Mersey Care NHS
NHS Foundation Trust

Quality Account 2015/16

Contents

1. PART ONE - Statement of Directors' Responsibilities

1.1 Introduction and Statement on Quality by Chief Executive and Chairman

We are delighted to present on behalf of the Trust Board, the Mersey Care NHS Foundation Trust Quality Account for 2015/16. This provides details of how we have improved the quality of care we provide, particularly in the priority areas we set out in our previous Quality Account (2014/15). The purpose of our Quality Account is to:

- enhance our accountability to our service users, carers, the public and other stakeholders of our quality improvement agenda
- enable us to demonstrate what improvement we have made and what we plan to make
- provide information about the quality of our services
- show how we involve and respond to feedback from our service users, carers and others
- ensure we review our services, decide and demonstrate where we are doing well but also where improvement is required.

We continue to make quality the defining principle of the Trust and demonstrate quality improvements in the care and services we provide. To assist us in determining our priorities for quality improvement for 2016/17 a range of engagement events were held with service users, carers and key stakeholders.

These events have strengthened our approach to providing a high quality experience of care which is both safe and effective. We will remain open and transparent about what we can, and will do, to improve quality and by involving other stakeholders we will find ways to work differently and more productively.

Mersey Care is striving to provide perfect care for the people we serve. At its core, this means we are an organisation that does not accept compromises in the quality of care or minimum targets set by others, but supports learning and improvement in our services so that we strive to get the basics of care right every time, for every service user. This is a bold ambition in difficult times, but with engaged and motivated staff and supportive commissioner and partner organisations, we firmly believe it is possible.

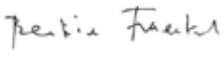
We hope that you find our Quality Account helpful and informative. The information supporting the content of the Quality Accounts is to our knowledge accurate and will be published by the Board on or before 30 June 2016.

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

- the Quality Account presents a balanced picture of the Trust's performance over the period covered
- the performance information reported in the Quality Account is reliable and accurate
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Account, and these controls are subject to review to confirm that they are working effectively in practice
- the data underpinning the measures of performance reported in the Quality Account is robust and reliable, conforms to specified data quality standards and prescribed definitions, and is subject to appropriate scrutiny and review
- the Quality Account has been prepared in accordance with Department of Health guidance.

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

By order of the Board

3rd June 2016		Chairman
2nd June 2016		Chief Executive
6th June 2016		Executive Director of Finance (Deputy Chief Exec)
3rd June 2016		Medical Director
2nd June 2016		Executive Director of Corporate Governance and Communicaitons
3rd June 2016		Executive Director of Nursing
2nd June 2016		Executive Director of Workforce

1.2 Statement by Director of Nursing – Executive Lead for Quality

The Trust Board has a statutory duty of quality and is responsible for the quality of care delivered across all services that Mersey Care NHS Foundation Trust provides. The Trust recognises that people come into Mersey Care at times of great distress, anxiety and confusion and for some this involves a restriction of their liberty. Mersey Care aspires to help each person live the fullest life possible, embracing a recovery-focused approach. The Trust works with individuals to understand their experiences, explore the meaning of their difficulties, and help find ways to change or cope better. Positive, collaborative and respectful working relationships are fundamental to these activities.

Mersey Care approved a Quality Strategy for 2011 to 2016 and has consistently improved quality in key areas.

In March 2015 the Trust Board approved the Trust's Framework for the Governance of Quality. Through the Framework the Trust will, on a weekly basis, evaluate our progress in delivering of the Quality Account priorities.

I have ensured that careful consideration has been taken of the feedback sought during the past year. The delivery of the Quality Account will be monitored by the Quality Assurance Committee, a committee of the Trust Board which will oversee the quality improvements in the priority areas. Details are included in this Quality Account. This has enabled the Trust to develop a better understanding of the needs of those who use our services and to provide a high quality service and will drive change, innovation and best practice, leading to the best possible outcomes for those we work with and care for.

I look forward to working with service users, carers, staff and other stakeholders in delivering improvements in quality over the next year.

Ray Walker
Director of Nursing

1.3 Our Vision, Values, Strategy and Services

1.3.1 Our strategic challenge

Mersey Care NHS Foundation Trust provides specialist adult mental health, learning disability and addiction services for the people of Liverpool, Sefton and Kirkby. We provide low and medium secure services for Merseyside and Cheshire and are one of only three trusts nationally to provide high secure services.

We provide services to three overlapping health and social care economies:

- Liverpool, Sefton and Knowsley (predominantly Kirkby) for local services
- Cheshire and Merseyside for low and medium secure services
- The North West of England, Wales and West Midlands for high secure services.

People often come into contact with our services at times of great distress, anxiety and confusion and it is at this time that they are at their most vulnerable. We aspire to help each person live the fullest life possible, embracing a recovery based approach with equality and human rights being intrinsic to the care we provide.

Our staff are passionate about mental health and wellbeing and about delivering the best possible services for the people we serve. We have national experts working in our organisation making real breakthroughs in mental health care, addictions and learning disabilities care, such as our nationally recognised work on human rights for people who have a learning disability and our work on reducing restraint in our services. Together we aim to provide the best possible care for the people and the diverse communities we serve.

However, achieving this in our current and future environment is not going to be easy. We are faced with more people with mental health needs yet with significantly less money in mental health and the wider NHS system to meet their needs.

Even in a tough financial climate we believe we should be striving to provide perfect care to those we serve because that is what we are passionate about and we know there are opportunities to sustainably improve our services and save money at the same time. This will be driven by our new clinical divisions, and supported by our corporate services and centre for perfect care and wellbeing in our shared commitment to 'get it right first time, every time' for patients. We also recognise that collaboration with neighbouring providers will enhance our offer of perfect care within an integrated pathway.

1.3.2 Our vision

Our vision is to strive for perfect care for the people we serve.

At its core this means we are an organisation that does not accept compromises in the quality of care or minimum targets set by others, but supports continuous learning and improvement by our frontline staff. Striving for perfect care also means delivering the highest quality care within the resources available to us. Although we are experts in providing more care for less money and have saved over £43.4 million over the last five years through careful financial management, we face a financial challenge over the next five years that will require an enormous effort from colleagues in our already busy services. We are required to save 21 percent of our current income over the next six years in order to manage within the resources available to us.

1.3.3 Our aims and objectives

Our vision is underpinned by four aims and 14 objectives. These aims and objectives are set out in our strategy wheel below, and describe our strategic direction and how we wish to be viewed both within and outside the Trust.

Our plan for the coming year is based around four aims and underpinning objectives that set out what we will achieve:

Our services - we will improve the quality of our services, and strive to provide safe, timely, effective, equitable and person-centred care every time, for every service user. This means getting the basics of care right consistently, repeatedly and predictably.

Our people - we will have a productive and high performing workforce that work in great teams, and we will work side by side with service users and carers.

Our resources - we will make full use of our resources, continuously finding ways to save time and money, ensuring our buildings work for us, and using technology to help improve our care

Our future - we will create opportunities for improvement and grow in the future, by working more closely with primary care and other organisations, delivering the benefits of research, development and innovation, and by growing our services.

These aims and objectives are captured in our strategy wheel. Each of our objectives is underpinned by costed programmes of work that have clear milestones and clear measures of delivery.

2. PART TWO

2.1 Priorities for Improvement 2016/17

In preparation for our Quality Account the Trust has undertaken a process of involvement and engagement with key stakeholders to establish their views on what our key priorities for 2016/17 should be. Representatives from the following groups have been engaged and invited to provide feedback on our priorities and the draft Quality Account:

- Healthwatch for Liverpool, Sefton and Knowsley
- Local Overview and Scrutiny Committees
- NHS England (Cheshire and Merseyside)
- Liverpool Clinical Commissioning Group
- South Sefton Clinical Commissioning Group
- Southport and Formby Clinical Commissioning Group
- Knowsley Clinical Commissioning Group
- Mersey Care's Service User and Carer Assembly
- Local service user groups.

In addition to the above, the perfect care steering group has considered suggestions for 2016/17 quality improvement priorities. These are consistent with the six key elements in the Trust Model of Quality:

- Patient safety
- Effectiveness
- Positive patient experience
- Timely care
- Efficient care
- Equitable care.

Many ideas and thoughts were shared, not just by staff and the Mersey Care Perfect Care Steering Group but by service users, Healthwatch and other stakeholders and these have all been given due consideration.

After consultation and discussion with the Trust Board the areas of quality improvement for 2016/17 will be:

Priority 1: No Force First

1) By July 2016, individualised performance outcomes and targets will be developed for each inpatient area.
2) By July 2016, a guide of strategies for implementing No Force First will be developed and roll-out commenced.
3) By July 2016, a research project will commence to evaluate the impact of on ward safety, staff and service user satisfaction and workforce metrics.
4) By September 2016 a policy on reducing restrictive practice will be developed.
5) By March 2017 there will be a further 20% reduction in restraint from the baseline, across all wards.

Priority 2: Towards Zero Suicide

1) By March 2017, safety planning intervention to be embedded at the following high risk points in local services:

   a. Safe inpatient discharge plan pathway

   b. Stepped Up care pathway.
2) By March 2017, all staff in primary service user contact roles will have undertaken level 2 team based clinical risk management and intervention training.
3) By December 2016, the Safe from Suicide team will monitor and measure suicide and near-fatal self-harm data and respond with enhanced support and interventions, including training, supervision, psychologically informed risk formulations and safety planning.
4) By December 2016, four pilot wards will have implemented a design based solution to reduce self-harm. This will be rolled out across all inpatient wards by March 2017.
5) By December 2016, a 'zero suicide app' will be developed for implementation across the Trust (in conjunction with Stanford University).

Priority 3: Improvements in Physical Health Pathways

1) By October 2016, the community physical health pathway will be reviewed and implementation of revised standard will commence in January 2017.
2) By March 2017, 100% of community service users on Care Programme Approach will have a completed physical health pathway.
3) By December 2016, 100% of inpatients will have metabolic screening completed in line with the National Audit of Schizophrenia standards.
4) By March 2017, 100% of all inpatients identified at risk, following cardio metabolic screening, will have a record of interventions offered.
5) By March 2017, all inpatients screened as smokers will have been prescribed nicotine replacement therapy on admission.

Design Thinking in the Built Environment

The quality of our built environment is a pivotal theme that underpins all our quality priorities for the coming year. There is a very strong evidence base and powerful service user and carer testimony for the importance of the built environment to mental health treatment and the wellbeing of those we serve. Mersey Care is planning to invest significantly in improving its estate over the next five years and it is important that we take this opportunity to ensure that our new buildings maximise potential quality value for service users and for those who work in our services. Therefore, all staff involved in the building design process will be trained in design thinking methodology, and all new Trust buildings will be designed using design thinking methodology and co-produced with service users and staff.

Monitoring and reporting arrangements

The delivery of the Quality Account will be monitored by the Centre for Perfect Care Committee and reported to the Quality Assurance Committee, which is a committee of the Trust Board.

A nominated lead will be identified for each priority.

The above priorities are all aligned to the Trust's Strategic Framework and ensure quality remains at the forefront of our agenda.

Perfect Care

Perfect care is all about our people. It was our people who managed the transition from big mental health hospitals in the 1980s to the community-based care that we provide today. It is our people who strive on a day by day basis to provide the best possible care for patients and it is our people who will improve our services based on their knowledge, and who will innovate to create models of care in mental health and wellbeing for the future.

Imagine what we could achieve if we were all pulling in the same direction because we all care about providing the best possible care for the people we serve?

We know that delivering the best possible care is what our staff really care about. Through our new Centre for Perfect Care and Wellbeing we are going to support their commitment to patient care so that they can improve the services we provide today, but also innovate in the services of tomorrow.

Perfect care means:

- setting our own stretching goals for improvements in care rather than aiming to meet minimum standards set by other organisations
- getting the basics of care right every time
- making improvements to the care we provide because we know it's the right thing to do for patients and because we care about the care that we provide
- helping people to try improvements, learn from their mistakes, and apply what works more rapidly
- helping our staff to innovate in ways that create better quality and outcomes for the people we serve whilst reducing cost.

We know from listening to our staff that they feel we already have many targets and this can feel like pressure to comply with minimum standards that aren't relevant to the care provided. We also know our staff are really committed to improving the care we provide but sometimes don't have enough time or support to make the improvements they know could make a big difference for those we serve.

There is a big difference between targets that feel like minimum standards and that are pushed on us, and goals that we agree and are motivated to achieve. Sometimes having goals really helps motivate people to achieve more than we think is possible.

Perfect care will set goals to focus our 'pull' for improvement on goals that our staff care about. Working towards these goals will mean working together to try new ways to improve care, learning from our mistakes, and preventing the same mistakes happening over and over again.

Commissioning for Quality and Innovation (CQUIN)

Linked to the Trust's areas of quality improvement for 2016/17 are the local and national CQUINs (the Commissioning for Quality and Innovation payment framework) for local and secure services.

There are two separate commissioner contracts covering local services and both have individual CQUIN schemes although the schemes are similar in content with some variation according to local need.

This information provides an overview in the 2016/17 Commissioning for Quality and Innovation (CQUIN) schemes. The report includes the CQUIN proposals from local commissioners and the national CQUINS, set out by NHS England.

CQUIN is a quality improvement incentive scheme which is mandated via the NHS standard contract CQUIN schemes will again amount to 2.5% of contract income in 2016/17. Each CQUIN scheme contains a number of different indicators intended to deliver demonstrable quality improvements.

NHS England determines the CQUIN schemes nationally for all providers of high, medium and low secure services.

For local services, NHS England will mandate a number of national CQUIN indicators for mental health providers and the Trust is required to negotiate and agree additional CQUIN indicators with commissioners, tailored to local need. The Trust will have two contracts with Liverpool Clinical Commissioning Group and another with South Sefton Clinical Commissioning Group and associates.

National CQUIN Requirements 2016/17

National CQUINs are published by NHS England, for 2016/17 there are only two that apply to the Trust.

CQUIN Indicator	Applicable Services	CQUIN Summary
NHS staff health and wellbeing	Mental health	Improving the health and wellbeing of NHS staff
Physical heath	Mental health	Improving physical healthcare of patients with mental health conditions

Secure Services Division CQUIN Requirements 2016/17

Draft CQUINs for secure services were published by NHS England and are summarised below:

CQUIN Indicator	Applicable Services	CQUIN Summary
Implementing sense of community in high secure wards	High secure	Developing a sense of community (SoC) across high secure wards to improve inpatient wellbeing through the development of being part of a positive community
Recovery Colleges for medium and low secure patients	Medium and low secure	Embedding a recovery-based approach to achieve a positive patient experience and reported outcomes, to improve clinical outcomes, reduce lengths of stay and fewer readmissions
Reducing restrictive practices within adult secure services	High, medium and low secure	The development, implementation and evaluation of a framework for the reduction of restrictive practices within adult secure services, in order to improve service user experience while maintaining safe services

Local Services Division CQUIN Requirements 2016/17

The Trust has separate contracts with Liverpool CCG and South Sefton CCG and associates for mental health and learning disability services. The following table summarises the proposed CQUIN indicators for each of the local services contracts:

CQUIN Indicator	Applicable Services	CQUIN Summary
Primary care liaison service (previously known as Collaborative Working)*	Liverpool CCG, South Sefton CCG and associates	Further development of primary care mental health liaison worker roles and engagement and support for GP practices
Digital maturity*	Liverpool CCG	Development of a health economy-wide digital maturity assessment tool, information sharing framework and implementation of shared records, guidance and principles
Transition from CAMHS to adult mental health and learning disabilities	South Sefton CCG and associates	Continuation of work from previous years to improve mental health pathways for young people
Addictions	Liverpool addictions services only	It is suggested that the Trust retains the performance and outcome measures indicator for 2016/17 and other additional elements added in 2015/16 are removed
Physical health training	Liverpool CCG only	Focus on staff training around physical health to improve the physical health of mental health service users in our care
IAPT – access to psychological therapies for older adults	Liverpool IAPT only	Increase the percentage of older people who experience depression and/or specific anxiety condition and enter psychological treatment

CQUIN indicators denoted with (*) have the same title but the detail is different for each contract.

