Liverpool Community Health NHS
NHS Trust

Liverpool Community Health NHS Trust
Quality Account 2017/18

Contents:

Appendices:

Chief Executive Summary

The Quality Account is an annual report to the public and stakeholders about the quality of services we provide. It explores the improvements that have been made over the past year, and those that we plan to make following a review of feedback from our stakeholders.

The Trust has experienced a challenging period subsequent to a series of critical Care Quality Commission (CQC) inspection reports in 2014 and a major independent review in March 2016. In February 2017, Dr Bill Kirkup published a clinical review into the failings of Liverpool Community Health NHS Trust (LCH) throughout 2010-2014. It found that the Trust's failings were a result of improper management leading to a series of poor and unsafe decisions. As the preferred provider for Liverpool community services, Mersey Care NHS Foundation Trust will continue to use the independent review to learn lessons and put appropriate practices in place, to ensure nothing like that will ever happen again.

After working together under an interim management agreement, Mersey Care took on the provision of Liverpool community services on 1 April 2018, following a formal process of approval conducted by NHS Improvement. The Trust welcomed colleagues from LCH to the Mersey Care family and have since been working as one enlarged organisation.

The acquisition of Liverpool community services has brought significant change and positive opportunities for Mersey Care**.** Taking on the provision of community physical health services for the populations of Liverpool and Sefton changes the nature of Mersey Care as a provider organisation and presents significant opportunity to provide integrated physical and mental health services, designed to meet the needs of the communities that we serve.

Quality and safety remains at the forefront of Mersey Care's strive for perfect care. The quality of care we provide is never compromised or limited by minimum targets. Instead, our ambitions to achieve perfect care support a culture of learning and continuous improvement. We strive to get the basics of care right every time, for every service user. A bold ambition at times, but with engaged and motivated staff and support from commissioners and partner organisations, we believe it is possible.

I hope that our Quality Account report demonstrates the hard work of the LCH team. As a Trust, LCH have experienced significant changes and seen many improvements over the past year. However, as we strive for perfect care we recognise that improvement is still required and plan to implement positive change in the forthcoming year.

As Chief Executive I can confirm to the best of my knowledge that the information contained in the Quality Report is accurate and will be published by the Board on 30 June 2018.

27.06.18 Date _____ Chief Executive

Quality Priorities for Improvement 2018/19

As of 1 April 2018, Liverpool Community Health (LCH) NHS Trust ceased to exist as a standalone organisation. All staff are now employed by Mersey Care NHS Foundation Trust and therefore work to the associated strategies, priorities, policies and procedures.

To facilitate this, the Trust agreed the following priorities:

- To support staff post transition on from the 1st April 2018
- To maintain business as usual post transition
- To work towards integration with Mersey Care services in relation to physical and mental
  Health services

Quality Priorities for Improvement 2017/18

As of 1 April 2017 the Trust's services began transferring to various new health care providers. An arrangement was put in place for LCH to be managed through an interim management agreement led by Alder Hey Children's NHS Foundation Trust from 1 May 2017. This provided access to senior management support whilst NHS Improvement continued work on identifying a more permanent provider for the remainder of LCH services.

In October 2017, after a further NHSI procurement process it was confirmed that LCH services would transfer to Mersey Care NHS Foundation Trust from the 1 April 2018. The interim management contract transferred from Alder Hey to Mersey Care from 1 November 2017 to 31 March 2018 before a full acquisition began on 1 April 2018.

The priorities set out below enabled work to progress during the transaction.

In last year's Quality Account we described three priority areas for 2017/18:

- Provision of support to staff in preparation for transfer to their new provider
- Continued delivery of safe and effective services through established locality model
- Smooth transfer of services to new providers

In preparation for the transfer, the following has taken place:

- **Provision of support to staff in preparation for transfer to their new provider:** Continued engagement, communication and support has occurred for staff regarding the management contracts and appointment of Mersey Care as the new provider in the form of engagement events. The Chief Executive Officer (CEO) provides a weekly blog to staff, updates have also been provided in 'LCH weekly' and 'Team Talk'.

- **Continued delivery of safe and effective services through established locality model:** Throughout the year full service delivery via localities has continued alongside robust performance and governance processes – details of our achievements are included in the Quality Accounts. Localities are now fully established with governance processes embedded. The Trust has continued to effectively respond to support the whole health system across the year. Additionally, Liverpool Clinical Commissioning Group (LCCG) is currently undertaking work on evaluating proactive care. It is of particular note that in October2017, 1,500 patients

had been supported on the proactive pathway as part of avoiding admission to hospital, and as a result of this admission levels to hospital have also fallen.

- **Smooth transfer of services to new providers:**
  The Trust continues to work closely with Mersey Care to ensure services are transferred across smoothly. Roadshows have been held following the TUPE (Transfer of Undertakings Protection of Employment Regulations 2006) process. Joint LCH and Mersey Care Transaction and mobilisation meetings have been held on a weekly basis to ensure a smooth seamless transaction of services for our patients and staff.

The provision of high quality patient care continues to be our main focus. During 2017/18 LCH provided and/or subcontracted 48 NHS services and the income generated by the NHS services reviewed in 2017/18 represents 100% of the total income generated from the provision of NHS services by LCH in 2017/18. LCH has reviewed all the data available on the quality of care in these services. The performance and quality of our services are reviewed through our performance, governance and spotlight meetings with reporting arrangements in place up to the Board via the Quality Committee (latterly the Quality Assurance Committee).

Celebrating our Achievements

In March 2018 an event was held to celebrate the hard work, commitment, dedication and care demonstrated by individual staff members and teams. It provided an opportunity to recognise those who work day in and day out to improve the lives of others and put their patients and their colleagues before themselves an opportunity to shine

At the event staff shared truly inspirational stories from saving lives and showing outstanding compassion to patients and their families to innovative projects including support for some of the most vulnerable people in Liverpool. The celebration provided a great opportunity to recognise a number of staff who have worked for the NHS for 40 years or more, dedicating their lives to delivering and supporting high quality patient care, they are truly extraordinary and it's a remarkable achievement.

Whilst it was a night of celebration, it also marked the end of an era as Liverpool Community Health will become part of Mersey Care NHS Foundation Trust.

Safety Improvement Plan

Although the Trust did not formally 'Sign up to Safety', we have continued to progress six areas within our Safety Improvement Plan since 2014/15.

Priority 1: Infection Control

In line with other Trusts, and as part of patient safety initiatives, we follow national standards for infection control and have a dedicated Infection Prevention and Control Team who support the organisation to meet these standards. Our aim is to prevent harm by assuring that we are doing all we can to provide clean and infection free environments for our patients and the public. We have an Infection Prevention and Control Team who support staff to work to the national standards for infection control set out in the Health and Social Care Act 2008 (Hygiene Code).

Each year an annual work plan is developed, which includes a range of infection control audits across our services and other work programmes aligned to the reduction of Healthcare Associated Infections (HCAI).

Update on Progress

- We have a well-established Infection Control Group which reports into the Patient Safety Sub Committee.
- The Post Infection Review (PIR) process is now firmly in place where we work in partnership with other providers and commissioners to review any cases relating to Methicillin-resistant Staphylococcus Aureus (MRSA) or Clostridium Difficile (CDI). This supports lessons learnt, supervision and revalidation for nurses.
- We continue to undertake a range of infection control audits across our services, including cleanliness audits. All audits are reported at locality level and reported through performance reports and locality meetings.
- An infection control policy manual is in place which has replaced a number of separate policies; this improves ease of access for staff.
- A named link nurse from the infection control team works with each locality.
- The Trust successfully implemented a flu outbreak protocol for nursing homes across Liverpool for prescribing antiviral treatment to prevent cross-infection. The protocol was enacted by our Community Matrons during this year's flu season and was very effective across 5 outbreaks in care homes which prevented many admissions to hospital.

Priority 2: Patient Experience

The Customer Service Team incorporates patient experience, Patient advice liaison service (PALS), Equality and Diversity, Claims and Complaints.

Update on Progress

- Friends and Family Test (FFT) is used to gain feedback from patients, across the year the Trust average has been 98% positive rating and approximately 800 responses per month.
- Surveys were undertaken in 9 identified services, overall results were positive. Any service improvements identified were taken forward by the respective service.
- In collaboration with Liverpool Clinical Commissioning Group (LCCG) and other local providers, we are members of Patient experience liaison group. The purpose of the group is to feedback on the CCG patient experience strategy, Trusts will then use the objectives from this to update/develop their strategy for 2018/19.
- The Patient Experience Sub Committee has been revised and reports into the Quality Assurance Committee.
- There is a named member of the team who is the main link for each locality; this enables timely support to staff for different patient experience initiatives or issues. Locality specific feedback is shared with staff through governance meetings.
- The Trust has continued to work in collaboration with Healthwatch Liverpool across the year.
- Healthwatch Liverpool undertook visits to four of our services and produced a report on their findings; these will be used to help the Trust continually improve the services provided.
- Reports are provided to each locality governance meeting that triangulate information relating to patient experience through complaints, PALS, FFT, claims and

compliments. Services are asked to review and undertake local service improvements based on feedback.

- Black Box Thinking has been used to share learning for clinical observations, complaint investigation training, medication issues, learning from serious incidents, learning from deaths and harms and safeguarding. In total 7 sessions have been held, with positive evaluation from staff.

Compliments, Comments and Complaints

Customer service and patient experience are definitive indicators in measuring the quality of services we provide. As such, we aim to learn from every comment, compliment and complaint received.

For 2017/18 the Trust received 1,477 formal compliments, 978 PALS queries (this includes those services who transferred out to other providers to the point of transfer), 19 concerns and 68 formal complaints (including Sefton until transfer). The average time to respond to a formal complaint during 2017/18 was 29 working days.

We thoroughly investigate every complaint received in an open, fair and transparent way. We are committed to providing timely responses and implementing learning from complaints to improve patient outcomes. Further information can be found at http://www.liverpoolcommunityhealth.nhs.uk/contact-us/patient-experience/

LCH is a learning organisation, so we see complaints and concerns as an important means to improving our performance. In 2017/18 the main four issues identified from complaints were related to:

- Clinical Care (30)
- Attitude (12)
- Communication and Information (5)
- Continuing Health Care (CHC) (3)

The issues raised by patients, families or carers through complaints inform staff training and development as part of on-going service improvement. We have taken a number of actions to improve patient experience within the four areas above and from lessons learnt relating to complaints and have:

- Continued to provide bespoke and one to one customer services training.
- Established internal training package to support complaint investigations for investigating officers.
- Reviewed our complaints policy and processes.
- Developed and maintained a 'Being Open' template and complaints pack to support staff.
- Worked in partnership with the local CCG to evidence lessons learnt for shared complaints.
- Worked with localities to focus upon patient experience with a particular emphasis to support staff to use and share lessons learnt and to use the actions to improve the quality of our services and focus on SMART actions to improve patient experience and safety.
- Continued to provide staff training to enable delivery of high quality end of life care.
- Introduced pan locality black box sessions.
- Maintained positive patient feedback strategy
- Continued engagement with health watch
- Worked with LCCG to review systems and processes for continuing health care (CHC).

LCH Board papers and meetings are open to the public and information is published on the Trust website every month www.liverpoolcommunityhealth.nhs.uk.

Priority 3: End of Life Care

The Trust strives to deliver high quality end of life care for patients in their own home. Standards are set based on national best practice. The Trusts well established end of life group is chaired by the Associate Medical Director and includes external membership from local hospital, commissioners and hospices and key external stakeholders including UC24, Woodlands, Supportive and End of Life Care service (STARs) and Marie Curie.

