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Independent Practitioner's Limited Assurance Report to the Council of Governors of Mersey Care NHS Foundation Trust on the Quality Report

We have been engaged by the Council of Governors of Mersey Care NHS Foundation Trust to perform an independent limited assurance engagement in respect of Mersey Care NHS Foundation Trust's Quality Report for the year ended 31 March 2019 (the "Quality Report") and certain performance indicators contained therein against the criteria set out in the 'NHS Foundation Trust Annual Reporting Manual 2018/19' and additional supporting guidance in the 'Detailed requirements for quality reports 2018/19' (the 'Criteria').

Scope and subject matter

The indicators for the year ended 31 March 2019 subject to the limited assurance engagement consist of the national priority indicators as mandated by NHS Improvement:

- Early intervention in psychosis (EIP): people experiencing a first episode of psychosis treated with a NICE-approved care package within two weeks of referral;
- Inappropriate out-of-area placements for adult mental health services.

We refer to these national priority indicators collectively as "the indicators".

Respective responsibilities of the directors and Practitioner

The Directors are responsible for the content and the preparation of the Quality Report in accordance with the criteria set out in the 'NHS Foundation Trust Annual Reporting Manual 2018/19' and supporting guidance issued by NHS Improvement.

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that:

- the Quality Report is not prepared in all material respects in line with the Criteria set out in the 'NHS foundation trust annual reporting manual 2018/19' and supporting guidance;
- the Quality Report is not consistent in all material respects with the sources specified in NHS Improvement's "Detailed requirements for external assurance for quality reports 2018/19"; and
- the indicators in the Quality Report identified as having been the subject of limited assurance in the Quality Report are not reasonably stated in all material respects in accordance with the 'NHS Foundation Trust Annual Reporting Manual 2018/19' and supporting guidance and the six dimensions of data quality set out in the "Detailed requirements for external assurance for quality reports 2018/19".

We read the Quality Report and consider whether it addresses the content requirements of the 'NHS Foundation Trust Annual Reporting Manual 2018/19' and supporting guidance, and consider the implications for our report if we become aware of any material omissions.

We read the other information contained in the Quality Report and consider whether it is materially inconsistent with:

- Board minutes for the period 1 April 2018 to 29 May 2019;
- papers relating to quality reported to the Board over the period 1 April 2018 to 29 May 2019;
- feedback from commissioners dated 20 May 2019;
- feedback from governors on 25 April 2019;
- feedback from local Healthwatch organisations dated 23 and 24 May 2019;
- feedback from the Sefton Metropolitan Borough Council Overview and Scrutiny Committee dated 20 May 2019;
- the Trust's 2017 complaints report published under regulation 18 of the Local Authority, Social Services and National Health Service Complaints (England) Regulations 2009;
- the national patient survey dated 15 November 2018;
the 2018 national staff survey dated 26 February 2019;
the Head of Internal Audit’s annual opinion over the Trust’s control environment dated March 2019;
the Care Quality Commission’s inspection report dated 5 April 2019; and
any other information obtained during our limited assurance engagement.

We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with these documents (collectively the “documents”). Our responsibilities do not extend to any other information.

The firm applies International Standard on Quality Control 1 (Revised) and accordingly maintains a comprehensive system of quality control including documented policies and procedures regarding compliance with ethical requirements, professional standards and applicable legal and regulatory requirements.

We are in compliance with the applicable independence and competency requirements of the Institute of Chartered Accountants in England and Wales (ICAEW) Code of Ethics. Our team comprised assurance practitioners and relevant subject matter experts.

This report, including the conclusion, has been prepared solely for the Council of Governors of Mersey Care NHS Foundation Trust as a body, to assist the Council of Governors in reporting Mersey Care NHS Foundation Trust’s quality agenda, performance and activities. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2019, to enable the Council of Governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors as a body, and Mersey Care NHS Foundation Trust for our work or this report, except where terms are expressly agreed and with our prior consent in writing.

Assurance work performed

We conducted this limited assurance engagement in accordance with International Standard on Assurance Engagements 3000 (Revised) ‘Assurance Engagements other than Audits or Reviews of Historical Financial Information’ issued by the International Auditing and Assurance Standards Board (‘ISAE 3000’). Our limited assurance procedures included:
• evaluating the design and implementation of the key processes and controls for managing and reporting the indicators;
• making enquiries of management;
• limited testing, on a selective basis, of the data used to calculate the indicators tested against supporting documentation;
• comparing the content requirements of the ‘NHS foundation trust annual reporting manual 2018/19’ and supporting guidance to the categories reported in the Quality Report; and
• reading the documents.

A limited assurance engagement is narrower in scope than a reasonable assurance engagement. The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.

Limitations

Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information.

The absence of a significant body of established practice on which to draw allows for the selection of different, but acceptable, measurement techniques that can result in materially different measurements and can affect comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision of these criteria, may change over time. It is important to read the Quality Report in the context of the criteria set out in the ‘NHS foundation trust annual reporting manual 2018/19’ and supporting guidance.
The scope of our limited assurance work has not included governance over quality or non-mandated indicators, which have been determined locally by Mersey Care NHS Foundation Trust.

Our audit work on the financial statements of Mersey Care NHS Foundation Trust is carried out in accordance with our statutory obligations and is subject to separate terms and conditions. This engagement will not be treated as having any effect on our separate duties and responsibilities as Mersey Care NHS Foundation Trust's external auditors. Our audit reports on the financial statements are made solely to Mersey Care NHS Foundation Trust's members, as a body, in accordance with paragraph 24(5) of Schedule 7 of the National Health Service Act 2006. Our audit work is undertaken so that we might state to Mersey Care NHS Foundation Trust's members those matters we are required to state to them in an auditor’s report and for no other purpose. Our audits of Mersey Care NHS Foundation Trust's financial statements are not planned or conducted to address or reflect matters in which anyone other than such members as a body may be interested for such purpose. In these circumstances, to the fullest extent permitted by law, we do not accept or assume any responsibility to anyone other than Mersey Care NHS Foundation Trust and Mersey Care NHS Foundation Trust's members as a body, for our audit work, for our audit reports, or for the opinions we have formed in respect of those audits.

**Basis for qualified conclusion**

The indicator reporting the proportion of people experiencing first episode psychosis or ‘at-risk mental state’ who wait two weeks or less to start NICE-recommended package of care did not meet the six dimensions of data quality in the following respects:

- **Accuracy** – Our testing identified that relevant data for August 2018 could not be located and therefore we have been unable to determine that data relating to that period has been accurately included in the performance indicator according to the definitions set out in the applicable guidance.
- **Completeness** – Our testing identified that relevant data for August 2018 could not be located and therefore we have been unable to determine that the data has been correctly included in the performance indicator according to the definitions set out in the applicable guidance.

**Qualified conclusion**

Based on the results of our procedures, with the exception of the matter reported in the basis for qualified conclusion paragraph above, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2019:

- the Quality Report is not prepared in all material respects in line with the Criteria set out in the ‘NHS foundation trust annual reporting manual 2018/19’ and supporting guidance;
- the Quality Report is not consistent in all material respects with the sources specified in NHS Improvement’s ‘Detailed requirements for external assurance for quality reports 2018/19’; and
- the indicators in the Report identified as having been subject to limited assurance have not been reasonably stated in all material respects in accordance with the ‘NHS foundation trust annual reporting manual 2018/19’ and supporting guidance.

Grant Thornton UK LLP

Grant Thornton UK LLP
Chartered Accountants
Birmingham Office, The Colmore Building, 20 Colmore Circus B4 6AT

29 May 2019
1.1 Introduction and Statement on Quality by the Chief Executive

We are delighted to present on behalf of the Board of Directors, the Mersey Care NHS Foundation Trust Quality Report for 2018/19. 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 (2017/18). The purpose of our Quality Report 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 stakeholders
- 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 2018/19 a range of engagement events were held with key stakeholders.

Mersey Care’s vision is to provide Perfect Care that enables people with physical health and mental health conditions, learning disabilities and addictions to live longer, healthier lives.

2019 is the first year of a new five year strategy. We will continue our focus on Perfect Care, improving quality and safely reducing cost. But we also need to change our focus for the future. We need to develop more preventative and integrated services for children, young people and adults that enable them to take a more active role in their own health and we must think differently about our workforce models and realise the potential benefits of digital technology.

Our long term strategy is to develop new clinical models to prevent crisis in community settings, enable people to take more control of their own health and integrate services. These exciting new service models, developed using co-production with service users and carers, along with the continued development of a Just and Learning Culture and a focus on quality and inclusion, will make us the employer of choice in our sector.

Delivering our strategy will enable Mersey Care to remain in financial balance, through service redesign that develops more preventative and integrated services, but also through focusing on our main financial risks of medical recruitment, corporate services and community services. We will also invest in improving our digital and physical estate so that Mersey Care has a solid platform to enable our new service models for the future.
Mersey Care cannot rise to the quality, workforce and financial challenges we face by working on our own. The development of partnerships with other providers at neighbourhood, place and Cheshire and Merseyside levels is essential to the future sustainability of our services.

22 May 2019

Joe Rafferty
Chief Executive

1.2 Our Strategic Direction: Transforming our Trust

1. Public services play a critical role in helping and protecting people, but we know something is not working. Despite having a number of excellent hospitals, a thriving voluntary and third sector and good quality social services, local services are not solving the most intractable health challenges, with huge variation in health outcomes even within neighborhoods of Liverpool. We know that individuals and families with the most complex needs experience multiple interventions from different services and agencies and yet all too often remain trapped in repeating cycles of intervention. People’s lives and associated health problems are increasingly complex and require services to work together in order to be effective, but all too often individual organisations offer services in isolation. As is set out in the Five Year Forward View and the Cheshire and Merseyside Sustainability and Transformation Plan, the NHS part of this system is not financially or clinically sustainable in its current form.

2. Mersey Care faces a range of challenges and uncertainties in the next five years which will require fundamental redesign of our clinical, workforce and operational models. Doing more ‘business as usual’ faster and more efficiently is not going to be a sufficient response to these challenges.

3. In summary, our long term strategy is to continue to improve quality and cost in our services, and from this strong platform, develop more preventative, integrated community-based services. In response to the longer term workforce challenges, our strategy is to become an employer of choice, attracting people to work for Mersey Care but also developing and retaining people once they have joined the Trust. Our strategy for guaranteeing the longer term financial sustainability of our services is to develop a more preventative (and thus cost-effective) clinical model and focus on our three key financial risks – medical recruitment, community services and corporate services. Strategic investment is also important to the financial sustainability of our services, and we plan to invest in estate and digital infrastructure so that we have a solid platform for improvement and integration in the future. Our long term strategy also reflects the need for Mersey Care to work as part of a wider system at neighbourhood, place and system levels because the challenges we face require a collaborative effort to overcome them.
4. Our key long-term challenges and solutions are set out in the table below, alongside the initiatives set out in this plan to address those challenges and the associated resourcing/investment.

<table>
<thead>
<tr>
<th>Programmes</th>
<th>Initiatives</th>
<th>Measures</th>
<th>Programmes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Our services</td>
<td>Strive for perfect care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Our people</td>
<td>Become the employer of choice in our sector</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Our resources</td>
<td>Develop a solid financial, estate and digital platform for future Integration</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Our future</td>
<td>Work with and learn from others to have greater impact</td>
<td></td>
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</table>
1.3 Improving Quality

5. Mersey Care was formed in 2001 and in that time we have seen a great deal of change, both in terms of the fields in which we work and the pressures under which we deliver our services. What hasn’t changed is the motivation and commitment of our staff to provide the highest possible standard of care to those they serve. In order to support our staff and ensure that they can continue to do the best job possible for those they serve, we have recognised that we need to adjust the way in which we support improvement in our services from getting the basics of care right, through to pioneering work that influences changes to practice in our sector nationally.

6. Mersey Care has an overall ‘Good’ rating from the CQC. In 2019, services were rated as ‘Good’ for being safe, effective, caring, and responsive, and outstanding for well led. This is an improved position since the 2017 inspection when the Trust was rated as Good overall, but ‘Requires Improvement’ for being safe.

1.4 Pursuing Perfect Care

7. Perfect Care means getting the basics of care right every time, whilst setting our own stretching goals for improvement and relentlessly pursuing safer care through a learning culture. In practice this means that we try to make every episode of care Safe, Timely, Effective, Equitable, Efficient and Positively experienced (STEEEP).

8. We have set ambitious goals in pursuit of perfect care:
   a) Reducing Restrictive Practice;
   b) zero suicide for those in our care;
   c) physical health for service users;
   d) A just and learning culture;
   e) Zero deterioration of pressure ulcers within our care in 2019/20;
   f) Learning from deaths;
   g) Reducing Delayed Discharges in Mental health.

9. The Centre for Perfect Care and Well-being (the Centre) was established in January 2014 and has been successful in challenging stigmatised attitudes towards suicide, reducing self harm and assaults on our inpatient wards, and implementing the Reducing Restrictive Practice guidance in mental health. Building on this success, Mersey Care is striving for a step change in improvement, whereby everyone feels that quality improvement is their business and continuous improvement is supported at every level, and in all roles in Mersey Care. To support continuous improvement in this way, it is important to see quality improvement activity as a continuum, ranging from our ability to improve care that falls below basic standards, right through to world-leading innovation, research and development.
2.1 Priorities for Improvement 2019/20

In preparation for our Quality Report the Trust has undertaken a process of involvement and engagement with key stakeholders to establish their views on what our key priorities for 2019/ should be.

10. Representatives from the following groups have been engaged and invited to provide feedback:
   a) Healthwatch for Liverpool, Sefton and Knowsley;
   b) Local Overview and Scrutiny Committees;
   c) NHS England (Cheshire and Merseyside);
   d) NHS Liverpool Clinical Commissioning Group;
   e) NHS South Sefton Clinical Commissioning Group;
   f) NHS Southport and Formby Clinical Commissioning Group;
   g) NHS East Lancashire Clinical Commissioning Group;
   h) Knowsley Clinical Commissioning Group;
   i) the Council of Governors;
   j) local service user groups.

11. In addition to the above, the perfect care steering group has considered suggestions for 2019/20 quality improvement priorities. These are consistent with the six key elements in the Trust’s Model of Quality: STEEEP:
   a) Safety of Patients
   b) Timely care
   c) Effectiveness
   d) Efficient care
   e) Equitable care
   f) Positive patient experience.

12. After consultation and discussion with key stakeholders and with the Trust Board the areas of quality improvement for 2019/20 will be:
   a) Priority 1: Reducing Restrictive Practice
      i) Full compliance with the reducing restrictive practice guide by March 2020.
      ii) Reduce restraints in SLD services from 2018/19 baseline by 50% in 2019/20.
b) **Priority 2: Towards Zero Suicide**  
   ii) Develop world leading practice guidance on reducing self harm in people with Personality Difficulties by October 2019.

c) **Priority 3: Improvements in Physical Health Pathways**  
   i) Focus on improving access to End of Life Care for all servicers across Mersey Care.  
   ii) Develop clear pathway for each Division to access End of Life Care.  
   iii) 100% Compliance for the physical health pathway (Annual Health Check) for community service users on care programme.

d) **Priority 4: A Just and Learning Culture**  
   i) Develop a tool / framework to support restorative conversations in practice.  
   ii) Develop a tool/framework (aligning to our organisational values) that supports civility in practice.  
   iii) Every team to have a Just and Learning conversations about learning from routine and what goes right, as well as when something doesn’t go to plan.  
   iv) Review the Datix pro-forma, process, pathways and guidance.

e) **Priority 5: Reduction in Community Acquired Pressure Ulcers**  
   i) Zero deterioration of pressure ulcers whilst under our care

f) **Priority 6: Learning from Deaths**  
   i) Four thematic reviews will be conducted per year on analysis of mortality figures by March 2020.  
   ii) Process for undertaking pathway reviews will have been developed and implemented in association with the partner organisation March 2020.  
   iii) Data from GPs, specifically the cause of death will be used as part of the mortality review process.

g) **Priority 7: Reducing Delayed Discharges in Mental health**  
   i) Aim for Zero Delay in discharge for patients.  
   ii) Set clear goals with the Division for reducing length of stay.

13. Following the transaction of Community Health the Trust has a focus on improving child health and delivering the healthy child program. We will particularly focus on two areas to improve care as part of child health.

a) **Education and Health Care Plans**  
   i) Discharge all of the actions required to address issues identified as part of the 2019 SEND inspection by March 2020.

b) **Lost Contact Process**  
   i) Delivery of a signed off process for safe management of lost contact population by September 2019.
Ensuring Equality and Tackling Health Inequalities

14. All work streams within this project are looking at the specific issues for people who are more likely to experience discrimination within mental health and learning disability services. This has included specific analysis for BME people in relation to each work stream priority.

15. Each priority lead will ensure this is reflected in the work stream reporting framework.

Monitoring and Reporting Arrangements

16. A nominated lead will be identified for each priority and will chair a work stream forum which will coordinate progress and monitor activity.

17. The delivery of the Quality Report will be monitored by the Centre for Perfect Care Sub Committee and reported to the Quality Assurance Committee and the Executive Committee, both of which are committees of the Board.

