Outstanding ☆

Mersey Care NHS Foundation Trust

Learning Disability and Autism Secure Services

Quality Report

V7 Building
Kings Business Park
Prescot
Liverpool
L34 1PJ
Tel: 0151 473 0303
Website: www.merseycare.nhs.uk

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Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RW41P	Specialist Learning Disability Division	Woodview Ward 1 Woodview Ward 2 Woodview Ward 3 Maplewood: Coniston and Grasmere Maplewood: Newton and Slaidburn Maplewood 2 Maplewood 3 West Drive LSU 2 West Drive 3 West Drive Ravenswood (Stepdown) Moor Cottage North Lodge	BB7 9PE

Summary of findings

		Pendle Drive Trentville	
RW4X6	Gisburn Lodge	Gisburn Lodge	BB7 4HX
RW4X8	Inpatient Secure Daisy Bank	Daisy Bank	LA1 3JW
RW4X9	Inpatient Secure North Lodge	North Lodge	LA1 5AH
RW4X5	Scott House	Scott House	OL11 5QR

This report describes our judgement of the quality of care provided within this core service by Mersey Care NHS Foundation Trust. Where relevant we provide detail of each location or area of service visited.

Our judgement is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from people who use services, the public and other organisations.

Where applicable, we have reported on each core service provided by Mersey Care NHS Foundation Trust and these are brought together to inform our overall judgement of Mersey Care NHS Foundation Trust.

Summary of findings

Ratings

We are introducing ratings as an important element of our new approach to inspection and regulation. Our ratings will always be based on a combination of what we find at inspection, what people tell us, our Intelligent Monitoring data and local information from the provider and other organisations. We will award them on a four-point scale: outstanding; good; requires improvement; or inadequate.

Overall rating for the service	Outstanding ☆
Are services safe?	Good ●
Are services effective?	Outstanding ☆
Are services caring?	Outstanding ☆
Are services responsive?	Outstanding ☆
Are services well-led?	Good ●

Mental Health Act responsibilities and Mental Capacity Act / Deprivation of Liberty Safeguards

We include our assessment of the provider's compliance with the Mental Health Act and Mental Capacity Act in our overall inspection of the core service.

We do not give a rating for Mental Health Act or Mental Capacity Act; however we do use our findings to determine the overall rating for the service.

Further information about findings in relation to the Mental Health Act and Mental Capacity Act can be found later in this report.

Summary of findings

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Summary of findings

Overall summary

We rated learning disability and autism secure services as outstanding because:

- Staff were highly skilled at anticipating and de-escalating behaviour that might have led to violence or self-harm.The trust had trained its staff to use effective de-escalation techniques. Staff developed, applied and reviewed good positive behavioural plans; especially for patients who were individually nursed. As a result, staff used physical restraint and other restrictive interventions on many fewer occasions than in the past.
- Person-centred therapeutic interventions were being delivered to patients to support them to achieve improved independence and wellbeing. There was a wide variety of activities available to patients both on and off site. Information in a variety of formats had been developed to ensure that it was easy for patients to communicate and to express their needs. All patients had access to a wide range of social, recreational, therapy based interventions, and a recovery college called 'our shared college'. Individualised care had been adapted to meet patients' specific communication needs. All patients had received input from speech and language therapists where necessary to ensure their communication needs were met.
- Staff ensured patients and relatives were engaged with assessments, care plans and discharge arrangements. Patients were involved in developing their own care plans and staff provided them with copies which were in an 'easy read' format to meet their needs.
- The service was proactive in promoting equality and diversity and meeting the specific needs of vulnerable groups of patients. The service had introduced a health awareness and improvement initiative called 'Dr Feel Well'. This project aimed to improve patients' physical health by the use of patient education, guidance and encouragement.
- Interactions between staff and patients demonstrated personalised, collaborative, recovery oriented care planning and involvement. All patients had a moving on plan, which the individual and other stakeholders had developed collaboratively. Some patients had been involved in filming a number of short videos about the wards with the trust's patient led media crew.These videos were available online to help new patients know what to expect from admission and the transforming care agenda.
- Comprehensive risk assessments for patients were completed and reviewed. Patients' individual care and treatment was planned and best practice guidance was implemented, ensuring outcomes were monitored and reviewed.
- Staff had an understanding of the Mental Capacity Act 2005 and the Mental Health Act 1983. They assessed mental capacity and enabled patients to make decisions where possible. Staff routinely referred patients for advocacy support if they lacked the capacity to do so themselves.
- Staff received mandatory training, specialised training, supervision and appraisals. Staff had knowledge and skills to deliver effective care and treatment. Staff received support, appraisals, mandatory, specialist training, and supervision from their managers and peers. There was an ongoing recruitment programme to fill vacancies and managers ensured that bank and agency staff were familiar with the service and patients. The division monitored and adjusted staffing levels daily in response to risk on the wards and monitored and reviewed their divisional risk register.
- Patients were protected and safeguarded from avoidable harm and incidents were appropriately reported to the local authority. Staff had received training in safeguarding and mandatory training compliance levels for staff were good.
- Patients and their carers were positive about the care and treatment they received and staff behaviours were responsive, respectful and caring. Staff involved patients and their carers in the care and treatment they received.
- The autism risk group provided a proactive, creative and dynamic approach based on best practice

guidance and psychosocial approach to risk, engaging all patients that attended in self-discovery. There was an established championing recovery meeting co-produced with patients and facilitated monthly. Patients attended as designated recovery champions for their wards to share ideas and plan new recovery focused activities from their perspective. Staff empowered patients to have a voice. Patients reported their opinions and views were listened to and considered by staff in all aspects of their care.

- The management and governance arrangements within the division were effective.
- Managers were able to provide information into the governance meetings and staff received regular feedback from these meetings. They were kept up to date about the trust and wards' performance.

Summary of findings

The five questions we ask about the service and what we found

Are services safe?

Good

We rated safe as good because:

- All wards were clean and equipped to a high standard. All furnishings were in good order and the environment was safe for patient use.
- Staffing levels on every ward were appropriate to meet the needs of patients. Ward managers had adequate resources to employ regular bank staff who were known to patients and staff. As a result, section 17 leave and other activities were rarely cancelled.
- Overall, the core service mandatory training compliance figure was 90% against a trust target of 90%.
- Risk assessments were completed for all patients. These had been developed collaboratively with patients. An easy read version was used to discuss and explain risk issues to patients.
- Each ward had a structured hand over routine, focussing on specific risks and positives about each patient. Relevant incidents, lessons learnt and other important information was clearly disseminated during hand over meetings.
- A new initiative had been introduced to reduce the amount of physical restraints, seclusions and the use of intramuscular medication. Staff were trained to use effective de-escalation techniques, which had greatly reduced the number of restrictive interventions.
- There was an incident reporting system in place that all staff knew how to use. Following incidents de-briefs were offered to all staff and patients involved. The service promoted restorative practice to address issues between patients. This meant that patients were encouraged to take ownership of problems and seek solutions.

Are services effective?

Outstanding

We rated effective as outstanding because:

- All care plans were extremely holistic, personalised and recovery orientated. Care plans contained highly detailed patient information that had been developed collaboratively and included the patient's views.
- The positive behaviour support model was fully embedded in the service. All patients had positive behaviour support plans, which had been completed with multi disciplinary input to support patients with learning disability and challenging behaviour.

Summary of findings

- Psychological support was widely available and delivered in a variety of formats to meet individual needs. Psychological interventions and formulations were an intrinsic part of assessments, care plans, positive behaviour support plans and multi disciplinary meetings.
- All patients' physical health care needs were addressed on admission and highlighted within care plans. There were specific learning disability health assessment screening tools to support staff to deliver health care that was appropriate for the patient group and meeting national standards. There was a health promotion programme aimed at educating patients regarding healthy lifestyles and diets.
- The electronic record system was of excellent design allowing staff to easily find relevant patient care records in order to deliver care safely. Documents were always stored correctly meaning information was readily available.
- Staff had a sound knowledge and understanding of the 'stopping the over medication of people with learning disabilities or autism' agenda. Medication was not prescribed to manage challenging behaviour unless all other interventions had failed. Medication was reviewed regularly in line with national guidelines.
- Staff were highly skilled in specialist learning disability and autism care. Staff received a wide range of additional training to ensure they had the skills to promote best practice in treatment and care for patients with learning disability. In the last 12 months, staff had completed 2477 additional specialist training courses.
- Staff supervision and appraisal rates were high throughout the service at 86% and 90% respectively.
- The service employed a wide range of mental health and learning disability staff who were accessible to all wards. Staff disciplines included occupational therapists, social workers, psychologists, pharmacists, and doctors of various grades. Each discipline was able to input into the multi disciplinary meetings and care planning process to promote holistic care.
- The service had strong links with third sector organisations and promoted collaborative working for patients approaching discharge. The service provided patient specific bespoke training to external providers to ensure the transition of care was a safe process.
- Staff maintained Mental Health Act documentation to a high standard. The service had greatly improved the recording of

Summary of findings

detained patients' rights being explained to them. Also, the recording of patients' section 17 leave, including the outcome of leave and the patient's views, had improved to meet the required standard.

- Mental Capacity Act assessments and processes were followed robustly for all patients who may lack capacity. Mental capacity assessments were comprehensive and detailed patient's views and opinions. Staff understood the procedure for following the best interest checklist and outcomes were clearly recorded.

Are services caring?

Outstanding 

We rated caring as outstanding because:

- Patients reported that staff treated them very well. Patients described staff as being kind and helpful and having their best interests at heart. Patients spoke about staff endeavouring to ensure patients' needs were met and going the extra mile.
- We observed many positive interactions between staff and patients. This included staff using specific communication techniques to speak to particular patients. Staff displayed caring and respectful attitudes towards patients at all times.
- Patients were heavily involved in many aspects of the service. This included being active partners in their own care.
- Staff empowered patients to have a voice. Patients reported their opinions and views were listened to and considered by staff in all aspects of their care.
- Patients embarked on learning journeys with other patients and staff, allowing coproduced learning and the breaking down barriers and stigma.
- Patients were involved in service improvements through various forums such as a monthly 'speak up' group and patient community meetings. Patients' views were captured and considered on all new service initiatives.
- Patients had opportunities for learning and work opportunities within the trust through 'our shared college'.
- The service promoted the 'triangle of care' best practice in mental health care for the inclusion of carers. Each ward had a named carer's champion link person.

Are services responsive to people's needs?

Outstanding 

We rated responsive as outstanding because:

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- Some patients had been involved in filming a number of short videos about the wards with the trust's patient led media crew. These videos were available online to help new patients know what to expect from admission and the transforming care agenda.
- There was robust support in place for patients both pre and post discharge. Discharge plans were comprehensive and included the patient and future provider. This meant that patients were more likely to successfully move on to community settings.
- There was a wide variety of activities, courses, individual and group therapies available to patients both on and off site. Activity levels were recorded and met or exceeded the target for 25 hours of meaningful activity per patient per week.
- The trust's 'our shared college' provided opportunities for patients to learn new skills, gain accredited qualifications, meet new people and socialise as well as being involved in various groups.
- There was an established championing recovery meeting co-produced with patients and facilitated monthly. Individuals attended as designated recovery champions for their wards to share ideas and plan new recovery focused activities from their perspective.
- The service was proactive in promoting equality and diversity and meeting the specific needs' of vulnerable groups of patients. The trust provided a support group 'The Avenue' for patients who were lesbian, gay, bisexual or transgender as well as a women's action group for example.
- Staff had provided information in a variety of formats to ensure that it was easy for patients to communicate and to express their needs as well as complain or raise a concern.
- Information about the service and individual care had been adapted to meet patients' specific communication needs. All patients had received input from speech and language therapists where necessary to ensure their communication needs were met.
- All patients had a moving on plan, which the individual and other stakeholders had developed collaboratively. Care and treatment reviews had been completed in line with NHS England's commitment to transforming services for patients with learning disabilities, autism or both.