Update on Progress

- A full transformation plan for end of life care has been established to draw together the initiatives in progress to enhance end of life care.
- Service improvements have been initiated, including same day access to continence pad provision.
- Personalised End of Life Care plans have been implemented across localities together with on-going audits. Documentation has been updated into single document to include Verification of Expected Death to make record keeping more effective for staff.
- Improved coding on EMIS allows work to be evidenced.
- Education programmes for staff to ensure staff have the required skills and competencies to support patients with palliative and end of life needs. The Specialist Palliative Care Team are involved in delivering mandatory updates for Unified Do Not Attempt Cardio-Respiratory Resuscitation (uDNACPR) and the use of the uDNACPR document itself via cardiopulmonary resuscitation (CPR) sessions.
- A review of verification of expected death (VoED) training and usage has been undertaken which the team deliver.
- Collaborative working is taking place with primary care to improve the effectiveness of the Gold Standard Framework meetings and where issues are identified to improve advanced care planning.
- An e-learning package for ‘Advanced Syringe Driver’ has been developed for completion on a 2 yearly basis.
- A Training needs analysis for palliative care education is being produced and will be available by Quarter 1 2018/19.
- Bereavement cards have been introduced.
- The End of Life working group oversees our End of Life and Do Not Attempt Cardio-Respiratory Resuscitation (uDNACPR) policies and any issues regarding end of life care. It reports into the Clinical Effectiveness Sub Committee.
- Dashboards for the review of incidents relating to end of life care are being developed and the Palliative care team are now involved with all Being Open meetings involving palliative patients or unexpected deaths.
- Benchmarking has been undertaken against Care of the Dying National Institute for Health and Care Excellence (NICE) guidance and action plan developed to support continuous service improvement.
- Subcutaneous hydration guidelines have been reviewed and developed into Trust policy.

- Responding to deaths policy has been implemented across the trust with a governance framework supporting this, the Palliative care team support all discussions around unexpected deaths – for further information please see page 27.

Priority 4: Harm Free Care

'Harm Free Care' is a collective term used for different patient safety initiatives aimed at ensuring patients are kept safe and free from harm in our care. The four main avoidable harms are the prevention of Pressure Ulcers, Catheter Acquired Urinary Tract Infections (CAUTI); Falls; and Venous Thromboembolism (blood clot in the calf). A Locality Clinical Lead provides leadership and oversight of each work programme and the Harm Free Care sub groups report into the Patient Safety Sub Committee.

Pressure Ulcers

The prevention and management of pressure ulcers remains our highest clinical risk and is an issue across the whole health economy due to increasing complexity of patients who remain at home or in residential homes or nursing homes. This has been an organisational priority over previous years and remains a priority.

A Pressure Ulcer Reduction Programme is in place which is now led by the Clinical Lead for Central Locality has six key themes for action following a review of all investigations into pressure ulcers since 2016. The success of this programme has been supported by the Skin Service, Safeguarding, Governance and Quality teams in developing these initiatives and working with teams to embed at service level to ensure that pressure ulcer reporting is escalated promptly and lessons learnt are shared throughout the organisation. In addition the Trust has commissioned and received a report from NHS England to inform future workstream.

Each of the six themes below have outcome measures set:

A significant amount of quality improvement work has been undertaken since 2016 and has been reported in previous Quality Accounts. Work has continued during 2017/18.

Update on Progress

- Continued 'Theory Thursdays' and 'Topic Tuesdays' delivered by skin service to teams.
- Bespoke support to teams when a community acquired pressure ulcer has occurred.

- 21 of 'PURPLE' – Pressure Ulcer Reduction Programme Learning & Education has been produced since 2016. This is used as a communication and education tool at team level.
- 7 top tips for carers launched.
- Pressure Ulcer Passport piloted and rolled out.
- Public engagement to support 'Stop the Pressure' day.
- 4 pressure ulcer forums held.
- External review from National Health Service England (NHSE) commissioned.
- 'React to Red' (national programme for Care Homes) – awareness of the programme to staff and electronic access to the resources for staff.
- Continued membership of the Cheshire and Merseyside Pressure Ulcer Network and Quality Forum.
- Aggregated review undertaken of Community Acquired Grade 4 Pressure Ulcers to cross check themes to against reduction programme, this will inform work plan for 2018/19.
- Self-care information produced by Equipment Specialist Team for patients at risk of pressure damage.
- Therapy decision chart developed to inform therapy staff when to escalate patients at risk to community nurses.

Incident Reporting:

'Daily Datix'	All incidents reported are reviewed on a daily basis.
'Weekly Meeting of Harm'	Incidents reported that week are reviewed with locality staff.
'Being open'	Where all moderate and severe harms are reviewed and 'Duty of Candour' (DoC) process commences if applicable.
'Weekly Safety Huddle'	This is different to the safety huddle described above and is where key themes from all localities 'Weekly Meeting of Harm are discussed and escalated if required. Some common themes identified are poor discharges and medication issues which are reported back to local hospitals in which they occurred.
'Weekly Stand- up'	From 01/11/2017, LCH also attended weekly 'stand-up' were issues that require senior support are escalated and discussed.

Outcomes

Overall there has been an increase of 23% in the total number of pressures ulcers reported which demonstrates a continued improvement in the open and honest reporting culture. Although there has been an increase in the number of Grade 4 Community Acquired and Avoidable Pressure Ulcers compared to the previous year, there has been a reduction of 9% in the total number of Community Acquired and Avoidable Grade 2, 3 and 4 pressure ulcers

during 2017/18 with individual reductions of 17% (5) and 6% (1) in Grade 2 and 3's respectively.

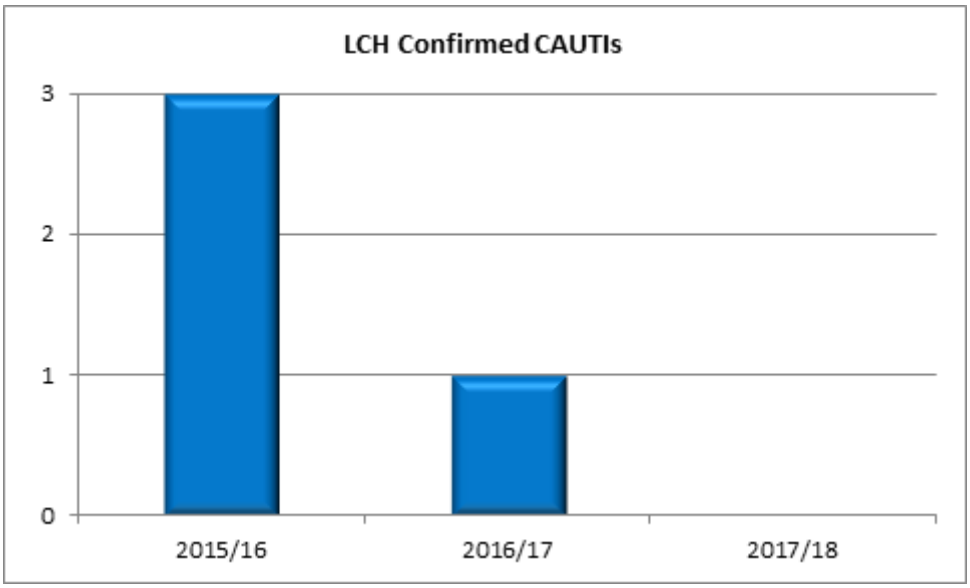
Whilst last year, the distribution of Community Acquired and Avoidable pressure ulcers was relatively even, during 2017/18 there are particular hot spots across the city with nearly 70% being reported across just 4 teams. The Trust have supported the teams with bespoke support.

Catheter Acquired Urinary Tract Infections (CAUTI)
CAUTI's continue to be reported via our governance processes.

Update on Progress

There have been zero confirmed CAUTIs during 2017/18 which is a further reduction compared to the 1 that was reported during 2016/17 and the 3 the previous year.

Number of Confirmed CAUTI's



Falls

Falls prevention has been a priority over previous years, as work has progressed a broader focus has been developed which has been taken forward by the Falls Harm Free Sub group and led by the Clinical Lead from Central Locality.

Update on Progress

Falls Policy: The Policy includes specific information on Service approach to prevention and management of falls across for:

- Community Domiciliary Service Delivery
- Bed Based Service Delivery

- Care Home Service Delivery

All areas have put together a flowchart to assist in signposting staff on prevention and management of falls.

E-Learning – an e-learning package to support all front line clinical services in prevention and management of falls has been developed and has been piloted underwent full rollout April 2017.

Patient Carer Information – a patient/carer leaflet has been developed and was rolled out along with the e-learning package in April 2017. It is expected that this information can be audited following the development of the EMIS solution for falls.

EMIS Recording - The Harm Free Group identified that services had no way of identifying patients who were at risk of falling or who had had a history of falling other than reviewing detailed clinical records or where a fall had resulted in harm which was subsequently subject to an investigation. To support identification of at risk patients, the Group have engaged with I-Mersey to identify an EMIS coding solution. This has now been agreed, service templates are being reviewed to incorporate new coding.

Witnessed Falls / Root Cause Analysis (RCA) - For the period 1st April – 31st March 2018 the Trust reported 0 witnessed falls resulting in harm. Any witnessed moderate or severe falls would be investigated in line with the Trusts Serious Incident (SI) processes.

Clinical Audit - The priority for Falls Harm Free Group has been to develop a baseline. Audit will therefore follow once the baseline established. The Trust will report on a falls audit within Occupational Therapy and Falls Team as part of Clinical Audit plan which looks at the effective of Multidisciplinary Team (MDT) working in falls prevention groups. The audit was completed, a report produced and an associated action plan is in place.

Venous Thromboembolism (VTE)

VTE (a blood clot in the calf) is incorporated into the Harm Free Care Group.

Update on Progress

- The Trust policies on VTE (blood clot in the calf) are current and available for all staff to access; Deep vein thrombosis (DVT) & VTE Management policy.
- The Trust work towards reducing harm events through the recognition of DVT, diagnosis of VTE and treatment thus improving safety across the Trust.
- An audit was undertaken at Old Swan Walk-in-Centre (WIC) on a sample of 312 patients who presented with potential DVT - full details can be found on page 19.
- LCH has reported zero cases of VTE during 2017/18.

Priority 5: Deteriorating Patient

For patients in our care, we use a number of clinical assessment tools to inform clinical decision making and monitor patient outcomes. The tools help staff identify when patients may be unwell or their condition is deteriorating, it also helps to identify those at risk of sepsis.

- The Trust held a number of staff forums to support the roll out of the recording of observations based on set standards for recording based on clinical condition.

- Staff have been provided with the required equipment to record observations.
- Collaborative working has been undertaken with primary care regarding escalation of deteriorating patients.
- The Trust plans to launch NEWS2 in 18/19.
- The Trust has an established resuscitation and mortality group which reports into the Trust Quality Committee.
- The Manchester Triage system in our Walk-in Centres (The Manchester Triage System is a clinical risk management tool used worldwide to safely manage patient flow when clinical demand exceeds capacity).

Equality and Diversity

Equality and diversity for LCH is about understanding and reducing health equalities for our staff and all groups and communities in the city by identifying and overcoming barriers to access and inclusion across the range of health services and practices. For our communities this means a service that is fair, flexible, engaged and responsive to cultural, physical and social differences.

The Trust values and respects the diversity of its employees, and aims to recruit a workforce which reflects our diverse communities. We welcome applications irrespective of people's age, disability, gender, race or ethnicity, religion or belief, sexual orientation, or other personal circumstances. We have policies and procedures in place to ensure that all applicants are treated fairly and consistently at every stage of the recruitment process, including an invitation to the first stage of the selection process and consideration of reasonable adjustments for people who have a disability. For disability symbol users (Disability Confident) we make five commitments:

- We guarantee to interview all applicants with a disability who meet the essential criteria for a job vacancy and to consider them on their abilities.
- We will discuss with employees who have disabilities what we and they can do to make sure they can develop and use their abilities.
- We will make every effort when employees develop a disability to make sure that they stay in employment.
- We will take action to ensure that all employees develop the appropriate level of disability awareness needed to make our commitment work.
- We will review the five commitments every year to see what has been achieved. We will plan ways to improve and we will let employees know about progress and future plan.