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

2.2 Review of Quality Performance 2018/19

19. In June 2018, the Trust published its Quality Report reporting on the quality of services against six areas of priority. Following engagement with key stakeholders the following priorities would be the key areas of quality improvement:

   a) Priority 1: Reducing Restrictive Practice
   b) Priority 2: Towards Zero Suicide
   c) Priority 3: Improvements in Physical Health Pathways;
   d) Priority 4: A Just and Learning Culture;
   e) Priority 5: Reduction in Community Acquired Pressure Ulcers
   f) Priority 6: Learning from Deaths

20. Table 1 below summarises the elements of achievements in relation to these priority areas.

<table>
<thead>
<tr>
<th>Priority</th>
<th>Description</th>
<th>Delivery</th>
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<tbody>
<tr>
<td>1</td>
<td>Reducing Restrictive Practice</td>
<td>Achieved</td>
</tr>
<tr>
<td></td>
<td>• Develop and implement a strategy on rapid tranquillisation and depot administration to reduce prone restraint by 50% from baseline by March 2019;</td>
<td>Achieved</td>
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<td></td>
<td>• Reduce physical restraint associated with self-harm by 20% by March 2019 and develop a clinical model which incorporates assessment management strategies and training that manages both risk to self and others;</td>
<td>Achieved</td>
</tr>
<tr>
<td>Priority</td>
<td>Description</td>
<td>Delivery</td>
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| 1        | • Review of ligature incidents by June 2018 and develop an implementation plan to address risks using the strategies from the P4P2 project;  
• Implement Zero Segregation action plan to reduce long term segregation by 20% from the baseline cohort by the end of financial year 2018 – 2019;  
• By March 2019 a further Research Evaluation of the implementation of the Guide to Reducing Restrictive Practice Guide will be completed;  
• Compile and publish good practice stories on reducing restrictive practice from across the Trust by December 2018 | Achieved |
| 2        | Towards Zero Suicide  
• 100% of patients in Local Services Division in-patient settings who have the capacity to engage in the process will be offered the opportunity of completing a safety plan on-going. By March 2019 50% of patients discharged from Local Services Division in-patient settings will be discharged with a safety plan;  
• targeted suicide prevention interventions to be provided to teams that have experienced a suicide or near fatal event as an on-going intervention;  
• 100% of former Liverpool Community Health staff will complete Level 1 Suicide Awareness Training by March 2019;  
• 7-day follow up for those service users on care programme approach. By June 2018 we will understand the areas that need additional support. By March 2019 we will meet the national target of 95% compliance;  
• Centre for Perfect Care to provide an analysis of post incident reviews of suicides to identify key targeted areas for improvement by March 2019. | Partially Achieved, Achieved, Achieved, Partially Achieved, Achieved |
| 3        | Improvements in Physical Health Pathways  
For clinical staff to recognise the deteriorating patient through NEWS2 to ensure prompt intervention to treatment required;  
Measures:  
• 100% of inpatient wards have implemented NEWS2  
• 100% of inpatient wards have implemented the sepsis pathway  
• Physical health community division implemented NEWS2;  
By March 2019, the physical health pathway (Annual Health Check) for community service users on care programme approach will be fully implemented. | Achieved, Achieved, Achieved, Partially Achieved |
<table>
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<tr>
<th>Priority</th>
<th>Description</th>
<th>Delivery</th>
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<tbody>
<tr>
<td>4</td>
<td><strong>Just And Learning Culture</strong></td>
<td>Achieved</td>
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<td></td>
<td>- By the end of March 2019, 100% of leaders Band 7 and above and equivalent will have been assessed and have a development plan to support their teams in a Just and Learning environment;</td>
<td>Achieved</td>
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<td></td>
<td>- To support colleagues' psychological safety through the development of bullying awareness for staff based on a preventative approach to recognise bullying behaviour and develop a process to resolve issues;</td>
<td>Achieved</td>
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<td></td>
<td>- To develop a standardised framework to support learning from incidents including supporting staff, how to debrief, and to provide governance and validation mechanisms to improve the safety and experience of the people we serve and our colleagues so that risks are addressed and learning is maximised;</td>
<td>Achieved</td>
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<td></td>
<td>- Produce a guide for colleagues and service users on Just and Learning expectations to describe the shared responsibility between individuals, teams and the organisation to create a safe and compassionate environment.</td>
<td>Achieved</td>
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<tr>
<td>5</td>
<td><strong>Reduction of Community Acquired Pressure Ulcers</strong></td>
<td>Achieved</td>
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<td></td>
<td>- Raise awareness training for managing pressure ulcers in the mental health in patient wards;</td>
<td>Achieved</td>
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<td></td>
<td>- Reduction plan in place with a target trajectory for reduction of Grade 2 and 3 pressures ulcers;</td>
<td>Achieved</td>
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<tr>
<td></td>
<td>- Zero grade 4 pressure ulcers.</td>
<td>Not Achieved</td>
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<tr>
<td>6</td>
<td><strong>Learning from Deaths</strong></td>
<td>Partially Achieved</td>
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<tr>
<td></td>
<td>- Scope for reviewing individual community deaths will have been agreed and implemented by March 2019;</td>
<td>Achieved</td>
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<td></td>
<td>- Scope for reviewing individuals in mental health care will have been reviewed and new standards adopted by March 2019.</td>
<td>Achieved</td>
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<td></td>
<td>- Single action plan for monitoring completion of learning points will be developed and completion of actions monitored by March 2019;</td>
<td>Achieved</td>
</tr>
<tr>
<td></td>
<td>- Four thematic reviews will be conducted per year based on an analysis of mortality figures by March 2019;</td>
<td>Achieved</td>
</tr>
<tr>
<td></td>
<td>- Process for undertaking pathway reviews will have been developed and implemented in association with partner organisations March 2019;</td>
<td>Partially Achieved</td>
</tr>
<tr>
<td></td>
<td>- Data from GPs, specifically the cause of death will be used as part of the mortality review process.</td>
<td>Partially Achieved</td>
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## Detailed Progress on Quality Report Objectives 2018/19

### Priority 1 Progress: Reducing Restrictive Practice

Dr Jennifer Kilcoyne is the Consultant Psychologist is the nominated lead for No Force First.

<table>
<thead>
<tr>
<th>Priority 1 Objectives for 2018/19</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Develop and implement a strategy on rapid tranquilisation and depot administration to reduce prone restraint by 50% from baseline by March 2019</strong></td>
</tr>
</tbody>
</table>

- The trajectory for reductions in prone restraint to administer rapid tranquilisation and depot medication required a Trust total of no more than 5 incidents per month by the end of Q2. The target was achieved during the quarter however, during September the Secure Division did not meet the performance target of (1) as (2) services required IM medication and were placed in the prone position for it to be administered safely. The Personal Safety Service have been in contact with the respective wards and offered additional support and training.
- We have developed a number of work streams to continue to reduce the use of planned prone restraint to support the safe administration of rapid tranquilisation and depot medication through; a) the delivery of PSS Training, ensuring it is only used if there are cogent reasons for doing so b) by exploring alternative sites to administer depot and rapid tranquilisation medication c) engagement sessions to explore the reasons why nursing staff are not considering administering prescribed medication in alternative sites and d) reviewing all prone restraints across the Trust and providing additional support.
- We are also in the process of developing a blended training package to enhance staff confidence in administering depot medication and rapid tranquilisation in alternative sites. We foresee this training being delivered through an e-learning package, clinical skills trainers and the Personal Safety Service.

<table>
<thead>
<tr>
<th>Reduce physical restraint associated with self-harm by 20% by March 2019 and develop a clinical model which incorporates assessment management strategies and training that manages both risk to self and other</th>
</tr>
</thead>
<tbody>
<tr>
<td>- The trajectory for reductions in physical restraint associated with self-harm required a Trust total of no more than 39 incidents per month by the end of Q3. The target was exceeded by some considerable distance throughout the quarter.</td>
</tr>
<tr>
<td>- Local division remained marginally above target (n = 7 against a target of 5 by end of quarter) and although Brunswick ward spiked during November. There were no real hot spots in December, with the 7 incidents dispersed across 4 different wards. Brunswick ward have now completed their ‘discovery’ work under the auspices of the self-harm project, and identified priority interventions they will implement to reduce further incidents. This work continues through the ward.</td>
</tr>
<tr>
<td>- Specialist LD division were responsible for the majority of incidents during the quarter 1 to 3 ), with just three wards – 1 Woodview, Newton &amp; Slaidburn and the Star Unit – responsible for almost 90% of incidents by end of quarter. Considerable work has been undertaken to understand this spike in restraints, which would appear to be an unintended consequence of advice given in the wake of a serious incident last year. An action plan has since been implemented to reverse the trend, which, as can be seen,</td>
</tr>
</tbody>
</table>
appears to be having a positive impact. The wards in question are also part of the self-harm project and are currently implementing PDSA cycles which are due to be evaluated at the end of Q4.

Review of ligature incidents by June 2018 and develop an implementation plan to address risks using the strategies from the P4P2 project

- The trajectory for the reduction in ligature incidents required a Trust total of no more than 49 incidents per month by the end of Q3. After recovering the Q2 closing position going into October, another spike ensued, peaking at 138 in December. Local and Specialist LD Divisions accounted exclusively for this total with 121 and 17 incidents respectively.
- In Local division, Dee ward alone was responsible for 55% of all incidents having experienced a significant spike towards the end of the quarter. The vast majority of these incidents were attributed to one particular patient. The patient was admitted in crisis at the end of November, with ligaturing as a long-standing behaviour both in the community and during repeated admissions – and subsequently engaged in the behaviour almost daily, sometimes up to five times per day. The majority of incidents resulted in ‘no harm as the ligatures were loosely tied and often removed by the patient themselves. The MDT have since been working hard to secure the patients discharge pathway. The remaining incidents were dispersed across 10 wards with no other obvious ‘hot spots’ or special cause variations.
- In Specialist LD division the 17 ligature incidents were dispersed across four wards, with three of them – Newton & Slaidburn, 1 Woodview, and Coniston & Grasmere – accounting for 94% of incidents (n = 16). The three wards in question are all involved in the self-harm project and were represented at the ‘Sharing the Learning’ event at the start of the quarter in October, where potential mitigation strategies were identified. PDSA cycles have subsequently been implemented on all three wards and these are due to be evaluated at the end of Q4.

Implement Zero Segregation action plan to reduce long term segregation by 20% from the baseline cohort by the end of financial year 2018 – 2019

- The trajectory target required of cumulative days of long term segregation was 17848 days by the end of Q2. The target was achieved by 637 days by Q2

Secure Division
- We are currently nursing (28) patients in long-term segregation at Ashworth Hospital. We have recently had an increase in the use of long-term segregation due to a small number of patients relapsing in mental state and new admissions from the Prison Service who are currently acutely unwell, remain a high risk of assaulting others and require intensive care and treatment to stabilise them.
- We have developed a driver diagram below to help translate our high level improvement goal into a logical set of underpinning goals and projects. It captures the entire change programme into a single diagram and also provides a measurement framework for monitoring progress.
Long term segregation – length of stay

<table>
<thead>
<tr>
<th>Long term segregation – length of stay</th>
<th>April 2018</th>
<th>May 2018</th>
<th>June 2018</th>
<th>July 2018</th>
<th>August 2018</th>
<th>Sept 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-3 months</td>
<td>13</td>
<td>12</td>
<td>14</td>
<td>7</td>
<td>9</td>
<td>12</td>
</tr>
<tr>
<td>4-6 months</td>
<td>4</td>
<td>6</td>
<td>7</td>
<td>5</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>7-12 months</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>5</td>
<td>7</td>
<td>7</td>
</tr>
<tr>
<td>Over 12 months</td>
<td>11</td>
<td>8</td>
<td>8</td>
<td>8</td>
<td>8</td>
<td>8</td>
</tr>
</tbody>
</table>

Current Progress:
- 13.6% reduction in cumulative days since April 2018.
- 31% reduction from patient baseline April 2018 cohort (26) patients nursed in LTS (6) progressed (2) returned to LTS.
- 42% reduction in length of stay in LTS over 12 months since April 2017.
- During September 2018 we obtained permission from the commissioner for (1) service user in our MSU at Scott Clinic to be transferred to long term segregation from seclusion due to risk, safeguarding issues and to reduce restrictions that was being applied whilst nursed in seclusion.

Specialist Learning Disability Division
- We are currently nursing (1) service user in long term segregation in our MSU at Woodview since 15/05/18 (121 days). However, we have ended long segregation for (2) service users since April 2018.

By March 2019 a further Research Evaluation of the implementation of the Guide to Reducing Restrictive Practice Guide will be completed.

- The Trust Research & Development Team are in the process of scoping out a potential independent evaluation with Manchester Metropolitan University with Professor Joy Duxbury

Compile and publish good practice stories on reducing restrictive practice from across the Trust by December 2018.

- We have tasked divisional leads to explore best practice across the Trust in relation to the implementation of the 6 core ward based interventions and evidenced based approaches from the Guide to Reducing Restrictive Practice.
- We continue to engage our service users from across the 3 divisions to obtain their views on the impact this has had on supporting their physical and psychological wellbeing and recovery. We are also planning to develop a video consisting of service users and staff to highlight good practice stories within the Trust.
**Priority 2 Progress: Zero Suicide**

Dr Rebecca Martinez, Consultant Psychiatrist/Associate Medical Director for Suicide Prevention, is the identified lead for this priority area and chairs the Safe from Suicide team established to oversee the implementation of the Zero Suicide Strategy and Policy.

### Priority 2 Objectives for 2018/19

**100% of patients in Local Services Division in-patient settings who have the capacity to engage in the process will be offered the opportunity of completing a safety plan on-going. By March 2019 50% of patients discharged from Local Services Division in-patient settings will be discharged with a safety plan**

- The reporting tool to monitor safety planning is now available within RiO, although there has been a delay in this being implemented and extracting information from this tool is still being developed. An alert will also be present within RiO to ensure that patients with safety plans are easily identifiable and the safety plan can be easily accessed in times of need.
- All adult wards have been offered the safety plan training and in line with the implementation plan champions have been identified by the ward managers for each ward. The Centre for Perfect Care (CfPC) has Quality Improvement staff that are trained in delivering safety plans and will support the champions in the continued roll out.
- The CfPC will continue to work alongside the ward champions to identify and update safety plans.

### Targeted suicide prevention interventions to be provided to teams that have experienced a suicide or near fatal event as an on-going intervention

- Suicide prevention training has been delivered to the majority of inpatient areas, with the older peoples services being delayed in receiving the training in any aspect of suicide prevention. Plans have been established to deliver the training in these areas.
- Additional areas within the community setting such as A and E liaisons, Criminal Justice staff have all been trained in suicide prevention. The development of the new crisis teams has agreed to have suicide prevention as a core learning strategy and we will be training any new staff to this service in due course.

### 100% of former Liverpool Community Health staff will complete Level 1 Suicide Awareness Training by March 2019

The Suicide awareness training is now available and being accessed by community Division – please see graph on the next page.
7-day follow up for those service users on care programme approach. By June 2018 we will understand the areas that need additional support. By March 2019 we will meet the national target of 95% compliance.

Centre for Perfect Care to provide an analysis of post incident reviews of suicides to identify key targeted areas for improvement by March 2019.

- Initial work has been commenced on this area, with a number of topics being highlighted as areas for improvement over the current year. Such as MDT Processes (including Standards and Quality of service), Clinical Interventions (development of risk plans and skills of staff to undertake these), Documentation (effective communication and adequate supervision). The role of Carers and Families to be more involved in the care and treatment of their loved ones; by way of them feeling supported, listened to and informed by staff. Further analysis of themes over previous years is still being completed, but analysis completed to date highlights similar themes in previous years.
<table>
<thead>
<tr>
<th>Priority 3: Progress Improvements in Physical Health</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jenny Hurst Deputy Director of Nursing is the nominated lead for this priority area. A Trust wide physical strategy group supports and oversees this priority area.</td>
</tr>
</tbody>
</table>

**Priority 3 Objectives for 2018/19**

**For clinical staff to recognise the deteriorating patient through NEWS2 to ensure prompt intervention to treatment required**

**Measures:**
- 100% of inpatient wards have implemented NEWS2
- 100% of inpatient wards have implemented the sepsis pathway
- Physical health community division implemented NEWS2;

All inpatient wards have implemented NEWS2 and sepsis pathway. Community have implemented NEWS2 and sepsis pathway. NEW2 training is mandated from April 19 for all clinical staff band 3 to 8a.

Trust Wide Policy for Recognising the Deteriorating Patient developed and Trust Website

**By March 2019, the physical health pathway (Annual Health Check) for community service users on care programme approach will be fully implemented.**

- There are numerous work streams under development to address the need to improve the compliance for completion of physical health checks for community service users.

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*Percentage of community service users on CPA who have an annual health check – Trust*
By the end of March 2019, 100% of leaders Band 7 and above and equivalent will have been assessed and have a development plan to support their teams in a Just and Learning environment

- PACE (appraisal) process is the main mechanism for assessment and development planning against the Trust values / behaviours and competence.
- A leadership competency framework was developed and incorporated within the 2018-19 PACE process.
- As at end of September 2018 82% of people at Band 7 and above have had completed PACE and therefore been assessed, had feedback and have agreed their development priorities and plans with their line manager in accordance with our Just and Learning Culture.
- For the former Liverpool Community Health managers (LCH) who have not used PACE, the approach has been different. Assessment has been undertaken as part of the THRiVE process and will be aligned to PACE upon implementation later this year. To date 46 former LCH Band 7 and above have or are completing THRiVE.
- An evaluation and review of progress to date is being conducted. Those yet to complete this process have been identified and plans to support will be agreed and put in place to ensure 100% of those in scope meet the Just and Learning Culture objective. In the meantime the refresh of Mersey Care values has been approved. The additional value and behaviours associated with Support will be incorporated within PACE 2019-20. By this time all MCT will use PACE.

To support colleagues’ psychological safety through the development of bullying awareness for staff based on a preventative approach to recognise bullying behaviour and develop a process to resolve issues

- This will be part of the framework being developed for PACE 2019/20

To develop a standardised framework to support learning from incidents including supporting staff, how to debrief, and to provide governance and validation mechanisms to improve the safety and experience of the people we serve and our colleagues so that risks are addressed and learning is maximised

- A guide will be produced for colleagues and service users on Just and Learning expectations to describe the shared responsibility between individuals, teams and the organisation to create a safe and compassionate environment will include the development of bullying awareness
Priority 5: Reduction of Community Acquired Pressure Ulcers

Nicky Ore, Clinical Lead Sefton Locality, is the nominated lead for this priority.

### Priority 5 Objectives for 2018/19

- Raise awareness training for managing pressure ulcers in the mental health in patient wards;
- Reduction plan in place with a target trajectory for reduction of Grade 2 and 3 pressure ulcers;
- Zero grade 4 pressure ulcers.

- The Trust has continued to develop an action plan to reduce pressure ulcers across the community and raise awareness across mental health. We have worked in collaboration with NHS Improvement and perfect care team to implement the reduction program
- Pressure Ulcer dashboard at locality/ divisional level is now implemented.
- Further work underway to capture deterioration of pressure ulcers on caseload this will be mobilised in Quarter 1 2019/20.
- Team level dashboards have been implemented to support monitoring of targets via Pressure Ulcer Reduction Harm Free Care Group, Locality Governance and Performance meetings this across the district nursing workforce. This is to be rolled out to the AHP workforce in 2019-20.
- All Pressure ulcers monitored weekly via daily Datix report in the locality, Locality Safety Huddle and Divisional Safety Huddles. The 72 hour review process is fully embedded.

