WIRRAL PLACE BASED PARTNERSHIP BOARD
27 JULY 2023

REPORT TITLE:	**KEY ISSUES RELATING TO QUALITY AND SAFETY: (REPORT FROM THE QUALITY AND SAFETY GROUP)**
REPORT OF:	**LORNA QUIGLEY ASSOCIATE DIRECTOR OF QUALITY AND SAFETY ON BEHALF OF WIRRAL PARTNERS**

REPORT SUMMARY

The aim of this report is to identify key issues identified relating to Quality and Safety through the Wirral Quality and Performance Group and other relevant sources. The report includes: Issues of concern Alert, issues of a general update, which will include those where updates have been requested Advise and issues for assurance Assure. In addition to identifying key issues, the report highlights where appropriate the actions that have taken place and the timescale of completion.

RECOMMENDATION/S

The Wirral Place Based Partnership Board is recommended to note the areas of concern contained within the report, and the actions that are being taken.

SUPPORTING INFORMATION

1.0 REASON/S FOR RECOMMENDATION/S

1.1 This report will continue to evolve as the process develops. This includes the addition of Key Performance Indicators relevant to the system and quality issues relating to all providers.

2.0 OTHER OPTIONS CONSIDERED

2.1 No others at this stage.

3.0 BACKGROUND INFORMATION

3.1 **Items for Alert**

3.2 **Mental Health**

3.3 Cheshire and Wirral Partnership (CWP) had an unannounced CQC inspection commencing on 4th July 2023. This has included the acute Psychiatry in patient beds across the 3 sites and Psychiatric Intensive Care (PICU).

3.4 There are several patients with mental health needs who are receiving care out of area- particularly Psychiatric Intensive care. This leads to a poor patient experience and outcomes for patients. NHS Cheshire and Merseyside are working with Cheshire Wirral Partnership to reduce the number of patients receiving care out of area by facilitating prompt discharges from local inpatient facilities using the Multi-Agency Discharge Event methodology (MADE).

3.5 **SEND** (progress against the Written Statement of Action (WSoA))

3.6 Monitoring meetings with the Department for Education (DfE) and NHS England (NHSE) continue, progress against the SEND WSoA continues, however several actions are behind planned trajectory.

3.7 A Rapid Improvement Plan is in place and progress has been made, and support sought by system leaders. There is an expectation from regulators (Dfe and NHSE) that by October 2023 there will be:

- evidence that delivery is making a difference (e.g., through the KPIs or lived experience)
- that the delivery plan is back on track against the agreed timescales
- that the data dashboard is showing an improvement and
- examples of how the analysis is leading to an issue being raised strategically, direction being given, action completed and then reporting over time showing a change to the initial issue.

3.8 Items to Advise

3.9 **C-Difficile Review**

3.10 A 3-day system review was undertaken by NHS England between 18th -20th April of the causes of C difficile infections within Wirral.

3.11 Clostridium difficile (C-Difficile) is a bacterium found in the intestine. It can be present in healthy people and cause no symptoms, however C-Difficile can cause imbalance in the bacteria within the gut and this can occur when people are taking antibiotics. Clostridium Difficile infection (CDI) is highly infectious and will spread through contact with a contaminated environment or person, it also causes severe harm to vulnerable people within the Borough.

3.12 Wirral PLACE rate of C-Difficile infection cases has been significantly higher than the national average since 2014. Rates increased dramatically in 2019 however the start of the pandemic in 2020 saw a huge reduction. However, since January 2021the rates have been increasing and has reached a similar level as it was in 2011. At year end (2022/2023), the Wirral system has reported the highest case rate per 100,000 population across Cheshire and Merseyside.

3.13 The review focused on the Wirral system and followed the patient pathway from primary care, community (including dental services), acute and specialist providers and include the transfer of care between health and social care aspects of the system.

3.14 Terms of reference (ToR) were agreed between region and PLACE leads and fell under the key headings. These were used to guide conversations.

- •Leadership and Culture
- •Governance and Assurance
- •Incident reviews and learning
- •Transfer of care
- •Education and training
- •Antimicrobial Stewardship
- •Sampling and processing
- •Clinical procedures and processes

3.15 Stakeholders including GP's, Public Health, Health Protection, Pharmacists, Laboratory Staff and Dentists were invited to contribute and participate as part of focus groups or as part of visits to health providers.

3.16 During the 3 days the escalating picture for CDI and the wider infection agenda within the Wirral system was explored. Recognition that to improve the situation an understanding where and how the break in the chain of infection can be achieved is required.