Equality & Diversity Training

The Trust provides Equality and Diversity mandatory training to all staff. The table below shows a breakdown of localities and services who have undertaken this training:

	Central Liverpool Locality	North Liverpool Locality	Sefton Locality	South Liverpool Locality	Corporate Division	Nurse-Led Services	Trust Total
Equality & Diversity Training	92.6%	94.2%	94.4%	95.5%	97.5%	94.0%	92.6%

We are an Age Positive Employer Champion. This award is an accreditation by the Age Positive team on behalf of the Department of Work and Pensions for demonstrating positive employment practices in relation to Age Diversity. Finally, we are a signatory on the Mindful Employer Charter. Mindful Employer aims to increase awareness of mental health at work and providing on-going support for employers in the recruitment and retention of staff. The Charter is about *working towards* achieving the principles of Mindful employer it is not about the immediate fulfilment of them.

Our Vision
Our vision is to be a champion and leader in promoting diversity, managing diversity and challenging discrimination. Diversity implies that we acknowledge people's differences whether they are visible or non-visible and attempt to promote the differences in a positive way. We deliver our services via a workforce that is made up of many talented individuals with a large diversity of backgrounds, perspectives, styles and characteristics.

Monitoring Progress Using the Equality Delivery System (EDS 2)
The Department of Health (DH), through the Equality and Diversity Council, introduced a new Equality Delivery System aimed at improving the equality performance of the NHS, embedding equality into mainstream business and ensuring all NHS organisations are meeting their obligations under the Equality Act 2010. Within EDS there are 18 outcomes – over four goals which are:

1. Better Health Outcomes for All
2. Improved Patient Access and Experience
3. Workforce
4. Inclusive Leadership at All levels

Based on transparency and evidence, commissioners, Healthwatch organisations and other interested groups locally agree one of four grades annually for Trusts. Based on the grading annual improvement plans will show how the most immediate priorities are to be tackled, by whom and when. Each year, organisations and local interests will assess progress and carry out a fresh grading exercise. In this way, the EDS will foster continuous improvements.

What We Have Achieved in 2017/18

Learning Disabilities - We are working in partnership with colleagues in acute Trusts as part of the Liverpool Learning Disabilities Acute and Primary Care Network. Together we have developed a generic risk assessment for learning disabilities and a stage one training programme for staff. In addition changes will be made to our electronic systems so that we can begin to collect and analyse information about our patient's learning disability status and be better informed about reasonable adjustments. EMIS will be amended so that staff can add to records to identify patients with additional needs.

Vision Impairment - Bradbury Fields is the largest provider of services to blind and partially sighted people in Merseyside. LCH has regular recorded a slot on an Audio Newsletter produced by Bradbury Fields which means that services and campaigns can be promoted to people who may not use conventional types of communication. The LCH dental health team have also engaged with the charity to help dental students get a familiarisation of the needs of blind people in relation to health care.

Participation in Clinical Audit

We are committed to improving the quality of our services and regularly review clinical practice against locally and nationally agreed standards – this is known as Clinical Audit.

There are different types of Clinical Audit that we can participate in:

National Clinical Audits and Patient Outcomes Programme (NCAPOP)
These are released by the 'Healthcare Quality Improvement Partnership (HQIP) on an annual basis. Their vision is to improve health outcomes by enabling those who commission, deliver and receive healthcare to measure and improve healthcare services. Each year, HQIP release an annual audit plan which Trusts can review and choose to participate if the subject matter is relevant to their organisation.

During 2017/18 1 national clinical audits and 0 national confidential enquiries covered NHS services that LCH provides.

During that period LCH participated in 1 national clinical audit and 0 national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The national clinical audit that LCH was eligible to participate in during 2017/18 was the National Clinical Audit for Intermediate Care:

National Clinical Audit – Intermediate Care:
The Trust participated in 100% of the national clinical audit that the Trust was eligible to undertake. The national clinical audit that LCH participated in, and for which data collection was completed during 2017/18, is 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 of Intermediate Care (NAIC) 2017
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: 100%.

Evidence from the audit demonstrates that intermediate care works with more than 91% of service users either maintaining or improving their level of independence in undertaking activities of daily living, during their episode of care. In 2017, the mean percentage improvement in dependency levels recorded were 31% for home.

Reflecting the increased dependency of people in bed based services in the 2017 sample, a lower proportion returned home and a higher proportion returned to acute hospitals, than in 2015. However, overall the percentages of people returning home for the intermediate care remained high at 80%.

The experience of intermediate care service users was generally positive with all the aspects of services investigated by the Patient Reported Experience Measure (PREM) obtaining high results. Over 91% of people felt they had been treated with dignity and respect. The median PREM summary scores for homes are similar to those recorded in NAIC 2015.

From the open narrative question, the most common source of praise was staff attitudes and 'receiving good service or care'. The most common themes for service improvement were communication and the need for joined up services.

To ensure continued improvement in these areas the Trust will continue to work closely with our partners in acute services and seek to continually audit and verify our performance.

Trust specific Clinical Audits (Local Clinical Audits)
Each year we develop an annual clinical audit forward plan as part of our commitment to continually improve the quality of our services. The forward plan sets out an overview of the planned activity for the year through a structured programme of audit projects that review clinical practice against local and national best practice standards. We monitor our progress against our clinical audit plan through our Clinical Effectiveness Sub Committee and reports to our Quality Assurance Committee. Priorities for audit included NICE (National Institute for Health and Care Excellence) guidance and other local service audits.

In line with the move to locality working, each locality now sets its own locality clinical audit plan. Progress or any exceptions are reported through both locality governance meetings and Clinical Effectiveness Sub-Committee.

During 2017/18 we planned to undertake 70 clinical audits and as of March 2018, 38 of these audits have been completed and published with 63 actions currently identified. A total of 25 of those actions have been implemented.

Of the 32 clinical audits remaining, 20 are still on-going and 12 are not being continued.

Our audits for 2017/18 covered a range of subjects including:

- **District Nursing** – Insulin Prescription Sheet
- **Health Visiting** – Infant feeding audit
- **Adult Speech and Language Therapy** –A comparison of Adult Speech and Language Therapy (SALT) service provision when compared with NICE guidance for patients with Parkinson's disease.
- **Medicines Management -** Implementation of LCH Guidance: Administration of Low Molecular Weight Heparin by Liverpool Community Health Registered Nurses
- **Walk in Centres** - VTE / DVT Audit
- **Physiotherapy Team** – An audit to determine the incidence/frequency of patients referred into the Community Physiotherapy team who require on-going Physiotherapeutic rehabilitation Vs those who require our professional opinion/advice and subsequent signposting onto other services

Examples of our re-audits included:

- **District Nursing and Treatment Rooms** –Wound Assessment re-audit
- **Skin Service** – Leg Ulcer re-audit
- **Sexual health** – Herpes re-audit

Following each audit, an action plan is developed based on the findings and recommendations to practice. These are managed and monitored via locality governance groups and reported into the Clinical Effectiveness Sub-Committee.

The reports of the 54% (38) local clinical audits were reviewed by the Trust in 2017/18 and we intend to take the following actions to improve the quality of health care provided:

Progress on Actions taken forward during 2017/18 and Plans for 2018/19

In last year's Quality Accounts, the Trust identified a number of areas for action to improve our systems and processes for clinical audit:

- Re- audits were identified to be included in the 2017/18 plan, for 2018/19 we will undertake a similar process in each locality.
- Results and findings of audits are reported and shared through locality governance meetings and pan-locality via the Clinical Effectiveness Sub Committee which has locality representation.
- A number of audits against NICE guidance were undertaken during 2017/18 and these form part of our future annual audit plans. For 2018/19 services will continue to include NICE for audit where appropriate.
- All audits are monitored for progress via locality governance meetings. This includes all open actions and timescales for closure.
- Within each locality, the Clinical Lead oversees clinical audit plans for their respective locality. Staff have been supported to develop their skills to undertake audit through training sessions and support from the Governance and Quality leads in each locality.
- We have worked with local CCG's who are working with local providers to set up a collaborative working group.

North Locality

Audit title- Patients referred Community Physiotherapy Service who require on-going physiotherapeutic rehabilitation compared to those who require professional advice and signposting.

Aim of the Audit

To understand the reasons that patients only received one or two treatments from the different areas of the Physiotherapy service and whether in each individual cases, one or two visits were appropriate.

The service were concerned that the service may have been receiving inappropriate referrals from specific areas e.g. from services within the Trust or from the primary, secondary, and tertiary care organisations. Depending on the outcome it was thought that education sessions may need to take place with referrers. Looking in detail at the reasons behind why these patients who received one or two treatments was also a means of reviewing patient notes, to determine the decisions made by all members and levels of the team and so auditing decisions made within assessment and treatment.

Audit Results

Following on from the services initial concerns that high numbers of patients were discharged after only one or two treatments, the audit confirmed the appropriateness of these referrals and discharges.

A significant number of patients were given advice on contracture management, provided with exercises or given leaflets on condition management. The referencing to the exercises and advice differed slightly in each case and led the service to explore whether the information given to patients and carers was standardised. It is essential when having offering any exercise advice or management plan that the instructions are concise, easy to follow and regularly reviewed and up-dated.

There were a small number of patients who had been referred inappropriately, hence the need to inform our co-workers in the MDT of which areas of patient care we would be most

effective, however there were less than the service had thought. The service continues to explain their role when triaging and contact the referrer to explain if the referral was inappropriate.

Service Improvement Actions

- Review information given to patients and carers regarding contracture management ensuring it is up to date and patient and carer friendly.
- Review respiratory advice leaflets, ensuring it is up to date and patient and carer friendly.
- Ensure that there is a system in place within the team which ensures that advice and information leaflets are reviewed and up-dated when necessary, or yearly.
- Provide education around the roles of community physiotherapists at the neighbourhood MDT's to improve team members knowledge of the role.

Central Locality

Audit title – Phlebotomy Requests

Background

Phlebotomy staff perform blood tests; staff usually cover a community clinic in the morning seeing on average 48 patients in a four hour period. They will then have a list of patients to see as home (domiciliary) visits in the afternoon. Alternatively they may have a full list of patients to see as domiciliary visits over the course of the day.

The service has a service level agreement (SLA) in place that states routine requests will be seen within 5 working days and urgent requests within 24 working hours. It was becoming apparent that many of these referrals are not being undertaken within the expected time frame or on the first visit due to various reasons. Not only does this result in the patient being delayed in being seen and having samples obtained but requires additional resources as further visits are required.

Audit Results

- 42% of the returns were due to there being no answer when the phlebotomist attended.
- 10% of returns were made as the phlebotomist did not have time to attend the address.
- 16% of the patients were not at home at the time of visit which demonstrates not all referrals for domiciliary visits are for patients who are housebound, however some patients may have been attending other hospital appointments.
- 6% of patients were not at the address given on either the ICE request or EMIS record when the phlebotomist visited.
- 8% of patients refused to have bloods obtained; this information is cascaded back to the GP using a template document on EMIS.
- 4% of patients were non-compliant to having bloods obtained, this may be due to an underlying condition that permanently or temporarily impairs capacity to consent or comply.
- Only 4% of blood tests during the audit were not obtained due to poor venous access or staff being unable to obtain.
- The SLA sets out that patients referred for routine domiciliary phlebotomy will be seen within 5 working days and any urgent requests within 24 working hours. In view of the initial referral being returned for various reasons only 23% of these patients were seen within the guidance of the SLA. 25% of patients were seen between 6 – 18 working days, resulting in potential delays in management but also resulting in more than one visit per patient and on some occasions patients had 3 visits. Most

patients have two visits made before the referral is sent back to the GP advising of the reason for not obtaining the bloods.
- During the audit 57% of the patients did not have bloods obtained which would result in wasted visits, delay in management and may result in the GP having to re-refer back to the service.