As at end of March 2019, performance against targets as follows:
- Category 2 Community Avoidable Acquired (CAA) – Target 23
- Category 3 CAA: 27 – Target 29
- Category 4 CAA: 7 – Target 0
- Deterioration of category 2/3 and category 3/4: Work underway to capture timely data this will be part of the dashboard going forward and will mobilise in Quarter 1 2019/20.

### Category 4

- Strategy meetings have been delivered to identify immediate learning in relation to Category 4 pressure ulcers.
- Following review of all strategy notes gaps in practice have been identified .Quality Improvement Alerts were developed and implemented across the division and wider organisation to support immediate learning.
- Category 4 pressure ulcers have been a key area of focus at both the divisional and executive safety huddles and this work continues.
- Specialist Tissue Viability Nurse reports implemented in Quarter 3 these are now completed for all CAA Categories 3 and 4 Pressure Ulcers to support Root Cause Analysis (RCA) investigations. Further review has been undertaken to evidence effectiveness of this process and the RCA template is being further adapted to reduce duplication and ensure specialist oversight to support the improvement programme.
- Last category 4 reported was 10th January 2019 in Central Locality – 85 days without a category 4
The pressure ulcer reduction programme continues to be developed and extended with a work plan and action plan in place to support. The pressure ulcer action plan has been updated to reflect aims / objectives and outcomes. Work has now been implemented to understand and support the needs of the other divisions across MCFT in pressure ulcer awareness and prevention.

**Target 1 - 20% reduction compared to 2017/18 for Category 2 Community Acquired Avoidable Pressure Ulcers.**

The current level of performance against target – Grade 2: 3 (YTD)

*Category 2 Community acquired pressure ulcers*

Mersey Care NHS Foundation Trust - Community Acquired and Avoidable Pressure Ulcer Grade 2 - 20% Reduction by March 2019

**Target 2 - 10% reduction compared to 2017/18 for Category 3 Community Acquired Avoidable Pressure Ulcers.**

Community acquired grade 3 pressure ulcers YTD.

*No of Category 3 community acquired avoidable pressure ulcers*

Mersey Care NHS Foundation Trust - Community Acquired and Avoidable Pressure Ulcer Grade 3 - 10% Reduction by March 2019
Target 3- Zero Category 4 Community Acquired Avoidable Pressure Ulcers (STEIS).

- Current level of performance Category 4

Mersey Care NHS Foundation Trust - Community Acquired and Avoidable Pressure Ulcer Grade 4

![Bar Chart]

- Apr-18: 0
- May-18: 0
- Jun-18: 0
- Jul-18: 0
- Aug-18: 0
- Sep-18: 4
- Oct-18: 1
- Nov-18: 1
- Dec-18: 1
- Jan-19: 0
- Feb-19: 0
- Mar-19: 0

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## Priority 6 Objectives for 2018/19

Steve Morgan, Director for Patient Safety, is the nominated lead for this priority.

- **Scope for reviewing individual community deaths** will have been agreed and implemented by March 2019;
- **Scope for reviewing individuals in mental health care** will have been reviewed and new standards adopted by March 2019;
- **Single action plan for monitoring completion of learning points** will be developed and completion of actions monitored by March 2019;
- **Four thematic reviews** will be conducted per year based on an analysis of mortality figures by March 2019;
- **Process for undertaking pathway reviews** will have been developed and implemented in association with partner organisations March 2019;
- **Data from GPs, specifically the cause of death** will be used as part of the mortality review process.

- The scope for agreeing deaths has been agreed for the community division and an implementation is now being put in place. This has included changes being made to the Datix reporting form to enable staff in the division to report incidents more easily. The scope has been broadened at the request of the Executive Director responsible and will include all deaths of patients who have been receiving clinical care by the division. The new system will commence in November 2018.
- A further W.T.E. post has been recruited to and will be fully in place by December 2018 to increase the capacity of the team to undertake the enhanced number of reviews. This post is currently for a year using LCH improvement funding. The Consultant Psychosis role has now been fully appointed too, for two sessions per week, they are taking the lead in providing support and supervision to the Mortality and Incident Practitioners and proffering medical guidance during RCA reviews.
- The Trust have asked the CCG to provide support in gaining access to GP information they have agreed to do this and have confirmed that having GPs involved in undertaking reviews of deaths is part of their plan. The Trust has confirmed that they are happy to share information on the process used to undertake reviews if this will help GPs to engage.
- The Trust as completed a thematic review into deaths of patient with a diagnosis of Dementia, an action plan is currently being put in place and will be monitored by the Mortality Review Group.
2.3 Statements of Assurance from the Board: Review of Services

21. During 2018/19 Mersey Care NHS Foundation Trust provided NHS services to a number of NHS Commissioners, including public health (local authorities).

22. During 2018/19, the Trust contracted with:
   a) NHS Liverpool CCG (with Liverpool City Council) and NHS Sefton CCG (and associates), for local mental health and learning disability services across the Liverpool, Sefton, Knowsley, Halton, St Helens and West Lancashire areas;
   b) NHS Liverpool CCG for community services, including pre-birth to 19 services commissioned by Liverpool City Council through the contract;
   c) NHS Liverpool CCG for addiction services;
   d) NHS Liverpool CCG for Improved Access to Psychological Therapies (IAPT);
   e) NHS South Sefton CCG, NHS Southport and Formby CCG, NHS Liverpool CCG and Aintree Hospital NHS FT for Sefton community physical health services. Some of these services are sub-contracted to North-West Boroughs NHS Trust;
   f) Sefton Council:
      i) Residential Substance Misuse Medically Managed Detoxification Service,
      ii) Ambition Sefton – Adult Substance Misuse Treatment and Recovery Service (within the Ambition Sefton contract there are a number of Pharmacy Services that provide Needle Exchange and Supervised Consumption);
   g) NHS England (through its regional and various sub-regional teams) for:
      i) low, medium and high secure services (also provided to NHS Wales in respect of high secure services);
      ii) low and medium secure services for specialist learning disabilities services,
      iii) personality disorder services at HM Prison Garth;
   h) Spectrum CIC for provision of mental health services in HMP Liverpool
   i) Aintree University Hospitals NHS Foundation Trust for the Liverpool Community Alcohol Service, bariatric support services, Litherland Walk-in Centre and services provided as part of the Liverpool Diabetes Partnership;
   j) NHS East Lancashire CCG (and associates) for low and medium secure services and enhanced community support services for specialist learning disabilities services;
   k) NHS North Lancashire and South Cumbria CCG for Learning Disability Specialist Support Teams
   l) NHS Trafford CCG (and associates) for low and medium secure services and enhanced community support services for specialist learning disabilities services
   m) Alder Hey Children’s NHS Foundation Trust – CQUIN transition from CAMHS to Adult Mental Health and Learning Disability Service;
n) Liverpool Women’s NHS Foundation Trust for Perinatal Mental Health Service (funded till June 2018);
o) Manchester Mental Health and Social Care Trust for psychiatry services to HMP Manchester;
p) National Probation Service for community personality disorder services, Resettle and Psychologically Informed Planned Environment (PIPE) services;
q) NHS East Lancashire CCG for Learning Disabilities Enhanced Support Services
r) Lancashire Care NHS Foundation Trust for Dental services for low and medium secure services. This is a commissioned service i.e. expenditure;
s) Lancashire Care NHS Foundation Trust for Speech and Language Services. This is a commissioned service i.e. expenditure.
t) Liaison & Diversion service (CJLT) - within secure main contract;
u) Sex Offender Treatment Programme at HM Prison Wymott – within OPD element of main secure contract;
v) Psychiatry service to HM Prison Altcourse (Primecare);
w) National Probation Service / NOMs OPD work in Cheshire.

23. The Trust also provides staff support services to a number of local NHS and non-NHS organisations,
   a) NHS Shared Business Service;
b) Liverpool Heart and Chest Hospital NHS Foundation Trust;
c) Southport College;
d) Aintree University Hospitals NHS Foundation Trust;
e) St Helens Council;
f) Liverpool Mutual Homes;
g) Liverpool Women’s Hospital NHS Foundation Trust;
h) The Walton Centre NHS Foundation Trust;
i) Liverpool Community Health NHS Trust;
j) Royal Liverpool & Broadgreen University Hospitals NHS Trust;
k) St Helens & Knowsley Hospitals NHS Trust;
l) VIVUP;
m) Royal Surrey;
n) Bristol Commissioning Support Unit

24. Mersey Care has reviewed all of the data available on the quality of care in all of these services
25. The Trust also hosts Informatics Merseyside which provides services to a range of local NHS organisations.

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

National Clinical Audit Reports 2018/19

26. During 2018/19 twelve national clinical audits and two national confidential enquiry covered relevant health services that Mersey Care NHS Foundation Trust provides.

27. During that period Mersey Care NHS Foundation Trust participated in 83% (n10/12) of national clinical audits and 100% national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

28. The national clinical audits and national confidential enquiries that Mersey Care NHS Foundation Trust was eligible to participate in during 2018/19 are as follows:
   a) National Confidential Enquiry into Suicide and Homicide by people with Mental Illness;
   b) Learning Disability Mortality Review Programme (LeDeR);
   c) National Clinical Audit on Psychosis EIP Spotlight;
   d) National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme (NACAP) Pulmonary rehabilitation;
   e) Falls and Fragility Fractures Audit programme (FFFAP) National Audit Inpatient Falls
   f) National Audit of Cardiac Rehabilitation
   g) National Clinical Audit of Anxiety and Depression (NCAAD) Core Audit
   h) National Clinical Audit of Anxiety and Depression (NCAAD) Psychological Therapies Spotlight
   i) POMH: Assessment of side effects of depot and LAI antipsychotic medication;
   j) POMH: Rapid Tranquillisation;
   k) POMH: Prescribing Clozapine;
   l) POMH: Monitoring of patients prescribed lithium.

29. The national clinical audits and national confidential enquiries that Mersey Care NHS Foundation Trust participated in during 2018/19 are as follows:
   a) National Confidential Enquiry into Suicide and Homicide by people with Mental Illness;
   b) Learning Disability Mortality Review Programme (LeDeR);
   c) National Clinical Audit on Psychosis EIP Spotlight;
d) National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme (NACAP) Pulmonary rehabilitation;
e) National Clinical Audit of Anxiety and Depression (NCAAD) Core Audit
f) National Clinical Audit of Anxiety and Depression (NCAAD) Psychological Therapies Spotlight
g) National Audit of Care at the End of Life (NACEL)
h) National Audit of Intermediate Care (NAIC)
i) POMH: Assessment of side effects of depot and LAI antipsychotic medication;
j) POMH: Rapid Tranquillisation;
k) POMH: Prescribing Clozapine;
l) POMH: Monitoring of patients prescribed lithium.

30. The national clinical audits and national confidential enquiries that Mersey Care NHS Foundation Trust participated in, and for which data collection was completed during 2018/19, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

<table>
<thead>
<tr>
<th>National Audit Title</th>
<th>No of Cases Submitted</th>
<th>No of cases as a % of number required</th>
</tr>
</thead>
<tbody>
<tr>
<td>National Confidential Enquiry into Suicide and Homicide by people with Mental Illness;</td>
<td>73 submitted, 12 returned</td>
<td>100%</td>
</tr>
<tr>
<td>Learning Disability Mortality Review Programme (LeDeR);</td>
<td>The Trust has not yet had any targeted feedback from the programme.</td>
<td></td>
</tr>
<tr>
<td>National Clinical Audit on Psychosis EIP Spotlight</td>
<td>200</td>
<td>100%</td>
</tr>
<tr>
<td>National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme (NACAP) Pulmonary rehabilitation</td>
<td>Case submission not commenced</td>
<td></td>
</tr>
<tr>
<td>National Clinical Audit of Anxiety and Depression (NCAAD) Core Audit</td>
<td>100</td>
<td>100%</td>
</tr>
<tr>
<td>National Clinical Audit of Anxiety and Depression (NCAAD) Psychological Therapies Spotlight</td>
<td>11</td>
<td>18%</td>
</tr>
<tr>
<td>National Audit of Care at the End of Life (NACEL)</td>
<td>16</td>
<td>100%</td>
</tr>
<tr>
<td>National Audit of Intermediate Care (NAIC)</td>
<td>NA</td>
<td></td>
</tr>
<tr>
<td>POMH: Assessment of side effects of depot and LAI antipsychotic medication</td>
<td>Sept 18 Not Published</td>
<td></td>
</tr>
<tr>
<td>POMH: Rapid Tranquillisation;</td>
<td>59</td>
<td>100%</td>
</tr>
<tr>
<td>POMH: Prescribing Clozapine;</td>
<td>158</td>
<td>100%</td>
</tr>
<tr>
<td>POMH: Monitoring of patients prescribed lithium.</td>
<td>Feb 19 – March 19 Not published</td>
<td></td>
</tr>
</tbody>
</table>
31. The reports of 3 national clinical audits were reviewed by the provider in 2018/19 and Mersey Care NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided:

a) From the National Clinical Audit on Psychosis (year 1 2017/2018) the actions to improve quality are:-
   i) Continue the development of the community physical health pathway with improved specialist staff to support access and record keeping systems and an intranet portal developed to support the physical health pathway.
   ii) Review provision and access to psychological therapies;
   iii) Review the record keeping associated with engagement/involvement of service users in prescribing decisions.

b) From the National Audit of Care at the End of Life (NACEL) the actions to improve quality are:
   i) Review of the End of Life Care Plan and include as part of electronic patient record on EMIS;
   ii) To undertake monthly audits to ensure key stages of the pathway are being met;

c) National Audit of Intermediate Care (NAIC) the actions to improve quality is:
   i) The findings from the audit have been included in the review of the Integrated Community Reablement and Assessment Service (ICRAS) across both Liverpool and South Sefton.

Participation in Trust Wide Clinical Audits

32. The reports of 80 completed clinical audits were reviewed by the Trust in 2018/2019 and it intends to take action to improve the quality of healthcare provided (see Annex 3 Actions against the key themes from these local clinical audits reviewed in 2018/19).

33. 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.

2.5 NHS Staff Survey Results 2018

34. The annual NHS Staff Survey was conducted between 5 October and 30 December 2018, the Trust achieved a response rate of 51% which is above national average of 45%. Following the acquisition of Liverpool Community Health NHS Trust (LCH), Mersey Care’s Staff Survey responses are now benchmarked against Combined Mental Health/Learning Disability and Community Trusts as its comparator group. There are 30 other organisations within this comparator group.

35. Given the changes to our organisational structure following the acquisition of LCH, there is no comparable data provided by the Survey Co-Ordination Centre. This analysis has been conducted internally where possible for guidance to indicate trends from previous years. To this effect 2018 will become ‘Year Zero’ of the new
integrated organisation and the new reporting format to provide the benchmark for future results.

36. The Trust’s results for this year are encouraging in terms of comparison against national average and against 2017’s results. The Trust is either meeting or above average in 6 out of the 10 key themes. When we compare our results by question with the previous year, our results are as follows:

| Number of questions where we have improved | 59 |
| Number of questions where the results are the same as the previous year | 12 |
| Number of questions where we have seen a slight deterioration | 11 |
| Number of questions which are new so have no direct comparator | 8 |

37. In relation to Overall Staff Engagement the Trust has achieved a score of 7.0 which meets the national average for our comparator group. All clinical divisions have seen improvements in relation to engagement. After a decrease in medical staff engagement, this group have seen a notable improvement, reflecting the work undertaken in this area and the implementation of the Medical Senate.

38. The Trust has also seen notable improvements in each of the questions that make up the Safety Culture, which has been a key area of focus for the Trust in line with the Just and Learning Culture work. Particular improvements were noted in the Community Division who undertook the survey for the first time as part of Mersey Care following the acquisition in April 2018.

39. These results were presented to the Trust Board of Directors in March 2019, as well as cascaded through divisional workforce groups. Results will be shared with front line staff as part of the Spring Roadshows taking place in April and May and used to generate discussion between staff and senior manager about their experience at work.

40. The Trust’s People Plan has previously identified 5 key priorities that will improve staff experience and ensure Mersey Care is an employer of choice. These 5 areas directly link to the 10 new themes of the Staff Survey; on-going progress of actions will be monitored by the Board and by the Strategic Workforce Group. Divisional action plans in response to findings are being developed and will be presented to the relevant Operational Management Boards.

http://www.nhsstaffsurveyresults.com/local-breakdowns-questions/
2.6 Research and Development

41. This year priority has again been given to supporting NIHR (National Institute for Health Research) adopted studies. A wide range of student, staff and internally generated research studies have also been facilitated. We have supported 117 open studies (including those in set-up, actively recruiting and in write up), of which 58 were adopted NIHR studies and the remaining 59 were student, Trust specific and own account studies.

42. The number of service users recruited during this period to participate in research, approved by a research ethics committee was 899. In addition, 108 staff and 134 carers and 43 others participated in research studies – a total of 1184. Of these, 333 service users, 87 carers and 26 staff and 6 others (a total of 452 recruits) were from NIHR adopted portfolio studies and 732 from non-adopted studies.

43. Performance metrics for NIHR adopted studies are based on approval times and delivery of participants to time and target. We have maintained our excellent record in achieving time to set up, first participant and time to target throughout 2018/19 and have again surpassed the recruitment target for the number of people participating in NIHR research.

44. Research effort to support Trust priorities this year has continued, including self-harm, suicide, reducing restrictive practice, physical health.

45. The range of studies being supported continues to be varied including community health, parental mental illness, service users as parents and parenting practice, learning disability, mental health, forensic, genetics, dementia, IAPT, social work, perinatal mental health, injecting drug users, alcohol abuse and offender personality disorder pathway. The R&D team have supported the trust’s first Lewy Bodies Dementia study. We are also supporting the identification of potential dementia participants for an open Phase I clinical trial looking to reduce the production of a
specific protein in the brain which may affect the progression of AD in collaboration with the Royal Liverpool Hospital.

46. The acquisition of Liverpool Community Health NHS Trust (LCH) and the return of services in Liverpool Prison have allowed us to support a wider range of studies. These have included: Rethinking Strategies for Positive New-born screening; improving vaccination amongst Polish and Romanian migrants; Accessing medicines at end of life; trial of a safer sex intervention; Strengths/limitations on District Nursing teams completing Continuing Healthcare Assessments for patients. A new study is being supported in HMP Liverpool looking at dementia and cognitive impairment in the older prison population identifying healthcare needs for older prisoners.

47. The highest recruiting study this year was also our first significant commercial study, generating income to the trust. 106 service users were recruited within both time and recruitment target. This was a single site study looking at the effect of Clozapine and other antipsychotic treatment on circulating B cells with the potential for repurposing this drug. Very positive feedback on our support has been received from the sponsor.

