 1 & 2: 01 April – 30 Sept 2024 to assure safety

Safe Staffing Governance

The Trust has a robust governance framework in place to support monitoring and oversight of safe staffing, this includes the following:

- Monthly review at SAFE Operations Group (SOG) and People and Culture Oversight Group (PCOG)
- Report by exception to Integrated Performance Board (IPB) based on risk escalation
- Quarterly reporting to People and Culture Committee (last review June 2024)
- Quality and Safety Committee oversight based on risk escalation
- Bi-annual high-level assurance report to the public Board of Directors

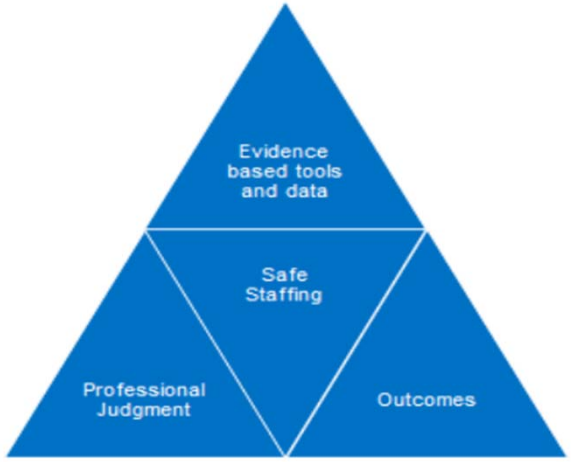
Regulation 18

- Sufficient numbers of suitably qualified, competent, skilled and experienced persons must be deployed in order to meet the requirements of this Part
- Persons employed by the service provider in the provision of a regulated activity must:
  - receive such appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform
  - be enabled where appropriate to obtain further qualifications appropriate to the work they perform, and
  - where such persons are health care professionals, social workers or other professionals registered with a health care or social care regulator, be enabled to provide evidence to the regulator in question demonstrating, where it is possible to do so, that they continue to meet the professional standards which are a condition of their ability to practise or a requirement of their role

Principles of safe staffing

[National Quality Board Safe Staffing guidance]

[NHSE Developing Workforce Safeguards]



Expectation 1	Expectation 2	Expectation 3
Right Staff 1.1 evidence-based workforce planning 1.2 professional judgement 1.3 compare staffing with peers	**Right Skills** 2.1 mandatory training development and education 2.2 working as a multi-professional team 2.3 recruitment and retention	**Right Place and Time** 3.1 productive working and eliminating waste 3.2 efficient deployment and flexibility 3.3 efficient employment and minimising agency

Implement Care Hours per Patient Day

Develop local quality dashboard for safe sustainable staffing

Measure and Improve
- Patient outcomes, people productivity and financial sustainability -
- Report investigate and act on incidents (including red flags) -
- Patient, carer and staff feedback -

Compassion | Open | Trust

NHS
Wirral Community Health and Care
NHS Foundation Trust

CICC Safe Staffing

- A safe staffing model has been developed to demonstrate the available clinical and professional resource at CICC to ensure safe staffing
- Local **governance safe staffing** processes have been reviewed and will be supported by the introduction of daily board rounds
- **Escalation levels have been** strengthened to ensure transparency to the senior leadership team, supporting mitigation of risk
- Support is also available from the **Nights Community Nursing Team**

Safe Staffing Model

CICC Safe Staffing

- The night baseline staffing model on Bluebell and Iris wards was changed in October 2023 from 2 Registered Nurses and 4 Health Care Assistants to 2 Registered Nurses and 3 Health Care Assistants.
- The Safer Nursing Care Tool (SNCT) was updated in November 2023. This evidence-based tool enables assessment of patient acuity and dependency incorporating staff multipliers to ensure that nursing establishments reflect patient needs.
- The first audit using the updated tool was undertaken across CICC during April 2024. The results of the audit will be considered following a further data collection which is currently in progress.
- The CHPPD used in the Safe staffing data has been reviewed to incorporate the requirement for high-visibility bays to assure safety and for one-to-one care delivery. This data is reflected in the CHPPD calculations from August onwards.

CICC Safe Staffing

- The national requirement for reporting safe staffing for NHS organisations that provide inpatient/bedded units uses the consistent metric of Care Hours Per Patient Per Day
- CHPPD is a measure of workforce deployment in ward-based settings and increasingly forms an integral part of a ward/unit/trust review and oversight of quality and performance indicators to inform quality of care, patient outcomes, people productivity and financial sustainability
- This ensures skill-mix is well-described and the nurse-to-patient ratio is considered when deploying clinical professionals to provide planned care, reflected alongside an aggregated overall actual CHPPD
- This metric measures nursing input only, with the wider multi-disciplinary team including therapy contributing to the overall establishment to assure safety