Service Improvement Actions
- There are inconsistencies with referrals and when these are sent back to GP, standard operating procedures to be reviewed to make them more robust.
- Communication can be improved between referring clinicians and the service to ensure all patients are seen in the right place at the right time.

South Locality
Audit Title - Venous Thromboembolism (VTE) Harm Free Group

Background:
Venous thromboembolism (VTE) is a condition in which a blood clot (thrombus) forms in a vein. It most commonly occurs in the deep veins of the legs or pelvis; this is called deep vein thrombosis or DVT. The thrombus may dislodge from its site of origin to travel in the blood particularly to the pulmonary arteries which is known as pulmonary embolism, or PE. The term VTE includes both DVT and PE.

VTE is an important cause of death and its prevention and management is a priority for the NHS. The House of Commons Health Committee reported in 2005 that an estimated 25,000 people in the UK die from preventable hospital-acquired venous thromboembolism (VTE) every year. This includes patients admitted to hospital for medical care and surgery. The inconsistent use of prophylactic measures for VTE in hospital patients has been widely reported. A UK survey suggested that 71% of patients assessed to be at medium or high risk of developing deep vein thrombosis did not receive any form of mechanical or pharmacological VTE prophylaxis (NICE 2017). Non-fatal VTE is also important because it can cause serious longer-term conditions such as post-thrombotic syndrome and chronic thromboembolic pulmonary hypertension.

.

As set out in Liverpool Community Health (LCH) Quality Accounts since 2015/16, VTE was identified as one of the four main avoidable harms under the 'Harm Free Care' Workstream. 'Harm Free Care' is a collective term used for different patient safety initiatives aimed at ensuring patients are kept safe and free from harm in our care.

The Aim of the Audit:
To look at the amounts of referrals received:

- To ascertain how many of these referrals were showing positive D-Dimer.
- To show that the service is effective in identifying patients who have potentially got a DVT.
- To support the fact that the service helps to reduce the amount of patients attending A&E/MAU inappropriately.
- How many those referred with positive D-dimer also had positive Ultra Sound.
- To show it helps reduce and improve the patient journey and outcome.

Findings:
- 561 patients attended Old Swan Walk in Centre (OSWIC) over a six month period with suspected DVT.

- Of the 561 patients D-Dimer was positive in 307 (55%) cases which meant in order to conclusively exclude a DVT an Ultrasound was required.
- All patients who could not get an Ultrasound appointment within 4 hours received a dose of low molecular anticoagulant (Daltaparin) in line with NICE recommendations and VTE Pathway.
- Of the 307 patient referred for Ultrasound scan 61 (20%) were found to be positive and then went to the medical assessment unit for further management.

Conclusion:
61 scans were found to be positive; early management and treatment may have helped save potentially 61 lives or prevented serious longer-term conditions associated with complication of untreated DVT.

80% (246 out of the 307 patients) who had positive D-Dimers went on to have a negative Ultrasound, therefore avoiding Acute Medical Unit (AMU) admission.

The patients with a positive test (n=307) were then referred on for a scan at RLUBHT and of these 20% (n=61) went on to be actively treated for a DVT via AMU.

Locality Clinical Audit Priorities for 2018/19

With the transition to Mersey Care, the Trust will work closely to mirror the systems and processes of Mersey Care for clinical audit. Locality clinical audit plans will reflect the needs of the services in that locality. For some of our larger services audits across all localities will be undertaken. Each locality will develop an audit plan for 2018/19.

Each locality has identified audits across all services to be undertaken during 2018/19 which will be monitored through locality and Trust governance systems. Examples of the types of audits planned are provided below:

Planned audits cover a range of subjects including:

- IV Antibiotics audit (IV Therapy Team)
- 28 Day Mortality audit (Community Assessment Team)
- Completion of the Tooth Extraction Surgical Safety Checklist (Dental Service)
- Management and Administration of Children's own medicines in special schools (special Schools)
- Clinical Content Audit (community Matrons)
- National Audit of Intermediate Care (Intermediate Care Services)

Examples of our re-audits include:

- Liverpool Out of Hospital Service – Estimating Date of Discharge
- Health Visiting – Clinical Content

Participation in Clinical Research

As a result of the extended period of uncertainty around the future structure of community services prior to the transition to Mersey Care NHS Foundation Trust. LCH did not undertake clinical research for 2017/18.

The number of patients receiving NHS services provided or sub-contracted by Liverpool Community Health (LCH) between Quarter 1 and Quarter 4 in 2017/18 that were recruited during that period to participate in research approved by a research ethics committee was 0 a 100% decrease from 2016/17 total of 307.

Healthy Child Programme

The Trust provides a number of children's services. Nationally, a Healthy Child Programme (HCP) has been set out that looks at pre-birth to 19 years which encompass our Health Visiting and School Health Services. To ensure the implementation of the standards set out in the HCP, in 2016 a detailed action plan was designed and implemented. The purpose of this was to review and ensure the mandated contacts within the HCP for the pre-birth to 5 year age group were undertaken and achieved within the standards set. The assessments are undertaken at key points within the first 1000 days of a child's life and if achieved within this timeframe, support is provided ensuring the child achieves best outcomes and expectations.

Within the pre-birth to 5 year HCP there are 5 mandated visits out of the 7 areas that are monitored, with Breast feeding and assessment at 15 months included within the reporting structure as added targets.

The 7 areas that are monitored are:

- Antenatal visits completed at 28 weeks or above*
- New birth visit in 14 days*
- New birth visit after 14 days but within 21 days*
- 6 – 8 week follow up visit*
- 12 month review by age 1*
- 12 month review by 15 months
- Age 2 – 2.5 year reviews completed*
- Breastfeeding prevalence

*mandated visits as set out by the HCP

Locality reports are produced on a monthly basis for each standard. This enables each Health Visiting team to identify any areas of concern or non-achievement of the set standards. The data reports a significant increase in the completion of antenatal visits since 2016 with antenatal contacts achieved to the required standard across the Liverpool footprint.

Out of the remaining 4 mandated visits 2 have achieved target consistently and 2 are just below target with action plan developed to underpin achievement by end of year.

For the HCP standards set out for the School Health service; we are currently working with commissioners and performance analysts to clearly identify collation of the 5 assessment points within the 5-19 HCP. Work is also being undertaken to consider how the quality aspects of all work can be audited and reported alongside collation of the mandated contacts.

Commissioning for Quality and Innovation (CQUIN)

CQUINs are based on national best practice or local priorities that support and encourage improvement and innovation. A proportion of LCH income in 2017/18 was conditional on achieving quality improvement and innovation goals agreed between LCH and any person or body they entered into a contract, agreement or arrangement with for the provision of NHS services, through the Commissioning for Quality and Innovation payment framework. Further details of the agreed goals for 2017/18 and for the following 12 month period are available on request from CustomerServicesDepartment@LiverpoolCH.nhs.uk

We meet regularly with our commissioners to discuss CQUIN and once a quarter we provide our progress to date and receive their response. At the end of each financial year we obtain our final overall position of achievement from our commissioners.

The following CQUIN's were agreed between the Trust and Liverpool Clinical Commissioning Group (LCCG) and NHS England (NHSE) for the provision of NHS services:

CQUIN	Commissioner	End of year Achievement
Health and wellbeing	Liverpool CCG	Full
Supporting safe and proactive discharge	Liverpool CCG	Full
Preventing ill health by risky behaviours	Liverpool CCG	Partial
Improving the assessment of wounds Personalised care and support planning	Liverpool CCG Liverpool CCG	Partial
School age immunisation logic model	NHSE Cheshire & Merseyside	Full

Health & Wellbeing (NHSE)

This is a National CQUIN set out by NHS England and supported by local commissioners. There are two indicators below applicable to the Trust for 2016/17 which are:

- Measure of staff health and wellbeing organisation wide.
- Improving the uptake of flu vaccinations for front line staff within the Trust.

The revised Health and Wellbeing CQUIN was launched in April 2017 as an incentive for providers to implement changes that will improve the health and wellbeing of their workforce. The stated benefits of the changes are as follows: improved patient safety and experience, improved staff retention and experience, reduced costs to the trust, setting an example for other industries to follow and reinforces public health promotion and prevention initiatives.

Measure of staff health and wellbeing

The National 2016 NHS staff survey reported that, on average, 25% of NHS staff had suffered from musculoskeletal (MSK) issues due to work related activities in the last 12 months. Over a third of staff also reported feeling unwell due to work related stress.

This CQUIN element is based on results in two of the three health and wellbeing questions in the NHS annual staff survey questions. The two questions do not have to be pre-selected before the staff survey results, with 50% of the value of this indicator relating to performance in one question and the remaining 50% of the value relating to performance in a second question

Improving the uptake of flu vaccinations for frontline staff within the Trust.

Frontline healthcare workers are more likely to be exposed to the influenza virus, particularly during the winter months when some of their patients will be infected. It has been estimated that up to one in four healthcare workers may become infected with influenza during a mild influenza season. A much higher incidence than expected in the general population.

The aim of the CQUIN is to vaccinate 70% of the Trust frontline staff during September and inclusive of December 2016. The Trust vaccinated a total of 70.7% of the front line healthcare workers.

Supporting safe and proactive discharge (LCCG)

This is a two year CQUIN that works across local health economies that aims to improve discharges for patients across all wards within hospitals.

The desired outcomes are an improvement in patient outcomes, improvement in patient flow, and reduction in delayed discharges (and thus reduction in associated costs).

As part of the CQUIN, the Trust demonstrated the following to provide assurances to CCG:

- Map and streamline existing discharge pathways across community providers and roll-out protocols in partnership across local whole-systems.
- Develop and agree with commissioner a plan, baseline and trajectories which reflect impact of implementation of local initiatives to deliver the a reduction in discharge rates

Preventing ill health by risky behaviours (LCCG)

This CQUIN seeks to help deliver on the objectives set out in the Five Year Forward View (5YFV), particularly around the need for a '…radical upgrade in prevention…' and to '…incentivising and supporting healthier behaviour'. The proposal also supports delivery against the FYFV efficiency target by generating a projected national net cost-saving to the NHS over the course of the CQUIN.

The CQUIN is broken down into 5 indicators, the trusts performance is measured against a baseline figure for each indicator set internally at the commencement of the CQUIN, with the marker for success being set as expanding on the number of patients who :

- Number of patients who undergo a tobacco screening
- Number of patients who receive tobacco brief advice.
- Number of patients who receive tobacco referral and medication offer
- Number of patients who undergo a alcohol screening
- Number of patients who receive alcohol brief advice.

Improving the assessment of wounds (LCCG)

Currently 30% of chronic wounds identified in the CQUIN as wounds that have failed to heal for 4 weeks or more, do not receive a full assessment which is based on research evidence and best practice guidelines. Failure to complete a full assessment can contribute to ineffective treatment which therefore delays the rate of wound healing for patients.

The objective of this CQUIN is to establish a baseline figure through clinical audit for the number of full wound assessments that are completed during Quarter 1. An improvement plan will then be established to improve upon the baseline.

Personalised Care and Support Planning (LCCG)

More than half of the population live with long term conditions and 5% of these people account for more than 75% of unscheduled hospital admissions. Many of these people (35%) indicate they have low or very low levels of knowledge, skills and confidence to self-care, in order to manage their health and wellbeing and live independently. These people have a poorer quality of life, make more unwarranted use of public services and cost more to public services.

