The National Staff Influenza Programme 2023/24

Meeting	Board of directors		
Date	17/10/2023	**Agenda Item**	17
Lead Director	Paula Simpson, Chief Nurse		
Author(s)	Claire Wedge, Deputy Chief Nurse, Helen Lundy, Clinical Safer Staffing Lead, Fiona Fleming, Head of Communications and Marketing Rachel Newland, Communications and Marketing Manager		

Action required (please select the appropriate box)

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

Purpose

The purpose of this report is to provide assurance to the Board of Directors that a robust plan is in place for the effective delivery of the staff Influenza programme 2023/24.

Executive Summary

As social contact returned to pre-pandemic norms, the number of flu cases in the 2022/23 flu season was higher than levels observed during the COVID-19 pandemic flu seasons, returning to levels seen pre-pandemic.

It is therefore imperative that robust plans are developed and implemented to effectively deliver an accessible staff influenza programme during 2023/24 to maximise protection across the workforce.

This paper outlines the Trust's approach to delivering the staff influenza programme during 2023/24 and includes an influenza assurance framework provided by NHS England (Appendix 1).

Risks and opportunities:

Nothing to report by exception to the Board of Directors.

Quality/inclusion considerations:

Quality & 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:

Nothing to report by exception to the Board of Directors.

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 - Improve the wellbeing of our employees	Place - Improve the health of our population and actively contribute to tackle health inequalities

The Trust Social Value Intentions

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

If Yes, please select all 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 is asked to be assured that the Trust has a robust plan in place for the effective delivery of the staff influenza programme during 2023/24.

Report history (Please include history of where the paper has been presented prior to reaching this meeting, including the title of the meeting, the date, and a summary of the outcome)		
Submitted to	**Date**	**Brief summary of outcome**
No previous reporting history.		

Wirral Community Health and Care NHS Foundation Trust

The National Staff Influenza Programme 2023/24

Purpose

1. The purpose of this paper is to provide assurance to the Board of Directors that a robust plan is in place for the effective delivery of the staff Influenza programme during 2023/24.

Background and rationale

2. During 2022/23 staff influenza vaccination uptake amongst NHS healthcare workers was 51.8%.

3. The staff influenza uptake in Wirral Community Health and Care NHS Foundation Trust (WCHC) during 2022/23 was 64.1%.

4. As social contact returned to pre-pandemic norms, the number of flu cases in the 2022/2023 flu season was higher than levels observed during the COVID-19 pandemic flu seasons, returning to the levels seen pre-pandemic.

5. Whilst COVID-19 continues to circulate, there is the potential for co-circulation of influenza, COVID-19 and other respiratory viruses.

6. It is therefore imperative that robust plans are developed and implemented to effectively deliver an accessible staff influenza programme during 2023/24 to maximise protection across the workforce.

2023/24 Staff influenza programme

7. A staff influenza group including key internal stakeholders and specialists from across the Trust was established in July 2023 to support the delivery of the 2023/24 programme.

8. The CQUIN financial incentive scheme is in place and includes the staff flu vaccination programme for all NHS Trusts. The CQUIN goal is to vaccinate between 75% - 80% of all frontline and non-clinical staff who have contact with patients and service users.

9. The Trust has therefore set a minimum internal ambition of an 80% uptake with a 100% offer for all frontline staff for this year's programme.

10. On 21 September 2023, guidance was published by NHS England outlining the approach for COVID-19 and seasonal flu vaccination programmes, to maximise workforce protection supporting winter resilience.

11. To support assurance to the Board of Directors, the Trust has completed an assurance framework which has been developed for use by NHS England. This can be utilised as part of a wider Board Assurance Framework for Winter.

12. The assurance framework is presented for public assurance in **Appendix 1**, evidencing full compliance across all applicable areas.

13. The Trust's staff influenza campaign commenced on 02 October 2023, implementing a blended delivery model. This approach has been established based on lessons learned

from the 2022/23 campaign, with the aim of maximising accessibility to flu vaccines for all Trust staff.

14. The model will include peer to peer vaccinations within teams, and a flexible vaccination team administering vaccines at bases Trust-wide both in and out of hours.

15. Effectiveness of these delivery models will be closely monitored by the staff influenza group throughout the programme, with adjustments being implemented as required to maximise uptake.

16. The Trust is aiming to have a minimum of 80% of staff immunised by the end of December 2023, to ensure maximum protection to Trust staff.

17. A concurrent staff COVID-19 booster vaccination programme will be available to staff across all geographical locations, via system mutual aid. This replicates the successful approach provided to Trust staff for primary and booster doses of COVID-19 vaccinations.

Staff Influenza Vaccine Plan

18. Vaccines will be provided via Wirral University Teaching Hospital NHS Foundation Trust (WUTH) as required, this will include QIVc and QIVr vaccines as follows:

    - QIVc- Cell-based quadrivalent influenza vaccine, licensed for individuals from 2 years
    - QIVr- recombinant quadrivalent influenza vaccine, Supemtek▼, licensed for individuals from 18 years, but also recommended for individuals who are 65 years and over

19. The ordering and delivery model ensures a continuous supply of vaccines to meet demand, effectively managing storage requirements and minimising wastage.

Communications Strategy

20. It is recognised that the communication strategy implemented during the 2022/23 programme was key to supporting the uptake amongst Trust staff. The 2023/24 programme will therefore build on this foundation of knowledge and experience to maximise the outcome of the programme.

21. The communications strategy will use the **EAST** framework - Easy, Attractive, Social, Timely, replicating last year's successful approach.

    - Making it **easy** - it is important we keep messages as simple as possible and make it as easy as possible for people to know about the vaccination and how/where to get it.
    - Making it **attractive** - by developing our own campaign style, based on the success of last year's, we will ensure the visuals are engaging and, where appropriate, in line with the overarching *'Get vaccinated. Get winter strong'*. Get your flu vaccination' messaging to reflect the Health Care Worker Winter vaccination campaign.
    - Making it **social** - we will demonstrate that getting the flu vaccination is the 'norm' and the right thing to do this winter. We will do this through social networks, including the staff Facebook group, and our other digital channels to encourage behaviours and ensure the message can be easily shared between colleagues.
    - Making it **timely** – after giving our staff the 'heads up' that the flu vaccine is coming, we will communicate with staff regularly via our regular channels, and target teams where necessary.

22. The primary focus will be on practical messages that inform staff how to get their vaccine, where to go and safety messages. This will be supported by messages on why getting the vaccine is important – how it helps to protect others, etc.

23. All campaign messages will be underpinned by the 'protect yourself, get vaccinated' message, and 'get winter strong' message where appropriate, to tie in with winter health messages and the COVID-19 booster programme nationally.

24. A message from the Chief Executive will be part of the campaign (e.g. alongside a photograph of her having the vaccine), this will be supported by the Chief Nurse.

25. An integrated mix of internal communications channels will be used to ensure the flu messages are received by all staff on a regular basis.

26. As in previous years, Influenza vaccine uptake statistics will be published in the form of a leadership board, provided by the IPC Team/Business Intelligence Services.

The Incentive

27. Whilst incentives schemes have been run in the past, there is no evidence that they have directly influenced individual choice to take up the vaccine.

28. We do not incentivise the COVID-19 booster which is of equal importance.

29. Staff have a responsibility to make an informed choice to take up both the Influenza and COVID-19 vaccine.

30. There is also the question of funding and perception of spending money on an incentive.

31. Communication efforts will be channelled into providing clear information on benefits and access to the vaccines.

Board action

32. The Board of Directors is asked to be assured that the Trust has a robust plan in place for the effective delivery of the staff Influenza programme during 2023/24.

