Mersey Care NHS Foundation Trust

Inspection report

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Ratings

Overall trust quality rating	Good
Are services safe?	**Requires Improvement**
Are services effective?	**Requires Improvement**
Are services caring?	**Outstanding**
Are services responsive?	**Good**
Are services well-led?	**Outstanding**

Our findings

Our reports

We plan our next inspections based on everything we know about services, including whether they appear to be getting better or worse. Each report explains the reason for the inspection.

This report describes our judgement of the quality of care provided by this trust. We based it on a combination of what we found when we inspected and other information available to us. It included information given to us from people who use the service, the public and other organisations.

We rated well-led (leadership) from our inspection of trust management, taking into account what we found about leadership in individual services. We rated other key questions by combining the service ratings and using our professional judgement.

Overall summary

What we found

Overall trust

We carried out two announced and four unannounced inspections of six of the mental health and community health services provided by this trust, and one unannounced inspection of an adult social care location, as part of our continual checks on the safety and quality of healthcare services. We inspected Ashworth, the high secure hospital because this must be inspected every five years in order to inform the High Secure re-authorisation process, and the last inspection was in 2017 where it was rated good. We inspected acute wards and psychiatric intensive care units (PICU) and community inpatients because we had received information giving us concerns about the safety and quality of these wards. We inspected the forensic and secure wards and wards for people with a learning disability and/or autism because the service had changed significantly since the last inspection and to review outstanding breaches of regulation in the forensic services. We inspected community health services end of life care to review outstanding breaches of regulation. We inspected the adult social care location as it had not previously been inspected under adult social care methodology.

At the last inspection of the trust, we inspected some of the services under the heading of specialist services for people with a learning disability and/or autism. This core service does not exist as part of our current methodology, and those services are now included in the forensic and secure wards inspection.

In 2017, Wavertree Bungalow had been inspected as a hospital location. However, due to changes made by the trust to the registration of this service this was now an adult social care location. In line with our current methodology, the findings from this report will inform the judgements we make about how well-led this trust is, but the ratings will not be aggregated and therefore will not impact on the overall trust ratings. This report will be published separately.

We also inspected the well-led key question for the trust overall because the trust now delivered services formerly run by two different trusts, and to inform the re-authorisation of the High Secure Hospital.

We did not inspect the following core services, which have outstanding breaches of regulation, because we did not have current risk based concerns about these services at the time of inspection. As a result of this, the historical ratings have remained and have been used to determine the overall ratings for each key question and for the trust as a whole:

Our findings

- Community mental health services for working age adults
- Community mental health services for people with a learning disability and/or autism
- Community health services – adults
- Community health services – walk-in centres

We undertook a focused inspection of the walk-in centre core service and mental health crisis core service in 2022, as part of a piece of work looking at urgent and emergency care across the system. These services were not rated at this inspection and no breaches of Regulation were issued.

We did not inspect the following core services, which have changed significantly since the last inspection as they were transferred from another provider to Mersey Care NHS Foundation Trust, because we did not have current risk based concerns about these services at the time of inspection. As a result of this, the historical ratings have remained and have been used to determine the overall ratings for each key question and for the trust as a whole:

- Wards for older people with mental health problems
- Mental health crisis services and health based places of safety
- Community based mental health services for older people
- Community mental health services for people with a learning disability or autism
- Community health services for children, young people and families
- Specialist community services for children and young people
- Community health – Sexual health services

We did not inspect the following core services that have no outstanding breaches of regulation:

- Substance misuse services
- Community dental services

We are monitoring the progress of improvements to these services and will re-inspect them as appropriate.

Our rating of the trust stayed the same. We rated them as good because:

- We rated caring as outstanding, responsive as good, and safe and effective as requires improvement. We rated the trust as outstanding in well-led.
- At this inspection, we rated three of the trust's mental health services as good, and one as requires improvement. We rated two of the trust's community health services as good and none as requires improvement. We rated the adult social care location as requires improvement. In rating the trust, we took into account the ratings of other core services not inspected this time.
- The trust had the leadership capacity and capability to deliver high quality, sustainable care. Succession planning was in place and leaders had the skills, knowledge and experience to perform their roles and demonstrated integrity in doing so. Leaders were visible and approachable and understood the actions needed to mitigate challenges to quality and sustainability.

Our findings

- The trust had a clear vision and set of values and a robust and a challenging and innovative strategy was in place with quality and sustainability as top priorities. Staff, patients, carers and external partners had the opportunity to contribute to discussions about the strategy and the leadership team regularly monitored and reviewed progress on delivering it.
- The trust had planned services to take into account the needs of the local population. The trust engaged closely with the Cheshire and Mersey Integrated Care System and fully aligned its strategy to local plans in the wider health and social care economy. Plans were consistently implemented and had a positive impact on the quality and sustainability of services.
- The trust's culture was centred on the needs and experiences of people who used services. We were told about and observed staff caring for patients in a kind and compassionate manner. Through the acquisitions of other services, the trust had sought to embed areas of good practice in their own ways of working if it was better for patients and staff.
- Staff were proud of the organisation as a place to work and spoke highly of the culture. There was a strong organisational commitment and effective action towards ensuring that there was equality and inclusion across the workforce. Staff had access to training, supervision and appraisals and there were opportunities for professional development.
- The trust's steps towards a culture change, focusing on a just and restorative learning approach had seen a reduction in formal disciplinaries. The culture encouraged openness and honesty at all levels within the organisation and staff felt able to report concerns. The trust took appropriate learning and action as a result of concerns raised and sought to learn from incidents, deaths, complaints and the wider system.
- The trust took a pro-active approach to managing staffing pressures and had a clear workforce plan in place. This included a focus on growing their own staff and the retention of existing staff, which saw trust turnover rates reducing at the time of inspection. The trust managed daily staffing levels dynamically to ensure patient safety.
- There was effective accountability across the trust with systems in place to ensure the flow of information from ward to board and back again. Leaders were clear about their areas of responsibility and there was a visible and consistent approach to risk management and board assurance. Appropriate governance arrangements were in place in relation to Mental Health Act administration and compliance.
- The trust had clear and effective systems in place to provide assurance and escalate risk when needed. Performance was managed through clear structures and processes. Financial performance of the trust had been consistently strong and there were no examples of financial pressures compromising care. The trust worked with the wider health and social care system to plan for adverse events.
- The trust board received holistic information on service quality and sustainability. Leaders challenged and interrogated data and used performance measures to understand the challenges facing the trust at any given time. Systems that were in place to collect data were constantly being reviewed to identify how they could be improved. Submissions were made to external bodies as required and there had been no significant data or security breaches at the trust over the last 12 months.
- The trust was a forward thinking and pro-active partner and leader in the wider health and social care system. The trust was actively engaged in collaborative work with external partners, such as involvement with sustainability and transformation plans. Feedback from commissioners was that the trust was an excellent systems partner, supporting other partners and responding to concerns in the wider health economy.
- The trust took a leadership role in its health system to identify and proactively address challenges and meet the needs of the population. The trust had a lead role in the system response to the COVID-19 pandemic and continued to support partners with mutual aid.

Our findings

- The trust had a structured and systematic approach to engaging with people who used services, those close to them and their representatives. The trust had access to feedback from patients, carers and staff and were using this to make improvements. Patients, staff and carers were able to meet with members of the trust's leadership team and governors to give feedback.
- Quality improvement and innovation were central to the trust's vision to strive for perfect care. Staff had training in improvement methodologies and used data to drive improvement. The trust had worked with local and national providers as well as staff teams to identify new technology and innovative practices.
- Individual staff and teams received awards for improvements made and shared learning. External organisations had also recognised the trust's improvement work. The trust was actively participating in clinical research studies and in national improvement and innovation projects

However:

- The trust was experiencing staffing pressures across most services as a result of high levels of absence and vacancies. This impacted on patient's access to therapeutic activities and on staff wellbeing.
- Care plans were not always individual to the needs of the patient.
- The trust still provided dormitory accommodation which did not ensure the privacy and dignity of patients was protected. Some of the estates needed maintenance and repair. The environment at Wavertree Bungalow did not always meet the needs of people using the service.
- Governance systems did not always operate effectively in the core services. Audits did not always identify all areas for improvement and there was a lack of capacity and robust governance around medicines management in some areas.
- The trust was not always meeting its internal target in responding to patient complaints and the quality of investigations varied, although work was being done to improve this at the time of inspection. Some trust policy dates were overdue for review and some of the written Duty of Candour letters did not meet the requirements outlined in the trust policy.

How we carried out the inspection:

- In the acute and psychiatric intensive care unit (PICU) inspection we inspected 16 out of 17 wards, we did not inspect Hartley Hospital Southport. At Clock View Hospital we inspected four wards, Morris, Newton, Alt and Dee; at Broadoak Hospital we inspected Albert, Brunswick and Harrington wards; at Hollins Park Hospital Warrington we inspected both Sheridan and Austen wards; at Halton Hospital we inspected Weaver and Bridge wards; at The Knowsley Resource Centre we inspected Grasmere and Coniston wards; at St Helens Hope and Recovery Centre we inspected Taylor and Iris wards. We also inspected Windsor House which was a standalone acute ward. Newton ward at Clock View was the only PICU.
- In the forensics inspection we inspected ten wards and one individual placement. At Rowan View Hospital we inspected Astley ward, Eden ward, Rivington ward, Marbury ward and Delamere ward as an out of hours visit. At Rathbone Hospital we inspected Allerton ward. At Hollins Park Hospital we inspected Marlowe ward and Tennyson ward. At Whalley we inspected Maplewood 1 and Maplewood 2 and one individual placement at North Lodge.
- In the high secure hospitals inspection, we inspected 11 of the 13 wards; Arnold, Blake, Carlyle, Dickens, Johnson, Lawrence, Macaulay, Newman, Owen, Ruskin and Turner ward.
- In the inpatient wards for people with a learning disability we inspected the only ward; Byron ward.
- In the community end of life care inspection, we inspected two of the three teams.

Our findings

- In the community inpatients inspection, we inspected all four wards at Longmoor House.
- We inspected the only adult social care service provided by the trust; Wavertree Bungalow.
- We spoke with senior leaders as part of the trust-wide well led inspection.
- We spoke with 253 staff in face to face or virtual meetings including; health care assistants, nurses, doctors, allied health professionals, and managers.
- We attended and observed several meetings and committees held by the trust.
- We reviewed numerous records relating to the care and treatment of patients.
- We reviewed a variety of documents relating to the management of the trust and the services it delivers.
- We held seven focus groups including staff network groups, staff side and junior Doctors.
- We reviewed a variety of information we already held about the trust.
- We sought feedback from several of the trust's stakeholders such as Healthwatch, NHS England and advocacy services.

You can find further information about how we carry out our inspections on our website: www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

What people who use the service say

During our core service inspections, we spoke with 145 patients and 32 carers and family members. Patients, family members and carers spoke positively about the services.

Patients told us staff treated them well and with kindness. Patients told us staff were responsive to their needs and they felt able to talk to staff.

Patients in the community end of life care services told us nurses were caring, compassionate, and often, the care exceeded their expectations. They knew they could contact the service any time of day or night and they would be responded to and felt as though staff took their time to listen to them.

Patients on Byron ward told us staff were nice and respectful and spoke about a range of activities that staff supported them to access.

Patients in the acute and PICU services told us they felt safe and that staff treated them well and were supportive and caring.

Patients in the community inpatient hospital told us that staff listened to their needs and would share humour with them, which helped.

Patients in the forensics service told us they felt safe and that staff treated them well. Patients said they rarely had their escorted leave or activities cancelled, even when the service was short staffed. They told us they felt involved in their care.

Patients in the high secure service told us they mostly had positive relationships with staff and described staff as kind, friendly and caring.

Our findings

Carers at Wavertree Bungalow told us that staff were amazing and they felt their family member was safe at the service. Carers at Wavertree Bungalow told us they really trusted staff at the service and shared comments including 'the service was a lifeline' and 'it was one of those places we couldn't do without'. All families and carers we spoke with said they felt involved in their loved one's care and that staff communicated well with them.

However;

Some patients on Byron ward told us they found the noise on the ward too loud and that lunch was boring.

Patients in the high secure hospital expressed their frustration of the impact of staffing pressures on access to on and off ward activities and delays in accessing personal care.

