Mersey Care
NHS Foundation Trust

Mersey Care
NHS Foundation Trust

Quality Report 2022/23

Contents

EXTERNAL AUDITOR'S OPINION

Since Covid-19 there has been no external audit of the Quality Account.

PART ONE - INTRODUCTION AND STATEMENT ON QUALITY BY THE CHIEF EXECUTIVE

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 2022/23. 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 (2022/23). 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 2022/23 a range of engagement events were held with key stakeholders.

Since the National pandemic covid 19 there remains no requirement for external audit or scrutiny for the Quality Plan for 2022/23.

The unfolding impact of Covid-19 is becoming clearer to us, and the challenges of the pandemic are likely to continue for many years to come. As we address these immediate challenges, we must also plan ahead for the future challenges and opportunities for Mersey Care. This is in line with our long term strategy to pursue clinical excellence through Perfect Care and also develop more preventative and integrated service models to address the wider context that is influencing people's health, including the impact of Covid-19.

As a Trust serving people with complex physical, mental health, addictions and social needs, Mersey Care cannot improve the quality of health services without taking account of wider social issues, such as work, income, housing and social connections. To do this, we must work effectively with our partners to have greater impact beyond our traditional organisational boundaries, taking a population health management approach to reduce inequalities in access and outcomes for the people we serve.

Perhaps most importantly, tackling the challenges facing us requires a human-centred response, based on deep understanding of the people we serve, place and community.

We will focus our attention in the year ahead on developing greater insight about the experiences of our service users and communities and use this understanding to address inequalities in access to our services and to enable people to have greater control of their care, building on our history of designing and providing services in partnership with service users and carers.

	June 2023
Joe Rafferty **Chief Executive**	**Dated**

1.2 Our Strategy

1. Mersey Care's vision is to strive for perfect, whole-person care that helps people live happier, healthier lives.

2. Mersey Care has grown rapidly over the last ten years and we are taking stock of how we can create maximum value for our patients, communities, commissioners and partner organisations from our organisation. Our external environment has changed dramatically, with the lasting impact of a pandemic and associated social and economic changes, and the creation of Integrated Care Systems and 'Place' based decision making for health and care services.

3. As a result, we are moving to a new phase of our strategy - bringing together Mersey Care's services to be stronger and more effective. Our strategy is to balance operational excellence in our services today, whilst making opportunities to get ahead for the future.

4. Mersey Care is now one of the largest NHS trusts of our type in Europe. For 1.5 million people we are present from cradle to grave and head to toe through the breadth of services we provide. We have 1000 adult, older adult, learning disability, addictions and secure mental health beds, but we are a fundamentally a community-based organisation, key to health and wider prosperity in the Places we serve.

5. We have a tremendous opportunity to consider 'total health' for the people we serve - wellbeing, physical health, mental health, addiction and learning disabilities or neurodiversity - and to become more preventative and co-ordinated in the care we provide through our unique blend of all-age services and relationships with our partners. Our expertise in data and technology, for example in our leading telehealth platform, will allow us to transform care for people with long term conditions; and our success in attracting new investment in mental health research will allow us to bring new interventions and treatments to our communities.

6. Our approach aligns with the priorities set out in the NHS Long Term plan which details the need for collaborative working with our system partners and the expansion of community and mental health services. This includes transforming the way we care for people by giving them more control over their health and providing care in a joined-up way that is set in the communities in which people live.

OUR VISION

Our vision is to strive for perfect, whole-person care that helps people live happier, healthier lives.

NHS
Mersey Care
NHS Foundation Trust
Community and Mental Health Services

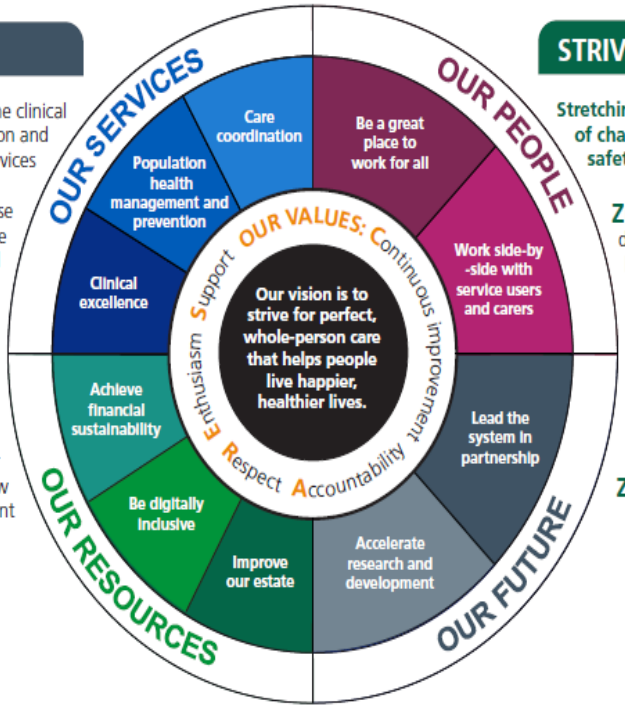
OUR GOALS

OUR SERVICES - Combine clinical excellence with prevention and care coordination in our services

OUR PEOPLE - More people choose to work at Mersey Care and service users feel they have more control over their health

OUR RESOURCES - Use our buidings, IT and money to enable clinical excellence with prevention and care coordination in our services

OUR FUTURE - Be a good partner organisation and strive for new advances in care and treatment



STRIVING FOR PERFECT CARE

Stretching goals to keep us at the forefront of challenges and maintain our leading safety status.

ZERO acceptance of racism, discrimination and unacceptable behaviours

ZERO restrictive practice

ZERO suicide

ZERO harm from medication

ZERO falls in our care

OUR VALUES

The way we will achieve our vision, mission and goals - built on a solid foundation of restorative just and learning culture.

C **Continuous improvement** – committed to making improvements to our services for the benefit of all

A **Accountability** – taking ownership to anticipate, develop and deliver high quality care

R **Respect** – how we treat others in an inclusive and supportive way

E **Enthusiasm** – demonstrate our passion and pride for what we do and how we do it

S **Support** – actively supporting others with compassion and courage

April 2022

1.3 Improving Quality

7. Mersey Care's current quality service rating is a 'Good' from the Care Quality Commission, with an 'Outstanding' rating for some of our service lines and an 'Outstanding' rating for the Well-led domain. This reflects an improvement in both the Safe and Well Led domains since our last inspection.

8. At a time when our services are significantly stretched following recovery due to the Covid-19 pandemic, Mersey Care has maintained good quality services and in recent years has demonstrably improved the quality of our services in areas such as use of out of area placements for local mental health services, use of restraint in our services, the development of specialist learning disabilities services, and the reduction of pressure ulcers in community services.

9. Whilst we are very proud of the quality improvement we have achieved to date, in the spirit of continuous improvement and striving for perfect care, we recognise there is always room for more.

10. We characterise the next phase of our improvement journey as being about embedding quality improvement techniques and results, including in these newly acquired services, so that we move from having some great examples of outstanding care to more systematic quality improvement that is everywhere in our organisation.

11. To reflect this quality improvement in the mainstream of our services, we continue to aim to have an overall CQC rating 'Outstanding' rating for our services by 2024.

12. Mersey Care has an overall 'Good' rating from the CQC. In 2023, services were rated as 'outstanding for caring, and for well led.

1.4 Pursuing Perfect Care

13. 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 **S**afe, **T**imely, **E**ffective, **E**quitable, **E**fficient and **P**ositively experienced (STEEEP).

14. We have set ambitious goals in pursuit of perfect care for 2023/24:

    a) Reducing Restrictive Practice;

    b) Zero Suicide for Those in Our Care;

    c) Zero Harm From Medication;

    d) Zero Acceptance of Racism, Discriminatory and Disrespect Behaviours;

    e) Zero Falls in Our Care;

    f) Learning from Deaths.

15. 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.

PART TWO – PRIORITIES FOR IMPROVEMENT 2022/23 AND STATEMENT OF ASSURANCE FROM THE BOARD

2.1 Priorities for Improvement 2022/23

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 2022/23 should be.

16. 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.

17. In addition to the above, the perfect care steering group has considered suggestions for **2022/23** quality improvement priorities. These are consistent with the six key elements in the Trust's Model of Quality: **STEEEP**:

a) **S**afety of Patients;

b) **T**imely care;

c) **E**ffectiveness;

d) **E**fficient care;

e) **E**quitable care;

f) Positive patient experience.

18. After consultation and discussion with key stakeholders and with the Trust Board the areas of quality improvement for 2022/23 will be to continue the objectives from 2021/22 priorities due to the Quality Account being nationally paused and remaining in a level 4 pandemic and therefore we were unable to deliver all the quality improvement that we would usually deliver on the key priorities:

a) **Priority 1: Reducing Restrictive Practice**

Zero Restrictive Practice:

i) Continue to Reduce Restrictive Practice to further enhance patient experience and safety, including developing technology to support service delivery.

ii) Share good practice and learning across the Trust with a particular focus on reducing restraint and long-term segregation in Specialist LD and Secure Services and reducing restraint associated with self-harm, for example ligatures, in mental health Services.

iii) Develop an improvement plan to predict and reduce assaults on staff and the associated harm.

iv) Identify where restrictive practice may be used in Community physical health services and agree an improvement plan.

v) Implement revised Mersey Care Reducing Restrictive Practice guide and audit compliance.

b) **Priority 2: Towards Zero Suicide**

i) Zero inpatient suicides.

ii) Implement eRisk training for all relevant staff and ensure competencies are demonstrated within teams. The number of safety plans offered to our service users to be increased and into business as usual practice.

iii) Implement team-specific suicide prevention training for Community physical health staff where evidence suggests there is higher risk of suicide.

iv) Implement revised Mersey Care suicide prevention strategy:

- To reduce ligature use and other forms of self-harm across inpatient services and to reduce the distress such incidents can have on all those involved. This includes key actions to reduce ligature use; in respect of therapeutic interventions, trauma-informed care, self-harm interventions, least restrictive practice, risk management, transitions in care, and operational issues.

- Roll out of eRisk training (effective risk intervention skills) for all frontline staff including the broader implementation of collaborative safety plans across inpatient and community teams.

- All single contact services to implement the safety plan flashcard as per mandatory eRisk training.

- Implement agreed transition processes within and out of our services using a standardised approach (checklist/protocol).
- Implement structured quality 48 hour follow up post discharge from hospital (PRISM).
- Implement effective interventions programme of work via the strategy group. Brief safety questions for suicide prevention in infrequent contacts (5Q).

v) Continue to develop effective partnerships with primary care, families, health and third sector agencies working together towards Zero Suicide.

vi) Work in partnership with Divisions to develop the urgent care model and interventions for those presenting with suicidal thoughts and plans according to evidence base and intelligence data. This will standardise practice and make urgent care safer 2022/23.

c) **Priority 3: Zero Harm from Medication:**

i) Zero moderate/severe harm incidents relating to medicines.

ii) Zero preventable harm from clozapine.

iii) 100% of inpatient acute antibiotic prescribing reviewed within 72 hours.

iv) 100% of medication administered as injectable rapid tranquilisation with a risk of psychological harm will be subject to a multidisciplinary review within 48 hours.

d) **Priority 4: A Just and Learning Culture**

i) Zero Tolerance of disrespectful behaviour in Mersey Care.

ii) 100% of new starters to receive Respect and Civility awareness on induction by March 2022. Develop Respect and Civility tools to be used as part of team based working interventions to improve patient and staff safety.

iii) Create psychological safety at team level by embedding evidenced-based team working through Mersey Care team accreditation and culture of care improvement plans.

iv) Embed Just and Learning principles within a new complaints procedure and practice framework by March 2022.

v) Promote Mersey Care's Just and Learning journey, achievements and developments in relation to our people and clinical practices to share our learning widely in the NHS and beyond.

vi) Zero acceptance of racism, discrimination and unacceptable behaviour.

e) **Priority 5: Zero Falls in Our Care**

i) 100% of inpatients have a falls screening within 24 hours of admissions and those at risk of falls have a multifactorial risk assessment in place by March 2022.

ii) 20% reduction in moderate harm related to falls in inpatient areas from 2021/22 baseline by March 2022. Moderate harm includes fractures and head injuries.

iii) Standardise the falls risk assessment process across community settings by March 2022.

iv) Develop a clear pathway for access to support services for those identified as at risk of falling in the community by March 2022 supported by our integrated care teams.

f) **Priority 6: Learning from Deaths**

i) Four thematic reviews will be conducted in the year based on analysis of mortality data by March 2022.

19. Following the transaction of Community Health the Trust has a focus on improving child health and delivering the healthy child program:

a) **0-19 Service Priority**

Priorities for Children Services 2022/23

20. **Improvement in completion and return of Review Health Assessments (RHA) for Children in Care (CIC) in line with statutory timeframes to the standard dictated by the RHA quality assurance framework.**

21. Review Health Assessments (RHA) for Children in Care (CIC) are split into three categories – In Area (IA), Out of Area (OOA) and Children in Care of Other Local Authority (CICOLA), the last quarterly report submission saw an increase in compliance in RHA for In Area CIC against Q2 2022/23 submission, as detailed below:

- IA RHA for Q3 2022/23 achieved 96.36% against a target of 100% (95.03% in Q2 2022/23).

22. This upward trajectory is due to a number of service improvement initiatives including changes to systems and processes, enhancements to locally held databases and a cleanse of EMIS to ensure that all CIC are recorded correctly. There is an acknowledgement that there is further work required to improve the RHA for OOA CIC and CICOLA, and work is ongoing with the Designated Nurse

23. **Standardisation of process for booking Healthy Child Programme mandated visits across the 0-5 portfolio.**

24. Since a citywide (Liverpool) tracker and associated time barred processes were developed and deployed in August 2022, there has been only one instance of a monthly target not being met (up to and including January data) this was in relation to Antenatal visits for the month of December 2022. All visits are now planned in an appropriate and timely manner and assurance is provided through the tracker meeting process which is chaired by Operational Managers.

Priorities for Children Services 2023/24

25. Introduction of a children and young people specific safety plan on the RIO system. A mental health safety plan is a preventative tool designed to support those who struggle with mental wellbeing to avoid crisis and support community care.

26. With the aim of reducing the numbers of 'children not brought' to speech and language therapy appointments a letter will be developed to issue to parents and carers four weeks prior to potential discharge.

Ensuring Equality and Tackling Health Inequalities

27. All work steams 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.

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

Monitoring and Reporting Arrangements

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

30. 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.

31. 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 2022/23

32. In June 2022**,** 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: Zero Harm from Medication;
    d) Priority 4: A Just and Learning Culture;
    e) Priority 5: Zero Falls in Our Care;
    f) Priority 6: Learning from Deaths.

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

Table 1: Quality Report Progress 2022/23

Detailed Progress on Quality Report Objectives 2022/23

Priority 1: Progress: Reducing Restrictive Practice
Dr Jennifer Kilcoyne is the Consultant Psychologist is the nominated lead for No Force First.
Priority 1 Objectives for 2022/23
AIM: Reduce restraints

Zero Restrictive Practice:

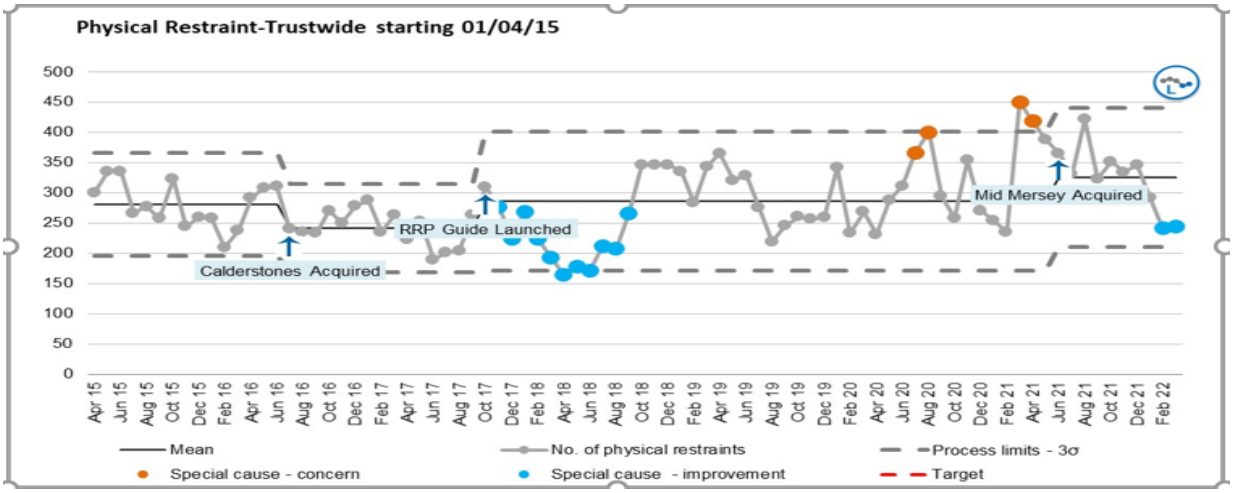
i) Continue to Reduce Restrictive Practice to further enhance patient experience and safety, including developing technology to support service delivery.

ii) Share good practice and learning across the Trust with a particular focus on reducing restraint and long-term segregation in Specialist LD and Secure Services and reducing restraint associated with self-harm, for example ligatures, in Local Services – ongoing.

iii) Develop an improvement plan to predict and reduce assaults on staff and the associated harm.

iv) Identify where restrictive practice may be used in Community physical health services and agree an improvement plan.

v) Implement revised Mersey Care Reducing Restrictive Practice guide and audit compliance.