2.2 Statements of Assurance from the Board

2.2.1 Review of Services

During 2015/16 Mersey Care NHS Foundation Trust provided 42 NHS services to NHS commissioners, including public health (local authorities).

During 2015/16, the Trust contracted with:

1) NHS Liverpool CCG (with Liverpool City Council) and NHS Sefton CCG (and associates), for local mental health, learning disability and addiction services across the Liverpool, Sefton, Knowsley, Halton, St Helens and West Lancashire areas.

2) Liverpool, Sefton, Knowsley, Halton, St Helens, Wirral and Lancashire Local Authorities for addiction services.

3) NHS England (through its regional and various sub-regional teams) for:

i. low, medium and high secure services and colleagues from NHS Wales in respect of high secure services

ii. mental health and addictions services in HMP Liverpool and HMP Kennet

iii. personality disorder services at HMP Garth.

4) Aintree University Hospitals NHS Foundation Trust for the Liverpool Community Alcohol Service and psychological support for Weight Management and Bariatric Services.

5) Walton Centre NHS Foundation Trust for Neuropsychology and Neuropsychiatry services.

6) Manchester Mental Health and Social Care Trust for psychiatry services to HMP Manchester.

7) National Probation Service for community personality disorder services, Resettle and Psychologically Informed Planned Environment (PIPE) services.

The Trust also provides staff support services to a number of local NHS and non-NHS organisations, and hosts Informatics Merseyside.

Mersey Care has reviewed all of the data available on the quality of care in all of these services.

The income generated by the NHS services reviewed in 2015/16 represents 100% of the total income generated from the provision of NHS services by Mersey Care NHS Foundation Trust for 2014/15.

2.2.2 NHS Staff Survey Results 2015

Indicators KF19 (percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months).

- Key Finding 19 on the 2015 Staff Survey is "Organisational and management interest in, and action on, health and wellbeing" - our score was 3.68 (out of 5) which benchmarks us as average against other mental health trusts
- Key Finding 23 is "Percentage of staff experiencing physical violence from staff in last 12 months" - our score was 3% which is 1% lower than last year and benchmarks us as average against other mental health trusts
- **Indicator KF27 (percentage believing that the Trust provides equal opportunities for career progression or promotion) for the Workforce Race Equality Standard.1**
- Key Finding 27 on the 2015 staff survey is "Percentage of staff/colleagues reporting most recent experience of harassment, bullying or abuse - we scored 57% which benchmarks us as average against other mental health trusts
- Key finding 21 is "Percentage believing that the Trust provides equal opportunities for career progression or promotion" - our score is 81% which benchmarks us as lower than average against other mental health trusts.

2.2.3 Participation in National and Local Clinical Audits and National Confidential Enquiries

National Clinical Audit Reports 2015/16

During 2015/2016, five national clinical audits and one national confidential enquiry covered the services that Mersey Care NHS Foundation Trust provides.

During that period, Mersey Care participated in 100% of national clinical audits and 100% of national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that the Trust was eligible to participate in during 2015/16 are as follows:

- National Confidential Enquiry into Suicide and Homicide by people with Mental Illness
- National Physical Health CQUIN of Cardio Metabolic Assessment for patients with Schizophrenia
- National Early Intervention in Psychosis Audit
- National POMH: Antipsychotic Prescribing in People with Learning Disabilities
- National POMH: Prescribing Valproate for Bipolar Disorder
- National POMH: Prescribing for Substance Misuse: Alcohol Detoxification.

The national clinical audits and national confidential enquiries that Mersey Care participated in during 2015/16 are as follows:

- National Confidential Enquiry into Suicide and Homicide by people with Mental Illness
- National Physical Health CQUIN of Cardio Metabolic Assessment for patients with Schizophrenia –
    - Local Division 100 out of a possible 100 was uploaded for this audit
    - Early Intervention Team Physical Health Audit - Liverpool Early Intervention Team; sample of 29 and Sefton and Kirkby Early Intervention Team; sample of 14 (awaiting final report)
- National Early Intervention in Psychosis Audit – Liverpool Early Intervention Team and Sefton and Kirkby Early Intervention Team 100 out of a possible 100 was uploaded for this audit (awaiting final report)
- National POMH: Antipsychotic Prescribing in People with Learning Disabilities – 38 out of a possible 38 was uploaded in June 2015; the final report was received in July 2015
- National POMH: Prescribing Valproate for Bipolar Disorder – 35 out of a possible 35 was uploaded for this audit in September/October 2015, the final report was received in March 2016
- National POMH: Prescribing for Substance Misuse: Alcohol Detoxification – 39 out of a possible 39 was uploaded in January/February 2016 (awaiting final report).

The clinical audit and effectiveness team carried out several pilot audits throughout 2015 for the National Physical Health CQUIN of Cardio Metabolic Assessment for patients with Schizophrenia. This enabled any areas of concern to be highlighted and acted upon in a timely manner before the specified upload took place.

Analyses of both the National Physical Health CQUIN of Cardio Metabolic Assessment for patients with Schizophrenia and the National Early Intervention in Psychosis Audit was carried out immediately after upload by the clinical audit and effectiveness team to enable the Trust to prevent delay in implementing any changes required whilst awaiting the final reports.

Participation in Trustwide Clinical Audits

The reports of 16 clinical audits were reviewed by the Trust in 2015/16 and it intends to take action to improve the quality of healthcare provided (see appendix 1 for list of clinical audit topics and brief synopsis).

All of the Trust's clinical audits are presented to and reviewed by the Quality Assurance Committee and Audit Committee and provide the assurance that quality issues are being addressed at Board level. The Trust encourages all services to be quality focused and as such encourages all clinical areas and disciplines to participate in the review of services through clinical audit. Audit findings have been shared at divisional governance forums.

2.2.4 Research and Development

The Trust has continued to give priority to supporting NIHR (National Institute for Health Research) adopted studies along with a large variety of student and staff studies. The Trust has 78 open studies, of which 29 are adopted NIHR studies and the remaining 49 are student studies and Trust specific studies. Performance metrics for NIHR adopted studies are based on approval times and delivery of participants to time and target and the Trust has consistently achieved these over the past year.

The number of service users recruited during this period to participate in research, approved by a research ethics committee was 401. In addition, 294 staff and 70 carers participated in research studies along with 29 participants from case file/other research projects – a total of 794 this year. Of these, 319 recruits were from NIHR adopted portfolio studies and 475 from non-adopted studies. In addition, approximately 50 staff participated in a study looking at staff perceptions of safety while at work, and whether the physical environment had any effect on inpatient aggression entitled (Physical Environment, Staff Perceptions of Safety and Aggressive Incidents within UK Mental Health Services (PESSA-UK), through completing online questionnaires.

Although 78 studies were open during this period, the research and development team invested resources in further studies which were withdrawn, not approved or did not progress to full application: eg. study review, expressions of interest not relevant, studies deemed audit/innovation/evaluation.

The range of studies being supported is changing with a welcome increase in the number of research projects looking at learning disability, genetic and dementia related topics.

Recruitment, consent and retention into mental health and dementia studies continues to be complex and often time-consuming due to the nature of our service users' ill health. Despite these difficulties, the highest recruitment to an NIHR adopted study was conducted across our four memory assessment services where overall, 100 service users participated in a project funded by the Department of Health to help understand how people benefit from memory assessment services.

The Trust was the first site nationally to approve and recruit the very first participant to a study entitled "SHAPE" (Supporting adults with High functioning Autism and Asperger's Syndrome): mapping and evaluating specialist autism team service models. This is particularly significant as it was the first adopted learning disability study supported in the Trust and was achieved through excellent collaboration between the research and development team, the clinical service and the researchers.

The Trust was also recently the first to recruit a participant to a specific arm of genetic study entitled MOLGEN (Clozapine induced Myocarditis). Myocarditis is seen as one of the most common side affects to the drug clozapine which can make a person seriously ill. By identifying the genes that pre-dispose individuals to these reactions, genetic tests could be introduced to ensure the drug is only administered to patients who are safe to receive it. This study builds upon our work and positive links with pharmacogenetics at the Wolfson Centre for Personalised Medicine at the University of Liverpool.

The Trust continues to support several studies within the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH) programme. The Centre for Mental Health and Safety at the University of Manchester share their results annually and the findings from the latest report and input from the research team are guiding the Centre for Perfect Care's work in developing new safety plans with joint working with Centre for Mental Health to deliver our zero suicide goal.

The Trust successfully delivered the final phase of a three year project entitled 'Innovate Dementia' in collaboration with our UK partners at Liverpool John Moores University funded from the INTERREG IVB funding stream. This project tackled the challenges faced by the increasing number of people living with dementia using collaboration in the areas of lighting, living environments, models of access, nutrition and exercise underpinned by the use of technology. People living with dementia were central to all aspects of delivery of the project and in-product development, innovation and testing. This project built significant relationships with business, health, social care and academia which are being built upon through the Innovate Depression workstream in the Trust.

The Trust has continued to host an NIHR study being successfully led by a psychologist in the Trust, working in collaboration with the Universities of Liverpool and Bangor. This project aims to establish whether the application of a human rights based approach to healthcare leads to significant improvements in the care and wellbeing of people with dementia in hospital inpatient and care home settings.

Funding has been confirmed from the NIHR for a randomised controlled trial (RCT) to investigate whether MBT (Mentalisation Based Therapy) is an effective treatment for high-risk men in the community with antisocial personality disorder as part of the Offender Personality Disorder Pathway. The Trust will be one of 11 sites in the UK and the study will be jointly delivered by the National Probation Service and partner Health Service Providers as an integrated part of the Offender Personality Disorder Pathways Strategy. The Tavistock and Portman NHS Foundation Trust will be the lead co-ordinating site for the project with training and ongoing supervision provided by the Anna Freud Centre.

The NWC AHSN, the NWC CLAHRC and LHP have provided opportunities for the Trust to build further research partnerships and provided opportunities for a wide variety of innovation initiatives. These developments have built upon the Trust's established partnerships with academia, the CCG, service users and carers, city councils and third sector organisations.

The Trust has again invested in fixed term research assistant posts with the University of Liverpool via a collaborative project entitled ARISE (Applied Research, Innovation and Service Evaluation). Currently there are 1.8 whole time equivalent research assistants supporting perfect care research and innovation projects including safety planning, self harm and a project entitled Living Life to the Full being delivered in Talk Liverpool IAPT and the Recovery College. The group is currently sharing expertise in the evaluation of the recently formed HOPE self harm service in the mental health liaison teams at Royal Liverpool University Hospital and Aintree University Hospital (a service for people presenting with self harm to accident and emergency departments). ARISE is undertaking a robust evaluation of this service, with two main research aims. Firstly, to validate and evidence the use of a model combining Psychodynamic Interpersonal Therapy (PIT) and Cognitive Analytic Therapy (CAT) in the specific treatment of self harm, and secondly, to evidence any potential improvements in patient psychological wellbeing following the service intervention.

Another initiative with colleagues from the University of Liverpool entitled RISCC (Research in Secure Care) has continued to flourish with the continued investment in a research associate and collaboration in several projects and bids including a project with Mersey Deanery to improve the research skills of ST5 psychiatry trainees through supervised participation in research projects.

The Trust is supporting the national genomes project (100,000 Genomes Project) which aims to sequence 100,000 whole genomes from NHS patients by 2017 to accelerate the development of new diagnostics and treatments for patients. The project will focus on patients with rare disease and their families. When established as a delivery partner, the Trust will initially support the recruitment of participants with severe learning disabilities with associated congenital malformation and autistic tendencies. It will enable Mersey Care to be formally involved in the emerging medical field of neuro-genomics. This project is not classed as research but a transformative programme to build infrastructure and knowledge in participating trusts.

A tailored research training package, commissioned and being delivered in collaboration with the University of Liverpool is progressing well. The group has identified their own research question exploring perceptions of the prevalence of borderline personality disorder compared with recorded diagnosis. A literature review has been completed, a proposal written and ethical approval received. Recruitment of participants has begun and, following analysis, a paper will be co-authored and published. Training, direction and support are provided by the academics involved and the research and development manager. If this proves successful, it is anticipated that further groups will be facilitated to develop a pool of skilled, research ready service users and carers who can become more fully involved in delivery, as well as participants in research projects and bids.

Collaboration for research continues with UK universities including Liverpool, Manchester, London, Central Lancashire, Bangor, Edge Hill and Liverpool John Moores. International research links have also expanded over the last year including joint bids, honorary contracts, memorandums of understanding and joint working with colleagues in Norway, Netherlands, Switzerland, Sweden, Australia, Maastricht and the USA.

The full implementation of the Health Research Authority (HRA) new processes for the delivery of research in the NHS is expected to have significant impact on the delivery of research for both the Trust and researchers in the coming year.

2.2.5 Sign Up to Safety Campaign

Sign Up to Safety is a national initiative to help NHS organisations and their staff achieve their patient safety aspirations and care for their patients in the safest way possible.

Mersey Care is committed to Sign Up to Safety and support the philosophy of locally led, self-directed safety improvement.

The original sign up to safety pledges were developed with the clinical divisions and signed off by the executive team. They were developed to ensure they mirror the objectives contained within the Quality Account and align with our perfect care goals.

The pledges listed below have been further developed to ensure they are specific and take account of the continually developing perfect care initiatives that continue to impact on all parts of the organisation.

These revised pledges will be presented to the executive team for approval in May and posted on the Sign Up to Safety website by 1 June 2016.

The revised pledges are as follows:

The Five Sign Up to Safety Pledges

1. Putting Safety First

We are committed to reducing avoidable harm in our organisation. We will do this by focusing on our zero suicide, no force first and self harm projects. Safety is at the centre of our perfect care work and one of our six quality domains.

2. Continually Learn

We will make our organisation more resilient to risks by acting on feedback from patients and by constantly measuring and monitoring how safe our services are. Post incident reviews, particularly related to serious self harm and suicides will be a significant part of this process. The mortality review process will also continue to be updated to reflect the recommendations of the MAZARS review.

3. Honesty

We will be transparent with people about our progress to tackle patient safety issues and support staff to be candid with patients and their families if something goes wrong. We will continue to develop our internal systems for raising concerns and appoint a 'speak out safely' guardian. We will continue to implement the national Duty of Candour guidance in full and measure the use of this process across the organisation. Encouraging and guiding our staff to raise concerns using a variety of methodologies will remain a key priority.

4. Collaborate

We will take a leading role in supporting collaborative learning to ensure improvements are made across all of the services that patients use. We are part of a UK collaborative with six other hospitals and The Risk Authority at Stanford in the United States working on a 'partnership for patient protection' project which aims to raise patient safety to a new level using technology never used in healthcare, to make our services the safest in the world.

Working closely with our commissioners we will review our root cause analysis to ensure it meets national guidance and develop internal outcome measures.