Paula Simpson, Chief Nurse

Contributors:
Claire Wedge, Deputy Chief Nurse
Helen Lundy, Clinical Safer Staffing Lead
Fiona Fleming, Head of Communications and Marketing
Rachel Newland, Communications and Marketing Manager

11 October 2023

Wirral Community Health and Care NHS Foundation Trust

Appendix 1

	Governance	Evidence	Trust self-assessment
1.	Do you have a named SRO for the flu programme?	The SRO for the Trust's flu programme is the Chief Nurse / Director of Infection Prevention and Control.	
2.	Do you have an established flu programme committed to the delivery of flu vaccinations that feeds into the Trust board?	The Trust has an established flu programme committed to the delivery of the staff influenza programme. Progress is reported to the Board of Directors via the Quality and Safety Committee, who receive an updated position via the quarterly IPC assurance report.	
3.	Is Flu delivery reported into the overall Trust governance structure?	Flu delivery is embedded throughout the governance of the organisation, ensuring Trust-wide visibility from operational level to the Board of Directors.	
4.	Do you have a robust governance link to system leaders?	The Trust has an active presence at all relevant system meetings and direct links to system leaders.	
5.	Do you feed into the ICS Flu Board?	The Trust has a reporting route into the ICS via the Chief Nurse.	
6.	Did the Board receive a report evaluating the lessons learned from the 22/23 flu programme?	The Board of Directors received a report evaluating the lessons learned from the 2022/23 flu programme via the DIPC Annual report in June 2023.	
7.	Has this been converted into an action plan for improvement in 22/23?	Lessons learned from the 2022/23 flu programme have informed action and driven improvements in the 2023/24 programme.	
	Supply		
8.	Have you ordered supply via the Commercial Medicines Unit Framework or via alternate routes (such as directly from wholesalers) and received confirmation of delivery dates of stock?	Supplies have been procured via a local partner NHS Trust who have the required wholesale dealers license.	
9.	Have you ordered sufficient flu vaccine supply to cover 100% of your frontline HCWs?	The Trust has access to sufficient flu vaccine stock to cover 100% of staff.	

10.	Have you ordered sufficient flu vaccines to cover pregnant women if you offer have a maternity service?	The Trust does not offer a maternity service; however, pregnant staff will be offered the flu vaccine in accordance with national guidance.	
11.	Have you ordered the recommended vaccine types for the various age cohorts?	The Trust's Lead Pharmacist has ensured appropriate ordering of flu vaccines to support an inclusive approach to the campaign.	
12.	Have you ordered the recommended vaccine types for those who may present with allergies to certain vaccines or, who cannot accept certain vaccination types?	The Trust's Lead Pharmacist has ensured appropriate ordering of flu vaccines to support an inclusive approach to the campaign.	
13.	Do you have appropriate storage facilities to store flu vaccinations?	The Trust will continue to utilise the appropriate storage facilities established over recent years for the 2023/24 staff flu campaign.	
14.	If you are not vaccinating staff on site, can you confirm you have signposted your HCW to an alternative convenient site?	The Trust will offer flu vaccines across all main bases supporting ease of access. Eligible staff will also be sign-posted to their GP Practice, if this is a preferred option.	
15.	Have you considered flexible delivery models for staff to access the vaccine (e.g. roving models/easy-access clinics)?	A blended delivery model has been established to maximise accessibility to flu vaccines for all Trust staff. The model will include clinics offering scheduled appointments, peer to peer vaccinations within teams, and a flexible vaccination team administering vaccines at bases Trust wide both in and out of hours.	
16.	Have you identified appropriate spaces to run vaccinations clinics?	The Trust has access to appropriate spaces to run vaccination clinics for staff as required, this builds on lessons learned from the 2023/23 campaign.	
17.	Do you have a robust method of inviting staff to receive a vaccination (e.g. a local booking system that staff can easily access)?	The Trust is able to implement an on-line booking system for staff flu vaccinations using simply book via the staff intranet. Currently, the preferred method of delivery is via walk in clinics and peer vaccinations at team meetings.	
	Delivery		
18.	If you are not vaccinating staff on site, can you confirm you have signposted your HCW to an alternative convenient site?	Staff vaccinations will be available for administration on site. Signposting to alternative options has been conducted to maximise accessibility and choice.	
19.	Have you considered flexible delivery models for staff to access the vaccine (e.g. roving models/easy-access clinics)?	A flexible delivery model has been designed and is being implemented to support the 2023/24 staff flu campaign.	

20.	Have you identified appropriate spaces to run vaccinations clinics?	Access to clinics will build on the campaign delivered in 2022/23, responding to lessons learned and feedback from staff.	
	Communications		
21.	Do you have a robust method of inviting staff to receive a vaccination (e.g. a local booking system that staff can easily access)?	There is a robust communications campaign in place to promote where and when staff can get vaccinated.	
22.	Is information on where to receive a vaccination readily available to staff?	Information will regularly be shared via The Update, on StaffZone and on the staff Facebook group, as well as Trust-wide email messages where appropriate.	
23.	Is information on importance of flu vaccinations readily available?	As above, including signposting to further information where necessary (eg NHS website) and new statistics from the media, to encourage uptake.	
24.	Have you a communications and engagement plan to target those hard-to-reach staff groups?	The communication plan is inclusive and includes all staff groups to maximise impact and outcomes.	
	Workforce		
25.	Have you identified the workforce required to deliver the flu programme?	The workforce has been identified to deliver the flu programme, including a dedicated lead with a wealth of experience in delivering operational vaccination programmes	
26.	Can you confirm you've reviewed and understand the workforce requirements for flu delivery (e.g. National Protocol, PGD, PSD).	The Trusts' seasonal influenza group has responsibility for ensuring the programme is aligned to the workforce requirements for flu delivery.	
	Co-administration		
27.	Are you planning to co-administer / co-deliver flu and COVID-19 vaccines and have considered timing and workforce to enable this?	The Trust will only be directly administering the flu vaccine to staff in 2023/24. Staff will be supported to access a concurrent staff COVID-19 booster vaccination programme via system mutual aid to maximise protection.	
	Data capture and reporting		
28.	Do you have licence to use NIVs to record flu vaccinations?	The BI team have access to NIVs, however, an internal data collection system is also being utilised for the 2023/24 programme to closely monitor uptake. This will be reported via a bespoke dashboard in TIG.	

29.	Have staff been identified and trained on NIVs to record vaccinations at point of delivery?	All vaccinators have previously received training on the NIVs system.	
30.	Do you have a SPOC and a superuser for NIVS?	The SPOC for NIVS is the Head of Business Intelligence (BI).	
31.	Have you removed any staff no longer employed, or contracted, by the Trust from the ESR system? Have you got a regular process in place to ensure ESR is up to date?	A robust mechanism has been established between the BI and HR teams to ensure reporting is reflective of the workforce.	
32.	Do you have an appropriate process in place for reviewing uptake with a view to improving performance?	The BI team are building a bespoke dashboard within the Trust Information Gateway (TIG) system providing real time reporting at service level. This approach will be tracked throughout the Trust's governance and action taken to continuously encourage uptake.	

Compassion Open Trust

Wirral Community Health and Care NHS Foundation Trust

Mortality Report: Learning from Deaths Framework Quarter 1: 1 April 2023 – 30 June 2023

Meeting	Board of Directors		
Date	17/10/2023	**Agenda Item**	18
Lead Director	Nick Cross, Medical Director		
Author(s)	Nick Cross, Medical Director		

Action required (please select the appropriate box)

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

Purpose

The purpose of this paper is to seek assurance from the Board of Directors in relation to the publication of the learning from deaths appendix on the Trust website which is included within the report.