Are services well-led?

We rated well led as good because:

Good

Summary of findings

- Staff were aware of the trust's vision and values.
- The wards had a strong identity and were committed to enabling people with a learning disability achieve improved independence, wellbeing and recovery.
- Managers attended divisional governance meetings, and received regular feedback on the wards performance of which was closely monitored with the aim to improve the services and drive improvement. The trust leadership has implemented and overseen ongoing changes across all of its services and have continued to improve the care and treatment of the patients in the service.
- The management were regularly reviewing the divisional risk register and had a good oversight of the risks with action plans in place.
- The organisation was working with other stakeholders, and commissioners of services to
- identify the current and future risks and to put systems in place to monitor and address the ongoing transforming care agenda.
- Staff received regular supervision, training and appraisals.
- Staff were supported by their managers and team members and had regular handovers to update them on the patients on a daily basis.
- Managers at team level were able to submit items onto the risk register and these were regularly reviewed and actioned.
- The ward staff were committed to quality improvement and innovation.

Summary of findings

Information about the service

Mersey Care NHS Foundation Trust provides specialist learning disability services predominantly across the North West of England including areas of Lancashire, Greater Manchester and South Cumbria. Prior to July 2016, Calderstones Partnership NHS Foundation Trust ran the service.

The service supports patients with a learning disability who require treatment in specialist and secure services, including those with forensic needs and those who present with severe, enduring challenging behaviour. At the time of our inspection, all of the patients were detained under sections of the Mental Health Act 1983. The service had 19 wards for medium and low security as well as step down and enhanced facilities. The majority of wards were located within the Whalley site and four wards were in Lancaster, Gisburn and Rochdale.

The medium secure wards were:

- Woodview 1 (six beds for female patients)
- Woodview 2 (12 beds for male patients)
- Woodview 3 (12 beds for male patients)
- Gisburn Lodge (16 beds for male patients, located in Gisburn)

The low secure wards were:

- Maplewood (Coniston and Grasmere) (12 beds for female patients)
- Maplewood (Newton and Slaidburn) (12 beds for female patients)
- Maplewood 2 (16 beds for male patients with learning disability and mental health needs)
- Maplewood 3 (16 beds for male patients with learning disability and personality disorder)
- West Drive (15 beds for male patients and five beds for female patients)

The step down wards were:

- Ravenswood (two beds for female patients)
- 3 West Drive (15 beds for male patients)

The enhanced support wards were:

- Scott House (15 beds for male patients, located in Rochdale)
- North Lodge, (four beds for male patients, located in Lancaster)
- Daisy Bank, (one bed for a male patient, located in Lancaster)
- 2 West Drive (12 beds for male patients)

The trust also provides individual packages of care for patients with learning disabilities and autism who have complex needs. These individuals would find it difficult to live with other people. The services are in houses within the Whalley main site or on the outskirts of the site. We inspected the individualised services at:

- Pendle Drive (one bed for a male patient)
- Moor Cottage (one bed for a male patient)
- Trentville (one bed for a male patient)
- North Lodge (one bed for a male patient)
- Scott House (one bed for a male patient based in Rochdale)

The patients cared for in these services are funded through NHS England specialist commissioners and clinical commissioning groups.

When we inspected Calderstones Partnership NHS Foundation Trust in October 2015, we rated forensic inpatient/secure wards as good overall. We rated this core service as good for safe, effective, caring, responsive and well led. We rated wards for patients with learning disability or autism as good overall with requires improvement for safe.

We issued Calderstones Partnership NHS Foundation Trust with one requirement notice for wards for patients with learning disabilities. This related to regulations under the Health and Social Care Act (Regulated Activities) Regulations 2014, Regulation 18 relating to staffing. We found that staff were not adequately trained in life support.

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Following that inspection we told Calderstones Partnership NHS Foundation Trust that it must take the following actions to improve:

- The provider must ensure that staff attend the life support training to the trust's required level of 80%.

We also told Calderstones Partnership NHS Foundation Trust that it should take the following actions to improve:

- The provider should ensure that all staff receive an annual appraisal.
- The provider should continue to review night time staffing arrangements whilst recruiting the additional band 5 nurses.
- The provider should ensure that staff receive regular supervision and that this is documented.
- The provider should ensure that staff and patients are debriefed following a difficult incident and evidence is available to confirm they have taken place.
- The provider should ensure that regular staff meetings take place to enable staff to share information, ideas and experiences.
- The provider should ensure that staff receive all required information during handovers.
- The provider should ensure that the training in prevention and management of violence and
- aggression reaches the trust target of 80% attendance.
- The provider should date the actions on the environmental risk assessments to enable monitoring and progress of the actions.
- The provider should ensure that staff understand the MCA and their role in relation to the Act.
- The provider should review the spiritual support available to patients and ensure that staff are aware of the provision to increase access.
- The provider should ensure that staff on Maplewood 1 and 2 allocates dedicated staff members to respond to activated alarms.

On this inspection, we checked whether Mersey Care NHS Foundation Trust had taken action on these issues. We found that the requirement notice had been fully met by Mersey Care NHS Foundation Trust.

Our inspection team

The team was led by:

Head of Inspection: Nicholas Smith, Head of Hospital Inspection, Care Quality Commission

Team Leaders: Lindsay Neil and Sharon Marston, Inspection Managers, Care Quality Commission

The team that inspected this core service comprised: five Care Quality Commission inspection staff, two national advisors, three qualified nurses who were specialist advisors, one expert by experience and one CQC Mental Health Act reviewer. A CQC pharmacy inspector also attended for one day of the inspection week.

Why we carried out this inspection

We undertook an announced focused inspection of Mersey Care NHS Foundation Trust because there had been a significant change in the trust's circumstances. The trust had acquired Calderstones NHS Foundation Trust on 1 July 2016.

We also planned this inspection to include high secure services (a new core service) and to assess if the trust had addressed some of the areas where we identified breaches of regulation at our previous inspection in June 2015 (published October 2015).

Summary of findings

How we carried out this inspection

To fully understand the experience of people who use services, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

We inspected Mersey Care NHS Foundation Trust's specialist learning disability and autism forensic inpatient wards as one specialist core service. We carried out an announced inspection on the 8 March 2017 and 20 to 24 March. We carried out an unannounced inspection on 30 March 2017 to the Whalley site.

Before the inspection visit, we reviewed information that we held about these services, asked a range of other organisations for information and attended nine meetings. These included:

- community meetings
- an autism risk group
- a speak up group
- a service user involvement group
- family and carer group
- the Avenue (LGBT)
- women in secure hospitals
- no force first.

During the inspection visit, the inspection team:

- visited all 19 of the wards at the four hospital sites and looked at the quality of the ward environment and observed how staff were caring for patients
- spoke with 44 patients who were using the service
- spoke with the managers or acting managers for each of the wards
- spoke with 78 other staff members; including doctors, nurses, occupational therapists, psychologists and social workers
- spoke with the chief operating officer with responsibility for the service
- attended and observed three multi-disciplinary meetings
- collected feedback from two patients using comment cards
- spoke with five carers of patients who were using the service
- looked at 55 treatment records of patients
- looked at 47 prescription charts
- observed specific patient and staff interactions on five wards
- looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the provider's services say

We spoke to 44 patients and five family members and received two comment cards from patients. We also attended many group sessions where patients attended.

Patients told us that staff were respectful, caring, kind and understanding. They also told us that staff were interested in their wellbeing and about staff being involved and being supportive of them.

They told us that they felt safe on the wards. Carers and family members we spoke with felt their family members were safe and they were involved in their care where necessary. They felt the staff were helpful and they could contact the wards at any time if they had a concern or problem.

Most patients we spoke with said they were fully involved in the care they received and had information about the ward and information about their rights. Most said they were involved in decisions about their care and had been involved in discussions about their care plans. They also said they had access to an advocate.

Most patients we spoke with said they were involved in lots of activities and groups and there were enough staff and that activities were rarely cancelled. Although some said the activities were sometimes cancelled, these were usually rearranged.

Summary of findings

The patients we talked with explained that they were involved in and informed about the service by the 'speak up' groups they attended. Information was made available to them in accessible formats to meet individual needs.

Patients told us that there were many ways for them to ask questions or raise concerns which included community meetings, newsletters and the speak up group.

Others raised concerns about the food on the wards and not being paid for meaningful work. Some patients described their concerns about moving on whilst others were positive but unhappy with the delays.

Good practice

- There was good practice and application of positive behavioural plans. These were especially comprehensive for patients who were individually nursed.
- The autism risk group provided a proactive, creative and dynamic approach based on best practice guidance and psychosocial approach to risk, engaging all patients that attended in self-discovery.
- There was an established championing recovery meeting co-produced with patients and facilitated monthly. Patients attended as designated recovery champions for their wards to share ideas and plan new recovery focused activities from their perspective.
- The service had introduced a health awareness and improvement initiative called 'Dr Feel Well'. This project aimed to improve patient's physical health by the use of patient education, guidance and encouragement.
- All patients had access to a wide range of social, recreational and therapy based interventions and a recovery college called 'our shared college'.
- Accessible information, aids and adaptations to meet communication needs were individually tailored to enable all patients to have a voice and be involved in their own care and treatment.
- Patients had been involved in filming a number of short videos about the wards with the trust's patient led media crew. These videos were available online to help new patients know what to expect from admission and the transforming care agenda.
- The service was proactive in promoting equality and diversity and meeting the specific needs' of vulnerable groups of patients.

Mersey Care NHS Foundation Trust

Other specialist services

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Woodview Ward 1 Woodview Ward 2 Woodview Ward 3 Maplewood: Coniston and Grasmere Maplewood: Newton and Slaidburn Maplewood 2 Maplewood 3 West Drive Low Secure Unit 2 West Drive 3 West Drive Ravenswood (Stepdown) North Lodge Moor Cottage Pendle Drive Trentville	Specialist Learning Disability Division
Gisburn Lodge	Gisburn Lodge
Daisy Bank	Inpatient Secure Daisy Bank
North Lodge	Inpatient Secure North Lodge
Scott House	Scott House

Mental Health Act responsibilities

We do not rate responsibilities under the Mental Health Act 1983. We use our findings as a determiner in reaching an overall judgement about the Provider.

Staff were trained in the Mental Health Act and Code of Practice and all of the wards were above the trust mandatory training figure of 90% in this training. Staff

demonstrated a good understanding of the Mental Health Act and how this applied to their roles. Staff were kept updated regarding any amendments to the Mental Health Act by bulletins via email.

Staff maintained Mental Health Act documentation to a high standard. Patient's section 132 rights were explained to them regularly and documented clearly with the care record. Patient's section 17 leave also clearly recorded and included the outcome of leave and the patient's views.

A Mental Health Act administration team were based within the service. The Mental Health Act administration team regularly completed audits regarding Mental Health Act documentation and reported findings to the senior management team.

Patients had access to independent mental health advocates who visited each ward on a weekly/ monthly basis or as required. Information about the independent mental health advocacy service was clearly displayed in ward areas. Staff were aware of how to refer patients to advocacy services.

Mental Capacity Act and Deprivation of Liberty Safeguards

Staff were trained in the Mental Capacity Act and Deprivation of Liberty Safeguards, which was part of the mandatory training programme. Staff had an excellent understanding of the Mental Capacity Act and how this was applied in practice. An audit completed in February 2017 found that 80% of staff understood the Mental Capacity Act.

Mental capacity assessments were completed to a high standard. They were detailed, decision specific and the reason for lacking capacity was clearly summarised. Capacity assessments had been completed for all decisions where a patient may lack capacity. The best interest checklist was followed and decisions included the patient's views, wishes and background.

Good

Are services safe?