Trust wide Safe Staffing: 6 Monthly Reviews

- The Trust has developed and embedded a process for six-monthly safe staffing reviews across operational services
- This is to assure safety in the context of the safe staffing principles, providing assurance against CQC regulation 18
- The Trust have undertaken the Trust-wide six-monthly safe staffing assurance review across all clinical services during May/June 2024 with data reviewed through PCOG. The recent review of Safe Staffing across all services demonstrated that the majority of services felt they were safely staffed when fully established. A small number of services had some residual concerns about their staffing levels however assurance was given that these issues were being managed and mitigated at local level.
- Within the Community Nursing teams the Quality team have been assisting in the validation of future establishment setting/safe staffing through the use of the NHSE pilot of the Community Nursing Safer Staffing Tool (CNSST). This is presently on hold nationally with a re-launch expected during Q4 2024/25

Compassion | Open | Trust

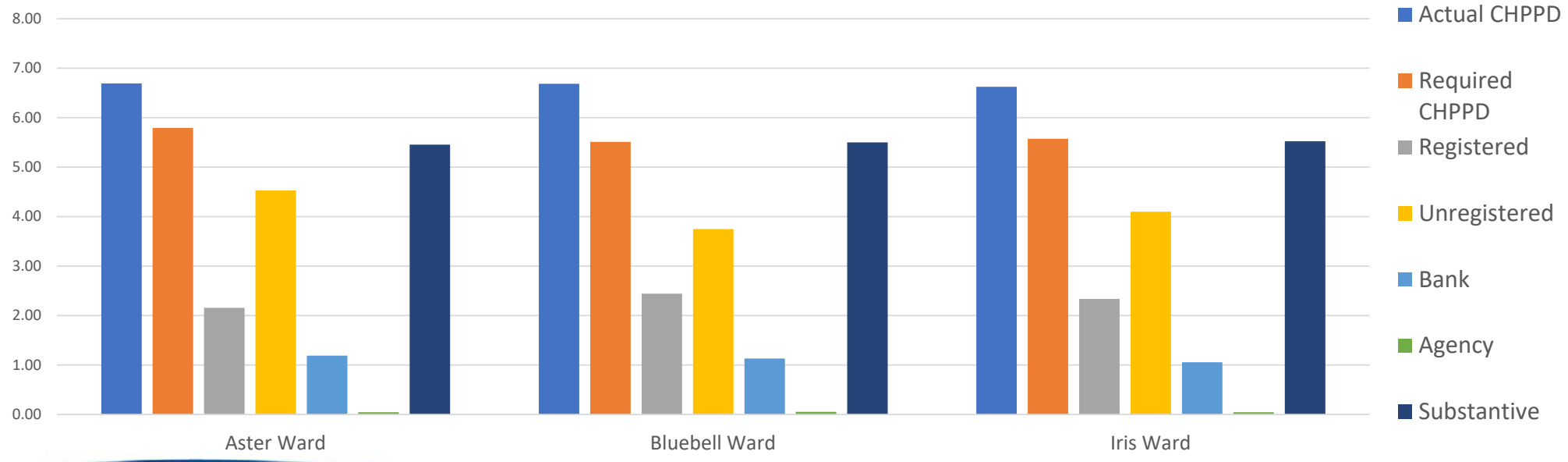
NHS
Wirral Community Health and Care
NHS Foundation Trust

Safe Staffing Data: CICC
Quarter 1 & 2: April – June & July – Sept 2024

Compassion | Open | Trust

NHS
Wirral Community Health and Care
NHS Foundation Trust

Ward Staffing Summary compared against Care hours Per Patient Day (CHPPD) – Q1 April - June 24



Compassion | Open | Trust

NHS
Wirral Community Health and Care
NHS Foundation Trust

Ward Temporary Staffing Breakdowns: April - July 2024

Data available from SafeCare

Aster Ward	
Temp Cover	**% Split**
Agency	1.13%
HCA	0.00%
RN	1.13%
Bank	19.65%
HCA	17.29%
RN	2.37%
Substantive	79.21%
HCA	51.10%
RN	28.11%
Grand Total	100.00%

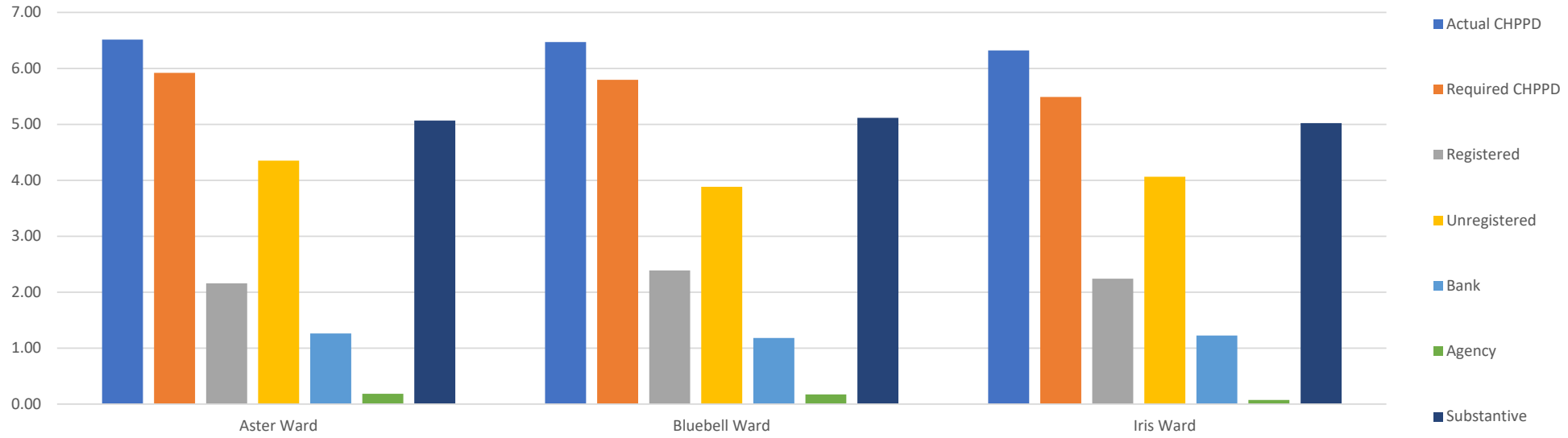
Bluebell Ward	
Temp Cover	**% Split**
Agency	1.27%
HCA	1.00%
RN	0.00%
Bank	19.87%
HCA	17.16%
RN	2.71%
Substantive	78.86%
HCA	46.53%
RN	32.33%
Grand Total	100.00%