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 Q1 2023/24, along with a summary of thematic learning identified during investigation into these cases.

All deaths reported to the Trust in Q1 have flowed through the Trusts governance processes. There are no deaths that were attributable to the care delivery provided by our Trust and therefore no specific learning.

Risks and opportunities:

Not applicable.

Quality/inclusion considerations:

Quality & Equality Impact Assessment completed and attached: No.

Financial/resource implications: None

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	Populations - People and communities guiding care	Place - Improve the health of our population and actively contribute to tackle health inequalities

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 approve appendix 1 to be published on the public facing website

Report history (Please include history of where the paper has been presented prior to reaching this meeting, including the title of the meeting, the date, and a summary of the outcome)

Submitted to	Date	Brief summary of outcome
Quality & Safety Committee	13.09.2023	Committee were assured

Wirral Community Health and Care NHS Foundation Trust

Mortality Report: Learning from Deaths
Quarter 1: 01 April 2023 – 30 June 2023

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. 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 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.

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 which have occurred in a place where we are commissioned to deliver services, are discussed at both the Quality and Governance Multi-disciplinary Safety Huddle and 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 investigation reports 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 and who is responsible for the Learning from Deaths agenda.

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

12. 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.

13. 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.

14. 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.

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, Chief Nurse and Deputy Chief Nurse for all reported unexpected deaths. This includes integrating the Mortality Screening Tool with Datix.

16. 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.

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. 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.

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.

Q1 2023/24 WCHC Reported deaths (Datix incident reporting)

23. During Q1 there were a total of 8 reported deaths none of which were within scope for reporting.

24. During Q1 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 (Q4)		
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	6	
Total Deaths reviewed through SUDiC methodology	6	

Summary of Thematic Learning

25. Each unexpected death reported during Q1 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.

26. Of the total deaths reported in Q1, 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. There were no learning themes identified for the Trust.

27. Given the Trust's significant reach in the provision of Children and Young People services across Cheshire and Mersey ICB, the membership of the Mortality Review Group has expanded to include the Trust's Child Death Overview Panel (CDOP) representative. This will enable to group to have visibility of any thematic learning across the whole of Cheshire and Mersey and thereby create opportunities to embed this into Trust services, where this is appropriate.

Recommendations

28. 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.

29. 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.

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

Dr Nick Cross
Executive Medical Director

5 September 2023

Appendix 1

Learning from Deaths Q1 23/24 Report

The following data represents the high-level reporting of deaths which occurred within our services over the period of Quarter 1 2023/24.

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 six child deaths reported during this quarter, which followed the appropriate investigation processes and there was no learning specific to the Trust.

We continue to promote shared learning across the health and care sectors and work collaboratively with our system partnership to identify and address the impact of Covid-19 within all the communities in which we provide services, focusing on addressing health inequalities on a population-based approach.

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

5 September 2023

Compassion Open Trust

Wirral Community Health and Care NHS Foundation Trust

Controlled Drugs Accountable Officer's Annual Report 2022-2023

Meeting	Board of directors		
Date	17/10/2023	**Agenda Item**	19
Lead Director	Nick Cross, Medical Director		
Author(s)	Nick Cross, 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 1 April 2022 to 31 March 2023 and provides assurance that the Trust is compliant with updated controlled drug legislation and that controlled drug systems, procedures and incidents are regularly reviewed and actions are taken as necessary to strengthen controlled drugs 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:

- 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 to which the Trust is an active member

Risks and opportunities:

There are no risks currently on the CD 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	People - Improve the wellbeing of our employees	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 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 that controlled drugs are handled safely throughout Trust Services

Report history (Please include history of where the paper has been presented prior to reaching this meeting, including the title of the meeting, the date, and a summary of the outcome)		
Submitted to	**Date**	**Brief summary of outcome**
Quality & Safety Committee	13.09.2023	Committee was assured

Wirral Community Health and Care NHS Foundation Trust

Controlled Drug Accountable Officer's Annual Report

1 April 2022- 31 March 2023

Introduction

1. Accountability for the safe management of controlled drugs sits with the Trust Board via the Controlled Drugs Accountable Officer (CDAO). This report from the Trust's CDAO provides assurance that the Trust is compliant with updated 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 outlined 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 next 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.

The Remote Prescribing Policy (SOP120) and the Clinical Protocol for Non-Medical Prescribing within Adult Palliative care (MMCP13) have both been updated in July 2023 to include the Teletriage and CIRT Services. The scope of prescribing of controlled drugs has also been expanded to align with the evolving roles of services and the increasing complexity of patients being treated. Although these updates fall outside the reporting period, this is included for information.

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

4. Palliative care leads, specialist nurses and representatives from medicines management teams throughout Wirral Place, met to discuss learning from the Gosport War memorial Community Hospital enquiry. (The enquiry identified 456 patients who had died earlier than expected between 1987 and 2001, patients had been prescribed strong opiates inappropriately and their dosing was not titrated to individual patient needs).

   To ensure a similar tragedy was avoided in Wirral, during 2021 2022, Wirral palliative care leaders agreed: anticipatory syringe driver prescriptions should not be issued unless a patient on long-acting opioids was expected to lose their oral route in the coming days. Additionally, any new symptoms requiring extra sedating medications should not be added to a syringe driver without a face-to-face review by a practitioner. This change in practice continues to be followed. During 2022 2023, this advice was reinforced by re-circulating the advice in the Medicines Management Bulletin and it is now included in the Non-Medical Prescribing within Adult Palliative Care Clinical Protocol (MMCP13).

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

5. 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

6. 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.

   These procedures ensure CDs are denatured prior to appropriate destruction and are compliant with current legislation and best practice.

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

The Management and Use of CDs is Audited to Evidence the Safe Use of CDs

7. 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. Following the audits, associated action plans were monitored via the Medicines Governance Group.

8. Controlled drug prescribing continued to be audited by reviewing ePACT prescribing data. This information was presented each quarter at the Medicines Governance Group. 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.

9. Most controlled drug prescribing occurred within GP Out of Hours. Trust procedures dictate that quantities should be sufficient only to allow the patient time to obtain further supplies from their own GP. Large quantity prescribing was therefore challenged and fed back to the prescriber via line management. Unusual patterns of prescribing were also investigated by the Medicines Management Team. During the reporting period there were no CD queries that needed to be forwarded to the NHSBSA for further investigation.

10. In February 2023, the Medicines Management Team completed a Trust wide CD audit, using the CD Local Intelligent Network Assurance Framework Self-Assessment. The associated action plan was tracked through the Medicines Governance Group. Changes following the audit include:

- Freedom To Speak Up information on Staffzone has been updated to include concerns relating specifically to misuse of medication.
- Medicines Management training has been updated to include information on reporting concerns with regards to misuse of medication and discussion around relevant CD policies.

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

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

    Prior to delivering care to end of life patients via a syringe driver, nurses and second checkers were required to pass competencies designed to ensure they had the necessary knowledge and numerical skills to deliver care via syringe drivers.