By safe, we mean that people are protected from abuse* and avoidable harm

* People are protected from physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse

Our findings

Safe and clean environment

All of the wards were clean and tidy and the furniture was in good condition. Domestic staff kept their equipment in locked cupboards and we saw cleaning schedules that were completed and up to date which demonstrated the wards were cleaned regularly. Infection control procedures were in place and the wards had an identified infection control lead. There was hand cleaning gel outside all of the wards we visited and staff prompted visitors to use the hand gels before accessing the wards.

Patient-led assessments of the care environment checks had been completed for inpatient areas. These were self-assessments undertaken by teams including NHS staff and at least 50 per cent members of the public or patients (known as patient assessors). They focus on different aspects of the environment in which care is provided, as well as supporting non-clinical services such as cleanliness. In relation to the environment, patient-led assessments of the care environment data looked at cleanliness, condition, appearance, maintenance, and dementia friendly. In 2016, the assessments highlighted for the first time how well the premises from healthcare providers were equipped to meet the needs of people with disabilities. The most recent patient-led assessments of the care environment were carried out when the services were previously managed by Calderstones Partnership NHS Foundation Trust before transferring to Mersey Care NHS Foundation Trust in July 2016. Overall, Calderstones Partnership NHS Foundation trust scored better than the England average in all three comparable areas including 'cleanliness' (99%), 'condition, appearance and maintenance' (98%) and 'disability' (96%). All sites received a better than average score for all areas particularly for 'cleanliness' where Scott House, Gisburn Lodge and Lancaster service all received a score of 100%. When comparing the trust's overall scores achieved in relation to the environment in 2016, there were small increases in both comparable areas. The largest increase was seen in relation to 'condition, appearance and maintenance' by four percentage points, followed by 'cleanliness' at one percentage point. Our inspection of the ward areas confirmed that Mersey Care NHS Foundation Trust was maintaining the high standards reached during the 2016 patient-led assessments of the care environment assessments.

The layout of the some wards did not allow staff to fully observe all parts of the wards. However, this was mitigated by use of risk assessments, mirrors, regular checks and good relational security arrangements. The layout of West Drive low secure unit did not allow staff to observe all parts of the ward. During the inspection, we checked records, which confirmed curved mirrors had been ordered to be fitted in the corridors to improve observations and a date for fitting had been arranged. All wards had access to ligature cutters and the availability of these was checked daily.

At Scott House, there was obscured glass fitted in some of the patients' bedrooms. Although this provided some privacy, it did not allow the patients to look out into the surrounding countryside. This was discussed with the manager and during the inspection; they immediately sought quotes and planned for the work to be completed to ensure patients could see out without their privacy being compromised.

Maplewood 1 (Coniston and Grasmere) was overlooked by neighbouring homes due to trees having been felled. The manager of the ward had raised this with more senior managers within the trust due to the privacy of the female patients being compromised. The trust had responded to this and ordered a privacy fence during the inspection week with plans for fitting confirmed.

All of the wards complied with the guidance on same sex accommodation. Patients had lockable

spaces to store their possessions in their rooms.

The wards had access to fully equipped clinic rooms and had accessible resuscitation equipment with signage identifying the location. Access to emergency medication was held at central points (reception areas) throughout the main site in Whalley.

All wards have had an environmental suicide risk assessment undertaken in the last 12 months, which was supported by updated management plans. When ligature

points had been highlighted as a risk, an action plan was produced to remove or manage the risk locally on the wards. Staff were made aware of the ligature points and these had been discussed within their team meetings and some within their supervision meetings. The ligature risk assessments were completed by a specialist advisor link and peer from another ward to provide an objective view as part of ongoing quality review visits. The trust had an on-going programme of refurbishment in order to reduce the amount of ligature points within inpatient areas.

The trust divisional risk register identified a risk that if the ligature anchor points were not managed appropriately then this may result in patient safety incidents occurring. There was also an identified risk in relation to secure wards at Whalley site regarding the risk of patients climbing on fixed objects within secure services. The trust had measures in place to mitigate these and the divisional risk manager informed us that patients were observed in these areas at all times.

The 27 identified risks at the time of the inspection were reviewed by the trust weekly at a surveillance meeting.

There was good evidence of physical security in all the wards and units. In the reception, areas of the medium and low secure wards, the staff signed in using a fob system. On the other wards, staff and patients signed in and out confirming who was in the building at any time. Staff collected keys and personal alarms from the reception on entering the secure buildings and gave them back in as they left. Entrance to the wards for visitors, staff and patients was via an airlock in the medium and low secure wards. There were procedures and checks to ensure that the alarms and keys were safely managed. There was evidence on all the wards that a security nurse who was a dedicated member of staff on each shift checked the physical security of the building and relational arrangements.

Safe staffing

Mental health trusts are required to submit monthly safer staffing reports and undertake six-monthly safe staffing reviews led by the director of nursing. This is required to monitor and ensure adequate staffing levels for patient safety. The trust used the 'Telford Model of Professional Judgement', to agree the most appropriate size and mix of ward nursing establishment. This approach was both consultative and engaging; calculating registered and unregistered staffing requirement hour by hour over a 24-hour period. This then converted the requirement into whole time equivalents and mapped planned staffing requirements against current budgets to identify any variance.

Staffing levels were measured daily on each ward against the actual staff on shift by the senior operational team and the senior operational manager for therapies and patient experience who was present at the daily handover to ensure that patient activities went as planned. The division had a 'real time staffing' app which measured planned and actual staffing using information from the division's E-rostering system.

Shift leaders were identified daily on each ward. There was a daily morning meeting where they would check that staffing levels matched the identified need. Any issues around staffing were escalated immediately to an operations manager. Shift leaders would identify staff roles and responsibilities on the wards and reported any issue where staff sickness or deficiencies of staff occurred. This was to ensure any staff shortages were highlighted and the wards were safe. A weekly staffing group monitored staffing and safety on wards, sickness rates and use of bank and agency staff were also reported by the divisional team. Staff were moved to other wards if required based on the need of the ward. The wards had introduced a twilight shift 12 am-12pm where an additional staff member was allocated to each ward.

The division had staff allocated to the bronze and silver on call in the division who were notified twice daily about the current staffing situations. Where there were issues with sickness or bank/agency staff not arriving for shifts then staff were redeployed accordingly to cover immediately.

The trust informed us that the overall staffing planned against actual staffing levels each month was above 100%.

This evidenced the trust were meeting the requirements for safe staffing levels for inpatient services by the current safer staffing guidance, which had been designed to support decision makers at ward and service level.

Learning disability forensic secure wards had 491 whole time equivalent substantive staff with a 28% turnover.

The trust provided whole time equivalent nursing staff vacancy figures month on month for the 12 months prior to inspection. These showed vacancies for unqualified staff had decreased over this time period. The vacancy figure

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peaked in month four at 54 and month five at 56 over the 12 month period. However, in the three months prior to inspection (month 10, 11 and 12), the number of vacancies for unqualified staff was lowest at 21, 19 and 16 respectively.

At the time of inspection, Ravenswood had the lowest unqualified vacancies followed by Scott House. These services were over staffed by eight and three unqualified staff respectively.

Woodview low secure unit had the highest unqualified staff vacancies at six followed by Woodview ward 3 with four.

The whole time equivalent vacancy figure for qualified staff had increased over the 12 months prior to inspection. The figure was lowest for month two at 18. Between month five and 12, it fluctuated between 40 and 45. Ravenswood, Moor Cottage, Pendle Drive and Trentville all had no qualified staff vacancies and West Drive had the highest at nine followed by Woodview ward 2 which had five.

Despite the challenges, the service faced with recruitment and retention of staff due to the uncertainty about the future plans of the hospital division. We found that this was being managed effectively with the use of regular bank and agency staff. There was no evidence to indicate that staffing levels had negatively affected the quality of patient care.

The trust had identified a risk on their register in 2015 at Calderstones and this was then placed onto the overall Mersey Care risk register. The risk related to unsafe staffing levels and reported: 'As a result of the ward staffing establishment and additional staffing being unable to meet the staffing requirements of inpatient wards at times of increased clinical need, there was a risk that staffing levels on the ward would be below what was clinically required which may impact on patient to staff experience and/or safety and training'. This risk was now rated as green and remained on the overall trust risk register with a review date in place. The risk was overseen by the trust risk management team.

Staff sickness rates ranged from 3.5% to 27% across the teams from September 2016 to February 2017. The teams had an overall sickness rate of 7.4%.; Maplewood (Newton and Slaidburn) reported the highest sickness rate of 27% and 21% respectively. There had been an upward trend in sickness rates. This was discussed with the management team at Whalley and was being managed on a daily basis and shifts filled with bank and regular agency staff to ensure safety was maintained on all of the wards. In addition, the team has a vacancy rate of 26% at Gisburn Lodge that being the highest on the wards and minus 5.50% (over establishment) on North Lodge ward for the same period. The trust had identified this on their divisional risk register and this was being monitored daily and weekly and reviewed by the risk management team weekly.

The trust provided staffing data as the number of hours and not as the number of shifts due to using two different systems because of the transfer of services from Calderstones NHS Foundation Trust.

From January to December 2016 across all wards, the bank usage to cover sickness, absence or vacancies was 130,087 hours, agency staff covered 115,218 hours. There were a total of 72,818 hours, which were unable to be filled by bank or agency staff. We were unable to translate this into more meaningful data, for example into the number of unfilled shifts, because the trust told us that the length of a shift at the trust varied so an accurate representation of a shift could not be calculated.

Maplewood 2 ward used the highest number of bank staff with bank staff covering 13,725 hours, Woodview ward 3 followed with 12,662 hours filled. West Drive low secure unit had used the most agency staff to cover 22,489 hours.

Where possible the trust avoided the use of agency workers and attempted to fill the required shifts with bank nurses. The trust block booked the same agency staff and regular agency staff on the wards so that patients could become familiar with them. Staff told us that the wards were rarely short staffed and patients did not raise staffing levels as a concern. Managers on the wards reported that where they needed additional staff or where there had been an increase in observation levels, they allocated staff in a timely way to maintain safety on the wards. There were instances where some activities or leave had been rearranged however, this was reported as minimal by the trust. The trust monitored any cancellations of activities and leave. Some patients reported some activities had been rearranged however: patients told us there were many activities on offer. The trust cancelled 22 activities in September 2016 out of 2226 activities delivered. In October 19 were cancelled out of over 3000 activities and in December six out of 1000 activities were cancelled. Patients had a named nurse and received regular 1-1 time.

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The trust confirmed that all bank staff completed the trust induction and were trained in the same level of conflict resolution and personal safety as substantive staff.

The trust reported there was still an issue regarding the employment and the recruitment of staff into advertised posts for registered nurses who were band five and six. The trust was addressing some of the national recruitment issues by providing training to nurses to address specialised learning disability training needs. They were also providing additional training for support staff in this area.

As at 21 January 2017, the core service mandatory training compliance figures ranges were 90% against a trust target of 90%. The data submitted via each ward dashboard for January 2017 indicated most mandatory training figures were above 75%.

The trust risk register highlighted one risk relating to staff training within the teams. A lack of staff being trained in immediate life support, which presented a risk those patients, would not receive timely care for cardiac or respiratory arrest. When we inspected the service in October 2015, we found that Calderstones Partnership NHS Foundation Trust had breached regulations, which related to staff not being adequately trained in life support. Recent figures for each ward reviewed for the period in January 2017 indicated all teams had now achieved the trust compliance figures of 95%. This meant the trust had taken effective action to address the concerns we raised with the previous provider.

All wards reported they had adequate medical cover throughout the day and night and a doctor could be contacted throughout the night and would attend the wards in an emergency if needed. A senior nurse was identified throughout the day and night to manage, support and attend to any emergencies on the wards.