Iris Ward	
Temp Cover	**% Split**
Agency	0.13%
HCA	0.13%
RN	22.24%
Bank	19.97%
HCA	2.27%
RN	77.63%
Substantive	43.32%
HCA	31.35%
RN	2.97%
Grand Total	100.00%

Compassion | Open | Trust

NHS
Wirral Community Health and Care
NHS Foundation Trust

Ward Staffing Summary compared against Care hours Per Patient Day (CHPPD) – Q2 July - Sept 24



Compassion | Open | Trust

NHS
Wirral Community Health and Care
NHS Foundation Trust

Ward Temporary Staffing Breakdowns: July - Sept 2024

Data available from SafeCare

Aster Ward	
Temp Cover	**% Split**
Agency	3.41%
HCA	3.18%
RN	0.23%
Bank	24.88%
HCA	24.88%
RN	0.00%
Substantive	71.72%
HCA	40.37%
RN	31.35%
Grand Total	100.00%

Bluebell Ward	
Temp Cover	**% Split**
Agency	2.50%
HCA	1.67%
RN	0.00%
Bank	13.46%
HCA	12.26%
RN	1.20%
Substantive	84.04%
HCA	50.94%
RN	33.11%
Grand Total	100.00%

Iris Ward	
Temp Cover	**% Split**
Agency	0.62%
HCA	0.34%
RN	0.28%
Bank	19.48%
HCA	17.75%
RN	1.73%
Substantive	79.90%
HCA	47.95%
RN	31.95%
Grand Total	100.00%

Compassion | Open | Trust

NHS
Wirral Community Health and Care
NHS Foundation Trust

Safety Analysis: CICC
Quarter 1 & 2: April – Sept 2024

Governance

- Reported incidents are managed in accordance with the Trust's incident reporting policy and robust governance framework
- Incidents are reviewed monthly at locality SAFE/OPG meetings
- All moderate harm incidents are reviewed bi-weekly at the Patient Safety Incident Governance meetings
- Triangulation of incidents with complaints, concerns and claims occurs at the monthly Safety Risk and Learning Panel implementing thematic reviews as required, in accordance with the patient safety incident response framework
- The Patient Safety Incident Governance Meeting and Safety Risk and Learning Panel both report to the Trust's Clinical Risk Management Group (CRMG) which meets every two weeks
- CRMG reports by exception to the monthly SAFE Operational Group (SOG) reporting monthly to Integrated Performance Board (IPB)
- IPB reports by exception to the appropriate Committee prior to reporting to the Board of Directors
- Safe Staffing levels are considered throughout each stage of the governance process

Safety Analysis: CICC: 01 April – 30 Sept 2024

- A review of available data for CICC has been conducted for Quarter 2 2024/25, triangulated with staffing levels and CHPPD to assure standards of safety
- During Q2 there were a total of 454 incidents reported across 36 incidents codes
- The highest reported incident category was Slips, Trips and Falls (109) followed by Medication (126) and Pressure Ulcers (28)
- 28 Pressure Ulcers were reported and of these 23 were acquired prior to admission to CICC
- 5 Pressure Ulcers developed under the care of CICC, all were recorded as low harm
- 11 incidents were categorised as moderate harm: 8 Pressure Ulcers (referred to the Trust), 1 admission planning incident to CICC from a partner organisation and 2 Slips, trips and falls occurring at CICC

Safety Analysis: Summary

- The safety systems and mitigations in place at CICC appear to have been effective in minimising impact to patient safety; this will continue to be monitored through the Trust's governance framework
- Mitigations continue to include utilisation of the available clinical and professional resource at CICC, including therapy staff

Freedom to Speak up bi-annual report

Meeting Title	Board of Directors		
Date	11/12/2024	**Agenda Item**	19
Lead Director	Paula Simpson, Chief Nurse		
Author(s)	Alison Jones, Freedom To Speak Up Guardian		

Action required (please select the appropriate box)

To Approve ☐	**To Discuss** ☐	**To Assure** ☒

Purpose

The purpose of this bi-annual report is to provide assurance to Board of Directors regarding Freedom to Speak Up activity and learning during the reporting period 01 April 2024 – 30 September 2024.