Outstanding practice

We found the following outstanding practice:

Trust wide:

- Leaders within the trust gave staff time to focus on continuous learning and innovation. For example, the HOPE(S) model was a human rights-based model developed by staff within Mersey Care, that encouraged teams to **H**arness the system through key attachments and partnerships; created **O**pportunities for positive behaviours, meaningful and physical activities; identified **P**rotective and preventative risk and clinical management strategies; and built interventions to **E**nhance the coping skills of both staff and patients, while the **S**ystem was managed and developed. There were clear links between the overarching HOPE(S) model and the focus the trust took on reducing restricted practices. The HOPE(S) model was embedded across the trust and a partnership between NHS-led provider collaboratives and Mersey Care was established, with an over-arching aim to deliver the HOPE(S) clinical model of care to reduce LTS, at scale, in services for people with a learning disability or autism.
- The trust had embedded their reducing restrictive practice work and we saw the positive impact of this during the core service inspections. The trust had a 'No Force First' ethos that had seen a 10% decrease in incidents of restraint in 2021/2022 when compared to the same period last year, and assaults on staff had reduced by 12%. Furthermore, an independent evaluation conducted by Manchester Metropolitan University, observed an overall 20% reduction in the use of restraint, and an accompanying reduction in the duration of restraint incidents, with the vast majority lasting for less than five minutes.
- Mersey Care headed up the first NHS led Global Centre for Research on Mental Health Inequalities, led by their Global Research Director. The new centre aimed to bring together international academics and clinical practitioners to support research, learning, develop expertise, training and community engagement and involvement on issues that lead to widening mental health inequalities

Community Inpatients:

- Quality improvement initiatives were embedded in the service and regularly reviewed to gauge their success. For example, the falls quality improvement plan and falls alarm prevention pathway, which had significantly reduced the number of falls at the service.

Our findings

- Ward managers and staff had the autonomy to introduce and trial new projects and if successful, roll them out to the rest of the service. For example, the introduction of a specialist sub-epidermal (SEM) scanner on one of the wards, which helped to identify the risk of pressure ulcers before visible signs of tissue damage developed.

Forensic inpatient or secure wards:

- The service had an embedded ethos of least restrictive practice. Staff were supported by a trust team and divisional lead to review all restrictive practice. Use of restrictive practices was low. We saw a commitment by staff to utilise least restrictive options and a willingness to challenge practice if appropriate.
- The service had an embedded ethos of quality improvement. Individual wards had on-going quality improvement projects. Staff felt empowered to raise quality improvement ideas with management. Support was available from a Trust team. The service had mechanisms in place to learn and improve from adverse incidents, feedback and complaints.
- The service was part of the triangle of care project. Triangle of care is a national initiative originally launched on acute mental health wards that focuses on the principle of carers, patients and staff working in equal partnership. It encourages carer participation and the development of processes and forums for their involvement. Wards had completed triangle of care self-assessments and developed action plans from the findings.

High Secure Hospitals:

- No Force First was the philosophy that underpinned the trusts restrictive practice reduction programme (RRP). The key components were collaborative individualised care with patients using data to inform clinical practice and using the lived experience of patients to motivate change for staff. This was a trauma informed approach that included understanding behaviour that challenges, taking account patients traumatic history. The trust had revised the policy taking account of the Use of Force Act. The RRP policy supported the implementation of RRP and outlined the trusts key commitment to reduce conflict, restriction and harm to patients and staff. The trust had a dedicated team to deliver the RRP, which was integrated in clinical divisions and supported by the Board and Centre for Perfect Care. The trust had won the following awards for this work:
  - Patient Safety Awards. Winner in ‘Changing Culture’ category (2019)
  - Health Service Journal Value Awards. Winner ‘Communication’ category (2018)
  - Restraint Reduction Network Leadership Awards winner in ‘Innovative Practice’ category (2018)
- Quality improvement projects to promote the trust restrictive reduction programme continued this work. On Lawrence ward, staff took a quality improvement approach to supporting a patient with high complex needs and poor response to previous antipsychotic medicine. The patient had a history of treatment resistant schizophrenia with unpredictable and impulsive episodes leading to assaults on staff and patients. The care team follow NICE guidelines QS80, Psychosis and Schizophrenia in Adults in developing a plan to help improve the patient’s compliance with medicine and plan interventions in the least restrictive way. Over time, the patient’s compliance with medication improved and their level of engagement on the ward increased.
- In March 2022, Lawrence ward reduced its capacity to five patients due to business continuity, four of whom were in LTS and one in seclusion. Staff used this opportunity to take a quality improvement approach with the aim of reducing the patients time in LTS. Staff were able to provide more intense one to one session with patients and with less patients on the ward, encourage them back into the main ward environment. During this brief period, the ward team were able to reduce time spent in LTS and reduce the patient’s isolation.

Our findings

Areas for improvement

Action the trust MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the trust MUST take to improve:

We told the trust that it must take action to bring services into line with six legal requirements. This action related to five core services.

High Secure Hospitals:

- The trust must ensure that the care and treatment of service users meets their needs and reflects their preferences. The trust must ensure that patients have access to meaningful activities, and that this is monitored. (Regulation 9(1)(b)(c).
- The trust must ensure that all appropriate Venous Thromboembolism (VTE) risk assessments are completed on admission to the hospital and reassessed as needed, as recommended by NICE NG89 guidance 2018. (Regulation 12(1)(a)
- The trust must ensure that sufficient numbers of staff are deployed to make sure that they can meet people's care and treatment needs. (Regulation 18 (1)

Acute wards and Psychiatric Intensive Care Units:

- The trust must ensure all care plans reflect the patient voice and be individualised (Regulation 9)
- The trust must ensure that care and treatment is provided in wards that maintain and protect the privacy and dignity of the patient. (Regulation 10)
- The trust must ensure that care is provided in wards which protect patient's safety, and are properly maintained. (Regulation 15)

Forensic or secure inpatient wards:

- The trust must ensure that staffing levels are sufficient to enable compliance with the trust observation policy and provide greater consistency for patients (Regulation 18 (1)

Community End of Life Care:

- The trust must ensure that systems and processes operate effectively and consistently across the service with sufficient oversight to ensure community end of life care services are monitored and improved. (Regulation 17 (1) (2) (a)

Wards for patients with a learning disability and/or autism:

- The trust must ensure it has sufficient oversight to ensure that all annual health checks are carried out and that all patients have an accurate and contemporaneous record of care including comprehensive assessments, one page profiles, hospital passports and falls risk assessments. (Regulation 17 (2) (b) (c)

Our findings

Action the trust SHOULD take to improve:

Trust wide

- The trust should ensure that there is ongoing monitoring and oversight of the impact of dormitories on the privacy and dignity of patients, until the steps being taken to eradicate dormitories are completed.
- The trust should ensure that capacity and governance concerns continue to be addressed within the pharmacy teams to enable effective medicines management across services.
- The trust should ensure that audits identify areas for improvement and that those are acted upon to ensure improvement in quality and safety are made as required.
- The trust should ensure that complaints are responded to within the trust target and that complaint investigations are thorough and consistent and completed in line with trust policy.
- The trust should ensure that letters sent under Duty of Candour adhere to the trust policy and statutory guidance.
- The trust should ensure that all policy review dates are updated to reflect the most recent review and the date they are next due.

High Secure Hospitals:

- The trust should ensure that all wards are in a good state of repair and that the sluice on Carlyle ward and bedrooms on Carlyle and Johnson ward are subject to the required repair to ensure the sluice drains correctly and bedrooms are redecorated.
- The trust should ensure that the appropriate Mental Health Act authorities are in place for the prescribing and administration of medicines.
- The trust should ensure that medicines are being managed safely on the opening of the product as per their relevant manufacturing guidance.
- The trust should ensure there is a system in place to monitor the clinical supplies stored in the Health Centre by visiting clinicians.
- The trust should consider gradually upgrading its signage to make it more accessible for patients and staff with dyslexia or other reading difficulties.

Acute wards and Psychiatric Intensive Care Units:

- The trust should ensure that they monitor and reviews arrangements to ensure that medicines with a minimum dosage interval are administered as prescribed.
- The trust should ensure that patient allergies are correctly recorded.
- The trust should ensure people prescribed valproate who were of childbearing age meet the requirements of the pregnancy prevention programme.
- The trust should ensure all physical health checks are completed after rapid tranquilisation.

Forensic or secure inpatient wards:

- The trust should ensure the pharmacy team has capacity to provide support for medicines optimisation.

Our findings

- The trust should ensure that the monitoring of blood glucose levels is recorded consistently on Eden ward

Wards for patients with a learning disability and/or autism:

- The trust should consider providing an enhanced level of autism training to all staff to ensure they are able to meet the complex needs of people at the service.
- The trust should ensure that patient feedback in relation to food and menu choices is acted upon.
- The trust should ensure that audits are effective and result in embedded changes to practice.
- The trust should ensure that staff are appropriately skilled to manage competing needs in order to reduce people's levels of distress.
- The trust should consider how to effectively manage people's different sensory needs.

Community End of Life Care:

- The trust should continue to ensure that staff have the opportunity to be involved in the development of the service including information about the outcomes being achieved.
- The trust should ensure staff always have access to the necessary clinical equipment to carry out their role.
- The trust should ensure all district nursing staff delivering palliative care are aware of the single point of access number, so they can escalate concerns in a timely way.
- The trust should ensure staff in Liverpool and South Sefton are up-to-date with their appraisals.
- The trust should ensure that written information about coping with dying is always shared with patients and their families.

Community Inpatients:

- The trust should ensure that all staff complete mandatory and role specific training. In particular, training in basic life support or immediate life support.
- The trust should ensure care plans reflect patient's individual needs. These should include care plans for medicines prescribed to control behaviour that could be challenging.
- The trust should review and monitor arrangements to make sure that medicines with a minimum dosage interval are administered as prescribed.

Is this organisation well-led?

Our rating of well-led stayed the same. We rated it as outstanding.

Leadership

Leaders had the skills, knowledge and experience to perform their roles. They had a good understanding of the portfolios they managed and were visible in services and approachable for patients and staff**.**

Our findings

The trust had the leadership capacity and capability to deliver high quality, sustainable care. Board members had the skills, knowledge, experience and integrity needed to lead the trust. They understood the challenges to quality and sustainability and could identify the actions needed to address them.

The executive team comprised a Chief Executive, Executive Director of Nursing and Operations (who was also Deputy Chief Executive of clinical services), Deputy Chief Executive of non-clinical services, Executive Director of communications, corporate governance and estates, Executive Director of strategy, Executive Director of workforce, Executive Medical Director and Executive Director of finance. The trust also had a non-voting Director of strategy. The Chief Executive had been in post since 2012 and had previously been Chief Executive at another NHS organisation.

There was a new Chair in post, who had taken up position three days before the inspection and the Deputy Chair had been acting Chair during the short transition period. The retiring Chair had served for 14 years due to the move to Foundation Trust status in 2016, which meant the length of the Chair's term had re-set. Since the last well led inspection, three new Non-Executive Directors (NED) and two new Executive Directors had been appointed, along with a new non-voting Director. During our well-led review, we spoke with most of the board members and the trust secretary. Executive and Non-Executive Directors had an in-depth understanding of the running of the trust. The trust's Chief Executive and senior leadership team were also well-sighted on national and local issues that impacted on service provision.

NHSE told us that the full board was well established and stable, with a broad range of experience and skills appropriate to the delivery of high-quality sustainable care. The Director of Finance had appropriate experience and was supported by a capable finance department.

The trust had a lead for child and adolescent mental health, learning disability and autism. The deputy director of nursing and quality was the executive lead for safeguarding. The trust had a named doctor for safeguarding children and adults and a professional safeguarding lead. The medical director was the lead for mortality.

Prior to the inspection we observed a board meeting, a council of governors meeting, people committee and quality committee. We also attended audit committee during the well-led inspection. We saw that discussion on issues was balanced and effective, and that decisions were informed by consideration of quality, performance and strategy. Non-Executives provided constructive challenge and expertise.

The board had 16 voting members, with one NED vacancy at the time of inspection. The executive team had four women (44.44%) and no (0%) black and minority ethnic members. The non-executive board had one (12.5%) black and minority ethnic member and three (37.5%) women. The trust identified this wasn't reflective of the population it serviced and were taking steps to recruit more black and minority ethnic members.

The trust board and senior leadership team displayed integrity on an ongoing basis. Fit and Proper Person checks were in place in the six board members files we checked. There were effective systems in place to ensure that board members were fit for the role on appointment and throughout their employment. This included an annual self-declaration, checks on the insolvency register and disqualified directors list, disclosure and barring service checks, professional body registration checks, proof of qualifications and references.

The trust planned board development days throughout the year, and although these had been impacted by the COVID-19 pandemic, one was planned for the day after our inspection.

Our findings

Succession planning was in place across the trust. The trust had commissioned an external board skills review to inform the recruitment of their NED vacancy and to plan for the potential changes over the coming two years, as five NEDs were coming to the end of their terms. The Chief Executive was able to demonstrate how succession planning had featured in the recruitment of the Executive team.

When senior leadership vacancies arose the recruitment team reviewed capacity and capability needs and the trust reviewed leadership capacity and capability on an ongoing basis. The trust had distributed leadership portfolios according to individuals' expertise, capability and motivation. There were clear priorities for sustainable, compassionate, inclusive and effective leadership.

The trust leadership team had a comprehensive knowledge of current priorities and challenges and took action to address them. The leadership team had established lines of responsibility via their action plan to areas requiring improvement.

NHSE told us the trust had bespoke, values-led leadership programmes accessible to all staff. The trust had a leadership development programme, which included succession planning. The trust's leadership development pathway was open to all staff and included three values-based core programmes: 'strive' for bands 5 and below, 'thrive' for bands 5 to 7, and 'drive' for bands 8a and above.