We spoke with staff throughout the inspection process and attended various focus groups with staff from different disciplines. Nursing and occupational therapy support staff reported that staff were passionate about their jobs caring for patients. They were able to see a positive impact with patients as well as being part of a strong working and peer support team. They reported that mandatory training was monitored well and debriefs were carried out after an incidents and they felt supported. They reported staffing as an issue in relation to the number of permanent staff and the lack of experienced staff. They also felt induction could be tailored to a more specific unit or ward they were assigned to. They did not always feel valued by the senior management however, they reported at local level they did.

Assessing and managing risk to patients and staff

We reviewed 55 sets of care records across all of the wards. All patients had an up to date, detailed risk assessment and positive behavioural support plans in place. Any new patients referred or admitted to the wards had a full assessment of risk completed.

Patients were involved in their own risk assessments and a traffic light system was used to review and discuss the patient's own risks. Multidisciplinary team meetings were held weekly on most wards where patient risk was reviewed and openly discussed with patients. An audit we reviewed that was part of the commissioning for quality and innovation measures set out by NHS England with regards to secure patients active engagement programme (collaborative risk) showed that 100% of patients had a normal risk profile (risk profile in place), 99% of patients had a user friendly risk profile in place and 93% of patients had a clinical note confirming that the risk profile had been completed collaboratively. This audit identified 73% of the trust qualified staff had received training on collaborative risk.

The wards had positive handover reviews twice a day where each patient was rated using red, amber, green and positive remarks were recorded for each patient as well as 1-1 time with staff. As part of the template, a section was documented to address the potential for bad news and how would staff respond to individuals. The use of positive words during the staff handover was part of the trusts 'perfect care' commitment and encompassed 'no force first' building on their work with 'safe wards'. This handover ensured that key functions on the wards were handed over to the receiving shift leader, for example medication keys and emergency response roles.

The wards had access to a team within the trust where they utilised a positive intervention programme service team as an approach to working with difficult to engage patients. We saw this being discussed within a multidisciplinary team meeting as a way to reintegrate a patient who had been nursed in isolation. The use of this team was discussed with the patient within this meeting.

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The trust provided data of their incidents across the wards from 1 January 2016 to 31 December 2016 :

- The number of incidents of use of seclusion was 409 with the highest use on Woodview 1, with 117 uses (medium secure female) and Maplewood (Coniston and Grasmere) (low secure female) with 90 uses.
- The number of incidents of use of long-term segregation was 54 with the highest being 20 on Woodview ward 1 and 12 on Woodview ward 2.
- The total number of incidents of use of restraint was 1504 with the highest again on Woodview 1 with 307 and second highest being on Flat 1b within West Drive (low secure) with 164 incidents followed by Maplewood (Newton and Slaidburn) with 157.
- The number of different patients where restraint was used on was 115 - the highest number reported was on Maplewood 2 with 16 different patients over this period; and Woodview ward 3, Gisburn Lodge, Maplewood (Coniston and Grasmere), all with 11 different patients.
- The number of prone restraints was reported as 18 uses with all reported on 1b West Drive and these were over a three month period.
- The number of incidents resulting in the use of rapid tranquilisation was 47 with 38 reported on Maplewood (Coniston and Grasmere) and six uses on Woodview Ward 1.
- The total number of incidents of use of mechanical restraint was 11, with seven of these reported on Woodview Ward 3, three at Gisburn Lodge and one use on Woodview Ward 1.

Where mechanical restraint (such as handcuffs) was used, this was used only for patients being transferred to and from prison. This meant that handcuffs were not used for any clinical interventions

The incidents that led to restraint and the number of seclusions had reduced within the division. The trust provided data to confirm this from October 2015 to February 2017. This clearly provided evidence that the trust had reduced their restrictive practices. The figures identified that in October 2015, 217 incidents had led to restraint these figures continued to reduce showing 203 in June 2016,173 in October and 153 in January 2017 and 93 in February 2017.

Staff told us they routinely used de-escalation techniques and we observed staff calming patients who were distressed.

The trust provided narrative and summaries for each ward where incidents, restraints and restrictive intervention incidents had occurred. This helped to address and highlight areas where rises and decreases had occurred and to place some context on incidents. This covered the period from September 2016 to February 2017 for all clinical areas.

Some of the addressed reasons for increased and decreased incidents across all of the wards included patients transferring between wards, patient medication changes, changes in patient's security levels and reintegrating patients following long term segregation.

On 1 Woodview, staff were committed to reduce restrictive practice and had introduced the barrier to change checklist in December 2016. This assessment tool aimed to reduce the use of seclusion. The team also introduced a clinical model in December to reduce the long-term use of segregation within medium and low secure services. In January 2017, the team initiated the use of restorative practice as a means of resolving conflict. These initiatives, alongside safe wards and the continual support of a consistent team had resulted in 18 less incidents in February 2017 compared to January and an 80% reduction of the use of rapid tranquilisation. Time spent in seclusion and the use of T-Supine restraints (patients being placed on their back) reduced by between 65% and 80%.

On Maplewood (Coniston and Grasmere), incident numbers had shown a continuous downward trend from 26 per month to 13 per month between September 2106 - February 2017, following the introduction of the no force first initiative in December 2016. This had involved regular reflective practice with the multidisciplinary team to develop a greater understanding of each patient's presentation and possible triggers. The psychological treatment service provided weekly sessions to discuss the women's formulation with the staff and a staff clinical supervision session. This had led to a greater understanding of each patient.

In January 2017, restorative practice was introduced into the service to assist in resolving conflict, alongside safe wards, which was already embedded in practice. This, along with the constant drive to engage the patients via the

mutual expectation 'Improving Lives' meeting had impacted positively. There had also been no seclusion incidents for almost two months with the introduction of the 'Solutions Not Seclusion' initiative, which was coproduced with the patients and the multidisciplinary team. Rapid tranquilisation had not been utilised since November 2016 for any patient on these wards. Focused group work was ongoing to maintain the reduction in all interventions and use of restrictive practices.

Maplewood (Newton and Slaidburn) had seen a similar reduction in incident numbers and had been seclusion free for approximately two months with the introduction of the 'Solutions Not Seclusion' initiative, which was also coproduced with the patients and the multidisciplinary team. There has been no use of rapid tranquilisation and time spent in T-Supine showed a marked decrease between January and February 2017. The ward had benefitted from a more stable staff team, increased levels of occupational therapy involvement and more community leave for the patients. This team had also been involved in the implementation of No Force First initiative and the psychological treatment service had provided weekly sessions to discuss the women's formulation with the staff and a staff clinical supervision session. Restorative practice has also been introduced to assist in reducing conflict, alongside the continued use of safe wards interventions.

All patients that were nursed under an individual package of care had monthly safeguarding assurance review checks in place. The ward manager in conjunction with the responsible clinician, patient, multidisciplinary team, independent Mental Health Act advocates and family members were involved and contributed where appropriate. The clinical nurse manager reviewed the safeguarding assurance review forms and they were then sent to the quality and safety link person who would review the action plans produced and agree or disagree with the actions. These were tracked at the monthly safeguarding assurance review meeting and the quality and safety link person visited the patients monthly (positive welfare officer visit). We were informed the information from these review meetings were also shared with the commissioners. We reviewed one patient safeguarding assurance review forms covering a two month period. These were detailed and contained action plans, which were red, amber, and green, rated. This form of assurance provided scrutiny of the individual patient's care and treatment whilst also addressing staffing, supervision, transition and moving on, safety, safeguarding and incidents as well as behaviour and therapies.

Patients who were being nursed in isolation (long term segregation) were being regularly reviewed externally and within the multidisciplinary team meetings.

Track record on safety

We analysed data about safety incidents from three sources: incidents reported by the trust to the National Reporting and Learning system, the Strategic Executive Information System and serious incidents reported by staff to the trust's own incident reporting system. These three sources were not directly comparable because they use different definitions of severity and type and not all incidents were reported to all sources. For example, the National Reporting and Learning system does not collect information about staff incidents, health and safety incidents or security incidents.

Between 1 November 2015 and 31 October 2016, the learning disability secure wards reported 21 serious incidents, which required investigation. Twenty-nine percent of the incidents were categorised as 'disruptive/ aggressive/ violent behaviour' (six incidents) and 29% also for 'abuse/alleged abuse of adult patients by staff' (six incidents). Three incidents were included in the trust's internal data but were not present on the Strategic Executive Information System extract during the same period.

Trusts are required to report serious incidents to Strategic Executive Information System. These include 'never events' (which are serious patient safety incidents that are wholly preventable). Between 1 November 2015 and 31 October 2016, the learning disability secure wards reported 18 serious incidents, which required investigation. There were no never events reported. Six of these were categorised as 'abuse/alleged abuse of adult patient by staff' (33%) followed by 'disruptive/ aggressive/ violent behaviour' (28%, five incidents).

There had been 328 safeguarding referrals made during 1 January 2016 to 31 December 2016. Figures provided showed the highest were on Maplewood 2 with 49, Gisburn Lodge had 37, and Maplewood Coniston and Grasmere had

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33. Woodview ward 3 had 32. Moor Cottage, North Lodge, Pendle Drive had no incidents reported. In the six months prior to inspection, staff were up to date in all areas of safeguarding training with 99% of staff having completed it.

The specialist learning disability division had effective systems and process in place to help ensure that patients who used services were safeguarded from risk. The service worked in collaboration with their host local authorities to ensure safeguarding incidents were properly looked into when required. Staff also worked closely with the police where patients had reported any incidents the police needed to be made aware of. Staff held monthly meetings with the local authority and the police to receive and provide updates on any outstanding safeguarding alerts. Staff notified the local authorities of safeguarding issues that arose in their services directly and via their performance reporting. Managers ensured all staff were aware of safeguarding procedures to help reduce risks to patients using their services. Managers were implementing new reporting processes to ensure staff learn and apply learning from any safeguarding incident to help further strengthen safeguarding in the future.

A medicines E bulletin was posted on the trust intranet dated October 2016 and was accessible to staff. The aim of this e-bulletin was to bring current awareness of information on various topics of interest, which included medicines and safety news, recent publications and other news regarding new and current guidance. The overuse of psychotropic medicines in learning disabilities was also included. This included information about the 'stopping the over medication to patients with a learning disability' agenda and attached reference website links for staff to read. This was new guidance launched in June 2016 which encouraged prescribing healthcare professionals to review inappropriate prescriptions for people under their care who have a learning disability and/or autism.

A specialist pharmacist provided clinical support to each ward once a week checking prescription cards to ensure medicines optimisation. Additional visits were made on request when new patients were admitted, to ensure that patients' medicines were checked and reconciled in line with best practice guidance (NICE NG5: medicines optimisation: the safe and effective use of medicines to enable the best possible outcomes). The trust had not commissioned easy read medicines information leaflets, but we were told that these would be individually sourced on request and developed 'in-house'.

We checked seventeen prescription cards, eight at Gisburn Lodge, five on Slaidburn, and three on Newton ward and one on Grasmere ward. These records were clearly maintained and when patients were detained under the Mental Health Act, the appropriate legal authorities were in place for medicines to be administered. We saw that where needed, additional physical health checks and therapeutic drug monitoring was carried out and recorded. Monitoring was important to ensure patients were physically well and that they receive the most benefit from their medicines. However, modified early warning scores were not recorded weekly, as stated in the trust's policy. Managers told us that where patients had additional health needs than these were completed more frequently and the onsite health centre managed and oversaw these. The introduction of the modified early warning scores was relatively new to the trust division and this was still being embedded into practice with staff training also being delivered. Additionally, records for one patient showed that on the two occasions where rapid tranquilisation was administered, observations had not been recorded as frequently as indicated in current guidance (NICE NG10 Violence and aggression: short-term management in mental health, health and community settings May 2015)

Medicines including controlled drugs were stored securely in the clinic rooms and checks of the room and fridge temperatures were completed to ensure they were suitable for medicines storage.