Executive Summary

This bi-annual report provides an overview of Freedom to Speak Up (FTSU) activity during Q1 and Q2 of 2024/25. It covers the following key areas:

- Summary of Concerns Reported
- Concerns Reported by Service
- Predominant Themes identified
- Outcomes and Learning
- Our People
  - Feedback from Satisfaction Questionnaires
  - Monitoring information
- Key successes

Board of Directors are asked to note that Quality and Safety Committee approved the recommendation to extend the life span of the Trust's strategic plan in relation to FTSU from the current one year (2024/25) to a three-year plan (2024/27). This will support the Trust's agreed strategy for FTSU and be in line with other NHS organisations.

Strategic (Board Assurance Framework - BAF) and operational Risks and opportunities:

Whilst this does not link to any specific risk, the existence of a healthy speaking up culture remains pivotal to ensure a strong focus on safe, effective practice for both staff and people accessing services

Quality/inclusion considerations:

Quality & Equality Impact Assessment completed and attached No.

This is an assurance report detailing Freedom To Speak Up concerns reported in the last financial year. The Speaking Up policy, which supports the governance and process of speaking up, contains the Quality & Equality Impact Assessment

Financial/resource implications:

None identified

The Trust Vision – To be a population health focused organisation specialising in supporting people to live independent and healthy lives. The Trust Objectives are:

- Populations – We will support our populations to thrive by optimising wellbeing and independence
- People – We will support our people to create a place they are proud and excited to work
- Place - We will deliver sustainable health and care services within our communities enabling the creation of healthy places

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

People - Improve the wellbeing of our employees	Populations - Safe care and support every time	People - Better employee experience to attract and retain talent

The Trust Social Value Intentions

Does this report align with the Trust social value intentions? Yes.

If Yes, please select all of the social value themes that apply:

Community engagement and support ☐

Purchasing and investing locally for social benefit ☐

Representative workforce and access to quality work ☒

Increasing wellbeing and health equity ☒

Reducing environmental impact ☐

Quality & Safety Committee is asked to consider the following action		
The Quality and Safety Committee is asked to be assured by the Freedom to Speak Up Bi-Annual Report for 2024/2025 and support its progression to board of Directors QSC is asked to approve the recommendation to extend the Trusts Freedom To Speak Up strategic plan from the current one year document to a three year document		
Report history (Please include details of the last meeting that received this paper, including the title of the meeting, the date, and a summary of the outcome). This provides the audit trail through the governance structure.		
Submitted to	**Date**	**Brief summary of outcome**
Quality and Safety Committee	06/11/2024	Assurance provided and approval gained to extend life span of FTSU Strategic Plan to three years.