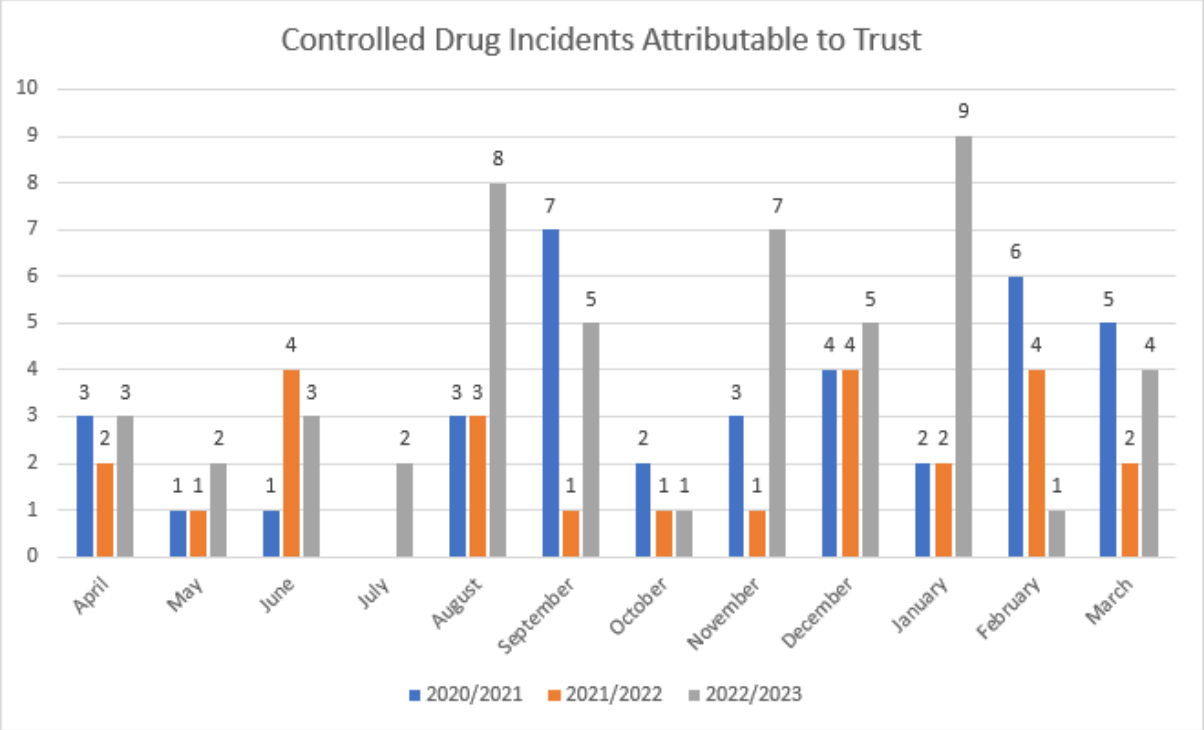
    The amended Wirral-wide guidance on when to initiate palliative care syringe drivers was re-circulated directly to nurse managers and via the Trust's Medicines Management Bulletin.

    A pharmacist from the Trust's Medicines Management Team attended Mersey Regional Local Intelligence Network (LIN) meetings on behalf of the Trust's CDAO. This meeting is 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. During the reporting period, the meetings were virtual.

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

12. 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 2022-2023. Incidents reported 2020-2021 and 2021-2022 are included for comparison.



13. All the reported CD incidents were low or no harm and most of the incidents involved documentation errors where there were discrepancies in the number of CDs, but on investigation there was found to be no missing stock. There were however peaks in the reporting in August, September and November 2022 and January 2023.

14. The August and September peaks were associated with several incidents reported within CICC. In three of the incidents, patients had been discharged from the unit and had their CD medication returned to them without the CD register being updated. The stock balances within the CD register were therefore found to be incorrect. In response to these incidents, MMSOP56 the procedure for safe handling of medicines within CICC was updated and further training was provided to reinforce agreed processes and a planned face to face CD audit of the wards carried out by the Medicines Management Team was brought forward.

15. Three of the incidents that occurred in November 2022 were due to codeine tablets being unaccounted for, on investigation, two of the incidents were due to documentation errors, but in one incident, the loss of two tablets could not be accounted for. This loss was reported to the CD LIN.

16. The January peak involved incidents from several services with no new associated themes. However of note, one of the incidents reported was the discovery of oxycodone ampoules in the Virtual Frailty Ward medicines cabinet and register. This medication was not stocked within the unit and it was concluded that this CD had previously been prescribed to an individual patient. All staff were made aware that once a medication is prescribed to a patient, it is the patient's property and must not be removed from their home to be administered to another patient. In addition, the procedure MMSOP59 was updated to reinforce the appropriate

handling of patient's own CDs. The oxycodone ampoules were taken to a community pharmacy for disposal in line with legislation.

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

17. Up until December 2022, the Trust pharmacists reported all controlled drug incidents to the local intelligence network. High risk incidents were reported immediately, reporting low or moderate incidents were reported each month. There were no high-risk incidents submitted during the reporting period.

18. 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

    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 CQC

19. The Safe Management of Controlled Drugs Annual Update 2022 was published by CQC July 2023. The update included a section that collated concerns raised nationally by LIN meetings. These concerns included: Ineffective governance in services, where workload pressures sometimes meant that staff were unable to carry out audits regularly or in as much detail as necessary- WCHC have two services that carry CDs as stock and CICC where patients' own prescribed CDs are stored and administered to patients. The Medicines Management Team are able to visit both sites that stock CDs and the three wards to undertake CD audits annually.

    Another concern raised by the LINs was the diversion of CDs in lower schedules that do not legally require storage in CD cabinets or recording in CD registers. GP Out of Hours and the Walk-In Centres stock codeine tablets the only stock medicine that falls into this category within WCHC. Following advice from the local LIN, although not legally required, the services maintain a register of codeine tablets. Assurance is given that the services are using this register due to the fact that any stock discrepancy are reported via Datix and investigated.

    The national LINs also reported the concern that CDs are being diverted by both health and care professionals- WCHC have during the reporting period, raised awareness of how to report concerns that CDs could be being used inappropriately and what to look out for within the "Freedom to Speak Up" section of Staff Zone. Awareness of misuse of CDs has also been incorporated into the Community Nursing Medicines Management training.

18. Conclusion

This report provides an overview of how the Trust has engaged fully with the local healthcare community and the Mersey Regional Local Intelligence Network, ensuring the governance arrangements surrounding the handling of controlled drugs comply with best practice.

Nick Cross - Medical Director & Trust CDAO

Lisa Knight - Lead Pharmacist

September 2023

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

Compassion Open Trust

Wirral Community Health and Care NHS Foundation Trust

Medicines Optimisation Annual Report 2022-23

Meeting	Board of Directors		
Date	17/10/2023	**Agenda Item**	20
Lead Director	Nick Cross, Medical Director		
Author(s)	Nick Cross, Medical Director with contributions from Lisa Knight Lead Pharmacist		

Action required (please select the appropriate box)

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

Purpose

This annual report provides assurance to the board that medicines throughout Trust services are handled safely and in line with best practice.

Executive Summary

This report covers the reporting period 1 April 2022 to 31 March 2023 and outlines the activities undertaken throughout the Trust to optimise the use of medicines.

This report does not include the management of controlled drugs which will be reported in a separate controlled drug annual report 2022 2023.

The report should be read in conjunction with the two tri-annual reports previously presented to the board covering the periods 1 April to 31 July 2022 and 1 August to 30 November 2022.

The report includes a summary of core medicines management activities covering the whole reporting period and a summary of medication incident themes reported 1 December 2022 to 31 March 2023.

Risks and opportunities:

This annual report relates to: Organisational risk ID:2890 where there is a risk of patients not receiving medicines as prescribed within CICC. The present risk score is 9 likelihood 3 and consequences 3, this has met the target risk score. The risk will be archived with a new risk opened to reflect the on-going quality improvement.