Some emergency equipment and medicines were available on the ward and these were in date. First line intravenous cardiac arrest drugs had been removed from the emergency drug boxes on each ward and these were held at central points (four reception areas and at the healthcare centre) throughout the main site in Whalley as well as Scott House and Gisburn Lodge. The locations of these emergency drug boxes were displayed on every ward with signage in reception areas. The trust had provided a rationale for the location of these emergency drugs and their accessibility and decisions in response to the Resuscitation Council UK guidance they had interpreted and applied. The trust had completed emergency drills to identify any issues and actions for improvements. An action

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plan had been produced following their drill in January 2017 with all green indicators to state the actions had been implemented. Of the two drill exercises we reviewed the second showed an improvement in their response time of less than three minutes and therefore learning had been implemented.

Divisional drill dates had been identified for each ward and these were identified once a year.

Reporting incidents and learning from when things go wrong

Staff we spoke with knew how to report an incident or an accident and how to report it on their electronic incident reporting system. We saw evidence that staff had identified and reported incidents appropriately to reduce risks. For example: a member of staff explained how they had noticed that a patient appeared to be experiencing symptoms of hyperkinesia (excessive abnormal movements) which may be related to side effects of their medication which increased the risk of choking. These had been raised and red flagged on their internal system to alert staff to these issues as well as being fed back to the ward managers to seek appropriate intervention.

Ward managers informed staff of feedback from incidents and accidents on a regular basis through team meeting, supervision and alerts, which were emailed to staff that summarised learning from incidents. The positive handover reviews held twice daily on the wards included weekly key communication messages/themes to inform staff of local, divisional lessons identified from incidents, investigations and complaints and included key messages from the chief operating officer. Weekly key communication messages/themes were also addressed in these handovers to inform staff of local and divisional lessons identified from incidents, investigations and complaints and included key messages from the chief operating officer.

Debriefing sessions had taken place for staff and patients following serious incidents and the psychology department were involved in these, supporting both staff and patients. Community meetings and mutual restorative practice sessions were available to patients and staff to discuss any altercations that may have arisen on the wards.

The trust provided ward managers with information about post death reviews and lessons learnt recommendations. The ward managers shared this information with their team during team meetings so that staff were informed of any lessons learnt and recommendations. Positive practice was also reflected in these reviews and shared with staff.

The Chief Coroner's Office published the local coroner's reports to prevent future deaths, which contained a summary of recommendations, which had been made, by the local coroners with the intention of learning lessons from the cause of death and preventing deaths. The trust advised that they had not been issued with any prevention of future death reports in the last 12 months.

Duty of Candour

Ward managers we spoke with were aware of the duty of candour and actions that would need to be taken. Staff knew of the duty of candour principles in dealing with patients, and felt that they had always been open and transparent with patients if things went wrong. The trust had a policy outlining the duty of candour requirements that provided guidance for staff. The policy stated staff should meet with patients and carers about an adverse incident within 48 hours of the incident having occurred. The incident management reporting also referenced the duty of candour principles.

The trust had a speak up guardian. This was someone dedicated solely to give all staff the freedom to speak up for themselves and their patients. This encouraged staff to share their concerns in a confidential manner. The speak up guardian's telephone and email details were available to staff to access.

Are services effective?

Outstanding ☆

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

Our findings

Assessment of needs and planning of care

We examined 55 patients care records and found that comprehensive and timely assessments were completed following admission to the service. Risk assessments were detailed and up to date and demonstrated patient involvement. Physical examinations on admission were completed and recorded. All care plans were personalised, holistic and recovery orientated. Patient views were evident. Care plans were of a high quality and contained detailed information regarding physical health monitoring such as asthma, diabetes and weight problems. All patients had detailed positive behaviour support plans, which had been completed in conjunction with them. Positive behaviour support plans were an intrinsic part of the treatment process for patients with learning disability or autism as defined by guidance from NHS England (Transforming care for people with learning disabilities, 2015). They included a functional analysis of behaviour, primary, secondary and tertiary preventative strategies. Positive behaviour support plans included de-escalation techniques and described what should happen if restrictive interventions were needed.

Staff showed understanding that it was important to recognize triggers and have effective methods of intervening before situations became difficult and required the use of more restrictive interventions. They were aware of, and used de-escalation techniques. Sensory assessments were also available and present for patients for whom this would be suitable. For patients with the most complex needs, the environments had been adapted to support them to develop more positive behaviours. Patients were offered and encouraged to have copies of their care plans, which they could store in their rooms. Two recent care and treatment reviews completed in January 2017 highlight good practice in relation to positive behaviour support plans, risk assessments and detailed person centred care plans and activity plans. Care and treatment reviews were completed independently from the hospital.

Care records were stored electronically on a secure computer system that all necessary staff could access, including bank staff. Regular agency staff also had access to the electronic care records following appropriate induction and training. Patient information stored within the electronic record system was correctly filed and staff could easily navigate the system to locate the information they needed quickly.

Best practice in treatment and care

We looked at a total of 47 prescription charts and found that medication was prescribed within British National Formulary limits. Multi-disciplinary meetings were attended regularly by pharmacists who gave advice on prescribing guidelines such as National Institute for Health and Care Excellence (CG76, Medicines adherence: involving patients in decisions about prescribed medicines and supporting adherence, 2009), along with recommendations from the Royal College of Psychiatrists, trust policy and British National Formulary limits. We spoke to eight doctors who understood the 'stopping the over medication of people with a learning disability' strategy and gave examples of good prescribing practice. This included examples of using the minimum effective dose and a multidisciplinary approach to managing difficult behaviour. Doctors could give clear rationales for when anti-psychotic medication had been prescribed to manage symptoms of unpredictable and harmful behaviour. Side effect rating scales were used to assess patient's side effects from medications, which were discussed with patients. Medications were reviewed during multi-disciplinary meetings on a fortnightly basis.

There was a wide range of psychological interventions available included group session in the adapted sex offender treatment programme and the adapted dialectical behaviour therapy programme. Individual sessions were available for the following therapies:

- cognitive behavioural therapy
- dialectic behavioural therapy
- cognitive analytical therapy
- systemic approaches
- positive behaviour support
- art psychotherapy
- acceptance commitment therapy
- person centred counselling
- consultancy

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There was a recovery college which facilitated group sessions in the following areas:

- resettlement support: moving on group
- mindfulness and self soothing
- anxiety management
- relationships and personal awareness
- wellbeing and mental health
- self compassion
- personality disorder awareness
- therapeutic community meetings
- recovery based arts projects
- autism risk group

There was also an established recovery college meeting to monitor and track the commissioning for quality and innovation targets for medium and low secure, which was attended by a range of professionals including therapists and nurses.

Psychological formulations were embedded within the multidisciplinary team meetings and the care planning process. Specific psychological interventions were identified for individual patients. Information from psychological formulations was shared with the patient and their care team. Specific training, case management discussions and reflective time was provided to staff by the psychology team to support other staff to understand the needs of the patients and how best to support them. There was a target to offer a psychological assessment within two weeks for urgent referrals and all other referrals within six to 18 weeks. At the time of the inspection there were 19 patients awaiting psychological assessment or therapy. Patients had waited between zero and 10 weeks. There were 136 patients who had actively engaged in psychological work during the last 12 months.

The service had an onsite health centre, which patients could access for any health issues. Health centre staff were trained to use the Lester tool. This was as a prompt for clinical staff conducting physical health checks with patients. The tool reminded staff which tests to request, summarised National Institute for Health and Care Excellence guidance around interpreting the results and gives recommendations on the interventions, which should be offered, to each patient. The tool prompted and guided staff in relation to patients' smoking, lifestyle, weight, blood pressure, diabetes and cholesterol. The tool incorporated guidance from the National Institute for Health and Care Excellence such as psychosis and schizophrenia in adults, (CG178), psychosis and schizophrenia in young people, (CG155) and the quality standard for psychosis and schizophrenia in adults, (QS80).

Outside of working hours, patients had access to ward doctors and on call doctors within the service. For any specialist healthcare, patients were referred to local acute hospitals. Staff had close links with the learning disability liaison nurses within the acute hospitals who supported patients to receive appropriate care and treatment at the local general hospital.

All patients had received an annual health check and monthly health checks. Patients were referred to the health centre or acute hospital for any follow up treatment. All patients, where appropriate, had up to date physical health care plans, which detailed any physical health needs. These included obesity, epilepsy, diabetes, and asthma. The physical health care plans documented patients' health needs, recent health data and plans to treat the health problem. We saw evidence of these being followed and reviewed regularly. The service had recently introduced the modified early warning score (a health screening and rating tool) to monitor patients physical health. The tool outlined actions for interventions. At the time of inspection, 43% of staff were trained to use this tool. There were plans to incorporate this training into the induction programme. Staff explained they found this tool helpful and gave them confidence to escalate any health concerns.

The service had also introduced a health awareness and improvement initiative called 'Dr Feel Well'. This project aimed to improve patient's physical health by the use of patient education, guidance and encouragement. Patients were encouraged to exercise in a way that was individual to the patient. For example, clubbercise, aerobics, zumba dancing and rambling walks. The physical health plans had been developed using a multidisciplinary approach, which included the views of the patient and input from other professionals such as occupational therapists and dieticians. Health and diets were regularly discussed in ward community meetings with patients. Agreements had been mutually made with patients to restrict the number of takeaways to weekly or in some cases monthly.

Are services effective?

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The service had access to onsite dieticians who were a visible presence on the wards. Patients with obesity and diabetes could be referred to the dietician who would give advice to patients regarding healthy diets. The service employed a chronic disease nurse three days a week to lead on the monitoring of blood pressure and asthma, diabetes and epilepsy reviews. Fifty-six staff across the site had received and were up to date with epilepsy and midazolam training.

The service also had an onsite dentist. Patients within the stepdown or enhanced support services had the option of using a community dentist within the local area.

There was a physical health policy in place that was accessible to staff and outlined duties and responsibilities for staff to follow.

Rating scales to assess and record patient's severity of symptoms and outcomes were used such as health of the nation outcome scales for people with learning disabilities, recovery star and the model of human occupation screening tool. These were completed six monthly and fed into the care programme approach review process.

Audits completed by nursing staff included:

- medication audits
- ward clerk audits
- fridge temperature checks
- clinic room audits
- safety audits
- ligature audits
- Mental Health Act audits

Audits for patient group interventions were audited for effectiveness by staff in partnership with patients. Information collated from audits was shared with ward managers and the senior management team.

Skilled staff to deliver care

Each ward had access to the following staff disciplines:

- occupational therapists
- psychologists
- social workers
- pharmacists
- speech and language therapists
- nurses
- consultant psychiatrists
- dieticians
- junior doctors

Staff had been allocated to each ward dependent on the needs of the patient group. Patients and staff confirmed there was no waiting list to see any particular professional. The service employed 37 occupational therapy staff, 23 psychology staff, three social workers, six speech and language therapists, four pharmacists, 20 doctors and a part time dietician. These disciplines worked across the service and were accessible to every ward.

Staff were experienced in their roles and responsibilities. Many staff had been employed by the service for many years. Newer staff were well supported by their peers.

New staff received three levels of induction into the service. This consisted of a corporate induction, the specialist learning disability divisional induction and a ward based induction. Staff received information regarding the service values, security procedures and individual ward processes.

Staff supervision rates were high throughout the service with the average supervision rates for the last six months being 86%. The exception to this was Maplewood 2 ward, which was 65% of staff receiving regular supervision in the last six months and West Drive low secure unit being 69%. These wards had an increase in staff sickness and vacancy rates during this period, which affected the supervision figures. Staff explained they had access to one to one clinical and managerial supervision and group supervision that was arranged on a monthly basis. All staff reported that the level of supervision they received was good.