This CQUIN scheme is to incentivise the change in behaviours and methodologies that allow patients to take greater control over their health and wellbeing. A core component is personalised care and support planning which is; a) an intervention that supports people to develop the knowledge, skills and confidence to manage their own health and wellbeing and that leads to the development of a care plan and b) an enabler that supports patients to understand the local support mechanisms that are available to them.

School age immunisation logic model (NHSE Cheshire & Merseyside)
This 2017-19 CQUIN scheme will commence with a 2016/17 focus on the development of the Health Care Assistant role in the delivery of the NHS Universal Childhood Flu vaccination programme. The NHS Universal Childhood Flu vaccination programme continues to grow in line with national roll out plans; each academic year, 1-2 new cohorts are added to the programme. In order to ensure a sustainable model of delivery; there is an opportunity to review the roles and skill mix required of school nursing services to meet the growing demands on the service.

The 2017-18 school age immunisation workforce CQUIN scheme will support providers in scoping and testing an enhanced Health Care Assistant role, to include delivery of a nasal flu vaccine. Developing the Health Care Assistant role will allow services to begin to determine an optimum immunisation service/team to include key roles, skill mix and WTE establishment for a given school/geography.

Care Quality Commission

As with other NHS providers of healthcare, the Trust is required to register with the Care Quality Commission (CQC) and its registration status is 'Requires Improvement'. CQC inspection reports can be found at www.cqc.org.uk/provider/RY1

LCH is subject to periodic reviews by the Care Quality Commission, the last review was February 2016. This was an announced focused inspection for which the report was published in July 2016; the full report can be viewed through the link above.

During inspections, the CQC look at 5 key areas to determine:

1. Are they safe?
2. Are they effective?
3. Are they caring?
4. Are they responsive to people's needs?
5. Are they well-led?

Based on the findings, CQC then set out 'Inspection Area Ratings' the Trusts are set out below (from report published on 8th July 2016)

- Safe Requires improvement
- Effective Requires improvement
- Caring Good
- Responsive Requires improvement
- Well-led Requires improvement

CQC uses the descriptions below in the formulation of their reports.

☆	**Outstanding –** the service is performing exceptionally well.
●	**Good** – the service is performing well and meeting our expectations.
●	**Requires improvement** – the service isn't performing as well as it should and we have told the service how it must improve.
●	**Inadequate** – the service is performing badly and we've taken enforcement action against the provider of the service.
●	**No rating/under appeal/rating suspended** – there are some services which we can't rate, while some might be under appeal from the provider. Suspended ratings are being reviewed by us and will be published soon.

The inspection report found that the Trust had recruited more front-line clinicians to ensure safer staffing levels, and delivered significant improvements to its intermediate care services. Inspectors also highlighted significant improvements in the culture of the organisation and praised the Trust for the measures it had introduced to keep staff safe. The July 2016 CQC inspection report also identified areas for further improvement, including:

- Ensuring the Trust properly documents the way it is responding to the NHS duty of candour.
- Ensuring robust systems are in place for all services to monitor and improve the quality of service provision.
- Allied Health Professional (AHP).
- Review the Trust 0-19 service to ensure compliance with span of control for health visitors and 5 mandated healthy child programme visits.
- Ensure robust Governance structure across the Trust.

The Trust undertook the following actions to address the points made in the CQC's assessment:

The Trust responded to the reports with an integrated Improvement Plan, to proactively resolve the issues raised, and formally respond to requirement notices and identified deadlines. The 2016/17 improvement plan had 30 actions. Each action had a corresponding monitoring Committee, Executive and Management Lead, progress update, evidence to support progress, completion date and RAG status. Collaborative working occurred with CQC and our local commissioners to progress our improvement plan. In January 2017, the CQC returned to LCH for a major review meeting prior to the separation of the Trust. In the feedback, at the conclusion of the review meeting, the CQC highlighted significant improvement across all five inspection domains and with particular reference to culture, quality & safety, Allied Health Profession waiting times, and the well led element domain.

The Trust made the following progress by 31st March 2018 in taking such action the full CQC action plan was reviewed at the Planning and Performance Committee in July 2017 and an engagement meeting took place with CQC on 26th July 2017 where it was confirmed that the action plan had been closed following completion of all actions. On-going monitoring of sustainability actions is monitored via the current Committee structures.

As the Care Quality Commission took enforcement action against LCH in 2016/17, it is noted that at the point of transfer of LCH to Mersey Care, this notice remains as the Trust did not

have a formal re-inspection due to the fact that was going through a transaction. It is anticipated that a full CQC inspection will occur during 2018/19.

The Trust participated in a CQC Local System Review in February 2017 alongside other providers which was led by Liverpool City Council.

The Department of Health instructed NHS Improvement to commission Dr Bill Kirkup to undertake a review with terms of reference that set out to look not only at LCH but at the wider health economy and the role of regulators between November 2010 and December 2014. The findings of this review are being taken forward through an improvement plan.

This review can be found:

http://www.liverpoolccg.nhs.uk/media/2939/gb-10-18-appendix-kirkup-report.pdf

Duty of Candour

Following the publication of the 'Francis Inquiry Report' (2013) and the recommendation for openness, transparency and candour; providers were required to have systems and processes in place to ensure open and honesty with patients when things go wrong with their care and treatment. It is also a regulation by the CQC (regulation 20).

The Trust has processes in place to consider 'Duty of Candour' for each incident or moderate, severe harm or death. In addition, other incidents that result in lower levels of harm may be considered depending on the seriousness of the incident.

Following a Mersey Internal Audit Agency (MIAA) review of Duty of Candour in 2016, the Trust updated its processes to ensure full compliance.

Duty of candour is managed via the locality governance structure. Each locality submits a quarterly duty of candour audit which is presented to Patient Safety Sub Committee via the Patient Safety report.

We maintain compliance by triggering the Duty of Candour process for cases that meet the criteria once the case has been formally reviewed at our Being Open meetings.

The process includes:

- Formally recording of the Duty of Candour discussion on the Datix Incident management system.
- An initial letter is sent to the patient / carer, explaining actions to be taken by the Trust together with a designated contact for any questions.
- An investigation of the incident is undertaken.
- Once the investigation is completed, a Duty of Candour follow up letter is sent, offering the recipient a face to face meeting to explain the content and a copy of the investigation if required.
- The above points are also formally documented in the patient's records.

Responding to Deaths

As a Community Trust, many patients known to our services may also be in receipt of care from other agencies such as their GP or Local Authority. In addition, patients may move between different care settings such as hospital, residential or care homes. Following the release of 'National Guidance on Learning from Deaths' (2016), Trusts were required to set up systems, processes and governance to respond to any expected or unexpected deaths.

An unexpected death is defined as: "Any death not due to terminal illness or, a death the family was not expecting". It may also apply to patients where the GP has not attended within the preceding 14 days, where there is any suggestion of suspicious circumstances, trauma or neglect, patients who die within 30 days of discharge from secondary care, patients without an end of life care plan.

An expected death can be defined as "a death where a patient's demise is anticipated in the near future and the doctor will be able to issue a medical certificate as to the cause of death (i.e. the doctor has seen the patient within the last 14 days before the death)" (Home Office 1971). When someone is dying they should be cared for with an end of life care plan. This is a multidisciplinary decision and when a death occurs whilst on such a care plan we can be assured that this was an expected death. Deaths which occur outside of such a care plan will need to be reported and reviewed to decide if they are unexpected and require further investigation.

How the Trust implemented this

To support the implementation of this initiative, the Trust has:

- Established governance systems for recording and reporting, including a mortality dashboard.
- Provided awareness and support to front line staff to ensure deaths are reported as per Trust process.
- Developed a 'Responding to Deaths' policy.
- Provided senior leadership for the initiative through the Medical Director and Associate Medical Director.
- Involved front line staff and the Specialist Palliative Care Team (SPCT) who undertake regular reviews and surveys of patients who are on or have been on their case load to assess the patient and carer/family experience of end of life care received.
- Rolled out the recording of clinical observations with escalation procedures for a senior review if required.
- Worked in partnership with primary care GP's - as patients known to LCH services are overseen and managed through GP's practices. The Trust is working towards ensuring any mortality/death reviews are undertaken in collaboration with primary care colleagues to ensure that reviews are transparent and supported by all those involved in the care of the patient.
- Reviewed the effective use of the new uDNACPR policies.
- Reviewed how the learning from child deaths is disseminated: The results of child death investigations are multi-factorial and usually involve many different agencies. Processes for ensuring that any learning is fed back to the Trust from the Child Death

Overview Panel for dissemination is being taken forward through our Safeguarding Children's Team link.

How deaths are reviewed

As part of our governance procedures, 'Being Open' meetings are held each locality attended by a group of key clinical team members. The Being Open meetings carry out a review of the death of a patient using a standardised checklist. The key purpose of this review is to ensure that all appropriate care was delivered in a timely manner. The patient's records (including the medical record, patient assessment and plan of care and acute hospital record where appropriate) are reviewed as part of this process.
All unexpected deaths or concerns are then reported to the Associate Medical Director and Mortality Team for a structured case note review. The structured case note review is where the patient's records are reviewed including transfer of care/ admission, medical management, care plans, observation charts, evaluation and communication sheets and a chronology of events with findings recorded on a template. The Team review all the deaths and decide whether any additional cases require further review.

Any Unexpected Death requiring immediate escalation is reported to the senior clinical and management team. A mortality strategy group is set up to review the case. Deaths that are assessed as avoidable will be classed as a SI and reported on StEIS. A full Root Cause Analysis (RCA) is commissioned to be completed within 60 days. All other unexpected deaths should be reported to the Mortality Group following discussion at the locality Being Open meeting, so that any further investigations or actions can be taken locally.

Duty of Candour is undertaken in line with the Trust's policy.

It is important to note that within a hospital setting, overall mortality rates are measured using HSMR (Hospital Standardised Mortality Ratio) and SHMI (Summary Hospital-level Mortality Index) to quantify mortality rates. There are also tools available to explore the more qualitative aspects of mortality and End-of-Life (EoL) Care.

It is also important to recognise that the tools to measure mortality related to hospital care also take into account those patients who die within 30-days of their discharge from an acute hospital. It is therefore the whole patient pathway that needs to be scrutinised, not just the hospital in-patient stay. For example, could the admission have been avoided in the first place (e.g. with better EoL care at home), or was there a failing of processes after discharge that contributed to the death of the patient.

As a community trust, HSMR and SHMI are not appropriate tools to use for Community or Intermediate Care services. However, it is important to learn lessons from mortality information and statistics.

During 2017/18 1033 of the Trust's patients died. Of these 841 were under the district nursing teams and 192 under the community matrons. 169 of the total number of deaths had an end of life care plan in place. 42 coded as expected death. Many of these patients will have died in hospital and therefore not recorded as deaths in LCH care. It is important to note that there is a discrepancy in reporting of deaths by community staff compared to figures we have of patients leaving the caseload due to death.