5. Support

We will help people understand why things go wrong and how to put them right. We will give staff the time and support needed to improve and celebrate progress. Staff involved in incidents and complaints will be supported when things go wrong and also enable them to learn from these events. We will continue to develop our internal mechanisms for supporting staff including the use of counselling and post incident debriefs.

We will continue as part of Duty of Candour to appoint family liaison officers who will support family members and carers when incidents occur and ensure they are guided and supported through the entire post incident review process.

2.2.6 2015/16 CQUIN Goals

In 2015/16 2.5% of Mersey Care income was conditional on achieving quality improvement goals agreed between the Trust and its commissioners, through the Commissioning for Quality and Innovation (CQUIN) payment framework. The Trust was also assigned three sets of CQUIN indicators, relating to local services, low and medium secure services, and high secure services. As at the end of March 2016, the Trust has under achieved the national Physical Health CQUIN. The Trust did, however, achieve all commissioner indicators for high secure services and low and medium secure services. Local services requirements were overall under achieved. Table 2 provides a summary of local, low and medium secure and high secure services CQUIN performance for 2015/16.

2015/16 CQUIN Update

The Trust reported that all milestones were achieved, with the following exceptions:

- National Physical Health CQUIN Part 1 (Cardio Metabolic Assessment for Patients with Schizophrenia)
- National Physical Health CQUIN Part 2 (Communication with GPs) indicator, failed to achieve the set target for the audit carried out in quarter two. It has been confirmed that £0.04 million has been returned to commissioners
- Local Physical Health CQUIN for Liverpool CCG. Analysis of the audit revealed that the local division in Liverpool did not achieve quarter three and four targets for the medical assessment aspect. The financial impact is that £0.02 million has been returned to Liverpool CCG for underperformance.

TABLE 2: CQUIN UPDATE

Liverpool CCG CQUINs	RAG Status
National Physical Health Part 1 Cardio Metabolic Assessment and Treatment for Patients with Psychoses Improving physical healthcare: a) To reduce premature mortality in people with severe mental illness b) Of all mental health and learning disability services users across Mersey Care NHS Foundation Trust	**A**
National Physical Health Part 2 Communication with General Practitioners Improving physical healthcare: a) To reduce premature mortality in people with severe mental illness b) Of all mental health and learning disability services users across Mersey Care NHS Foundation Trust.	**R**
National Urgent Care Improving diagnosis and re-attendance rates of patients with mental health needs at Accident and Emergency	**G**
Improving Youth Mental Health and Learning Disability To continue to improve transitions from child and adolescent mental health services to adult mental health and learning disability services, building on the findings of the 2014/15 CQUIN, with an expanded remit.	**G**
Local Physical Health The annual health check ensures service users have a comprehensive physical and mental health assessment supporting care pathways at discharge and reducing the negative impact of untreated physical morbidity on recovery.	**A**
Collaborative Working The introduction of a system for collaborative working will help primary and secondary care work more effectively together to anticipate and manage complex physical and mental health care needs.	**G**
Digital Maturity - Digital Maturity Assessment Digital Maturity Assessment.	**G**
Digital Maturity - Life Enhancing Technology Digital Maturity - Life Enhancing Technology.	**G**
Digital Maturity - Interoperability with Localities and Neighbourhoods Digital Maturity - Interoperability with Localities and Neighbourhoods (working closely with ILINKS).	**G**
Accreditation Programme for Psychological Therapies Services - IAPT To gain accreditation with the national Accreditation Programme for Psychological Therapies Services (APPTS), organised by the Centre for Quality Improvement (CCQI). This will be achieved by the Talk Liverpool service being measured against a set of quality standards through self review, involving therapists and service users, and a peer review visit.	**G**

Liverpool Public Health - Addictions CQUINs	RAG Status
Improving Physical Health The annual health check ensures service users have a comprehensive physical and mental health assessment supporting care pathways at discharge and reducing the negative impact of untreated physical morbidity on recovery.	**G**
Dual Diagnosis Dual diagnosis - facilitates the closer working relationships between mental health, addiction services and primary care, which improve patient safety, patient experience and quality of life through reconciliation of treatments and clear pathways.	**G**
Learning From Service Users Experience Patient Experience and Performance Outcomes - service users who are fully engaged in the care they receive have the capacity to achieve the best outcomes, facilitating a reduction in relapse and a reduction in avoidable representations.	**G**
Performance and Outcomes Patient Experience and Performance Outcomes - service users who are fully engaged in the care they receive have the capacity to achieve the best outcomes, facilitating a reduction in relapse and a reduction in avoidable representations.	**G**
South Sefton CCG and Associates CQUINs (Awaiting final quarter four feedback).	
National Physical Health Part 1 Cardio Metabolic Assessment and Treatment for Patients with Psychoses Initial internal analysis of the quarter four National Royal College of Psychiatrists (RCPsych) audit shows that the local division has not achieved the 90% target for inpatient areas. The expected financial impact is that the Trust will receive 25% of the monies; therefore £0.07 million has been returned to commissioners.	**A**
National Physical Health Part 2 Communication with General Practitioners Improving physical healthcare: a) To reduce premature mortality in people with severe mental illness. b) Of all mental health and learning disability services users across Mersey Care NHS Foundation Trust.	**R**
National Urgent Care – Reduction in A&E Mental Health Attendances Improving diagnosis and re-attendance rates of patients with mental health needs at Accident and Emergency.	**G**
AQ - Dementia Strategic alignment with the regional Advancing Quality programme, which is evidence and research based and known to yield improved outcomes.	**G**
AQ – Early Intervention in Psychosis Strategic alignment with the regional Advancing Quality programme, which is evidence and research based and known to yield improved outcomes.	**G**
Mental Health Tariff Cluster Specification and Outcomes Initiating a programme of work to develop cluster care packages and outcomes.	**G**
Transition from Child and Adolescent Mental Health to Adult Mental Health and Learning Disabilities To continue to improve transitions from child and adolescent mental health services to adult mental health and learning disability services, building on the findings of the 2014/15 CQUIN, with an expanded remit.	**G**
Collaborative Working The introduction of a system for collaborative working will help primary and secondary care work more effectively together to anticipate and manage complex physical and mental health care needs.	**G**

High Secure Services CQUINs	RAG Status
Supportive Observations Develop best practice observation Guidelines for high secure services for self harm, suicidality, violence, falls and absconsions	G
Long Term Segregation Develop best practice guidelines for patients managed in long term segregation.	G
Healthy Lifestyles - Patients Shop Nutritional monitoring of the patient shop.	G
Carer Involvement Evaluate the effectiveness of carer involvement strategies and further develop ways to involve carers, family and friends at a local and regional level. To support carer involvement with their relatives in secure care, (particularly in the first three months of care) and then on to the point of discharge. Better ways of involving and engaging carers to promote the recovery of patients.	G

Medium and Low Secure Services CQUINs	RAG Status
National Physical Health CQUIN Cardio Metabolic Assessment and Treatment for Patients with Psychoses Improving physical healthcare: a) To reduce premature mortality in people with severe mental illness b) Of all mental health and learning disability services users across Mersey Care NHS Foundation Trust.	G
Collaborative Risk Assessment Active engagement programme to involve all secure service users in a process of collaborative risk assessment and management.	G
Evaluate the effectiveness of carer involvement strategies and further develop ways to involve carers, family and friends at a local and regional level. To support carer involvement with their relatives in secure care, (particularly in the first three months of care) and then on to the point of discharge. Better ways of involving and engaging carers to promote the recovery of patients.	G
Supporting Service Users to Stop Smoking Improve the smoke free status of the service. Adherence to NICE guidance on interventions. Continued support during leave and discharge.	G

Further information regarding CQUIN can be found at: merseycare.nhs.uk

2.2.7 Care Quality Commission

Mersey Care is required to register with the Care Quality Commission and its current registration status is: 'Registered without any improvement conditions'. The Care Quality Commission has not taken enforcement action against the Trust during 2015/16 and the Trust has not participated in any special reviews or investigations by the Care Quality Commission during the reporting period.

The registration system of the Care Quality Commission ensures that people can expect services to meet the fundamental standards based on the key areas of:

- Person-centred care
- Dignity and respect
- Need for consent
- Safe care and treatment
- Safeguarding service users from abuse and improper treatment
- Meeting nutritional and hydration needs
- Premises and equipment
- Receiving and acting on complaints
- Good governance
- Staffing
- Fit and proper persons
- Duty of candour.

All mental health trusts are now subject to the CQC intelligent monitoring system. The CQC published the third intelligent monitoring report for mental health trusts in February 2016. In summary, the Trust was identified as having six risks with two elevated. The Trust was given an overall risk score of ten (maximum possible score 142) with 64 areas with a number of risks identified out of 72 applicable indicators. The risks are:

Safe

- Proportion of mortality among people in contact with community mental health teams aged 0 to 74 (elevated risk)
- Composite indicator showing Trusts flagging for risk in relation to the number of deaths of patients under the Mental Health Act.

Effective

- Monitoring of alcohol intake in the past 12 months
- Has family intervention ever been offered to the service user?

Responsive

- Composite indicator to assess bed occupancy
- Proportion of care spells where patients are discharged without a recorded crisis plan (elevated risk)
- PLACE (patient-led assessments of the care environment) score for facilities.

Well-led

- Proportion of days sick in the last 12 months for nursing and midwifery staff.

The organisation is sited on these areas of risk and is putting in place quality and performance improvement plans.

Mersey Care was subject to a series of unannounced Care Quality Commission inspections in 2014/15 including inspections of both local and secure services as part of their programme of inspections. These inspections consider the following:

- Is the service safe?
- Is the service effective?
- Is the service caring?
- Is the service responsive?
- Is the service well-led?

Mersey Care was subject to 26 unannounced Care Quality Commission/Mental Health Act inspections in 2015/16 of both local and secure services as part of their programme of inspections. These inspections consider the domains:

- Purpose, respect, participation and least restriction
- Admission to the ward
- Tribunals and hearings
- Leave of absence
- General healthcare
- Other areas such as environment, standard of food etc.

The CQC reports have all been responded to within agreed timescales and have shown in the vast majority of cases that previous issues raised have been actioned appropriately. The inspections have highlighted the following areas during recent reviews:

- Suitability of the environment
- Use of Section 58, 132 and 17 of the Mental Health Act (1983)
- Care plans not being shared with service users.

The Trust has seen a noticeable improvement in the use of the Mental Health Act over the past year particularly in relation to the use of sections 132 and 58.

Further information about the Care Quality Commission registration status of Mersey Care can be found at: www.cqc.org.uk/directory/rw4

The CQC attended the Trust to complete a review of services on 1 June 2015 following a rigorous process of data collation that continued beyond the actual visit.

As part of their review the CQC:

- Visited 57 wards and teams
- Talked with more than 305 patients, carers and family members
- Observed how staff were caring for people
- Carried out 33 home visits with staff to people receiving care
- Looked at the personal care records of over 520 patients
- Attended 27 multi-disciplinary team meetings
- Observed 12 handovers
- Interviewed over 450 individual frontline members of staff
- Interviewed over 50 corporate staff and members of the Board
- Met with staff side union representatives
- Met with the service user assembly
- Met with 13 service user groups
- Met with local stakeholders, commissioners and local authority representatives.

The CQC has now provided the Trust with their feedback and identified a series of areas that require improvement:

- In community learning disability services, systems and processes did not effectively assess, monitor and improve the quality and safety of the services provided. We found concerns with accuracy of recording and quality of data to monitor compliance with waiting and response times. There was no effective system to monitor referrals, waiting lists and unmet needs. There was a clear system in place to report incidents, however, we were concerned about the lack of a comprehensive investigation into a serious incident affecting a member of staff last year
- In rehabilitation services, Rathbone Rehabilitation Unit had a comprehensive ligature risk assessment with points identified and actions to minimise risk of service users tying ligatures. However, this risk assessment did not assess the risk posed in the garden area which had gym equipment, smoking shelter and benches
- In rehabilitation services, individual supervision rates across the service were not in line with Trust policy of four to six weekly
- In the three months prior to our visit there were a total of 188 shifts that required extra cover, of these shifts, 159 were filled leaving around 15% of shifts below numbers clinically required. This is a breach of regulation 18 (2)(a)
- In older people's inpatient services, the Trust had not ensured that patients were treated with dignity and respect. This was because Irwell ward did not comply with the guidance on same sex accommodation. Patients of Irwell ward did not have their privacy promoted. Patients of Irwell ward were not provided with food and drinks in a manner that promoted their independence and dignity
- The Trust had not ensured that care and treatment was provided in a safe way for patients in terms of the risks presented by the environment. This was because Irwell ward did not have action plans to mitigate against the risk of suicide that the environment may present. Identified risks were not appropriately addressed in care plans on Irwell ward. The Trust had not ensured that staff, particularly health care assistants of Irwell ward, were appropriately skilled and supervised or supported in their role. This was because the staff did not receive sufficient support and training to meet the needs of patients with dementia. This is a breach of regulation 10
- In inpatient learning disability services, the care and treatment must only be provided with the consent of the relevant person. The registered person must act in accordance with the Mental Capacity Act 2005. Staff at Wavertree Bungalow had limited knowledge of the MCA 2005. All staff were not trained in MCA 2005. Mental capacity assessments to consent to treatment and admission were not carried out and no best interests meeting were held. At STAR Unit, where best interests meetings were needed, this was not done in a proper manner. This is a breach of regulation 11(1)(3)
- In adult inpatient/PICU services, rapid tranquilisation was not carried out in accordance with NICE guidance as patients did not always have physical healthcare checks carried out afterwards, which may put them at risk. This was in breach of regulation 12 (a)(b)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014
- At a Trustwide level, there was evidence that individuals were not receiving timely access to psychological therapies. The Trust should review waiting times and ensure that action plans are in place so that people receive timely access to psychological intervention. This was in breach of regulation 18(a)(b)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

All of the above compliance notices were received by the Local Services Division. The Secure Services Division received recommendations related to 'should do's' and local action required. These will not be scrutinised specially by the CQC, but picked up via ongoing inspections.

A process of implementing an action plan was put in place immediately and the vast majority of actions have now been completed. The actions related to reduced psychology resources have extended closure dates due to the requirement to recruit further staff, which is now underway following enhanced funding being approved. The Trust meets with the CQC on a quarterly basis to share progress on actions previously agreed. The Trust has a meeting scheduled with the CQC in May 2016 to share progress with the comprehensive review action plan, written evidence of progress has already been shared so this session will provide an opportunity for the CQC to clarify the level of progress being made.

Mechanisms are in place in Mersey Care to enable services to monitor compliance with the CQC regulations on a regular basis including the introduction of surveillance mechanisms on a divisional, corporate and executive level. In addition, the Trust continues to implement internal Trust Quality Review Visits which somewhat mirror that of the CQC. These visits take place weekly and are both announced and an unannounced and include out of hours visits across inpatient and community services. This process provides verification of compliance to self-assessments and allows triangulation of assurances.

Table 1 below outlines the aggregation tool for the five domains.

Table 1: Summary of CQC Inspection Findings 2015

Overall rating for services at this Provider	**Good**
Are Mental Health Services safe?	Requires improvement
Are Mental Health Services effective?	Good
Are Mental Health Services caring?	Good
Are Mental Health Services responsive?	Good
Are Mental Health Services well-led?	Good

2.2.8 Duty of Candour

Candour is defined in Robert Francis' report as: 'The volunteering of all relevant information to persons who have or may have been harmed by the provision of services, whether or not the information has been requested and whether or not a complaint or a report about that provision has been made.