Mersey Care is committed to both reducing and preventing all forms of restrictive practice. No Force First is our restraint reduction quality improvement programme that reduces conflict and restrictive practices which can lead to physical and psychological harm. Physical restraint is a negative, traumatic, and potentially dangerous experience for both service users and staff.

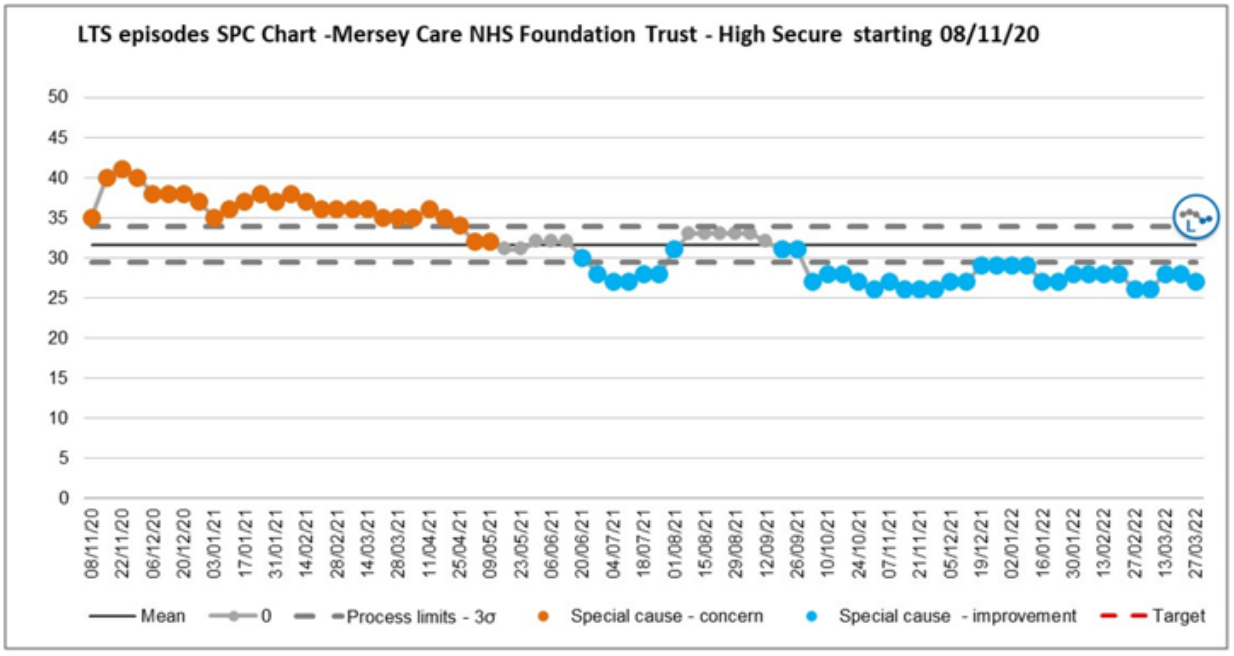
No Force First Restraint Reduction Strategy is fully embedded and recognised as the overarching restraint reduction approach across all Merseycare services and is nationally recognised by CQC. Additionally, Zero Restrictive Practice is recognised as a key priority within the Trust and has executive board level prioritisation as a Perfect Care Goal.

On 28th of May and 8th of June 2022, the Trust Reducing Restrictive Practice Programme was relaunched. The Chief Executive Officer Joe Rafferty, Deputy Chief Executive Trish Bennett, Chief Medical Officer Noir Thomas and Clinical Director for Centre for Perfect Care as well as other Senior clinicians from across the Trust reinforced the trust commitments and reaffirmed Executive and Board support for Zero restrictive practice as an ongoing Trust key priority.

The Trust has national certified training in Personal Safety Training to Reduce Restrictive Practice - The personal safety training is accredited by BILD Act and meets the standards set out by the Restraint Reduction Network. The training is human rights based and trauma informed focused. There is a concerted effort to support staff to understand the importance of culture and to view patients as individuals with unique needs that should be accounted for in the delivery of care. Furthermore, the personal safety service and reducing restrictive practice team offer support to teams to develop bespoke interventions to support the reduction of restrictive practices as well as share good practice from other areas within the Trust.

There are three Reducing Restrictive Practice Monitoring Groups that are well established in each division, with oversight by Trust wide group that collate, monitor, celebrate and looks to support teams to respond meaningfully and responsively to support reductions in Restrictive practices. As part of the meetings teams are encouraged to share good practice as well as any lessons from each other. The Trust Reducing Restrictive Practice Implementation group was launched in January 2023.

Long term segregation



Assaults on staff

The Trust has experienced a 22.6% reduction in assaults on staff and 49.4% reduction in assaults on staff causing harm against baseline.

Secure & SLD Division (MH) Assaults on staff

Secure & SLD Division (MH) has experienced a reduction of 36.4% of assaults against staff and a 77.8% reduction in assaults on staff causing harm against baseline.

Secure & SLD Division (LD) Assaults on staff

Secure & SLD Division (LD) has experienced a reduction 44.4% in assaults on staff and a 69.2% reduction in assaults on staff causing harm against baseline.

Local Division Assaults on staff

The Local Division data highlights a 14.3 % Increase in assaults on staff but a 3.6% reduction on assaults in staff causing harm against baseline.

Blanket restrictions

The use of blanket restrictions across the Trust has increased as the pandemic, staffing shortages and pressures has prolonged. For example, in response to rising rates of infections, restrictions were placed on Section 17 leave, family visits, inter ward social activities. This has had an adverse impact on patients (as well as families) as most patients cite these activities as coping or protective factors. Through the Reducing Restrictive practice Monitoring Groups divisions are identifying and creating a register of blanket restrictions within their areas to be shared with the senior leadership teams for oversight. The aim is to reduce to the minimum mandated blanket restrictions in all areas as well as for clear and robust oversight and governance to be in place.

Rapid Tranquilisation

The use of rapid tranquilisation across Local and Secure Division has remained low with negligible numbers recorded however Mid Mersey have experienced a significant increase in the months of January and February 2022 resulting in 106 incidents compared to 29 in the months of November and December 2021. A 72-hour review of the incidents has been requested to understand the reasons for the significant increase and explore if lesser restrictive practices could be utilised.

The National HOPE(S) Programme NHSE Collaborative

The collaboration between NHS England and the Centre for Perfect to implement the HOPE(S) programme will run to December 2024. It sits alongside a trauma response model for families and carers whose loved ones are living in segregation which has also been developed. The initial focus will be on CYP, autistic adults and people with a learning disability to end segregation and support them to return to their communities. Funding has been agreed in the MOU with NHS England and the contract has been signed ensuring that the Trust is funded appropriately in each of the three years.

The recruitment process has commenced to recruit 16 WTE HOPE(S) practitioners to support the implementation of the national programme. 12 practitioners have been recruited this year with seven practitioners commencing in post in March 2022. The remaining posts have been advertised region specific and interviews are planned for week commencing 11/04/22. The posts will be covered through a secondment agreement from any NHS funded provider within the NHS led provider collaboratives to December 2024. Sixteen senior practitioners will be on a three-year development programme.

An independently chaired National Oversight Group meeting has been established and 3 meetings have taken place. The group meets quarterly and have responsibility to oversee the implementation of the programme and ensure outcomes are delivered.

A HOPE(S) diploma qualification is currently being developed in collaboration with the British Institute for Learning Disability and the Restraint Reduction Network to support the legacy of the programme. Additionally, Manchester Metropolitan University have submitted a research proposal to undertake an evaluation of the programme.

The programme has engaged a wide range of key stakeholders during phase 1 of the programme and delivered awareness training to over 120 CQC inspectors. In terms of HOPE(S) Training for High Secure Services a total of (n83) multidisciplinary team members from at Ashworth Hospital have received the 2 days HOPE(S) Introductory training and the service have identified further 3 training dates for 2022 at present. Importantly, there is an acknowledgement that there is a need to increase the capacity of trainers for the HOPE(S) at Ashworth, thus (n3) clinicians including the Nurse consultant for Reducing Restrictive practices, Senior clinical Nurse for Reducing Restrictive practices and the Clinical lead for the Positive Intervention Programme undertook the 5 day HOPE(S) Train the Trainer programme to gain accreditation as trainers. An additional two clinicians have been identified to complete this training in May. Furthermore, HOPE(S) training has been extended to teams in MSU were numbers of patients in LTS are increasing.

Protected Characteristics

An equality analysis was undertaken under the Trust Reducing Restrictive Practice Policy (SD48) which examined the level and nature of restrictive practices with service users with protected characteristics. This concluded that service users from a BAME background were significantly overrepresented in High Secure restraint incidences.

The Secure & SLD Division is committed to ensuring patients from a BAME background are not disproportionately subject to restrictive practices, therefore in response to the data an action plan has been developed by the senior leadership team to ensure independent oversight and review: Hari Sewell an independent Race relations consultant is working with the division to explore these issues and understand the experiences of the patients from a BAME background. Unfortunately, this piece of work has been significantly slowed down due to the ongoing Covid-19 pandemic and affiliated restrictions as well as staffing shortages resulting in business continuity arrangements.

The Trust-wide Mental Health Law Governance Group have also raised the matter of over representation of BAME patients with regards to the Mental Health Act and commissioned a piece of research to interrogate anecdotal evidence that suggests that BAME patients are overrepresented. This work is ongoing.

The Mental Health Units (Use of Force) Act, 2018 has increased focus on issues of race, culture and implores services to make greater strides to eradicate restrictive practices in all services but to have a good understanding of protected characteristics and the unique cultural factors that impact different populations. The Reducing Restrictive Practice Policy has been updated to reflect and ensure that the Trust meets the criteria set out in the legislation.

Actions that have ben identified to support this agenda are as below:

1) **Review the independent mental health advocates input to ensure they are actively involved in the clinical care of people from a BAME background representing the person's views and rights specifically around restrictive interventions.**
The Divisional advocacy lead has explored current advocacy input with service users from a BAME background with advocates from High Secure. Meetings with advocacy are scheduled and there are ongoing discussions with regards provision with the Reducing Restrictive practice monitoring group.

Pursue an external independent review of current practice from an independent expert in the field of reducing inequality for those from groups with protected characteristics.

This work has been delayed due to the pandemic but is ongoing. Hari Sewell – Honorary Senior Research Fellow at University of Central Lancashire has been contacted as an independent expert in the field of reducing inequality for those from groups with protected characteristics. A proposal consisting of a number of options and associated costings has been agreed by the senior leadership team.

Explore BAME representation in the persons care perhaps as peer support or advocacy.

This work has been delayed due to the pandemic but is ongoing. Feedback is awaited from other work streams by advocacy and the external independent review of current practices to enable planning in this area.

2) **Full scale roll out of cultural sensitivity training for staff by the human rights and equality advisor for the service**.
This work has been delayed due to the pandemic but is ongoing. The Trust community development officer and the divisional equality and human rights advisors have been asked to develop an implementation plan to deliver cultural sensitivity training across the service.

3) **All patients from a BAME background to be provided the opportunity to discuss their experience.**
A BAME patient group has been established in High secure and although in its infancy will seek to bring patients from a BAME background to discuss and share their experiences.

An ongoing issue in High Secure Services is the need for a cultural hairdresser to meet the needs of patients from a BAME background. Concerted effort by the Division and the High Secure Commissioner Alison Cannon has to date yielded little success. The Senior Leadership team continue to attempt to exhaust all avenues to ensure this and other cultural needs are met.

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 2022/23
Zero inpatient suicides in 2022/23
1. Zero inpatient suicides in 2021/22 and 2022/23:

a) There have been three inpatient suspected suicides in 2022/23 (until 19 March 2023) two were patients on leave from the ward. One was a patient on a secure ward. There are no coroner outcomes from these three deaths at present.
b) Zero Suicides across all Mersey Care services remains a key ambition and work continues to learn from incidents to inform further action required. A review of all in-patient deaths over the last 10 years has been conducted to help strengthen this understanding and identify any further change required as part of inpatient transformation. During 2022/23, there has been the implementation of the ligature reduction guide across inpatient services, with a range of environmental work taking place including the installation of collapsible doors. There has also been the creation of an inpatient strategy group for oversight of inpatient clinical services and governance. An audit of the ligature reduction guide is due to take place in 2023/24 to inform further improvements.

2. Implement eRisk training for all relevant staff and ensure competencies are demonstrated within teams. The number of safety plans offered to our service users to be increased and into business-as-usual practice:
   a) eRISK (effective Risk Intervention Skills) training aims to enhance knowledge, skills, competencies, and confidence of the workforce to carry out risk assessments, formulation, management plans and safety plans – this has continued to be rolled out during 2022/23 with 3655 (93.9%) of 3892 eligible clinical staff trained across the Trust as of 19 March 2023. This is a 35.9% increase compared to February 2022 when there were 2342 staff trained.
   b) Safety planning is a core component of suicide prevention and is contained within the eRISK training as a module for broader spread. The Trust has an aim to offer all service users a safety plan. A reporting form is available within the clinical records system for monitoring with 5230 safety plans being offered as of 19 March 2023. There were 81 safety plans offered in February 2022 compared to 538 in February 2023 an increase of 84.9%. There is an audit planned to review the quality of safety plans in 2023/4. Additional work is being undertaken for further adaptions of the safety plan for Children and Young people (initial participation work took place in January 2023) and those with Neuro Diversity issues.

3. Implement team-specific suicide prevention training for Community physical health staff where evidence suggests there is higher risk of suicide:
   - During 2022, the training that had previously been piloted within the Motor Neurone Disease (MND) Team is being re-developed for wider testing in spring/summer 2023 across physical health services, including pain management services. This includes the re-development of a suicide prevention six step action plan, originally designed for the MND team. A standard operating procedure to support physical health staff to raise issues following contacts where suicide risk is indicated is also being developed.

4. Implement revised Mersey Care suicide prevention strategy:
   a) The Zero Suicide approach has now been standardised across the whole of the organisation following the acquisition of North West Boroughs and on-going changes within divisional structures. Six key priorities were identified in 2022/23, as the key essential elements to be progressed across the organisation:

i) To reduce ligature use and other forms of self-harm across inpatient services and to reduce the distress such incidents can have on all those involved. This includes key actions to reduce ligature use; in respect of therapeutic interventions, trauma-informed care, self-harm interventions, least restrictive practice, risk management, transitions in care, and operational issues.

ii) Roll out of eRisk training (effective risk intervention skills) for all frontline staff including the broader implementation of collaborative safety plans across inpatient and community teams.

iii) All single contact services to implement the safety plan flashcard as per mandatory eRisk training.

iv) Implement agreed transition processes within and out of our services using a standardised approach (checklist/protocol).

v) Implement structured quality 48 hour follow up post discharge from hospital (PRISM).

vi) Implement effective interventions programme of work via the strategy group. Brief safety questions for suicide prevention in infrequent contacts (5Q).
The Zero Suicide Strategy subgroup has continued to review progress against the board approved priority areas, addressing any operational challenges. The Safe from Suicide Team provide reports to Trust leadership forums and strategy groups to review progress and provide oversight. As the organisation has re-structured over the last year, the divisional monitoring and engagement is being reviewed with a re-look at internal governance structures to provide assurance in 2023/24.

vii) Continue to develop effective partnerships with primary care, families, health and third sector agencies working together towards Zero Suicide:

- Mersey Care acknowledge the importance of system working and support partnership action required for the prevention of suicide as a shared responsibility. We are an active member of the CHAMPS Partnership, as well as connecting into Local Authority suicide prevention groups. Due to several social factors sitting outside of the control of mental health services alone, a collaborative action plan has been established with Liverpool City council to explore approaches to reduce suicides across the city region. A project lead (funded by Liverpool Public Health) has also been employed to oversee this work across the wider city region. Further partnerships continue to be sustained and developed at place level.

viii) Work in partnership with Divisions to develop the urgent care model and interventions for those presenting with suicidal thoughts and plans according to evidence base and intelligence data. This will standardise practice and make urgent care safer 2022/23:

- The new suicide prevention strategy aligned to the Urgent Care model is developed to include a pilot of the new evidenced based suicide prevention pathway. This pathway ensures rapid intervention following self-harm and suicide attempts. Interventions are NICE compliant and promote resolution of crisis.
- A pilot of the pathway (innovate St Helens) is due to commence in spring 2023 following quality improvement cycles.