Leaders ensured that they were visible and approachable. Staff who spoke with us during our inspections of core services knew who the Chief Executive and previous Chair of the trust were, with the new Chair only having started just prior to inspection.

There was a programme of board member visits to services and staff fed back that leaders were approachable; the findings of which were shared in committee and board meetings. Visits had been suspended during the COVID-19 pandemic, but they had recommenced with a total of 132 visits taking place between January – November 2022. All people, including staff, patients, carers and members of the public were able to tell the chief executive what they thought about the trust through the CEO's 'tell Joe' email address.

The trust had a senior leadership team in place with the appropriate range of skills, knowledge and experience. Two Deputy Directors of Nursing, a Director of Operations and a Deputy Director of Therapies, Psychological and Allied Health Professionals supported the Executive Director of Nursing and Operations and attended committee meetings.

Since the last inspection, the trust had made changes to the leadership structure below board level. The trust was working through a change process to their organisational design at the time of inspection. This was described as a 'hop, skip and jump' and the trust were in the second phase. Following the acquisition of North West Borough Healthcare NHS Foundation Trust on 1 June 2021, the acquired services had initially moved into their own clinical division to allow a period of stability for the mid-Mersey services. However, this new organisational design moved all the clinical services into three clinical divisions;

- Secure care which included high secure mental health inpatient services, medium secure mental health and learning disability inpatient services, low secure mental health and learning disability inpatient services, offender health services and forensic community services. This division also included non-forensic learning disability community and inpatient services at the time of inspection.

Our findings

- Community Care which included physical health community, inpatient and outpatient services across five geographical/service areas; Liverpool services; children, families and Sefton services; dental and Knowsley, Halton, Warrington and St Helens services; urgent care services; and the care management team which included reception services, equipment services and clinical governance.
- Mental Health Care which included a range of mental health community, outpatients and non-forensic inpatients services across four geographical/service areas; mental health and addiction services; mental health community services; mental health urgent care and short term assessment.

A fourth division included trust-wide support services, such as insight, strategy, enablement and experience. The purpose of this change was to ensure standardisation and safety across the whole trust, to realise the clinical and operational benefits of the acquisition, to embed the operational framework and to mitigate risk.

The three clinical divisions worked across six places; Liverpool, Sefton, St Helens, Knowsley, Halton and Warrington. The trust also had an effective divisional and professional leadership team working across the divisions and places. Each division had a Divisional Director who reported to the Director of Operations. The structure was supported by a range of Associate Directors of Nursing, Heads of Operations, Allied Health Professionals or Nursing and Clinical Services Managers.

The pharmacy service was undergoing organisational change to establish a single integrated team with clear management and reporting responsibilities. Limited capacity within the pharmacy team meant that at ward level, resource was targeted to areas of risk such as completing medicines reconciliations and maintaining ward stocks. Agreed investment meant that the trust could now work towards the integration of pharmacy services into multidisciplinary teams across the trust, delivery of strengthened medicines governance, and provision of person facing clinical services. Delivery of medicines optimisation would help to ensure that patients got the best outcomes from their medicines and supported delivery of the trust's 'zero harm from medication perfect care goal'.

Vision and Strategy

There was a clear vision and set of values, with quality and sustainability as the top priorities. The trust values were presented under the acronym 'CARES' and stood for continuous improvement, accountability, respect, enthusiasm and support. Trust values were integral to recruitment processes, staff appraisals and staff awards. Staff knew and understood what the vision, values and strategy were, and their role in achieving them.

There was a robust, realistic strategy for achieving the priorities and delivering good quality sustainable care. The strategy was challenging yet achievable. A 'strategic wheel' illustrated how the trust intended to achieve its vision, which was to strive for perfect, whole-person care that helped people live happier, healthier lives. Perfect care was defined as 'stretching goals to keep us at the forefront of challenges and maintain our leading safety status'. This included 'zero acceptance of racism, discrimination and unacceptable behaviours; zero restrictive practice; zero suicide; zero harm from medication and zero falls in our care.'

The trust had four strategic objectives as follows:

- Services - combine clinical excellence with prevention and care coordination in our services
- People - more people choose to work at Mersey Care and service users feel they have more control over their health
- Resources - use our buildings, IT and money to enable clinical excellence with prevention and care coordination in our services

Our findings

- Future - be a good partner organisation and strive for new advances in care and treatment

The current focus for medicine management was the delivery of service transformation. Senior leaders worked collaboratively to identify the type and level of resources required to deliver a safe, effective, and efficient service. A high-level implementation plan showed phased delivery over the next 3 years, with benefits realisation from quarter 4 2022/23. Senior management and governance arrangements for medicines management had been agreed, although capacity for governance work was limited. Key performance and quality indicators had been drafted to measure the impact of the changes.

One of the deputy directors of nursing held responsibility for infection prevention and control. There were systems in place to manage and monitor the implementation of the trust's infection prevention and control strategy.

Staff, patients, carers and external partners had the opportunity to contribute to discussions about the strategy, especially where there were plans to change services. For example, the idea to build the new medium secure hospital, Rowan View, round in shape was taken from a service user suggestion. The trust had also recently reviewed their carer's strategy in consultation with carers, where they were invited for afternoon tea to share their thoughts.

The trust held a series of 'mega conversations' with staff in 2021 to assist them in setting out the key priorities for 2022/23, which were as follows:

- Improving access to our services and reducing unwarranted variation in key areas across the enlarged trust. We will tackle variation in waiting times for our mental health and therapy services
- Strengthening the resilience of out of hospital services to care for people safely in the community and supporting efficient patient flow in our health and care system
- Prioritising safety standards, including safe staffing, across our services and supporting teams to achieve 'outstanding' in our Quality Review framework
- Maximising opportunities to be more preventative in our services, identifying and meeting people's needs earlier. We will pilot an extension of the Life Rooms in Mid Mersey and reach out proactively to marginalised and underserved communities, working in partnership with local VCSE organisations
- Increasing care coordination for people with complex needs, particularly at points of transition. Reducing hand offs and points of assessment within Mersey Care's own services and working closely with partners to deliver joined up care. We will strengthen the family, children and young people focus across Mersey Care
- Continuing our journey to becoming an anti-racist organisation and pursuing our perfect care goals
- Tackling our key workforce challenges by supporting health and wellbeing, managing absence and through new approaches to vacancy hotspots
- Implementing our patient engagement and experience plan to build patient experience and side by side working with service users and carers more fully into the design and delivery of our services
- Enhancing the framework and operating standards for safe virtual consultation which considers digital inclusion; and bring together our multiple clinical information systems
- Continuing to invest in fit for purpose inpatient hospitals and community facilities in the communities we serve. This includes prioritising patient safety and backlog maintenance across the enlarged Trust whilst continuing development of our low secure unit and Liverpool 2 builds

Our findings

- Building on our relationships with partners in each of the places that we serve; as well as partners in the Cheshire and Merseyside system, so that we can achieve more in collaboration than as one organisation alone.

The leadership team regularly monitored and reviewed progress on delivering the strategy and most areas were on track at the time of inspection. Delivery against the operational plan priorities was reported through the executive performance report and reviewed with each division in quarterly performance reviews. Strategic plans were consistently implemented and had a positive impact on the quality and sustainability of services.

There was a demonstrated commitment to system-wide collaboration and leadership. During the COVID-19 pandemic, the Trust played an integral part in the safety of the system by setting up the neutralising monoclonal antibodies service (NMABs), hosting the Cheshire and Mersey resilience hub for all staff to access during the pandemic and opening a new hospital to assist with the pressures within the acute services. The trust also supported with system leadership the move of one acute hospital into a new building.

The trust engaged closely with the Cheshire and Mersey Integrated Care System and aligned its strategy to local plans in the wider health and social care economy. The Chief Executive was part of the Integrated Care Board. Mersey Care had planned services to take into account the needs of the local population. The trust was using data and intelligence to understand their population health and working with system partners to develop services that were more preventative in their approach.

The trust was aware of the impact of health inequalities on the population it served and tackling health inequalities was embedded throughout the trust's strategies and work programmes. Mersey Care was the host of the Cheshire and Merseyside System P programme (System P), which aimed to help those providing health, social care and wider support to share knowledge, learn from it and then work together to provide care more effectively. System P aimed to analyse data to identify gaps and overlaps and to highlight opportunities to make small changes to the system which could improve the health of the local communities.

Mersey Care headed up the first NHS led Global Centre for Research on Mental Health Inequalities, led by their Global Research Director. The new centre aimed to bring together international academics and clinical practitioners to support research, learning, develop expertise, training and community engagement and involvement on issues that lead to widening mental health inequalities.

The trust had a range of other strategies to support the success of the overall strategy, examples included children and young people strategy, Life Rooms strategy, digital strategy and patient safety strategy. The trust also had a strategy for meeting the physical healthcare needs of patients. One of the trust's priorities was improving care co-ordination and integrating physical and mental health care for those most vulnerable, such as patients with a learning disability and children and young people. The trust set out its aim to remove the boundaries between physical and mental health care and to work closely with Primary Care Networks and community services to provide holistic, joined up care.

The trust embedded its vision, values and strategy in corporate information received by staff. Staff in the core service's we inspected knew and understood the trust's vision, values and strategy and how achievement of these applied to the work of their team.

Culture

Our findings

During the inspection we spoke with 253 staff and received feedback from more staff during focus groups. There were high levels of satisfaction across staff and almost all staff told us they felt respected, supported and valued. However, some staff in the community end of life care service told us they did not feel fully supported and involved in the development of the service.

The trust's strategy, vision and values underpinned a culture which was patient centred. The trust's culture was centred on the needs and experience of people who use services. The conversations that we observed at the trust board meetings focused on the patient experience and the vision to strive for perfect care.

NHSE told us that the trust's vision of perfect, whole person care that helps people live longer, healthier lives, achieved a patient focus based on deeper insight and population health intelligence, aided by digital maturity. They felt the trust demonstrated innovation based on an understanding of patient's needs, developing service solutions that gave people a more active role in their own care and wellbeing. NHSE viewed Mersey Care as seeking to develop more preventative interventions by working in partnerships that extended influence beyond the services they directly provided.

Most staff felt positive and proud about working for the trust and their team. The annual NHS Staff Survey was conducted between 4 October and 27 November 2021 and the trust achieved a response rate of 32%, which was a 5% decrease from 2019 and below the national response rate of 52% for Mental Health & Learning Disability and Mental Health, Learning Disability& Community Trusts. The trust identified that staffing and operational pressures had contributed to the response rate and were seeking staff feedback in other formats, such as roadshows, forums, breakfasts, team-based working, and improvement/design methodologies that were incorporated within the annual engagement plan. Mersey Care also undertook a quarterly Culture of Care Barometer, a quarterly Pulse survey and was an early adopter of the National Bank Staff Survey, which was launched in 2022.

When compared to the average scores for 'Mental Health & Learning Disability and Mental Health, Learning Disability& Community' Trusts, the 2021 results show that Mersey Care were either meeting or exceeding the national average for 7 of the 9 themes in 2021. These were morale, staff engagement, compassionate and inclusive, recognised and rewarded, voice that counts, safe and healthy and teamwork. The two areas where the trust scored below the national average were 'always learning' and 'flexible working'. The trust had put an action plan in place in response to the survey results, which included an engagement campaign with staff, implementation of the Team Canvas (which was an agreed purpose and set of values and behaviours developed by each team with the aim of providing a basis for conversations about psychological safety and restorative justice), planned leadership sessions and the consultation, development and implementation of a Culture, Engagement & Belonging Strategic Plan. The staff survey 2022 was ongoing at the time of inspection.

The trust recognised staff success by staff awards and through feedback. Mersey Care had 'Star Awards' for staff, where people could nominate any individual or team who worked for the trust for their hard work, commitment to perfect care and achievements. The trust also held annual 'Positive Achievement Awards' which acknowledged the work of staff in each division in a series of categories, including improving the service user experience, innovation, commitment to clinical care and a team of the year category.

There was strong collaboration, team-working and support across all functions and a common focus on improving the quality and sustainability of care and people's experiences. Teams had positive relationships, worked well together and addressed any conflict appropriately. There were cooperative, supportive and appreciative relationships among staff. Staff and teams worked collaboratively, shared responsibility, and resolved conflict quickly and constructively.

Our findings

During our inspections we observed staff treating patients with kindness and respect. Patient feedback was that staff were caring and worked hard to meet their needs. However, we found during our core service inspections that care plans on the acute and PICU wards were not always personalised and individual to the patient.

The trust had a 'No Force First' ethos that had seen a 10% decrease in incidents of restraint in 2021/2022 when compared to the same period last year, and assaults on staff had reduced by 12%. Furthermore, an independent evaluation conducted by Manchester Metropolitan University, observed an overall 20% reduction in the use of restraint, and an accompanying reduction in the duration of restraint incidents, with the vast majority lasting for less than five minutes.

Staff felt able to raise concerns without fear of retribution. The culture encouraged openness and honesty at all levels within the organisation, including with people who use services, in response to incidents. Leaders and staff understood the importance of staff being able to raise concerns without fear of retribution. In a recent campaign to encourage people to speak up, the Chief Executive had advised staff that if they were concerned about something but fearful of reporting it to the trust, they should report it to the Police, showing that speaking up to anyone about anything was paramount.