- Duty of Candour guidance is formally considered for each incident of moderate, severe harm or death. In addition, other incidents that result in lower levels of harm may be considered depending on the seriousness of the incident. Data is stored on the Trust risk management system in adherence to Duty of Candour. This is shared with the Trustwide Quality Assurance Committee on a bi-monthly basis. Each incident that fits the criteria for Duty of Candour is allocated a family liaison manager, this will be at ward/team manager level and above depending on the nature of the incident
- Service users and their families will receive information on the role of the family liaison manager in writing, which includes providing advice and guidance on any reviews that will take place, the role and function of any potential coroner's inquest, and sign posting them for further help and support. Their role is separate from the incident investigators role. An independent incident review undertaken by NICHE has recently praised the way it worked with the family and cited this as good practice
- The Trust has provided training to staff on duty of candour and the role of the family liaison manager. Guidance is also available via the Trusts Being Open policy. The Trust's Patient Advice and Liaison lead oversees the implementation of the Being Open policy and provides guidance to staff on its implementation.

2.2.9 Data Quality

Good quality information (that is information which is accurate, valid, reliable, timely, relevant and complete) is vital to enable individual staff and the organisation to evidence that they are delivering high quality/perfect care that supports people on their recovery journey, and to reach their goals and aspirations whilst keeping themselves and others safe.

Good quality information also enables the efficient management of services, service planning, performance management, business planning, commissioning and partnership working.

The Trust has a corporate data quality policy, a data quality strategy and an agreed set of data quality standards in place with an annual data quality action plan and regular audits. The Data Quality Steering Group oversees the action plan, monitors the results of audits and reviews the scores from the Information Governance Toolkit on data quality.

The Trust has implemented a performance indicator kite-mark system to provide assurance that the information reported to the Board and its committees is of good data quality. The kite-mark system requires internal or external audit opinion on each indicator covered by the kite-mark on a three yearly basis.

The Trust commissioned Mersey Internal Audit Agency to undertake three data quality audits of key performance indicators during 2015/16. Two of these audits resulted in opinions of limited assurance (priority one indicators and priority three indicators). Action plans were developed in response to the findings. For the first audit (priority one indicators), all actions have now been completed. For the priority three indicator audit, the action plan will be fully implemented by 30 September 2016 and delivery will be reported to the Audit Committee. The Trust can confirm that the findings from the internal audits do not impact on the nationally mandated indicators reported in the Quality Account.

Additional pieces of work to provide assurance of the quality of data underpinning our activity reporting have been undertaken under the direction of the Head of Performance Improvement and Customer Relationship Management.

One of these pieces of work was an internal review of data recording which included data analysis and clinical audit. This commenced in July 2015 and was completed by the end of April 2016.

The review covered the following areas:

- Referrals
- Clinical contacts
- Caseloads
- Clustering
- Clinical pathways
- Data quality and clinical audit.

An action plan in response to the findings of phase one was prepared and has been received by the Audit Committee. The action plan is on target to be delivered.

Mersey Care submitted records during 2015/16 to the Secondary Uses service for inclusion in the Hospital Episode Statistics which are included in the latest published data. The percentage of records in the published data which included:

- the patient's valid NHS number was: 99.8% for admitted patient care and 100% for out patient care.
- the patient's valid General Medical Practice Code was: 99.7% for admitted patient care and 99.6% for outpatient care.

Latest data (SUS DQ dashboard) available from HSCIC on 24 March 2016 relates to month10 2015/16 (April 2015 to January 2016).

Information Governance

The Trust Information Governance compliance score 2015/16 was 84% (Green – satisfactory) with the Trust attaining a minimum level two in all standards. The Trust was also awarded "significant assurance" status following audit of the Information Governance Toolkit.

3. PART THREE

3.1 Review of Quality Performance 2015/16

In June 2015, the Trust published its Quality Account reporting on the quality of services against six areas of priority. Following extensive engagement with key stakeholders, it was decided that following the work that had been undertaken to achieve these priorities, the following six specific areas would be the key areas of quality improvement:

• Priority 1: No Force First

By March 2016 all wards will have introduced the No Force First initiative that will result in a Trustwide reduction in the use of physical and medication led restraint (achieved).

• Priority 2: Zero Suicide

By September 2015 a Safe from Suicide team will be established, the team will be led by a new associate medical director. The Safe from Suicide team will monitor and report to the Board on the progress against the Board approved (May 2015) Zero Suicide strategy. We will work with academic partners and establish a definitive baseline measure for suicide (achieved).

• Priority 3: Improvements in Physical Health

We will commence a staged implementation of a Smoke Free policy in September 2015 (achieved). We will monitor the impact of the policy on service user experience via our monthly patient experience survey (achieved). All inpatients will have metabolic screening completed in line with the National Audit of Schizophrenia standards by March 2016 (not achieved).

• Priority 4: Falls

The Trust will approve a revised fall strategy by September 2015 (achieved). The Trust will achieve a 20% reduction in the harm associated with falls by March 2016 (not achieved).

• Priority 5: Self Harm

The Trust will approve by September 2015 a management of self harm strategy (achieved). The Trust will evaluate the pilot project in accident and emergency to reduce people re-presenting with self harm at accident and emergency by October 2015 and set with new ambitious targets approved by the Quality Assurance Committee based on the outcomes of the review of the pilot (partially achieved). The Trust will achieve a reduction of 20% in harm associated with the use of ligatures in inpatient settings (not achieved).

• Priority 6: Recovery Focussed Outcome Measures

There is no national consensus on outcome measures covering the breadth of services provided by the Trust. We will establish outcome measures for the three initiatives below. We will commence collection of this data from April 2016 (achieved).

- No Force First
- Zero Suicide
- Physical healthcare.

Priority 1: No Force First

The nominated lead for this area is Dr Jennifer Kilcoyne, Lead Consultant Clinical Psychologist.

The No Force First programme continues to be one of the key components of the Trust's perfect care aspirations and aims to eliminate physical restraint and medication-led restraint within Mersey Care NHS Foundation Trust.

No Force First initiative was highlighted in the CQC report with high levels of staff engagement and understanding of the processes noted by inspectors.

The project plan, position paper, criteria and menu of strategies is agreed by both divisions and implementation plans are developed.

End of Year Report

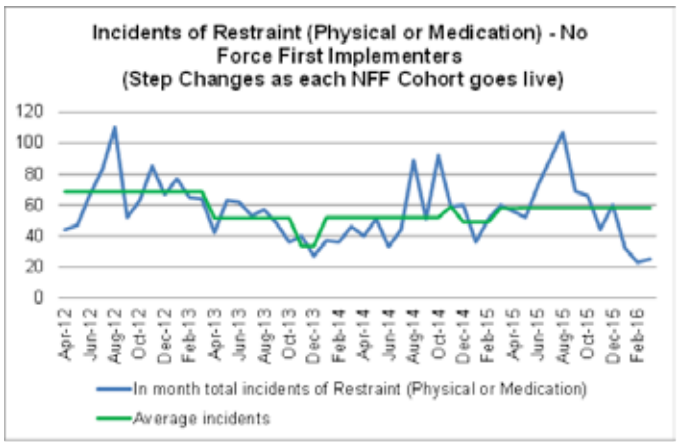
1) NFF has been introduced onto all inpatients wards (achieved).
2) Reduction in restraint levels on NFF implementer wards from baseline levels (achieved).

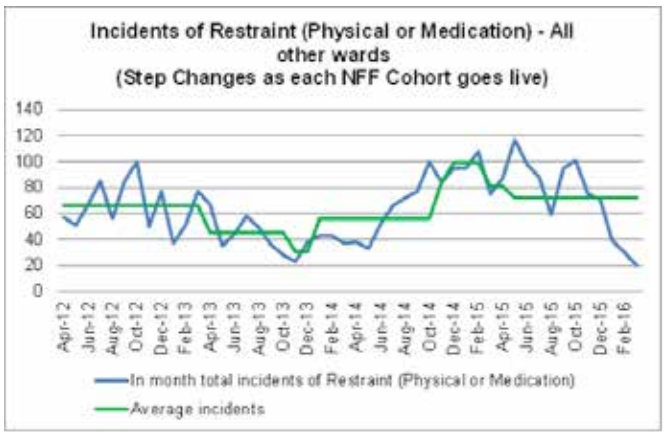
Impact Data

The data on reducing medication and physical restraint has been variable over the year. The challenges included three service users on the cohort one wards who had previously shown excellent reductions in levels of restraint experiencing a particularly difficult time over a four month period (June to September 2015) last year. This resulted in a significant increase in levels of restraint to manage extreme levels of self harm and assaultive behaviour. Following this spike in the data points the levels have returned to the previous low levels and the service user who was most distressed was cared for appropriately and has since been discharged due to significant improvements.

The data on medication and physical restraint is shown here.

In addition to specific incidences which affect our data as more wards roll out the process there is increased variability of the approach. We have developed a number of strategies to address these difficulties and improve sustainability and consistency across wards and clinical teams which are described.





To summarise across all NFF wards at different stages of implementation there has been a 15% decrease in the use of restraint since the initial baseline period (April to March 2012/13). These gains represent significant variation in success with some wards achieving well over 50% reductions and some experiencing increases. This is against a back drop of increasing incidents in aggression and assaults across all wards. On the wards which did not implement NFF until recently there was an increase of restraint by 9%.

Implementation dates were staggered for each cohort of wards as follows:

Cohort	Ward	Baseline Start	Actual Start
1	Gladstone/Morris	01/04/12	01/04/13
1	Poplar	01/04/12	01/04/13
1	Star	01/04/12	01/04/13
2	Dee/Alexandra	01/11/12	01/11/13
2	Keats	01/11/12	01/11/13
2	Oak	01/01/13	01/01/14
3	Ivy	01/11/13	01/11/14
3	Johnson	01/12/13	01/12/14
3	Harrington	01/12/13	Delayed
3	Albert	01/12/13	Delayed
4	Alt	01/03/14	01/03/15
4	Newton	01/03/14	01/03/15
4	Irwell	01/03/14	01/03/15
4	Blake	01/05/14	01/05/15
4	Tennyson	01/05/14	01/05/15

All remaining wards had awareness training and preparation in relation to No Force First principles (including Harrington and Albert Wards).

Sustainability

- We continue to progress on the five year implementation plan to ensure NFF is sustained in culture and clinical practice change.
- A guide of the most effective interventions is currently being developed by a project group to be completed by June 2016 and will commence roll out across the wards from July 2016. Some wards are finding challenges in meeting reduction targets therefore future plans are examining strategies to increase sustainability and further support to wards in achieving objectives and Plan Do Study Act cycles. Once the guide is implemented it will be evaluated to determine its impact. Individualised performance outcomes will be developed in future and the Advancing Quality Alliance (AQuA) is continuing to provide some support to a small number of wards and the Aston Team Coaching approach is also supporting staff teams.
- A research evaluation of the effective components of NFF is currently being developed.
- Secure Division Restrictive Practice Reduction Implementation Group now incorporates all developments and initiatives in relation to NFF with a view to greater integration. This process will be paralleled by the Local Division in the near future.
- Personal Safety Service Training will incorporate NFF training as an integral part of the mandatory components. The training will be governed by a curriculum group which will ensure that the training is consistent with national guidance and NFF principles.
- A training DVD and workbook package has been developed to train new starters and bank/night staff in between mandatory training sessions.
- Posters of criteria and expectations for all staff and service users are currently being designed and produced.
- Mentorship hubs between wards will be fully established after the summer.

National Profile

- A NFF conference was delivered by the NFF team to Mersey Care and Calderstones staff and over 31 external organisations, service users and carers on 29 February which was attended by over 200 people in two sessions. This was a very successful event and generated a lot of national interest in the approach
- A clinical model of Reducing Segregation (developed at Ashworth) which incorporates NFF principles has been successfully piloted at Rampton and Broadmoor Hospitals and a roll out of this approach is due to start in the autumn
- The model will also be piloted at three high secure prisons in the summer of 2016
- NFF at Mersey Care continues to be acknowledged nationally by the Department of Health in its publications and events as a leader in restraint reduction. A number of the team presented at the DoH's request at national conferences in London and Manchester. The team was invited to and presented at a conference on Excellence in Mental Health in Newcastle hosted by Geraldine Strathdee. Requests for various presentations on NFF including from Royal College of Nursing and Division of Clinical Psychology have been received and allocated
- A case study of good practice was submitted to National Quality Board and the team are awaiting feedback whether it will be included in the report
- The team has been requested by the National Association of Psychiatric Intensive Care Units to host a national event on their behalf
- NFF was cited in the Care Quality Commission report 2014/15 on Monitoring the Mental Health Act as a positive reduction strategy
- The NFF project won the Changing Culture category at the National Patient Safety awards in June 2015.

Priority 2: Zero Suicide (achieved)

The nominated lead for this area was Dr Rebecca Martinez, Consultant Psychiatrist and associate medical director for Suicide Prevention.

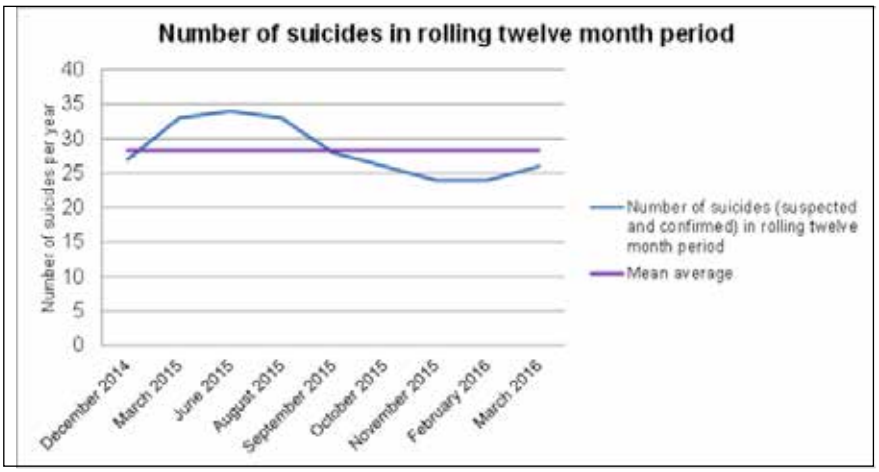
The priority areas for work and achievements within the first year of implementation, since the Zero Suicide policy launch in September 2015 are:

1. Implementation of learning strategy
2. Post incident review process
3. Implementation of risk formulations and safety plans
4. Standardised care pathways
    a. Post inpatient discharge
    b. Stepped up care services.

In terms of primary outcome measures we are monitoring the numbers of suicide and are working on a plan of year on year reduction of numbers of suicides, using the 2014/15 data as our baseline.

We can report that there were 33 suicides for people under our care or within 12 months of discharge from our services for the one year period 2014/15. For the same time period the data for 2015/16 is 26. Table 1 refers.

Table 1: Number of Suicides in Rolling 12 Month Period



Progress in the Key Priority Implementation Areas

1. **Implementation of learning strategy**
    a. Development of a bespoke e-learning training resource completed.
    b. Ten per cent of the workforce has completed the e-learning, on going support through ESR to achieve full completion of training in the workforce.
    c. Level 2 and 3 training materials currently being developed.
2. **Post incident review process**
    a. Suicide clinical lead participating and supporting the 72 hour review process of all possible and suspected suicides.
    b. Suicide clinical lead providing support to teams affected by a suicide.
    c. Proactive risk management offered.
3. **Implementation of risk formulations and safety plans**
    a. Implementation plan in place and rolled out according to projections.
    b. Pilot sites in Brunswick ward and the Park Unit.
    c. Support available for roll out at four inpatient sites and adhered Stepped Up Care teams.
4. **Standardised care pathways**
    a. Contribution to transformational change process, including zero suicide compliance for the Stepped Up Care policy and work on the inpatient transformational work stream.