Quality/inclusion considerations:

Quality & Equality Impact Assessment completed and attached No.

A Quality Impact Assessment is not required because this report does not fulfil the criteria for requiring a Quality Impact Assessment, an Equality Impact Assessment is not required because optimisation of medication is of benefit to all regardless of any protected characteristics

Financial/resource implications:

There are no associated financial implications 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	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

The Board of Directors is to be assured that medicines are handled safely throughout Trust services.

Report history (Please include history of where the paper has been presented prior to reaching this meeting, including the title of the meeting, the date, and a summary of the outcome)

Submitted to	**Date**	**Brief summary of outcome**
Quality & Safety Committee	13.09.2023	Committee was assured.

Wirral Community Health and Care NHS Foundation Trust

Medicines Optimisation Annual Report 2022-2023

Introduction

1. Throughout 2022-2023 Wirral Community Health and Care NHS Foundation Trust remained committed to the proper and safe management of medicines and the principle that patients who use Trust services would receive the right choice of medicines at the right time.

2. The Trust was required to comply with Health and Social Care Act 2008 (Regulated Activities) Regulation 2014 (Part 3) Regulation 12 (g) which states that healthcare organisations must demonstrate, "proper and safe management of medicines."

3. This annual medicines optimisation report provides formal assurance to the board of the activities involving medicines undertaken across the organisation for the reporting period 01 April 2022 to 31 March 2023.

4. This report does not include the management of controlled drugs which will be reported in a separate controlled drug annual report 2022-2023.

5. The report should be read in conjunction with the two tri-annual reports previously presented to the board covering the periods 1 April to 31 July 2022 and 1 August to 30 November 2022. This report will include a summary of the activities covering the whole reporting period in addition to specific information relating to the reporting period 1 December 2022 to 31 March 2023.

A summary of the activities to support medicines optimisation 2022-2023

Practitioners were supported in their roles by evidence based clinical guidelines, procedures, and patient group directions (PGDs)

6. Evidence based procedures defining best practice for the handling of medicines were provided for the workforce, providing a framework outlining expected standards of practice. During 2022-2023 the Medicines Governance Group oversaw the development or update of 22 procedures and guidance documents and 27 PGDs were developed or updated. See appendix 1 for full details of documents reviewed or updated 2022-2023.

7. During the reporting period, procedures were developed for the new service, Virtual Frailty Ward. This service had the added complexity of being a joint venture with Wirral University Teaching Hospital (WUTH) and therefore needed to be developed in partnership with WUTH.

The Trust adopted relevant local and national guidelines.

8. New and updated national evidence-based guidance documents (i.e., NICE/MHRA) were scrutinised and where relevant, changes were made to internal documents, such as patient group directions and procedures to reflect these updates.

9. E-learning on the use of PGDs was adopted from e-Learning for Health for all practitioners using PGDs as part of their job role. This training was recommended as the best available PGD e-learning package by the Specialist Pharmacy Services national lead pharmacist for PGDs.

10. During the reporting period, Wirral Place adopted the North-West Coast Clinical Network, "Guidance on Consensus approaches to managing Palliative Care Symptoms." This guidance was new to the Wirral, the Medicines Management Team supported its roll out by discussing the guidance with the palliative care specialist nurses, the palliative care consultant for St John's hospice and signposting clinical staff to the guidelines via the Medicines Management Bulletin.

Staff accessed training to enable them to be competent in their knowledge of medicines.

11. Practitioners were responsible for keeping up to date by accessing medicines information from the multiple national NHS approved agencies.

12. The Medicines Management Team acted as a medicine's information resource for front line trust staff. This resource was regularly used by Community Nursing, especially when nurses were unsure if a particular medicine was safe to be administered in the community.

13. The in-house Medicines Management Bulletin also provided clinical information, highlighting updates in national guidance, changes in local procedures and raising awareness of learning from incidents. Bulletins written during the reporting period are available via the Trust Website. Dissemination of the bulletins was monitored via the monthly SAFE medicines management audit.

14. E-learning was utilised and monitored via ESR for safe insulin administration, antimicrobial stewardship (AMR) and the newly adopted PGD training. At the end of Q4 compliance rates for eligible staff were 80.44% for safe use of insulin, 95.83% for AMR and 92.56% for PGD training. The lower rate of completion for safe use of insulin is being investigated and support is being put in place to ensure eligible staff are given time to complete their mandatory training.

15. In addition, the Trust pharmacists provided medicines management training via a combination of secure face to face training and training via Microsoft Teams, supporting the training of student nurses, newly qualified nurses and nurses working within CICC and Community Nursing. From 1 April 2022 to 31 March 2023, the Medicine Management Team delivered regular monthly training sessions for Community Nurses and CICC. In addition, extra training slots were delivered to CICC on an ad hoc basis as new staff came into post.

Governance Structures were strengthened to support Non-Medical Prescribers

16. Non-medical prescribers (NMPs) were supported by the Trust's NMP Lead who provided prescribing inductions, quarterly NMP forums (via Microsoft Teams) and biannual prescriber refresher training.

17. The Trust's NMP Lead continued to work collaboratively with the Learning and Organisational Development Team to strengthen governance processes enabling experienced Trust V300 prescribers to supervise and assess students as a Designated Prescribing Practitioner (DPP) during their V300 prescribing course. The DPP database was continually updated as prescribers became eligible to take on the DPP role. There were 42 NMPs who were eligible to be a DPP at the start of Q1 2022, this increased to a total of 50 NMPs eligible at the end of Q4. Having sufficient staff to undertake the role of DPP enabled the Trust to take full advantage of available places on prescribing courses.

Prescribing activity was monitored.

18. E-Pact prescribing data was analysed at the monthly Medicines Governance Meetings. Controlled drug prescribing, antimicrobial and V300 non-medical prescribing were monitored quarterly.

19. V300 data linked to individual non-medical prescribers was cascaded to service managers to facilitate discussions between line managers and prescribers enabling improvements in quality and cost-effective prescribing. Where unusual prescribing activity was identified, in the absence of an appropriate explanation, the Business Service Authority (BSA) was contacted to recall the prescription. During 2022-2023 there have been numerous examples of prescribed medication found to be incorrectly attributed to WCHC prescribers. These incidents were escalated and where the prescribing costs meet a certain threshold, the cost of the drugs are reimbursed. Due to the time lag in prescribing data, there is a delay in recovering funds. For example, the costs of Methylphenidate prescribed by The Stein Centre and identified as incorrectly attributed in December 2021, were reimbursed during 2022-2023.

20. Antibiotic prescribing was audited. During 2022-2023 the team undertook six mini audits of antibiotics associated with a high risk of Clostridioides difficile (C. diff) prescribed within the Urgent Care Services (covering both GP Out of Hours and the Walk-In Service). In each of the audits, 20 patient records were examined by extracting information from the electronic patient record. The percentage compliance with Pan Mersey and NICE guidelines is shown in the table below. For all patient records where a deviation from guidelines was noted, this was fed back to the individual prescriber via their clinical manager who advised on how their prescribing could be improved in line with guidelines.

Month	Medication	% Compliance with guidance
April 22	Cefalexin	70%
June 22	Cefalexin	80%
August 22	Quinolones	50%
October 22	Quinolones	89%
December 22	Co-Amoxiclav	90%
February 23	Cefalosporins	65%

21. Where compliance levels were low, the audits were repeated. It was noted for both cefalexin and quinolone prescribing, repeating the audits following staff feedback improved the percentage of compliance against Pan Mersey and NICE guidelines. The cefalosporin audit was repeated using June prescribing data, this showed an increase in adherence to guidelines to 85%.