48. Recruitment to a national genomics project (100,000 Genomes Project) which aimed to sequence 100,000 whole genomes from NHS patients to accelerate the development of new diagnostics and treatments has now been completed. The project focused on patients with rare disease and their families. We supported the recruitment of participants with severe learning disabilities with associated congenital malformation and autistic tendencies. Clinicians are now waiting for individual service user results to be fed back from the research team.

49. The Trust continues to support several studies within the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH) programme.

50. Recruitment is continuing to 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 is one of only 11 sites in the UK and the study is being jointly delivered by the National Probation Service and partner Health Service Providers as an integrated part of the Offender Personality Disorder Pathways Strategy.

51. Expansion of a range technology based studies has continued through collaborative links with our academic partners. These have included SWiM (Strength Within Me), a study to develop an algorithmic risk score that is valid in predicting suicide risk. Recruitment within in-patient wards to the pilot feasibility study is now complete with publications being drafted. Phase 2 is in the planning stage. A second Trust study under the GDE work plan is AVERT which is using free text clinical data to investigate the feasibility of conducting sophisticated artificial intelligence (AI) analysis on clinical text data to predict future health outcomes.

52. A common dilemma facing district nurses and community matrons is the grading and classification of pressure ulcers. Investigations have often revealed inconsistencies in how they are recorded, making it difficult to track accurately any improvement or
deterioration. Liverpool and South Sefton Community division’s skin team are working with Liverpool John Moores University on a pilot research study to test the efficacy of an automated pressure ulcer management tool. The tool uses state-of-the-art machine learning and objection detection to grade and report on the characteristics of each stage of a pressure ulcer. The study will evaluate the potential of the tool for use in day-to-day clinical practice.

53. Engaging service users and carers is crucial to ensure research leads to improvements and changes in healthcare delivery which is core to providing patient-centred care. The ability to demonstrate meaningful participation within research from PPI groups also promotes opportunities for external funding. The Specialist Learning Disability Division (SLDD) based on the Whalley site have offered service users an opportunity to be involved in the early stages of planning two research studies. Both were in preparation for external funding bids. One was a project using an inclusive participatory approach to explore what the experiences and aspirations for future care transitions of autistic people living in forensic hospitals and how can these help to shape future service delivery with the University of Leeds. The second was a bid to review approaches used to prevent and reduce the use of restrictive interventions on adults with learning disabilities with Manchester Metropolitan University.

54. With the planned closure of LD service provision on the Whalley site, it is imperative that this process is captured and monitored to measure impact and for future reference. The Whalley site is supporting an undergraduate project titled; The Impact of the Transforming Care Agenda upon inpatient services users within England’s last specialist NHS Learning Disability hospital…. A staff perspective.

55. Working in collaboration with Lancaster University, the Whalley site Research Practitioner and the Whalley site Speech and Language Therapy Lead, are undertaking statistical and qualitative analysis concerning a checklist devised by the Speech and Language Lead. This checklist is measuring the effectiveness of a tool called ‘Enhanced Communication Tool’. Colleagues at Lancaster University are assisting in assessing the effectiveness of the tool with the aim of validating it and rolling this out within a number of differing services, including secure LD, Youth Offending and Prison/Probation services/settings.

56. Patient and Public Involvement and Engagement (PPIE): The Whalley site has welcomed a number of academics and visiting researchers who are interested in capturing the views and opinions of both the Service Users who reside at Whalley and the staff who work there. This has largely involved working in partnership with the Media Crew. The Media Crew are a service user led group facilitated by Occupational Therapy services who focus on co-producing and designing accessible information and thus promoting engagement in the development of; posters, leaflets, short films, welcome packs for new service users and story boards. The group also advise on a range of topics including research/service evaluation design, methodology and dissemination. The group meets on a weekly basis and are experts in co-producing materials and planning projects.

57. Working collaboratively within the Research Team, People Participation Team, Trust Legal Services and Service User consultation groups, a Research Volunteer
Agreement has been developed to facilitate and safeguard research volunteers. The purpose of the agreement is to actively engage with any potential Research Volunteers and support them in a safe manner to undertake a range of research activity. Research Volunteers arise in a range of ways and the lack of any formal governance to both support and protect these individuals was identified by the R&D team. Hence, the Research team compiled their own bespoke agreement which is being reviewed prior to formal introduction. Two members of the R&D team are also supporting a group of service users and carers in the Life Rooms encouraging and supporting involvement in research and evaluations.

58. The Health Research Authority (HRA) directs that GDPR has to be included in participant information sheets but the wording and language for some service users is very difficult to understand. The R&D team have worked with service users, Speech and Language therapists and colleagues to develop an easy read which the HRA are keen to review and potentially use nationally.

59. A group of service users and carers have worked in collaboration with the University of Liverpool to develop and deliver their own research project looking into staff perceptions of working with service users with borderline personality disorder. A paper on the findings has been drafted with plans to submit for publication imminently.

60. A service user has been supported in his research application for an MSc in Personality Disorder looking at staff experience of "crisis calls" in a specialist MH service for patients with a diagnosis of emotionally-unstable PD.

61. The R&D Team have continued to promote a national initiative entitled Join Dementia Research (JDR) with the use of a recruitment booth from the JDR team and have achieved the second highest uptake of JDR in the NW Coast region.

62. The R&D team has developed a quarterly research newsletter whose main focus is promotion of research to service users and carers but also to raise the profile of research to staff.

63. The team has introduced thank you letters for service users, carers, staff and teams who support research studies. Continued support for research will support Clinical Divisions evidence facilitation of research, engagement, partnership working and expertise of service user groups to facilitate participation in research as part of future CQC inspections.

64. The Research team is part of the Centre for Perfect Care and the website (www.centreforperfectcare.com/) now holds all the information and advice relating to the process for submitting research and a comprehensive list of all studies currently open to recruitment.

65. Development of research skills in the workforce has continued to be supported including training on the legal requirements for clinical trials, Good Clinical Practice training, shadowing opportunities for students, internships, Masters qualifications, and the Comprehensive Research Network (CRN) Advanced Leadership Programme.
66. The R&D team has encouraged an increasing number of medical colleagues to evidence research in their core competencies and has supported clinical teams that have had little research experience previously.

67. Through an established collaboration with the University of Liverpool entitled the ARISE (Applied Research, Innovation and Service Evaluation) and the employment of a Research Associate and Research Assistants, several research and evaluation projects have been delivered to support the Perfect Care priorities and develop programmes of research to support Perfect Care. These have included :- CORE24; SWiM app; Management of Aggression; HOPE (Hospital Outpatient Psychotherapy Engagement Service) evaluation (a service providing rapid access to psychological therapy, specifically tailored for those presenting at Accident & Emergency Departments in Liverpool City Centre following an episode of self-harm). The HOPE evaluation lead to a successful bid to Liverpool CCG for funding to investigate the potential for making a shift to delivering this self-harm intervention in the community. Following this, a bid has now progressed to stage 2 for funding to test out the delivery of this service in the community – Community Outpatient Psychotherapy Engagement (COPE).

68. Collaboration with R&D colleagues at North West Boroughs Healthcare NHS Foundation Trust (NWBHFT) has continued with the aim of widening access to clinical trials to Service Users.

69. We have established and continue to build strong links and networks with other research active organisations including the Innovation Agency, Liverpool Health Partners (LHP), Northwest Coast Genomics Health Care Alliance and the Collaboration for Leadership in Applied Health Research and Care (CLAHRC). We remain involved in the analysis of data from the CLAHRC Household Survey which supports the discovery of local level and socio-economic factors that affect inequalities in physical and mental health with other partners.

70. We continue to maintain links with the NW Coast Clinical Research Network, Liverpool University, Liverpool John Moores University, Edge Hill University, University of Central Lancashire, Chester University, Lancaster University, Manchester Met University and Manchester University. High Secure Services have maintained and built upon their longstanding collaboration with UCLAN. We have been involved in a number of international, national and local research projects and external funding bids. International research links have also included joint bids, honorary contracts, memorandums of understanding and joint working with colleagues in Norway, Denmark, Netherlands, Switzerland, Sweden, Australia, Maastricht, Old Dominion University, Virginia, USA; University of Western Sydney, Australia. Ashworth Research Centre has also supported students from Germany and Russia. The R&D team continue to work collaboratively with the North West Mental Health Research Alliance.

71. The Trust is one of eleven partners in the Liverpool Health Partners (LHP) initiative which has a vision to promote and grow research in the Liverpool region based around the specific local population health needs. The trust has been working to support the formation of the Joint Research Service (JRS) which will go live in mid
May 2019 with the aim of reducing bureaucracy and set up time for external researchers. The JRS will be formed through the co-location of support staff from across the LHP members. Due to the small R&D team resource, no trust staff will physically move to the JRS base but funding will be provided for a post in the specialist team. We will work closely with the JRS team through sharing expertise and knowledge and contribute fully to the updated data management/performance system. LHP membership will allow the trust to build stronger relationships and collaborations with partner trusts that are skilled in the delivery of clinical trials with high quality clinical trial facilities and resources. It is anticipated that this will give the trust safe and trusted environments to deliver clinical trials collaboratively in the future.

72. The outcomes of several funding bids with academic colleagues from various universities are awaited. One successful bid, with the University of Liverpool, plans to develop a social network Intervention to support recovery for people living with severe mental illness.

73. The R&D team relocated in October 2019 to a base in indigo which supports improved and safer working (e.g. lone working in community/home environments), better collaboration and supports team cohesion.

74. The specialist knowledge and skills within the team have been acknowledged via the Whalley site Research Practitioner being approached by the NIHR to peer review a proposed RCT feasibility study application submitted to the NIHR funding competition.

75. Staff projects have lead to successful publication in peer reviewed journals. For example: Zulaikha Khan, Arun Chidambaram, Michaela Thomson, Courtney Hurst, (2019) “An exploration of MDT views on key factors to consider when determining a service users required level of security”, Journal of Forensic Practice, Vol. 21 Issue: 1, pp.38-49.

76. A challenge for the coming year will be to deliver our first clinical trial as a site with support from the sponsor - Imperial College London. The study is entitled: *The clinical effectiveness and cost effectiveness of clozapine for inpatients with borderline personality disorder: randomised controlled trial*. Delivery of this study is not anticipated to be easy but it will provide experience to the R&D team and the Principal Investigator. Maintaining the number of adopted NIHR studies is expected to be challenging and unpredictable with an increasing emphasis on delivering Trust specific studies and external funding bids rather than relying on external studies.

### 2.7 Sign Up to Safety Campaign

77. 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.

78. Mersey Care is committed to Sign Up to Safety and support the philosophy of locally led, self-directed safety improvement.
79. 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 Report and align with our perfect care goals.

80. The Trust has continued, as part of its Duty of Candour policy 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. All national targets are now being achieved. The Trust has identified an individual manager in the Trust who coordinates the Trust’s response to Duty of Candour Incidents this has increased the quality of the work undertaken. They have also:

a) updated policy and procedure;
b) provided training to staff particularly in High Secure Services;
c) undertaken the role of Family Liaison Manager for the majority of incidents within the Local Division;
d) Monitored incidents to ensure that those incidents that meet the criteria for Duty of Candour are moved through the agreed process.

81. The Sign Up to Safety agenda in the Trust has been reviewed. Following a stock take of progress made so far the Just Culture campaign and appointment of the Freedom to Speak up (FTSU) Guardians have been focusing on reducing the concerns that many staff have had when an incident has occurred. Previously staff have felt that they would be blamed for the incident and potentially suspended. The FTSU guardian role has provided staff with a vehicle to raise their concerns about risks and safety in a way that is controlled, supportive and remains internal to the trust. This means that the organisation can deal with issues more contemporaneously and implement remedial actions to enhance the safety and quality of service provision.

82. The Trust has been working with Stanford University to undertake improvement work to reduce the number of self harm incidents in the Trust. It has used Design Thinking Methodology to do this. Changes to practice have included:

a) using safety huddles to share information with staff on current plans to manage ward/ incident risk;
b) providing specific training on the prevention and management of self harm to staff;
c) increasing social and recreational activities;
d) providing patients with alternatives to self harm;
e) increasing the availability of therapeutic problem solving groups;
f) providing staff with time to reflect on the care they give and learn from their experiences with the aim of enhancing their resilience and skill.

83. The Trust continues to review the number and type of assaults that are inflicted on staff with the aim of identifying ways that the number and level of harm caused by of assultive behaviors can be reduced. The Trust’s Personal Safety Team have focused their work on providing clinical guidance to staff regarding specific and
complex individuals as it was recognised that the majority of violent incidents were caused by a small number of vulnerable and complex patients. The number of violent incidents across the Trust is gradually reducing in the Trust. The PSS teams have also been actively involved in supporting wards in implementing the smoke free policy with the aim of increasing safety and reducing assaultive behavior.

**Mortality - Learning from Deaths**

84. The Trust continues to fund a Mortality and Incident Review Team to meet Trust priority 6 for 2019/20. The team has been expanded to allow for the quality and timeliness of reviews undertaken to be maintained. The Trust has used national and Royal College guidance, attendance at local and national conferences, involvement of specialists from MAZARS and support from our commissioners to ensure that the work being undertaken is current and able to meet best practice.

85. The Trust has committed to reviewing all deaths of patients who utilise its clinical services. The scope for reviewing deaths within community services was agreed in 2018/19 and was implemented from November 2018. Reporting to commissioners on these deaths will begin from Q1 2019/20.

86. All deaths that are in scope are reviewed by the Trust using its three stage process:
   a) triage using the agreed review tool;
   b) Structured Judgment Review (SJR)/seventy two hour review;
   c) Root Cause Analysis Review

87. The screening tool used by the team for reviewing deaths has been adapted following the Trust’s participation in the pilot of the Royal College of Psychiatrists mortality screening tool. The Trust’s Associate Medical Director for learning reviews actively participated in the feedback on this, presenting to the Royal College in London.

88. The screening tool highlights ‘red flags’ where further more detailed review is warranted. Additional red flags applicable to physical health cases were added in consultation with community services staff and commissioners to ensure that reviews are applicable to all patients under the care of the Trust.

89. The Trust will continue to develop the screening tool to optimise its use in practice and maximise learning from reviews of deaths that are undertaken.

90. The Mortality and Incident Review team is now supported by the Associate Medical Director for learning reviews which allows for an MDT (multi-disciplinary team) approach to be utilised for oversight of reviews undertaken. The team meets weekly to consider any SJR’s and is able to source subject matter expertise and engage provider partners if necessary to allow for a fuller review of a patient pathway. Feedback is given promptly to team concerned during the course of the meeting to allow for learning to take place.

91. The Trust continues to undertake a series of thematic mortality reviews to identify learning following the deaths of patients in certain diagnostic groups. The reviews
undertaken have included deaths in those with a dementia diagnosis and a review of Learning disability deaths which was supported by Mazars. Actions that have emanated out of these have included work on advanced care planning for those with dementia which is now underway.

92. The Trust reports the findings of this process on a bi-monthly process to the Quality Assurance Committee and the Board of Directors as per national guidance.

93. To continuously improve the quality of incident reviews the Trust has supported key staff to undertake an academic course facilitated by the University of Central Lancashire, with further places sourced for 2019/20.

94. Additional training on incident reviews has been delivered within the Community Services Division by the Director of Patient Safety to improve the quality of reporting and enhance the resulting learning and improvement opportunities. A member of the Mortality and Incident Review team has also been allocated to support the Division’s review process and a ‘buddy’ system for new reviewers has been established to allow for maintenance of standards and to maximise learning.

95. A process mapping exercise is now underway to consider how the Trust undertakes incident reviews to ensure that a single methodology is used across all its services underpinned by just culture principles.

96. The Trust is now focusing on increasing the number of wards that undertake Safety Huddles within the organisation; the aim is to provide more clarity re the role and function of huddles, though at the same time ensuring they are used to enhance the specific risks of the ward.

97. The Trust will be developing a project to focus on reducing the variance of clinical practice across inpatient wards, recent incidents have shown that there are significant differences in the way that staff in inpatient area provide care, this also occurs across shifts on the same ward. The Trust will use Design Thinking Methodology to identify a small number of standards to implement.

**Supplementary Mortality Data for Quality Account 2018-2019**

**Item 27.1 - Total number of deaths 2018 – 2019**

98. Deaths are continuously being reported within the Trust through incident reporting systems. Changes were made within the year in reporting mechanisms with a move to use of a single incident reporting system for mental health and community services from February 2019. Additionally, from November 2018, the Community services division had begun reporting on all deaths of patients who had been in contact with clinical services within the previous 30 days.

99. Deaths are also now reported to the incident reporting system from the mental health services patient administration system, RIO, which pulls this information directly from the NHS spine (national patient data system). Work is underway with the provider of the patient administration system for the Community services division to explore if a similar transfer of data is possible.
100. It should be noted that some Q4 deaths may have been reported in Q1 2019-2020 and will be listed for review during that period, details will not be available on these cases until the next reporting year and this number may increase as deaths are reported.

**Total number of deaths by quarter 2018-2019**

<table>
<thead>
<tr>
<th></th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>304</td>
<td>352</td>
<td>712</td>
<td>820</td>
<td>2,188</td>
</tr>
</tbody>
</table>

**Incidence of death by quarter 2018-2019**

101. There has been an increase in the number of deaths reported and therefore increased demand for review. In mid quarter 3 it was agreed that the organisation would report all deaths that involved patients who it had cared for across all clinical divisions. Currently the Trust is not able to review all cases due to the numbers involved, it is though prioritising review for those deaths that are unexpected, where concerns had been expressed by the treating team, the patient was treated by the organisation on a long term basis and or they were recently admitted or discharged. The team will review its current scope to ensure that its target numbers are met.

102. All deaths of patients with Learning disability reported were reviewed within the year.

103. All child deaths were reviewed via the Child Death Overview Panel process.
### Deaths reviewed 2018-2019

<table>
<thead>
<tr>
<th></th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Incidence of death</td>
<td>304</td>
<td>352</td>
<td>712</td>
<td>820</td>
<td>2,188</td>
</tr>
<tr>
<td>Deaths reviewed</td>
<td>241</td>
<td>264</td>
<td>306</td>
<td>94</td>
<td>905</td>
</tr>
</tbody>
</table>

**Deaths reviewed by quarter 2018-2019**

**Item 27.3 - Proportion of deaths likely attributable to care**

104. Problems with care can be identified through the adverse incident and mortality review processes. Deaths from suspected or actual suicide are escalated as Serious Incidents according to the national framework and reviewed by root cause analysis (RCA) investigation.