Priority 3: Improvements in Physical Health (partially achieved)

The nominated lead for this priority is Dr Simon Tavernor, Consultant Psychiatrist and Associate Medical Director.

Smoke Free Services (achieved)

An incremental approach to the implementation of a nicotine management policy is in train with planned Trustwide smoke free services by August 2016.

A lead clinician (Band 8a) has been appointed for a 12 month term to support this work stream.

The medium secure, Scott Clinic site has been smoke free from July 2015.

Low secure services implemented smoke free on 1 April 2016.

The Local Division is supporting service users in the community. Local Division has agreed further implementation milestones towards a smoke free GO-LIVE date of 1/08/2016. The Division has implemented smoke free on 4 April 2016 at the Rathbone site.

The lead will commence an evaluation to support the process for monitoring the impact and effectiveness of the policy on service user experience and stakeholder perceptions. This will report by December 2016.

Cardio Metabolic Screening (not achieved)

Changes to the ePEX screens have been implemented. The Local Division continues to monitor weekly performance which continues to demonstrate improved compliance.

A physical health training plan has been developed with the Learning and Development team and a variety of study days are now available to access via the Learning and Development Prospectus.

Strategic links have been made with the local transformation lead in the clinical commissioning group and we are now members of the redesign groups for respiratory, cardiovascular disease and diabetes. The Trust also had a representative at Liverpool CCG's Cardiac Summit.

The Division has established a "Physical Health Community of Practice" with local stakeholders. Membership is strengthening links with local community and "Healthy Liverpool". The group will be integrated into the Collaborative Community of Practice group for 2016/17.

There has been engagement with the lead for diabetes and we are in the process of agreeing pathways and training for 2016/17.

The first audit showed that the Local Division achieved an overall result of 41%. The following is a breakdown of compliance by individual screening and interventions:

- Quarter four audit results show overall Trust compliance 70%*
- 100%* Secure Division, and 67%* Local Division.

*These figures are provisional and we are awaiting the ratified results from the Royal College of Psychiatrists (time scale May 2016).

The project lead has rated this priority area amber due to outstanding work required to reach 100% compliance with screening and intervention in the Local Division.

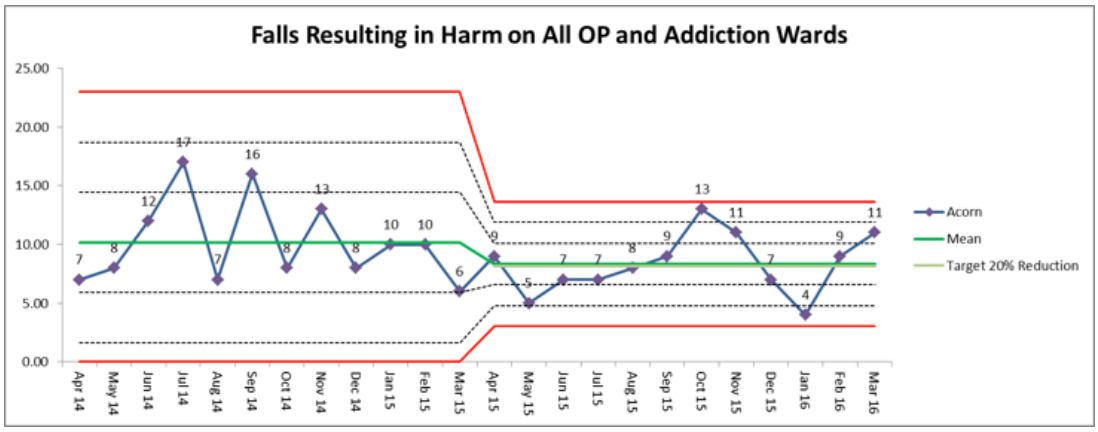
Priority 4: Falls (partially achieved)

The nominated lead for this priority area was Tony Crumpton, Head of Safety and Security.

The Trust falls strategy has been revised by the Trust Falls group and includes reviewing falls against agreed standards with a focus on assessing whether falls are avoidable or unavoidable. Future reports will provide further analysis in this area. (achieved)

The Trust falls target 2015/16 agreed by the commissioners was for a reduction in the number of falls resulting in harm by 20% compared with the previous year. At the 31 March 2016 a reduction in harm of 18% was recorded. (Not achieved)

The following table shows data for all older people's and addiction wards:



All older people & addiction wards	Falls resulting in harm	Falls resulting in no harm	Total falls	Monthly average of falls resulting in harm	20% reduction target
2014/15	122	203	325	10.17	
2015/16	100	226	326	8.33	8.13

NB. Figures represent an 18% reduction in falls resulting in harm.

The graph demonstrates that the number of falls resulting in harm per month has reduced from 10.17 to 8.33 (an 18% reduction from the baseline). Whilst the 20% target was not achieved, we can see that the amount of variation per month has significantly decreased which indicates improved falls prevention and management.

In addition, frailty reviews take place across older people's wards.

These reviews take place weekly in ensuring that physical health needs, post fall huddles/72 hour incident investigations take place. In addition, dependent on whether our own falls standards are met, it is determined whether a fall which has occurred was avoidable or unavoidable (ie. an unavoidable fall is one where all standards are met eg. falls assessment referrals etc.) and a fall still occurred.

During 2015/16 (April 2015 to 31 March 2016) 262 falls across complex care were reviewed as unavoidable, whereas 15 were identified as avoidable representing 5%. It is this area that we need to continue to focus on.

Over the last year all older people's wards have received standardised equipment to detect when service users deemed at high risk of wandering/falling get out of bed/or a chair. This approach utilises pressure sensors. The system was adopted after a successful pilot agreed through the Trustwide falls meeting.

An internal audit undertaken during 2015 of falls and falls prevention in relation to NICE clinical guidance (NICE CG161) showed that 100% of service users identified in the audit had received a multifactorial falls assessment and that all service users on older adult wards were reviewed at a weekly frailty review. It is proposed to amend the general observations form to enable staff to record environmental checks.

Improvements to the environment on Irwell ward have been made to the lighting and reducing the amount of clear glazing. A new anti-slip floor which is dementia friendly is due to be fitted during 2016/17.

The CQC noted excellent practice in relation to management of falls on Acorn ward and Heys Court.

The care zoning pilot on Oak ward has now concluded and has demonstrated a marked decrease in falls over that pilot period. This will now be embedded in practice.

Frailty reviews are regarded as best practice and will continue to take place weekly in all older adult clinical areas.

Priority 5: Self Harm (partially achieved)

The nominated lead for this priority area was Dr Cecil Kullu, Consultant Psychiatrist.

A Management of Self Harm Strategy was approved in September 2015. This was incorporated into the Suicide Strategy. (Achieved)

The Trust will evaluate the pilot project in A&E to reduce people re-presenting with self harm at A&E by October 2015 and set with new ambitious targets approved by the Quality Assurance Committee based on the outcomes of the review of the pilot. (Partially achieved)

The aim of the self harm work was to reduce repeat attendances at A&E for people who present following an episode of self harm and to reduce the proportion of people attending A&E with serious self harm following an earlier episode of self harm. Both aims were informed by the NICE quality standard on the management of self harm.

The inpatient and wider community work will be progressed through the zero suicide initiative.

A self harm management pathway for the Mental Health Liaison Team has been developed for people presenting to the A&E at RLUH and includes provision of evidence based brief psychological intervention namely Psychodynamic Interpersonal Therapy (PIT). The clinic based service providing this is the Hope Service.

This project is being evaluated by Liverpool University through ARISE and will be completed by end of August 2016. Both quantitative and qualitative outcome measures are being collected.

ARISE have undertaken an analysis on the first six months of pre and post intervention presentations. Analysis included a matched sample (age, gender and presentation) compared to treatment as usual (taken from 2014). There results have not yet shown a statistical significance in difference in frequency of presentation and this is due to the low numbers in the dataset, however there has been a trend towards reduction. This will become clearer as more data is collected over the coming months.

Review of the existing data of repeat attendance suggests reduction in severity of harm and improvement in engagement with other services.

Recent data from the Risk Authority (Mersey Care risk identification report) identified self harm (mostly through ligaturing) as one of the key areas in our inpatient units. This is being addressed using Design Thinking Methodology (collaboration with Stanford University) to find solutions with end users.

The number of ligature incidents resulting in harm has significantly increased during this financial year compared with those occurring between 1 April 2014 and 31 March 2015. (Not achieved)

Ligature Incidents

Financial Year	Low harm	No harm	Total
2014/15	**29**	**153**	**182**
2015/16 forecast	**63**	**390**	**453**

The Trust is including its strategy around management of self harm within the Zero Suicide Strategy development and the priority lead is working closely with the priority lead for zero suicide to ensure alignment between the two priorities.

Priority 6: Recovery Focussed Outcome Measures (achieved)

The nominated lead identified for this priority area is Wendy Copeland-Blair supported by Dr Sudip Sikdar, Consultant Psychiatrist.

The Measuring the Outcomes of Our Care Group has developed a framework for outcomes measurement across all Trust services.

The Trust's outcomes framework will be focussed on:

- My mental health condition: I have seen an improvement in my symptoms and have been supported to be a partner in making decisions about my care
- My experience of services: I was treated with care, respect and dignity when I had contact with Mersey Care services
- My physical health: I am healthy enough to carry out my daily activities; I don't worry about my health
- My recovery: I live a satisfying and hopeful life and can do things that mean something to me.

The Trust has agreed that these outcomes should be measured using the following framework:

a) Clinician Reported Outcome Measures (CROMs)

b) Patient Reported Outcome Measures (PROMs)

c) Patient Reported Experience Measures (PREMs)

d) Social outcomes

e) Clinical effectiveness/patient safety outcomes

f) Recovery-focussed outcomes

g) Process measures.

A suite of CROMs and PROMs have been agreed across both clinical divisions and have been shared with commissioners. For the Local Division, the recently developed cluster specific community pathways define both the activities and interventions that will be undertaken for service users and the outcome tools that will be routinely used. The data from the CROMs and PROMs will be used, along with other measures including those associated with our perfect care initiatives to provide insight into the outcomes we are achieving.

Now that the framework and measures have been agreed, an implementation plan is being developed by the outcomes project team to support the capture and reporting of the required data across the Trust. This will be delivered during 2016/17. Diagram 1 refers.

Diagram 1: Outcome Measures

3.2 Quality Indicators

Mersey Care considers that the data is as described due to the robust governance arrangements in place across the organisation.

A comment has been made against each individual indicator to provide context. Mersey Care is continually taking positive action to address all quality indicators including those listed in the table overleaf.

NHS trusts are required to publish the data reported by the Health and Social Care Information Centre (HSCIC) for each indicator for the reporting period, ie. the 2015/16 financial year. For some indicators, no data or only partial year data is available for 2015/16. The latest data set should be published for last two reporting periods or data covering the minimum of a year.

The data reported below relates to the latest information available via the defined data sources as at 17 May 2016.

Comparisons are with other mental health/ learning disability providers.

MANDATED INDICATOR	DATA PERIOD (H&SCIC Indicator Portal accessed 6 May 2016)	DATA SOURCE	MERSEY CARE NHS TRUST	NATIONAL AVERAGE	HIGHEST NATIONAL POSITION	LOWEST NATIONAL POSITION	STATEMENT
The data made available to the National Health Service trust or NHS foundation trust by the Health and Social Care Information Centre with regard to the percentage of patients on Care Programme Approach who were followed up within seven days after discharge from psychiatric inpatient care during the reporting period.	Q1 2015/16 Q2 2015/16 Q3 2015/16 Q4 2015/16	http://www.england.nhs.uk/statistics/statistical-work-areas/mental-health-community-teams-activity/	98.2% 98.0% 98.7% 100.0%	97.0% 96.8% 96.9% 97.2%	100.0% 100.0% 100.0% 100.0%	88.90% 83.40% 50.0% 80.0%	Mersey Care considers that this data is as described for the following reasons: it has been submitted in accordance with detailed reporting local guidance informed by national reporting rules and advice taken from regulators over the years. The trust has taken the following actions to improve this percentage, and so the quality of its services, by establishing performance reports within its business intelligence system available to operational staff that enables ready identification of those due to be followed up and also enables scrutiny of any "breaches" to enable lessons to be learnt and practice changed if required to avoid similar situations occurring in future.
The data made available to the National Health Service trust or NHS foundation trust by the Health and Social Care Information Centre with regard to the percentage of admissions to acute wards for which the Crisis Resolution Home Treatment Team acted as a gatekeeper during the reporting period.	Q1 2015/16 Q2 2015/16 Q3 2015/16 Q4 2015/16	http://www.england.nhs.uk/statistics/statistical-work-areas/mental-health-community-teams-activity/	98.9% 99.6% 99.6% 100.0%	96.3% 97.0% 97.4% 98.2%	100.0% 100.0% 100.0% 100.0%	18.3% 48.5% 61.9% 84.3%	Mersey Care considers that this data is as described for the following reasons: it has been submitted in accordance with detailed reporting local guidance informed by national reporting rules and advice taken from regulators over the years. The trust has taken the following actions to improve this percentage, and so the quality of its services, by establishing performance reports within its business intelligence system available to operational staff that enables scrutiny of any "breaches" to enable lessons to be learnt and practice changed if required to avoid similar situations occurring in future.

MANDATED INDICATOR	DATA PERIOD (H&SCIC Indicator Portal accessed 6 May 2016)	DATA SOURCE	MERSEY CARE NHS TRUST	NATIONAL AVERAGE	HIGHEST NATIONAL POSITION	LOWEST NATIONAL POSITION	STATEMENT
The data made available to the National Health Service trust or NHS foundation trust by the Health and Social Care Information Centre with regard to the percentage of staff employed by, or under contract to, the trust during the reporting period who would recommend the trust as a provider of care to their family or friends.	2015	"Dataset: 21. Staff who would recommend the trust to their family or friends (Q21d) http://www.nhsstaffsurveys.com/Page/1019/Latest-Results/Staff-Survey-2015-Detailed-Spreadsheets/"	61%	58%	82%	37%	Mersey Care considers that this data is as described for the following reasons: it has been obtained via the annual national NHS staff survey survey which is subject to ROCR approval. Mersey Care has taken the following actions to improve this score, and so the experience of staff, by having established internal governance processes in all divisions to ensure appropriate review and response to results. This is supported by a programme of activities led by our workforce and organisational effectiveness teams.
The data made available to the National Health Service trust or NHS foundation trust by the Health and Social Care Information Centre with regard to the trust's "Patient experience of community mental health services" indicator score with regard to a patient's experience of contact with a health or social care worker during the reporting period.	2012 2013	"Indicator: 4.7 Patient experience of community mental health services (https://indicators.ic.nhs.uk/webview/)"	88.1 89.3	86.5 85.8	91.8 91.8	82.6 80.9	The trust considers that this data is as described for the following reasons: it has been obtained via the annual national community mental health service user survey which is subject to ROCR approval. The trust has taken the following actions to improve this score, and so the quality of its services, by the development of an internal patient experience survey across both inpatient and community services. The two clinical divisions have established internal governance processes to ensure appropriate review and response to results. This is supported by review by a trust wide quality surveillance meeting on a monthly basis and review on a quarterly basis by the trust's quality assurance committee where specific areas of focus are identified.