Staff we spoke with on inspection knew how to use the whistle-blowing process and about the role of the Freedom To Speak Up (FTSU) Guardian. The trust reported that awareness of the FTSU role had increased from 63% to 84% in 2022.

The trust had a Freedom To Speak Up strategy and a policy. The policy met the standards set out in NHS Improvement's 'Freedom To Speak Up: Raising Concerns (whistleblowing)' policy (2016). Staff were provided with Level 1 and 2 training packages from the National Guardians Office and the trust planned to launch the Level 3 training which had just been developed.

The trust had appointed a Freedom To Speak Up Guardian team of 4.2 whole time equivalents, and provided them with sufficient resources and support to help staff to raise concerns. The trust FTSU guardians worked across the divisions, with one providing the team leader role. They had the training and experience to be able to perform their roles. They raised awareness through the trust website/intranet, posters and by visiting sites, for example attending the 'breakfast meetings' at the Whalley site enabling them to speak to large numbers of staff.

There was an executive and non-executive lead who met bi-monthly with the FTSU team and the team met quarterly with the chair and chief executive. The team reported that relationships were positive and that the non-executive lead had an independent role in reviewing investigations. The team had close links with the staff networks and with the Quality Review Visit (QRV) team, working together to identify areas where support was needed for staff and sharing intelligence. This was being formalised in the development of a Raising Concerns Oversight Group which involved clinical divisions and teams from corporate services including Perfect Care, QRV, Health and Well Being, Organisational Effectiveness, Staff Side, Equality, Diversity and Inclusion team and workforce. The aim was to share information about the activity of teams to identify hotspots and themes and to prevent duplication. A biannual report was submitted to the Quality Committee, which showed that in 2021/2022, a total of 248 contacts were made with the Guardians. The report outlined complex cases, themes and actions taken.

The team had identified the need to support staff from all cultures and backgrounds to feel able to speak up, and so had appointed a Black and minority ethnic staff member to work alongside them for 12 months to bridge that gap. The role involved working alongside the staff networks to improve systems and processes for accessing the guardians. This role had been so successful that it had been appointed to permanently.

Our findings

The team was currently piloting the champion role, something they had taken from the acquisition of North West Boroughs Foundation Healthcare Trust (NWBFHT) as positive practice which they were keen to embed. The team were recruiting any interested staff, including those who had gone through the FTSU process so they could speak first-hand about their experience and encourage others to speak up. The Guardians felt than an open culture was present within the trust and had been further embedded over recent years, however the trust was aware there was further work to be done on supporting people to speak up.

Staff could report concerns directly to the Chief Executive through the 'tell Joe' email, through their union representative or Freedom to Speak Up guardian or by following the trust whistleblowing policy. Appropriate learning and actions were taken as a result of concerns raised.

The trust had a Guardian of Safe Working Hours, who was new into post with Mersey Care but had been a Guardian since 2016. Under the 2016 Terms and Conditions for doctors and dentists in training introduced by the Department of Health, there is a requirement for the Guardian of Safe Working Hours to submit a quarterly report to the trust board. This has been delegated to the trust's Quality Committee. We reviewed the four quarterly reports that had been submitted between 01 July 2021 until 30 June 2022 and the annual report covering 01 August 2021 to 31 July 2022. During this time period, no fines had been issued and the trust had received 16 exception reports for safe working hours, the majority of which related to out of hours work. All exception reports were satisfactorily resolved, usually within seven days, and no safety concerns were identified.

The Guardian of Safe Working Hours had a dedicated slot on both the Mersey Care and Mid-Mersey Division junior doctors' virtual induction programme in August 2022. This was to provide an overview of the role, exception reporting and work schedules. There had recently been a Junior Doctors' forum meeting for the whole trust-wide trainees chaired by the Guardian of Safe Working Hours and Director of Medical Education.

At the last inspection in 2018, we recommended that the trust should ensure that junior doctors feel able to make exception reports when working above their agreed hours. Both the Guardian and the Medical Director told us that exception reporting was encouraged and supported. We held a focus group with Junior Doctors and found that the Doctors were aware of who the Guardian was and their role. Exception reporting was seen as the mechanism to be used to report problems with safe working hours, and they felt that this system worked well. Doctors told us that they rarely went over a 12 hour shift and took their breaks, however they raised concerns about limited space in the environment to take those breaks.

The trust worked with trade unions. A bi-monthly Joint Negotiating Consultative Committee was held, during which representatives had been given the opportunity to chair and some felt they were able to have a voice. However, feedback from representatives was mixed. During a focus group we were told that representatives felt the trust was not pro-active in addressing concerns, that reps did not feel valued by senior managers and that access to the Executive team was varied.

Managers addressed poor staff performance where needed. The trust had a disciplinary policy, which aimed to take a compassionate approach to handling conduct concerns in line with the Just and Learning Culture. The policy outlined the roles and responsibilities of all those involved and set its aim as ensuring staff were treated fairly, objectively and with consideration.

The trust had managed 26 disciplinaries involving staff in the 12 month period until 09 November 2022. Through acquisitions, the trust had applied their restorative just and learning approach and seen a reduction in formal

disciplinary investigations due to misconduct and gross misconduct. We saw that initial reviews often triggered early interventions, such as training or staff coaching, which helped support staff and resolve issues. These initial reviews had also identified organisational or systemic factors behind the concern, which resulted in changes to policy, the environment, or standard operating procedures.

We reviewed five cases where disciplinary action was taken, the five cases covering different staff grades within the service. We saw that the trust was following the trust policy.

The trust had a 'Respect, Civility and Resolution' policy, which had replaced the 'Dignity at Work' and 'Early Resolution' policies. The policy aimed to encourage positive employee relations and to prevent bullying, harassment and any form of unacceptable behaviour between colleagues and aligned with one of the trust's values; Respect.

The trust had managed 41 early resolution cases and dignity at work cases in the 12 month period until 09 November 2022. We reviewed five of these cases and found that policy was being followed in all instances and a fair resolution was reached.

The trust had a policy for monitoring professional registration 'Verification of statutory registration of temporary and permanent colleagues.' The registration of staff was checked as part of the recruitment process and the temporary staffing team and medical staffing team checked the registration of all agency and locum workers prior to commencing any work for the trust.

The trust had a policy for monitoring Disclosure and Barring Service (DBS) checks. The DBS process had recently been audited by Mersey Internal Audit Agency which highlighted that the trust benchmarked over and above other NHS trusts in its application of the DBS process and that it fulfilled all legal requirements.

The trust had a core mandatory training programme in place for all staff. The overall training compliancy target was 95%, which had been reached in September 2022 for the first time since December 2021. Training compliance had reached 94% in May, June, July and August 2022. Safeguarding Adults level 1, 2 and 3 compliance (target 90%), and Safeguarding Children level 1 and 2 compliance (target 90%) had continued to be achieved in July, August and September 2022. Safeguarding Children level 3 compliance (target 90%) was 88% in July, 89% in August and 89.98% in September 2022.

The trust also provided role specific training, core service training and continuing professional development. The courses delivered depended on the staff team and role.

The trust monitored training at both team and divisional level. On the core service inspections, staff told us they were up to date with mandatory training and we saw evidence that managers monitored training compliance. We found that training compliance was generally good across the board and where there were courses that were below the trust targets, managers were aware of these and places were booked.

The trust employed registered learning disability nurses as well as registered mental health nurses. The trust also had a team of three registered learning disability nurses who mentored trainee nursing associates in secure, mental health and community care. At the time of inspection, all staff had to complete an e-learning package on learning disability awareness as part of their induction. However, there was no additional role specific training at a more advanced level for those providing care and treatment for patients with a learning disability.

Our findings

The Health and Care Act 2022 introduced a new legal requirement on 01 July 2022 for all registered health and social care providers to ensure that their staff receive training in learning disability and autism, at a level appropriate to their role. The trust had been a pilot site for the roll out of this training and was launching the role specific three modules in January 2023 using subject matter experts. The trust told us that autism awareness training was included in the learning disability awareness training and completed by all staff on induction. Again, the roll out of the role specific training would include more advanced autism training.

The trust's target for staff compliance with clinical supervision was 90%. The relevant trust policy stated that clinical staff must have a minimum of six supervision sessions annually unless there were mitigating circumstances authorised by the service manager. The clinical supervision target of 90% had been achieved consistently since April 2022. Staff on most inspections told us they had access to supervision. However, in the end of life community team staff said supervision was often cancelled due to staffing pressures.

All staff had the opportunity to discuss their learning and career development needs at appraisal. This included agency and locum staff and volunteers. There were mechanisms for providing all staff at every level with the development they needed, including appraisal and career development conversations. The trust's target for appraisal compliance was 95%. The trust had launched a new appraisal system in May 2022, since which 72% of staff had completed an annual appraisal. The trust was on trajectory to achieve 95% by March 2023. Figures indicated, 94% of staff who had completed their appraisal to date were either very satisfied or satisfied with their appraisal.

The trust had a 'Management of Complaints' policy that had been ratified in April 2022 and was due for review in April 2025. The policy had been reviewed during the COVID-19 pandemic to take account of capacity issues and again following the acquisition of North West Boroughs Healthcare NHS Foundation Trust (NWBHFT) to ensure processes were aligned for staff transferring from that organisation.

The trust had received 516 complaints between 08 November 2021 and 08 November 2022, of which none had been referred to the Parliamentary and Health Service Ombudsmen (PHSO). During the same time period, there had been 71 complaints raised with the Patient Advice and Liaison Service (PALS).

The trust had a target for acknowledging complaints within 3 working days and resolving them within 25 working days. An extension to this could be agreed with the complainant for more complex complaints, however, it was not to exceed six months. The trust's internal monitoring showed that between 01 November 2021 and 01 November 2022, the trust had closed 493 complaints, of which 161 were within 25 working days, 316 were within six months and 16 were outside of that time period.

The trust was taking action to improve this. They stated compliance against the target had been impacted by the guidance given to trusts during the COVID-19 pandemic to pause the management of complaints and the acquisition of NWBHFT, however at the time of inspection the trust reported the backlog had been fully addressed. The management of complaints had also been impacted by the trust being in business continuity, the separation of the PALS and complaints team for a short time, the lack of reviewers due to staffing levels and the complaints team all remote working from home at the time.

To improve the timeliness of responding to complaints the team had set up weekly complaint surgeries with each division to review any open and ongoing complaints, ensure reviewers were allocated in a timely way and provide

support to reviewers to discuss cases. The complaints team RAG rated each case dependent on length of time open. A report was provided to the executive safety huddle each month including the number of cases over 25 working days and over 6 months. An overview of complaints management including the live data was provided bi-monthly to the Quality Committee for scrutiny and then summarised in the highlight assurance report to the Board of Directors.

We reviewed twelve complaint investigations. We found that the trust did not always handle complaints effectively. Investigations were not always thorough, documentation was not always accurate, and they were often not completed within the trust target. There was limited evidence of ongoing engagement with the complainant during the investigation period in some cases, and in those where 'holding' letters were sent they did not provide an anticipated date of resolution.

Two of the complaints reviewed were dealt with by PALS and for one of these the response did not cover all aspects of the patient's complaint. One complaint was ongoing at the time of inspection and one was retracted by the complainant, although it was already outside the trust target by that point and there was no evidence of support offered to the complainant. Of the remaining eight complaints, six did not evidence a thorough investigation, three did not evidence a detailed outcome or action plan for the lessons to be learned, seven were resolved outside of the trust 25 day target and three were completed outside of six months.

To further support the reduction in delays in providing responses and to improve the quality of investigations, the complaints team had proposed a new closure process, which was planned to take effect from 01 December 2022. This involved providing a copy of the investigation report to the complainant, rather than waiting for it to be summarised into a letter, with only designated executives able to sign off a complaint report. The trust felt this would also ensure the investigation reports were consistent, thorough and transparent.

Following the inspection, the trust told us that standard operating procedures for the management of complaints had been reviewed and embedded to ensure standardisation and consistency. Complaints team members had also undertaken complaints investigation training to support the learning review methodology and seven minute briefings were undertaken following complaint reviews to enable timely sharing of learning.

The trust received 3315 compliments between 01 December 2021 and 01 December 2022. Themes were positive feedback about services and the care provided and recognition of staff's kindness and those that went above and beyond. The services in Southport and Sefton received the most compliments.

The trust applied Duty of Candour appropriately, although the written letters were not always reflective of this. The trust's Duty of Candour policy met the requirements of the regulation and was last reviewed in January 2022. The trust had Duty of Candour champions in each division who were brought together in regular meetings to share learning or discuss issues.

During our inspection we undertook a detailed review of six incidents where the trust had applied duty of candour. Staff had informed people of the incident in writing. However, the written letter did not always explain all known facts, outline immediate steps taken to rectify the issue or provide a sincere apology.

The trust told us that the letters were standard templates that came from the electronic system and the trust recognised they were not reflective of the work the trust did to meet the duty of candour requirements. The trust placed more

importance on the way they engaged with patients and their families, which was done face-to-face. Every patient involved in a serious incident was allocated a family liaison officer (FLO), which was a new process they had taken from the acquisition of NWBHFT. The FLO would support the patient and family through the investigation and would provide the full explanation and sincere apology in person.