105. Other deaths are reviewed through the mortality screening process and progress to structured judgement review (SJR) where the mortality team feel that there are concerns for care. During the reporting period the mortality team introduced a ‘red flag’ system, based on a Royal College of Psychiatrists pilot review tool, to identify key features, aspects of illness or elements of care which warrant further detailed review by SJR. Additional ‘red flags’ were incorporated into the screening tool applicable to physical health deaths.

106. During the reporting period a mortality multi-disciplinary meeting with Consultant leadership was established to consider SJR’s as a team.

107. Of those deaths reviewed during 2018-2019 none of the cases reviewed by SJR during the reporting period were felt to have been more likely than not to have resulted from problems with care.

108. From those deaths investigated through the RCA process, those with root causes suggesting avoidability are shown in the table below.

<table>
<thead>
<tr>
<th>Deaths linked to care concerns 2018-2019</th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4 (provisional)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cases</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>0 (provisional)</td>
</tr>
<tr>
<td>% age of deaths occurred</td>
<td>0.65</td>
<td>0</td>
<td>0</td>
<td>0 (provisional)</td>
</tr>
</tbody>
</table>
109. 5 RCA reviews for deaths which occurred in the 2018-2019 reporting period remain in progress at the time of this report. Any attribution to care problems for these reviews will be reserved until full details are known and will be reported in the end of year summary 2019-2020.

**Item 27.4 - Key learning from reviews highlighted in 27.3**

110. The Trust currently does not have a drafted Bereavement Policy to guide staff in management of a significant loss for patients.

111. The Trust needs to provide training and refresher training in risk assessment of patients in mental health services. This should include preparation for staff to be able to assist service users in developing safety plans.

112. There should be a review of the CPA process to ensure that it is robust and safe

**Item 27.5 - Actions as a result of key learning identified in 27.4**


114. Suicide risk training continues to be rolled out across all divisions. Risk assessment training, along with Safety Plan training has been developed and is being rolled out across the Local services division and will continue to be monitored through the Local services division overall Serious Incidents action plan.

115. A whole-system review of the CPA process has taken place and the actions are now being monitored through the Local division overall Serious Incidents action plan.

**Item 27.6 - Assessment of impact**

116. Actions are divisionally led and assurance is provided through divisional governance processes or, where impact is Trust-wide, the Mortality Review Group.

**Item 27.7 - Number of reviews completed 2018-2019 for deaths which occurred 2017-2018**

117. This detail was not included in the previous reporting period document.

118. It is not possible to draw information from that period for all divisions now within the Trust due to the acquisition of new services and changes to incident reporting systems and new death reporting and review mechanisms which were introduced part way through 2017-2018.

119. On the Trust incident reporting system 34 deaths were reported and reviewed in 2018-2019 which had actually occurred during 2017-2018.

**Item 27.8 - Estimate of the number of deaths in 2017-2018 with completed reporting in 2018-2019 likely to be attributable to care**

120. Two of the 34 deaths noted in 27.7 above progressed to RCA investigation and noted root causes suggestive of attribution to poor elements of care.
121. There have been changes in the organisation and in Trust mechanisms as noted within 27.1 and 27.7 that make extrapolation of percentages regarding these details for the period problematic.

Item 27.9 - Revised estimation of deaths from previous reporting period 2017-2018 attributable to problems with care

122. It is not possible to present this information as these details were not included in the previous reporting period.

123. The Five Sign Up to Safety Pledges:

   a) **Putting Safety First** - the Trust is committed to reducing avoidable harm in the 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;

   b) **Continually Learn** - the Trust will make the 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;

   c) **Honesty** - the Trust will be transparent with people about the progress it has made 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 “Freedom to Speak Up” 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;

   d) **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 as safe as possible.

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

   e) **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
2.8 Commissioning for Quality and Innovation (CQUIN)

124. Details of the CQUIN Schemes for 2017/19 are provided. The Trust will report quarter four CQUIN targets to commissioners on the 30th April 2019 and commissioners are expected to confirm performance in May 2019.

125. The Trust will report ‘green’ for all CQUIN targets in quarter four, with the following exceptions.

126. The Local Division may fail to achieve the National Physical Health CQUIN. The division is taking the following action to improve performance. A maximum of £0.124m may be identified to reinvest in the service to improve performance:

a) the division continues to monitor compliance with the Inpatient Physical Health Assessment form, in conjunction with PHYSCOC 8 and the Single oversight framework;

b) the division is working with the BI and performance teams to develop performance monitoring systems for community teams. This should enable the division to target areas of underperformance;

c) NHS England has included Early Intervention in Psychosis Teams (EIP) in the NCAP audit for 2018-19 which now included specific indicators for the group to monitor smoking cessation and BMI outcomes. The Modern Matron for Physical Health – Local Division and the EIP service have worked together to ensure that accurate data is provided for audit purposes. Early indications from the trust internal audit team predict a significant improvement in audit performance which is expected to be confirmed once the full NCAP results are published in June 2019;

d) the audit for Inpatient and Community Teams will not be part of the NCAP audit but will revert back to the CQUIN audit undertaken by the Royal College of Psychiatrists. The Local Division Modern Matron for Physical Health has suggested changes to the internal audit process to improve the quality of the data supplied which will include clinical input. These results will be published in June 2019;

e) for the Collaboration with Primary Care Physicians indicator, the Modern Matron for Physical Health – Local Division is in dialogue with commissioners in order to improve communication across Primary and Secondary Care, and to develop a shared care protocol.

127. There is a risk that Liverpool Community Services may not achieve the Personalised Care and Support Planning CQUIN, £0.97m may be identified to be reinvested back in the service for underperformance. The service has an action plan in place in order to address the shortfall in care plans. Commissioners have confirmed that payment for the Personalised Care and Support Planning CQUIN will be paid to the Trust when the annual target of 72 patients has been achieved and the shortfall has been addressed.

128. The South Sefton Community Services Division may fail to achieve the Supporting Proactive and Safe Discharge. Work is currently underway with the Service Lead and
Care Manager to look at ways of achieving the targets in Q4, £0.11m may be identified to reinvest in the service for underperformance.

129. The Staff Survey results, part of the Corporate CQUIN, Improvement of Health and Wellbeing were published in February 2019. The trust has failed the CQUIN targets, under this year’s contractual arrangements for the Local and Community Services Divisions £0.228m may be identified to reinvest back into the CQUIN to improve performance. For the Secure and Specialist Learning Disability Divisions, £0.052m may be returned to commissioners for underperformance.

130. NHS England is has reviewed the CQUIN Guidance. From April 2019, both the CCG and Prescribed Specialised Services (PSS) CQUIN schemes will be reduced in value by 50% to 1.25% with a corresponding increase in core prices through a change in the tariff uplift. The CQUIN scheme has been simplified, focusing on a small number of indicators aligned to key policy objectives drawn from the Long Term Plan.

**Local Services Division CQUIN Schemes 2018-19**

<table>
<thead>
<tr>
<th>CQUIN Indicator</th>
<th>Summary:</th>
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<th>Deliverables</th>
</tr>
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<tbody>
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<td>1a. Amanda Smith</td>
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<tr>
<td></td>
<td>1b. Healthy food for NHS staff, visitors and patients.</td>
<td>1b. Joanne Ashley</td>
<td>1b. Changes in catering provision to reduce the fat, sugar and calorie content of food and drink items on trust sites. The improvements made in 2017-18 to be maintained.</td>
</tr>
<tr>
<td></td>
<td>1c. Improving the uptake of flu vaccinations for front line staff within Providers.</td>
<td>1c Joanne Scoltock</td>
<td>1c 75% of frontline staff to have received their flu vaccination by the 28th February 2019.</td>
</tr>
<tr>
<td>National Physical Health</td>
<td>2a. Improving Physical healthcare to reduce premature mortality in people with SMI: Cardio Metabolic Assessment and treatment for Patients with Psychoses</td>
<td>Nicola Lamont</td>
<td>2a To demonstrate cardio metabolic assessment and treatment for patients with psychoses in the following areas:</td>
</tr>
<tr>
<td></td>
<td>2b. Collaboration with primary Care Clinicians</td>
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<td>• Inpatient wards – 90%</td>
</tr>
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| | | | • Smoking outcome indicator –
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</table>
| Primary Care Liaison     | Improving collaborative working between Primary and Secondary Mental Health Care. | Alex Henderson  | Development of a Primary Care Liaison service to establish closer links between Secondary and Primary Care. The four core elements are:  
| Service                  |                                                                          |                 |  - Direct Patient Care – brief interventions.  
|                          |                                                                          |                 |  - Support and Advice for Primary Care Practitioners  
|                          |                                                                          |                 |  - Education and Service Development.  
|                          |                                                                          |                 |  - Bringing Secondary Care closer through shared learning. |
| Improving attendances    | Improving services for people with mental Health needs who present to A&E. | Jane Chaffer    | Where a 20% reduction of attendances for the cohort of frequent attenders was achieved in year 1, the number of attendances in the group remains at least 20% less than the baseline level in 2016/17; or where the 20% reduction was not achieved, the 20% reduction should be achieved.  
| at A&E                   |                                                                          |                 | Building on the work in year 1, identify a new cohort of frequent attenders to A&E during 17/18 that would benefit from psychosocial interventions and work to reduce by 20% their attendances to A&E during 2018/19. |
| Preventing ill           | **Part a. Tobacco screening**                                            | Linda Roberts  | Trust to demonstrate for all                                                                                                                  |
## Health by risky behaviours – Alcohol and Tobacco

**Part b.** Tobacco Brief Advice
**Part c.** Tobacco referral and Medication Offer
**Part d.** Alcohol screening
**Part e.** Alcohol brief advice & referral

- Lead: inpatient admissions
  - Percentage of adult patients screened for tobacco and alcohol use.
  - Patient records to include status and referral as necessary
- Deliverables: Trust to evidence that improved clinical pathways for interventions are in place and that relevant staff are trained to deliver brief advice and interventions.

## Child and Young Person MH Transition

- Transition out of children’s and young people’s Mental health Services (CYPMHS).
- Lead: Phil Laing
- Deliverables: Trust to collaborate with acute colleagues to evidence improvements to the experience and outcomes for young people as they transition out of Children’s and Young Peoples Mental Health Service.

## IAPT- Training and education for community based nurses

- Training for community nurses to recognise and respond to people with poor psychological wellbeing and comorbid chronic physical health conditions.
- Lead: Jo Webster
- Deliverables: The aim is to educate Community Practitioners to understand long term conditions and their link to poor mental health. This will inform referral to IAPT and voluntary sector provision and enable practitioners to offer initial low level interventions.

## Secure Division CQUIN Schemes 2018-19 (High Secure Services)

## Increasing Physical Activity for Secure Patients

- All patients in HSS to be offered 90 minutes of moderate exercise each week. For patients with specific physical or mental health issues a bespoke activity plan should be offered
- Lead: Danny Angus
- Deliverables: • Improved recording of patients physical exercise uptake
  • Increase in access to physical exercise for all patients
  • Increase in uptake of physical exercise by individual patients
  • Bespoke physical exercise plans for patients who have specific needs
  • Improved sense of patient well being and motivation
<table>
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| Reducing Long Term Segregation | To support HSS in reducing the use of long term segregation in an innovative and systematic way by producing and implementing a strategy to prevent and reduce the use of LTS | Danny Angus | • To reduce long term segregation by an agreed % in the baseline cohort  
• To demonstrate improved experience, access and inclusion, quality of life and recovery outcomes for those in LTS  
• To improve the physical health outcomes for patients in LTS  
• To reduce incidents of conflict  
• To reduce incidents of physical restraint and Response team interventions  
• To reduce work related sickness and associated costs to the organisation related to physical restraint and associated stress  
• To develop high levels of competency and resilience in staff teams |
| Reducing Psychological and Emotional Impact on Secure Staff | The aim of the CQUIN is to assist staff in the recognition of their own responses and will enhance their capacity to manage the on-going personal and professional challenges inherent in providing relational security for people with wide ranging and long standing needs. The development of trauma informed systems will provide a proactive approach to ensure staff are appropriately supported, trained and cared for. | Frank McGuire | • Enhanced staff well-being  
• Reduction in the level of absenteeism and sickness  
• Increased use of supervision  
• Enhance staff motivation  
• Increased use of reflective practice  
• Improved ward environment  
• Increased awareness of evidence base on developmental trauma  
• Implementation of trauma specific processes and procedures  
• Enhanced staff knowledge, confidence and competency (self perception) |
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<td>Audit of patient records to take Place in Q4.</td>
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<td>90% of patients to have an up to date CPA (care programme approach), care plan or a comprehensive discharge summary shared with their GP. Audit to take place in Q2.</td>
</tr>
<tr>
<td><strong>Recovery College for Medium and low secure patients</strong></td>
<td>Education and training programmes to support recovery.</td>
<td>Fran Cairns</td>
<td>The establishment of a co developed and co delivered programmes of education and training to complement other treatment approaches in adult secure services.</td>
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<td>Reducing Restrictive Practices within Adult Secure Services</td>
<td>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 whilst maintaining safe services.</td>
<td>Danny Angus</td>
<td>The overall aim is to develop an ethos in which people with mental health problems are able fully to participate in formulating plans for their well-being, risk management and care in a collaborative manner. As a consequence more positive and collaborative service cultures develop reducing the need for restrictive interventions.</td>
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<td>Discharge and Resettlement</td>
<td>Reduction of length of stay in specialised MH Inpatient Services</td>
<td>Lisa Rens/ Toni Vaughan</td>
<td>This CQUIN is designed to achieve at least a 10% reduction in the current average length of stay</td>
</tr>
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</table>
| Preventing ill health by risky behaviours – Alcohol and Tobacco | Part a. Tobacco screening  
Part b. Tobacco Brief Advice  
Part c. Tobacco referral and Medication Offer  
Part d. Alcohol screening  
Part e. Alcohol brief advice & referral | Dale Williams/ Mo Sidat | Trust to demonstrate for all inpatient admissions:  
- Percentage of adult patients screened for tobacco and alcohol use.  
- Patient records to include status and referral as necessary.  
Trust to evidence that improved clinical pathways for interventions are in place and that relevant staff are trained to deliver brief advice and interventions. |

### Specialist Learning Disabilities Division CQUIN Schemes 2018-19

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| National Physical Health | **1c.** Improving the uptake of flu vaccinations for front line staff within Providers.  
2a. Improving Physical healthcare to reduce premature mortality in people with SMI: Cardio Metabolic Assessment and treatment for Patients with Psychoses. | **1c Bridget Clancy** | **1c** 75 % of frontline staff to have received their flu vaccination by the 28th February 2019.  
**2a Dale Williams** To demonstrate cardio metabolic assessment and treatment for patients with psychoses in the following areas: Inpatient wards – 90%  
• All community based mental health services for people with mental illness (patients on CPA), excluding EIP services – 65%  
• EIP Services – 90%  
• BMI Outcome indicator – 35%  
• Smoking outcome indicator – 10%  
Audit of patient records to take Place in Q4.  
90% of patients to have an up to date CPA (care programme approach), care plan or a comprehensive discharge summary shared with their GP. Audit to take place in Q2. |
| Recovery College for Medium and low secure patients | **2b.** Collaboration with primary Care Clinicians.  
Education and training programmes to support recovery. | **Fran Cairns** | The establishment of a co developed and co delivered programmes of education and training to complement other treatment approaches in adult secure services. |
| Reducing Restrictive Practices within Adult Secure Services | 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 whilst maintaining safe services. | **Danny Angus** | The overall aim is to develop an ethos in which people with mental health problems are able fully to participate in formulating plans for their well-being, risk management and care in a collaborative manner. As a consequence more positive and collaborative service cultures develop reducing the need for restrictive interventions. |
| Discharge and Resettlement | Reduction of length of stay in specialised MH Inpatient Services | **Lisa Rens/ Toni Vaughan** | This scheme is designed to achieve at least a 10% reduction in the current average length of stay. |
## CQUIN Indicator

### Preventing ill health by risky behaviours – Alcohol and Tobacco

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  Trust to evidence that improved clinical pathways for interventions are in place and that relevant staff are trained to deliver brief advice and interventions. |

### Exit / Transition Strategy service users Moving to Community Settings

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<tbody>
<tr>
<td>Lisa Rens/ Toni Vaughan</td>
<td>To support the transfer of patients on the Whalley site to supported living in the community.</td>
</tr>
</tbody>
</table>

## Community Services Division CQUIN Schemes 2018-19 (South Sefton Services)

### National Staff Health & Wellbeing

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<td>1c. Improving the uptake of flu vaccinations for front line staff within Providers.</td>
<td>1c Joanne Scoltock</td>
<td>1c 75 % of frontline staff to have received their flu vaccination by the 28th February 2019.</td>
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### Supporting proactive and safe discharge

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<tbody>
<tr>
<td>Improving the discharge process for patients.</td>
<td>Michelle Bilsbarrow/ Cathy Long</td>
<td>Establish a baseline for the collation of data and then reporting on the timeliness of Fast Track Assessments, Health Needs Assessments and CHC Discharge Support Tool, against locally agreed targets</td>
<td></td>
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### Improving the assessment of wounds

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<tr>
<td>Improving the assessment of wound care for patients.</td>
<td>Michelle Bilsbarrow/ Jacqueline O’Riley</td>
<td>Target to increase the number of wounds which have failed to heal after 4 weeks that receive a full wound assessment.</td>
<td></td>
</tr>
</tbody>
</table>
### Preventing ill Health by risky behaviours – Alcohol and Tobacco

**Part a.** Tobacco screening  
**Part b.** Tobacco Brief Advice  
**Part c.** Tobacco referral and Medication Offer  
**Part d.** Alcohol screening  
**Part e.** Alcohol brief advice & referral

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| Catherine McGiveron/Annemarie Howard | Trust to demonstrate for all inpatient admissions:  
- Percentage of adult patients screened for tobacco and alcohol use.  
- Patient records to include status and referral as necessary.  
Trust to evidence that improved clinical pathways for interventions are in place and that relevant staff are trained to deliver brief advice and interventions. |

### Personalised care and Support Planning

Embedding personalised care and support planning for patients with long term conditions.