Compassion | Open | Trust

NHS
Wirral Community Health and Care
NHS Foundation Trust

Freedom To Speak Up Bi-Annual Report April 2024 – September 2024

Alison Jones: FTSU Guardian

Date: 11 December 2024

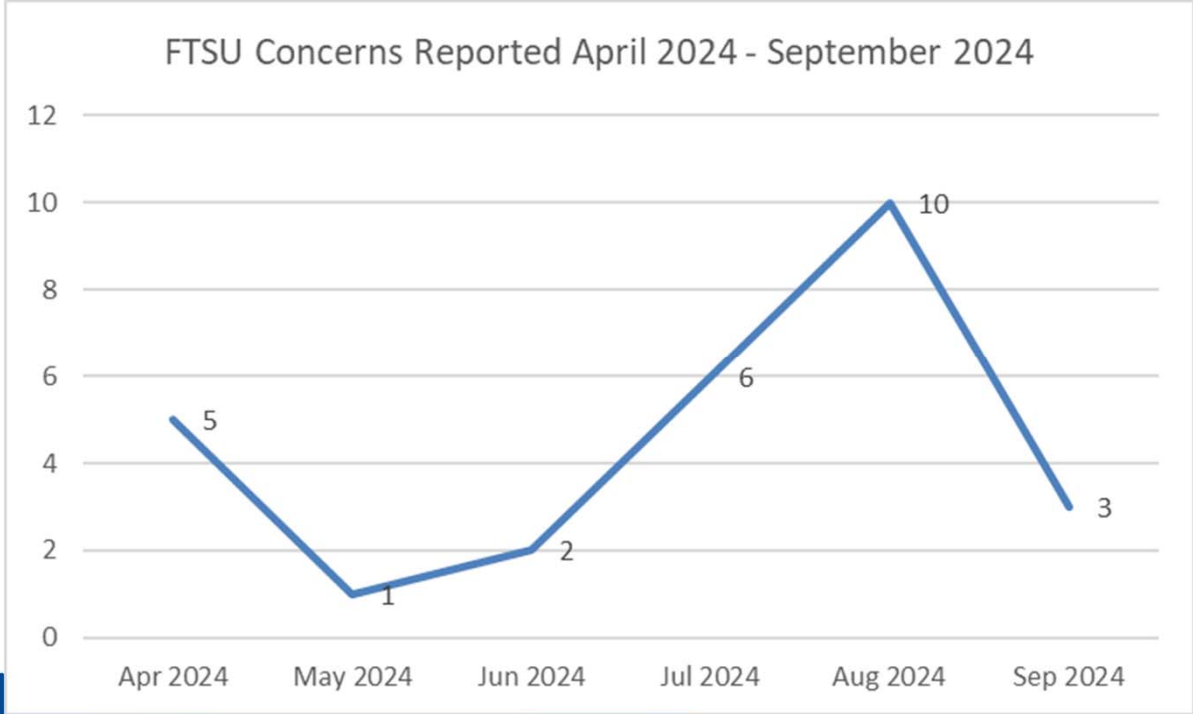
Contents of Report

Governance

How FTSU is monitored and supported

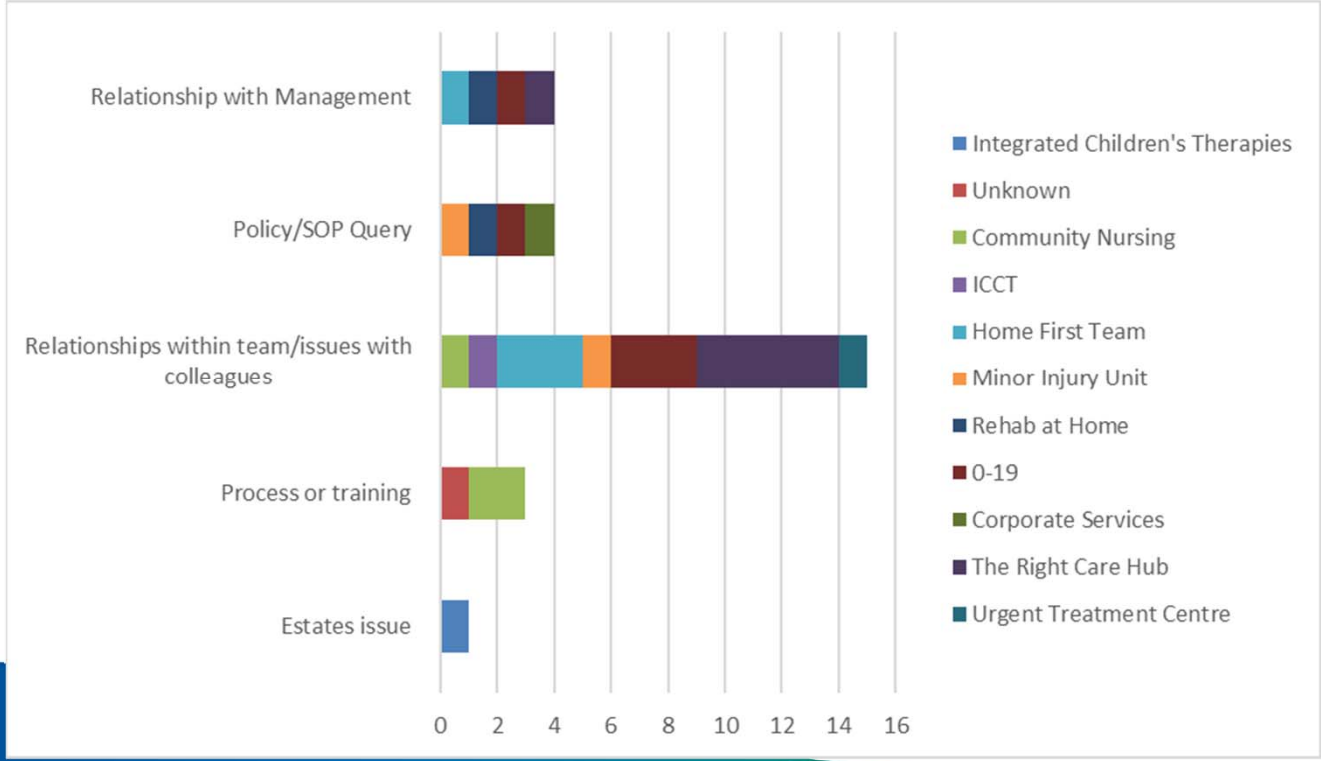
- Freedom To Speak Up Guardian who supports staff who raise concerns and promotes a culture of open reporting
- 134 FTSU Champions across the Trust promoting a speak up culture
- Speak Up policy in line with recommendations from the National Guardians Office
- FTSU Guardian is supported by both an Executive and Non-Executive Board member
- FTSU Guardian meets every other week with Chief Operating Officer, Chief Nurse, Chief People Office and their deputies
- Quarterly FTSU Steering Group to monitor themes and learning as well as triangulation with other sources
- FTSU Guardian presents a bi-annual report to Quality and Safety Committee and Trust Board