Priority 3: Zero Harm From Medication
John Crosby Deputy Medical Director, the nominated lead for this priority area.
Priority 3 Objectives for 2022/23
Zero Harm From Medication:
1. Zero moderate/severe harm incidents relating to medicines is an ongoing goal, we have had 3 incidents of this nature this year and all have been reviewed and have been presented at the clinical senate. 2. Zero preventable harm from clozapine. There has been a clozapine task force set up to review management of clozapine. A new clozapine policy has been written and will be launched June 2023. 3. 100% of inpatient acute antibiotic prescribing reviewed within 72 hours. There remained a focused review and audit of this target and continues to require a continued due to the varied results across the services. We are waiting for final quarter audit results and then will target teams who are remained to need to improve performance. The new digital solution will enable an automated reminder on EPMA. 4. 100% of medication administered as injectable rapid tranquilisation with a risk of psychological harm will be subject to a multidisciplinary review within 48 hours. The pilot site agreed is at Dee ward. This will link in with new Rapid Tranquilisation dashboard that is to be launched at clinical senate. The aim if the pilot is successful, it will be rolled out to all mental health wards, this will not remain a goal for 2023/24.

Priority 4: A Just and Learning Culture
Amanda Oates, Executive Director of Workforce is the nominated lead for this priority
Priority 4 Objectives for 2022/23
Zero tolerance of disrespectful behaviour in Mersey Care
• Objectives within the Respect and Civility Group to address unacceptable behaviour. • The Respect and Civility Group will review all existing Respect and Civility tools (e.g. the Respect and Civility Jigsaw) in-line with Zero tolerance of unacceptable behavior, with a special review on microaggressions. • This work was due to be reviewed and completed within quarter four (2021/2022), however, due to business continuity this has been revised for completion by end of quarter one in the new financial year (2022/2023). Once completed this will then be publicised accordingly within the Trust forums and Communication bulletins.
100% of new starters to receive Respect and Civility awareness on induction by March 2022/23. Develop Respect and Civility tools to be used as part of team based working interventions to improve patient and staff safety.
• The Operational Workforce Group agreed to add Respect and Civility training to all staff ESR profiles which was completed in April 2021. • The package was rolled out Trust-wide as a one off Continuous Professional Development module. • As of 01/02/2022 87.14% of colleagues had completed their Respect and Civility eLearning module. Work is ongoing to attain 100% of colleagues completing this awareness.

- The Respect and Civility E-Learning package has been included as part of all RJC programmes and referenced in Team Canvas guidance and training resources.

Create psychological safety at team level by embedding evidenced-based team working through Mersey Care team accreditation and culture of care improvement plans.

- Mersey Care's team development works to embed philosophies of psychological safety, compassion and innovation and using evidence-based principles to build structure, process and management of interpersonal difference as key characteristics of teams that perform highly.
- The Team Canvas tool is a critical element of the Quality Review Visit programme which feeds into the Team Accreditation process, supporting standardisation across the organisation.
- The Quality Review Team and Organisational Effectiveness have worked together to improve and speed up the support offer given to teams who require improvement following QRV inspections.
- Over 60**%** of teams across the organisation have complete their own Team Canvas.
- Team performance and engagement are measured by the Trust Culture of Care Barometer and are reviewed regularly; Team leaders and senior leaders clear on performance levels of teams and their contribution to organisational objectives.
- The survey has an average response rate of 21%. With the feedback is used to ensure plans are relevant and impactful.

Embed Just and Learning principles within a new complaints procedure and practice framework by March 2022/23.

- The MCFT Complaints Policy has been reviewed and we are currently working to the draft version whilst this goes through validation processes.
- The policy ensures an increased focus on listening to, acting upon and learning from feedback from service users because of the importance placed on our values of prioritising the patient voice.
- Wherever possible we will now look towards local resolution in the first instance with the complainant avoiding progression to formal complaint.
- Team learning will take place following all complaints this can and often is now supported by the Complaints Team using a team-based learning review approach. 7-minute briefings are also developed and shared across the wider team / service / division to support shared learning across.
- The 7-minute briefing is well embedded within community and is being rolled out across all divisions in March for complaints.

Promote Mersey Care's Just and Learning journey, achievements, and developments in relation to our people and clinical practices to share our learning widely in the NHS and beyond

- We have worked with NHSe/I and Northumbria University to develop a Virtual Community of Practice platform which aims to serve as a resource and knowledge exchange for people and organisations making the shift from learning to implementation of a restorative just culture.

- Having been moved to consider business continuity the Community of Practice will launch on Monday 28 March 2022, with over 2,000 people who have experienced the Restorative Justice Culture Programmes being invited.
- The external Restorative Just Culture programme delivered in partnership with Northumbria University continues to be in high demand and on track to have delivered 15 cohorts between April 2021 and March 2022.
- The Executive Director of Workforce is in discussions with NHS England and NHS Improvement to commission further programmes linked to the national Respect and Civility and Patient Safety agenda.

Zero acceptance of racism, discrimination and unacceptable behaviour

- The Trust re-launched this priority in July of this year to be Zero Acceptance of Racism, Discriminatory and Disrespect Behaviours. We have agreed our strategy and action plan which was approved in November 2022 by the Board of Directors. We have also refreshed our civility and respect grids through a micro aggression lens.
- Work is ongoing following the receipt of the findings of the expert report to develop a strategy to enable the trust to achieve Zero tolerance. Which will begin with training and socialising of the need for positive action being developed.
- We have continued to work closely with our BAME staff networks and develop their involvement and voice.
- Our work features in several national publications including NHS People Plan, NHS England's The Future of NHS HR/OD recommendations, NHS England Patient safety toolkit etc. We also received a visit from the National People Director in October 2022.

Priority 5: Zero Falls in Our Care

Fran Cairns, Deputy Director of Therapies, Psychological and Allied Health Professionals is the nominated lead for this priority.

Priority 5 Objectives for 2022/23

Objective 1: 100% of inpatients have a falls screening within 24 hours of admissions and those at risk of falls have a multifactorial risk assessment in place by March 2023

- The falls screening tool and multi-factorial risk assessment (MFRAT) has been implemented across all inpatient wards in Community Care, Mental Health Care and Secure Care Divisions. This is part of the admission checklist for all wards and should be completed within 24 hours of admission.
- The compliance on the completion of the MFRAT within 24 hours of admission and the completion of a care plan if required following the MFRAT is monitored via the Perfect Care dashboard through the Executive Performance Report and also through the monthly Trust wide Zero Falls in Our Care meeting.
- The compliance on the completion of the MFRAT within 24 hours at Longmoor House in the Community Care Division has remained at 100%. The completion of the falls care plan has fluctuated between 93%-100% over the last 12 months, however in March 2023 the compliance had been achieved (above 98%).
- The compliance on the completion of MFRAT across Mental Health Care Division within 24 hours is not within the target set, the commissioning target has changed from 48 hours to 24 hours and reasons for not meeting the target has been due to increased admissions and acuity, alongside patients declining the assessment. The Division is auditing the number of assessments refused and daily monitoring of compliance continues, as well as discussions at the inpatient safety huddles and divisional falls meetings. In the last 12 months the Mental Health Care Division has come together as a combination of Mid Mersey inpatient wards (former Mid Mersey Division) and Liverpool and Sefton inpatient wards (former Local Division). The previous Mid Mersey Division wards were using an MFRAT, however, there was a slight variation to the Liverpool and Sefton wards therefore this form and the process has now been standardised in RiO and the falls care plan template is being added to RiO imminently. Once this has been added, the KPI's will be further aligned and captured in the formal reporting.

Monthly Metric	Target	Division Metric Relates To	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
Falls Management: All admissions to be risk assessed using an appropriate tool within 24 hours (Inpatients Only) (Monthly in Quarter)	98%	Mental Health Care Division (MH & Mid Mersey)	82.35%	88.89%	84.91%	100%	83.19%	65.93%	59.05%	93.44%	78.61%	82.05%	80.75%	78.60%
Falls Management: Of the patients identified as at risk of falling to have a care plan in place	98%	Mental Health Care Division (Former Local Only)	100%	100%	98.11%	100%	100%	100%	100%	77.27%	78.26%	100%	96.30%	88.89%
Falls Management: All admissions to be risk assessed using an appropriate tool within 4 hours (Inpatients Only) (Monthly in Quarter)	98%	Community Care Division				100%	100%	100%	100%	100%	100%	100%	100%	100%
Falls Management: Of the patients identified as at risk of falling to have a care plan in place	98%	Community Care Division				100%	96.51%	95.38%	93.94%	100%	100%	97.78%	97.92%	98%

- Further work needs to take place across the Secure Care Division to ensure the MFRAT is completed within 24 hours of admission with a care plan if required. From April 2023 the Secure Care compliance will be reported via the Perfect Care dashboard.
- The Falls e-learning has been implemented for all clinically facing staff and the compliance is above 90% for all Divisions. The content has been reviewed and refreshed:

Measure	Target	Month	Community Care	Corporate	Mental Health Care	Secure Care	Overall Trust
Falls Level 1 E-Learning Training Compliance	90%	Apr-22	93.79%	29.10%	89.26%	85.73%	84.55%
		May-22	93.74%	56.90%	95.27%	89.79%	88.85%
		Jun-22	94.97%	68.86%	96.34%	90.47%	91.01%
		Jul-22	95.89%	72.48%	96.80%	93.05%	92.64%
		Aug-22	95.87%	79.97%	97.68%	94.03%	93.94%
		Sep-22	96.80%	83.81%	98.06%	94.38%	94.92%
		Oct-22	96.97%	85.88%	98.12%	94.62%	95.30%
		Nov-22	97.91%	88.58%	98.41%	96.39%	96.52%
		Dec-22	98.28%	90.79%	98.46%	96.34%	96.92%
		Jan-23	98.29%	89.90%	98.58%	95.90%	96.75%
		Feb-23	98.57%	93.20%	98.68%	96.35%	97.38%
		Mar-23	98.88%	94.08%	98.75%	97.14%	97.80%

- A standardised flow chart has been developed for the completion of the inpatient MFRAT to further support clinicians in completing this and a handbook is available as part of the level 2 training, alongside face-to-face training delivered by the Trust-wide Falls & Manual Handling Coordinator.
- Level 3 training has been piloted and a paper presented to the Workforce meeting, the delivery of this and alignment to staff roles is currently being reviewed, alongside staff competencies.

Objective 2: 20% reduction in moderate harm related to falls in inpatient areas from 2021/22 baseline by March 2023. Moderate harm includes fractures and head injuries

- In the last 12 months there have been 3,206 falls reported across the Trust, both witnessed and unwitnessed in inpatient and community services. This equates to approximately 267 falls reported per month across the Trust.
- 1,116 falls reported were in inpatient services, this equates to approximately 93 falls per month. 26 of the falls were reported as moderate harm or severe harm with all other falls being low or no harm reported. The majority of these falls took place in Older Adult wards.
- There were 18 moderate harm falls incidents reported and 8 severe harm falls incidents reported. The tables below show the number of moderate harm related to falls in inpatient areas and the baseline:

Falls resulting in moderate / severe harm	Community Care	Mental Health Care	Secure Care
2021/22 baseline	2	16	2
2022/23	9	14	3
% increase / decrease	350%	-12.5%	50%

- A thematic review took place of all falls that occurred across the inpatient wards that resulted in moderate harm or above and were StEIS reportable within the review period of August 2021 – September 2022. The aim of the thematic review was to explore the findings / concerns raised in 11 incident reports, identify any key themes/improvements in practice and recommend actions which could be implemented across the organisation. There were 14 recommendations from the review and the main themes included:
  - Further training for clinical staff to support the understanding other factors impacting on falls, including the clinical condition of the patient and the environment. This will inform the multifactorial risk assessment and care plan.
  - Availability and storage of equipment and education to support falls reduction, e.g. bed sensors. The process for accessing equipment in a timely manner in mental health wards needs to be improved including support for moving a fallen person and standardised information relating to falls prevention linking back to national guidance.
  - Physiotherapy and Occupational Therapy provision to be reviewed in relation to falls prevention to ensure equitable access and support for falls prevention.
  - Documentation to be improved, both within the electronic patient records and on datix in relation to the detailed information required for falls prevention and management and to standardise the 72-hour review process for falls in relation to information reviewed and subject matter experts being involved. Consideration needs to be given regarding the implementation of hot debriefs to support learning.

  The action plan is overseen in the Trust-wide Zero Falls in Our Care meeting and is due for completion by July 2023.
- The total number of falls per 1,000 occupied bed days in Community Division has fluctuated due to the acuity of patients on the ward, in the month of March this is 3.86 against a 5.7 target and has been under the target for 3 consecutive months. Quality improvement work has continued at Longmoor House to support the reduction of falls in Community Care Division and a thematic review has also taken place with key learning shared.

Monthly Metric	Target	Longmoor House – Community Care Division											
		Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23

Falls: Number per 1,000 Occupied Bed Days	5.7	7.34	4.07	5.51	3.13	3.77	7.37	6.16	3.57	8.03	3.51	5.23	3.86

Further updates:

- The new RADAR system will support the falls data to be captured in a way that can be shared with teams.
- The SA30 Slips, Trips and Falls Prevention and Management Policy has been reviewed and refreshed.
- Divisional Falls Leads are in place to support the Falls governance meeting and the Trust-wide Zero Falls meeting has a project plan supported by PMO. Divisional Zero Falls meetings have been established to ensure oversight within the Divisions. The falls data is reviewed on a monthly basis and the key performance indicators within the Perfect Care Dashboard are being refreshed.
- Mersey Care continue to be part of the National Audit of In-Patient Falls.
- The Trust Falls Lead is part of new building or major refurbishment meetings to share learning and support the development of environments that look at falls prevention from the outset.
- There is a Trust intranet page for falls for staff across the Trust to access which supports shared learning and best practice: https://yourspace.merseycare.nhs.uk/falls-prevention

Objective 3: Standardise the falls risk assessment process across community settings by March 2023

- This objective has been carried over into 2023/24 due to delays with COVID-19 pandemic.
- Now that the MFRAT has been implemented across all inpatient wards the learning will be shared for the MFRAT for community settings.
- The current FRAT in RiO being used in Mid Mersey and Community Division has been aligned in the first instance whilst an MFRAT is being developed to ensure standardisation.
- A task and finish group has been established with representation from all Divisions to develop the Community risk assessment process.

Objective 4: Develop a clear pathway for access to support services for those identified as at risk of falling in the community by March 2023 supported by our integrated care teams

- This objective has been carried over into 2023/24 due to delays with COVID-19 pandemic.
- Mersey Care currently have Specialist Falls Teams in the Community and a review of what good looks like in relation the workforce has been completed North Sefton and Liverpool teams.
- Work has commenced to map current provision of support services for those identified as at risk of falling across Cheshire and Merseyside which will support the development of a pathway.

Zero Falls in Our Care Objectives for 2023/24

Goal 1: Standardise the falls risk assessment process across community settings by March 2024

Goal 2: Develop a clear pathway for access to support services for those identified of at risk of falling in the community by March 2024

Goal 3: Use of digital innovations, patient experience, data and research to drive standardisation and continuous quality improvement centred on falls prevention by March 2024

Goal 4: Enhance the multi-disciplinary team focus on falls prevention and management by March 2024

Priority 6: Learning from Deaths

Priority 6 Objectives for 2022/23

Dr Panchu Xavier, Director for Patient Safety is the nominated lead for this priority

- **Four thematic reviews will be conducted per year based on an analysis of mortality figures by March 2022.**

Five thematic mortality reviews were conducted during the year, including reviews within the following groups of diagnoses prior to death:

- **Psychosis:**

  Learning included improved monitoring of physical health and communication between primary and secondary care is needed. There were a high proportion of drug use and related deaths, perhaps more pathways should be considered to mitigate against this risk.
- **Retrospective review of Covid-19 associated deaths in Ashworth High Secure Hospital:**

  Learning included contributory factors were unavoidable such as the physical condition of the patient or physical structure of the hospital. Staff were not always compliant with PPE practices and hand hygiene standards were of the required standards.
- **Retrospective review of Covid-19 associated deaths in Older People's inpatient areas:**

  Learning included Consultants/medics to discuss religious and spiritual needs with patient and family when discussing Advance Care Planning. A discussion with family on a case by case basis if family are able to visit their dying relative on the ward.
- **Deaths in patients new to Mental Health services**

  Learning included Psychological formulation should be considered for patients experiencing suicidal ideation as part of the treatment plan during their period of acute care admission. Transitions in care processes from ward to CRHT Team should ensure that the Safety Plan clearly informs the 48 hour follow up.
- **Mental Health inpatient deaths:**

  All but one have been presented to the Trust-wide Mortality Review Group, with the remaining review completed but due for presentation at the April 2022 meeting of this committee.