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<tbody>
<tr>
<td>Michelle Bilsbarrow/Annemarie Howard</td>
<td>CQUIN delivery over two years to embed personalised care and support planning for patients with long term conditions. This will enable those patients to have the skills, knowledge and confidence to self care, in order to manage their own health</td>
</tr>
</tbody>
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### Community Services Division CQUIN Schemes 2018-19 (Liverpool Services)

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| National Staff Health & Wellbeing | 1a. Improving staff health and Wellbeing (staff survey).  
1c. Improving the uptake of flu vaccinations for front line staff within Providers. | 1a. Donna Jones  
1c. Joanne Scoltock | 1a. A 5% improvement in the answer to 2 out of 3 questions on the staff survey, relating to health and wellbeing, MSK and stress, in order to demonstrate the trusts commitment to staff health and wellbeing. Baseline survey is the 2016 staff survey  
1c 75 % of frontline staff to have received their flu vaccination by the 28th February 2019. |
| Improving the assessment of wounds | Improving the assessment of wound care for patients. | Karina Woodyer Smith | Target to increase the number of wounds which have failed to heal after 4 weeks that receive a full wound assessment. |
| Preventing ill Health by risky behaviours – Alcohol and Tobacco | Part a. Tobacco screening  
Part b. Tobacco Brief Advice  
Part c. Tobacco referral and Medication Offer  
Part d. Alcohol screening | Dave Jones | Trust to demonstrate for all inpatient admissions:  
- Percentage of adult patients screened for tobacco and alcohol use.  
- Patient records to include |
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<tbody>
<tr>
<td>Part e. Alcohol brief advice &amp; referral</td>
<td>status and referral as necessary. Trust to evidence that improved clinical pathways for interventions are in place and that relevant staff are trained to deliver brief advice and interventions.</td>
<td>Lynda Taylor</td>
<td>CQUIN delivery over two years to embed personalised care and support planning for patients with long term conditions. This will enable those patients to have the skills, knowledge and confidence to self care, in order to manage their own health and live independently.</td>
</tr>
<tr>
<td>Personalised care and Support Planning</td>
<td>Embedding personalised care and support planning for patients with long term conditions.</td>
<td>Lynda Taylor</td>
<td>Two year CQUIN with 2017/18 focusing on the development of the Health Care Assistant role in the delivery of the NHS Universal Childhood Flu vaccination programme.</td>
</tr>
<tr>
<td>School age immunisation workforce development</td>
<td>Workforce development for the school immunisation programme</td>
<td>Lynda Taylor</td>
<td></td>
</tr>
</tbody>
</table>

**Financial Statement**

131. The trust has seven main contracts which each attract their own National and Local Commissioning for Quality and Innovation (CQUIN) schemes. The total trust CQUIN value for 2018-19 is £7.495m. The National CQUINs are mandated as part of the NHS standard contract local CQUINs are negotiated with commissioners in line with Trust and CCG local priorities. The trust reported quarter four CQUIN performance to commissioners on the 30th April 2019 and commissioners are expected to confirm performance by the end of May 2019.

**2.9 Care Quality Commission**

**Registration and CQC Ratings**

132. Mersey Care is required to register with the Care Quality Commission and during 2018/19 there was a number of changes made to register correctly all community services and dental practice locations with CQC, there are no conditions attached to the CQC registration.

133. The Care Quality Commission last inspected the Trust between October and December 2018, and the report following this inspection visit was published on 5 April 2019. The current CQC rating is GOOD following that process of inspection, and the position has strengthened, with the Trust attaining the rating of good for the
Safe, Effective, and Caring and Responsive domains and outstanding for the Well Led domain.

134. The CQC has not taken enforcement action against the Trust during 2018/19 and the Trust has not been subject to any in-depth enquiries or investigations by the Care Quality Commission during the reporting period.

135. CQC undertook an announced focused inspection of Mersey Care NHS Foundation Trust during March 2018 because:
   a) there had been a significant change in the Trust’s circumstances. The Trust had acquired South Sefton community services from Liverpool Community Health Trust on 1 June 2017 and Liverpool Community Services from the same Trust on 1 April 2018;
   b) the inspection was to include the annual Well led inspection of services;
   c) CQC had to assess if the Trust had addressed some of the areas where they identified breaches of regulation at their previous inspection in June 2017.

136. During this focused inspection the CQC inspected the following core services provided by the Trust:
   a) Acute wards for adults of working age and psychiatric intensive care units;
   b) Wards for older people with mental health problems;
   c) Wards for people with a learning disability or autism;
   d) Long stay/rehabilitation wards for working age adults;
   e) Community-based mental health services for adults of working age;
   f) Community health services for adults;
   g) Community health services for children, young people and families;
   h) Community dental services;
   i) End of life care.

The CQC also visited three of the trust’s walk-in centres: Smithdown Road Children’s NHS Walk-in Centre; Liverpool City Centre NHS Walk-in Centre and Old Swan NHS Walk-in Centre.

137. The ratings of these specific services were published following inspection in December 2018 (published April 2019) are as follows
   a) Acute wards for adults of working age and psychiatric intensive care units – Good;
   b) Wards for older people with mental health problems – Good;
   c) Wards for people with a learning disability or autism – Good;
   d) Long stay/rehabilitation wards for working age adults – Good;
   e) Community-based mental health services for adults of working age – Requires Improvement;
f) Community health services for adults – Requires Improvement;
g) Community health services for children, young people and families – Good;
h) Community dental services – Good;
i) Community End of life care – Requires Improvement;
j) Walk In Centres – Requires Improvement.

Requirement Notices

138. The Trust was issued with a requirement notice in respect of 13 breaches of legal requirements, under the following 3 Regulations. The areas these relate to are summarised as follows:
   a) Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment in community mental health services for adults of working age, in community health services for adults, in walk-in centres and end of life care
   b) Regulation 17 HSCA (RA) Regulations 2014 Good governance in end of life care, and walk-in centres
   c) Regulation 18 HSCA (RA) Regulations 2014 Staffing in community mental health services for adults of working age, community health services for adults, and walk-in centres

139. These are described in detail in the published inspection report which can be found at http://www.cqc.org.uk/sites/default/files/new_reports/AAAJO888.pdf.

140. The Trust will respond as required with a provider action plan due to be submitted by 1 May 2019

Other CQC Activity

141. The Trust has participated in two thematic reviews across partner agencies where CQC look at the ‘whole systems approach’ to care being delivered.

142. These reviews have consisted of a focussed review of HMP Liverpool, which took place in October 2018 where Mersey Care was the provider of the mental health services and a system wide review of health services for Children Looked After and Safeguarding in Sefton’ with Sefton CCG as the lead, This took place in July 2018.

143. From the CQC report received following the review of HMP Liverpool it was noted that the services provided by Mersey Care had improved considerably and although not rated by CQC, there were notably only 3 “should do” recommendations made by CQC to Mersey Care.

144. The report regarding the system wide review of health services for Children Looked After and Safeguarding in Sefton’ identified a number of actions identified for healthcare partner organisations. A Task & Finish Group was set up to respond to the actions identified, this was led by Sefton CCG and Mersey Care were actively engaged and involved in this process.
145. During 2018/19 CQC published the review of older people’s services in Liverpool that had taken place in February 2018, led by the Local Authority. Again, there was system wide learning identified and Mersey Care have been actively engaged with this approach.

146. Across Mersey Care inpatient services that are registered to provide care to patients under the Mental Health Act (1983) the Trust was subject to 26 unannounced Care Quality Commission/Mental Health Act inspections in 2017/18 of wards within local, secure and specialist learning disability services as part of their programme of inspections. These inspections consider the domains:
   a) purpose, respect, participation and least restriction;
   b) admission to the ward;
   c) tribunals and hearings;
   d) leave of absence;
   e) general healthcare;
   f) other areas such as environment, standard of food etc.

147. The CQC’s Mental Health Act reports have all been responded to within agreed timescales and have shown in the vast majority of cases that previous issues raised have been acted upon appropriately. It is notable that in two areas there were no actions identified as provider requirements by CQC – this is significant, given the wide remit of these visits.

148. However, the inspections have highlighted the following areas during recent reviews:
   a) not all ward areas are able to clearly evidence that Care plans are being shared with service users;
   b) not all ward areas are able to clearly evidence that patients’ rights are being explained in accordance with the Code of Practice or Trust policy.

149. Completed provider action response plans have been sent to CQC for all ward areas describing the actions to be taken to address these shortfalls in practice.

150. In relation to wider Trust wide focus, there continues to be a particular focus on mortality reviews within the Trust, developing thematic reviews and undertaking detailed post death reviews following the guidance from the Mazars review report published in December 2015. There is a Trust Wide group that focuses on this area and learning from deaths to improve practice where this is possible.
2.10 Duty of Candour

151. Duty of Candour is ensuring all communication is open, honest and transparent, especially when related to a notifiable safety incident, as identified in Regulation 20 (Health and Social Care Act (2008) (Amendment) Regulations 2015). This includes informing people of the incident and providing an apology, truthful information and reasonable support. Regulation 20 is a direct response to recommendation 181 and the aim of this regulation is to ensure that healthcare providers are open and transparent with service users and other “relevant persons” in relation to care and treatment and sets out requirements that must be adhered to when things go wrong.

152. The definitions of openness, transparency and candour used by Robert Francis in interpreting the regulation are:

a) **Openness** - enabling concerns and complaints to be raised freely without fear and questions asked to be answered;

b) **Transparency** – allowing information about the truth about performance and outcomes to be shared with staff, patients, the public and regulators;

c) **Candour** – any patient harmed by the provision of a healthcare service is informed of the fact and an appropriate remedy offered, regardless of whether a complaint has been made or a question asked about it.

153. The Patient Experience/ Duty of candour Lead works closely with all clinical divisions to ensure that all appropriate incidents are identified as requiring the Duty of Candour process. Lead reviewers who are primarily clinical staff are supported by the Duty of Candour lead to share the findings of reviews in a timely and professional manner. This change of process has ensured that all national targets are now being met.

154. The Quality Assurance Committee receives updates at every meeting regarding adherence to each of the steps within the Duty of Candour national guidance, this includes information on:

a) informing service users/ carers verbally that an incident has occurred;
b) providing a follow up letter which includes details of any review process that will occur;

c) sharing the outcomes of the review process with service users/ carers.

155. All actions are recorded on the Trust’s Risk Management data base (Datix) as are copies of letters and incident reports.

a) Duty of Candour has been applied to 84 incidents from 1\textsuperscript{st} April 2018 to 31\textsuperscript{st} March 2019

b) there were 34 deaths where there was a full RCA (root cause analysis) review undertaken;

c) there were 11 incidents with severe harm, including 3 self harm, 7 grade 4 pressure ulcers and a homicide;

d) of the 39 moderate harm incidents, 27 related to G3 pressure ulcers, 4 to medication related incidents, 7 relating to care and treatment, and one fall.

e) a family liaison or clinical lead was appointed to all 84 incidents, there were 2 cases where the patient or family declined any further contact.

f) an apology and letter was given all cases apart from 4 were there was no family or contact details

g) of all completed reviews where the patient or family were involved the reports have been share with the patient or family.

<table>
<thead>
<tr>
<th>Duty of Candour Incidents</th>
<th>84</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breakdown of Duty of Candour Incidents</td>
<td>Total</td>
</tr>
<tr>
<td>Death</td>
<td>34</td>
</tr>
<tr>
<td>Severe Harm</td>
<td>11</td>
</tr>
<tr>
<td>Self-harm Incidents</td>
<td>3</td>
</tr>
<tr>
<td>Pressure Ulcer G4</td>
<td>7</td>
</tr>
<tr>
<td>Homicide Incident</td>
<td>1</td>
</tr>
<tr>
<td>Moderate Harm</td>
<td>39</td>
</tr>
<tr>
<td>Pressure Ulcers G3</td>
<td>27</td>
</tr>
<tr>
<td>Medication</td>
<td>4</td>
</tr>
<tr>
<td>Care and treatment</td>
<td>7</td>
</tr>
<tr>
<td>Fall</td>
<td>1</td>
</tr>
</tbody>
</table>
156. Duty of Candour targets have been fully met within the organisation, this has been achieved through the development of a Duty of Candour lead role within the organisation we who has:

a) updated the policy and procedure;

b) provided training to staff, particularly in High Secure Services;

c) undertaken the role of Family Liaison Manager for the majority of incidents within the Local Division;

d) monitors incidents to ensure that those incidents that meet the criteria for Duty of Candour are moved through the agreed process.

157. There are continued concerns regarding the time it takes to complete reviews and therefore feedback the findings to patients and their families, the improvement of this situation has been achieved through the appointment of the Mortality and Incident review team. Monitoring of all parts of the Duty of Candour process takes place via regular reports to the Quality Assurance Committee.

2.11 Data Quality Improvement Plans

158. 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.

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

160. The Trust has a Corporate Data Quality Policy in place and a trust Data Quality Strategy which includes an agreed set of Data Quality Standards. The trust Data Quality Steering Group meets bi-monthly and oversees an annual Action Plan which also feeds into the Information Governance Toolkit requirements for Data Quality including the Annual Audit of Nationally Submitted Data Sets e.g. CDS, MHSDS.

161. The Trust’s corporate Data Quality Team run regular validation routines on the trusts electronic health record systems and on the National Data Set submissions. Local and National Data Quality reports are used to validate and update data with key themes highlighted to Clinical Divisions for action.

162. The importance of Data Quality is also highlighted in Clinical Information Systems training along with the importance of Good Record Keeping.

Quality Report 2018/19

163. Mersey Care NHS Foundation Trust submitted records during 2018/19 to the Secondary Users service for inclusion in the Hospital Episode Statistics which are
included in the latest published data. The percentage of records in the published data:

a) which included the patient’s valid NHS number was:
   i) 99.4% for admitted patient care;
   ii) 99.6% for outpatient care

b) which included the patient’s valid General Medical Practice Code was:
   i) 99.9% for admitted patient care;
   ii) 99.8% for outpatient care.

Latest data (SIS DQ dashboard) available from NHS Digital on 4 April 2019 relates to M10 2018/19 (April 2018 to January 2019)

2.12 Information Governance

164. The new Data Security & Protection Toolkit 2018/19 was submitted in March with the Trust being awarded “substantial assurance” status following audit of the Data Security & Awareness Toolkit
### PART THREE – QUALITY INDICATORS

#### 3.1 Quality Indicators

Quality Report 2017/18 Nationally Mandated Indicators (Section 2.3)

NHS foundation trusts are required to publish the data reported by the NHS Digital for each indicator for the reporting period, i.e. the 2017/18 financial year. For some indicators, no data or only partial year data is available for 2017/18 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 25 April 2018. Comparisons are with other mental health / learning disability providers.

<table>
<thead>
<tr>
<th>Mandated Indicator</th>
<th>Data period</th>
<th>Data Source</th>
<th>Mersey Care NHS Foundation Trust</th>
<th>National average</th>
<th>Highest national position</th>
<th>Lowest national position</th>
<th>Statement</th>
</tr>
</thead>
<tbody>
<tr>
<td>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 7 days after discharge from psychiatric in-patient care during the reporting period.</td>
<td>Q1 2017/18</td>
<td></td>
<td>93.9%</td>
<td>96.7%</td>
<td>100.0%</td>
<td>71.4%</td>
<td>The Mersey Care NHS Foundation Trust 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 Mersey Care NHS Foundation 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 &quot;breaches&quot; to enable lessons to be learnt and practice changed if required to avoid similar situations occurring in future.</td>
</tr>
<tr>
<td></td>
<td>Q2 2017/18</td>
<td><a href="http://www.england.nhs.uk/statistics/statistical-work-areas/mental-health-community-teams-community-activity/">http://www.england.nhs.uk/statistics/statistical-work-areas/mental-health-community-teams-community-activity/</a></td>
<td>94.9%</td>
<td>96.7%</td>
<td>100.0%</td>
<td>87.5%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Q3 2017/18</td>
<td><a href="http://www.england.nhs.uk/statistics/statistical-work-areas/mental-health-community-teams-community-activity/">http://www.england.nhs.uk/statistics/statistical-work-areas/mental-health-community-teams-community-activity/</a></td>
<td>90.6%</td>
<td>95.4%</td>
<td>100.0%</td>
<td>69.2%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Q4 2017/18</td>
<td></td>
<td>98.4%</td>
<td>95.5%</td>
<td>100.0%</td>
<td>68.8%</td>
<td></td>
</tr>
<tr>
<td>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.</td>
<td>Q1 2017/18</td>
<td></td>
<td>88.9%</td>
<td>98.7%</td>
<td>100.0%</td>
<td>88.9%</td>
<td>The Mersey Care NHS Foundation Trust 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 Mersey Care NHS Foundation 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 &quot;breaches&quot; to enable lessons to be learnt and practice changed if required to avoid similar situations occurring in future.</td>
</tr>
<tr>
<td></td>
<td>Q2 2017/18</td>
<td><a href="http://www.england.nhs.uk/statistics/statistical-work-areas/mental-health-community-teams-community-activity/">http://www.england.nhs.uk/statistics/statistical-work-areas/mental-health-community-teams-community-activity/</a></td>
<td>94.0%</td>
<td>98.6%</td>
<td>100.0%</td>
<td>94.0%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Q3 2017/18</td>
<td><a href="http://www.england.nhs.uk/statistics/statistical-work-areas/mental-health-community-teams-community-activity/">http://www.england.nhs.uk/statistics/statistical-work-areas/mental-health-community-teams-community-activity/</a></td>
<td>91.4%</td>
<td>98.5%</td>
<td>100.0%</td>
<td>84.3%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Q4 2017/18</td>
<td></td>
<td>100.0%</td>
<td>98.7%</td>
<td>100.0%</td>
<td>88.7%</td>
<td></td>
</tr>
<tr>
<td>Mandated Indicator</td>
<td>Data period</td>
<td>Data Source</td>
<td>Mersey Care NHS Foundation Trust</td>
<td>National average</td>
<td>Highest national position</td>
<td>Lowest national position</td>
<td>Statement</td>
</tr>
<tr>
<td>-------------------</td>
<td>-------------</td>
<td>-------------</td>
<td>---------------------------------</td>
<td>-----------------</td>
<td>--------------------------</td>
<td>--------------------------</td>
<td>-----------</td>
</tr>
<tr>
<td></td>
<td>2015</td>
<td>Dataset: 21. Staff who would recommend the trust to their family or friends (Q21d)</td>
<td>61%</td>
<td>58%</td>
<td>82%</td>
<td>37%</td>
<td>The Mersey Care NHS Foundation Trust considers that this data is as described for the following reasons: it has been obtained via the annual national NHS staff survey which is subject to ROCR approval. The Mersey Care NHS Foundation Trust 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 and is monitored through the annual staff survey and quarterly Friends and Family Test results.</td>
</tr>
<tr>
<td>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.</td>
<td>2016</td>
<td>Dataset: 21. Staff who would recommend the trust to their family or friends (Q21d)</td>
<td>60%</td>
<td>61%</td>
<td>82%</td>
<td>45%</td>
<td></td>
</tr>
<tr>
<td>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.</td>
<td>2017</td>
<td>Dataset: 21. Staff who would recommend the trust to their family or friends (Q21d)</td>
<td>63%</td>
<td>61%</td>
<td>84%</td>
<td>42%</td>
<td></td>
</tr>
<tr>
<td>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.</td>
<td>2012</td>
<td>Indicator: 4.7 Patient experience of community mental health services</td>
<td>88.1</td>
<td>86.5</td>
<td>91.8</td>
<td>82.6</td>
<td></td>
</tr>
<tr>
<td>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.</td>
<td>2013</td>
<td>Indicator: 4.7 Patient experience of community mental health services</td>
<td>89.3</td>
<td>85.8</td>
<td>91.8</td>
<td>80.9</td>
<td></td>
</tr>
</tbody>
</table>