The trust took appropriate learning and action as a result of concerns raised. The trust sought to learn from incidents, deaths, complaints and the wider system. The trust had embedded a 'just and learning culture' which centred on the desire to create an environment where staff felt supported and empowered to learn when things did not go as expected, rather than feeling blamed. In the case of an adverse event, the trust sought to understand: "what was responsible, not who is responsible". The trust had appointed 'just and learning ambassadors' and their respect and civility agenda has been shortlisted for national awards.

The trust could evidence where they had learned from their acquisitions and made changes in their approach, and where they had taken good practice from the services they had acquired and embedded some of that into their own systems and processes, such as the FTSU champions and appointment of FLOs.

The trust took a structured judgement review approach to learning from incidents and undertook learning reviews, as opposed to investigations. The trust identified themes from learning and ensured that patient safety ran through the centre of any lessons to be learned. Learning was shared across the system, and if the trust undertook a full root cause analysis following an incident, they would invite other providers involved or impacted to an evaluation session at the end of the learning review. A patient safety report which highlighted learning to be shared was presented monthly at the Executive safety huddle and bi-monthly to Quality Committee.

The executive team were aware of the risks to patient safety associated with closed cultures. During our inspection, leaders told us of occasions where they had taken action due to pockets of concern about culture, with actions such as staff training, reflective practice and the presence of senior staff in the environment. The risk of closed cultures was at the forefront of the mind of the Executive and Non-Executive staff, and all were aware that they could not be 100% certain it was not happening in their trust. They described the importance of ensuring people felt able to speak up, using data to monitor indicators of culture and the visibility of leaders. The trust worked to achieve psychological safety and placed emphasis on the role leaders had to play in ensuring a culture of openness and transparency.

The trust had a Culture and People Plan 2022-2025 which brought together a set of actions to deliver on the NHS People Plan pillars of looking after people, belonging in the NHS, new ways of working and growing for the future. The plan included actions on workforce modelling, system design, organisation re-design, leadership development, education and training and health and wellbeing.

The trust employed approximately 11,000 staff. Historically, the trust had been an outlier locally, regionally, and nationally regarding its sickness absence rates and this had been highlighted frequently to various committees. Mersey Care reported that the provision of High Secure Services attributed to this, as when they review their figures excluding High Secure Services, the rates were more in line with the average sickness rates. The trust also stated that North West sickness absence, as reported in the October North West Regional Workforce Update, was 6%, compared to a national average of 5.1%, one of only two regions currently reporting higher that 6%. The trust was also an outlier for the number of staff absent with long COVID.

At the time of inspection, the trust's overall sickness rate was higher than the average for mental health and learning disability trusts (which was 5% according to figures published by NHS Digital). The latest CQC Insight report in October 2022 indicated that the following measures were much worse when compared nationally (July 2021 to June 2022):

Our findings

- Proportion of days sick in the last 12 months for Healthcare Assistants (%)
- Proportion of days sick in the last 12 months for Nursing and Midwifery staff (%)

The report also indicated that the following measures were worse when compared nationally (July 2021 to June 2022):

- Proportion of days sick in the last 12 months for Non-Clinical staff (%)

The trust absence rate was 8% at the last inspection in 2018 and had been consistently above the target of 4.43% since 2019. Sickness rates were at their highest in January 2022 at 11.85%. This was gradually reducing and was currently at its lowest at 7.6% in November 2022.

The Board and committees were well sighted on the staffing picture through various papers and reports. A 'delivery against workforce plans' paper went to People Committee in November 2022, along with two papers outlining workforce challenges in vacancies and improving absence. Recruitment and staffing featured high on the trust risk register and all Executives and Non-Executives were able to articulate the challenges during the inspection.

The trust had plans in place to reduce sickness absence. They had established an 'Improving Absence (Sickness) Review Group and reviewed the trust's 'Management of Attendance' policy in partnership with staff side and operational managers to ensure it was fit for purpose and included best practice from other NHS organisations. In 2021, a consultative piece of work was undertaken in relation to sickness absence and feedback was that managers wanted more tools to better monitor and manage absence, which had led to the procurement of some absence manager software. This was being piloted at the time of inspection and due to roll out in early 2023.

Although staff had access to support for their own physical and emotional health needs through occupational health, there were some improvements identified for the provision of this service. One of the recommendations of the revised trust policy was to align it to the occupational health & wellbeing service to ensure the trust was more proactive in the prevention and early intervention of absence, and the re-design work was underway. The trust had recruited to new posts called 'Health and Well Being Facilitators' who were due in post in January 2023. They had also applied a recruitment and retention premia onto the Consultant Occupational Physician and Occupational Health Advisor posts and approved short-term additional funding to reduce the waiting times within the Psychological Therapies team for staff.

Turnover of staff had increased through 2021 and early 2022, however at the last report in October 2022 it was 1.05%, which was lower than the trust target of 1.32%. This was an improving position compared to the trust level turnover rate of 1.37% in September 2022. The Trust was performing more favourably than the National Oversight Framework targets for national median (1.32%) and peer position (1.34%).

Insight showed that trust turnover rates had recently been reported as higher than sector turnover rates for Allied Health & Scientific, Therapeutic, Technical staff and Healthcare Assistants, but have been lower than the sector turnover rate for Nursing and Midwifery staff and Medical and Dental staff.

Although there wasn't a vacancy target for Consultants, there were 40 vacant posts at the time of inspection. This was being managed by 29 locum staff in post and the goodwill of existing staff to cover the remaining 11 posts. There were a number of Specialty Doctors acting up, a rolling recruitment campaign and the introduction of non-medical prescribers in some areas to release capacity. The trust had a medical and dental workforce plan which outlined the trust actions, including a review of job descriptions, career conversations with senior trainees and the implementation of a recruitment and retention supplement.

Our findings

The trust had a target vacancy rate of 10%, although this hadn't been achieved since April 2021. The trust reported a gradual decrease in qualified nursing vacancies to 10.59% in October 2022. The NHS Shared Business Services who produce workforce analytics stated that the turnover rate at a typical trust at this time was 12% for qualified nurses. The Health Care Assistants vacancy target (5%) had been consistently achieved since April 2021, and most recently reported as 1.77% in October 2022, a decrease from 4.94% in July 2022.

The trust was taking action to reduce the vacancy gap, and since 1 September 2022 there had been 96 qualified nurse starters and 58 unqualified nurse starters. There were also 355 qualified nursing staff who had been offered a post and were due to commence employment by 31 March 2023. Additionally, there were a further 346 whole time equivalent qualified nursing posts that were being recruited to.

The trust had a focus on growing its own staff through the Registered Nurse degree top-up Programme and Nurse Associates Programme, of which they had trained 117 to date and had agreed to fund two further cohorts of 20 staff to complete the 18 month course. The trust had taken part in some successful international recruitment, with 17 international nurses recruited to work at Longmoor House. The trust was developing a competency framework to enable unqualified nurses to take on additional roles and release qualified staff capacity. Due to the national shortage of Learning Disability nurses, the trust had funded training for 11 staff from the secure division to complete an 18-month degree top-up programme for learning disabilities to support their workforce plans and increase their numbers of Learning Disability nurses. The trust had also adopted the NWBHFT approach of paying bank staff weekly, which had seen an increase in the bank fill rate from 36.5% in April to in 65% in October 2022.

The trust had launched its own preceptorship programme in September 2021, which was well received and we observed feedback from one newly qualified nurse given to People Committee about how positive their experience of the programme had been. The programme was supporting over 150 newly qualified nurses and Allied Health Professionals, and the trust planned to expand the preceptorship team and therefore the scope of the programme. The programme was proving to be a success in retaining staff with national attrition rates for the trust as less than 5% compared to a national figure of 12% and a regional figure of 10%.

However, although the trust ensured safe staffing levels were generally met, the impact was seen in other areas of care and treatment and on staff wellbeing. At Ashworth Hospital, staff were re-deployed across wards to ensure patients were safe, but this meant that patients had limited access to therapeutic activities and rehabilitation. In the forensic inpatient wards, staff spoke of missing breaks and breaching the trust observation policy due to being short staffed.

Staff felt equality and diversity were promoted in their day-to-day work and when looking at opportunities for career progression. The trust had an equality, diversity and inclusion team and an action plan. The director of workforce was the executive lead for equality and diversity. All trust policies included an equality impact assessment. The trust had recently won the HFMA National Healthcare Finance Awards 2022 for Diversity and Inclusion.

There was a strong organisational commitment and effective action towards ensuring that there is equality and inclusion across the workforce. The trust had pledged to become an organisation that was working to eradicate racism, discrimination and other untoward conduct and to develop systems and resources to support staff who may experience this. One of the trust's Perfect Care goals was zero acceptance of racism, discrimination and disrespectful behaviours. The trust had re-launched their anti-racism campaign, supported by an anti-racism group that met monthly. An anti-racism strategic plan was in place with a focus on education, challenge and support.

Our findings

The trust's workforce equality analysis report (1 January 2021 – 31 December 2021) showed that the combined, overall percentage of colleagues who identified as Black and Minority Ethnic in the total combined workforce at Mersey Care NHS Foundation Trust was 7.5%. The trust was keen to increase the number of staff from ethnic minority groups across the workforce by ensuring guaranteed interviews for these colleagues, updating recruitment training to include all levels of bias and expanding their training programmes for people wanting to join interview panels.

The Workforce Race Equality Standard (WRES) became compulsory for all NHS trusts in April 2015. Trusts must show progress against nine measures of equality in the workforce. The trust had a WRES action plan with six actions, including increasing the overall representation of Black, minority and ethnic staff within the trust and at executive and board level, relaunching the Perfect Care Goal Strategy to communicate a clear message on the trust's stance to eradicate racism and discrimination, increasing the uptake of Black, minority and ethnic staff accessing non-mandatory training and development programmes, and reviewing the data around disciplinary processes and the disproportionate likelihood of Black, minority and ethnic colleagues to enter formal procedures.

The trust's workforce equality analysis report (1 January 2021 – 31 December 2021) showed that 6% of the total workforce population identified themselves as having a disability of long-term condition. The trust wanted to increase the number of staff declaring their disability as they felt the figure wasn't reflective of the workforce. The trust was focusing on inclusive recruitment and had introduced disability awareness training and values-based interview training to identify affinity bias in interview panels. They planned to introduce workplace adjustment passports and had rolled out a dyslexia/dyspraxia training programme.

The Workforce Disability Equality Standard (WDES) is comprised of a set of ten metrics. These aim to compare the experiences of disabled and non-disabled staff in the NHS. The trust had an action plan with the following key themes:

- Securing Senior Leadership support for the WDES action plan.
- Promoting the use of ESR self-service to improve the known disability status of our workforce.
- Working to improve reasonable adjustments to support applicants and employees who have a disability or long-term condition (LTC) in applications and work-based adjustments.
- Reducing negative and untoward conduct towards colleagues who have a disability or LTC.
- Ensuring colleagues who have a disability or LTC are supported to attend non-mandatory training and career development opportunities.
- Promoting the Trust's affirmative commitment toward its colleagues who have a disability or LTC through national and bespoke events.
- Working to improve the representation of colleagues who have a disability or LTC at Executive and Trust Board level

The trust's People and Culture Plan utilised the WRES and WDES and the trust's anti-racism strategic plan with the aim of ensuring all staff were treated fairly and any inequalities were addressed.

The trust had five staff network groups in place promoting the diversity of staff; Ability First, Black, minority and ethnic staff, staff with Dyslexia/Dyspraxia, LGBT+ staff and a Women's network.

The frequency of meetings ranged from monthly to quarterly. Feedback from staff networks was that the networks were well received by those at board level and that the executive team had an 'open door' approach to communicating with the staff networks.

Our findings

Governance

At trust level we found governance to be effective in that the trust board received holistic information on service quality and sustainability, leaders challenged and interrogated data and used performance measures to understand the challenges facing the trust at any given time and systems that were in place to collect data were constantly being reviewed to identify how they could be improved.

At core service level we found governance to be effective in four of the core services inspected at this time. However, in the community end of life service, we found that the approach to outcome monitoring and audits varied across the teams. In the wards for people with a learning disability and/or autism we found that not all patients had an accurate and contemporaneous record of care and assessments were not always present or up to date. On the first day of inspection at Wavertree Bungalow, the system for reviewing and having oversight of the needs and risks to people staying at Wavertree Bungalow was ineffective. The trust took immediate action and improvements had been made by the end of the inspection.

The trust had numerous policies to support staff in providing patient care and treatment that were available on their website or easily accessible internally to staff. We found four policies during inspection that were past their review date. The trust had a Policy Management Framework document which outlined the process for reviewing policies. Each policy had an executive lead responsible for the review and approval of these policies, supported by their teams. During the COVID-19 pandemic, the usual review process was suspended and replaced with new governance arrangements to ensure review and approval of policy documents which required urgent amendment only. Since that time, the Policy Management Framework had been updated to include details of the prioritisation of policy document reviews to ensure remaining documents were reviewed where needed, but in a systemised approach. Although review dates on documents may have expired, all policies and procedures were reviewed to ensure consistency as a result of the acquisition of NWBHFT in 2021. We found during core service inspections that staff adhered to policies as required.