  Learning arising from this group has been shared via Divisional representation at the Group for wider dissemination across the Trust and learning shared back to relevant

immediate teams.

2.3 Quality Improvement through Covid-19 Pandemic

In the last year:

We are proud of our achievements in the last year as Mersey Care has contributed to the Covid-19 response across the health and care system in North Mersey.

Understandably, the pressures of Covid-19 have prevented or delayed us from achieving the plans we set out at the start of the year in some areas. Despite this, we have managed to achieve significant improvements in the care we offer to the people we serve, and there are many areas in which our response to Covid-19 has allowed us to accelerate our plans to transform services.

Some highlights of the year:

- CQC inspection through in December 2022 receiving report March 2023 rating of Good overall and outstanding for caring and well led Recruited staff through international recruitment.
- Supported the system to maintain discharge and patient flow through the busiest winter the NHS has known.
- 20 RNs and in process of recruiting 50 RMNS with 8 already in post.
- Successfully rolled out a 12-month preceptorship course for Nurses, AHPs and associated nurses.

- Safely managed through robust strategic planning and maintained safe staffing 30 union strikes through December 2022 to April 2023.
- Successfully completed organisational change to embed the new acquisition of Northwest Boroughs and Southport and Formby into 3 divisions from 4 divisions.
- Successful landing of the acquisition of Southport and Formby Community Services May 2021 and embedded in our community care division.
- Successful landing of the acquisition of North -West Boroughs June 2021 and embedded within our community and mental care division.
- Expanded our telehealth services to monitor over 7,000 patients with a focus on management of long-term conditions and Covid oximetry at home.
- Rapidly mobilising video consultation solutions to all services, supporting around 2,500 individual consultations each month. This maintains an option even now we have resumed face to face consultation.
- Delivering approximately 22,000 bed days of community health care through the winter period, the equivalent of over 104 beds provided in the community.
- Implementing a 24/7 mental health support line 12 months ahead of schedule.
- Providing weekly support and an identified clinical lead to every care home.
- Supporting 650 people who are homeless through integrated pathways with our partners.
- Engaging over 600 staff and partners in developing Integrated Care Teams/ neighbourhood team working (Team 100).
- Mobilising a new Specialist Community Forensic Team across Cheshire and Merseyside.

- Implementing IT infrastructure upgrades and device deployments which routinely support over 2,000 staff per day to work effectively remotely.
- Maintained the developed outbreak management for Covid-19 led by the Director of Infection Control.
- Implement the new Board Assurance framework for IPC.
- Received Assurance from CQC that we were following national guidance to manage Covid-19 to maintain staff and patient safety. Including the learning to live with Covid process
- Implemented a vaccine centre and vaccinate 90% of staff for Covid-19 2 vacancies and 81% booster.
- Implemented process for offering all inpatient 2 vaccines and the booster and commenced spring 2023 booster vaccine for over 75 patients.
- Reviewed all outbreak and shared lessons learnt at Executive Safety Huddle.
- Implemented trust wide new ventilation assessments and set up ventilation safety group in line with new Infection control board assurance framework.
- Implemented new Cleaning Model across the Trust with a rapid response cleaning team available 7 days a week.
- Revised and implemented all new changes for learning to live with Covid.
- Continue to lead the NMABs service for patients. lead the triage process for Cheshire and Merseyside.
- Developed clinical harm review for all waiting list patient in line with national guidance
- Successfully achieved funding to develop in partnership with Liverpool University a Mental Health Research Unit
- Developed and due to launch new patient safety incident response Framework (PSIFR)

Collaborative working with System Partners to Ensure Safe Care for Our Community:

- Work collaboratively within the Cheshire and Merseyside System to support the admission avoidance and discharge process to maintain flow within the acute hospitals through what has been quoted the worse NHS winter
- Infection Prevention & Control Team provided advice support and visibility for all community settings including schools, special schools, GPs, dental services, and nurseries. Staff supported the community teams to implement and maintain adherence to UKSA guidance to protect the community from the spread of Covid-19.
- Infection Prevention & Control worked in collaboration with the CCG and Local Authority to develop training for care home staff. IP&C continue to support all outbreaks within care homes. Always available seven days per week to support and advice care homes to maintain safety of our communities' most vulnerable patients.
- Outside of acute hospitals this enabled the capacity to maintain within the acute setting.
- MCFT led and developed in collaboration/partnership with the wider system the resilience hub for providing the psychological support for NHS staff within the Cheshire & Merseyside footprint.
- Mersey Care provided mutual aid beds for Lancashire Care and CPW even when we had reduced our own capacity to ensure 2-meter distancing within all ward areas.
- Working in partnership to transition young adults into the adult community services. We have been successful and transition 17 young adults to date to our community services.
- In response to major incident in GMM provide mutual aid to support the closing of medium secure beds in GMM.
- Mersey Care, in collaboration with system partners, developed and mobilised the IMPaCT end of life model to provide a comprehensive service to patients, carers and professionals
- Mersey Care mobilised the Enhanced Health in Care Homes model in Liverpool working in partnership with Primary Care Networks, Local Authority and Care Homes. The service supports 84 CQC registered care homes in Liverpool.
- Working in partnership with LUFT in the development of Longmoor House to ensure effective discharge pathways away from acute beds..
- Currently working in partnership on development of robust Urgent Treatment Centre model to support our local populations.

Mersey Care collaborative work with family and carers

It's in line with CQC and Triangle of Care guidance for assessing how well mental health services support Carers in particular but when achieving the standard in mental health it is expected that we establish it in all services operated by the Trust:

- Recruitment of Strategic Carer Engagement Lead in January 2022 – Complete.
- Carers Strategy Task and Finish Group established April 2022 – Complete and ongoing.
- Engagement events planned for Summer 2022 to co-produce Trust Carers Strategy and Carers Charter – Complete.
- Carers Passports to be rolled out across the Trust in 2022. Passport developed – Rollout April 2023.
- Proposed relaunch of Triangle of Care audit in July 2022 across all areas of the Trust including Community Services to gain the maximum 3 star Triangle of Care membership rating. Not complete – Re launch April 2023.

- Family and Friends Tests regularly distributed across all Teams to support service development. FFT will be fully digitalised for all services in 2022 – Ongoing.

- The development of Trust wide Family Interventions merging best practice across Mid Mersey and Local Division – Ongoing.

Objectives for Carer Engagement 2023-24

The 5 priorities have been developed in the Trust Carer Strategy, coproduced by carers.

Priority: 1 Recognise and support carers:
- Board level commitment to our Carers Strategy and implementation plan.
- Introduction of Carer's Passports.
- Develop joint referral forms and launch of carer's pathway including onward referral access support through Life Rooms Learning and Pathways Advice Team.
- Identify and support carers in the workforce.
- Triangle of Care relaunch.

- Carer's Charter refresh.
- Introduction of Trust wide Carer Champions.
- Implementation of Trust wide data recorded system for carers.

Priority 2: Identify and support young carers to achieve their full potential:
- Staff engagement and training to support identification of Young Carers.
- Refresh of Identification of Young Carers guidance including updated referral pathways.
- Build and sustain relationships with local Young Carer support services.
- Engagement and events to develop co-production opportunities for Young Carer.

Priority 3: **Improve skills and training for carers and the workforce:**
- Trust-wide carer awareness training.
- Development and launch of Training Education and Support packages (TES) for carers.
- Improved training and awareness of Triangle of Care amongst restructured services following acquisition.
- Updated and accessible information packs/boards available at each of our sites.
- Review of Trust Carer policy.

Priority 4: Keep carers connected and involved:
- Triangle of Care relaunch.
- Carer involvement in all aspects of care planning, MDTs, discharge, and treatment planning.
- Increased level of co production opportunities with a clear, supportive process.
- Review of carer forums and support groups across the Trust.
- Improve data collection so carer feedback is captured, shared, and used wisely to improve patient and carer experience.
- Review and development of carer pages on Trust website.
- Key points of contact for carers in each service line.

Priority: 5 Carer diversity to be affectively and meaningfully supported:
- Development and maintenance of partnership working with local Voluntary, Community, Faith and Social Enterprise sector.

- Develop accessible information guides to services and translated and easy read information through liaison and advice from the Engagement team.
- Ensure smooth availability of interpreters by review of current contractual arrangements with providers of these services.
- Proactive identification of minority carer groups.

- Engage with national initiatives to ensure that our practice remains the best and up to date.

2.4 Statements of Assurance from the Board: Review of Services

34. During 2022/23 Mersey Care NHS Foundation Trust provided NHS services to a number of NHS Commissioners, including public health (local authorities).

35. During 2022/23, the Trust contracted with:

a) NHS Knowsley CCG & St. Helens CCG for local mental health services and learning disability services across Knowsley and St. Helens, and for community services, including children and young people's eating disorder services and adult community services in Knowsley;

b) 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; this included addiction services for Liverpool;

c) NHS Liverpool CCG for community services, including pre-birth to 19 services commissioned by Liverpool City Council through the contract;

d) NHS South Sefton CCG, NHS Southport and Formby CCG, NHS Liverpool CCG for Sefton community physical health services;

e) NHS Halton and NHS Warrington CCG for local mental health and learning disability services across the Halton and Warrington areas;

f) NHS Warrington CCG and Associates for perinatal and maternal mental health services;

g) NHS East Lancashire CCG (and associates) for low and medium secure services and enhanced community support services for specialist learning disabilities services;

h) NHS North Lancashire and South Cumbria CCG for Learning Disability Specialist Support Teams;

i) NHS Trafford CCG (and associates) for low and medium secure services and enhanced community support services for specialist learning disabilities services;

j) Sefton Council for Residential Substance Misuse Medically Managed Detoxification Service;

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

i) High secure services (also provided to NHS Wales in respect of high secure services).
ii) Low and medium secure services as lead provider in the Prospect Partnership
iii) Low and medium secure services for specialist learning disabilities services.
iv) Personality disorder services at HM Prison Garth
v) Mental health services in HMP Liverpool;

l) Liverpool University Hospitals NHS Foundation Trust for the Liverpool Community Alcohol Service, bariatric support services, Walk-in Centres and services provided as part of the Liverpool Diabetes Partnership;

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;

o) Liverpool Heart and Chest Hospital NHS Foundation Trust and Clatterbridge NHS Foundation Trust for mental health liaison services;

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

q) Mitie for Liaison & Diversion service (CJLT) in mid Mersey;

r) Psychiatry service to HM Prison Altcourse (Primecare);

s) National Probation Service / NOMs OPD work in Cheshire.

The services covered by contracts a) to f) novated to the Cheshire & Merseyside ICB on 1 July 2023, and the arrangements for g) and h) to the Lancashire and South Cumbria ICB, and i) to the Greater Manchester ICB on the same date.

36. The Trust also provides staff support services to a number of local NHS and non-NHS organisations.

37. The Trust also hosts Informatics Merseyside which provides services to a range of local NHS organisations.

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

National Clinical Audit Reports 2022/23

38. During 2022/23 12 national clinical audits and one national confidential inquiry covered relevant health services that Mersey Care NHS Foundation Trust provides.

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

40. The national clinical audits and national confidential inquiries that Mersey Care NHS Foundation Trust was eligible to participate in during 2022/23 are as follows:

a) National Asthma and COPD Audit Programme (NACAP), Core Audit and Survey;

b) Sentinel Stroke National Audit Programme (SSNAP);
c) National Clinical Audit of Psychosis, Early Intervention in Psychosis Teams (EIPT);
d) National Audit of Inpatient Falls, 22/23 (NAIF);
e) National Audit of End of Life, Round 4 (NACEL);
f) National UK Parkinson's Audit;
g) POMH Topic 1h&3e: Prescribing High Dose and Combined Antipsychotics;
h) POMH Topic 21a: The Use of Melatonin;
i) POMH Topic 7g: Monitoring of Patients Prescribed Lithium;

j) POMH Topic 20b: Improving the Quality of Valproate Prescribing in Adult Mental Health Services;
k) National Audit of Intermediate Care (NAIC);
l) National Diabetes Foot Care Audit (NDFA);
m) National Confidential Inquiry into Suicide and Homicide for People with Mental Illness (NCISH).

41. Mersey Care NHS Foundation Trust have participated in all mandated National Clinical Audits and National Confidential Enquiries that were applicable during 2022/23.

42. The national clinical audits and national confidential inquiries that Mersey Care NHS Foundation Trust participated in, and for which data collection was completed during 2022/23, 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.

National Audit Title	**Nº of Cases Submitted**	**Nº of cases as a % of number required**
National Asthma and COPD Audit Programme (NACAP)	60 (Mid Mersey) 29 (Sefton)	100%
Sentinel Stroke National Audit Programme (SSNAP)	69	100%
National Clinical Audit of Psychosis (EIPT)	389	100%
National Audit of Inpatient Falls, 22/23 (NAIF)	0	100%
National Audit of End of Life, Round 4 (NACEL)	1	100%
National UK Parkinson's Audit	30	100%
POMH Topic 20b: Improving the Quality of Valproate Prescribing in Adult Mental Health Services	84	100%
POMH Topic 1h&3e: Prescribing High Dose and Combined Antipsychotics	277	100%
POMH Topic 21a: The Use of Melatonin	82	100%

National Audit Title	Nº of Cases Submitted	Nº of cases as a % of number required
National Audit of Intermediate Care (NAIC)	0	-
National Diabetes Foot Care Audit (NDFA)	20	100%
National Confidential Inquiry into Suicide and Homicide for People with Mental Illness (NCISH)	40	71%

Please note data will be collected for POMH Topic 7g: Monitoring of Patients Prescribed Lithium on 29th March and 4th April 2023 via clinical audit days.

43. The reports of 12 national clinical audit were reviewed by the provider in 2022/23 and Mersey Care NHS Foundation Trust intends to take the following actions to improve the quality of health care provided.

National Clinical Audit of Psychosis Spotlight Audit, 2020/21 (Community Patients)

The national findings were published in January 2022 and initially presented at the Clinical Audit Assurance & Monitoring (CAAMG) in February 2022 and the Clinical Audit Forum (CAF) in June 2022. NCAP had analysed the physical health monitoring element of the data inaccurately within the report, CAAMG asked that this be reanalysed internally and presented back at April's meeting. The following actions were taken:

- The reanalysed results were received and approved by CAMMG.
- The Physical Health forms within Rio forms have been amended to include a family history of cardiovascular disease.
- The results have been disseminated via Quality Practice Alert (QPA) May 2022.

National Clinical Audit of Psychosis (NCAP) EIP Re-audit, 2021/22

The national findings were published in August 2022, preliminary results were presented to CAAMG in June 2022 and went back in August, as data was inaccurately published for the Trust by NCAP. Engagement work between the Royal College and NHS digital was undertaken to resolve the issue. The following actions have been taken:

- A deep dive into Mid Mersey referral to treatment times (RRT) data by the performance team.
- Aligning the process of recording RTT across the footprint. Meetings held to map processes and ongoing work to develop standardised SOP for teams.
- A pathways administrator has been appointed to monitor KPI outcomes.
- A MAST tool developed in local division to monitor pathway and KPIs.
- The BIT team have developed a report to NCAP KPIs.
- Screening tools shared.
- Development of a family therapy leadership pathway.
- Life rooms have been rolled out across Mid Mersey.
- Shared workshops and joint education across the Trust.
- Recruitment of physical health nurse (Knowsley & St Helens).

National Audit of Dementia, 2021

The national findings were published in September 2022. Individual site reports were published for each of the seven participating memory services and local action plans developed. A joint action planning meeting was held to encourage shared learning. The results were presented to CAAMG in June 2022. The following actions were taken:

- A review of the Trusts current assessment pathway to standardise practice.
- The review of the results encouraged shared learning between teams with regards to an internal referral system.
- From the results Halton Memory team are addressing the areas of poor practice by inform decision making in relation to post diagnostic support, OT delivery and referral to diagnosis work. Resulting in the team planning a suite of quality improvement work which is currently due to commence.