Concerns Reported

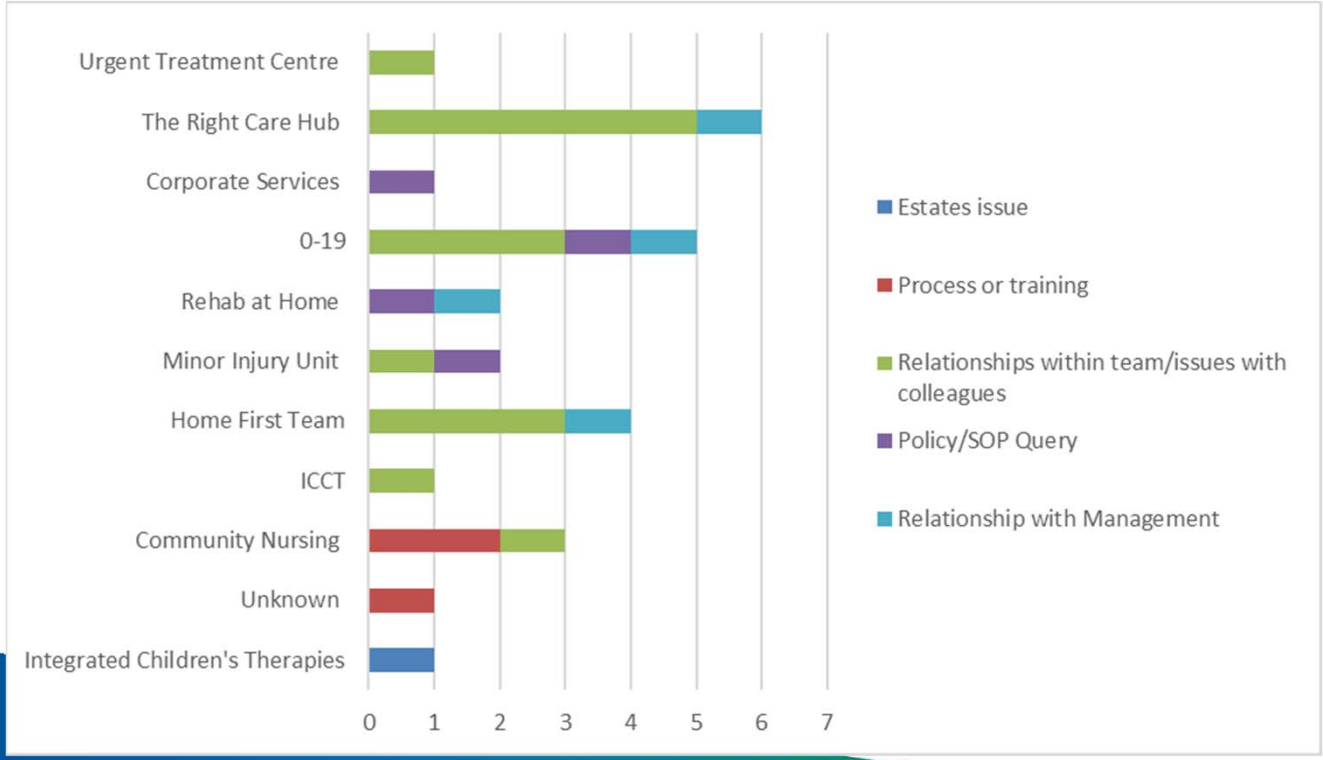


- 27 FTSU Concerns were reported April 24 – September 24
- This is a 50% increase on the same period last year
- 25 concerns have been investigated and closed
- 2 concerns are currently still open with ongoing investigation

Concerns Reported by Service and Theme



Concerns Reported by Theme and Service



Summary of Concerns Reported

- Highest number of concerns reported by Home First/Right Care Hub Teams and 0-19
- Highest theme of concerns reported is relationships and communication with colleagues and managers
- There has been a significant increase in the number of concerns reported compared to the same two quarters last year
- The majority of concerns are not patient safety related they indicate a need for support in team working, improvements in communication, behavioural standards and Learning and Organisational Development support

Confidence in FTSU Process

- 19 of the concerns (70%) were either reported openly by staff members or confidentially via the FTSU Guardian
- 8 (30%) of the concerns were reported anonymously.
- This shows an increase in the number of concerns being reported but also an increase in anonymous reporting
- Anonymous reporting increased following a promotion at the Get Together
- The anonymous concerns have been reviewed
  - 2 relate to reporting things the reporter felt could be improved on
  - 6 relate to communication/relationship issues either with managers or within the team

Outcomes and Learning

- Agreement between teams and Estates for conservatory at Highfield to be a shared resource during lunch period to allow for a quiet space away from desks
- Training and support offered to all staff to support the use of the new expenses system
- Cultural review within team supported by Deputy Chief Operating Officer and Learning and Development Team
- Errors in maternity leave payments rectified and apology given. Additional support provided by Service Lead for Team member to understand maternity pay entitlement and to feel better connected whilst on long term leave
- Team wide discussion and support from HR to assist team to understand appropriate boundaries to ensure both patient and staff safety

Outcomes and Learning Continued

- Support provided for a new Team Leader in developing their role and additional on going support put in place
- Review of managing attendance policy and guidance on needlestick injuries
- Review of Standard Operating Procedures for 0-19 and additional support provided
- Guidance shared with all staff re behavioural standards framework
- Additional support provided under the protected characteristic of Veganism including Trust wide promotions and Comms
- Local resolution re appropriate behaviours in the workplace and use of Behavioural Standards Framework
- Collaborative work with Infection Prevention and Control Team to support clinical staff