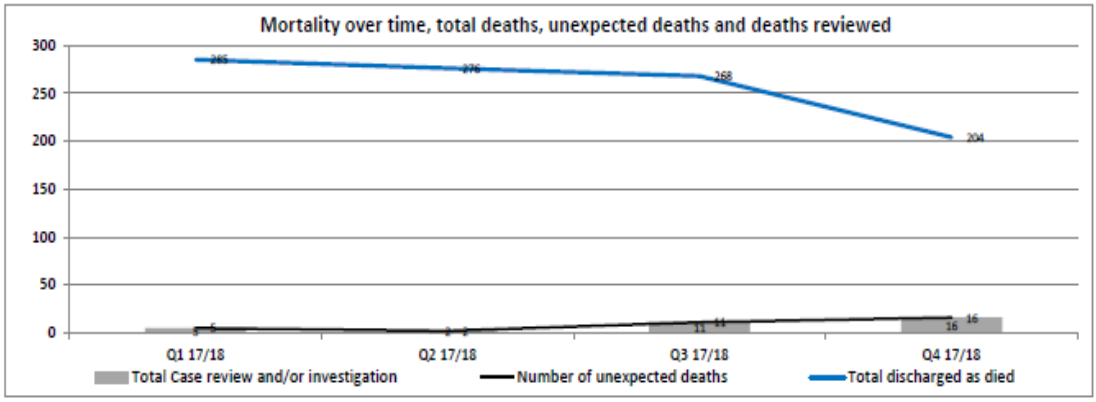
As of October 2017 in line with the Responding to Deaths Policy, staff members have been asked to record expected deaths on the EMIS computer record system. Expected deaths are

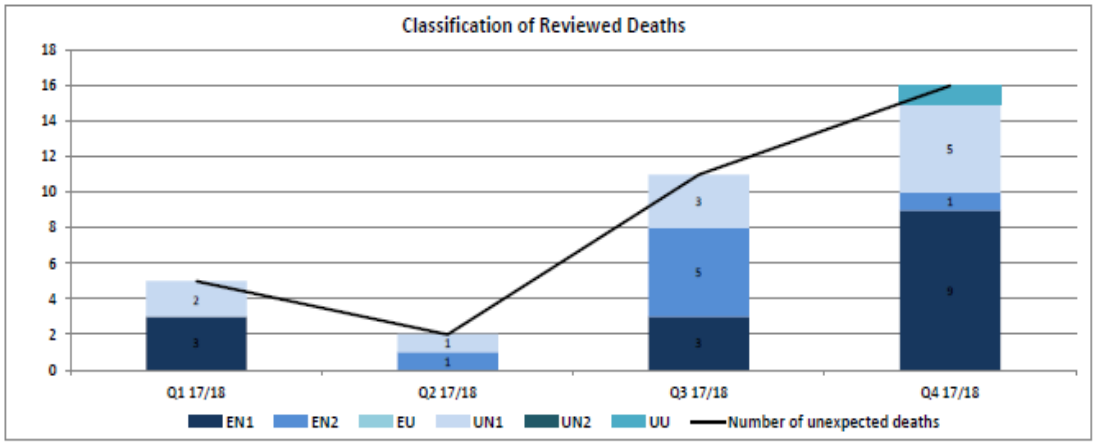
defined as those on an End of Life Care Plan. Unexpected deaths are to be recorded on Datix for governance review and referral for further investigation if appropriate.

This table comprises the following number of unexpected deaths which occurred in each quarter of that reporting period:

Responding to Deaths Dashboard

		2016/17	Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18	2017/18
	Number of unexpected deaths	n/a	5	2	11	16	34
Classification	EN1	n/a	3		3	9	15
	EN2	n/a		1	5	1	7
	EU	n/a					0
	UN1	n/a	2	1	3	5	11
	UN2	n/a					0
	UU	n/a				1	1
	Total Case review and/or investigation	n/a	5	2	11	16	34





Classification	Key	Description
Expected natural 1	EN1	Death occurs within the expected timeframe
Expected natural 2	EN2	Death expected but sooner than expected
Expected Unnatural	EU	Death expected but not from the cause expected e.g. Ca diagnosis but has drug overdose
Unexpected Natural 1	UN1	Sudden death from natural cause e.g. stroke or heart attack
Unexpected Natural 2	UN2	Sudden death from natural cause but didn't need to cause death, e.g. alcohol dependency
Unexpected Unnatural	UU	Homicide, abuse, drug overdose

For deaths initially classed as unexpected deaths, by 31.03.2018, 34 case record reviews and 7 investigations have been carried out in relation to all of the deaths included in item the above table.

Governance and Reporting

The governance structure for reporting of Mortality is via the Resuscitation & Mortality Group, through to the Patient Safety Sub-Committee and on up to the Quality Committee and the Board.

The Trusts mortality group monitors any unexpected deaths, reviews the findings and shares the learning from these through reports and an annual report.

Without an overview of mortality rates and knowledge of potential areas of quality improvement in end of life care, the Trust may miss opportunities to identify areas for improvement, and any emerging trends in mortality. A cross-organisational approach is required to ensure that the whole patient care pathway is scrutinised to identify areas for quality improvement.

Lessons Learnt and Actions taken

From case reviews and investigations there is often the opportunity to further improve even if care delivered had no impact on the death. Thematic reviews are undertaken in order to inform future learning.

For 2017/18 the key themes were:

Record keeping: examples of excellent and sub-optimal record keeping were identified. The findings from this have been fed back to inform mandatory training. Examples were also used within an end of life presentation at a Trust conference.

Patient centred care: excellent patient centred care was noted, this was fed back to respective teams and via staff forums.

Recognition of illness trajectory/approach of a patient's end of life: case reviews suggested that there was a need for an overview of the patient's illness journey and improved recognition that they were approaching the end of their life. There has been 1 recent complaint from a patient's family regarding this issue. A Black Box event took place on 28.06.18 to highlight this issue and present the complaint.

Accessing patient information: some difficulty in accessing records, internally and externally was experienced. Our informatics team are assisting with developing a pathway for internal case note review and a pathway for liaising with GPs to facilitate access to additional patient information required for mortality reviews.

Poor quality of hospital discharges: this was multi factorial and included failure to notify teams that an end of life patient is due to be /has been discharged, inadequate or missing medication information on TTO and lack of clear follow up arrangements by hospitals. Collaborative working has been taken forward with local Trusts thorough a discharge project being led by the Trust.

Escalation of clinical concerns: it was identified that there was a lack of clear pathway for escalation of clinical concerns about deteriorating patients to external organisations such as GPs. This formed part of the work regarding clinical observations and guidance for staff. The Trust is due to roll out NEWS2.

Training

There is on-going training and awareness for staff including the coding of expected deaths as per Responding to Deaths Policy, end of life care and capture of bereavement visits post death.

NHS Outcomes Framework

LCH submitted records on a monthly basis during 2017/18 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 which included the patient's valid NHS number was:

- 98.9% for admitted patient care
- 90.1% for accident and emergency care/Walk in Centre

The percentage of records in the published data which included the patient's General Medical Practice Code was:

- 99.8% for admitted patient care
- 90.6% for accident and emergency care/Walk in Centre

Information Governance

Information Governance is the term used to describe the standards and processes for ensuring that organisations comply with the laws and regulations regarding handling and dealing with personal information. Within our organisation we have clear procedures and processes to ensure that information, including patient information, is handled in a confidential and secure manner. The designated individual within the Trust who is responsible for ensuring confidentiality of personal information is the Caldicott Guardian; this position is held by the Associate Medical Director. The Trust also has a Senior Information Risk Owner (SIRO) who is responsible for reviewing and reporting on identifying any information and providing assurance on the management of information risk to the Board. This role is held by the Director of Finance.

Each year our Trust submits compliance scores to NHS Digital via the Information Governance Toolkit. The toolkit is an online system which allows NHS organisations and partners to assess themselves against the Department of Health's information governance policies and standards. It also allows members of the public to view our progress on improving our information governance standards.

There are three levels to the Information Governance (IG) Toolkit:

· Red - Not satisfactory

· Amber - Satisfactory with improvement plan

· Green - Satisfactory

LCHs Information Governance Assessment Report overall score for 2017/18 was 66% and graded a green satisfactory rating. The Information Governance Toolkit submission was subject to internal audit. The Trust received a Significant Assurance Rating.

The Trust reported 193 information governance incidents during the financial year, three of which were graded with a high risk rating. There were two incidents which required to be reported to the Information Commissioner's Office (ICO). These are currently under

investigation by the Trust. The Trust takes all data breaches and near-misses seriously and takes immediate action to mitigate the risk of such incidents occurring.

The Trust received 222 requests under the provisions of the Freedom of Information Act, 5 were not responded to within the statutory 20 day timeframe. This was mainly due to the complexity of the request and the gathering of the information requested. In all circumstances, the Trust informed the requestor of any delay.

Clinical Coding Error Rate

LCH was not subject to the Payment by Results clinical coding audit during 2017/18 by the Audit Commission.

LCH will be taking the following actions to improve Data Quality:

- Continue to monitor data via both external reports provided to commissioners and internal reporting, including giving EMIS service leads/team leaders the ability to monitor data through Self Service Reporting at any time. Such activity gives the service the ability to address any issues in a timelier manner and facilitate any training to be given by the Data Quality Team.
- Continue to raise awareness of Data Quality through educations sessions targeted at service level and will continue to act as a source of support on any aspect of Data Quality.
- Provide assistance and guidance to the Health Records Team in addressing the duplicates issue within EMIS in line with the agreed processes. Details of duplicates are provided via internal reporting and training has been given by Informatics Merseyside.
- Undertaken a Data Quality Audit of Loan Worker Devices on behalf of the Trust in an aim to establish a more robust process for monitoring and maintaining these devices.

Data Made Available by the Health and Social Care Information Centre (HSCIC)

Please note – until 01/06/2017 date (when Sefton transferred), the Trust had 1 intermediate care ward based in Aintree University Hospital which then transferred to Mersey Care NHS Trust.

Prescribed Information	**2015/16**	**2016/17**	**2017/18**
The data made available to the NHS Trust or NHS Foundation Trust with regard to the trust's **responsiveness to the personal needs of its patients** during the reporting period.	Data not available from HSCIC at time or report	N/A National Audit of Intermediate Care did not take place for 2016/17	The Trust consider that this data is as described – see page 15

Prescribed Information	**2015/16**	**2016/17**	**2017/18**
The data made available to the NHS Trust or NHS Foundation Trust 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**.	72%	68%	77%

The staff survey incorporates the Friends and Family test question above.

Staff Survey results
LCH considers that this percentage is as described for the following reasons:

Quality Health were commissioned to undertake the 2017 Staff Survey. A total of 1886 eligible staff from the Trust received a questionnaire. 778 staff completed the questionnaire which was a response rate of 40.3%%. The average response rate for Community Trusts was 50.1%%.

The purpose of this survey is to collect staff views about working in their NHS organisation. Data from the survey issued aims to improve local working conditions for staff and ultimately to improve patient care. Staff were asked to respond to a number of statements, examples of the feedback we received are included below:

Staff were asked if they would recommend the Trust to their family and friends. 77% of staff said they would recommend the Trust as place to receive care or treatment whilst 54% recommended it as a place to work. 24% of staff reported experiencing harassment, bullying or abuse from staff in last 12 months and 86% of staff reported believing that the organisation provides equal opportunities for career progression or promotion.

For the full 2017/18 staff survey report, please follow this link:
http://www.nhsstaffsurveys.com/Caches/Files/NHS_staff_survey_2017_RY1_sum.pdf

LCH has taken the following actions to improve these percentages above and so the quality of its services; upon completion of the staff survey, a report is provided back to the Trust with feedback on responses, benchmarks against previous years and a plan is then formulated to address any issues raised.

***note data below is for ward 35 until 01/06/2017 date when Sefton transferred**

Prescribed Information	**2015/16**	**2016/17**	**2017/18**
The data made available to the NHS Trust or NHS Foundation Trust by the health and Social Care Information Centre with regard to the **percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism** during the reporting period.	**99.9%**	**100%**	**100%**

Community Trusts are not required to report VTE to the Health and Social Care Information Centre, however, as we have intermediate care wards, this is carried this out locally and reported to Commissioners.

LCH considers that this percentage is as described for the following reasons – VTE risk assessment is part of the patient admission and assessment process, performance was monitored through our monthly performance data reports until the point of transfer.

LCH has taken the following actions to improve (maintain) this percentage and so the quality of our services by:

- Process in place through Daily Datix to monitor any reasons for exceptions that have impacted on the percentage risk assessed for example, patients who have become acutely unwell during admission who need transfer to Accident and Emergency Department.
- Monitoring through performance meetings and the Harm Free Care Sub Group until the point of transfer.