3.17 An acknowledgement that the entire patient pathway needs to be considered from a primary care level where interventions to improve diagnosis and management of a

primary infection may support a reduction in cases. Additionally, a recognition of the impact of health inequalities was having and the difficulties in getting full patient public engagement in a post pandemic landscape.

3.18 Comprehensive improvement plans designed by the acute trust the challenges faced by them strongly relate to their issues with capacity and flow. These are such, that ensuring patients are isolated promptly, that the areas have full deep cleans to reduce bioburden afterwards are often compromised.

3.19 However as a system there is clear evidence of strong relationships and collaboration between provider services, primary care, health protection teams, public health and there is strong Infection Prevention and Control leadership in most areas. The governance and assurance processes, although very complex, are in place although there is an over reliance on key individuals and in certain elements there is a lack of clarity.

3.20 Throughout the review, there were recommendations for individual organisations which will be addressed through organisational improvement plans were appropriate. In addition to this system themes were identified including:

- Governance structures, whilst in place were complicated and messages identified in reports at risk of being diluted through being escalated through multiple layers.
- Sampling and the management of samples impacted on all parts of the system and therefore patient outcomes whether in primary or acute care there were difficulties in ensuring a quality sample was taken and received by the lab in a prompt timespan. Patient and staff education needed to ensure samples taken and managed correctly.
- The populations health within the system appears to have become more challenged since the pandemic as delays in accessing healthcare has increased many already vulnerable groups risk factors and behaviours. It was reported that there were suspicious/ conspiracy theories about wider aspects of health than vaccination since the pandemic in certain groups.
- Transfer of care between organisations is often complicated by multiple care record platforms being used within the locality, with no interface between them to ensure safe transfer of information. In all parts of the system reports that delays in information transfer such as sample results has impacted on individual patient management.
- Training and education at all levels of the service has been challenged over the past 3 years with a heavy reliance on electronic learning platforms. Whilst effective at imparting information.
- The incidence and admission for urine infections is being collected and collaborative work between WUTH and public health has been happening, however due to a reduction in the continence team previous proactive work in the community is no longer possible and may be impacting on prescribing and admissions.
- Learning from incidents –throughout the system the infection incidents are being reviewed by their respective teams and the local learning is identified within those areas however this locality would benefit from learning becoming systemwide, not for the purposes of assigning blame, but to delve deeper to understand demographics and identify other risk factors.

3.21 Following the review, a number of recommendations have been made for the system and work is underway to develop a system improvement plan to tackle the themes identified. These recommendations will be managed though the Health Protection Board chaired by the Director of Public Health.

3.22 **Items to Assure**

3.23 **Quality and Performance Group**

3.24 The Quality and Performance Group met on 15 June 2023. The agenda included:

- The outcome of the C-Difficile review (contained within this report)
- Feedback from the NHS Cheshire and Merseyside Quality and Performance Committee.
- Out of Area Mental Health patients (contained within this report)
- Special Educational needs and Disabilities (SEND)- it was agreed that as this is a system priority, this would remain a standing agenda item for the group.

4.0 FINANCIAL IMPLICATIONS

4.1 None identified.

5.0 LEGAL IMPLICATIONS

5.1 Legal implications have been considered within this report relating to safeguarding and All Age Continuing care which are included within the report.

6.0 RESOURCE IMPLICATIONS: STAFFING, ICT AND ASSETS

6.1 None identified.

7.0 RELEVANT RISKS

7.1 Risks relating to All Age Continuing Care contained within NHS Cheshire and Merseyside risk register. System risks identified are included within the Wirral Place's risk register (C-Difficile, Safeguarding). Risks relating to organisations are within contained within organisations risk registers.

8.0 ENGAGEMENT/CONSULTATION

8.1 Partnership working in the development of the paper. Specific programmes contained within are subject to engagement and co-production.

9.0 EQUALITY IMPLICATIONS

9.1 Wirral Council has a legal requirement to make sure its policies, and the way it carries out its work, do not discriminate against anyone. An Equality Impact Assessment is a tool to help council services identify steps they can take to ensure equality for anyone who might be affected by a particular policy, decision or activity. Any service changes will be subject to an Equality Impact Assessment,

10.0 ENVIRONMENT AND CLIMATE IMPLICATIONS

10.1 There are no environmental or climate implications identified that would result from the proposal.

11.0 COMMUNITY WEALTH IMPLICATIONS

11.1 there are no community wealth implications identified within this paper.

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SUBJECT HISTORY (last 3 years)

Council Meeting	Date