Staff appraisal rates were also high with the average for the last six months being 87%. The exception to this was three West Drive at 65%, Coniston and Grasmere ward at 56%, Maplewood two ward at 70% and Scott House at 45%. Data for January and February 2017 showed that these figures had increased to the trust target of 90%. Staff reported that access to meaningful appraisals was good and they felt supported in their roles.

Regular team meetings were held on each ward on a monthly basis. Minutes from the meetings were emailed to all relevant staff. Staff were asked to share information with other staff who could not attend. Staff reported feeling involved and up to date with ward briefings and information.

Specialist training was widely available for all staff. Staff could access a range of training that was available on site and at other trust locations. Staff were encouraged to

attend relevant training to their role, which was supported by their line managers. In the last 12 months staff had completed 2477 additional specialist training courses which included the following:

- learning disability training 77
- autistic spectrum disorder training 105
- communication needs 211
- sex offender training 59
- psychological courses 178
- managing problematic behaviour 343
- choking 38
- epilepsy 661
- dementia 82
- physical health 68
- security 158
- managing risk 221
- mental health 25
- sensory skills 22

We observed staff demonstrating their specialist skills during an autistic spectrum disorder risk group. The group was attended by nine patients and was the ninth session of 20. The group had a zero dropout rate. It was facilitated by staff from various disciplines including nurses, speech and language therapists, occupational therapists and psychology staff. The purpose of the group was for patients with autistic spectrum disorder to understand other people's views in a non-threatening way. Staff used a variety of communication methods to demonstrate how certain behaviour could increase risks to people with autistic spectrum disorder in a way that people with autistic spectrum disorder could understand. The group was engaging, dynamic and encouraged self discovery through a number of activities which members were supported to be fully involved in.

There were policies in place to address poor staff performance, which managers were aware of and were able to follow. Managers could give clear examples of how issues had been dealt with and staff had been supported and disciplined appropriately.

Multi-disciplinary and inter-agency team work

There were regular and highly effective multidisciplinary meetings on each ward on a weekly basis. We observed three patient ward review meetings, which were attended by a doctor, a nurse, psychologist, occupational therapist, social worker and the patient. Staff from the patient's home team were also invited if appropriate. Meetings contained detailed discussions regarding physical healthcare, progress, risks, leave entitlement, patient views and Mental Health Act status. Each meeting was patient focused and respect was shown for the patient's views and opinions. We found that carers and families were regularly invited to meetings. Patients also had regular care and treatment review meetings in line with NHS England's guidelines. Patients within enhanced support services had monthly care and treatment reviews to discuss progress towards discharge.

We reviewed details of ward handover meetings, which showed effective communication between staff on different shifts. Staff gave detailed accounts of each patient including changes to presentation, risks, medication, physical health, relational security and other individual patient and ward issues. Risks were highlighted using a traffic light system to demonstrate to staff particular areas of concern.

Local area care coordinators were regularly invited to attend care programme approach review meetings and other relevant meetings. Information was shared appropriately and each professional's views were evenly considered. The service had a good working relationship with the safeguarding leads within the service and the local authority safeguarding team.

The service had developed strong links with third sector organisations. This included providing bespoke training in relation to the treatment and care of patients who were being discharged. Over the last 12 months, the service had provided patient specific training to 12 external agencies. This included:

- dialectic behaviour therapy for use with individual patients
- patient specific formulation, risk management and relapse prevention work
- individual communication needs and tools
- person centred positive behaviour support plans
- adapted sex offender treatment programme work regarding individual patients
- specific ways of managing self-harm

Are services effective?

Outstanding ☆

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

Working collaboratively with outside organisations was embedded within the service. Staff routinely worked alongside external agencies to ensure patients were safely transitioned to other placements. This was often for long periods of time.

The service was working closely with commissioners regarding the discharge planning of patients.

Adherence to the Mental Health Act and the Mental Health Act Code of Practice

Mental Health Act training was mandatory for staff. Compliance with Mental Health Act training over the last six months was 89% overall but most recent figures for February 2017 confirmed this being over 90%. Training was provided via a workbook, which staff completed and was scored by managers. Staff were kept up to date with legal information and updates by Mental Health Act lead email bulletin. There was also a weekly briefing email across the trust and Mental Health Act issues and news could be included in this. Staff we spoke to had a good understanding of the Mental Health Act code of practice and how this was implemented within the service.

Mental Health Act administrators scrutinised Mental Health Act documents prior to patients being admitted to the service.

The Mental Health Act administration team were based within the service and known to ward staff. Staff knew how to contact them for advice and guidance relating to the Mental Health Act. Mental Health Act administrators prompted staff to ensure that the Mental Health Act was being followed. This included reminding staff regarding upcoming section renewals, section 132 checklists and tribunal reports.

The service kept clear records of leave granted to patients, which included details of the outcome of the leave and the patient's views. The electronic recording system prompted and supported staff to include this information.

The service had received visits from a Mental Health Act reviewer on 16 wards in the last 12 months. The purpose of the Mental Health Act reviewer visits was to monitor the use of the Mental Health Act by speaking to patients, staff, relatives and carers and examining patient records and documents. Over the last 12 months, the service had been adhering to the Mental Health Act and code of practice in the majority of areas. However, the following themes were evident:

- the recording of patients section 132 rights under the Mental Health Act was poor on 12 wards
- recording of the outcome of section 17 leave and patients views on leave was poor on 13 wards
- there was no clear rationale for blanket restrictions on seven wards

We checked the Mental Health Act paperwork during this inspection for 43 patients across the site. We found that detention paperwork was filled in correctly and was up to date. Issues noted from previous Mental Health Act reviewer visits had been addressed. Staff routinely explained patients' rights to them and recorded this within the patients notes. Consent to treatment and capacity to consent assessments had been completed where applicable.

Mental Health Act administrators regularly audited these documents and escalated any concerns to the medical director, monthly doctors meetings and governance groups. The audits identified that external social workers were not always attending tribunal hearings. This was more closely monitored and information shared with senior managers.

Patients had access to independent Mental Health advocates who visited each ward on a monthly basis. Information about the independent mental health advocacy service was clearly displayed in ward areas. Staff were aware of how to refer.

Good practice in applying the Mental Capacity Act

Mental Capacity Act training was mandatory for staff. Compliance with Mental Capacity Act training over the last six months was 88% overall. The exception to this was Slaidburn (individual packages of care) at 63%. However, at the time of inspection all wards had reached the trusts target of 90%. Training was provided in the form of a workbook for most staff. Face to face, training was provided to doctors, ward managers, hospital managers and Mental Health Act administrators. An expert facilitated the face-to-face training and the information was cascaded to other staff. Staff demonstrated an excellent understanding of the Mental Capacity Act and how this applied in practice to the service. A Mental Capacity audit had been completed in February 2017 by the trust to assess staff awareness, knowledge and application of the Mental Capacity Act including Deprivation of Liberty Safeguards. The audit found that 80% of staff surveyed had a good understanding of the Mental Capacity Act.

Are services effective?

Outstanding ☆

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

There had been no deprivation of liberty safeguards applications made in the last six months.

We observed capacity being discussed in patient review meetings and we checked 50 patient's records. Capacity assessments had been completed to a high standard on all wards and staff were aware of the best interests checklist and decision making process. Capacity assessments were detailed and clearly demonstrated the five statutory principles. Assessments were decision specific and there was a clear rational regarding why patients lacked capacity. Capacity assessments had been completed for both simple and more complex decisions. Mental capacity consideration and assessment was embedded in the daily practice of staff of all disciplines.

Staff supported patients to make decisions such as using the correct communication aids as identified within care plans. For patients who lacked capacity, we saw evidence of staff considering patients' wishes, values and culture. The best interest checklist was followed and decisions were clearly recorded within the electronic recording system.

There was a Mental Capacity Act lead within the trust that was available to offer advice and guidance. The trust had a policy on the Mental Capacity Act and deprivation of liberty safeguards available to staff electronically. Staff were aware of this and felt they could also refer to this if necessary.

Outstanding ☆

Are services caring?

By caring, we mean that staff involve and treat people with compassion, kindness, dignity and respect.

Our findings

Kindness, dignity, respect and support

We spoke with 44 patients who were using the service and five carers of patients who were using the service. We met with many more patients and staff before and during the inspection at the groups we attended. Most of the patients across the whole of the service were positive about the way staff team treated them. The majority of the patients we spoke with were positive about the kindness, dignity and respect they received from staff as well as staff being interested in their wellbeing and about staff being involved and being supportive of them.

A few patients commented that not all staff knocked on their bedroom doors before entering and some staff were not always respectful and polite. Carers and or family members we spoke with felt their family members were safe and they were involved in their care where necessary. They felt the staff were helpful and they could contact the wards at any time if they had a concern or problem.

We observed staff treating patients with compassion and respect throughout the inspection. They allowed patients to express themselves and provided support, encouragement and reassurance ensuring they maintained the respect and dignity of the patients. We saw staff supporting patients who had limited verbal communication and staff were able to respond effectively to enable communication. They were able to respond to patients, which reduced any frustration they might have felt because they could not express themselves fully. Staff were able to describe patients' positive behavioural support plans, which enabled staff to effectively understand, anticipate and meet patients' needs.

We spoke with staff and observed their interactions with patients during the inspection period. We saw that they understood the needs of their patients well. We saw staff supported individual patients when changes to their behaviours occurred or where patients wanted to express their emotions. They provided practical and emotional support in a discreet way when staff needed to intervene. This prevented patient's behaviour escalating and avoided the use of restrictive interventions (restraint, seclusion or extra medication).Staff genuinely spoke about patients in a respectful and positive manner. This was observed in a multidisciplinary team meeting handover and in group ward meetings we attended.

During the inspection, we carried out two short observational frameworks for inspection sessions (SOFIs). SOFI is a tool used by inspectors to capture the experiences of patients who use services but may not be able to express their experience fully for themselves. We saw that staff responded effectively to patients because they understood them. We saw that the quality of interventions was caring and respectful of individuals. We saw no negative staff interactions and there was a high level of patient interaction with staff being proactive and genuinely interested in their patients as well as having fun in an appropriate way.

The involvement of people in the care that they receive

Most patients we spoke with mostly said they were fully involved in the care they received and had information about the ward and information about their rights. Most said they were involved in decisions about their care and had been involved in discussions about their care plans. They also said they had access to an advocate. Some patients told us they had been involved in the recruitment of staff and others said they would like to do this. Most patients we spoke with said they were involved in lots of activities and groups and there were enough staff and activities were rarely cancelled. Although some said, the activities were cancelled but these were usually rearranged.

The trust employed a director for service user and carer involvement who oversaw three main areas of service user and carer involvement :

- involving people in their own individual care and support
- enabling involvement in service user improvement in the overall running of the trust
- offering opportunities for learning or work.

Patients were invited to attend monthly 'speak up' group meetings. These meetings allowed patients to attend and have their say. They included information about new groups and activities running throughout the hospital. Patients were involved and asked about their views on new occupational therapy groups, pictorial menus introduced and information about local rambles and community fun runs as well as other topics.

Outstanding ☆

Are services caring?

By caring, we mean that staff involve and treat people with compassion, kindness, dignity and respect.

One service user meeting we attended highlighted that the trust were not paying patients/service users for real work opportunities. They gave an example about attendance at staff interviews.

Courses were developed and delivered for families and carers to access. These included health and well-being and dementia friends to enable families and carers to understand important issues that may affect them.

Patients, staff, families and carers could also access and become involved in short courses to help them understand patients recovery through activity, learn about 'all about my meetings', what person centred planning was and help them understand six 'Cs' of nursing.

Community meetings held on each ward provided opportunities for staff and patients to live and work together and talk about any issues affecting their ward. Project groups were also organised and patients were involved in planning events to raise and collect money for charities, organising parties and making art displays.