The trust had effective structures, systems and processes in place to support the delivery of its strategy including board committees, divisional committees, team meetings and senior managers. Leaders regularly reviewed these structures.

There was a board committee structure in place, with each committee chaired by a Non-Executive Director with the appropriate skills and knowledge, reporting to the board. The trust had seven committees that reported directly to the Board of Directors; audit committee; charitable funds committee; commissioning committee; people committee; quality committee; resources committee and renumeration committee.

Papers for board meetings and other committees were of a reasonable standard and contained appropriate information. We observed and reviewed papers from these sub-committees and the trust board. The board assurance framework (BAF) comprehensively described the risks facing the trust, the relationship between those risks, and the strategy for dealing with them. It was reviewed regularly and used to determine the board's cycle of business. We reviewed minutes of each of the seven committees, which showed that meetings were well-attended and that agenda items were escalated and acted upon as appropriate.

Performance data fed into the BAF. The BAF had been amended to include the Risk Universe, which was a list of risks or opportunities the organisation faced or may face, represented in a visual form. The Risk Universe was made up of the Trust's strategic wheel at the centre, with the risk grading going from green or low level of risk up to red for major risk. The trust was working on consolidating and reviewing risks based on calibration and some duplicated risks following the acquisition. There was evidence in the BAF of digital solutions being considered to reduce risks, such as using systems to highlight complex patients to support work prioritisation in the pharmacy team.

Our findings

Non-executive and executive directors were clear about their areas of responsibility. There were clear lines of responsibility for each board committee aligned with the board assurance framework. Risks were discussed and there was an appropriate flow of information between the board and its committees. There was appropriate challenge and support from non-executive directors to the executive management team in holding leaders to account on areas for improvement.

All levels of governance and management functioned effectively and interacted with each other appropriately. There was a visible and consistent approach to risk management and board assurance. A number of sub-committees, project groups and working groups reported into the board committees and were effective in monitoring performance and risk throughout the trust. Terms of reference for the board and committees were reviewed at least annually.

There was a reporting structure in place to manage the flow of information from directorate to executive management team and through to the board and relevant committees. Each committee also produced an annual report, which the audit committee reviewed against the terms of reference. There was evidence that people were held to account for delivery of actions.

Trust governors told us that the Executive team provided regular updates and were responsive to requests for information. They were directly involved in the appointments of the Non-Executive Directors and the Chair and felt they were listened to and able to hold them to account. They felt Executive and Non-Executive staff were capable and competent. Governors were sighted on the challenges for the trust and spoke about a positive culture and a desire to always improve. They felt there was a culture of co-production within the trust but reflected that the Board meetings would benefit from more input from patients and carers.

NHSE told us that the roles of responsibility and structures for accountability and governance were clearly established, including financial reporting to the Board and budget management throughout the organisation. The trust suffered a significant fraud of £900k in 2018/19 and had since strengthened financial standing instructions, assurance and governance processes.

Appropriate governance arrangements were in place in relation to Mental Health Act administration and compliance. There were robust arrangements to ensure that the trust discharged its specific powers and duties according to the provisions of the Mental Health Act 1983 (MHA). The use of the MHA was overseen by the MHA and Mental Capacity Act 2005 (MCA) Law Governance Oversight Group (MHLG) which reported to the Quality Committee, which in turn reported to the Board. The MHLG was attended by all divisions and a range of sub-groups reported to it, including the Reducing Restrictive Practice Monitoring Group. These sub-groups enabled much more detailed discussion of the issues within their remit than would have been possible in the MHLG alone.

The MHA function had recently moved into the patient safety directorate from the nursing directorate. The Mental Health Law Service Manager (MHLSM) reported through the Head of Governance and Safety to the Deputy Director for Patient Safety and the Director of Patient Safety, who reports to the Executive Medical Director. The MHLSM managed the Deputy MHLSM and the MHA administration team. There were 16 administrators in the MHA administration team and 2 part-time vacancies.

There was a separate MCA lead and staff team who were responsible for the transition from Deprivation of Liberty Safeguards to the Liberty Protection Safeguards. The MHA team was based across the trust in a number of locations, to aid access for staff.

Our findings

MHA and MCA training, delivered mainly via e-learning, was mandatory for staff. Staff were required to repeat the training every three years and the compliance rate for both MHA and MCA was 90% for mental health staff and 89% for secure services.

We attended a meeting of the MHLG on 29 November 2022. This was only the second meeting since the governance reorganisation, so the group was still becoming accustomed to its expanded role. There was extremely thorough and transparent discussion of all aspects of the MHA and MCA/DoLS, a summary of which was due to be forwarded to the Board. The team were dealing effectively with responses to CQC monitoring visits and aware of outstanding issues around some policies, procedures and staff knowledge of the MCA.

The MHLSM was responsible for the overarching MHA policy and all related operational policies. Specific MHA audits including consent to treatment, section 132 rights and capacity assessments were undertaken regularly across the trust, with a section 17 leave audit due to start. The figures and any section 136 breaches were reported to the MHLG. The MHLSM compiled MHA data into a biannual MHA & MCA compliance report which was reviewed by the MHLG, Quality Committee and the Board.

CQC MHA monitoring visit reports were sent to the relevant clinical leads, who formulated responses. The visit reports and responses were discussed at the Clinical Governance Oversight Group. Recent themes included assessments of capacity, consent to treatment and advising patients of their rights on an ongoing basis. The trust provided the CQC with statements of the action they were taking to address the specific concerns raised in these reviews.

Recent quality improvement initiatives included working with the electronic patient record system administration team to add to the suite of MHA-specific forms on the electronic patient record system. A dedicated form for documenting patient rights advice had just been completed. The MHA administration team was hoping to be able to return to face to face biennial meetings and annual away days following the COVID-19 pandemic.

The MHA department administered 3 service level agreements with local acute hospital trusts and psychiatric liaison teams and provided assistance with the operation of the MHA. Details of section 136 activity were provided to the MHLG and Quality Committee.

The MHLM, the Deputy MHLM and the MHA administration team maintained their MHA knowledge through legal updates and advice from their external solicitors and making use of online and social media resources, including the North West forum for mental health law. MHA administration team staff also received regular e-learning refreshers and were encouraged to attend a certificate course in mental health law.

Medicines management was not always well governed, although this had already been identified by the trust. In the acute and PICU service, records for people prescribed valproate who were of childbearing age did not always show that the requirements of the pregnancy prevention programme had been met. We also found that allergies were not always correctly recorded and that medicines with a minimum prescribed interval dose were not always correctly administered, which was also an issue on the forensic or secure wards. In the high secure hospital, we found that Venous Thromboembolism (VTE) risk assessments were not always completed on admission. We also found that staff did not always document the opening date of medicines and that clinical supplies left in the health centre by visiting clinicians were not always monitored. At Wavertree Bungalow, we found that the systems in place for administering people's medication were not always safe and medication records did not always accurately reflect the prescribed medicines people arrived with at the start of their stay.

Our findings

Significant organisational change was underway in response to a trust identified 'gap in basic service provision from a clinical pharmacy perspective and also governance'. Medicines Management was routinely reported via both the Quality Assurance and Resources committees with management of high scoring risks at the Executive Safety Huddle.

A new trust wide medicines governance structure had been established with clear reporting responsibilities to the Drug and Therapeutics Committee and Quality Assurance Committee. However, capacity to deliver the new structure was limited. There was a focus on strengthening links with divisional governance and ensuring learning from audit was captured at operational governance groups. Medicines management input into the divisional Medicines Incident Safety Huddles (MISH) was prioritised, with a view to increase this as capacity improved. Capacity also impacted on the delivery of medicines workstreams reporting to the Drugs and Therapeutics Committee for example, medical gases governance.

Staff at all levels of the organisation understood their roles and responsibilities and what to escalate to a more senior person. A clear safety framework set out the structure of ward/service team, division and senior trust meetings. Managers used meetings to share essential information such as learning from incidents and complaints and to take action as needed. Each team or ward held daily safety huddles, which fed into divisional safety huddles and from there into the weekly Executive safety huddles. Information from there was shared with the divisional senior leadership teams to the various committees and through to Board. Information flowed from Board to ward in the reverse order through the same channels.

The trust was working with third party providers effectively to promote good patient care. NHSE told us that the trust had established lines to Integrated Care System (ICS) reporting as part of overall system management and auditors had not flagged concerns to regulatory bodies.

The trust provided a mental health liaison service and was a member of the Psychiatric Liaison Accreditation Network (PLAN). Associated policies and procedures reflected PLAN quality standards. A partnership arrangement was in place for the provision of psychiatric liaison services with appropriate governance arrangements. Services were provided at three local acute hospitals and a focused inspection of the Psychiatric Liaison Services in March 2022 indicated that the partnership arrangements were working well.

Management of risk, issues and performance

The trust had clear and effective systems in place to identify learning from incidents, complaints and safeguarding alerts and make improvements. Performance issues were escalated appropriately through clear structures and processes. These were regularly reviewed and improved.

The trust had a programme of audits to monitor quality and safety, and systems in place to identify when action needed to be taken. Audit programmes were monitored to determine if they were on track and an update provided to the audit committee. The trust had a forward plan containing 70 National and local audits covering areas such as medication, record keeping and IPC.

Staff completed clinical and internal audits and we saw evidence of improvements in practice being made from clinical audit during our inspections of core services. However, we also found that in the community end of life care service some audits were of poor quality and we could not always see what actions had been taken to improve performance where audits identified deficits. We saw in the ward for people with a learning disability and in the high secure hospital that audits did not always identify where there were gaps or areas for improvement in medicines management and care planning. In the wards for people with a learning disability, although patients had regular access to physical health

checks and monitoring, two patients had not received their annual health check and not all patients had up to date falls assessments or hospital passports. At Wavertree Bungalow, the providers quality monitoring systems had failed to identify and mitigate risk in relation to the recording of medication stocks, cleanliness, upkeep and safety of areas within the home's environment.

The trust was signed up to POMH-UK medicines benchmarking audits to support continuous improvement in the safe use of medicines. Concerns over completion of Pregnancy Prevention Programme documentation were identified by the trust during data collection for the ongoing POHM-UK Valproate audit. Immediate steps were taken to raise awareness of this with responsible clinicians and a task and finish group was re-established to ensure the safe use of Valproate. On the ward for people with a learning disability there was a strong focus on deprescribing and achieving the aims of STOMP (Stop Over Medicating People with a learning disability).

Reporting responsibilities to the Controlled Drug Local Intelligence Network were met. High-risk areas identified through an internal audit in 2020/21 in relation to the safe management of controlled drugs had been actioned. However, the trust continued to identify instances of staff working outside the standard operating procedures relating to safe storage of controlled drugs. Appropriate governance arrangements for the management of patient group directives (PGDs) had been established.

The trust had developed a process of quality review visits (QRV), which took place across all teams and were carried out by a dedicated QRV team. Each team was assessed against a set of quality standards that were aligned with the Care Quality Commission's (CQC) five key questions. The process was intended to be a supportive one that focused on strengths and areas for improvement. Each visit resulted in a rating and an action plan, with the aim of supporting each team to reach a 'good' or 'good plus' rating. Reports were shared with the Executive Safety Huddle each month and an overview of QRVs was shared at Board meetings. BAF risks along with themes and learning from serious incidents, safeguarding's and complaints were then mapped to the concerns highlighted through QRV's to ensure the triangulation of risk and performance issues.

The Chief Coroner's Office publishes the local coroners Reports to Prevent Future Deaths which all contain a summary of Schedule 5 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 had received one Regulation 28 report in the last 12 months. This was in relation to an inpatient death by ligature and the trust took action to review their observation policy in light of learning from this.

Providers must report all serious incidents to the Strategic Executive Information System (StEIS) within two working days of identifying an incident. Between 1 April 2021 and 31 March 2022 there were 159 StEIS reported incidents reported onto the StEIS platform for both Liverpool Clinical Commissioning Group and Knowsley Clinical Commissioning Group (as lead commissioner for the former North West Boroughs Healthcare NHS Foundation Trust). At the time of inspection, serious incident management was delivered through a single set of arrangements with standardised processes across the entirety of the enlarged trust, which included mortality reviews. While business continuity arrangements were in place for many services due to the COVID-19 pandemic, serious incident reporting and management continued throughout this period.

The top three reported categories of StEIS incidents were patient death, self-harm and pressure/wound care. During the same period there were 80 reported deaths, 58 of which were possible suicides. This was an increase for the trust (the previous reporting period recorded 26 possible suicides) and was attributed to the acquisition of NWBHFT. At the time of inspection, the trust was undergoing a programme of extensive work to install door top alarms across their mental health inpatient estate.

Our findings

Incident data on suicides was closely monitored by the safe from suicide team led by the trust's Centre for Perfect Care, who worked with teams to identify any trends that may have developed, and opportunities for learning and/or thematic reviews. The trust's zero suicide action plan was regularly updated and based on the outcomes from both individual and thematic learning reviews. The action plan had multiple quality improvement workstreams underpinning the overall plan.