National Confidential Enquiry into Patient Outcome and Death, Physical Health in Mental Health Hospitals (NCEPOD), 2021/22

National report was published in May 2022 and reviewed by the leads, an action plan was developed and presented to CAAMG and the Physical Health Strategy Group. The Physical Health Strategy Group suggested a sub-group to review all actions of various pieces of physical health work currently active. The group agreed to incorporate the findings into overarching pieces of work.

National Audit of Falls Facilities Audit (NAIF), March 2021/22
National report was published in November 2022 and shared with the Trust falls leads. The report has been shared at the Trusts falls meeting. There is a falls thematic review with action plan linked to NAIF report being considered by the Trusts committees to:

- Review the “Hot De-brief” and 72-hour review templates against the NAIF templates.
- Medical response template for post fall.

POMH Topic 19b: Prescribing for Depression in Adult Mental Health Services
The national report was published in June 2022, the results and action plan were presented to CAAMG in August and CAF in October 2022. Also presented at the Drug and Therapeutics Group. The following actions were taken:

- A QPA was produced and disseminated to share the findings.
- Prompt sheets / posters for display in clinic rooms.

POMH Topic 1h&3e: Prescribing High Dose and Combined Antipsychotics
The national report was published in December 2022. The audit leads have reviewed the findings and a summary report has been drafted this will be presented at the High Dose Antipsychotic Group in April 2023 and the action plan will be finalised and approved.

National Audit of COPD Core Audit (NACAP)
The results are published bi-annually in September 2022 and March 2023. A draft local report has been developed for the Mid Mersey team and are with the leads for confirmation of actions and dissemination. The NACAP national report, “Drawing Breath” was published in February 2023 and shared with the audit leads for review, dissemination and consideration of any local action required.

Sentinel Stroke National Audit Programme Clinical (SSNAP)
The results were published in November 2022. A draft local report has been developed and are with the leads for confirmation of actions and dissemination.

National Diabetes Foot Care Audit (NDFA)
The results were published in May 2022. This was shared with the audit lead and a data cleanse was completed to ensure that any missing information was included for the second element of the audit, an update of status at 12 weeks from initial assessment.

National Audit of End of Life (Round 4)
Results published in March 2023 waiting action planning meeting.

National UK Parkinson's Audit
Results published in March actions planning meetings planned.

Participation in Trust-wide Clinical Audits

44. Clinical Audit Plan 2022/23
The Trust has developed a prioritisation model based on Healthcare Quality Improvement partnership (HQIP). High priority clinical audits that are mandated (national),

commissioning (CQUIN), regulatory/statutory (CQC or DoH) or deemed a high priority by the Trust form the basis of the Trusts clinical audit plan.

In addition to the national audits previously described the Trust has undertaken the following high priority audits detailed on the audit plan:

- CQUIN leg ulcer audits.
- National (non-mandatory) audits: 0-19 baby friendly initiative audit and national clinical audit of anti-libidinal medication prescribing practice.
- NEWS2 audits.
- Treatment/assessment of pressure ulcers.
- Multi Agency Risk Assessment Conferences (MARAC).
- Audit of inpatient wards to assess patients are receiving appropriate medical reviews in line with local Trust policies.
- Audit on the compliance of clozapine standards within clozapine clinics.
- Medicines management.
- End of Life audit.
- Greenlight toolkit audit.
- Musculoskeletal Service (MSK) documentation audit.

45. Local Clinical Audit
Clinical audit deemed as a priority by the local division is detailed on local division audit plans. This audit activity is registered with the clinical audit team and appropriate levels of support offered.

During 2022/23 there were 86 local levels audits registered with the team. Of these 21 are fully completed, 20 have working actions plans. A further 31 are at varying stages of the audit cycle of which 29 on track for completion and two are delayed.

A further 14 have been cancelled. The rational for this was three have been moved to the monitoring tracker as not deemed audit, one was confirmed as service evaluation and the remining due to inactivity.

46. Monitoring Tools
The clinical audit team support teams/wards within Mersey Care to routinely monitor practice by developing monitoring tools on the Trust Audit Management System (AMaT). Currently there are 69 monitoring tools registered which include:

- Clinical content monitoring tools (x19).
- Infection prevention and control monitoring tools (x15).
- Medicines Management (x4).
- Care programme approach (x2).

- Falls (x2).
- Record keeping (x2).
- CQUIN urinary tract infection (1).
- and a further 24 ward/team specific topics.

Monthly reports are generated for ten of the monitoring tools, eight require quarterly reports or on an ad hoc basis. The remaining monitoring are managed and reported by the division as and when required.

47. Clinical Audit Assurance and Monitoring Group

The Clinical Audit Assurance Monitoring and Group (CAAMG) is the oversight group for clinical audit. The main function of the group is to provide governance arrangements that monitor, review and report the systems in place to fulfil the Trusts audit plan. All high priority clinical audits and any local clinical audits that may result in shared learning or require escalation are reviewed and action plans scrutinised by the group. The meeting is chaired by the Trust Clinical Audit & Quality Lead. Leads from the Mental Health, Community divisions have been identified to form the membership and the first Trust wide meeting is planned for April 2023. In addition to divisional leads the Deputy Chief Pharmacist, Clinical Audit Manager, Clinical Audit Facilitators and Co-opted Specialist leads, will represent their service. The meeting intends to report into each divisional audit meeting ensuring the dissemination of all clinical audit activity.

48. Clinical Audit Days

During 2022/23, the team continued to host and strengthen the clinical audit days via Teams, which are facilitated by the clinical audit team for audits of high priority such as national audits, CQUINs, POMH and Trust high level objectives. The Trust are

encouraging all Junior Doctors at induction to participate in a clinical audit day during their rotation. This will enable the Trust to support them to fulfil the Junior Doctor requirements. A project lead, deputy lead and team are identified when it is decided to undertake an audit day to plan the audit through to the implementation of actions. A multidisciplinary team is formed, usually consisting of the clinical audit team, medical staff and trainee doctors, nursing staff, pharmacy, psychology, business intelligence and other specialist leads. There are many benefits of undertaking clinical audit days, these being:

- Data collection undertaken in a controlled environment.
- Quality/consistency of data collection and assured results.
- Timely collection of data.
- Multidisciplinary working.
- Promote collaborative team working.
- Lessons learned/shared learning.
- Fulfils Junior Doctors requirements.
- Raising the profile of audit.
- Ownership of actions by an established clinical lead and action plan group.
- Promotes teamworking.

The Trust hosted 14 clinical audit days during 2022/23 for the following high priority clinical audits:

- CQUIN Leg Ulcer (x4 days).
- POMH Topic 21a: The Use of Melatonin (x 2 days).
- National Clinical Audit of Psychosis (EIPT) (x 2 days).
- POMH Topic 20b: Improving the Quality of Valproate Prescribing in Adult Mental Health Services.
- NEWS2 secure and mental health (x 2 days).
- POMH Topic 1h&3e: Prescribing High Dose and Combined Antipsychotics (x 2 days).
- POMH Topic 7g: Monitoring of Patients Prescribed Lithium (x2 days).

49. Clinical Audit Forum

In April 2022 the Trust formed the clinical audit forum (CAF) across the whole footprint of the Trust, to enable the presentation and dissemination of clinical audit findings. The CAF aims to promote discussions, encourage shared learning, and inform of action planning from both high priority and local audits. Ongoing work is in place to develop this forum, to encourage attendance across all disciplines and enable it to be as accessible as possible with a constant review of dates and times. The sessions have been a success and generated many discussions and sharing of practice.

50. Audit Management Tracking System (AMaT)

The Clinical Audit Team continue to improve and develop their skills on AMaT to enable them to support, train and advise staff within the divisions how to complete their audits, monitoring tools and CQC self assessments and action plans via this system. At present there are 1793 Trust users and the Clinical Audit Team plan to complete further roll outs of audits and monitoring tools within the new financial year to these multi-disciplinary staff members. This is a transparent way of reporting has proved successful in demonstrating compliance and evidence when required.

51. 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.

CLINICAL AUDIT REPORT 2022/23	
Audit Theme	**Improvement Activities Arising from Clinical Audit Outcomes**
NICE	Clinical audits have been undertaken to assess aspects of the following NICE guidance and action plans developed to improve compliance: • CG179: Pressure ulcers audit resulted in the education of staff regarding the required standards of practice at the Quality and Safety Meetings and the merging of policies to standardise practice. • NG89: Venous thromboembolism (VTE) in over 16s resulted in the standardisation of the VTE assessment across the mental health care division wards.

Audit Theme	Improvement Activities Arising from Clinical Audit Outcomes
	• NG134: Depression in children and young people resulted in the guidance and links to access NICE guidelines being made available within the induction pack for new doctors. Additionally, adherence is reviewed during trainee supervision, team doctors' supervision and consultant peer group meetings. • CG155: Psychosis and schizophrenia in children and young people resulted in a pro-forma being developed for external services to report baseline information for new referrals. • NICE health topics for urinary tract infections resulted in a change to local process.
Physical Healthcare	Physical health has featured on the Trusts clinical audit plan and on local divisions audit plans. The clinical audit team provided representation at the Cardiometabolic Group were all physical health audits and actions are discussed. The following clinical audits have been undertaken to assess the physical health of patients and action plans developed to improve compliance: • A number of NEWS2 audits were completed on the Hollins Park secure wards, mental health wards and District Nursing Teams. For secure this resulted in a new SOP is being developed, a review of training and access to Rio for physical health. Within the District Nursing Teams there have been discussions with EMIS regarding recording of NEWS2. For mental health mandated Training on EoBs and Sepsis being rolled out across the whole of Mersey Care and the review of a joint policy and SOP. • An audit of venous thromboembolism (VTE) assessments on later life and memory wards resulted in the standardisation of the assessment across the whole of the mental health division. A Trust wide VTE group has now convened to monitor the standardisation of the Rio forms and processes as part of its remit. • An audit to assess nicotine management in adult inpatient wards in Mid Mersey Division against Trust guidelines has resulted in the development of an E-Learning package by the Trusts smoking cessation lead for all front-facing staff. A poster has been placed on the wards to raise awareness amongst service users of the impact of nicotine on physical and mental health. A review of assessment forms is being undertaken by the Physical Health Lead. • An audit of compliance of clozapine standards within clozapine clinics in Mersey Care highlighted an issue regarding physical health equipment. An outcome for the clozapine steering group to find an interim solution seek equipment.
Records Management	• A monthly clinical content monitoring tool is available to complete on AMaT. This is bespoke to individual teams within the community division and secure divisions. Work is in collaboration with the QRV team to consider standardising the clinical content monitoring tool.
Risk Assessment/Patient safety	There are monthly care programme approach / reducing restrictive practice and safety planning monitoring tools on AMaT, assessing elements of risk. The actions as a result of these are owned and monitored by the division:

Audit Theme	Improvement Activities Arising from Clinical Audit Outcomes
	• An audit to assess children and young people within Warrington community mental health services (CYPMHS) who are at risk have safety plans in line with standards set within the Effective Skills Intervention Handbook. As a result of the findings clinical case load monitoring is completed for all clinicians. Safety planning is discussed at clinical supervision, safety hurdles, and MDT following incidents. The Psychiatrist now requests completion of safety plan prior to consultation. • An audit of all inpatient wards to assess patients are receiving appropriate medical reviews in line with local Trust policies resulted in the standardisation of the daily morning review meeting across the footprint. All inpatients should be reviewed weekly to include documentation of clinical risk and observation levels. • An audit of safeguarding responses to patient-on-patient assaults within mental health inpatient wards resulted in an interactive training workshop being facilitated by the Safeguarding Adults Team for the trust covering mental health decisions, in addition to a QPA being completed to be shared with all staff. • An audit of risk related service user alerts on carenotes resulted in the review and update of the Trust SOP.
Medicines Management	• The Trust participated in all POMH audits applicable. • The controlled drug monitoring tools have been successfully rolled out Trust wide on AMaT and all actions are managed locally within the divisions. • A pilot of the safe and secure audit will be rolled out Trust wide on AMaT.
GP Communication	• The inpatient GP communication monitoring tool has consistently reached full compliance of 95% with a significant improvement also in the community clinic monitoring tool.

2.6 NHS Staff Survey Results 2022

49. The National Staff Survey is conducted independently from the Trust in line with national requirements, to assure staff regarding the confidentiality of their responses. The Trust provides feedback to staff on both the results and how the Trust intends to address any issues raised. The 2021 National Staff Survey for Mersey Care was conducted largely on line and was sent to all staff.

50. The Survey was conducted between 4 October and 27 November 2021, the Trust achieved a response rate of 32% which was a 5% decrease from 2019 and below the national response rate of 52% (up 3% from 2020) for Mental Health & Learning Disability and Mental Health, Learning Disability& Community Trusts.

51. Given the changes to our organisational structure following the acquisition of North West Boroughs and Sefton and Formby, and the new divisional structure implemented in April 2021, comparable data provided by the Survey Co-Ordination Centre is limited in its application. Analysis and comparison has been conducted where possible for guidance to indicate trends from previous years.

52. Further, in line with the commitment in 2021/22 to the National People Plan, the NHS Staff Survey has itself been redeveloped to align with the People Promise. This change has seen the 10 reporting themes being replaced with the 7 people promises plus Staff Engagement and Morale and the addition of 37 new questions and the removal of others. It should be noted that there is some impact on year-on-year comparison of performance.

53. The Trust has largely performed in line with national average for the relevant comparator group nationally and regionally. Out of 9 Key Themes the Mersey Care was in line with the national average for 7 out of 9, and slightly below the average for 2 out of 9 themes.

54. When we compare our results by question with the previous year, for the 104 questions asked as part of the key questions, our results are as follows:

Number of questions where we have improved	**12**
*Of which were statistically significant**	**0**
Number of questions where the results are the same as the previous year	**3**
Number of questions where we have seen significant deterioration	**33**
*Of which were statistically significant**	**19**
Number of questions that are new	**37**

** A variation of + or – 5% is deemed to be statistically significant*

55. The Trust's results for this year should be considered along-side the unprecedented and exceptionally difficult two years, the impact of the pandemic on the North West, the composition of the trust and the scale of change including the acquisition of Southport Community services, North West Boroughs FT increasing the size by 4,000 employees. Despite this the scores for Staff Engagement and Morale meet those of our comparators. Overall the Trust has either met or improved in 7 key themes falling slightly below the comparator scores in 2.

56. In relation to the theme of 'Overall Staff Engagement' the Trust has achieved a score of 7.0 which meets the national average for our comparator group.

57. The Trust continues to make progress and see improvements in 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 following questions:
- I would feel secure raising concerns about unsafe clinical practice.
- I am confident that my organisation would address my concerns.

58. Respect and Civility continues to be a highlight for the Trust reflecting the ongoing work in relation to this agenda. Questions relating to team working and shared objectives is reflective of the focus on introducing the Team Canvas across the whole trust. The importance of trust in the psychological contract is paramount and the high scores in staff feeling secure to raise concerns is positive and crucial to the next stages of the restorative just and learning culture journey.

59. The WRES questions relate to career progression, discrimination and bullying and harassment from staff, managers and members of the public. In all 4 areas BAME staff

responses are more negative than those of white staff; 3 out of 4 of these are statistically significant. 2 out of 4 questions have seen an improvement, the most significant of which is in relation to the percentage of BAME staff that have experienced discrimination from a manager or colleagues.

60. The Trust made explicit it's commitment in the form of a BHAG objective of zero acceptance of discriminatory behaviour introduced in 2020. The findings of the NHS Staff Survey are critical to understand the prevalence of discriminatory behaviour and identifying priority areas.

61. These results are indicative of the Trust's continued investment in establishing psychological safety and the alignment of this to patient safety and clinical excellence.

62. Results were shared with the Trust Board in May 2022 and People Committee in May 2022. Divisions will include survey results in the development of their divisional people plans.

2.7 Research and Development

63. Evidence suggests when healthcare organisations engage in research it is likely to have a positive impact on healthcare performance. Participation in clinical research demonstrates the Trust's commitment to improving the quality of care we offer and to making our contribution to wider health improvement. It also helps to ensure our clinical staff stay well informed of the latest treatment possibilities.

64. The number of patients receiving relevant health services provided or sub-contracted by the Trust in 2022/23 that were recruited during that period to participate in research approved by a research ethics committee was 528. An additional 242 other participants (e.g. staff, carers, healthy volunteer) were recruited during the year.