Patients were also involved in championing recovery at Mersey Care. Meetings happened monthly and patients could become involved. It aimed to help patients understand their recovery, feedback to their wards and helped to plan and run events.

The friends and families test completed in quarter three of 2016/2017 showed that out of 43 respondents, 21 were very likely to recommend this service to their friends and family if they needed treatment and care. Twelve respondents were likely to, four were neither likely nor unlikely and six respondents were unlikely or very unlikely to recommend this service to their friends and family if they needed treatment and care.

We left comment cards in all of the clinical areas and we received only two completed cards, which both said it was a good service and the staff go out of their way. However, one said their move on was taking too long. The low return rate may have been because we did not provide easy read comment cards as we normally do for inspections of learning disability services.

The trust promoted the 'triangle of care', best practice in mental health care for the inclusion of carers. The aim was to promote safety, recovery and sustain wellbeing in mental health by including and supporting carers as well as working to improve carer support. The trust had an identified lead for patient and carer participation. The carers group we attended confirmed that each ward had a named carer's champion link person. All of the wards had completed a triangle of care self assessment, including action plans the wards were working towards.

Within the specialist learning disability division, patients and staff worked in partnership to develop their care plans and coproduce their therapy, rehabilitation and recovery together. This enabled choice and control and offered opportunities for patients to be experts within their own care.

Individuals with lived experience co-delivered sessions to others to share their personal stories, knowledge and skills, inspiring others whilst developing their own skills and sense of self. Individuals embarked on learning journeys with other individuals and staff, allowing coproduced learning and breaking down barriers and stigma.

Are services responsive to people's needs?

Outstanding ☆

By responsive, we mean that services are organised so that they meet people's needs.

Our findings

Access and discharge

All admissions to the trust were planned admissions. The NHS England specialist commissioning team were gate keepers for patients admitted to the secure service. These patients had complex needs and presented with risky behaviours that necessitated a secure environment to protect themselves and others from harm.

Some patients had been involved in filming a number of short videos about the wards with the trust's patient led media crew. These videos were available online to help new patients know what to expect from admission and the transforming care agenda.

We case-tracked two patients who had been discharged from the service within the past six months. Trust staff had worked closely with external providers and community teams to help them understand patients' complex needs and ensure that placements would provide safe, quality care. We reviewed two discharge stories, which were produced with patients and given to patients and placement providers. This document included comprehensive information about patients' risks, strengths, environmental and personal needs, interests and hopes for the future. It was holistic, person-centred and easy to understand. Following discharge, the service had maintained contact with placement providers and community teams to offer support and evaluate their transition work. It was clear that both discharges had been successful. Patients and carers had sent back messages and photographs showing that patients were happy and participating in their new communities.

We observed a multi disciplinary meeting on Woodview medium secure unit. This meeting involved a full multi disciplinary team from the hospital and the patient attended the meeting. The team alongside the patient had developed tools, aids, communication adaptations and used photographs to assist the patient with their moving on plans. Care plans had been produced to share with the new providers of the individuals care. Care and treatment reviews had been completed in line with NHS England's commitment to transforming services for people with learning disabilities, autism or both. Care and treatment reviews were for patients whose behaviour was seen as challenging and/or for patients with a mental health conditions. They were used by staff and commissioners for patients in learning disability hospitals to help improve current and future plans for leaving hospital. Staff from the ward were in contact with family members and the transition team. This was to ensure the patient had the necessary support and communication tools to respond to the complex and sometimes difficult behaviours, which may be exacerbated by a patient's discharge.

The national target for referral to initial assessment was 14 days. 1 Woodview, 3 Woodview and Maplewood 2 had missed the referral to initial assessment by five days on average. The number of days from initial assessment to onset of treatment had a national target of 60 days. Maplewood 3, Westdrive and Woodview 3 and 1 Woodview had missed their targets with 101,116,122 and 97 days. These figures were because of delays in access to beds on these wards.

The trust provided details of bed occupancy rates for 30 wards between 1 January 2016 and 31 December 2016. These bed occupancy rates included leave days. Eight out of 30 wards had bed occupancies of 85% and above, although not all 30 wards were in use. 4 Daisy Bank, Trentville, North Lodge and Moor Cottage all had bed occupancies of 100%. Woodview ward 2 followed with 98%, Maplewood 2 and Maplewood 3 with 96% each, Maplewood Newton with 89% and 2 North Lodge Lancaster with 86%. The trust provided data on the number of patients moving wards per admission for the wards between 1 January 2015 and 31 December 2016. No patients were moved wards after 22:00pm, across all wards.

Between 1 January 2016 and 31 December 2016, patients within specialist services (including learning disability secure wards) had lengths of stay ranging between 201 to 8,089 days. The average length of stay for patients across the 12-month period was 2,324 days. North Lodge reported the highest average number of days with 5,633, for the 12-month period; Ravenswood enhanced support unit followed this with an average of patients staying for 5,536 days.

Over the past 10 months (March 2016 to December 2017), the highest reported delayed discharges on any ward in any month were six patients. The highest was on West Drive low secure unit, which peaked in July and August 2016 to six. However, West Drive low secure ward had shown a reduction from six to four patients with a delayed discharge in December 2016.

Are services responsive to people's needs?

Outstanding ☆

By responsive, we mean that services are organised so that they meet people's needs.

The second-highest ward was 2 West Drive. From March to June 2016, this ward showed four patients per month had a delayed discharge. This had improved showing only one in December 2016.

There were no reported delayed discharges on 1 and 2 Pendle Drive, Daisy Bank and North Lodge in Lancaster, South Lodge and Maplewood – (Newton and Slaidburn) over a 10 month period. All of the wards showed a reduction in delayed discharges over a 10-month period apart from Woodview Ward 1, showing one patient awaiting discharge over a period of 10 months. The trust provided information data to us about patients awaiting transfer to low secure units or enhanced support services from October 2016 to March 2017, with the length of wait and reasons where applicable. This identified that eight patients were awaiting transfer. The service was working closely with the commissioners and NHS England to make sure secure funding and the correct level of support was in place for patients moving to enhanced support services.

Managers on the medium secure wards identified that patients were on a waiting list to move to the low secure units. The low secure units were full to capacity throughout the specialist learning disability division. Referral, capacity and flow assessments were in place and these were a point of access into the service. The trust operational management team highlighted that delayed discharges were an issue. The trust and commissioners were working together to address issues on a daily, weekly basis. This was to transition patients onto appropriate and well planned homes with the necessary support.

One risk appeared on the board assurance report provided from the trust relating to delays in access to beds. This highlighted that delays in access to inpatient beds, meant that there was a risk of delayed treatment and poor patient care, which may result in adverse impacts on care and safety. This risk was currently rated as red by the trust.

A risk appeared on the risk register, which was provided by the trust, which related to access and discharge. There was a risk of delayed treatment and poor patient care due to delays in access to beds. This result in adverse impacts on care and safety.

A small number (six) complaints were made in relation to access, discharge and transfer arrangements, this included complaints relating to transferring to conditions of lower security, transfer nearer to the family home and an internal ward transfer issue.

The facilities promote recovery, comfort, dignity and confidentiality

Patient-led assessments of the care environment assessments were carried out. These were self-assessments undertaken by teams of NHS staff and others, and include at least 50 per cent members of the public (known as patient assessors). They focus on different aspects of the environment in which care is provided, as well as supporting non-clinical services such as cleanliness.

In relation to food, the 2016 PLACE data for services acquired from Calderstones Partnership NHS Foundation Trust was at 96% approval rate, which was four percentage points better than the England average (92%). Specialist Learning Disability Division (Whalley site) achieved the highest score for food at 96% followed by Gisburn Lodge at 93%. However, there was no scoring information available for Scott House and Lancaster Service. When comparing scores with those achieved for food in 2015, Gisburn Lodge saw an increase in their scores in 2016 by four percentage points and Specialist Learning Disability Division (Whalley site) saw a small decrease of one percentage point.

Some patients reported the choice, quality of food was not always good, and the food was not always that warm at the Whalley site. However, at Gisburn Lodge and Scott House patients reported they were very satisfied with the food. Patients were able to access drinks and snacks throughout the day.

We saw patients accessing the canteen at the Whalley site, which was also open to visitors and staff. Patients on the medium secure wards at Whalley had access to a vending machine and a patient run shop. Patients also had planned leave to access to the local area and many patients frequently visited the local village. A shop was available throughout the site and patients could access this whilst on leave from the wards.

The trust had recently introduced 'Dr Feel Well' on all of the wards we visited; monthly themes were discussed at patient experience meetings. These meetings encouraged patients to have an awareness and to participate in themes that addressed all aspects of health and fitness as well as

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Outstanding ☆

By responsive, we mean that services are organised so that they meet people's needs.

healthy eating and awareness of health related topics. We observed several of these meetings and patients were encouraged to participate and give their views on how they could try to implement changes on the ward. One example was where patients had decided that they would make different healthy smoothie drinks as an alternative to sugary drinks. Smoking was still allowed at the hospital in designated areas however, a date had been set for the hospital site to go no smoking in September 2017.Patients had the opportunity in these meetings to discuss smoking cessation and support available to them.

There were a full range of facilities available to patients at the Whalley site and patients at Gisburn Lodge, Scott House and the Lancaster services could access the onsite medical centre. Patients on site had access to a gym, college, social club and activities including:

- walking and rambling
- football
- shopping
- day trips
- voluntary work
- snooker, pool and bowling
- horse riding
- bingo
- gardening
- swimming and canoeing
- movie afternoons
- pampering sessions, relaxation sessions
- information technology groups.

Patients at Gisburn Lodge, Scott House and the Lancaster houses could access the facilities and activities within their local communities, which were planned alongside the occupational therapy team.

Patients were encouraged to identify activities they would like to engage in and occupational therapy staff met with individual patients to plan these activities. All patients had access to a minimum of 25 hours individually planned activities throughout the week. The trust recorded and monitored these to ensure these were being delivered to patients.

The trust's 'our shared college' provided opportunities for patients to learn new skills, gain accredited qualifications, meet new people and socialise as well as being involved in various groups. These groups included a thinking and talking group, moving on support group, healthy lifestyles, mindfulness and people skills. It also provided patients with access to 'bike ability', provided by specialist cycling trainers. This allowed patients to learn how to ride a bike as well as looking after a bike. Bicycles were also available for patients to practice cycling around the hospital and local area.

There was an established championing recovery meeting co-produced with patients and facilitated monthly. Individuals attended as designated recovery champions for their wards to share ideas and plan new recovery focused activities from their perspective.

Outside organisations provided accredited qualifications and courses providing different entry levels dependent on patient's ability. Some of these courses included a gym qualification, painting and decorating, window cleaning, food safety, English including functional skills and bike ability.

Community activities and courses were widely available off-site for people living on the hospital wards. These included access to support and social groups for patients who identified themselves as lesbian, gay bisexual or transgender. Patients also had access to horse riding, local football clubs, as well as specialist services for adults with learning disabilities named 'The Base' offering activities such as drama, arts and crafts and bingo as well as learning independent living skills.

The patients on all of the wards had access to a kitchen where they could make a hot or cold drink throughout the day and night. There was also access to snacks throughout the day and patients could buy their own food if they wished to and store it in the fridge. At Scott House, there was occupational therapy support. They provided individualised support to patients to plan, shop, prepare and cook their own meals.

All of the wards were clean and tidy and there were colourful pictures on display as well as photographs of key members of staff on each ward. Scott House had developed a one-page profile of their regular staff. This allowed patients to have information about the staff that cared for them. A range of information was displayed on

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the walls adapted to meet the needs of the individuals. For example, for patients with a diagnosis of autism they had simplified timetables and had rules and expectations of visitors to the wards. Information was displayed about group's available, local information and nearby support networks as well as ward activity timetables. Artwork was displayed throughout the wards; positive and motivational words relating to positive behavioural support plans and the 'safe wards' initiatives were displayed.