MANDATED INDICATOR	DATA PERIOD (H&SCIC Indicator Portal accessed 6 May 2016)	DATA SOURCE	MERSEY CARE NHS TRUST	NATIONAL AVERAGE	HIGHEST NATIONAL POSITION	LOWEST NATIONAL POSITION	STATEMENT
The data made available to the National Health Service trust or NHS foundation trust by the Health and Social Care Information Centre with regard to the number and, where available, rate of patient safety incidents reported within the trust during the reporting period, and the number and percentage of such patient safety incidents that resulted in severe harm or death.	April 2014 to September 2014 October 2014 to March 2015	"Dataset: 5.6 Patient safety incidents reported https://indicators.ic.nhs.uk/webview/"	2,430 incidents; 23.6 per bed day 2,450 incidents per organisation; 24.8 incidents per 1000 bed days	2,393 incidents per organisation; 34 incidents per 1000 bed days 2,428 incidents per organisation; 35 incidents per 1000 bed days	90.4 incidents per 1000 bed days 92.5 incidents per 1000 bed days	7.2 per 1000 bed days 4.8 per 1000 bed days	Mersey Care considers that this data is as described for the following reasons: it has been reported in accordance with the guidance laid down by the NRLS for recording patient safety incidents. The trust has taken the following actions to improve this rate, and so the quality of its services, by developing local action plans to increase reporting levels as well as deploying technology driven reporting platforms to encourage reporting in community settings. Following the implementation of the trust's mortality committee, the trust is to commence incident reporting on all deaths for service users who have had contact with the trust. This will enable a review of all deaths to identify if they should be reported as patient safety incidents and be subject to further investigation. Historically, the requirement has been to report "unexpected deaths" only. Quality surveillance dashboards have been developed to provide live whole trust incident monitoring and alerts.
	April 2014 to September 2014 October 2014 to March 2015	"Dataset: 5.6 Safety incidents involving severe harm or death https://indicators.ic.nhs.uk/webview/"	23 incidents resulting in severe harm or death (0.22 incidents per 1000 bed days) 36 incidents resulting in severe harm or death; 0.36 incidents per 1000 bed daysper 1000 bed days	24 incidents resulting in severe harm or death per organisation; 0.34 incidents per 1000 bed days 26 incidents resulting in severe harm or death per organisation; 0.37 incidents per 1000 bed days	3.03 incidents resulting in severe harm or death per 1000 bed days 2.93 incidents resulting in severe harm or death per 1000 bed days	0.03 incidents resulting in severe harm or death per 1000 bed days 0 incidents resulting in severe harm or death per 1000 bed days	Mersey Care considers that this data is as described for the following reasons: it has been reported in accordance with the guidance laid down by the NRLS for recording patient safety incidents. Following the implementation of the trust's mortality committee, the trust is to commence incident reporting on all deaths for service users who have had contact with the trust. This will enable a review of all deaths to identify if they should be reported as patient safety incidents and be subject to further investigation. Historically, the requirement has been to report "unexpected deaths" only. Mersey Care is taking the following actions to improve its services by using all data available to develop preventative strategies ie. falls reduction strategy, "No Force First" and suicide reduction strategy. The trust has implemented a series of perfect care projects in relation to suicide prevention, physical health care and restraint.

Readmissions

The Quality Account reporting arrangements for 2015/16 includes an indicator on readmissions for all trusts.

"Review of the HSCIC indicator portal for the Quality Account in 2014/15 highlighted the following methodology for reporting. The trust has been advised by the auditors that there is no change to the reporting requirements for the mandated indicators in 2015/16.

To find the percentage of patients aged 0 to 15 readmitted to hospital within 28 days of being discharged, download ""Emergency readmissions to hospital within 28 days of discharge: indirectly standardised percentage, <16 years, annual trend, P"" (Indicator P00913) from the HSCIC Portal and select from the "Indirectly age, sex, method of admission, diagnosis, procedure standardised percentage" column.

To find the percentage of patients aged 16 or over readmitted to hospital within 28 days of being discharged, download ""Emergency readmissions to hospital within 28 days of discharge: indirectly standardised percentage, 16+ years, annual trend, P"" (Indicator P00904) and select from the "Indirectly age, sex, method of admission, diagnosis, procedure standardised percentage" column. "

The latest version of both readmission reports were uploaded in December 2013 and the "Next version due" field states "August 2016".

As Mersey Care NHS Trust does not provide inpatient services for under 16 year olds, data for this indicator for the 0 to 15 year old patient group is not included.

No data relating to Mersey Care NHS Trust is included in the "Emergency readmissions to hospital within 28 days of discharge: indirectly standardised percentage, 16+ years, annual trend, P" (Indicator P00904) report downloaded from HSCIC indicator portal. Data for mental health trusts is incomplete with only a small number of trusts allocated to the mental health cluster reporting any data. Therefore it is deemed inappropriate to include any data for this indicator in the trust's 2014/15 Quality Account.

Dataset: 3.16 Unplanned readmissions to mental health services within 30 days of a mental health inpatient discharge in people aged 17 and over provides readmissions information at CCG level but not provider level. Data comes from MHLDS (previously MHMDS).

3.3 Consultation Process

The Trust consulted in a number of ways in preparing the accounts for publication. In line with its statutory obligations it actively engaged with the Service Users and Carers Assembly, who act as a critical friend to the Trust, Healthwatch groups and other stakeholders to obtain their views about the quality of Mersey Care's services and our priorities for the future.

3.4 External Perspectives on Quality of Service

Feedback will be requested from:

- Sefton Council Overview and Scrutiny Committee (Health and Social Care)
- Knowsley Health Scrutiny Sub Committee
- Liverpool Clinical Commissioning Group
- Healthwatch Liverpool
- Healthwatch Sefton
- Healthwatch Knowsley
- South Sefton Clinical Commissioning Group
- Southport and Formby Clinical Commissioning Group
- Knowsley Clinical Commissioning Group.

Our final report will reflect consideration of the feedback received from external partners.

4. PART FOUR - Signposts and Further Information

The Quality Account

Further information about the content of this Quality Account can be requested from the Director of Nursing:

Ray Walker on 0151 473 2965 or

Ray.Walker@merseycare.nhs.uk

Trust Services

Further detail about the services delivered by the Trust can be found at:

http://www.merseycare.nhs.uk/about-us/who-we-are/

Quality Strategy

A copy of our Quality Strategy can be requested from Helena McCourt, Deputy Director of Nursing.

CQUIN

For further information regarding the Trust's performance against local and national CQUINs please contact

Donna.porter@merseycare.nhs.uk

ImROC (Implementing Recovery through Organisational Change)

Further information about the ImROC project can be found at:

http://www.centreformentalhealth.org.uk/recovery/supporting_recovery.aspx

Health of the National Outcome Scales

Further information about HoNOS can be found at:

http://www.rcpsych.ac.uk/training/honos/whatishonos.aspx

Clinical Audit

A copy of the Trust's Clinical Audit Strategy can be requested from the Trust Secretary, Andy.meadows@merseycare.nhs.uk

Clinical Audit: A simple Guide for NHS Boards and Partners can be found at:

http://www.hqip.org.uk

Essential Standards of Quality and Safety/ Fundamental Standards of Quality and Safety

CQC Guidance outlining the Essential Standards of Quality and Safety can be found at: http://www.cqc.org.uk/search/site/standards?sort=default&distance=15&mode=html&f[0]=bundle%3Adocument

Information Governance

Details of the Information Governance Toolkit can be found at:

https://nww.igt.connectingforhealth.nhs.uk/about.aspx?tk=407133719719095&cb=08%3a55%3a37&clnav=YES&lnv=5

Performance Reports

Copies of Trust Board performance reports can be requested from the Trust Secretary, Andy.meadows@merseycare.nhs.uk or accessed via:

http://www.merseycare.nhs.uk/about-us/our-board/

5. GLOSSARY

Advancing Quality

Advancing Quality (AQ) is an innovative NHS quality programme focused on enhancing standards in patient care. It aims to give patients a better experience of health services, and ultimately, a better quality of life.

AQuA

AQuA is a membership health improvement organisation. Its mission is to stimulate innovation, spread best practice and support local improvement in health and in the quality and productivity of health services.

Care Quality Commission (CQC)

The Care Quality Commission (CQC) is the independent regulator of all health and adult social care in England. Their aim is to make sure better care is provided for everyone, whether that's in hospital, in care homes, in people's own homes, or elsewhere.

Clinical Audit

The review of clinical performance against agreed standards.

Commissioning for Quality and Innovation (CQUIN)

The CQUIN payment framework enables commissioners to reward excellence, by linking a proportion of English healthcare providers' income to the achievement of local quality improvement goals. The framework aims to embed quality within the commissioner-provider discussions and to create a culture of continuous quality improvement, with stretching goals agreed on contracts on an annual basis.

Cost Improvement Plans

A plan which delivers the same or improved level of clinical or non-clinical service for a reduced cost.

Foundation Trust

NHS foundation trusts are not-for-profit, public benefit corporations. They are part of the NHS and provide over half of all NHS hospital and mental health services. NHS foundation trusts were created to devolve decision making from central government to local organisations and communities. They provide and develop healthcare according to core NHS principles - free care, based on need and not ability to pay.

NHS foundation trusts can be more responsive to the needs and wishes of their local communities – anyone who lives in the area, works for a foundation trust, or has been a patient or service user there, can become a member of the Trust. These members elect the Board of Governors.

Health of the Nation Outcome Scales

These are 12 simple scales on which service users with severe mental illness are rated by clinical staff. The idea is that these ratings are stored, and then repeated - say after a course of treatment or some other intervention and then compared. If the ratings show a difference, then that might mean that the service user's health or social status has changed. They are therefore designed for repeated use, as their name implies, as clinical outcomes measures

Healthcare Quality Improvement Partnership (HQIP)

HQIP was established to promote quality in health services, and in particular to increase the impact that clinical audit has in England and Wales. It is led by a consortium of the Academy of Medical Royal Colleges, the Royal College of Nursing and National Voices.

IMROC (Implementing Recovery through Organisational Change)

This project aims to test a methodology for organisational change in six demonstration sites and help us improve the quality of our services to support people more effectively to lead meaningful and productive lives. The project provides an opportunity to demonstrate an innovative approach to quality improvement and cultural change across organisations. The project will assist us to undertake self-assessments against ten indicators, plan changes and report our outcomes over two years.

Information Governance Assessment

The purpose of the Information Governance Assessment is to enable organisations to measure their compliance against the law and central guidance and to see whether information is handled correctly and protected from unauthorised access, loss, damage and destruction.

Where partial or non-compliance is revealed, organisations must take appropriate measures, (eg. assign responsibility, put in place policies, procedures, processes and guidance for staff), with the aim of making cultural changes and raising information governance standards through year on year improvements.

The ultimate aim is to demonstrate that the organisation can be trusted to maintain the confidentiality and security of personal information. This in-turn increases public confidence that the NHS and its partners can be trusted with personal data.

The Information Governance Toolkit is a performance tool produced by the Department of Health. It draws together the legal rules and central guidance set out above and presents them in one place as a set of information governance requirements. We are then required to carry out self-assessments of our compliance against the IG requirements.

Quality Assurance Committee

The Quality Assurance Committee is a committee of the Trust Board which provides assurance to the Trust Board that quality in the Trust is of the highest standard. In discharging its responsibilities, the committee will assure itself of Trustwide approaches to:

- planning and driving continuous improvement
- identifying, sharing and ensuring delivery of best-practice
- ensuring that required standards and quality goals are achieved
- investigating and taking action on substandard performance
- identifying risks to quality of care.

National Confidential Enquiry

The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCI/NCISH) is a research project funded largely by the National Patient Safety Agency (NPSA). The project examines all incidences of suicide and homicide by people in contact with mental health services in the UK as well as cases of sudden death in the psychiatric inpatient population. The aim of the project is to improve mental health services and to help reduce the risk of these tragedies happening in the future.

National Patient Survey (Annual Service Users Survey)

A survey co-ordinated by the CQC that collects feedback on the experiences of people using Mersey Care NHS Foundation Trust mental health services. The survey can be community or inpatient focused. The results are used in a range of ways, including the assessment of Trust performance as well as in regulatory activities.

Patient Experience Tracker

A system that provides a simple and robust way of rapidly and frequently capturing and analysing results from a large number of service users without the need for paper based questionnaires and analytical resources. It provides a benchmark for practice and development of improvement strategies. The system consists of small, portable, mobile data capture units which are considered easy to use for service users and staff which capture data for analysis and report generation.

Payment by Results

The aim of Payment by Results (PbR) is to provide a transparent, rules-based system for paying trusts. It will reward efficiency, support patient choice and diversity and encourage activity for sustainable waiting time reductions. Payment will be linked to activity and adjusted for case mix. Importantly, this system will ensure a fair and consistent basis for hospital funding rather than being reliant principally on historic budgets and the negotiating skills of individual managers.

PLACE (Patient Led Assessment of the Care Environment)

An annual assessment of inpatient healthcare sites in England that have more than ten beds. It is a benchmarking tool to ensure improvements are made in the non-clinical aspects of patient care including environment, food, privacy and dignity.

PROMs (Patient Reported Outcome Measures)

Patient choice over treatment and care is a central feature of the NHS. Patients' experience of treatment and care is a major indicator of quality and there has been a huge expansion in the development and application of questionnaires, interview schedules and rating scales that measure states of health and illness from the patient's perspective. Patient reported outcome measures (PROMs) provide a means of gaining an insight into the way patients perceive their health and the impact that treatments or adjustments to lifestyle have on their quality of life. These instruments can be completed by a patient or individual about themselves, or by others on their behalf.

QIPP (Quality Innovation Productivity and Prevention Programme)

QIPP is a large scale transformational programme for the NHS, involving all NHS staff, clinicians, patients and the voluntary sector which aims to improve the quality of care the NHS delivers whilst making up to £20 billion of efficiency savings by 2014/15, which will be reinvested in frontline care.

There are a number of national work streams designed to support the NHS to achieve the quality and productivity challenge. Some deal broadly with the commissioning of care, eg. covering long term conditions or ensuring patients get the right care at the right time. Others deal with how we run, staff and supply our organisations, for example supporting NHS organisations to improve staff productivity, non-clinical procurement, the use and procurement of medicines, and workforce.

Perfect Care and Wellbeing Sub-Committee

This is a sub committee of the Quality Assurance Committee that provides assurance (via the Quality Assurance Committee to the Trust Board) that the Trust fully complies with the requirements of the DoH's Research Governance Framework for Health and Social Care by establishing and maintaining standards.

Safeguarding

The Government has defined the term 'safeguarding children' as: The process of protecting children from abuse or neglect, preventing impairment of their health and development, and ensuring they are growing up in circumstances consistent with the provision of safe and effective care that enables children to have optimum life chances and enter adulthood successfully.

Safeguarding adults - the systems, processes and practices in place to: ensure adequate awareness of issues about abuse of adults; ensure priority is given to safeguarding people from abuse; help prevent people experiencing abuse in the first place and recognising and acting appropriately when there are allegations of abuse and supporting the person who has experienced abuse.