The Mersey Care NHS Foundation Trust considers that this data is as described for the following reasons: it has been obtained via the annual national NHS staff survey which is subject to ROCR approval. The Mersey Care NHS Foundation Trust 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 and is monitored through the annual staff survey and quarterly Friends and Family Test results.
<table>
<thead>
<tr>
<th>Mandated Indicator</th>
<th>Data period</th>
<th>Data Source</th>
<th>Mersey Care NHS Foundation Trust</th>
<th>National average</th>
<th>Highest national position</th>
<th>Lowest national position</th>
<th>Statement</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>April 2016 to September 2016</td>
<td>Dataset: 5.6 Safety incidents involving severe harm or death</td>
<td>4,664 incidents; 35.4 per 1000 bed days</td>
<td>2,963 incidents per organisation; 46 incidents per 1000 bed days</td>
<td>89 incidents per 1000 bed days</td>
<td>10.3 per 1000 bed days</td>
<td>The Mersey Care NHS Foundation Trust 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 Mersey Care NHS Foundation 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 &quot;unexpected deaths&quot; only. Quality surveillance dashboards have been developed to provide live whole trust incident monitoring and alerts.</td>
</tr>
<tr>
<td></td>
<td>October 2016 to March 2017</td>
<td>Dataset: 5.6 Safety incidents involving severe harm or death</td>
<td>2,851 incidents; 22 per 1000 bed days</td>
<td>2,910 incidents per organisation; 41 incidents per 1000 bed days</td>
<td>88.2 incidents per 1000 bed days</td>
<td>11.2 per 1000 bed days</td>
<td></td>
</tr>
<tr>
<td></td>
<td>April 2016 to September 2016</td>
<td>Dataset: 5.6 Patient safety incidents reported</td>
<td>39 incidents resulting in severe harm or death (0.30 incidents per 1000 bed days)</td>
<td>33 incidents resulting in severe harm or death per 1000 bed days</td>
<td>4.07 incidents resulting in severe harm or death per 1000 bed days</td>
<td>0.04 incidents resulting in severe harm or death per 1000 bed days</td>
<td>The Mersey Care NHS Foundation Trust 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 Mersey Care NHS Foundation 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 &quot;unexpected deaths&quot; only. Quality surveillance dashboards have been developed to provide live whole trust incident monitoring and alerts.</td>
</tr>
<tr>
<td></td>
<td>October 2016 to March 2017</td>
<td>Dataset: 5.6 Patient safety incidents reported</td>
<td>74 incidents resulting in severe harm or death (0.57 incidents per 1000 bed days)</td>
<td>33 incidents resulting in severe harm or death per 1000 bed days</td>
<td>2.30 incidents resulting in severe harm or death per 1000 bed days</td>
<td>0.04 incidents resulting in severe harm or death per 1000 bed days</td>
<td></td>
</tr>
</tbody>
</table>

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.
3.2 Re-admissions

Quality Report 2018/19 Nationally Mandated Indicators (Section 2.3)

165. NHS foundation trusts are required to publish the data reported to NHS Digital for each indicator for the reporting period, i.e., the 2018/19 financial year. For some indicators, no data or only partial year data is available for 2018/19. The latest should be published for the last two reporting periods or data covering the minimum of a year.

166. The data reported below relates to the latest information available via the defined data sources as at 2 April 2019. Comparisons are with other mental health / learning disability providers.

Readmissions

167. The Quality Report reporting arrangements for 2018/19 includes an indicator on readmissions for all trusts. Review of the NHS Digital indicator portal for the Quality Account highlighted the following methodology for reporting (this was initially confirmed for the completion of the 2014/15 account, no change in methodology has subsequently been notified to the trust). To find the percentage of patients aged 0-15 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.

168. 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.

169. The latest version of both readmission reports were uploaded in December 2013 and the “Next version due” field stages “TBC”.

170. As Mersey Care NHS Foundation 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.

171. No data relating to Mersey Care NHS Foundation 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.

172. 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 2018/19 Quality Account.
173. Dataset: 3.16 (P01863) 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). The latest version was published March 2016 with the next version due June 2017.


3.3 Performance against NHS Improvement’s Single Oversight Framework Indicators

174. In preparing the Quality Report for 2018/19, NHS Foundation Trusts are required to report on indicators that appeared in both NHS Improvement's Risk Assessment Framework and the Single Oversight Framework.

175. Performance has been reported for the "Admissions to inpatient services had access to crisis resolution/home treatment teams" indicator in Section 2.3 (the core mandated indicators) so is not repeated here in line with the guidance.

176. Please note that the indicators for mental health trusts are reported on a quarterly basis so this is how the data is presented here and the full year position (based on the arithmetic mean) is calculated on that basis

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Performance threshold</th>
<th>Q1 2018/19</th>
<th>Q2 2018/19</th>
<th>Q3 2018/19</th>
<th>Q4 2018/19</th>
<th>Full year position</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accident and Emergency Maximum waiting time of four hours from arrival to admission/transfer/discharge</td>
<td>&gt;=95%</td>
<td>100.00%</td>
<td>100.00%</td>
<td>100.00%</td>
<td>100.00%</td>
<td>100.00%</td>
</tr>
<tr>
<td>Early intervention in psychosis (EIP): people experiencing a first episode of psychosis treated with a NICE-approved care package within two weeks of referral</td>
<td>&gt;=53%</td>
<td>60.00%</td>
<td>63.27%</td>
<td>63.75%</td>
<td>67.95%</td>
<td>63.74%</td>
</tr>
<tr>
<td>Improving access to psychological therapies (IAPT): Proportion of People completing treatment who move to recovery</td>
<td>&gt;=50%</td>
<td>50.28%</td>
<td>50.47%</td>
<td>47.42%</td>
<td>50.54%</td>
<td>49.68%</td>
</tr>
<tr>
<td>Improving access to psychological therapies (IAPT): people with common mental health conditions referred to the IAPT programme will be treated within 6 weeks of referral</td>
<td>&gt;=75%</td>
<td>96.58%</td>
<td>97.26%</td>
<td>98.42%</td>
<td>95.69%</td>
<td>96.99%</td>
</tr>
<tr>
<td>Improving access to psychological therapies (IAPT): people with common mental health conditions referred to the IAPT programme will be treated within 18 weeks of referral</td>
<td>&gt;=95%</td>
<td>100.00%</td>
<td>100.00%</td>
<td>100.00%</td>
<td>100.00%</td>
<td>100.00%</td>
</tr>
<tr>
<td>Inappropriate out-of-area placements for adult mental health services (OGDS) - External only</td>
<td>Q4 2018-19 - 169</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>13</td>
<td>18</td>
</tr>
<tr>
<td>Indicator</td>
<td>Threshold</td>
<td>Q4 – 2016/17</td>
<td>Q4 – 2017/19</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>------------------------------------------------------------------------------------------------</td>
<td>----------------------------------------</td>
<td>--------------</td>
<td>--------------</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ensure that cardio-metabolic assessment and treatment for people with psychosis is delivered routinely in inpatient wards</td>
<td>&gt;=90% green; &lt;90% red</td>
<td>66.00%</td>
<td>46.24%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ensure that cardio-metabolic assessment and treatment for people with psychosis is delivered routinely in early intervention in psychosis services</td>
<td>&gt;=90% green; &lt;90% red</td>
<td>Not Available</td>
<td>15.00%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ensure that cardio-metabolic assessment and treatment for people with psychosis is delivered routinely in community mental health services (people on CPA)</td>
<td>&gt;=65% green; &lt;65% red</td>
<td>8.00%</td>
<td>19.80%</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

177. The Cardio metabolic indicator audit results are unavailable until June 2019 after the Quality Report is published

3.4 Stakeholder Metrics

178. The following indicators have been selected in consultation with stakeholders and agreed by the Quality Assurance Committee, which is a committee of the Board, the indicators selected are presented for each of the following quality domains:

a) patient safety;

b) clinical effectiveness;

c) patient experience
# Stakeholder Metrics

<table>
<thead>
<tr>
<th>Theme</th>
<th>Indicator</th>
<th>Performance Threshold</th>
<th>Apr-17</th>
<th>May-17</th>
<th>Jun-17</th>
<th>Jul-17</th>
<th>Aug-17</th>
<th>Sep-17</th>
<th>Oct-17</th>
<th>Nov-17</th>
<th>Dec-17</th>
<th>Jan-18</th>
<th>Feb-18</th>
<th>Mar-18</th>
</tr>
</thead>
</table>
| Patient Safety*            | Incidents of Harm - Proportion of incidents that result in harm (classified as low, moderae, severe or death) | Green <=26.95%  
Amber<=31.62%  
Red >31.62%                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 10.31% | 9.31%  | 13.15% | 12.95% | 12.93% | 12.22% | 11.14% | 12.95% | 13.26% | 17.82% | 10.39% | 11.64% |
|                            | Safe Staffing - % of shifts filled by nurses against planned establishment (NHS England Fill Rate Measure/CHPPD) | % of shifts filled by nurses against planned establishment                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 105.19% | 109.92% | 108.69% | 109.58% | 105.24% | 100.30% | 112.62% | 111.91% | 106.71% | 109.35% | 108.59% | 106.97% |
|                            | Number of Out of Area Placements - External "Inappropriate" Only            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 0      | 11     | 8      | 3      | 4      | 9      | 3      | 4      | 6      | 0      | 0      | 0      |
|                            | Number of Out of Area Placements Occupied Bed Days - External "Inappropriate" Only |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 0      | 100    | 109    | 19     | 26     | 76     | 4      | 23     | 78     | 0      | 0      | 0      |
|                            | Bed Occupancy - Number of Occupied Bed Days (including Leave) - Cumulative | Green 85% to 90%  
Amber <85% or >90%  
Red <80% or >95%                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 17,506 | 35,019 | 53,744 | 71,965 | 90,244 | 135,100| 155,370 | 178,620 | 199,551 | 223,078 | 243,556 | 266,054 |
| Clinical Effectiveness     | Overall Patient Experience Score                                           | Green >=95%  
Red < 95%                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 95.13% | 95.35% | 95.53% | 95.18% | 95.27% | 94.46% | 95.09% | 95.35% | 97.33% | 96.09% | 95.18% | 93.25% |
|                            | Access to Services - Can you access services when you need them?          | Green >=95%  
Red < 95%                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 91.89% | 90.93% | 92.86% | 89.08% | 92.69% | 96.52% | 92.95% | 94.30% | 95.30% | 93.13% | 92.98% | 93.03% |
|                            | Involved in care - Have you been involved in the development of your care plan? | Green >=95%  
Red < 95%                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 96.38% | 95.35% | 98.16% | 96.08% | 96.80% | 96.02% | 95.00% | 96.35% | 98.88% | 98.10% | 93.57% | 93.20% |

* The third indicator Duty of Candour can be found within 2.10 of the report.
NHS Liverpool Clinical Commissioning Group
Quality Account Statement 2018-19
Mersey Care Mental Health and Community NHS Foundation Trust

NHS Liverpool, South Sefton and Knowsley CCGs welcome the opportunity to jointly comment on the Mersey Care NHS Foundation Trust Draft Quality Account for 2018-19. It is acknowledged that the submission to Commissioners was draft and that some parts of the document require updating. Commissioners look forward to receiving the Trusts final version of the Quality Account.

We have worked closely with the Trust throughout 2018-19 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 account reflects good progress on the delivery of 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 2018-19, which were:

- Priority 1: Reducing Restrictive Practice
- Priority 2: Towards Zero Suicide
- Priority 3: Improvements in Physical Health Pathways
- Priority 4: Just and Learning Culture
- Priority 5: Reduction in Community Acquired Pressure Ulcers
- Priority 6: Learning from Deaths

Following consultation with key stakeholders; these six priorities will be carried forward into 2019-20, with an additional priority;

- Priority 7: Reducing Delayed Discharges in Mental Health

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.

The Trust places significant emphasis on its quality and safety agenda and the pursuit of Perfect Care. These quality improvement priorities are consistent with the Trust’s Model of Quality ‘STEEEP’; Safety of Patients; Timely Care; Effectiveness; Efficient Care; Equitable Care and Positive Patient Experience. This is reflected in the work which the Trust has carried out around seven day follow up and annual health checks for service users on a care programme approach and the process for undertaking pathway reviews in association with partner organisations and obtaining data from GPs in relation to Learning from Deaths.
Through this Quality Account and on-going quality assurance processes, the Trust clearly demonstrates their commitment to improving the quality of care and services delivered.

Of particular note, during 2018-19; the Trust has undertaken work to improve outcomes on the following work streams:

- Physical restraint associated with self-harm has been reduced by 20%.
- 100% of staff who transacted from Liverpool Community Health have completed Level 1 Suicide Awareness Training.
- 100% of inpatient wards have implemented the National Early Warning Score; NEWS2.
- A standardised framework has been developed to support staff and learning from incidents.
- A reduction plan and target trajectory for pressure ulcers is in place.
- Scope for reviewing individual community deaths has been implemented.
- New standards have been adopted for the review of individuals in mental health care, in relation to Learning from Deaths.

Commissioners acknowledge the significant work undertaken by the Trust in relation to the transaction of Liverpool Community Health services, which took place in April 2018 and the ongoing work which is underway to align systems and processes across the Community and Mental Health Divisions. Reducing inpatient suicides to zero; improving Learning from Deaths and reducing the occurrence and deterioration of pressure ulcers are important priorities and focus areas for the Trust in 2019-20.

Commissioners are aspiring through strategic objectives and five 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 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  South Sefton CCG  Southport & Formby CCG  Knowsley CCG

Jan Ledward  Fiona Taylor  Dianna Johnson
Chief Officer  Chief Officer  Chief Executive
Date: 20 May 2019  Date: 17 May 2019  Date: 17 May 2019
The CCGs are pleased to note and acknowledge the progress made on “Reducing Restrictive Practice” with achievement of all six of the objectives identified and a reduction in the use of prone restraint by 50% from the baseline. Within the Specialist Learning Disabilities Division, it is noted that there has been an increase in the number of restrictive interventions in Quarter 2/3 and 4 of 2018-19. However, the CCGs note that the number of T-supine restraints has continued to be reducing and MCFT have been successful in reducing Safety Bed restraints for a number of patients.

The CCGs have been in discussions with MCFT with regard to the collection of data to show the intensity and length of incidents and thus providing additional reassurance and intelligence for this priority area. The CCGs continue to monitor this through detailed quarterly incident and restrictive intervention reports as part of the quarterly Quality Review Meetings with MCFT.

With regard to “A Just and Learning Culture”, the Trust has achieved all four of the objectives in relation to this priority. In particular, the CCGs note the work by MCFT to develop a standardised framework to support learning from incidents and the preventative approach taken to recognise bullying behaviour and help support psychological safety of staff.

The CCGs note the partial achievement of MCFT’s remaining four priorities for 2018/19. "Towards Zero Suicides", “Reduction of Community Acquired Pressure Ulcers”, “Improvements in Physical Health Pathways” and “Learning from Deaths”. However, it is encouraging to note the 100% achievement rates in relation to the “Improvements in Physical Health Pathways” for clinical staff to recognise deteriorating patients and ensuring prompt intervention to treatment. It is also positive to note that the work ongoing to implement last year’s objectives will continue into 2019/20.

With regard to “Learning from Deaths”, the CCGs note that MCFT participated in the Learning Disabilities Mortality Review Programme and the draft Quality Account states the Trust have not yet had any targeted feedback from this review. The CCGs recommend that the draft Quality Account provides further details on “Learning from Deaths” as per the prescribed information and form of statements as listed in the national reporting requirements for 2018/19.

The CCGs support the “Sign up to Safety” campaign and recognise the continuing work on this agenda within the Trust, particularly with the recent appointment of a lead manager to coordinate all Duty of Care work resulting in an increase in the quality of work undertaken. Whilst it is disappointing to note that the Quality Account does not detail the different ways in which staff can speak up (as per the national reporting requirements 2018/19 issued by NHS Improvement), the CCG recognises the excellent work carried out by the Trust’s Freedom to Speak Up Guardians which means the organisation is able to deal with issues and implement remedial actions to enhance the safety and quality of service provision. The CCGs commend the continuing collaboration with Stanford University using Design Thinking Methodology to reduce the number of self-harm incidents.

2018/19 Quality Indicators and CQRf:

With regard to the Specialist Learning Disability Service commissioned from MCFT by the CCGs on behalf of Learcassive, South Cumbria and Dewer Manchester, a small number of queries remain to be resolved in relation to the 2018/19 quality indicators. The CCGs continue to work with the Trust to ensure that the submitted data and information can be reconciled against the indicators, to review the 2018/19 Quality dashboard and provide assurance to stakeholders in terms of compliance with the applicable standards.
Three of the four Commissioning for Quality and Innovation (CQUIN) schemes for 2018/19 have been achieved. The achievement level of “improving staff health and wellbeing” is yet to be confirmed, dependant on the submission of further updates from MCFT.

During 2018/19, MCFT has participated in 83% (10/12) of all applicable National Clinical Audits and 100% of all National Confidential Enquiries. The CCGs note that MCFT reviewed three of the national audits and within the Quality Accounts, actions to improve the quality of healthcare from the National Clinical Audit on Psychosis, National Audit of Care at the End of Life and National Audit of Intermediate Care have been detailed.