The safe from suicide group reported to the strategic patient safety improvement group and quality improvement group, and also regularly reported to the executive safety huddle on progress of the zero suicide action plan. The trust hosted the charity 'Zero Suicide Alliance' which aimed to break the stigma around suicide and enable leaders to drive meaningful action to prevent suicide.

Never events are serious incidents that are entirely preventable as guidance, or safety recommendations providing strong systematic protective barriers, are available at a national level, and should have been implemented by all healthcare providers. This trust had reported no never events in the last 12 months.

Providers are encouraged to report patient safety incidents to the National Reporting and Learning System (NRLS) at least once a month. They do not report staff incidents, health and safety incidents or security incidents to NRLS. The trust's level of harm was in line with the NRLS average with 80% of incidents categorised as no harm.

The total number of incidents reported during financial year 2021-22 was 53,488, which was a rise from 2020-21 figure of 47,958. Staff reported incidents via an electronic system and the trust was moving to a new incident reporting system in April 2023, which would enable a greater depth of analysis of the data. The community division and secure division traditionally tracked slightly higher in numbers of incidents than other divisions due to the number of pressure and wound care incidents for community, and violence and aggression in secure services. The top three types of incidents were violence and aggression, self-harm and pressure/wound care.

The trust had planned well for the implementation of the new national Patient Safety Incident Response Framework (PSIRF), which set out the NHS's approach to developing and maintaining effective systems and processes for responding to patient safety incidents for the purpose of learning and improving patient safety. A draft plan had been sent to Quality Committee and two project managers were in place who had worked with early implementer sites across the country to take learning, which was then being shared across the Integrated Care System (ICS).

We reviewed six serious incident cases from the trust all of which had occurred in the 12 months prior to the inspection. All investigation reports were thorough, they appropriately established the facts of the incident and contained clear and relevant terms of reference. Investigators were appropriately trained. We saw evidence that patients' families and carers had been involved in investigations.

Investigation reports included a summary of contributory factors and root causes and action plans were in place to reduce the risk of the incident reoccurring. Staff involved in incidents were offered support in the form of debriefs and learning reviews.

The trust had a 'reporting, management, review and learning from incidents' policy (July 2021). The policy clearly outlined the processes for incident reporting and investigation. All incidents were reported on the trust's incident management system and reviewed by the ward manager/team leader and patient safety team and/or service line lead. If high levels of harm or significant learning was identified a 72-hour report was commenced. We reviewed some 72-hour reports during the inspection and found them clear, thorough and a method by which the trust and teams could implement immediate learning from an incident.

Our findings

Dependent on the outcome of the 72-hour report, consideration of a serious incident investigation was taken. There were three levels of review; concise, comprehensive and independent.

The trust monitored three targets for serious incidents; all incidents to be reported within 48 hours; all 72 hour reports to be submitted within five working days of reporting the incident on StEIS; and the completion and submission of the root cause analysis (RCA) investigation report to the commissioner within 60 working days.

The trust reported 364 serious incidents between 01 November 2021 and 01 November 2022. Of these, 258 were reported within 48 hours of identification, 49 related to incidents reported to the Cheshire and Merseyside Integrated Care Board (ICB) and 57 were reported to Specialist Commissioners using High Secure criteria. During this period, 258 72-hour reviews were undertaken, all but seven were submitted within agreed timescales. The trust submitted 90 RCA investigation reports during the same period, all of which were either submitted within 60 days or within extended timescales agreed with commissioners. Extension requests were monitored by both the division and patient safety team, with an escalation process in place, prior to submission to the Liverpool CCG and the ICB.

Action plans were developed and tracked at divisional level and by the Patient Safety Team, with a quarterly report going to Quality Committee. System wide learning was evident and other providers were invited to attend an evaluation session following a comprehensive review. The trust attended the Integrated Care Board (ICB) serious incident panel to share learning.

Themes, trends and areas for learning from incidents were reported each month to the Executive safety huddle and bi-monthly to Quality Committee. The trust had a variety of mechanisms through which lessons learned from incidents were shared such as; learning events, quality practice alerts, cumulative reviews, newsletters and seven-minute briefings and staff on inspection told us learning was shared.

We reviewed the trust policy SA45: Learning from Deaths. The process included the referral of all service users who had a diagnosed Learning Disability to the LeDeR (Learning Disability Mortality Review programme). The policy outlined how the trust would engage with families and carers, how themes would be identified, learning would be shared, and how deaths would be reviewed by the trust board.

We reviewed five sets of Mortality Review Group meeting minutes from within twelve months prior to inspection. There was an active action log, and the minutes evidenced the identification of themes and a standing agenda item to discuss the deaths of any service users with a learning disability.

We reviewed five recent deaths. The standard of information and relevance was high, and the adherence to policy was evident. Consideration of families both by duty of candour and from positive comments from families about their involvement showed a high level of care from staff and the trust. The approach to investigation was systematic and effective, capturing relevant facts and presenting them in a clear and concise manner.

Staff across the trust knew how to recognise and report safeguarding concerns. We reviewed the following trust safeguarding policies; Safeguarding Adults from Abuse; Safeguarding Children; PREVENT; Safeguarding Supervision; and Clinical, Managerial, Safeguarding supervision and reflective practice. All policies outlined the responsibilities of the trust in line with relevant national guidance and best practice.

The Director of Nursing and Operations was the executive safeguarding lead. The Trust was represented at a strategic level on the Local Safeguarding Adult Boards and Children's Partnership Forums across the Trust footprint, along with the Domestic Abuse Boards of Liverpool and Sefton with all other Boards supported by membership on steering and

operational groups. The Head of Safeguarding continued to sit on the Multi Agency Safeguarding Hub Strategic Board's within Sefton, St Helens and Knowsley. The Strategic Lead for Safeguarding chaired the Safeguarding Assurance Group (SAG) and attended Quality Committee, where the minutes of the SAG were shared along with a formal annual Safeguarding report.

We reviewed 10 child safeguarding referrals and 22 adult safeguarding referrals. There was evidence that staff recognised safeguarding concerns and reported appropriately, including concerns about self-neglect. However, although the referral document was present for the majority of child safeguarding referrals, it was not kept for adult referrals, meaning the trust could not be assured of the quality of the referrals made. The trust told us this was due to adult referrals being made using different electronic systems and that the plans to move to a new incident reporting system in April 2023 would improve the flow and accessibility of these referrals. The trust electronic patient record system also had a safeguarding section to capture safeguarding information.

We saw evidence that the trust's internal safeguarding team were knowledgeable and supportive. The trust told us that the internal safeguarding team triaged safeguarding referrals to encourage staff to report any concerns they had without overwhelming the Local Authority. The trust felt this system worked well and we saw evidence of referrals being escalated to the Local Authority appropriately.

Following the trust acquisition of NWBHFT, medicines related policy and procedures were being reviewed, as ways of working were aligned across the trust. Memos alerted staff to changes as medicines policies were reviewed and updated and new audit tools were being developed to measure compliance. For example, a revised controlled drug handling audit had been rolled out. However, capacity within the pharmacy team meant that implementing the revised safe and secure storage of medicines audit following a period of suspension was challenging. The trust also recognised the need to upskill staff to support in the development and delivery of audit action plans.

Systems were in place to ensure medicines incidents were recorded, investigated and reviewed to identify emerging themes. Learning was shared across the trust via Quality Practice Alerts (QPA).

The trust had processes in place to monitor community waiting times and executive leaders knew where the pressure points were. Waiting lists were monitored within monthly divisional performance meetings and waiting list performance was incorporated in the monthly executive performance report, which was presented at the trust's Quality and Resource Committees. A quarterly confirm and challenge performance meeting also took place per division which included waiting time breaches. Staff monitored patients on waiting lists. Waiting times were not meeting targets for the Speech and Language Therapy service and the psychology provision in Community Mental Health Teams. The community Eating Disorder service had the highest waiting times for assessment to treatment and this was on the trust risk register. An action plan was in place and recruitment was underway to address this with further financial investment being made into the service.

Senior management committees and the board reviewed performance reports. Leaders regularly reviewed and improved the processes to manage current and future performance. The trust monitored progress through the bi-monthly performance report to divisional leadership teams, the trust board and its committees. The performance report also included metrics on regulatory targets (CQC's five domains and NHS Improvement's single oversight framework). The trust used performance improvement plans, reviewed quarterly, to provide assurance around areas of underperformance.

There were robust arrangements for identifying, recording and managing risk issues and mitigating actions. There was alignment between the recorded risks and staff concerns. Staff had access to the risk register either at a team or division

level and were able to effectively escalate concerns as needed. Divisional senior managers were able to escalate clinical risks onto the trust risk register through the safety huddle. The trust board had sight of the most significant risks and mitigating actions were clear. Any risk rated 15 or higher went straight up to the board assurance framework and to the chief executive.

However, during our inspection of acute and PICU we found the trust had not taken sufficient action to maintain the environment at Windsor House. Maintenance plans were in place following the installation of door top alarms, but the issues had been present for some time. Some of the wards at the high secure hospital were due for refurbishment and the trust was exploring funding streams with commissioners at the time of inspection. On the first day on inspection at Wavertree Bungalow, some parts of the building were not suitably maintained or checked to make sure they were safe for people. Although some immediate improvements were made, some parts of the environment continued to pose a risk to people's health and safety, including parts of the garden and outdoor space. The trust was building a new hospital that was due for completion in Autumn 2024 which would eradicate dormitories, however at the time of inspection the trust still provided dormitory accommodation which impacted on the privacy and dignity of patients.

Overall themes from CQC's Mental Health Act monitoring visits were communicated to the board through the safety report. Clinical staff within the relevant division monitored and audited actions from the reports, with oversight from the trust's mental health law governance group.

Action plans were built into the risk register and were part of the regular review process. Potential risks were taken into account when planning services, for example seasonal or other expected or unexpected fluctuations in demand, or disruption to staffing or facilities.

The Deputy Chief Executive of Clinical Services and Executive Director of Nursing and Operations was the Accountable Emergency Officer (AEO) responsible for Emergency Preparedness Resilience and Response (EPRR). They were supported by a Responsible EPRR Senior Manager. An EPRR Policy was in place which was in line with the legislative requirements and guidance of the NHS England EPRR Framework, and the organisation's strategic objectives. The results of the annual EPRR assurance process were presented to the Board of Directors for assurance on an annual basis. An EPRR report was submitted to the Audit Committee on a six monthly basis and provided assurance regarding the position on training, exercising, lessons learned, planning and an overview of incidents.

The trust had a Major Incident Plan, an Adverse Weather Plan, a Community Outbreak Plan and each division had a tactical Business Continuity Plan. The Trust collaborated with partner organisations by attending the Local Health Resilience Partnership Practitioner Meetings and the Local Health Resilience Partnership Strategic Meetings. Joint plans were developed with partner organisations as required, such as the North West Emergency Accommodation Plan for Secure Services (NWEAPSS), MOU for high secure services with North West Ambulance Service (NWAS).

Where cost improvements were taking place there were arrangements to consider the impact on patient care. The trust undertook quality impact assessments for all proposed cost improvements. The trust's quality impact assessments effectively identified any potential adverse effects on services and were underpinned by sound clinical governance systems. They were signed off with the knowledge and participation of the clinicians who were delivering the services.

There were no examples of financial pressures compromising care. NHSE told us that the trust developed robust financial plans for NHSE in line with national requirements, and these were aligned to the overall strategy for the organisation and with the Integrated Care System (ICS).The trust had a strong track record of delivering on its financial plans, managing cash, capital and revenue effectively. NHSE had evidence that financial performance had been consistently strong, for example cash, capital and revenue plans being delivered in line with plans and national

requirements, and review meeting discussions with NHSE and the ICS had demonstrated that financial risks had been identified and mitigated by the trust. The trust had comprehensive financial information stored and reported from appropriate financial ledger systems. Information provided to NHSE had been consistent and reliable and accurately reflected the organisation. The trust finance department was accredited by Future Focussed Finance as level 3 (the highest level), which reflected comprehensive systems and engagement for staff development and best practice across a range of measures.

Information Management

The board received holistic information on service quality and sustainability. The trust had a Chief Information Officer. The trust digital strategy had been launched in 2018 and was under review at the time of inspection, with the new strategy to be launched in April 2023. The trust had a governance structure in place to support the delivery of information management; an Information Governance Group reported to the trust's Digital Board and through to Audit Committee.

The trust evidenced the importance of a digitally enabled trust in that the Chief Information Officer was part of the trust's board. The trust had an established information technology infrastructure, investment in which had enabled the digital teams to support the workforce to mobilise flexibly during the COVID-19 pandemic and offer patients a virtual service where needed and appropriate.

The board and senior staff expressed confidence in the quality of the data and welcomed challenge. The trust's executive performance report included regulatory and operational plan key metrics. It was presented at each meeting of the board, enabling executives and non-executives to quickly understand the challenges facing the trust at that time.