***note data below is for ward 35 until 01/06/2017 date when Sefton transferred**

Prescribed Information	2015/16	2016/17	2017/18
The data made available to the NHS Trust or NHS Foundation Trust by the Health and Social Care Information Centre with regard to the **rate per 100,000 bed days of cases of C.difficile infection** reported within the Trust amongst patients aged 2 or over during the reporting period.	**28.0%**	**36.7%**	**0%**

Community Trusts are not required to report the rate per 100,000 bed days of cases of C.difficile infection (CDI) – please see below:

LCH considers that this rate is as described for the following reasons – infection control monitoring systems are in place to investigate any cases of CDI. If an infection occurs, a Post Infection Review is undertaken, often with other healthcare providers to examine the main causes of what happened and identify any lessons learnt. These are formally reported as Liverpool or Sefton CCG cases (until 01/06/2017 date Sefton transferred), however they are declared to the Commissioning Support Unit (CSU) and NHS Improvement (previously TDA) along with any MRSA bacteraemia data.

LCH has taken the following actions to maintain this rate, and so the quality of its services. Following the post infection review, an action plan is developed and lessons learnt shared. From the reviews there have been no lapses in clinical care. Several actions and lessons learnt have been completed to improve patient care and prevent infection. This included:

- Improving collection of specimens to enable more timely identification of any infection.
- Audit and reporting of antimicrobial data, to improve prescribing and reduce risks.
- Enhanced genotyping when cases have occurred on single ward which has demonstrated no healthcare transmission.

A database of key data for each case has been developed by the Infection Control Team; this allows the identification of specific CDI reports, key themes, risk factors or hot spots.

Infection control continues to be part of mandatory training for staff, there was an identified infection control nurse who undertook regular audits across Ward 35 and supported staff to implement the infection prevention work plans which includes detailed audit, surveillance and infection control link nurse programme.

Our Medicines Management Team has been instrumental in establishing systems and process to monitor anti-microbial (antibiotic) prescribing; this supports the wider public campaigns to raise awareness that antibiotics are not required for colds and viruses; increased use of antibiotics is also one of the factors in cases of C.Difficile. There is an established Anti-Microbial Resistance Group in place which reports into Clinical Effectiveness Sub Committee, an annual report is produced, and a number of audits produced that benchmark against best practice.

Prescribed Information	2015/16	2016/17	2017/18
The data made available to the NHS 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 reporting period.	3184	3241	4054

The number and percentage of such patient safety incidents that resulted in severe harm or death. (Please note, these figures are taken from LCH Datix incident reporting system not HSCIC as figures are not published until September 2018).	116	100	198

LCH considers that this number is as described for the following reasons:

- The Trust has established incident reporting systems and risk management policies in place. Incidents are reported on Datix which localities review on a daily basis for type, severity, STEIS reporting and duty of candour.
- On a weekly basis localities review all incidents for key themes or trends at a 'Weekly Meeting of Harm'.
- At organisational level there is a pan locality weekly Safety Huddle where themes or trends are shared and escalated as appropriate.
- Incident reporting is included in performance reports to Committees and the Board. If a highly complex or a serious event occurs there are procedures in place for staff to escalate 24/7 through their line manager or on call manager.
- From 01/11/2017, LCH also attended weekly 'standup' were issues that require senior support are escalated and discussed.

LCH has taken the following actions to improve this number and so the quality of its services:

- staff are encouraged and supported to report incidents.
- Staff awareness and support for incident review and reporting is available at locality level from Governance & Quality leads, Care Managers and Clinical Leads.
- Incident reporting has been incorporated into staff training and bespoke communications have been disseminated.
- Monitoring of reporting across the year is included in the locality weekly meeting of harm report.
- There has also been a focus on promoting reporting within 24/48 hours for moderate and severe incidents. The progress against this is monitored at locality level and fed back to staff via staff governance meetings.
- Quality Forums and Black Box sessions are held where best practice and lessons learnt from incidents and service improvements are shared.

Prescribed Information	
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 aged— (i) 0 to 15; and (ii) 16 or over, Readmitted to a hospital which forms part of the Trust within 28 days of being discharged from a hospital which forms part of the Trust during the reporting period.	As a community provider, this mandated information is not applicable.

National Requirements

LCH routinely submit the Children's and Young Persons Health Service Information Data Set (CYPHS). This is a national dataset that all organisations that provide Community Services for children and young people under the age of 19 must collect and submit CYPHS to NHS Digital.

Other Quality Measures Which Remained a High Priority in 2017/18

National and local quality measures and performance within LCH
The table shows our achievements against the target sets nationally and locally:

Quality Domain	LCH Overall 2016/17	North Locality 17/18	Central Locality 17/18	South Locality 17/18	LCH Overall 2017/18	2017/18 Target	RAG
Safety							
Infection Prevention & Control: Compliance with HCAI Framework	Compliant				Compliant	Compliance against the framework	Green
Never Events	1	1	0	0	1	0	Amber
Serious Incidents These figures include Never Events as above.	29	13	11	10	34	29	Amber
Pressure Ulcers Community Acquired Grade 2(avoidable)	29	13	6	5	24	23	Amber
Pressure Ulcers Community Acquired Grade 3(avoidable)	18	8	3	6	17	16	Amber
Pressure Ulcers Community (avoidable)Acquired Grade 4	6	0	4	3	7	0	Red
Safety Thermometer	96.8%	n/a	n/a	n/a	97.1%	95%	Green
Effectiveness							
Breastfeeding prevalence at 6-8 weeks	31.2%	17.5%	41.2%	33.2%	**31.3%**	30%	Amber
Chlamydia Positivity Rates	748	n/a	n/a	n/a	939	749	Green
Vaccinations							
Human Papillomavirus (HPV) at 12-13 years (girls) Dose 2	88.7%	n/a	n/a	n/a	82.3%	90%	TBC Final results reported end of school year (August 18).
Other Measures							

Quality Domain	LCH Overall 2016/17	North Locality 17/18	Central Locality 17/18	South Locality 17/18	LCH Overall 2017/18	2017/18 Target	RAG
Complaints Not inc Sefton	100	21	22	21	64	N/A	Green
Walk-in-Centres Waiting Times (treated within 4 hours)	100%	n/a	n/a	n/a	100%	95%	Green
Adult AHP Incomplete Pathways (Liverpool) (Patients still waiting to be seen.)	8 weeks	9	8	9	8	8 weeks	Green

The following information provides examples about some of the quality measures and activities included in the table above.

Never Events

A Never Event is a serious, largely preventable patient safety incident (e.g. wrong site surgery), that should not occur if the right processes are in place. Each year a list of 'Never Events' is produced based on incidents that have been reported nationally. Should a Never Event occur, a review process called Root Cause Analysis (RCA) is undertaken to identify the cause of the event and develop an action plan to address the gap(s) identified in the system. The Trust had 1 never event relating to a wrong tooth extraction. This was fully investigated and local quality improvements undertaken to incorporate learning from Human Factors training.

Serious Incidents (SI)

A SI, in broad terms is something out of the ordinary or unexpected with the potential to cause harm to patients or the public. A SI involves one or more of the following:

- Avoidable serious injury or death
- Never Event not resulting in severe harm or death
- Serious damage to NHS property, e.g. fire, criminal activity
- Major health risk, e.g. outbreak of infection
- Large scale theft or fraud or where major litigation is expected

The organisation has had 34 SI's in the last year, the majority related to Pressure Ulcers.

All SI's are fully investigated, themes reviewed and actions put into place to prevent incidents from reoccurring. A Serious Incident/Never Event (SINE) panel has been established; this is chaired by a senior clinician, the purpose of this panel is to ensure the investigations are completed to organisational standard, or to identify if there is further information required. It also highlights pan locality themes for sharing lessons learned and ensures that internal and external deadlines are met.

Some of the actions and lessons learnt from our SI's are listed below:

- Lessons learnt are an agenda item at locality governance meetings;

- For quality assurance all SI reports are reviewed by Clinical Leads before going to SINE panel There is a system in place to flag any new themes to be incorporated into the harm free work programmes;
- Organisationally we share information on lessons learnt in a number of ways: local team learning and newsletters to set out best practice and examples of how local practice has been improved;
- Quality Forums and Black Box sessions are held across the year to share learning and ideas for service improvement;
- Pressure ulcers are our top reason for SI's, a pressure ulcer reduction programme is in place
- An aggregated review of all grade 4's has been undertaken to inform plans for 2018/19
- The Trust worked with an external expert to train staff to consider the 'Human Factors' in relation to investigations and to look how our current framework for undertaking RCA reviews can be adapted to reflect these additional areas.

Breast Feeding
Research demonstrates that coronary heart disease, cancers and childhood obesity, could be reduced by increasing breastfeeding rates. Increased breastfeeding rates at six to eight weeks after delivery continues to be a challenge and is wholly dependent on the numbers of mums who choose to breastfeed and who are supported to breast feed after delivery. We continue to work with other partners to improve the numbers of mothers' breastfeeding following the birth of their child, and continuation of breastfeeding as their child gets older.

Vaccinations and Immunisations (V&I)
Immunisation is a way of protecting against serious infectious diseases. The aim of vaccination and immunisation is to protect individuals from these illnesses and ensure there are enough members of the public protected to prevent disease outbreaks. The Trust delivers specific programmes of vaccinations and immunisations to children and adults and work in collaboration with GP's and commissioners to ensure these are delivered to identified groups within the local population.

Assurances on Quality of LCH Services Provided in 2017/18

Foundation Trust Application

In January 2015, LCH Trust Board formally withdrew its application to become a Foundation Trust. In 2015/16 LCH services went out to tender and a procurement process commenced to identify a new provider. As of April 2017, LCH services started to transfer to new providers. On 1st April 2018 the last group of community services transferred to Mersey Care NHS Foundation Trust.

Capsticks review of Quality, Safety and Management Assurance

Following the publication of the Quality, Safety and Management Assurance review in 2016, a number of 'Board Time Out' were held in addition to set Board meetings. These enabled the opportunity to discuss key strategic, operational and performance matters in more detail than would otherwise be possible at a formal Board meeting. A full action plan was devised based on the recommendations.
http://www.liverpoolcommunityhealth.nhs.uk/downloads/news/mar-16/Capsticks%20Report.pdf

The Trust subsequently:

- Developed an action plan to address the findings of the Capstick's report, this was reported directly to Board (and discussed at Board Time Out sessions).
- Reviewed the Trust Risk Management Strategy (February 2017).
- Reviewed and updated the Board Assurance Framework.
- Reviewed and updated the strategic risk register.
- Reviewed and updated Board Committees terms of reference.
- Reviewed Committee and Sub-Committee structures.
- Followed best practice by undertaking annual reviews of effectiveness for each Board committee as a part of the committees' reporting cycle.
- The action plan was closed down in 2016.

Kirkup Review

In November 2016, the Department of Health confirmed that it had instructed NHS Improvement to commission Dr Bill Kirkup to undertake a further review; this time into the reasons why Liverpool CCG, NHSI and other commissioners and regulators did not act earlier over the failures described in the Quality Safety and Management Assurance Review (Capsticks report). The Kirkup review was published on 8th February 2018. Following publication the Trust developed a plan based on the findings and recommendations which is monitored through the Trusts governance system.

http://www.liverpoolccg.nhs.uk/media/2939/gb-10-18-appendix-kirkup-report.pdf

Mersey Internal Audit Agency (MIAA)

The Trust retains the services of Mersey Internal Audit Agency (MIAA) to act as its Internal Auditors. During 2017/18, a total of 11 internal audit reports were issued, of which 1 provided high assurance, 7 provided significant assurance and 3 provided limited assurance. There were 0 reviews which received an assessment of "No Assurance".