65. The Trust was involved in 98 research studies in mental health, learning disabilities and community health services in 2022/23, 64 of which were new studies opened to recruitment at the Trust during this time. There has been an increase in requests for the Trust to act as a Participant Identification Centre for research studies with 15 opened during the year. The studies have included UK Clinical Research Network (UK CRN) portfolio research funded by the National Institute for Health Research or other grant programmes, commercially funded clinical trials of investigational medicinal products, and student research projects seeking to recruit patients, carers or members of staff. This has included both observational and interventional research. They have been across all ages, in areas such as dementia, schizophrenia, psychosis, perinatal mental health, learning disability, treatment resistant depression, long COVID, dental health and infant feeding. The Trust continues to support several studies within the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH) programme.

66. The Trust have supported the submission of external funding bids with a wide variety of collaborators and to a range of funding streams and has been awarded National Institute for Health Research Efficacy and Mechanism Evaluation and Health Technology Assessment grants.

67. The research team provided governance and support to 60 service evaluations during the reporting period.

68. We continue work collaboratively with the North West Coast Clinical Research Network, Applied Research Collaboration North West Coast, Liverpool University, Liverpool John Moores University, Edge Hill University, University of Central Lancashire, Manchester Metropolitan University and Manchester University. High Secure Services have maintained and built upon their longstanding collaboration with UCLAN. A Joint Chair in Connected Mental Health has also been established with Liverpool University.

Mortality – Learning from Deaths

69. The Trust continue to provide a dedicated Mortality and Incident Review Team to support delivery of Trust Priority 6.

70. The LeDeR reviewer programme, previously provided and delivered by the Trust, transferred to Cheshire and Wirral Partnership on 1 September 2022.

71. The Mortality and Incident review Team continue to utilise the adapted Royal College of Physicians specialist guidance along with support from our commissioners to ensure that the work being undertaken by the team is evidenced based and best practice. The Trust remains committed to reviewing deaths of patients who access its clinical services. The current Trust wide Learning from Deaths policy requires that all deaths that are in scope of the policy are reviewed by the Trust using the three-stage process

    as detailed below:

    a) Triage using the agreed review tool;
    b) Structured Judgment Review (SJR)/seventy-two-hour review;
    c) Learning Review.

72. The screening tool in use by the team for reviewing deaths mirrors the Royal College of Psychiatrists mortality screening tool for mental health trusts and is utilised under the guidance and oversight of the Director of Patient Safety.

73. The Mortality and Incident Review Team continue to deliver a multi-disciplinary team (MDT) approach to the oversight of reviews undertaken. The team meets weekly to review SJRs undertaken and will source subject matter expertise as required. Clinical teams responsible for patient care are now directly involved in the MDT process to support wider learning.

74. The Trust objective of the mortality review process is to undertake a series of thematic reviews to identify learning following the deaths of patients in certain diagnostic groups or demographic. The 2022/23 objective was to undertake four thematic reviews, to

    strengthen and enhance learning as an organisation, to date five thematic reviews have been completed:

    a) Inpatient physical health cause deaths;

b) Children and young people – SBAR child death review;
c) Respiratory cause deaths in learning disabilities;
d) Mental health inpatient deaths from suicide;
e) Autism and suicide.

75. The MRG meets bimonthly basis, where the thematic reviews are commissioned, presented, and where shared learning is identified. The Trust reports the findings of this process and learning on a bimonthly basis to the Strategic Patient Safety Group and Quality Committee via the Safety Report.

Supplementary Mortality Data for Quality Account 2022/23

Total number of deaths 2022/23

76. Deaths are reported through the Trust's incident reporting systems, and the mortality review process captured in the same system. It should be noted that some deaths which occurred in Q4 may not have been reported, as the reporting period for Q4 in the report is January 01– 28 February 2022 for reporting purposes.

Total number of deaths by quarter 2022/23

Quarter	Q1	Q2	Q3	Q4
Total	**1044**	**965**	**1203**	**1075 (to date)**

Number of deaths reported and reviewed 2022/23 (to date)

77. The Trust continues to see an increase in the number of deaths reported in 2022/23. There have been 4287 deaths reported in 2022/23 compared to 3720 in 2021/22. All deaths are reported in line with Trust Policy. Insight into the overall numbers of deaths is important to the Trust, however, a proportionate response to the review of deaths has been adopted, this is reflected in the Trust policy SA45. The Trust has prioritised the review of those deaths of patients in mental health and learning disability services, deaths that are unexpected, or where concerns about care had been expressed by the treating team or family. For probity, the Trust also reviews 5% of deaths where death was expected and there were no apparent causes for concern regarding care and treatment within the Trust.

78. All deaths of patients with Learning disability reported were reviewed within the year and were referred to LeDeR (Learning Disability Mortality Review programme).

79. All child deaths were reviewed via the Trust's participation in the Child Death Overview Panel process. This is overseen via Safeguarding processes.

Quarter 2022/23	Q1	Q2	Q3	Q4
Deaths reported	**1044**	**965**	**1203**	**1075**
Reviewed	**348**	**309**	**445**	**353**

Proportion of deaths likely attributable to care

80. Problems with care can be identified through both the adverse incident and mortality review processes. Deaths from suspected or actual suicide are escalated as Serious Incidents.

81. Other deaths are reviewed through the mortality screening process and progress to Structured Judgement Review (SJR). The mortality team have continued to use the 'red flag' system to identify key features, aspects of illness or elements of care which warrant the further detailed review offered by the SJR methodology.

82. The mortality team reviewed 1455 deaths in 2022/23 of which 232 were identified as meeting the criteria for an SJR. Of those 232 deaths reviewed during 2022/23 five of the 232 cases reviewed by SJR during the reporting period were identified as poor care. All cases where poor care was identified have been shared with the relevant division and further review undertaken with learning identified which has informed existing improvement plans.

83. Assurance on learning and improvement plans is presented at the MRG. All improvement plans continue to have progress oversight and updates at the bi-monthly MRG through to closure for assurance.

Key learning from reviews highlighted in 27.3

84. Learning identified from the reviews undertaken and all lessons learned are shared directly with team engaged in structured judgement review and respective divisional governance team. An example of wider collaborative action from identified learning is evidenced by a children and young people thematic learning review taken forward by the workforce development team and practitioners.

85. Findings from the thematic review indicated an increase in deaths in children in areas of high deprivation because of premature births and sudden unexpected deaths with potential causal factors being parental drug use; bed-sharing; child use of illicit drugs; smoking and alcohol use during pregnancy and neglect.

86. Simulation training was identified as a potential option. Simulation training has been led and developed by the practitioners with specific story boards related to incidents from the incident reporting system and scenarios that facilitate learning and discussion. Sessions are facilitated by the lead practitioner allowing ownership of the development and audit of outcomes. Audit of the process will be undertaken with support of Health Education Institute (HEI) colleagues when process of learning, reflection and scenarios have been completed.

87. All mortality thematic reviews are presented at the MRG. A small percentage of these are escalated for shared learning at Executive Safety Huddle.

2.8 Commissioning for Quality and Innovation (CQUIN)

98. CQUIN was suspended by NHSE during the Covid pandemic and reinstated in April 22.

99. Details of the 2022-23 CQUIN schemes are provided below.

100. The Trust is working with commissioners to move to one contact with the Integrated Care Board for services commissioned by the former CCGs from April 2023. For this financial year contracts have been maintained with our local commissioners with Liverpool CCG acting as the Lead Commissioner. As Commissioners did not formally sign contracts with the Trust, final financial allocations cannot be confirmed for each of the CQUIN indicators.

101. It is estimated that for Trust contracts for Community Care and Mental health Care Services contracts will be in the region of £5.5m.

102. There is no CQUIN for the High Secure Contract or services included with the PROSPECT Lead Provider Collaborative.

103. Under this year's contractual arrangements for the Mental Health Care and Community Care Divisions, the commissioners have signalled that any underperformance will be reinvested back into the CQUIN to improve performance.

104. The trust reported Quarter 3 CQUIN performance to commissioners in line with national reporting guidelines as specified in the CQUIN specifications in February 2022.

105. The trust is currently reporting RED for the Flu vaccination CQUIN. Compliance is currently 45%. The flu vaccination campaign finishes at the end of February 2023.

106. The Cirrhosis and Fibrosis tests for alcohol dependent patients CQUIN, has failed to become operational. Trust leads have worked extensively with consultant colleagues and acute providers in order establish referral pathways. The CQUIN failed to become operational due to the complexities of managing referrals to acute trusts and in establishing efficient pathways with all the acute providers across the trust footprint. The failure to operationalise the CQUIN has been escalated to the divisional senior leadership team and the Contracts Team will provide commissioners with full details of the work undertaken to achieve the CQUIN. This CQUIN was only to be reported on in Quarter 4.

107. The Trust is currently reporting RED for the Assessment, diagnosis, and treatment of lower leg wounds CQUIN. Work is underway with BI colleagues to ensure consistent data capture within clinical record systems as these vary across the trust services Work is ongoing to identify improvement trajectories to support the achievement of CQUIN targets. It is to be acknowledged the impact of services in BCP/loss capacity and cancellation of training has had on achieving the CQUIN target.

Mersey Care CQUIN Schemes Q3 2022-23

CQUIN Scheme	Division	CQUIN Details	Rag Q3
Flu Vaccinations for Frontline Healthcare Workers	All – Trust wide	Achieving 90% uptake of flu vaccinations by frontline staff with patient contact.	

Cirrhosis and fibrosis tests for alcohol dependent patients	Mental Health Care	Achieving 35% of all unique inpatients (with at least one-night stay) aged 16+ with a primary or secondary diagnosis of alcohol dependence who have an order or referral for a test to diagnose cirrhosis or advanced liver fibrosis.	
Routine outcome monitoring in CYP and perinatal mental health services	Mental Health Care	Achieving 40% of children and young people and women in the perinatal period accessing mental health services, having their outcomes measured at least twice.	
Routine outcome monitoring in community mental health services	Mental Health Care	Achieving 40% of adults and older adults accessing select Community Mental Health Services (CMHTs), having their outcomes measure recorded at least twice.	
Use of anxiety disorder specific measures in IAPT	Metal Health Care	Achieving 65% of referrals with a specific anxiety disorder problem descriptor finishing a course of treatment having paired scores recorded on the specified Anxiety Disorder Specific Measure (ADSM).	
Biopsychosocial assessments by MH liaison services	Mental Health Care	Achieving 80% of self-harm referrals receiving a biopsychosocial assessment concordant with NICE guidelines.	
Malnutrition screening in the community	Community Care	Achieving 70% of community hospital inpatients and community nursing contacts having a nutritional screening that meets NICE Quality Standard QS24 (Quality statements 1 and 2), with evidence of actions against identified risks.	
Assessment, diagnosis and treatment of lower leg wounds	Community Care	Achieving 50% of patients with lower leg wounds receiving appropriate assessment diagnosis and treatment in line with NICE Guidelines.	
Assessment and documentation of pressure ulcer risk	Community Care	Achieving 60% of community hospital inpatients aged 18+ having a pressure ulcer risk assessment that meets NICE guidance with evidence of actions against all identified risks.	
Appropriate antibiotic prescribing for UTI in adults aged 16+	Community Care	Achieving 60% of all antibiotic prescriptions for UTI in patients aged 16+ years that meet NICE guidance for diagnosis and treatment.	

Financial Statement

108. For the financial year to April 2023 CQUIN was estimated to be approximately £5.5m. As Commissioners did not formally sign contracts with the Trust, final financial allocations cannot be confirmed. Under this year's contractual arrangements, the commissioners have signalled that any underperformance will be reinvested back into the CQUIN to improve performance.

2.9 Care Quality Commission

Registration and CQC Ratings

102. A change to registered manager took place for Wavertree Bungalow. Documentation has all been processed and accepted, Amy Peacock is now registered manager for this location in place of Michelle Blackburn.

103. An application was submitted to add a location: HMP Altcourse. CQC have confirmed this has been approved and we await the formal Notice of Decision.

104. Paperwork for LSU Aspen Wood is currently being drafted to commence the registration process.

105. The remaining CQC registration activity is set out in the following table:

OUR ID	Date	CQC Ref	Location / Team	Details	Status
REG-37	24/03/2022	ENQ1-12826968998	Trustwide	Submitted additional application to cancel one regulated activity (Family Planning)	Complete
REG-38	05/04/2022	RGP1-12897843641	Ambition Sefton (South and Church St)	Received notice of decision to remove locations from the activity of - **Treatment of disease, disorder or injury** for the following locations - Ambition Sefton (South) and Ambition Sefton North (Church Street)	Complete
REG-39	05/04/2022	RGP1-12897843547	Ambition Sefton (South and Church St)	Received notice of decision to remove locations from the activity of - **Diagnostic and screening procedures** for the following locations - Ambition Sefton (South) and Ambition Sefton North (Church Street)	Complete
REG-40	05/04/2022	CRT1-12904539338	Trustwide	Received updated certificate of registration	Complete
REG-41	13/04/2022	ENQ1-12954345510	Wavertree Bungalow	Submitted SN15 - notification of change to update postcode for Wavertree Bungalow - The request is to update a postcode, currently the postcode on our Certificate of Registration ends W however this needs to be changed to end N	Complete
REG-42	13/04/2022	ENQ1-12954345510	Broadoak	Submitted SN15 - notification of change - The request is to update a postcode, currently the postcode on our Certificate of Registration is L14 3PE however this needs to be changed to L14 3PJ	Complete
REG-43	13/04/2022	ENQ1-12954345510	Clock View	Submitted SN15 - notification of change - The request is to update the number of the building for the address. Currently the building number is 9a on our Certificate of Registration however this needs to be changed to 2a	Complete
REG-44	13/04/2022	ENQ1-12954345510	Rathbone	Submitted SN15 - notification of change - The request is to update a postcode. Currently the postcode on our Certificate of Registration is L13 4AU however this needs to be changed to L13 4AW	Complete
REG-45	22/04/2022	CRT1-13013571917	Trustwide	Received updated certificate of registration	Complete

REG-46	26/04/2022	RGP1-13038477974	Trustwide	Received updated certificate of registration	Complete
REG-47	24/05/2022	RGP1-13083177328	Trustwide	Received Notice of decision to cancel registration as a service provider in respect of a regulated activity - Family Planning	Complete
REG-48	24/05/2022	CRT1-13215176769	Trustwide	Received updated certificate of registration	Complete
REG-49	12/08/2022	ENQ1-13748920606	Wavertree Bungalow	Submitted SN15 - notification of a change of registered manager from MB to AP	Complete
REG-50	12/08/2022	ENQ1-13748920606	Wavertree Bungalow	Submitted SN12 - Change to a Statement of Purpose from MB to AP	Complete
REG-51	12/08/2022	N/A	Trustwide	Statement of Purpose Appendix with changes submitted: Wavertree Bungalow (ASC) and LIP moves to V7. This was submitted to CQC on 09.01.23.	Complete
REG-52	30/08/2022	ENQ1-13864556246	Trustwide	Submitted updated Statement of Purpose (Narrative) as part of the process for updating Registered Manager at Wavertree Bungalow.	Complete
REG-53	13/10/2022	ENQ1-14157692296	Wavertree Bungalow	**(linked to ENQ1-13748920606)** AP submitted an application to register as a manager of regulated activities including CQC-DBS checks.	Complete
REG-54	04/01/2023	RGP1-14428879093	Wavertree Bungalow	Received updated certificate of registration (Registered Manager)	Complete
REG-55	09/01/2023	ENQ1-14759408934	Trustwide	Updated Statement of Purpose to reflect narrative for Wavertree Bungalow to advise this should be inspected under ASC. Also changes of community services moved from LIP to V7	Complete
REG-56	09/01/2023	ENQ1-14759408934	Trustwide	Statutory Notification of change to Statement of Purpose	Progressing
REG-57	09/01/2023	N/A	Trustwide	Statement of Purpose Appendix with changes submitted: Add location - HMP Altcourse effective from 1st April 2023. This was submitted to CQC on 10.01.2023	Complete
REG-58	10/01/2023	ENQ1-14766621610	HMP Altcourse	Application to add a location - HMP Altcourse, to commence 1st April 2023	Progressing
REG-59	10/01/2023	N/A	Trustwide	Draft Statement of Purpose Appendix with team changes - ongoing. Use this for any future submissions.	Pending
REG-60	08/02/2023	RGP1-14830314633	HMP Altcourse	Email received from CQC, detailing 17 data requests - response due 5pm Fri 17 Feb	Complete

Other CQC Activity

106. There is frequent communication between CQC relationship managers and the Trust Nominated Individual (DDoN & Quality). This includes requests into the Trust for information regarding responses to concerns, complaints clarification questions and data queries. All of these are answered and responded to in a timely manner and no issues have to date, been required to be escalated further.