6. APPENDICES

6.1 Services Delivered by the Trust:

CLINICAL DIVISION	SERVICE	SPECIALITY
Secure Division	High Secure Services (Mental Health and Personality Disorder Inpatients)	High secure
	Medium Secure Services (Inpatient and Community)	Medium secure
	Medium Secure Step Down Service (Inpatient)	Medium secure
	Personality Disorder Service (Community)	Medium secure
	Low Secure Unit (LSU) (Inpatient and Outreach)	Low secure
	HMP Garth Personality Disorder	Psychological services
	HMP Liverpool Mental Health Inreach Team	Adult mental health
	HMP Liverpool Primary Care Psychology Inreach	Psychological services
Local Division	Drugs Service (Inpatient and Community)	Addictions
	HMP Liverpool Drug Dependency Unit (DDU)	Substance misuse
	Alcohol Service (Inpatient and Community)	Substance misuse
	Liverpool Community Alcohol Service (LCAS)	
	Adult Mental Health Services (Inpatient and Community)	Adult mental health
	Liaison Services	Adult and older people's mental health
	Crisis Resolution and Home Treatment (CRHT)	Adult mental health
	Assertive Outreach Team (AOT)	Adult mental health
	Early Intervention in Psychosis (EIP)	Adult mental health
	ADHD	Adult mental health
	Family Support Workers	Adult mental health
	Care Home Inreach Team	Older peoples
	Dementia Care Navigator	Older peoples
	Network Employment	Adult mental health
	Triage Car	Adult mental health
	Psychiatric Intensive Care Unit (PICU)	Adult mental health
	Older Peoples Services (Inpatient and Community)	Older peoples
	Continuing Care	Older peoples
	Criminal Justice Liaison Team	Adult mental health
	Psychotherapy and Consultation Service	Psychological services
	Eating Disorders	Psychological services

CLINICAL DIVISION	SERVICE	SPECIALITY
Local Division	Personality Disorder Service	Psychological service
	Rotunda	Adult mental health
	Health and Wellbeing Service	Adult mental health
	Learning Disabilities (Inpatient and Community)	Learning disabilities
	Rehabilitation Service (Inpatient and Community)	Adult specialist
	Brain Injuries service (Inpatient and Community)	Adult specialist
	Learning Disabilities Postural Physio	Learning disabilities
	Learning Disabilities Care Facilitators	Learning disabilities
	Aspergers Team	Learning disabilities
	Community Residential Service (CRS)	Learning disabilities
	Dispersed Housing Scheme (DISH)	Adult specialist
Corporate Services	Staff Support	Adult mental health
	Dietician Services	All specialities

6.2 Feedback from Sefton Council Overview and Scrutiny Committee (Health and Social Care)

From: Debbie Campbell [mailto:Debbie.Campbell@sefton.gov.uk]

Sent: 23 May 2016 12:01

To: McCourt, Helena

Cc: Walker, Ray

Subject: Draft Quality Account

Dear Helena,

I write to advise you that Members of Sefton Council's Overview and Scrutiny Committee (Adult Social Care and Health) met informally last Friday, 20th May 2016, to consider the various draft Quality Accounts that had been received.

Members had no particular comments or concerns to raise in relation to Mersey Care's Quality Account and will not be submitting a formal commentary on your Trust's Quality Account this year.

However, Members were very pleased to have the opportunity to peruse the Quality Account and look forward to receiving your draft Quality Account next year.

Kind Regards,

Debbie

Debbie Campbell
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Democratic Services
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E-Mail: debbie.campbell@sefton.gov.uk
Fax: 0151 934 2034

6.3 Feedback from Knowsley Health Scrutiny Sub Committee

None received.

6.4 Feedback from South Sefton Clinical Commissioning Group, Knowsley Clinical Commissioning Group and Liverpool Clinical Commissioning Group

NHS South Sefton Clinical Commissioning Group | NHS Knowsley Clinical Commissioning Group | NHS Liverpool Clinical Commissioning Group

NHS Liverpool Clinical Commissioning Group – Quality Account Statements – Mersey Care NHS Trust

South Sefton, Southport & Formby, Liverpool and Knowsley CCGs welcome the opportunity to jointly comment on the Mersey Care NHS Trust Draft Quality Account for 2015/16. We have worked closely with the Trust throughout 2015/16 to gain assurances that the services delivered were safe, effective and personalised to service users. The CCGs share the fundamental aims of the Trust and supports their strategy to deliver high quality, harm free care. The CCGs would also like to acknowledge the Trust on achieving an overall rating of Good at their recent CQC Inspection. The Account reflects good progress on most indicators.

This Account indicates the Trust's commitment to improving the quality of the services it provides with commissioners supporting the key priorities for the improvement of quality during 2015/16.

Priority 1: No Force First

Priority 2: Zero Suicide

Priority 3: Improvements in Physical Health

Priority 4: Falls

Priority 5: Self Harm

Priority 6: Recovery Focussed Outcome Measures

This is a comprehensive report that clearly demonstrates progress within the Trust. It identifies where the organisation has done well, where further improvement is required and what actions are needed to achieve these goals, in line with their Quality Strategy.

We have reviewed the information provided within the Quality Account and checked the accuracy of data within the Account against the latest nationally published data where possible.

Through this Quality Account and on-going quality assurance process the Trust clearly demonstrates their commitment to improving the quality of care and services delivered. Mersey Care NHS Trust continues to develop innovative ways to capture

the experience of patients and their families in order to drive improvements in the quality of care delivered.

The Trust places significant emphasis on its safety agenda, with an open and transparent culture, and this is reflected throughout the Account with work continuing on the reporting of incidents and the embedding of learning across the organisation.

Of particular note is the work the Trust has undertaken to improve outcomes on the following work streams:

- CQC highlighted No force first initiative in their recent inspection report for high levels of staff engagement and understanding was noted by the inspectors.
- The first force initiative won the changing culture category at the National Patient Safety awards in June 2015.
- Continuing progress against the zero suicide strategy.
- Working with clinical stakeholders, service users and carers to agree specific outcome measurement tools and metrics.

The CCGs look forward to working with the Trust to ensure that there will be no inappropriate reduction in the availability of services as a result of the cost improvement programme (CIPs) and continuing work to ensure that the assessment of patients is timely so as to make a positive difference to the their lives and their families and carers.

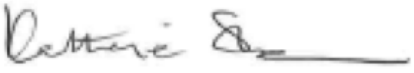
Commissioners are aspiring through strategic objectives and 5 year plans to develop an NHS that delivers great outcomes, now and for future generations. This means reflecting the government's objectives for the NHS set out in their mandate to us, adding our own stretching ambitions for improving health and delivering better services to go even further to tailor care to the local health economy. Providing high quality care and achieving excellent outcomes for our patients is the central focus of our work and is paramount to our success.

It is felt that the priorities for improvement identified for the coming year are both challenging and reflective of the current issues across the health economy. We therefore commend the Trust in taking account of new opportunities to further improve the delivery of excellent, compassionate and safe care for every patient, every time.

Liverpool CCG

Signed Date: 3/6/2016

Katherine Sheerin, Chief Officer



South Sefton CCG

Signed

Date: 23rd May 2016

Fiona Clark, Chief Officer

Knowsley CCG

Signed

Date: 1st June 2016

Dianne Johnson, Accountable Officer

6.5 Feedback from Healthwatch Liverpool

Quality Account Commentary 2015/16

Healthwatch Liverpool welcomes the opportunity to provide a commentary on this Quality Account. As part of its ongoing engagement with Mersey Care NHS Foundation Trust, Healthwatch Liverpool was consulted on the Quality Account priorities chosen by the Trust for the previous year and for 2016/17 alongside people using Trust services and other stakeholders. This commentary only relates to the issues covered in a draft Quality Account document provided to Healthwatch Liverpool prior to its publication.

Mersey Care's progress concerning its Quality Account priorities from 2015-16 is clearly outlined in the document, as are the priorities for 2016-17.

Healthwatch Liverpool welcomes the progress on Mersey Care's 'No Force First' initiative, which has led to a reduction in restraint being used overall, although with variations between wards and throughout the year. We welcome that this will continue to be a priority to firmly embed this approach, highlighting and spreading best practice.

Healthwatch Liverpool is pleased that the 'Towards Zero Suicide' initiative will remain a priority, and will include a focus on safe discharge pathways for inpatients as well as focusing on reducing levels of self-harm.

The Quality Account document clearly sets out the national and local Commissioning for Quality and Innovation (CQUIN) goals for 2015-16. Those focusing on improving the physical health of people who are under the care of Mersey Care were mostly not achieved, although improvements were made. We find the inclusion of the Clinical Audit report at the end of the Quality Account particularly useful, as this gives examples of some of the actions to improve the monitoring of physical health when people first are admitted to wards in the Trust. Physical health remains as a priority for 2016-17, and Healthwatch Liverpool looks forward to hearing about further progress in the area in the coming year.

We also are pleased to note that a Did Not Attend (DNA) audit was carried out, looking at the reasons why outpatient appointments are missed, as ensuring best use of appointments has benefits for the care and wellbeing of patients and for efficient use of Trust resources.

Healthwatch is pleased that the Care Quality Commission (CQC)'s in-depth inspection at the Trust during the year confirmed a positive overall picture and that the Trust has been responding to some issues that were raised as a result of that inspection.

Healthwatch Liverpool particularly welcomes that the Trust is recruiting more staff to deliver psychological therapies. This will help address patient concerns that Healthwatch Liverpool received and fed back to the Trust during the year about waiting times for people who had been referred to the 'Talk Liverpool' IAPT service and with the difficulties around access to psychological approaches for secondary care patients.

Healthwatch Liverpool will continue to gather and monitor patient experience feedback about local health and care services including Mersey Care, and looks forward to continuing engagement with the Trust about the quality and equality of its services during 2016/17.

6.6 Feedback from Healthwatch Sefton

None received.

6.7 Feedback from Healthwatch Knowsley

None received.

6.8 Feedback from Southport and Formby Clinical Commissioning Group

None received.

6.9 Trust Clinic Audit Report 2015/16

	NAME OF AUDIT	OUTCOMES	ACTIONS/IMPROVEMENTS
1.	**MUST Audit** Various MUST audits have been carried out on a quarterly basis throughout 2015/16 to measure the rate of screenings for malnutrition on admission, the use of the MUST tool, use of care plans and referral rates.	Over a twelve month period an increase of 5.3% from 91.08% to 96.38% was seen for adult inpatients screened for malnutrition on admission, using the MUST tool. 100% of patients had an appropriate care plan in place; however a decrease in compliance at 96.8% was reported in quarter 2, this reached 100% at quarter 4. High risk patient referrals to the Dietetics Team increased from 45% to 47.62% from quarter 2 to quarter 4.	Compliance of national and Trust policy regarding MUST nutritional screening and planning is discussed as a recurring agenda item at the Trust Physical Health Forum and Hospital Food Standards Steering Group – audit results discussed. Dieticians have been working with the BiT Performance Team to design a MUST audit report to enable access to all nutrition and referral information in a timely manner to identify gaps and improve referral rates and access to intervention.
2.	**Records Audit** This audit considered the requirements specified within Corporate Health Records Policy and Procedure (IT06) and the Information Governance Toolkit Standard 404. The aim of the audit was to monitor the standard of record keeping of clinical health records by all specialties.	Equality and diversity details show an overall increase in compliance from 76% to 83%. There is a significant improvement in the entry being keyed in on shift from 68% to 97% of cases. The entry is written in plain English including the correct use of grammar and spelling, however shows a decrease in compliance from 75% to 67%. Next steps/plan of care being visible showed a significant decrease in compliance from 66% to 53%.	The Trusts Health Records Sub Committee will increase awareness of good record keeping standards across both divisions by promoting "A Guide to Good Record Keeping" booklet available electronically and in manual format. An audit tool will be developed that will encompass a more detailed view of health records. This will be done in conjunction with members of the Data Quality Steering Group/Data Quality Manager. The process for the Trustwide Record Keeping Audit will be reviewed.

	NAME OF AUDIT	OUTCOMES	ACTIONS/IMPROVEMENTS
3.	**Falls Audit** Using a sample of patients from the older adult wards we monitored the assessment and actions carried out for service users who have either suffered a fall or are at high risk of falling within the Local Division at Mersey Care compared to the practice recommended by NICE within the Clinical Guidelines; CG161, Falls Assessment and Prevention of Falls in Older Adults	82% of service users were assessed using the Falls Risk Assessment Tool (FRAT) within 24 hours of admission or as soon as is reasonably practical. 100% of service users who were identified as high risk of falling had a multifactorial falls assessment and management plan in place. 41% of service users did not have a falls symbol displayed on information board or medicines chart. 100% of all service users on older adult wards were reviewed at weekly frailty awareness meetings and the information was recorded in the Frailty Review Documentation on ePEX. 94% of service users were referred when necessary to allied health professionals as required. 32% of service users were not promptly examined by a doctor following a fall.	Re-issue falls symbols and order instructions to clinical areas. Matrons to reiterate the need to complete post fall huddles, completion will be monitored at frailty reviews. Amend general observations form to include environmental checks. Will be raised at the Trustwide Falls Group.
4.	**MEWS (Modified Early Warning Score) Audit** The aim was to audit the compliance of MEWS across 12 eligible inpatient wards across the Local Division. A random sample of two patients per ward was selected; one long stay (over two weeks) and one short stay (less than seven days).	**New Admissions** 33% of service users had all observations completed at the prescribed frequency. 66% of service users had their overall MEWS score calculated correctly. Escalation to medical review occurred in 67% of cases indicated. **Long Stay Admissions** 75% of service users had all observations completed at the prescribed frequency. 58% of service users had their overall MEWS score calculated correctly. Escalation to medical review occurred in 33% of cases indicated.	Nursing staff to be made aware of their accountability in reviewing MEWS scores on each shift to ensure that they are calculated correctly and concerns have been escalated appropriately. Inpatient wards to request further training as and when required. MEWS audit to become integral to the Ward Assurance Framework which all wards will complete on a monthly basis to evidence compliance
5.	**Do Not Attempt Cardiopulmonary Resuscitation (DNACPR)** To audit the use of DNACPR orders in (Local and Secure Divisions) according to standards set out in Unified DNACPR Adult Policy, North West Policy.	There were incomplete DNR forms in care records. The information in the forms was too brief and uninformative. It was unclear who the DNR decision had been communicated with within the forms.	All clinical staff to be aware of the Unified DNACPR Adult Policy and the Trust's directives regarding DNACPR. Medical staff to be made aware of their accountability in ensuring that the order is valid and provide robust documentation of the required assessments and evidence.

	NAME OF AUDIT	OUTCOMES	ACTIONS/IMPROVEMENTS
5. cont			Ensure a full set of the Trust's directives regarding governance of the DNACPR orders are available and signposted in the relevant policies. Ensure that no inappropriate treatment takes place on a patient in the event of an incomplete, editable and unlocked form.
6.	**Care Programme Approach (CPA), Risk Assessment and Care Plan** The aim of the audit was to monitor standards of risk assessment and care planning within Mersey Care's Policy and Procedure for the Care Programme Approach. The audit focused on all community teams within the Local Division.	Overall team performance across all four individual standards varied. 96% of service users audited were assessed as having had a completed risk assessment. Whilst 83% of service users audited had an appropriate care plan to reflect assessed risk, the variance across teams ranged from 62.5% to 100%. There was a contingency/crisis plan in place in 67% of cases where risk was identified. 75% of service users risk assessment had been reviewed within a twelve month period.	To explore whether it is possible to incorporate an alert for updating/ completing CPA documentation within the new electronic clinical information system. Findings to be shared with teams to enable targeted improvement as required. This audit to be added to the junior doctors audit programme 2016/17 and to be repeated in April 2017.
7.	**DNA Audit – Community Outpatient Appointment and New Primary Care Referrals to Mental Health Services** The aim of the Did Not Attend (DNA) audit was to identify trends to DNA patterns and identify solutions to reduce the overall rate and to ensure outpatient appointment clinics are efficiently run, responsive and improve the service user experience.	**New Primary Care Referrals** All new GP referrals were entered on to the clinical information system within one working day of receipt. The demographics of the service user were adequate on the referral letter; however, some contact numbers were not recorded on the referral forms or not up to date which made it difficult for assessment staff to arrange appointments with individuals or follow up on DNAs. The quality of information provided by the GP/referrers varied across the Local Division and 90% of referrals had no documented evidence that the individual had consented to a referral to mental health services. Discussions with assessment staff highlighted that some individuals were surprised that they have been referred to mental health services when contacted by the team to discuss the pending appointment.	Development of a single point of access service specification to include review of the referral process. Review of the current model and development of new standards in managing/reducing DNA. Review of the Trust DNA Policy SD08 and align this with the Community Re-design Group. Re-audit to be added to the trainee doctors audit programme 2016/17.