There were facilities for children to visit in a separate area away from the main wards.

All wards had access to clinic rooms for carrying out physical examinations of patients. The rooms did not all contain an examination couch but all patients had their own room that could be used for private examinations when required.

All wards had a range of rooms to support the care and treatment of the patients. These included dining rooms, lounges, quiet areas and activity rooms. Patients were able to personalise their own rooms with photographs of family and friends. All patients had access to their bedrooms. In the low secure wards, they had their own keys so they could secure their belongings when they were not in the room. Some patients chose not to have a key to their room. In the medium secure wards, patients had access to their rooms and where patients had limited access; this was risk assessed and care plans produced to indicate the reason for this. All bedrooms had a lockable space within them for patients to store their valuables.

The wards had phones, which the patients could use to make a phone call in a private area. Patients had access to Wi Fi and computer rooms in supervised areas on the medium secure units. Most patients apart from the medium secure units had access to their own mobile phones and patients could use their bedrooms to make private calls.

There was access to evening and weekend activities and this was highlighted in the 'speak up' group minutes in March 2017.

The occupational therapy team held a monthly meeting called championing recovery at Mersey Care with patient and staff recovery champions, minutes of these meetings were observed. These meetings addressed patient recovery and access to various courses for example, understanding and managing anxiety, information about our shared college, and access to chaplaincy, recovery and outcomes conference. Patients at this meeting discussed a new document being produced called 'do you feel you are always involved in decisions'. Fourteen patients at this meeting confirmed they felt involved. Patients who were due to be discharged had volunteered to attend the 'moving on group' to talk about what it was like in the community and to share their thoughts about what they wished they had known before moving on.

Meeting the needs of all people who use the service

The Equality Act 2010 includes nine protected characteristics of age, disability, gender reassignment, race, religion or belief, sex, sexual orientation, marriage and civil partnership, pregnancy and maternity. Services must have regard for and make reasonable adjustments to ensure discrimination does not occur on these grounds. We found there was access to faith and spiritual leaders. There were rooms identified that could be used for prayer or religious services. The trust has a spiritual and pastoral care service that represents all religious denominations as well as a team of trained volunteers to promote race, religion, or belief equality for patients and staff to access. They also had a diversity unit providing support and advice to patients and staff on any equality and diversity issues.

Staff had developed a range of accessible information to meet individual communication needs across all the wards. Woodview Ward 1 had adapted their integrated daily therapy timetables. These included pictorial signs and symbols to meet all the needs of all of the patients on the ward. The speech and language therapy team worked with and alongside ward staff and patients to develop easily accessible information to meet individual communication needs. Staff on all the wards were able to make referrals to the therapy teams and every patient coming into the service received an assessment to address their communication, speech and language needs.

Staff had produced ward round communication passports and pictorial prompts to inform the multidisciplinary team about how to communicate with the patients and for patients to express their mood using pictorial images as well as aids and adaptations to enable the patient to understand their meeting.

Comic strip communication was also being used where symbols were used to represent social interactions and abstract aspects of conversation, and colour was used to

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represent the emotional content of a statement or message. These were used to represent a range of concepts that may be involved in a conversation. Communication profiles were also used. These provided a summary of individual patient communication strengths and difficulties with strategies of how staff should support patients.

Patients who had difficulties with communication, eating and drinking were provided with dysphasia assessments and staff were supported by the speech and language therapists to enable them to understand patient's communication passports and communication profiles. Talking mats (a communication aid where pictures can be arranged and rearranged to aid thinking and communication) were also used with some patients.

Patients on each ward had access to independent mental health advocates. Detained patients had a statutory right to access support to help from independent mental health advocates to enable them to understand their rights under the Act. Each ward had a named independent advocate. The patients on all of the wards were able to contact the advocates direct by telephone and their presence on the wards was weekly or more often when required. Staff were able to telephone and email the advocates to invite them to important meetings associated with patients care reviews and discharge planning.

The trust provided a support group 'The Avenue' for patients who were lesbian, gay, bisexual or transgender as well as a women's action group.

Patients with autism had access to the 'autism risk group'. We observed this group; nine male patients and 10 staff attended this from multidiscipline including speech and language therapists, psychology, nurses and occupational therapists. We observed various activities and scenarios that promoted areas of thought, discussion and understanding for patients with autism as well as staff. Various prompts, storyboards and picture cards were used to express risk and behaviours as well as promote individuality of patients, likes and dislikes. All of the patients and staff had completed 'homework' from the previous session. This identified special interests patients and staff had and promoted discussions around other patients interest and not just about patients own agendas.

Creative skills groups were provided for patients and staff to work together. These included relaxation, beauty and pamper, card making, DJ skills and music, needlework and arts and crafts, culture club and animal therapy. We saw patients from Maplewood one were involved in the animal therapy. Patients were walking animals around the ground areas.

Listening to and learning from concerns and complaints

There were 35 complaints made across the secure service in the twelve months leading up to our inspection, which was a reduction of 81 complaints since the last time we inspected in October 2015. Four of these complaints were upheld and four were partially upheld. No complaints have been referred to the ombudsman. The four complaints listed where no outcome had been provided, included wards Woodview ward 1, Gisburn Lodge, Maplewood 2 and Maplewood 3 all with one each.

Other specialist services (learning disability secure wards) received one compliment during the last 12 months 1 January 2016 to 31 December 2016 (extracted 17 January 2017) and this was for Maplewood 3 ward.

The most complaints received were about Maplewood 3 with nine complaints received in the last 12 months and Maplewood - Coniston and Grasmere and Maplewood - Slaidburn was the least with one complaint.

The top five primary reasons for the complaints included: 'patient's property and expenses' with seven, 'other' with seven, 'admissions, discharge and transfer arrangements' with six, 'all aspects of clinical treatment' with six, and 'attitude of staff' with four.

Information was displayed throughout the hospital wards to inform patients on how to make a complaint as well as information about how patients could contact the CQC to make a complaint about their detention under the Mental Health Act. Patients also had information about patient advice and liaison services should they have concerns they would like to be resolved as an alternative to going through the formal complaints process.

The patient advice and liaison services lead for the trust and Healthwatch Lancashire attended the patient engagement group to discuss the trust wide patient experience survey. This allowed patients to provide feedback on the Mersey Care questionnaire and suggested changes to make it easy read.

Are services well-led?

Good

By well-led, we mean that the leadership, management and governance of the organisation assure the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

Our findings

Vision and values

The trust had a board owned strategy; this was "to strive for perfect care and a just culture that is empowered by service users, carers and teams."

Their perfect care goals included 'our services, our people, our future, and our resources'. Their aims were to improve physical health and well-being to all their service users and staff, to strive for a fair and just culture, to adopt a no force first approach to avoid physical restraints, including medication led restraint as well as a zero suicide for patients in their care.

The trust's vision was to be recognised as the leading organisation in the provision of mental health care, addiction services and learning disability care.

Their values were:

- Continuous improvement
- Accountability
- Respect
- Enthusiasm

The ward staff were aware of the trusts' vision and values; information was displayed throughout the wards and within the trust's intranet.

Staff we spoke with were motivated, passionate, respectful and compassionate toward the patients they cared for. The wards we visited all worked well together and had regular ward meetings. We saw good teamwork and managers supported their staff well. Staff we spoke with were positive about the teams they worked and were positive about their work, albeit they were concerned about the future of their positions due to the external NHS England consultation regarding the provision of future learning disability and autism services. Staff knew who their senior managers were in the trust and they told us their managers could be approached.

Good governance

Effective governance systems were in place to support the delivery of the specialist learning disability division. They ensured staff were kept updated about the trust vision and direction. Each ward had a monthly dashboard produced so that managers were able to review their performance against mandatory training, patient experience scores, incidents, staff sickness, staff injuries, and any patient harm. This dashboard was shared with the ward teams and the clinical governance team had oversight of each ward.

Two risks were identified on the trust risk register, which related to good governance. One risk related to the potential for a breach of confidential information on all Woodview nurses bases'. Patients having access to overhear confidential information due to the layout of the particular base. The second identified risk related to the potential for a breach of security by unauthorised access to Whalley site. During our visit, we did not see any issues regarding Woodview nursing bases as staff completed their paperwork and records within a locked office, which was away from the ward areas. In relation to the second risk, although the hospital had direct access to the grounds, any access to the ward areas was restricted.

The recommendation action plan produced following the drill for responding to anaphylactic shock had not been escalated or taken through the clinical governance team. These recommendations/actions were discussed with the deputy chief operating officer who confirmed their action plan for learning had not gone through the clinical governance group and would be actioned to share their findings within the division.

The specialist learning disability division had established a mental health law governance group, which reported into the clinical governance committee. The mental health law governance groups purpose was to be responsible to the clinical governance committee by scrutinising and gathering assurance on the robustness of the arrangements in place within the division to meet its duties in relation to: the Mental Health Act, Mental Health Act code of practice, Mental Capacity Act, Mental Capacity Act code of practice, Deprivation of Liberty Safeguards code of practice and associated regulations, guidance and case law.

The group identified and reported to the clinical governance committee and trust regarding any risks or emerging concerns regarding compliance to the above.

Overall, the mandatory training compliance results were high as noted in the report earlier. Staff received clinical supervision with the exception of Maplewood 2, which was below 70% compliant in the last 6 months. The teams reported incidents and learning from these incidents were

Are services well-led?

Good

By well-led, we mean that the leadership, management and governance of the organisation assure the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

discussed. The ward information boards had patient feedback detailed 'you said, we did' as well as lots of information about 'safe wards' and the trusts new initiative 'Dr Feel Well'.

All teams had staff members identified as 'champions' in various areas for example safeguarding, infection control.

Leadership, morale and staff engagement

Since 17 January 2016, there have been 17 cases where staff from specialist services had been suspended. Of the 17 suspensions, 10 have been at Band 3 and seven at Band 2, which were all support work or non-nursing staff.

The trust was monitoring daily and aggregating monthly average sickness rates. Sickness rates ranged from 3.5% to 23% across the wards from September 2016 to February 2017. Although some ward had staff vacancies, this did not adversely impact on the quality of care provided to patients. The trust were monitoring staffing levels on the wards daily in addition to continually and actively recruiting into the vacant positions.

Staff informed us they were fully aware of the whistleblowing process and the duty of candour principles in the trust and had access to policies and procedures.

Of the staff we spoke with, staff morale was good and staff reported job satisfaction in the teams we visited.

Commitment to quality improvement and innovation

The specialist services participated in the 'Quality Network for Forensic Mental Health Services' accreditation scheme run by the Royal College of Psychiatrists. The current percentage of full compliance reported against the standards was as follows: West Drive 88% and Maplewood 86%. Gisburn 87% and Woodview 94%.

The trust had introduced 'the barrier to change', on 1 Woodview in the teams drive to reduce restrictive practice. This assessment tool aimed to reduce the use of seclusion. The team also introduced a clinical model in December to reduce the long-term use of segregation within medium and low secure services. In January 2017, the team initiated the use of restorative practice as a means of resolving conflict. These initiatives, alongside safe wards and the continual support of a consistent team have resulted in 18 less incidents in February 2017 compared to January and an 80% reduction of the use of rapid tranquilisation. Time spent in seclusion and the use of T-Supine (patients being placed on their back) restraints reduced by between 65% and 80%.

The specialist learning disability division were committed to address issues regarding the increased discharges of people from long-stay hospitals. They worked closely with the patients, commissioners and partners to plan for individuals to move closer to their own local areas where possible.

Within the specialist learning disability division, individual patients and staff worked in partnership to develop their care plans and coproduce their therapy, rehabilitation and recovery together. This enabled patient choice and control, and offered opportunities for individuals to be experts within their own care. Individuals with lived experience co-delivered sessions for others to share their individual and personal stories, knowledge and skills.