The internal audit reports covered a number of themes such as IG Toolkit, Incident Reporting, Treasury management and Sickness Absence.

For each internal audit review undertaken during the period there are agreed action plans in place with an assigned executive lead. The delivery of action plans is routinely monitored by the Audit Committee.

Appendix 1
Statement of Director's Responsibilities for the Quality Account.

The Directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 to prepare Quality Accounts for each financial year.

NHSI has issued guidance to NHS Trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that Trust boards should put in place to support the data quality for the preparation of the quality report.

In preparing the quality account, directors are required to take steps to satisfy themselves that:

- The content of the quality report meets the requirements set out in the NHS Reporting Arrangements 2017/18.
- The content of the Quality Account is consistent with internal and external sources of information including:
    - Board minutes and papers for the period April 2017 to May 2018.
    - Papers relating to Quality reported to the Board over the period April 2017 to May 2018.
    - Feedback from the commissioners dated May 2018
    - Confirm that Liverpool Scrutiny Committee have requested a final copy of the Quality Account.
    - Feedback from Healthwatch Liverpool
    - The National Staff Survey for 2017 presented to Trust Board on 27th February 2018.
    - MIAA position.
- The Quality Account presents a balanced picture of the NHS Trusts performance over the period covered;
- The performance information reported in the Quality Account is reliable and accurate;
- There are proper internal controls over the collection and reporting of the measures of performance included in the Quality and Account, and these controls are subject to review to confirm that they are working effectively in practice;
- The data underpinning the measures of performance reported in the Quality Account is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and the Quality Report has been prepared in accordance with NHSE standards to support data quality for the preparation of the Quality Account. (Available at: http://www.nhs.uk/aboutNHSChoices/professionals/healthandcareprofessionals/quality-accounts/Documents/2017/nhs-quality-account-reporting-arrangements.pdf

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.

Date…27.06.2018……Chairman

Date…27.06.2018…..Chief Executive

Appendix 2
What our regulators say about LCH

Statement from the Care Quality Commission
Our current rating of 'Requires Improvement' remains as LCH will not have a formal re-inspection due to the fact that the Trust is under transaction and therefore the requirement notices cannot be removed unless there is a repeat inspection of the Trust.

Other Regulators
The NHS Resolution (NHSR) handles claims made against NHS organisations and works to improve risk management practices in the NHS.

All NHS organisations in England can apply to be members of these schemes. Members pay an annual contribution (premium) to the relevant schemes, which is similar to insurance.
As part of this, all members of these schemes are subject to an assessment, based on 3 levels of compliance.

The NHSR has changed how they assess organisations and focus on a risk rating for Trusts which takes into account the previous finical year's claims and the evidence produced around lessons learnt from these cases. The Trust has a robust system and process to ensure lessons are learnt both at organisational and locality levels. The Trust are yet to be assessed by the new process.

Appendix 3
What our Commissioners and Healthwatch say about us:

Statement from Liverpool and South Sefton Clinical Commissioning Group

NHS South Sefton Clinical Commissioning Group

NHS Liverpool Clinical Commissioning Group

NHS Liverpool Clinical Commissioning Group
Quality Account Statement 2017/18
Liverpool Community Health

Liverpool and South Sefton CCGs welcome the opportunity to jointly comment on the Liverpool Community Health NHS Trust Draft Quality Account for 2017/18. It is acknowledged that the submission to Commissioners was draft and that some parts of the document require updating. Commissioners look forward to receiving the Trust's final version of the Quality Account.

It is noted that this is the final statement for the organisation due to the transaction of services into Mersey Care on 1st April 2018.

We have worked closely with the Trust throughout 2017/18 to gain assurances that the services delivered were safe, effective and personalised to service users. The CCGs share the fundamental aims of the Trust and support their strategy to deliver high quality, harm free care.

This Account indicates the Trust's commitment to improving the quality of the services it provides, with commissioners supporting the key priorities for the improvement of quality during 2017/18 which were:
Priority 1: Provision of support to staff in preparation for transfer to their new provider
Priority 2: Continued delivery of safe and effective services through established locality model
Priority 3: Smooth transfer of services to new providers

This report demonstrates progress within the Trust. It identifies where the organisation has done well, where further improvement is required and what actions are needed to achieve these goals.
Of particular note is the work the Trust has undertaken to improve outcomes on the following work streams:

- To support staff in transition, with continuous engagement, communication and support regarding the management contracts and appointment of Mersey Care as the new provider, in the form of engagement events.
- There has been continued delivery of safe and effective services through established locality models. It is of particular note that in October 2017, 1500 patients had been supported on the proactive pathway as part of avoiding admission to hospital, and as a result of this, admission levels to hospital have also fallen.
- The Trust has worked closely with Mersey Care to ensure services were transferred smoothly to the benefit of patients and staff.

The CCGs will be closely monitoring the ongoing work of the Pressure Ulcer Reduction Programme and developments in tissue viability awareness in the organisation going forward. The Trust had implemented a number of initiatives in relation to pressure ulcer reduction and has a comprehensive learning and competency framework assessment, which will continue into the new organisation.

The commissioners recognise that the Trust has undergone significant challenges during 2017/18, as it strives to improve the quality of care it delivers to patients. The commissioners also acknowledge the on-going challenges during 2018/19 regarding the transaction of services to a new provider of community services. It is well understood that during periods of transition and change, a strong focus on quality must be maintained in order to deliver positively experienced, safe and effective patient care.

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

It is acknowledged that this is the last Quality Account from Liverpool Community Health and that the priorities for 2018/19 will be reflected in the Mersey Care Mental Health and Community NHS Foundation Trust Quality Account submission, which will be responded to by Commissioners.

Liverpool CCG

Jan Ledward
Chief Officer
Date 23.5.18

South Sefton CCG

Fiona Taylor
Chief Officer
Date 21.05.18

Statement from Healthwatch Liverpool

Healthwatch Liverpool welcomes this opportunity to comment on the 2017-18 Quality Account for Liverpool Community Health NHS Trust. This commentary relates to the contents of a draft Quality Account document. The Trust became part of Mersey Care on 1st April 2018.

This commentary has also been informed by our ongoing engagement with Liverpool Community Health during 2017-18. We received feedback about the Trust through our information and signposting service, as well as via independent web-based resources such as www.careopinion.org.uk.
Additionally, in October 2017 Healthwatch Liverpool held Listening Events at the Old Swan, South Liverpool and Liverpool City Centre walk-in centres. At the latter venue we also spoke to people using the Abacus service, as it shares a waiting area with the walk-in centre. The feedback that we received from 112 people was mostly positive, especially about the staff and the services provided. There were a few, though not many, less positive comments, including about a lack of privacy by the reception desks at some sites.

Healthwatch Liverpool is assured that the Quality Account provides a good summary of the quality of services provided during 2017 -18. We recognise that this was not an easy year for Liverpool Community Health staff, and we are pleased to note that, despite this, progress was made on most of the priorities.
Understandably, there was a strong focus on ensuring that the change to a new provider ran smoothly, without interruption to services, and this remains a focus for 2018-19. Whilst the report feeds back on some of the 'business as usual' work carried out by the Trust in the past year, there are also some examples of initiatives leading to improvement, such as the implementation of a flu outbreak protocol for nursing homes and the pro-active care pathway, which have helped patients to avoid being admitted to hospital.

We welcome that a reduction in pressure ulcers remains a priority, especially in light of the increase in Grade 4 community acquired pressure ulcers in Liverpool.
With Liverpool community health services now having joined Mersey Care, we also welcome that one of next year's priorities is to ensure that all staff will be trained in suicide awareness.

The Trust serves and is staffed by people from diverse communities, and Healthwatch was pleased to see that reflected in the document. Examples such as those given about the work carried out to support people with a learning disability or people with vision impairments show some of the work that the Trust carries out to ensure its services are equitable for all patients in a clear and informative way.

Although not all priorities were met, overall we are of the view that the documents show that the Trust is continuing to improve the quality of its services.
With community health services now having become part of Mersey Care there is a unique opportunity to provide more holistic care to people and to help improve both their physical and mental health and wellbeing. Healthwatch Liverpool is looking forward to ongoing regular engagement with the Trust in 2018-19 in order to be able to monitor the progress of both quality and equality considerations for its services provided in Liverpool.

Statement from Liverpool Overview and Scrutiny Committee
Final copy only requested.

Appendix 4
Glossary

AMU	Acute Medical Unit
AHP	Allied Health Professional
AN	Ante Natal
CAUTI	Catheter Acquired Urinary Tract Infections
CCG	Clinical Commissioning Group
CDI	Clostridium Difficile Infection
CDOP	Child Death Overview Panel
CHC	Continuing Health Care
CPR	Cardiopulmonary Resuscitation
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation
CSU	Commissioning Support Unit
CYPHS	Children's and Young Persons Health Service Information Data Set
DATIX	Patient Safety and Risk Management Software
DH	Department of Health
DN	District Nurse
DNACPR	Do Not Attempt Cardio Pulmonary Resuscitation
DoC	Duty of Candour
DVT	Deep Vein Thrombosis
EDS	Equality Delivery System
EMIS	Egton Medical Information System
FFT	Friends and Family Test
GSF	Gold Standard Framework
GP	General Practitioner
HCP	Healthy Child Programme
HCAI	Healthcare Associated Infections
HQIP	Healthcare Quality Improvement Partnership
HPV	Human Papillomavirus
HSCIC	Health and Social Care Information Centre
HSMR	Hospital Standardised Mortality Rate
ICCT	Intensive Community Care Team
ICE	Integrated Clinical Environment
ICO	Information Commissioning Office

IG	Information Governance
IV	Intravenous
KPI	Key Performance Indicator
LCCG	Liverpool Clinical Commissioning Group
LCH	Liverpool Community Health NHS Trust
MAU	Medical Assessment Unit
MDT	Multidisciplinary Team
MIAA	Mersey Internal Audit Agency
MRSA	Methicillin-Resistant Staphylococcus Aureus
NAIC	National Audit of Intermediate Care
NCAPOP	National Clinical Audits and Patient Outcomes Programme
NHS	National Health Service
NHSE	NHS England
NHSI	NHS Improvement
NICE	National Institute for Health and Care Excellence
PALS	Patient Advice and Liaison Service
PE	Pulmonary Embolism
PIR	Post Infection Review
PURPLE	Pressure Ulcer Reduction Programme Learning and Education
PREM	Patient Reported Experience Measure
RAG	Red, Amber or Green
RCA	Root Cause Analysis
SALT	Speech and Language Therapy
SHMI	Summary Hospital-level Mortality Index
SIRO	Senior Information Risk Owner
SI	Serious Incident
SINE	Serious Incident/Never Event
SMART	Specific, Measurable, Achievable, Realistic and Timely
SLA	Service Level Agreement
SPCT	Specialist Palliative Care Team
STARS	Supportive and End of Life Care Service
STEIS	Strategic Executive Information Systems
TDA	Trust Development Authority
TUPE	Transfer of undertaking protection of employment regulations (2006)
uDNACPR	Unified Do Not Attempt Cardio-Respiratory Resuscitation
UC24	Urgent Care 24
V&I	Vaccinations and Immunisations

VoED	Verification of Expected Death
VTE	Venous Thromboembolism
WIC	Walk In Centers
WTE	Working Time Equivalent
5YFV	Five Year Forward View

Trust Headquarters
Liverpool Community Health NHS Trust,
2nd Floor Liverpool Innovation Park,
Digital Way, Liverpool
L7 9NJ
0151 295 3000
www.liverpoolcommunityhealth.nhs.uk

Follow us on Twitter: @nhsliverpoolch
Follow us on Facebook.com/nhsliverpoolch