Outcomes and Learning for CIRT/Right Care Hub

- Increased number of concerns, and increase in anonymous concerns, noted and discussed at wider FTSU Team meeting
- Chief Operating Officer and Deputy Chief Operating Officer to lead investigation and improvement plan
- All team members invited to meet with COO, Deputy COO or FTSU Guardian to discuss their concerns openly and in confidence
- Action plan created to support Team improvements and communication. Actions being monitored weekly by COO and Deputy COO with the support of the Service Leads, FTSU Guardian and Learning and Organisational Development Team
- On going communication with the whole team to feedback on improvements and provide support

FTSU Satisfaction Questionnaires

Questionnaires are sent out to reporters when a FTSU Concern has been closed

- The answers from the questionnaires are used to support the promotion of Speaking Up for everyone in the Trust
- As part of our compliance with the National Guardians Office we upload the percentage answer to the question Would you speak up again on a quarterly basis. This information is used by the National Guardians Office to gauge satisfaction with speaking up processes
- In Q1 and Q2 of 2024/25 : 85% of questionnaires returned stated the reporter would speak up again if needed, 7.5% answered Maybe and 7.5% answered Don’t Know
- The reporters who returned questionnaires also had the opportunity to add feedback comments if they wish to

Compassion | Open | Trust

NHS
Wirral Community Health and Care
NHS Foundation Trust

What Our People Tell US

Feedback from satisfaction questionnaires

We felt we were listened to and issues were addressed in a timely and appropriate manner

The matter was dealt with efficiently and in a timely manner. I am really pleased I took the opportunity to speak up

I had great communication following my FTSU and was kept informed at all stages of the enquiries

I felt that the Guardian took my concerns seriously and has kept it confidential to the extent that I wanted her to

Compassion | Open | Trust

NHS
Wirral Community Health and Care
NHS Foundation Trust

What Our People Tell US Continued

Feedback from satisfaction questionnaires

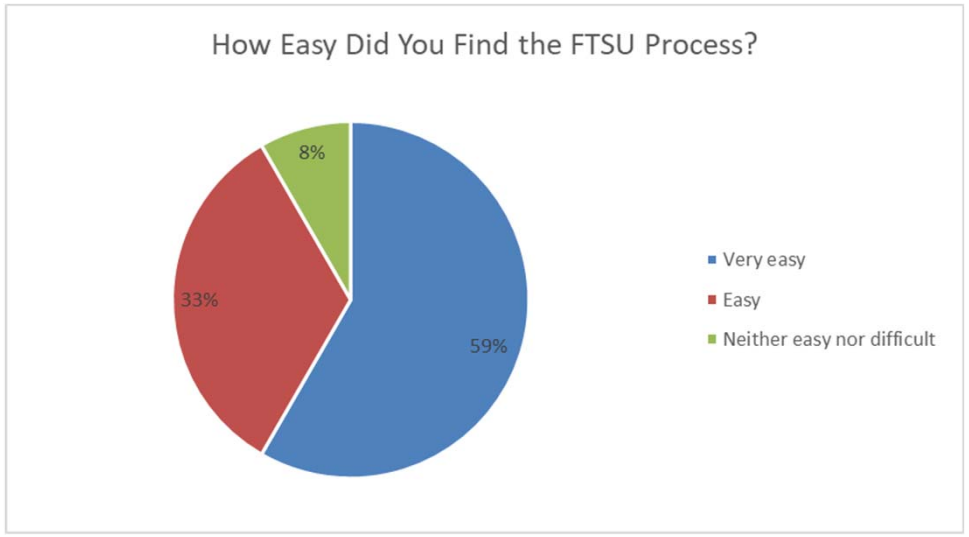
Concerns were listened to. Communications were excellent and actions were swift. Overall a great experience

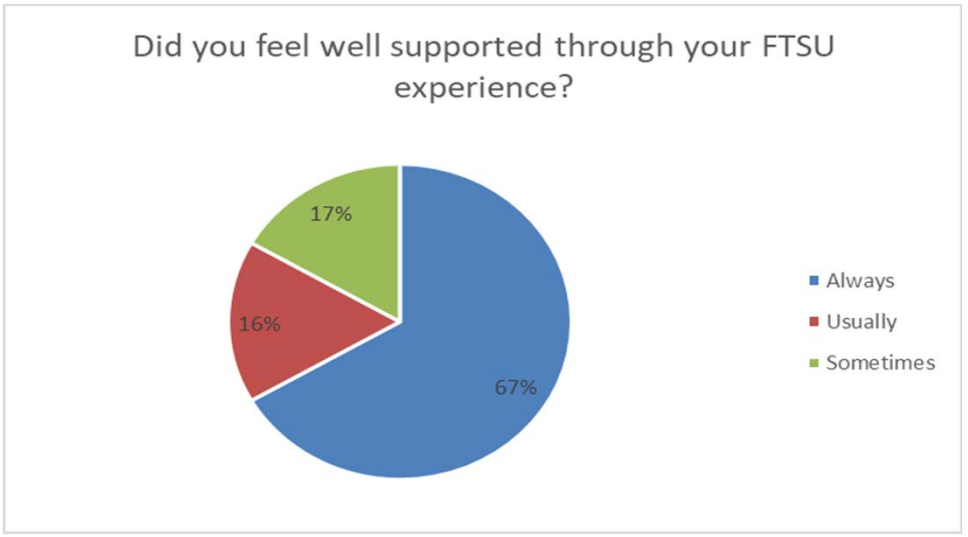
Kept Informed and issue resolved

The Guardian was kind and listened to my concerns she was able to put my concerns in a cohesive time line and did not rush or interrupt when I was speaking