22. A point prevalence audit was undertaken in March 2023 for all antibiotics prescribed during a 24-hour period within the Trust's Urgent Care Services. 45 patient records were scrutinised of which 93% were in line with local and national antimicrobial prescribing guidelines or had a clinically valid reason documented for deviation. In the three cases where there was no valid justification for deviation from guidelines, this was fed back to the prescribers via line management for learning.

Ensuring Medicines use is as safe as possible.

23. The handling of medicines was audited throughout the reporting period via monthly self-assessments which were documented via the SAFE system. The audits covered storage of medicines, handling of PGDs, prescribing, handling of medical gases with additional questions for CICC.

24. For further assurance, a base from each service was visited by a member of the Medicines Management Team to perform a Quality Assurance Visit. The data collected via the self-audits was triangulated against data collected by the Medicines Management Team. Findings from the Quality Assurance Visits found services to be mainly compliant with Trust standards, where deviations from best practice were identified, action logs were produced and follow up visits arranged to monitor completion of actions.

25. Additional audits undertaken 2022-2023 included an audit to investigate the use of Patient Group Directions within the Trust, audits of areas of the Trust where controlled drugs are kept and an audit of prescription form security. Each of the audits had associated action plans which were monitored via the Medicines Governance Group.

A Quality Improvement project was undertaken for the management of medicines within Community Intermediate Care Centre (CICC)

26. CICC is a reablement unit consisting of three wards. In a response to reported medication incidents, a CICC medicines management quality improvement was undertaken. In April 2022, EPMA (electronic prescribing and medicines administration) was introduced. The

system allowed for remote auditing of medicines entered onto the system and doses administered. This allowed for the quality improvement to have a clear auditable target which was a 50 % reduction in missed medication due to medication not being available to be achieved by the end of quarter four.

27. From October 2022, working in partnership with the CICC managers, the Medicines Management Team introduced weekly audits of EPMA utilising SystmOne. The number and details of missed doses due to medication not being available was fed back to ward managers to ensure that any problems could be identified, investigated and if possible, resolved.

28. The weekly audits also included checks on whether medication stock had been added onto EPMA and whether transcription of medication onto EPMA had been second checked in line with EPMA user guides. The audits were utilised to identify specific learning needs for individual staff, enabling a member of the Medicines Management Team or the Lead Nurse for Informatics to provide targeted support.

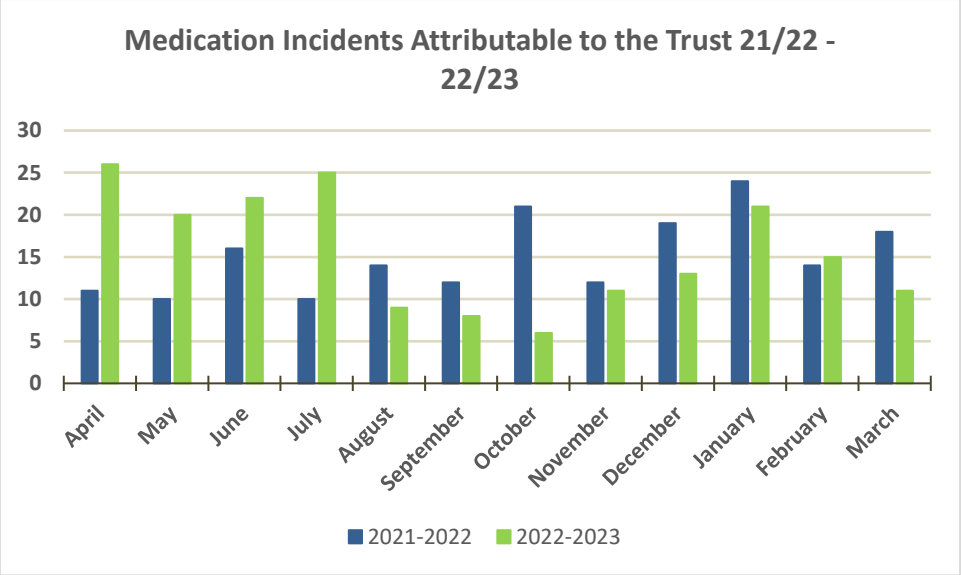
29. Working in partnership with the GP Practice, it was identified that prescription requests were not being prioritised from routine non-CICC patient requests. A mailbox rule was set up, so that all requests for medication were dropped into a separate subfolder collating them in one place allowing them to be actioned in a timely and efficient manner.

30. There was a reduction in missed doses due to medication not being available from Q2 to Q4 of almost 80%. The target of reducing missed medication due to medication not being available was achieved.

31. It is nationally recognised that missed medication doses is a significant area of concern within British hospitals and in-patient facilities, there is no data available to benchmark missed doses due to medication not being available against other similar in-patient facilities. During 2023-2024 the Medicines Management Team will reach out to other similar Trusts to seek comparative data.

Medication Incidents Attributed to the Trust were monitored at the Medicines Governance Meeting

32. The graph below outlines the number of medication incidents reported via the Trust's incident reporting system, which were attributed to the Trust 2022-2023, Incidents reported 2021-2022 are included for comparison.

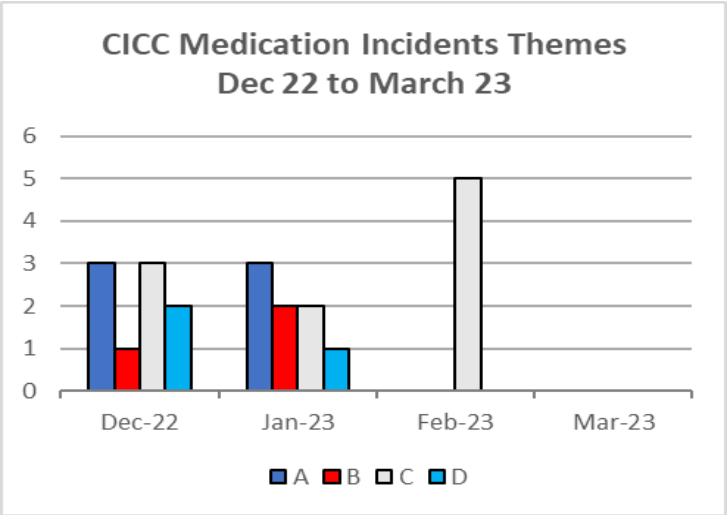


33. As soon as medicines related incidents are reported via Datix they are shared with the Medicines Management Team to investigate, look for potential patterns and potential strategies to reduce the risk of similar incidents occurring. Each month medication incidents attributed to the Trust are discussed at the Medicines Governance Meeting.

34. All of the reported incidents were low or no harm. The graph illustrates that the level of reporting of medication incident has been broadly in line with 2021 2022.

35. The greater number of medication incidents reported April to July coincided with the introduction of EPMA as staff members adapted to the new system. The subsequent improvement may have been due to staff members gaining experience and the impact of the Quality Improvement.

36. Themes from April 2022 to July 2022 and August 2022 to November 2022 are captured in the previous tri-annual reports. Themes noted during December 2022 to March 2023 are noted for CICC and separately for all other medication incidents within Trust services. Medication incidents that did not fall into identified themes are not included in the graph.