107. Likewise, the Nominated Individual regularly appraises CQC Lead inspector and relationship managers of high-level incidents, potential media interest or any other extra-ordinary event, and wherever possible this is done prior to formal reporting or data submissions to add context and minimise concerns.

108. CQC engagement meetings continue on a bi-monthly basis however the decision was made by CQC to stand down the meetings scheduled during the recent CQC Well-Led Inspection. The meetings resumed in March 2023 as planned.

109. We continue to submit data and information prior to these meetings as shown in the following table. This is collated centrally by CQC Team and sent to CQC prior to the

meeting to allow them to analyse the information provided to give focus where it is required:

Safety • Noscomial infections / COVID-19 • CAS Alerts • PLACE Inspections	**Skills and Knowledge** • Training	**Executive Directors / Non-executive Directors / senior staff**
Serious Incidents • StEIS / NRLS • Never events and serious incidents • Coroner Regulation 28 letters / inquests	**Patient Survey results** • FFT • Patient / Carer surveys	**Organisational changes**
Safeguarding • Local Authority enquiries / investigations • Whistle-blowing • Patient complaint / concerns on safety	**Service Planning**	**Freedom to speak up guardians** • Any relevant information or concerns from engagement with the Trusts Freedom to speak up guardian(s)
Staffing • Absence • Wellbeing	**Complaints and Compliments including trends and themes**	**Staff Engagement**
Medicines Optimisation	**Parliamentary and Health Service Ombudsman referrals**	**Potential issues of media interest**
Patient Outcomes • Results of any patient surveys	**Patient / carer engagement**	
Mental Health Act • Relevant Inspections and Mental Health Act Commissioner visits within the period	**Governance framework for quality, performance and risks** • Risk Register • BAF	

110. Mental Health Act visits are carried out using an unannounced visit approach. Across Mersey Care inpatient services that are registered to provide care to patients under the Mental Health Act (1983), the Trust was subject to 19 unannounced Care Quality Commission/Mental Health Act inspections in 2022/23 of wards within Mental Health Care and Secure Care as part of their programme of inspections. These services were:

Eden Ward	22/03/2022
Thornton Ward	22/03/2022
Turner Ward	11/05/2022
Morris Ward	18/05/2022
Macauley Ward	27/05/2022
Dunes Ward	08/07/2022
Byron Ward	14/07/2022
Irwell Ward	22/07/2022
Brain Injury Rehabilitation	13/08/2022
Austen Ward	23/08/2022
Iris Ward	20/09/2022
Harrington Ward	03/10/2022
Auden Unit	04/10/2022
Childwall Ward	22/10/2022
Blake Ward	28/10/2022
Carlyle Ward	18/11/2022
Moor Cottage and 1 and 2 Pendle Drive	12/12/2022
Allerton Ward, Rathbone	19/12/2022
Heys Court	16/01/2023

111. 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 Covid-19 response, environment, standard of food etc.

112. 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.

113. However, the inspections have highlighted the following themes:

a) Access to advocacy (in some areas);
b) Leave of absence;
c) Care plans;
d) Meaningful activity;
e) Staffing levels;

114. 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.

115. There were a lot of positive themes throughout the reports including how carers and patients spoke highly of staff which is the same theme picked up from the previous two years, demonstrating consistency within this area.

Summary of CQC Current Inspection Findings 2023

116. On 23 and 24 March, CQC carried out an unannounced focused inspection as part of a national review of urgent and emergency care systems. Mersey Care mental health psychiatric liaison teams based at the Royal Liverpool University Hospital and Aintree University Hospital (both part of the Liverpool University Hospitals NHS Foundation Trust) were chosen as part of the review, to examine the impact of psychiatric liaison within an urgent emergency care system, as well as any possible impact on patient safety. This was a focused inspection with emphasis on specific key lines of enquiry within the safe key question, the responsive key question and the well-led key question.

117. On 9 and 11 May CQC carried out an unannounced focused inspection as part of a national review of urgent and emergency care systems. Mersey Care walk-in centres in Nutgrove Villa, Litherland and Garston were chosen as part of the review, to examine the impact of walk -in centres within an urgent emergency care system, as well as any possible impact on patient safety. This was a focused inspection with emphasis on specific key lines of enquiry within the safe key question, the responsive key question and the well-led key question.

118. On 8th November the Trust were notified by CQC of a provider level inspection of Well-Led to take place on 6 and 7 December 2022, the portal was opened and data requests were received.

119. The inspection lasted from 8 November 2022 to 24 January 2023. During the inspection CQC carried out two announced and four unannounced inspections of six of the mental

health and community health services provided by the Trust, and one unannounced inspection of an adult social care location, as part of the continual checks on the safety and quality of healthcare services.

120. Ashworth was inspected because this must be inspected every five years in order to inform the High Secure re-authorisation process, and the last inspection was in 2017 where it was rated good.

121. Acute wards and psychiatric intensive care units (PICU) and community inpatients were inspected because CQC had received information giving them concerns about the safety and quality of these wards.

122. Forensic and secure wards and wards for people with a learning disability and/or autism were inspected because the service had changed significantly since the last inspection and to review outstanding breaches of regulation in the forensic services.

123. Community health services end of life care were inspected to review outstanding breaches of regulation.

124. Adult social care location – Wavertree Bungalow, was inspected as it had not previously been inspected under adult social care methodology.

125. The Factual Accuracy report has been received, checked and documentation completed and returned to CQC. We are awaiting publication of the outcome and final report at the time of writing.

2.10 Duty of Candour

126. The Trust policy for Duty of Candour and Being Open (SA13) January 22, is scheduled for January 24. The Duty of Candour quality improvement group implemented in January 2022 continues with a clear aim to strengthen duty of candour understanding and awareness across the trust in its application of duty of candour. This improvement work continues to support improvement in the trust's overall performance, reporting and compliance.

127. The Trust continues to ensure robust oversight and delivery of duty of candour compliance from both a regulatory and professional perspective. This is fundamental to support our leaning culture and our commitment to ensuring we are continuously open, transparent, and honest with those in our care. Duty of Candour oversight and compliance is reported as part of the monthly safety report to executive safety huddle, bi-monthly to our Quality committee/Board of Directors' reports and annually in our quality contractual requirements.

128. The DOC quality improvement plan over the past 12 months has included updating the datix incident management system to include the implementation of mandatory DOC reporting fields and accessible templates for completion by reporters and managers within the trust have been developed and implemented. This work has been replicated onto the new trust risk management system, RADAR which will mobilise on 01.04.23. These improvements continue to ensure there is consistent application and reporting of Duty of Candour across all Divisions.

129. A programme of Duty of Candour training continues to be delivered across the Trust. Additional training has been commissioned to enable bespoke divisional scenario based training sessions in relation to DOC. An in-house training package is under development by the Patient Safety Team to further enhance Duty of Candour understanding and awareness across the Trust.

130. Duty of Candour Champion roles were implemented within all clinical Divisions. The role of the DOC champion is to act as a subject matter expert, providing individual support and guidance to practitioners and to support the Divisions and undertake the quarterly duty of candour audits.

131. With effect from 1 April 2022 Duty of Candour Champions commenced auditing 5% moderate harm and above incidents in AMaT (digital audit management system). The trust has achieved substantial assurance for Q4 2021/22, Q1 2022/23 and Q2 2022/23. The audit for Q3 2022/23 is in progress at the time of writing this report. Divisional action plans are in place to support all areas of improvement identified.

2.11 Data Quality Improvement Plans

124. 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.

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

126. 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 Data Security and Protection Toolkit requirements for Data Quality including the Annual Audit of Nationally Submitted Data Sets e.g. CDS, MHSDS.

127. 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.

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

Quality Report 2020/21

129. Mersey Care NHS Foundation Trust submitted records during 2020/21 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) 93.8% for admitted patient care.
   ii) 99.8% for outpatient care.

b) which included the patient's valid General Medical Practice Code was:
   i) 100% for admitted patient care;
   ii) 100% for outpatient care.

Latest data (SUS DQ dashboard) available from NHS Digital on 12 April 2021 relates to M11 21 (April 2020 to Feb 2021)

2.12 Information Governance

130. The Trust published it's first Data Security and Protection Toolkit in March 2019 as "18/19 Standards Met", with the Trust being awarded "Substantial Assurance" following an audit of the Toolkit's evidence items.

The Trust also achieved "Standards Met" and "Substantial Assurance" for the Data Security and Protection Toolkit in the financial years of 2019/20 and 2020/21.
In 2021/22, the Trust achieved "Standards Exceeded" for the first time (due to the Trust attaining Cyber Essentials Plus) and was awarded "Substantial Assurance" following the audit.

The annual submission deadline for the Toolkit has now been nationally changed to June. As such, at the time of writing the Trust was working on its 2022/23 Toolkit evidence items and has completed phase one of its annual audit.

PART THREE – QUALITY INDICATORS

3.1 Quality Indicators

NHS foundation trusts are required to publish the data reported by the NHS Digital for each indicator for the reporting period, i.e. the 2021/22 financial year. For some indicators, no data or only partial year data is available for 2020/21 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 29 March 2022.

Comparisons are with other mental health/learning disability providers.

Mandated Indicator	Data period	Data Source	Mersey Care NHS Foundation Trust	National average	Highest national position	Lowest national position	Statement
The data made available to the National Health Service trust or NHS foundation trust by the Health and Social Care Information Centre with regard to the percentage of patients on Care Programme Approach who were followed up within 7 days after discharge from psychiatric in-patient care during the reporting period.	Q1 2022/23	http://www.england.nhs.uk/statistics/statistical-work-areas/mental-health-community-teams-activity/	94.67% (Internal Reporting)	A consultation on the Quarterly Mental Health Community Teams Activity return opened on 24th January 2020. The outcome of the consultation was published on 15th April 21 announcing the decision to retire this collection.			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 "breaches" to enable lessons to be learnt and practice changed if required to avoid similar situations occurring in future. The positions reported for Mersey Care NHS Foundation Trust are local internal positions. *Q4 data is currently only January and February 2023 data.
	Q2 2022/23		93.16% (Internal Reporting)				
	Q3 2022/23		93.41% (Internal Reporting)				
	Q4 2022/23		92.71% * (Internal Reporting)				
The data made available to the National Health Service trust or NHS foundation trust by the Health and Social Care Information Centre with regard to the percentage of admissions to acute wards for which the Crisis Resolution Home Treatment Team acted as a gatekeeper during the reporting period.	Q1 2022/23	http://www.england.nhs.uk/statistics/statistical-work-areas/mental-health-community-teams-activity/	90.07% (Internal Reporting)				
	Q2 2022/23		78.78% (Internal Reporting)				
	Q3 2022/23		79.70% (Internal Reporting)				
	Q4 2022/23		95.08% * (Internal Reporting)				

Mandated Indicator	Data period	Data Source	Mersey Care NHS Foundation Trust	Benchmark Average	Highest Benchmark Position	Lowest Benchmark Position	Statement
The data made available to the National Health Service trust or NHS foundation trust by the Health and Social Care Information Centre with regard to the percentage of staff employed by, or under contract to, the trust during the reporting period who would recommend the trust as a provider of care to their family or friends.	2018	Dataset: 21. Staff who would recommend the trust to their family or friends (Q21d)	68%	66%	79%	56%	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.
	2019		70%	68%	81%	57%	
	2020		74%	69%	84%	47%	
	2021		67%	65%	82%	45%	
	2022		67%	64%	80%	40%	

Mandated Indicator	Data period	Data Source	Mersey Care NHS Foundation Trust	National Average	Highest National Position	Lowest National Position	Statement
The data made available to the National Health Service trust or NHS foundation trust by the Care Quality Commission with regard to the trust's "Patient Overall experience of community mental health services" indicator score with regard to a patient's experience of contact with a health or social care worker during the reporting period.	2019	Indicator: 4.7 Patient experience of community mental health services Latest Update on NHS Digital Website - May 2020 Release There are no planned future updates for this indicator. The methodology for the indicator requires review, this is not actively being progressed at this time.	6.9	6.9	7.7	5.8	Indicator: 4.7 Patient experience of community mental health services. Latest Update on NHS Digital Website - May 2020 Release. There are no planned future updates for this indicator. Due to no planned future updates for this indicator, Mersey Care NHS Foundation Trust has reported on the Overall Score from the Annual Community Mental Health Survey. The community mental health survey is conducted on an annual basis to collect information about the experiences of people using NHS community mental health services in England.
	2020		7.0	7.0	7.8	6.1	
	2021		6.9	6.8	7.5	6.0	
	2022		6.7	6.7	7.8	6.1	

Mandated Indicator	Data period	Data Source	Mersey Care NHS Foundation Trust	National average	Highest national position	Lowest national position	Statement
The data made available to the National Health Service trust or NHS foundation trust by the Health and Social Care Information Centre with regard to the number and, where available, rate of patient safety incidents reported within the trust during the reporting period, and the number and percentage of such patient safety incidents that resulted in severe harm or death ** Please note latest data published reports annual data in comparison to previous data which reported six-monthly. It is also noted within the publication that: Some different patterns have been observed in the National Reporting and Learning System (NRLS) patient safety data which are likely to have been impacted by the coronavirus (COVID-19) pandemic. Statistics from the period Apr - Jun 2020 onwards should also be interpreted with care.	**April 2020 - March 2021	Indicator: 5.6 Patient Safety Incidents	14133 incidents; 64.8 incidents per 1000 bed days	7382 incidents per organisation; 9 incidents per 1000 bed days	236 incidents per 1000 bed days	21 per 1000 bed days	This indicator aims to measure the number of reported patient safety incidents across NHS care settings. The aim is for incidence reporting to increase as the culture of reporting all incidents spreads more widely across the NHS. The ultimate goal is that the number of reported incidents remains steady or decreases, as the habit of reporting incidents becomes routine and these are learnt from. 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 "unexpected deaths" only. Quality surveillance dashboards have been developed to provide live whole trust incident monitoring and alerts.
	October 2019 - March 2020		4147 incidents; 35.5 incidents per 1000 bed days	3471 incidents per organisation; 50.5 incidents per 1000 bed days	145.5 incidents per 1000 bed days	18.1 per 1000 bed days	
	March 2019 - September 2019		4268 incidents; 36.1 incidents per 1000 bed days	3448 incidents per organisation; 50.7 incidents per 1000 bed days	130.8 incidents per 1000 bed days	17.2 per 1000 bed days	
	**April 2020 - March 2021		416 incidents resulting in severe harm or death (1.91 incidents per 1000 bed days)	74 incidents resulting in severe harm or death per organisation; 0.59 incidents per 1000	3.3 incidents resulting in severe harm or death per 1000 bed days	0.00 incidents resulting in severe harm or death per 1000 bed days	
	October 2019 - March 2020		124 incidents resulting in severe harm or death (1.06 incidents per 1000 bed days)	32 incidents resulting in severe harm or death per organisation; 0.46 incidents per 1000	1.95 incidents resulting in severe harm or death per 1000 bed days	0.00 incidents resulting in severe harm or death per 1000 bed days	
	March 2019 - September 2019		118 incidents resulting in severe harm or death (1.00 incidents per 1000 bed days)	30 incidents resulting in severe harm or death per organisation; 0.45 incidents per 1000	1.57 incidents resulting in severe harm or death per 1000 bed days	0.00 incidents resulting in severe harm or death per 1000 bed days	

Readmissions

Dataset 3b (Indicator P01758) Emergency readmissions to hospital within 30 days of discharge provides readmissions information at Local Authority level but not provider level. Therefore, it is deemed inappropriate to include any data for this indicator in the Trust's 2022/23 Quality Account.

https://digital.nhs.uk/data-and-information/publications/clinical-indicators/nhs-outcomes-framework/current

3.2 Re-admissions

Quality Report 2022/23 Nationally Mandated Indicators (Section 2.3)

131. NHS foundation trusts are required to publish the data reported to NHS Digital for each indicator for the reporting period, i.e. the 2019/20 financial year. For some indicators, no data or only partial year data is available for 2019/20/21. The latest should be published for the last two reporting periods or data covering the minimum of a year.

132. The data reported below relates to the latest information available via the defined data sources as at 2 April 2020. Comparisons are with other mental health/learning disability providers.

Re-admissions

133. The Quality Report reporting arrangements for 2020/21 includes an indicator on readmissions for all trusts.

134. Dataset: 3.2 (Legacy unique identifier: P01845) Emergency readmissions to mental health services within 30 days of a mental health inpatient discharge in people aged 17 and over.