FTSU Satisfaction Questionnaires

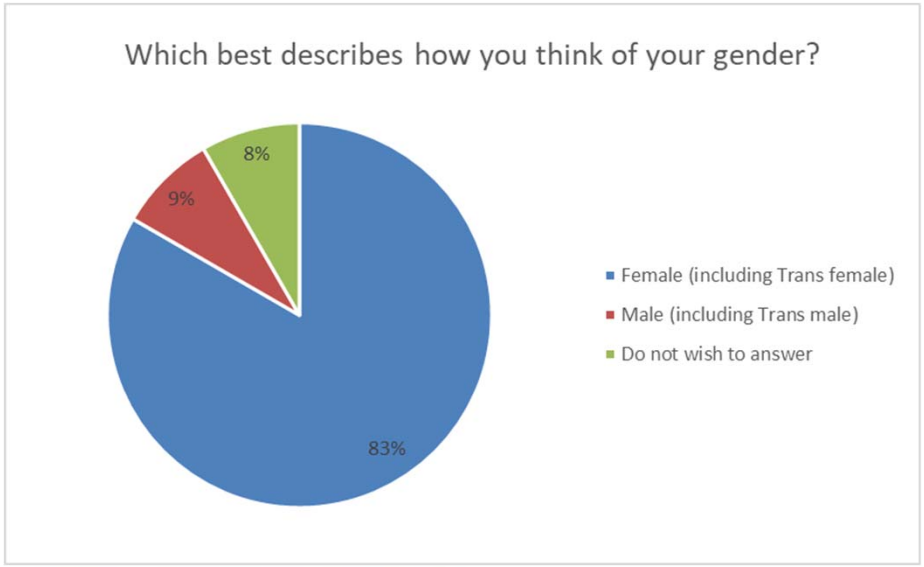
Information provided from reporters who returned satisfaction Questionnaires

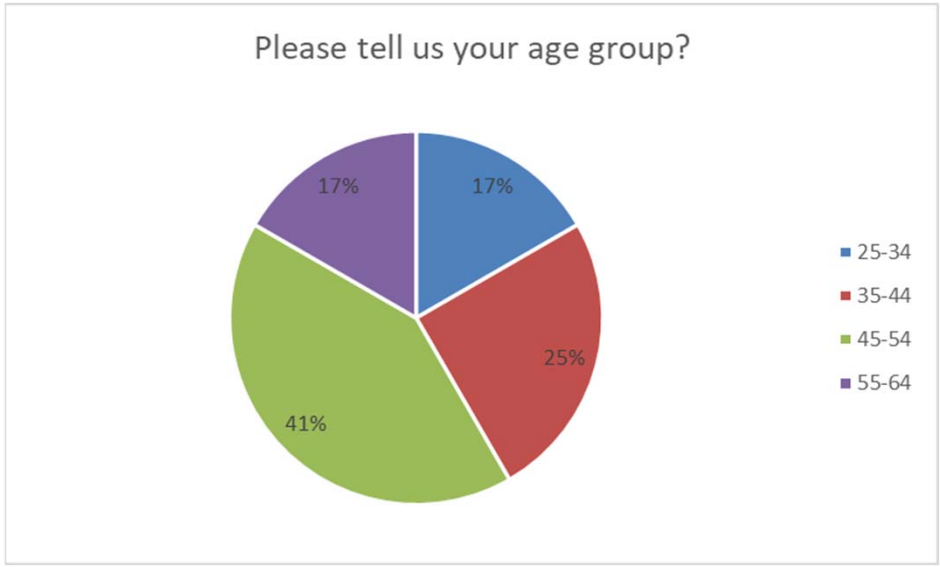




FTSU Satisfaction Questionnaires

Information provided from reporters who returned satisfaction Questionnaires





Successes

- Improved position in Community Nursing following consultation and monitored actions
- We currently have 134 FTSU Champions across all Trust sites and available in all Staff Network Groups to support our workers to speak up safely
- Refresher training sessions for FTSU Champions offered with training dates throughout 2024/25
- New Non-Executive Director with responsibility for FTSU now in post with induction provided by FTSU Guardian
- FTSU Strategic plan for 2024/25 launched, widely discussed and circulated throughout the Trust
- FTSU Communications plan developed and monitored Quarterly at FTSU Steering Group

Successes Continued

- FTSU ongoing improvement plan developed and monitored thorough quarterly FTSU Steering Group
- Board Development Sessions to take place in November 2024 to support further board assurance around FTSU processes and the ongoing monitoring of the National FTSU Toolkit for boards
- Ongoing monitoring of Speak Up, Listen Up, Follow Up training compliance
- Chairs of Staff Networks Groups attending Quarterly FTSU Champions Forum to support shared learning and promotion of Speaking Up