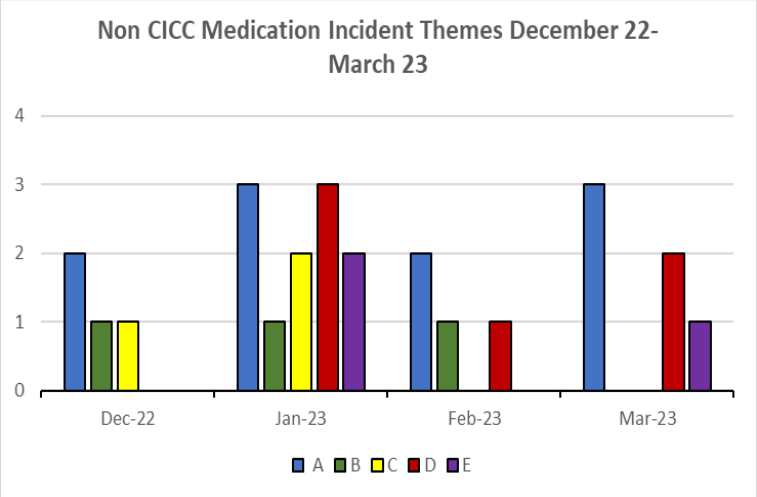
KEY	
A	CD documentation error
B	Missed Dose(s)
C	Transcribing Error
D	Medication not ordered in time.

37. It is of note that the number of missed doses reported on Datix was significantly less than those identified via EPMA audit. In part, this is due to the fact that the EPMA audits pick up every missed dose, so for example if a medication was given four times a day and missed, because it was out of stock, the EPMA audit would register 4 missed doses per day. If the same incident was raised on Datix, only one incident would be reported. However, there remains potential under reporting. The Medicines Management Team will work with the clinical lead for CICC and the ward managers to put strategies in place to increase incident reporting to ensure all clinically significant missed medication doses are reported via Datix.

38. Some of the identified themes from previous tri-annual reports had been resolved. During the reporting period April to July, there were some reports of missed venous thromboembolism prophylaxis. The missed doses were due to the DVT Service prescribing enoxaparin on electronic charts that needed to be printed off, this has now been resolved as DVT nurses now prescribe directly onto EPMA.

39. Reports of staff not entering stocks of medicines received into the ward has also resolved, as any patients who are admitted onto the wards who have not had their medication stock levels recorded onto EPMA are identified via the weekly EPMA audits which are shared with the ward managers to ensure required actions are completed.

40. Transcribing errors continue to be reported, however this has improved now EPMA is monitored weekly for second checks. A spike in February where five transcribing errors were reported by the ward pharmacist, highlights the need for continued vigilance. However, it should be noted that the risk to patients from transcription errors is mitigated by second checks and medicines reconciliation undertaken by the ward pharmacist.



KEY	
A	Incorrect drug stock count
B	Incorrect medication storage
C	Codeine stock count discrepancy
D	Incorrect dose administered
E	Incorrect medicines administered

41. For all services other than CICC, the Datix reports detailing incorrect drug stock counts all involve stock medicines within Sexual Health not being accounted for. In all of the incidents, the records were checked and usually found to be due to staff documentation

errors. Athough good record keeping is to be promoted, the Datix reports gave assurance that stocks of medication within Sexual Health were carefully monitored.

42. This was also the case for discrepancies in the stock counts of codeine tablets within Urgent and Primary Care. Where discrepancies in stock levels were identified, the discrepancy was investigated and in the majority of cases the missing stock was found and stock counts corrected.

43. In all medication incidents where the incorrect dose or incorrect medication was administered, the incidents were fully investigated for potential learning, with the patient and staff members involved appropriately supported. None of the errors resulted in moderate harm or above

Future Plans for 2023-2024

44. During 2023-2024 the Medicines Management Team will work with all stakeholders to support the expansion of Frailty Virtual Wards and Home First ensuring procedures are in place surrounding the handling of medicines.

45. The Medicines Management Team will continue to work with Wirral Place as a key stakeholder to support antimicrobial stewardship throughout Wirral.

46. Building on the improvements in the handling of medicines within CICC, a quality improvement plan for 2023-2024 will be produced and overseen by the Clinical Risk Management Group . The Medicines Management Team will continue to produce weekly audits within EPMS and work with the ward managers to identify areas of potential improvement.

47. There is currently a pilot to introduce Elastomeric Devices for intravenous antibiotics within community nursing. This is an ICB project with numerous stakeholders. The Medicines Management Team will work with OPAT and specialist pharmacist to ensure that Trust employed community nurses receive required training and are supported by evidence based procedures.

48. The Medicines Management Team will work with the Wirral Commisioning Support Medicines Management Team with a view to adopt prescribing support software within GP Out of Hours. It is anticipated that its introduction will improve the quality and cost effectiveness of prescribing within the service.

Summary

49. The financial year 2022-2023 has provided unique challenges. This report provides an overview of these, along with the associated activity required to ensure there is a robust, comprehensive governance framework relating to management of medications within the Trust.

Dr Nick Cross
Executive Medical Director

Lisa Knight
Lead Pharmacist

Appendix One

Medicines Management Documents Written or Updated

Medicines Management Policy

GP11 Policy for the safe handling and administration of medicines

Medicines Management Procedures

MMSOP03 Procedure for administration of intravenous antibiotics

MMSOP07 Procedure for as required medication via subcutaneous cannula.

MMSOP17 Procedure for disposal of patient's own controlled drugs

MMSOP19 Procedure for removal of IUD

MMSOP27 Procedure for fitting IUD

MMSOP30 Procedure for emergency use of oxygen in the community

MMSOP36 Procedure for toenail surgery

MMSOP56 Procedure for handling of medicines within CICC

MMSOP04- Procedure for McKinley Syringe Driver

MMSOP12- Procedure for Immunisation

MMSOP24- Procedure for Managing an Anaphylactic Emergency

MMSOP28- Procedure for Witnessing Destruction of Controlled Drugs

MMSOP34- Procedure for Management of Controlled Drugs within Urgent and Primary Care

MMSOP37- Safe and Secure Management of Midazolam within Community Dental

MMSOP46- Procedure for Conscious Sedation using Nitrous Oxide

MMSOP52- Administration of Nasal Flu Vaccine by Non-Registered Nurses

MMSOP56- Procedure for the Management of Medicines within CICC

MMCP07- for providing specialist palliative care advice.

MMSOP37- safe and secure management of midazolam within community dental

MMSOP51- Immunisation of school aged children (ratified via Divisional SAFE)

MMSOP58 procedure for administration of vaccines via PSD

Patient Group Directions Written or Updated

PGD for HPV vaccine for MSMs

PGD for HPV vaccine for schools

PGD for Pre-exposure prophylaxis for HIV

PGD for Imiquimod 5%

PGD for Proxymetacaine 0.5% eye drops.

PGD for Tropicaine 1% eye drops.

PGD for Aspirin- Urgent and Primary care and Heart Support

PGD for Codeine- Urgent and Primary Care

PGD for Salbutamol- Urgent and Primary Care

PGD for DTaPIPV- Health Visitors- East Cheshire

PDG for LAIV (nasal flu vaccine)- School Nursing

PGD for inactivated influenza vaccine- School Nursing

PGD for Td/IPV- School Nursing

PGD for Benzylpenicillin for pneumococcal septicaemia

PGD for Ulipristal for emergency contraception

PGD for Levonorgestrel for emergency contraception

PGD for Benzylpenicillin for pneumococcal septicaemia

PGD for sodium chloride 0.9% flushing vascular access devices.