MCFT has reported a Trust-wide position, for Quarter 4 of 2018/19, of 98.4% of patients on the Care Programme Approach being followed up within 7 days of discharge, the national target is 95%. The CCGs are pleased to note that the commissioned Specialist Learning Disability service achieved performance of 100% for this indicator throughout 2018/19.

In relation to the data quality targets for submission of valid NHS Number and General Practitioner Code information to NHS Digital (SLS), the Quality Account reports performance for both indicators in excess of 99.4%, for all episodes of care. The CCGs are pleased to note that the commissioned service achieved performance of 100% for valid NHS Number submission throughout 2018/19. In relation to Information Governance, the CCGs note that MCFT was awarded “substantial improvement” status following audit of the Data Security & Awareness Toolkit 2018/19.

With regard to patient experience, the draft Quality Accounts are reporting on results from 2017/18 and therefore the CCGs would recommend that up to date information is made available. It is positive to note the Trust’s Patient and Family Test scores have continuously improved over 2018/19, with 77% of participating respondents likely or highly likely to recommend the service to family or friends if they needed care and treatment.

Results of the 2018 National NHS Staff Survey are encouraging, with the Trust either meeting or performing above average in 6 of the 10 key themes. In relation to Overall Staff Engagement, the Trust has achieved a score of 7.9 which is in line with the national average for MCFT’s comparator group. The CCGs are pleased to see notable improvements in each of the questions that make up the Safety Culture domain which also aligns to the Just and Learning Culture work undertaken by MCFT.

The draft Quality Account does not reference the rate of patient safety incidents however, the CCGs note that publicly available data shows MCFT’s reported rate of patient safety incidents per 1000 bed days for the period October 2017 to March 2018, was 25 and is consistent with the figure of 22 reported last year. The CCGs engage with MCFT through the quality review process and consistently receive quarterly reports detailing incidents by cause group. In relation to Enhanced Support Services, the number of incidents over Q4 2018/19 was 577 and attributable to an average of 33 service users. Although this figure is high, the CCGs continue to monitor themes and trends and are committed to supporting the Trust to implement learning from such incidents across the Specialist Learning Disabilities division.

Although data on Complaints are not reported in the Quality Account, the CCGs receive quarterly reports through the quality review process and are pleased to note that zero complaints were received in relation to the commissioned Enhanced Support Service during 2018/19.

Priorities for 2019/20:

The Quality Account details MCFT’s achievements and challenges whilst setting out clear priorities for 2019/20. The CCGs support these priorities as a continuation of previous work and committed plans to further improve commissioned services and increase the quality of patient experience. Furthermore, the CCGs are pleased to note the involvement of key stakeholders when consulting on the quality improvement priorities.

The CCGs support MCFT’s approach to quality improvement and look forward to continuing to work with the Trust throughout 2019/20 to ensure that the services commissioned for our patients are at the highest quality standard and provide safe, personal and effective care.

Yours sincerely,

[Signature]
Mrs Kathryn Lord
Interim Director of Quality and
Chief Nurse Associate
East Lancashire CCG
Healthwatch Liverpool welcomes this opportunity to comment on the 2018-19 Quality Account for Mersey Care NHS Foundation Trust.

We base these comments on the contents of a draft Quality Account which was provided to us prior to publication, as well as our ongoing engagement with the Trust and feedback received from a variety of sources including [www.careopinion.org.uk](http://www.careopinion.org.uk), patients and families.

As with all Trusts in Liverpool, we hold annual Listening Events where a team of staff and volunteers from Healthwatch Liverpool visits the hospital to speak to patients and visitors about their experiences. These events are intended to provide a snapshot of what patients and visitors think about the service. The Trust can then use this feedback in conjunction with other patient experience measures to provide valuable insight.

This year’s Listening event at community services was at the Liverpool Walk-in Centres in October 2018 and Broadoak Unit for mental health services in November 2018. Feedback overall was positive, although there were suggestions for improvements too; all feedback was shared with the Trust.
Since January 2019 we have been working with Talk Liverpool, Mersey Care’s Improving Access to Psychological Therapies (IAPT) service, to gather feedback about some of the group sessions they provide; this will be collated and passed back to the Trust soon.

Mersey Care has seen major change this year, with Liverpool community services that had previously been managed by Liverpool Community Health being incorporated into the Trust. It would be impossible for the Quality Account to provide an overview of the quality of all the services provided, but it is positive to see more detailed explanations about the priorities, and how and why they have, or have not, been met.

The quality priorities for the coming year have been clearly set out. Several of the overarching quality priorities from both community and mental health services are continued from the previous year, with new targets set.
We are pleased to see that work to ensure the sharing of learning from both community and mental health services is ongoing. We also welcome that work will continue on those priorities where less progress was made than hoped, such as the reduction of pressure ulcers and the reduction of restrictive practice.

As part of work around Learning from Deaths, the trust has acknowledged that there are differences in how staff provide care in inpatient areas. We welcome the Trust taking this opportunity to reduce variance and share best practice.

Healthwatch Liverpool is looking forward to ongoing, regular engagement with the Trust in 2019-20. This engagement will cover both community health and mental health services, taking into account quality and equality considerations and with a focus on patient experience.
Healthwatch Sefton would like to thank the Trust for the opportunity to comment on the draft Quality Account 2018-19. We attended the Quality Account session on the 3rd May 2019 at which the Trust presented and this was very useful. In addition, our two representatives on the Sefton MBC Adult Social Care and Health Overview and Scrutiny Committee (OSC) attended a quality account event (10th May) at which the trust also presented.

In reviewing the readability of the report there is no summary of the different services which the trust now provide within the report and this would have been helpful. The trust is our provider for Mental Health and Learning Disability service across the Borough and is the provider of community services for south Sefton.

In reviewing the work to reduce restrictive practice it is positive to see that all of the targets set were achieved, particularly the target to reduce physical restraint by 20%. The words ‘restrictive practice’ may not resonate with a member of the public reading this document and a summary of what this means would have been helpful. The work undertaken to review ligature incidents was noted and in reviewing the data we noted the spike in incidents during December 2018. However a comprehensive account of the reasons for the increases were provided in the account and it was positive to see that the Trust has been able to identify the wards in which the majority of incidents have occurred.

In looking at the Trusts work towards zero suicide, three of the five areas prioritised were only partially achieved, however the work undertaken is commendable as this is such an important area. The focus on following up patients on the care programme approach within 7 days of discharge from psychiatric in-patient care must also be noted, with the Trusts target just below the national average, quarter 4 showing a higher than national average target.

In reading progress for those areas which relate to improvements in physical pathways, it was great to see the use of the NEWS2 (recognising the deteriorating patient) and the achievements in this area.

The Trusts overall work to reduce pressure ulcers is noted, in particular, the reductions in the number of community acquired and avoidable pressure ulcers. However, we do note that there were Grade 4 pressure ulcers reported during this period and therefore zero tolerance was not achieved. This is an area we will be monitoring and would like to see zero tolerance in the next reporting period. We note the priority set for ‘zero deterioration of pressure ulcers whilst under our care’ for the coming 12 month period.
We have worked proactively with our community division colleagues in the past 12 months and have established a great working relationship with this division. During the 12 months we have been invited to attend and contribute to the divisions patient experience group and this has been very productive.

In reading the report, we read that the South Sefton Community Services Division may fail to achieve the ‘Supporting Proactive and Safe Discharge’. We are aware of the work currently taking place to look at ways of achieving the targets in Q4, and hope that the identified reinvestment to support the service has/will be allocated.

We have regular contact with managers and staff within the community division and we would like to see our relationship with managers and staff from other divisions, improve over the next 12 months. We highlighted this in last years account and our informal meetings with the Trust have come to a halt. We would really welcome a discussion with the Trust and our Healthwatch colleagues about how we can build up this work again.

In reviewing the report from a public perspective, it would be helpful if the report had a glossary to support the reader in understanding abbreviations and terms. We felt that there was a lack of information within the account relating to ‘experience’. It would have been useful for us to have been able to read about the work being undertaken to improve feedback and experience on the trusts services, including some case studies, as this area was lacking within the report. Again there was a lack of information within the report relating to equality and equity of service provision.

We would like to congratulate the Trust on its current CQC rating ‘Good’, with the Trust attaining the rating of good for the Safe, Effective, Caring and Responsive domains and outstanding for the Well Led domain. We however note the areas which have been shared within the report which require improvement and we will be ensuring that we monitor the areas, by asking for up to date information over the next 12 months.

Healthwatch Sefton will continue to work in partnership with the Trust to support the ongoing work to improve the overall care and services provided to both patients and their visitors. We will be particularly keen to see progress on the Trusts focus on the integration of physical and mental health.
Dear Mr. Rafferty,

Mersey Care NHS Foundation Trust – Quality Account 2018/19

As Chair of Sefton Council’s Overview and Scrutiny Committee (Adult Social Care and Health) I am writing to submit a commentary on your Quality Account for 2018/19.

Members of the Committee met informally on 10th May 2019 to consider a small number of Quality Accounts, together with representatives from Healthwatch Sefton and from the local Clinical Commissioning Groups. We welcomed the opportunity to comment on your Quality Account and I have outlined the main comments raised in the paragraphs below.

Jenny Hurst, Deputy Director of Nursing, attended from your Trust to provide a presentation on the Quality Account and to respond to our questions on it.

We had chosen to comment on the Trust’s draft Quality Account, insofar as it relates to community health services in the south of the Borough, as we had also heard from the Provider for services in the north of the Borough.

We received a presentation from the Trust representative outlining the following:-

- CQuin Update;
- Quality Account Priority 2018/19;
- Reducing Restrictive Practice;
- Reduction in Prone Restraint;
- Reduce Physical Restrain Associated with Self-Harm by 20% by March 2019;
Review of Ligature Incidents by June 2018 and Develop an Implementation Plan to Address Risks;
Implementation Zero Segregation Action Plan to Reduce Long-Term Segregation by 20% From the Baseline Cohort by end of financial Year 2018-19;
Current Progress;
Priority Areas Progress Update 2018/19;
Zero Suicide - 100% of Former Liverpool Community Health Staff will complete Level 1 Suicide Awareness Training by March 2019;
Zero Suicide – 7-day Follow-Up;
Improving Physical Health Pathways;
Just and Learning Culture;
Reduction in Pressure Ulcers – Increasing Reporting / Reduced Harm;
Learning from Deaths;
Priority Areas for 2019/20;
Reducing Delay Discharges in Local Division; and
Next Steps.

We heard about progress made around zero suicide; national early warning scores to improve the detection and response to clinical deterioration, including sepsis; and the development of an open and transparent culture within the Trust that enables staff to raise issues. This latter issue is important, given some of the difficulties encountered by community health staff under their former Trust.

We were advised that there has been an increase in awareness and reporting on pressure ulcers which has led to huge achievements in the reduction of grade 4 pressure ulcers being detected within the community. At the time of our meeting, the Trust had gone 85 days without a grade 4 pressure ulcer being detected. We asked whether incidents of serious pressure ulcers are linked to people being left to stay in bed too long and were advised that the main issue is that senior staff need to go out to assess pressure ulcers, if they occur, the aim being to prevent grade 3 pressure ulcers developing into grade 4 ulcers. Some patients may not accept all the equipment offered them in such instances, although compromises may be reached.

It was reported that connections with GPs would be reviewed this year and opportunities to learn from poor care would be examined. Patients with a mental health diagnosis should have the same access to services as everyone else and clearer pathways for referrals are required.

It was pleasing to hear that the overall summary of the Trust’s most recent Care Quality Commission inspection was “good” in all domains, with “Outstanding” under the Well-Led domain.

One of our Healthwatch representatives raised the point that there are a number of Providers within the Borough of Sefton, which can make things difficult from a carer’s perspective. He asked how effective communication and integration with other Providers is and it was acknowledged that there are some gaps and that work is on-going to look at pathways to ensure the best possible experience for patients. There is also the possibility of having a district nurse going into the Boothroyd Unit in Southport, which would assist with integration. It was also acknowledged that some information governance systems within the
NHS do not “talk” to each other and the CCG representative reported on on-going strategic work to provide more integrated systems within Merseyside. Healthwatch also pointed out that having to repeat a patient’s story to every Provider can be upsetting for patients and carers, and it was considered that the way in which services are commissioned contributes to this issue. In general, nurses are being told to specialise in their specific area which, in the long run, requires more visits from different Providers. The CCG representative told us that it is a strategic aim to provide a seamless journey for the patient and that patient records should stay with them on their journey. The Trust representative indicated that the Trust will have an overarching co-ordinator in place to progress integration work and she offered to feedback on the issues raised at the meeting.

We very much appreciated the opportunity to scrutinise your draft Quality Account for 2017/18 and were grateful for the attendance at our meeting by the Trust representative. I do hope you find these comments, together with some of the suggestions raised at the meeting, to be useful.

Please accept this letter as the Sefton OSC’s formal response to your draft Quality Account.

Yours sincerely,

Councillor Mhairi Doyle, M.B.E.
Chair, Overview and Scrutiny Committee (Adult Social Care)
1. In preparing the Quality Report, directors are required to take steps to satisfy themselves that:

   a) the content of the Quality Report meets the requirements set out in the NHS foundation trust annual reporting manual 2018/19 and supporting guidance;

   b) the content of the Quality Report is not inconsistent with internal and external sources of information including:

      i) Board minutes for the period 1 April 2018 to 28 May 2019,

      ii) papers relating to quality reported to the Board over the period 1 April 2018 to 28 May 2019,

      iii) feedback from commissioners dated 20 May 2019,

      iv) feedback from governors on 25 April 2019,

      v) feedback from local Healthwatch organisations dated 23 and 24 May 2019,

      vi) feedback from the Sefton Metropolitan Borough Council Overview and Scrutiny Committee dated 20 May 2019,

      vii) the Trust’s 2017 complaints report published under regulation 18 of the Local Authority, Social Services and National Health Service Complaints (England) Regulations 2009,

      viii) the national patient survey dated 15 November 2018,

      ix) the 2018 national staff survey dated 26 February 2019,

      x) the Head of Internal Audit’s annual opinion over the Trust’s control environment dated March 2019,

      xi) the Care Quality Commission’s inspection report dated 5 April 2019;

   c) the Quality Report presents a balanced picture of the NHS Foundation Trust’s performance over the period covered;

   d) the performance information reported in the Quality Report is reliable and accurate;

   e) there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice;
f) the data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and 

g) the Quality Report has been prepared in accordance with NHS Improvement’s annual reporting guidance (which incorporates the Quality Report regulations) as well as the standards to support data quality for the preparation of the Quality Report.

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

By order of the Board of Directors:

Beatrice Fraenkel, Chairman
22 May 2019

Joe Rafferty, Chief Executive
22 May 2019
<table>
<thead>
<tr>
<th>Audit Theme</th>
<th>Improvement Activities Arising from Clinical Audit Outcomes</th>
</tr>
</thead>
</table>
| NICE                     | • ECT Consent NICE TA59 & CG90 amend consent form to include recording of religion  
• Autism NICE QS151 improve recording of engagement with carers  
• Borderline personality disorder CG78 improve timeliness of diagnosis and promote completion of admission checklist  
• Dementia NG97 improved information from pharmacy about whether memantine added or substituted  |
| Physical Healthcare      | • A review of the physical health care pathway for patients with both serious mental illness and first episode of psychosis have been reviewed including additional clinical support and improved documentation within the clinical notes. Re-audit has noted significant improvement.  
• Repeated attempts with inpatients on mental health adult acute wards around smoking cessation including introduction of controlled access to e-cigarettes  
• Clozapine assay required further work to investigate the adherence considering after dose change, side effects, smoking cessation or clinical need  
• Improvement of the diabetes management of inpatients on mental health adult and older people's wards  
• Expanded reporting of wounds being managed by Podiatry services to explain in more detail the aetiology, introducing a proforma to capture essential information  
• Improvement of day 1 and day 3 blood samples for patients on IV therapy.  |
| Records Management       | • Address the functionality within the clinical records system to enable countersignature of clinical entries  
• Improved reporting of follow up on actions arising from incident reviews.  |
| Risk Assessment/Patient safety | • Review of the referral process to DVLA around driving restrictions to psychiatric inpatients.  
• For venous leg ulcers a 'sockit' box was introduced and standardised use of compression hosiery  
• For pressure ulcer care a Risk Stratification Tool has now been agreed for implementation following testing in divisional pilot sites and recording all moisture-associated skin damage (MASD) within local reporting systems (Datix) in addition to pressure ulcers. The aim of reporting moisture lesions is to capture data in relation to all skin damage  |
<table>
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<tr>
<th>Audit Theme</th>
<th>Improvement Activities Arising from Clinical Audit Outcomes</th>
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<tbody>
<tr>
<td></td>
<td>• Improve the communication of the Environmental Suicide Risk Audit (ESRA) across ward teams</td>
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<td></td>
<td>• Review processes within the Patient appointment centre and how the DNA’s are communicated to each respective clinical</td>
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<td>team to discuss as part of the MDT process.</td>
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<td>• A review of the CPA process Trust wide to ensure a standardised and consistent trust-wide approach to CPA to ensure</td>
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<td>care plans are service user directed and strengths-based with clear goals to support the service user’s recovery.</td>
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<td></td>
<td>• A review of the process around recording risk assessment before section 17 leave and upon return from leave.</td>
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<tr>
<td>Medicine</td>
<td>• Improved compliance with Pan Mersey Anti-Microbial Formulary for Non-Medical Prescribers</td>
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<tr>
<td>Management</td>
<td>• Improve the quality of care planning for dual diagnosis patients with opioid dependency</td>
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<td></td>
<td>• Developing a standardised template as part of discharge communication to provide assurance to GP that discharge</td>
</tr>
<tr>
<td></td>
<td>medication has been provided.</td>
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<tr>
<td></td>
<td>• An alert added to Depot Card and clinical notes to ensure that care coordinators and any other practitioner have a visual</td>
</tr>
<tr>
<td></td>
<td>reminder of the annual review date</td>
</tr>
<tr>
<td></td>
<td>• An Aide memoire added to Depot Cards with recommended physical health monitoring requirements</td>
</tr>
<tr>
<td>GP Communication</td>
<td>• Piloting the eDischarge process in the care records to improve the 24 hour/7 day compliance with discharge notification</td>
</tr>
</tbody>
</table>