	NAME OF AUDIT	OUTCOMES	ACTIONS/IMPROVEMENTS
7. cont		All referrals had a presenting problem recorded; however, this varied in the quality of detail provided by the GP/referrer across the Local Division. Risk information – 60% of referrals had no risks identified and 48% of referrals did not have the risk assessment completed; therefore, it would be difficult to prioritise appointments based on limited risk information. 64% of the referral letters did not provide evidence of any previous primary care interventions as per NICE guidelines indicate, prior to referral to tier 4 services which may contribute to the high DNA rate. The quality of information recorded in the clinical records following the triage discussion varied across the Local Division and the triage rationale was not clear regarding presentation or allocation for appointments (urgent or routine). There was only 10% of service users contacted by the assessment team to remind them of the appointment. 83% of service users were notified of an appointment by letter; however, the time scales of these being sent out varied across all teams with some letters only being sent out a week before the appointment. There were only 52.5% of service users contacted by the assessment services on the day of the DNA to ascertain reason of non attendance or update on mental state. Although, 74% of the DNA was discussed in the next triage meeting, the quality of information recorded varied across the three sites and no clear rationale to outcome of the DNA clinical discussion was recorded to support further OPA or discharge planning. 79% of referrers were notified of non attendance by letter; however, there is no evidence that the service user was written to following DNA.	Development of a single point of access service specification to include review of the referral process. Review of the current OPA model and development of new standards in managing/reducing DNA. Review of the Trust DNA Policy SD08 and align this with the Community Re-design Group. Re-audit to be added to the trainee doctors audit programme 2016/17.

	NAME OF AUDIT	OUTCOMES	ACTIONS/IMPROVEMENTS
7. cont		**Community DNA OPAs** Only 50% of service users were sent a reminder letter one week before their appointment was due; however, some service users were written to months in advance; therefore, this may not support OPA attendance due to timescales. 79% of service users were contacted by telephone one to two days before their appointment. 51% of service users who DNA was clustered 1 to 5. 82% of service users were on non CPA (medic only). 100% of CPA service users who DNA their appointment were followed up within one week and the outcome was recorded in the clinical record. 70% of non CPA DNA had some form of review by the clinician assigned to the OPA; however, the quality of the review/decision was difficult to ascertain as the recording varied across the three sites. 62% of DNA had a contact recording the outcome of DNA or follow up plan. 25% of GPs were notified by letter within the five working days deadline (SD08 policy) following the service user's DNA. 50% of service users who DNA their last appointment had a previous DNA within the last two years; furthermore, 46% have DNA on one to six occasions over this time period. 19% of GPs were notified by letter within the five working days deadline (SD08 policy).	

	NAME OF AUDIT	OUTCOMES	ACTIONS/IMPROVEMENTS
8.	**Triangle of Care Audit** The aim of the audit was to identify the key elements from the Triangle of Care Assessment Tool that can act as the benchmark against which to measure compliance. This will enable the Local Division to evaluate practice and to ensure safe working practices that involve the carer in the service user journey. The audit sample covered all community teams and inpatient wards in the Local Services Division.	81% of carers were identified with the service user during the assessment process. 55% of carers were regularly updated and involved in the service users' care plans and treatment plans and were compliant with the standard. 40% of carers were encouraged to share information regarding the service user to inform assessment and treatment. 0% of carers were offered an early formal appointment to hear story, history and address any carer concerns. 22% of carers were involved in the discharge planning process. 5% of carers had treatment and strategies for medication explained to them. Consent was sought from 11% of service users when sharing consent with carers. Agreement was reached with 3% of service users about the level of information that can be shared with their carer. Although overall there has been a low level of compliance with the standards, this could be due to poor recording. The current clinical information system does not have a dedicated area where carer contact can be recorded.	Explore the possibility of having a dedicated area on the clinical information system for staff to record carer contact and involvement. The Division, at the end of February 2016, had achieved 57.9% compliance with Carer Awareness training. The Division needs to achieve full compliance. Ensure all teams complete quarterly Triangle of Care assessment and involve carers in this process. Re-audit standards in 12 months time.
9.	**Discharged Service User Experience in Adult Mental Health in Relation to NICE Clinical Guidance Audit** To examine the preparation of service users by multi disciplinary teams for discharge back to the community. To identify delays, blocks and highlight what helps in ensuring a service user progresses through their inpatient journey and what impedes discharges.	98% of cases indicated that any changes to a service users care, particularly discharge, was discussed and planned carefully beforehand with the service user and was structured and phased. 67% of the service users care plans supported effective collaboration with social care and other care providers during endings and transitions, and included details of how to access services in time of crisis. 30% of cases evidenced both arrangements with involved family or carers was discussed before discharge or transfer of care and they also discussed service user's	MDT reviews to include service user's readiness for discharge in planning meetings. Named inpatient nurse should ensure that if the patient has no family or carers identified then this is clearly documented in the clinical record and an alternate source of support should be offered. Review discharge planning process to ensure that the service users are fully prepared for discharge and have access to the correct contact numbers for the team or out of hours.

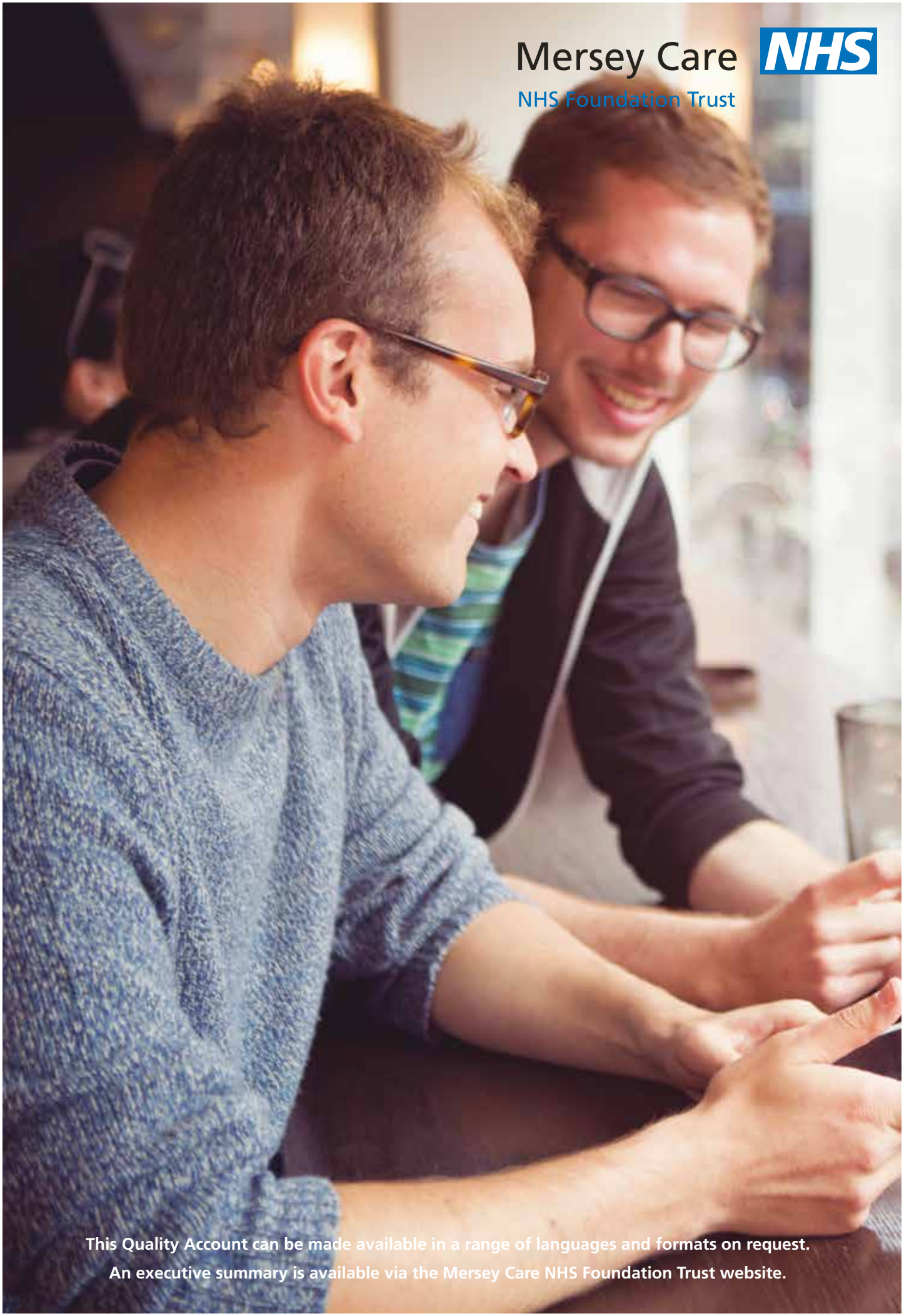
	NAME OF AUDIT	OUTCOMES	ACTIONS/IMPROVEMENTS
9. cont		financial and home situation; including housing, before they were discharged from inpatient care. 40% of cases partially met this standard. 80% of service users were given clear information about all possible support options available to them post discharge or transfer of care. 100% of service users were given at least 48 hours notice of the date of their discharge from a ward when plans for discharge are initiated by the service.	Ensure staff are continually adhering to Trust Discharge Policy by carrying out six monthly re-audits and establishing any areas of concern or training needs.
10.	**Cardiovascular Disease; Management of Stable Angina, Chronic Obstructive Pulmonary Disease, and Hypertension Audit** To monitor the physical health interventions offered and provided to patients within the Secure Division at Mersey Care compared to the practice recommended by NICE within the Clinical Guidelines; CG126, Management of Stable Angina, CG101, Chronic Obstructive Pulmonary Disease and CG127, Hypertension.	**Management of Stable Angina** 100% of service users with stable angina were offered a short acting nitrate for preventing and treating episodes of angina. 100% of service users with stable angina were considered for the prescription of Aspirin 75mg daily by healthcare professionals. 100% of service users with stable angina and Diabetes were prescribed an Angiotensin-Converting Enzyme (ACE) Inhibitor. **Chronic Obstructive Pulmonary Disease** 100% of service users who have a diagnosis of COPD had an FEV1 recorded; their smoking status reviewed and were offered a flu vaccine and/or Pneumovax. 100% of service users with a diagnosis of COPD were prescribed oral or inhaled steroids. **Hypertension** 94% of service users, who had a clinic blood pressure of 140/90Hg or higher, had regular hypertension reviews, were offered lifestyle interventions and were commenced on anti-hypertensive therapy. 100% of service users who had a diagnosis of diabetes or chronic kidney disease and their clinic blood pressure was 130/80Hg or higher, had regular hypertension reviews, were offered lifestyle interventions and commenced anti-hypertensive therapy.	To explore whether it is possible to incorporate an alert for updating/ completing CPA documentation within the new electronic clinical information system. Findings to be shared with teams to enable targeted improvement as required. This audit to be added to the junior doctors audit programme 2016/17 and to be repeated in April 2017.

	NAME OF AUDIT	OUTCOMES	ACTIONS/IMPROVEMENTS
11.	**Diabetes** To monitor the physical health interventions offered and provided to patients within Mersey Care Secure Division compared to the practice recommended by NICE within the listed Clinical Guidance CG66, Diabetes Type II.	100% of service users with type II diabetes had their HbA1c levels measured at the correct monthly intervals to control their blood glucose. 100% of service users with a diagnosis of type II diabetes who were not previously diagnosed with hypertension or renal disease had their blood pressure measured at least annually. 100% of service users whose blood pressure reached and consistently remained at the target were monitored every four to six months and checked for possible adverse effects of anti-hypertensive therapy. 100% of service users had a full lipid profile, including high density lipoprotein (HDL) cholesterol and triglyceride estimations when they were assessed for cardiovascular risk after diagnosis, annually and before starting lipid modifying therapy. No patients audited were offered structured education around the time of their diagnosis of type II diabetes as education is offered on an individual basis when required.	We have contacted Xpert and Desmond but our patient numbers are too small to be accredited. We will continue with the individualised packages and look at the National Diabetes Prevention Programme. All aspects of the audit will continue to be measured in the new Wellman's Monthly Checks audit that will be completed throughout 2016/17 to ensure the high standard of care continues.
12.	**Nutrition Support in Adults and the Management of Obesity** The Nutrition Support in Adults Audit will focus identification of nutritional screening on admission, care plan, review of intervention, documentation, and enteral feeding. The Management of Obesity Audit will focus identification of nutritional screening on admission, care plan, review of intervention, pharmacological treatments, bariatric surgery and documentation.	**Nutrition Support in Adults** 100% of newly admitted service users were nutritionally screened using Mersey Care's adapted MUST Screening Tool within 72 hours of admission. 100% of service users with a MUST score of medium risk 1 or high risk 2+ had an individualised MUST nutritional care plan produced and documented in their patient records and were referred to a dietician. 100% non compliance was seen where service users with a MUST score of medium risk 1 and high risk 2+ should have their MUST score reviewed on a weekly basis.	72 hour admission MUST added to the admission checklist. Reasons for breach of the 72 hour admission nutrition screening to be documented in clinical notes. To review MUST screening process for long standing stable nutrition, support patients and amend the screening tool accordingly. Secure matrons to ensure that all clinical staff attend the Trust MUST training sessions. Screening tools and referral process to be displayed in all ward clinic rooms and health centre. Consider holding a regular physical health MDT to discuss other treatment options (pharmacological, bariatric and gym) in line with NICE Guidance.

	NAME OF AUDIT	OUTCOMES	ACTIONS/IMPROVEMENTS
12. cont		**Management of Obesity** 50% of newly admitted service users were not nutritionally screened using Mersey Care's adapted MUST Screening Tool within 72 hours of admission. 71% of service users with a MUST score of high risk obesity 0 had an individualised MUST nutritional care plan produced and documented in their patient records and the patient referred to a dietician. 78% of service users who met the criteria for Orlistat did not have the use of the drug recorded in the patient weight management care plan and if the drug was deemed inappropriate. Justification for non prescription was not documented in the patient records.	Wards to email dieticians with the MUST details and reasons for breach etc. This will then be documented in patient's clinical notes by the dieticians. Matrons to ensure that the clinical staff are booked onto the Trust MUST training. Dieticians to add the referral guidelines to MUST training package. Include direction in the Weight Management Pathway to follow the guidance in the BNF for the prescription of Orlistat. Review of Mersey Care HSS Guidelines for prescription of Orlistat.

Mersey Care

NHS Foundation Trust



This Quality Account can be made available in a range of languages and formats on request.

An executive summary is available via the Mersey Care NHS Foundation Trust website.