PGD for Ulipristal for emergency contraception

PGD for Levonorgestrel for emergency contraception

PGD for doxycycline for Urgent and Primary care

PGD for Men B for Health Visitors

PGD for Azithromycin for Chlamydia

PGD for Doxycycline for Chlamydia

PGD for Combined oral contraception.

PGD for Combined hormonal contraception patches.

PGD for Progesterone only oral contraception

Homely remedy for glycerin suppositories for CICC

Other Trust Medicines Related Documents Ratified During the reporting period.

Your Opioid Patient Information Leaflet

Syringe Driver Patient Information Leaflet

7 Rights of Medicines Administration CICC

Immunisation training package for sexual health

Clinical Guidance Adopted August to November 2022

North-West Coast, Palliative Care Clinical Practice Summary 2021, “Guidance on consensus approaches to managing palliative care symptoms.

EPRR – Core Standards Annual Self-Assessment 2023

Meeting	Board of Directors		
Date	18/10/2023	**Agenda Item**	21
Lead Director	Mark Greatrex, Deputy Chief Executive & Chief Finance Officer		
Author(s)	Mick Blease LSMS/EPRR Lead		

Action required (please select the appropriate box)

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

Purpose

To provide assurance to Board that the Trust has completed the annual core standards assurance process.

Executive Summary

The Trust is required to complete an annual self-assessment against 58 core standards that are attributed to community providers. In addition to these standards there are 10 further standards associated with EPRR training as part a deep dive process.

This process has now been completed and provides an overall percentage compliance of 95% with an overall assessment of "Substantially Compliant

Risks and opportunities:

There are no risks associated with this report

Quality/inclusion considerations:

Quality & Equality Impact Assessment completed and attached No.

Financial/resource implications:

There are no additional financial or resource implications associated with 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	Place - Make most efficient use of resources to ensure value for money	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 note that the trust has completed the annual EPRR core standards self-assessment assurance process

Report history (Please include history of where the paper has been presented prior to reaching this meeting, including the title of the meeting, the date, and a summary of the outcome)

Submitted to	Date	Brief summary of outcome

Wirral Community Health and Care NHS Foundation Trust

EPRR – Core Standards

Annual Self Assessment - 2023

Purpose

To provide assurance to Board that the Trust has completed the annual core standards assurance process and to seek agreement with the rating of **"Substantial"** that has been assigned to the Trust following the annual core standard self-assessment.

Background

NHS England is responsible for gaining assurance that the NHS is prepared to respond to incidents and emergencies, while maintaining the ability to remain resilient and continue to deliver critical services. This is achieved through the EPRR annual assurance process.

The assurance process requires the Trust to undertake a self-assessment against the core standards.

Self-Assessment Process

As a community provider the Trust is asked to self-assess against 58 pre-determined standards. This represents an increase of three on the These standards are to be rated as follows: -

Compliance level	Definition
Fully Compliant	Fully compliant with the core standard
Partially Compliant	Not compliant with the core standard. The organisation's EPRR work programme demonstrates evidence of progress and an action plan is in place to achieve full compliance within the next 12 months.
Non-Compliant	Not compliant with the core standard. In line with the organisation's EPRR work programme, compliance will not be reached within the next 12 months.

That self -assessment process has now been completed by the EPRR lead who has assessed the Trust as follows: -

Domain	Total Applicable Standards	Fully Compliant	Partially Compliant	Not Compliant	Not Applicable
Governance	6	6	0	0	0
Duty to risk assess	2	2	0	0	0
Duty to maintain plans	11	10	1	0	0
Command and control	2	2	0	0	0
Training and exercising	4	4	0	0	0

Response	5	5	0	0	0
Warning and informing	4	3	1	0	0
Cooperation	4	4	0	0	0
Business continuity	10	9	1	0	0
CBRN	10	10	0	0	0
Total	**58**	**55**	**3**	**0**	**0**

This assessment provides an overall compliance percentage of 95% with an overall assessment of "Substantially Compliant".

There are three standards that have been assessed as partially compliant. These standards relate to Mass Casualty Plan's, our Media Strategy, and the Business Impact Assessment element of Business Continuity Plans.

Standard 15 relates to Mass Casualty Plans. The Trust supports the "Mersey Cheshire Area Mass Casualty Plan" with the provision of assistance to deal with P3 casualties. The details of that provision are included in the NWAS combined Mass Casualty Distribution Plan. This plan is not current and not tested recently.

Standard 36 relates to the media strategy. The Trust media strategy outlines actions during a Major Incident and is supported by the "Incident Communications Plan". The Strategic Level of the On Call system is the designated spokesperson during a major Incident. The assessment identified a gap in media training for the Strategical level of the on-call system.

Standard 46 relates to the Business Impact Analysis (BIA) element of business continuity plans. The Business Continuity Plan refers to BIA at Stage 1 of the Toolkit, (Section 13). Section 7 of the plan identifies the Business-Critical Functions of the Trust. Business Continuity Plans are reviewed annually. On assessment there is no evidence relating to the documented process for conducting a Business Impact Assessment.

A full action plan to address the standards not identified as being fully compliant is included at **Appendix A** below.

Deep Dive

The "Deep Dive" element of this years Core Standards Self-Assessment process addresses EPRR training.

There are 10 standards associated with Community Trust providers with in the Deep Dive section and the Trust is assessed as follows: -

Deep Dive	Total Applicable Standards	Fully Compliant	Partially Compliant	Non Compliant	Not Applicable
EPRR Training	10	9	1	0	0
Total	**10**	**9**	**1**	**0**	**0**

DD6 Relates to training data. The EPRR lead keeps records of those individuals they have delivered training to. Furter work needs to be completed with the Learning and

Organisational development Team to embed EPRR training into the training records across the organisation. Loggist, On Call Induction, Hazmat Training records included.

The self-assessment will be subject of a further assessment by the regional NHS England EPRR team. This assessment was planned to be carried out 2nd – 5th October 2023. At the time of preparing this report no additional feedback has been received from NHS England.

Recommendation

1. Board are assured that the trust has completed the annual EPRR core standards self-assessment assurance process.
2. Board agree with the rating of Substantial being assigned to the Trust following the completion of that process.

Name: **Mick Blease**

Job Title: **LSMS/EPRR Lead**

Date: **11th October 2023**

Wirral Community Health and Care NHS Foundation Trust

Appendix A
Action Plan Template
KEY (Change status)

1 Recommendation agreed but not yet actioned
2 Action in progress
3 Recommendation fully implemented

Action plan lead	EPRR Core Standards 2023 – Mick Blease

	Actions required	Completion date	Person responsible	Change stage	Description of current position	Evidence of Completion
1.	**Standard 15** – Mass Casualty Plan Liaise with NWAS to ascertain what plans are in place to Review and Test.	01.02.2024	EPRR Lead	1	Current NWAS regional Plan is out of date and no evidence of testing. The sad event of the 29th September 2023 when a coach overturned on the M53 may provide evidence of testing plans as this has been described as a mass casualty event.	
2.	**Standard 36** – Media Strategy. Review Media Training Provision for On Call Manage and arrange Initial and Refresher Media training.	01.03.2024	EPRR Lead/Fiona Fleming	1	A number of the Strategic level On Call have been trained in media strategy that would benefit of refresher training. There are also new members to this cohort that have not received any training.	

3.	**Standard 46** – Business Impact Analysis Review Business Continuity arrangements to include Business Impact Assessment into that process.	01.12.2023	EPRR Lead	1	BC Plan is due to be reviewed	
4.	**DD06** - Training Data. EPRR and L&OD Team to identify mechanism that captures EPRR Training across the organisation	01.01.2024	EPRR Lead/L&OD Lead	1		