135. The ongoing review by NHS Digital of Emergency Readmissions which includes indicators across the framework hasn't restarted since the beginning of the pandemic this indicator is designated as an experimental statistic. Experimental statistics are official statistics which are published in order to involve users and stakeholders in their development and as a means to build in quality at an early stage. The data available from February 2021 provides readmissions at CCG level but not provider level.

136. https://digital.nhs.uk/data-and-information/publications/statistical/ccg-outcomes-indicator-set/october-2020/domain-3-helping-people-to-recover-from-episodes-of-ill-health-or-following-injury-ccg/3-2-emergency-readmissions-within-30-days-of-discharge-from-hospital

3.3 Performance against NHS Improvement's Single Oversight Framework Indicators

137. In preparing the Quality Report for 2020/21, NHS Foundation Trusts are required to report on indicators that appeared in both NHS Improvement's Risk Assessment Framework and the Single Oversight Framework.

138. 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.

139. 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.

Performance against NHS Improvement's Oversight Framework Indicators (Part 3 of the Quality Report)
In preparing the Quality Report for 2021/22, NHS Foundation Trusts are required to report on indicators that appeared in both NHS Improvement's Risk Assessment Framework and the NHS Oversight Framework. 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. 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. * Q4 data is currently only January and February 2022. This will be updated once March 2022 data is available.

3.4 Stakeholder Metrics

140. 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

Theme	Indicator	Performance Threshold	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
Patient Safety	Incidents of Harm - Proportion of incidents that result in harm (classified as low, moderate, severe or death)	2019-20 Baseline: 20.34%	21.82%	24.23%	24.73%	23.63%	20.82%	20.37%	20.92%	22.05%	21.70%	20.74%	21.48%	19.26%
	Safe Staffing - % of shifts filled by nurses against planned establishment (NHS England Fill Rate Measure/ CHPPD	% of shifts filled by nurses against planned establishment	51.63%	48.38%	53.78%	110.27%	104.68%	103.51%	105.28%	108.81%	106.94%	103.69%	103.75%	Due 19th April 2021
Clinical Effectiveness	Number of Out of Area Placements - External "Inappropriate" Only - Occupied Bed Days	STP Q4 2020 - 2021 = 0	5	19	0	0	81	0	0	36	0	0	0	0
	Number of Out of Area Placements Occupied Bed Days - External "Inappropriate" Only - Count of Patients	0	1	1	0	0	4	0	0	3	0	0	0	0
	Bed Occupancy - Number of Occupied Bed Days (including Leave) - Cumulative (Excludes Ward 35)	Not Applicable	18570	38528	58145	78250	97589	117466	137150	157579	178157	197848	215279	234649
Patient Experience	Overall Patient Experience Score - Mental Health Friends and Family Test	Green >=95% Red < 95%	Submission Suspended								87.73%	93.09%	89.15%	Due 21st April 2021
	Overall Patient Experience Score - Community Friends and Family Test	Green >=95% Red < 95%	Submission Suspended								92.09%	96.15%	98.95%	Due 21st April 2021
	Involved in care - Have you been involved in the development of your care plan? Mental Health Inpatient Only	Green >=95% Red < 95%	94.37%	91.00%	96.24%	91.86%	93.13%	96.90%	92.21%	92.38%	94.23%	98.24%	94.81%	93.83%

ANNEX 1
STATEMENTS FROM COMMISSIONERS, LOCAL HEALTHWATCH ORGANISATIONS AND OVERVIEW AND SCRUTINY COMMITTEES

COMMISSIONERS

NHS
Liverpool
Clinical Commissioning Group

NHS
South Sefton
Clinical Commissioning Group

NHS
Knowsley
Clinical Commissioning Group

NHS Blackburn with Darwen Clinical Commissioning Group
NHS East Lancashire Clinical Commissioning Group
Mersey Care NHS Foundation Trust Quality Account 2022/23

NHS Liverpool ICB
Quality Account Statement 2022/23
Mersey Care Mental Health and Community NHS Foundation Trust

NHS
Cheshire and Merseyside

Liverpool Place
The Department
2 Renshaw Street
Liverpool
L1 2SA
Tel: 0151 247 6436
Email: Jane.Lunt@liverpoolccg.nhs.uk
Executive Assistant: Debbie.Richardson@liverpoolccg.nhs.uk

Ms T Bennett
Deputy Chief Executive of Clinical Services & Chief Nurse
Mersey Care NHS Foundation Trust
V7 Building, Kings Business Park
Prescot
L34 1PJ

2nd June 2023

Dear Ms Bennett

Re: Quality Accounts 2022 - 2023

I am writing on behalf of Cheshire and Merseyside ICB representatives along with NHSE/I Specialist Commissioning who had the opportunity to jointly comment on the Mersey Care NHS Foundation Trust draft Quality Account for 2022-23. Partners express their thanks for the Quality account presentation that was delivered to Cheshire and Merseyside commissioners for 2022 – 2023 on Thursday 18th May 2023.

This letter provides the response from NHS Liverpool place as lead commissioner on behalf of Cheshire and Merseyside ICB colleagues.

Cheshire and Merseyside ICB recognise the pressures and challenges for the organisation and the local health economy in the last year. Particularly in respect to post COVID pressures, winter pressures, industrial action, mutual aid for Greater Manchester Mental Health, CQC inspection, a whole organisational change and changes within leadership roles.

We note the Priorities, key achievements and progress made in 2022 – 2023:

1. The panel acknowledged the positive interventions that have enhanced safer staffing. There appear to be good achievements around recruitment and retention. The implementation of funding 20 staff as part of "grow your own" was identified as a proactive initiative. The positive work to enhance safer staffing and the good achievements around recruitment and retention were acknowledged. The initiation of the preceptorship programme will enhance support to staff and retention.

2. The collaboration the Trust have implemented with system partners has been beneficial. This has allowed safe care in the community – IMPaCT end of life model, Enhanced Health in Care Homes as examples. Multi agency working to support discharges and collaborative working with families and carers was also acknowledged

by the panel. Mutual aid to other organisations over the past twelve months was evidenced and seen as best practice.

3. The alignment of physical and mental health divisions will benefit patient care and their journey. The development of the clinical harm review based on risk framework and the adoption of a single incident management reporting system were all identified as positive practice to best enhance patient care.

4. The CQC inspection carried out in 2022 / 2023 with a "Good" rating received.

On behalf of Cheshire and Merseyside ICB / Liverpool place have noted and accepted the Trust's ambition and intention to continue the work in relation to PSIRF implementation. The panel acknowledged the need for a focus in 2023 / 2024 Quality Account on community services for paediatrics – highlighting initiatives involving physical health. Safeguarding children and adults would benefit a focus as part of the governance reporting.

Cheshire and Merseyside ICB / Liverpool Place recognises the challenges for providers in the coming year. We look forward to continuing working with Mersey Care NHS Foundation Trust during 2023 – 2024 as you continue to deliver improvement in service quality, safety, and patient experience, as well as continuing to strengthen integrated partnership working to deliver the greatest and fastest possible improvement in people's health and wellbeing within a strong, safe and sustainable health and care system.

Cheshire and Merseyside ICB / Liverpool Place would like to take this opportunity to say thank you to Mersey Care NHS Foundation Trust staff for their care, courage, and commitment to the ensuring the population of Liverpool, Cheshire and Merseyside receive high quality, safe and effective care and for your on-going commitment locally to system partnership working.

Yours sincerely

Jane Lunt
Associate Director for Quality and Safety Improvement
Liverpool Place.

NHS Cheshire and Merseyside
Regatta Place, Brunswick Business Park,
Summers Lane, Liverpool, L3 4BL

Enquiries@cheshireandmerseyside.nhs.uk
Cheshireandmerseyside.nhs.uk

Mersey Care Foundation Trust Quality Account 2022-2023 Commentary

Healthwatch Liverpool welcomes the opportunity to comment on this 2022-23 Quality Account for Mersey Care Foundation Trust.

We base our commentary on the Quality Account report itself, our engagement with the Trust, and feedback and enquiries that we receive throughout the year.

We are aware that in many ways this was a year of consolidation and standardisation of systems and procedures for the trust, with the changes as a result of the acquisition of North West Boroughs now implemented and embedded.

We acknowledge that work has continued to recruit and retain staff, something which all NHS Trusts are struggling with and which was exacerbated by the pandemic. We would hope to see shorter waiting times to access services and assessments as a result of increased staffing levels, however we do realise that this is not something that can be resolved overnight.

One – possibly the only - positive outcome from the pandemic has been to see increased collaborative working across the NHS and beyond, with Mersey Care taking an active role in this. For example, we think the IMPaCT end of life model can make a real difference for patients.

The quality account appears to have more information about the Trust's mental health care services than about the physical health care services it provides, something that we hope to see addressed in future reports. The overarching priorities which the trust continued from the previous year are outlined, and we welcome that there is an increasing focus on equality and health inequalities, including for people from Black, Asian and Minority Ethnic (BAME) backgrounds. We look forward to learn more about the outcomes from the actions the Trust aims to take to address this.

Sadly, there were 3 suicides by people under Mersey Care services this year; we welcome the renewed focus on ligature reductions as we know that this has been an issue in the past as well as more recently. We were pleased to see that the Trust is working with Liverpool City Council on suicide prevention.

In the 'Learning from Deaths' chapter we note that there was an apparent substantial increase in deaths; we are not clear about the reasons for this increase, nor if this is linked to the acquisitions and related growth of the trust, or if there are other reasons. The report states some deaths were due to poor care, but again there is little detail to explain this, or how any learning from this was disseminated. The suggestion to have more pathways to deal with a "high proportion of drug use and related deaths" makes sense, and we would welcome more services for people with a dual diagnosis, as those are often few and far between if they exist at all.

We learnt about several new Trust initiatives in the past year, some but not all mentioned in the quality account; for example, the in-person public engagement events that the trust has started to roll out are a pro-active way to inform and capture feedback, especially as not everyone has access to computers/the internet.

We are pleased that the new Trust carer's strategy is aiming to work beyond mental health. We also welcome that there is recognition that carers from BAME backgrounds may not always have the same access to support, and that the Trust will ensure information is made available in other languages and appropriate formats, as it is required to do by the accessible information standard.

We were also pleased to see the expansion of the maternal mental health initiative, the Silver Birch hubs; providing a more multi-faceted approach to support struggling new birth parents hopefully will provide a much better experience for them.

In Liverpool the building work for the new mental health hospital on the Mossley Hill site is progressing. Whilst we think it is positive that shared dormitories will be a thing of the past, we are aware that less beds will be available compared to the current time. This is a concern, especially considering increasing demand. Both commissioners and providers will need to ensure that enhanced and expanded community services are available to prevent people falling between the gaps, and/or being placed in beds far from their homes.

We have had regular and constructive engagement with the Trust in 2022-23. As part of this we carried out a listening event at the lymphoedema clinic in Speke in September 2022, and in collaboration with several other local Healthwatch worked on a project about the Tier 3 Long Covid Services which Mersey Care provides, with the report published in November 2022.

In addition we worked on a project about access to gender identity health care which included feedback about CMAGIC, a pilot service provided by Mersey Care that aims to improve access, with a report ready to be published in June 2023.

We are planning further engagement with Mersey Care and its service users and visitors during 2023-24, and we look forward to our ongoing work with the Trust.

Mersey Care NHS Foundation Trust.
Commentary for the trusts Quality Account 2022/23

Healthwatch Sefton would like to thank the trust for presenting their Quality Account at the presentation event which took place 18th May. We were also invited and attended an online event which the trust held to review progress with the past 12 months priorities and engage with us on priorities for the coming year (16th March).

In reading the report from a public perspective, we did find a number of issues with the readability of the report. Many acronyms were used and although some are explained this does not occur throughout the document. The inclusion of a glossary would have been useful. We appreciate we have reviewed a draft of the document but readability would be enhanced if pictures and more images were included to help break up the text.

We have found this account hard to read in terms of the data shared and use of tables and therefore our commentary is mainly based on the issues we have found relate to our work with the trust. However, within the 'Introduction and Statement on Quality by the Chief Executive', it was good to read a clear explanation of the purpose of the account, to support the reader in understanding its purpose. We note that the Trust has a new chairperson in place and a number of new non-executive directors joining the trust.

It would have been good to have a dedicated section for patient experience and how working with patients and reviewing their experiences has led to service improvements and has enhanced quality. We could not see any reference to the number of enquires into the PALS service or the number of complaints received and lessons learnt. We are aware that trust has not been able to approve the new complaints procedure and practice framework and that the draft is currently going through the validation process. We acknowledge the 7-minute briefing for complaints which is well embedded within community division and will be rolled out across all divisions.

Through our work at Sefton Place we have evidenced the collaborative work to support the admission avoidance and discharge process to maintain flow within the acute hospitals through what has been quoted the worse NHS winter.

We are a member of the Community Services Division 'Patient Experience Group' and there is a standard agenda item for Healthwatch. We have good relationships with key personnel, including the Assistant Director of Nursing, CYP Families & Sefton Place.

In last year's commentary, we noted the work to reduce the number of pressure ulcers across the community division and again we can see key targets have been achieved. It was noted however that the target of patients with lower leg wounds

receiving appropriate assessment diagnosis and treatment in line with NICE Guidelines was not achieved as part of the CQUIN scheme.

We are also a member of the Mental Health Care Division 'Patient Experience and Engagement Meeting' and throughout this period, issues raised have been escalated and actioned. One of the key outcomes from this was our being put into contact with our Clinical Service Managers for Community Mental Health (Sefton Place). Regular meetings are now held and enquires are quickly responded to.

When looking at progress in reducing restrictive practice and the focus on protected characteristics, we note that most of the planned work has been delayed due to the pandemic. It was however good to read that a BAME patient group has been established in High Secure.

It was good to read about the continued work towards zero suicides and the review of all in-patient deaths over the last 10 years which was conducted to help strengthen understanding and identify any further change required as part of inpatient transformation.

We are told that zero moderate/severe harm incidents relating to medicines is an ongoing goal. We note that there have been 3 incidents of this nature this year and all have been reviewed and have been presented at the clinical senate.

In reviewing results from the NHS Staff Survey 2022, the trust achieved a response rate of 32% which was a 5% decrease from 2019 and below the national response rate of 52% for Mental Health & Learning Disability and Mental Health, Learning Disability & Community Trusts. We will be interested to learn of any internal plans to support staff over the coming 12 months.

We recognise the work to recruit and retain staff and how staff have been employed through international recruitment, other recruitment success during this period and the guidance and support put in place for newly qualified practitioners through the roll out of the 12-month preceptorship course.

We submitted evidence to the Care Quality Commission (CQC) for their inspection of the trust through December 2022 and have been working in partnership with the trust to independently review community service provision, engagement at health centres across Sefton taking place between January and March. A report will be shared with the trust with a number of recommendations.

Healthwatch Sefton would like thank the Trust for their supportive and collaborative approach to working with us as a critical friend and in listening and responding to the stories and feedback from patients, carers and families. We have welcomed the introduction of the quarterly Healthwatch Professionals meetings during this period as they provide a chance to gain updates and an opportunity for us to share key areas of feedback we have gathered. We know the next 12 months will provide both opportunities and challenges and acknowledge how the trust maintained safe staffing during union strikes. We look forward to working with the trust moving forward.

healthwatch
St Helens

OVERVIEW AND SCRUTINY COMMITTEE

Sefton Council

No scrutiny committee review of Quality Account due to COVID-19

ANNEX 2
STATEMENT OF DIRECTORS' RESPONSIBILITIES FOR THE QUALITY REPORT

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 2022/23 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 April 2022 to May 2023,

      ii) papers relating to quality reported to the Board over the period 1 April 2022 to April 2023,

      iii) feedback from commissioners dated,

      iv) feedback from governors on April 2023,

      v) feedback from local Healthwatch organisations dated,

      vi) No feedback from the Sefton Metropolitan Borough Council Overview and Scrutiny Committee,

      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 November 2022,

      ix) the 2022 national staff survey dated November 2022,

      x) No Head of Internal Audit's annual opinion over the Trust's control environment,

      xi) the Care Quality Commission's inspection report dated April 2023;

   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;

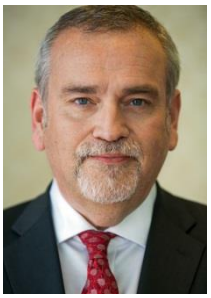
   f) the data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and

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:

Rosie Cooper, Chairman
May 2023



Prof Joe Rafferty CBE, Chief Executive
May 2023