The trust was aware of its performance through the use of key performance indicators (KPIs) and other metrics. There were clear and robust performance measures, which were reported and monitored. These could be seen at team, service line and divisional level.

Leaders used meeting agendas to address quality and sustainability sufficiently at all levels across the trust. Staff said they had access to all necessary information and were encouraged to challenge its reliability. We observed staff from ward to board challenge and interrogate data, for example in safety huddles and staffing meetings at ward level and in committee and board meetings at executive level. There were effective arrangements to ensure that the information used to monitor, manage and report on quality and performance was accurate, timely and relevant. Action was taken when issues were identified.

Team managers had access to a range of information to support them with their management role. This included information on the performance of the service, staffing and patient care. Information was in an accessible format, timely, accurate and identified areas for improvement. However, there were plans in place to align some systems and make improvements in data quality. For example, from April 2023 the three existing risk management systems would be replaced with a single reporting system aligned with the Patient Safety Incident Response Framework (PSIRF) to make it easier to track incidents and learn from them, to drive patient safety improvements. The trust also hoped this new system would enable them to filter the themes from complaints more robustly than through the current system.

Work was also underway to harmonise the trust's electronic prescribing and medicines administration (EPMA) systems, although this was limited by capacity within the pharmacy team. The trust was additionally seeking a solution to an older EPMA system used in addiction services that was out of support and not dictionary of medicines and devices compliant, limiting any future interoperability.

Our findings

Staff had access to the IT equipment and systems needed to do their work and any issues were escalated for action as needed. For example, there was a risk on the BAF relating to internet connectivity at the Broadoak site. Plans were in place to double the internet speed and this work was ongoing at the time of inspection.

Systems were in place to collect data from wards/service teams and the trust were exploring system improvements which would enable the trust to seek assurance without being over-burdensome on staff. An objective of the trust's People and Culture Plan 2022-2025 was to enable digital infrastructure and embed digital systems to ensure effective decision making.

Work had begun, using an external digital specialist, to develop a new business intelligence dashboard. The new dashboard aimed to support both measurement and triangulation of workforce and cultural metrics to patient safety and quality. The data and system aimed to provide greater insight to support prevention and early intervention against workforce and team risks.

The trust was still aligning systems and data collection following the acquisition of NWBHFT. The trust had moved to a single staff electronic record and finance system, however there were a number of patient record systems in use across the trust. This presented a risk for patients who accessed different areas of the service to ensure their information followed them, so the trust had a process whereby each system would flag if the patient was already active on another record system and staff would be able to click through a link and access their notes.

In July 2021, a review was undertaken on the number of clinical systems in use across the Trust and a high-level recommendation was provided for the Trust to consolidate the number of clinical systems. The phase 1 recommendations from the review had been implemented and a significant number of corporate systems had also been aligned. The phase 2 recommendations were being reviewed which focused on the electronic patient record system in use within Secure Health Care Division and Community Health Care Division, where they may be further opportunities for alignment. A clinical system strategy group was chaired by Trust's Medical Director and supported by the Chief Digital and Information Officer and Chief Clinical Information Officer along with senior representatives from the clinical division to review the conditions for further system harmonisation across Community Health and Secure Health Services.

Leaders submitted notifications to external bodies as required. There were effective arrangements in place to ensure that data or notifications were submitted to external bodies as required. The trust was proactive in working with commissioners and regulators.

There had been no significant data or security breaches at the trust over the last 12 months.

Information governance systems were in place including confidentiality of patient records. The Director of Finance was the Senior Information Risk Officer and the Medical Director was the Caldicott Guardian. All staff had to undertake mandatory data security awareness training and compliance was above the trust target in most teams.

There were robust arrangements (including appropriate internal and external validation) to ensure the availability, integrity and confidentiality of identifiable data, records and data management systems, in line with data security standards.

Engagement

The trust was a forward thinking and pro-active partner and leader in the wider health and social care system. The trust had been brought in to support other providers at times of need and were often asked by the system to provide care for

the most complex patients. They were respected and viewed as a system leader in some areas, such as reducing restrictive practice and their 'Just and Learning Culture'. There were examples of other providers learning from them and embedding this practice in their services. The trust had recently been involved in the co-production of the Mental Health, Learning Disability and Autism Quality Transformation Programme and were thanked by NHSE/I for their work on this.

The trust had been successful in their acquisitions of services from four other NHS providers in the last six years and had managed the transitions well. They had navigated the challenges of bringing together services whilst maintaining the safety of service provision and had brought staff with them on that journey. The trust demonstrated a commitment to acting on feedback and took learning from one acquisition into the next.

The trust now worked with six local authorities, in over 300 teams, providing almost 1000 inpatient beds. They worked collaboratively with external colleagues and the local authorities and were present on numerous panels and reviews. However, commissioners in the Liverpool place felt that further development of the working relationships between Liverpool local authority and the trust were required to achieve a more pro-active and early help response.

The trust was actively engaged in collaborative work with external partners, such as involvement with sustainability and transformation plans. The trust continued to provide mutual aid to the system with support into care homes and additional step down beds. The trust had contributed significantly to the system wide response to the COVID-19 pandemic, for example they had established a 'home swabbing' team, a 'roving vaccination' team and provided staff for step down services to support discharge, flow and rehabilitation. The trust continued to contribute to the wider system by providing leadership and mutual aid to the implementation of the new model of palliative care (IMPaCT), leading the care home response by providing a weekly check in and support with infection, prevention and control, releasing physiotherapists to acute services to enable nursing staff to support accident and emergency departments and providing a dedicated integrated team to support the homeless population in Liverpool.

Mersey Care was the lead provider in the Cheshire and Mersey Adult Secure Lead Provider Collaborative (LPC); the PROSPECT LPC. NHS England devolved commissioning responsibility to Mersey Care for adult low and medium secure mental illness and learning disability services in Cheshire and Mersey on 1 November 2021, with the associated budget of £56.4m. This devolved responsibility made Mersey Care responsible for strategic planning and service development, clinical oversight and quality assurance of the services, contractual, financial and informational oversight and governance of the LPC.

The HOPE(S) Collaborative was a new initiative established in light of NHS England's drive to support clinical teams across the country to reduce the use of highly restrictive interventions such as long-term segregation (LTS). A partnership between NHS-led provider collaboratives and Mersey Care was established, with an over-arching aim to deliver the HOPE(S) clinical model of care to reduce LTS, at scale, in services for people with a learning disability or autism. Sixteen senior practitioners had been recruited on a three-year development programme until December 2024 and seconded into Mersey Care from all regions in the country.

In Knowsley, the trust had been proactive in the establishment of the 2-Hour Urgent Community Response programme, including to Knowsley Care Homes, to provide out-of-hospital care, signpost patients to Community Services, and avoid accident and emergency attendance and non-elective admissions wherever possible. Commissioners also noted that the trust engaged very well with the Children's Partnership, the SEND Partnership, the Safeguarding Adults Board, and relevant sub-groups, in addition to being a system leader on Neglect.

Our findings

The pharmacy team worked across the integrated care system in Liverpool place, supporting ongoing work focussing on medicine management in care homes. Following recent incidents, they were also working with local acute trusts to understand the barriers to acute trust staff administering depots for patients admitted under their care.

Senior managers, on behalf of front-line staff, engaged with external stakeholders such as commissioners and Healthwatch. Feedback from place-based commissioners was that the trust was an excellent systems partner, supporting other partners and responding to concerns in the wider health economy. They were satisfied with the timeliness and completeness of data received from the trust, although noted that recent changes to the management structure within the organisation and the re-organisation of commissioning arrangements across the ICS had caused some disruption to effective working relationships.

People who used services, the public, staff and external partners were engaged and involved to support high-quality sustainable services. This included those with a protected equality characteristic. The trust had a structured and systematic approach to engaging with people who used services, those close to them and their representatives. The trust had a programme of service user and carer engagement. Board of Directors' meeting agendas included a personal story from a patient, carer or member of staff. Patient/carer representatives were involved in staff recruitment.

The trust had opened 'life rooms' in Walton, Sefton and Bootle. Mersey Care's Life Rooms offered preventative interventions alongside core treatment services, enabling people to take more control over their health and recovery. They formed part of the trust's overall strategy for whole-person care. The trust continued to expand the Life Rooms offer, for example by working with public health teams to deliver the Life Rooms social model of health across libraries, one stop shops and children's centres across Liverpool. In 2022 and 2023, the trust planned to extend the Life Rooms approach across mid Mersey, in partnership with local voluntary and community sector organisations.

The trust had access to feedback from patients, carers and staff and were using this to make improvements. The trust used the Friends and Family Test (FFT) to gather feedback and in October 2022 had received 500 responses, 89% of which were positive.

Communication systems such as the intranet and newsletters were in place to ensure staff, patients and carers had access to up to date information about the work of the trust and the services they used. Patients, carers and staff had opportunities to give feedback on the service they received in a manner that reflected their individual needs.

The trust sought to actively engage with people and staff in a range of equality groups. Information sharing about the possible side-effects of medicines was identified as an area where the trust could improve (NHS Community Mental Health Survey benchmark report 2022). The trust was rolling out a digital solution (using a QR code) to enable patients to access medicines information in a video. This was currently available in six languages including British Sign Language.

The trust had a structured and systematic approach to staff engagement. The trust offered a range of engagement opportunities to try and support staff through organisational change, including a dedicated transformation mailbox and informal coffee catchups, alongside more formal meetings. NHSE told us the trust had a process of engagement with staff and patients, including surveys, friends and family tests and Board interaction with staff teams.

Staff were involved in decision making about changes to the trust services. For example, following the growth of the trust in 2021, they reviewed and updated their staff charter, values and behaviours framework to ensure it was inclusive to those who joined from other organisations. This work was carried out in partnership with staff and was the basis for the People Promise and Charter.

Our findings

We observed a Council of Governors meeting as part of this inspection and held a focus group with Governors. The trust had 10 staff Governors, 10 public Governors and 10 service user/carer Governors. The trust offered Governors training on appointment and they were actively involved in the operation of the trust. Patients, staff and carers were able to meet with members of the trust's leadership team and governors to give feedback.

Learning, continuous improvement and innovation

There was evidence of learning and innovation as the trust acquired and developed new services. Mersey Care NHS Foundation Trust had expanded significantly since being awarded foundation trust status in 2016. The trust acquired Calderstones NHS Foundation Trust in 2016 and opened Clock View Hospital and the Life Rooms in Walton in the same year. In 2017, the trust opened Life Rooms in Sefton and became the provider of community health services in South Sefton. The trust went on to acquire Liverpool Community Health NHS Trust in 2018 and opened Life Rooms in Bootle. Hartley Hospital in Southport was opened in 2019, then in 2020 the trust opened a new medium secure hospital, Rowan View, at Maghull Health Park. The acquisition of North West Boroughs Healthcare NHS Foundation Trust took place in 2021, along with the transfer of Southport and Formby community services. During this period of time, the trust had grown from 4500 staff to over 11000 staff, from 36 sites to 171 sites and from an income of £230million to an income of £600million.

There were robust systems and processes for learning and continuous improvement. Effective systems were in place to identify and learn from unanticipated deaths. Learning was shared and used to make improvements.

Staff had training in improvement methodologies and used standard tools and methods. The trust had a dedicated quality improvement team of nine staff within the Centre for Perfect Care. The Centre for Perfect Care coordinated and facilitated individual projects and aimed to strive for significant quality improvement and innovation in mental health. Following the acquisition of NWBHFT, the trust took the opportunity to review their approach to quality improvement and sought an external company to support them in getting an overview of the position in each organisation and find a way to take the best parts of both approaches forward.

The Centre for Perfect Care supported staff to access national evidence to support their clinical decision-making, form their ideas for improvement into viable proposals reflecting the strategic priorities of the trust, and involve patients and carers in a meaningful way. The Centre for Perfect Care used the Model for Improvement, a nationally recognised tool that was supported by the Plan, Do, Study, Act (PDSA) cycle. There was an emphasis on exploring ideas and testing them out on a small scale to evaluate the benefits before introducing them fully into services. The trust shared examples of QI projects that had led to change in areas of suicide prevention and the reduction of self-harm on inpatient wards.

Staff used data to drive improvement. Within the Community division, a series of quality improvement projects were delivered to reduce the number of falls at Longmoor House. Initiatives included daily staffing and zoning boards, a falls prevention video, a new daily safety huddle, 'don't fall, just call' signs, and falls prevention posters. From a peak of 15 falls per 1,000 beds days in June 2021, the team had seen a significant reduction and had remained below the national average of 5.67 falls per 1,000 bed days for four out of the previous six months as at August 2022.

Quality improvement and innovation were central to the trust's vision to strive for perfect care. Leaders and staff embraced continuous learning, improvement and innovation. Staff had time and support to consider opportunities for improvements and innovation and this led to changes. There were organisational systems to support improvement and innovation work. The Centre for Perfect Care had worked with local and national providers as well as staff teams to identify new technology and innovative practices, such as;

Our findings

- SEM Scanners, a portable hand-held skin assessment device, incorporated into the former Liverpool Community Health division's award-winning pressure ulcer reduction programme.
- The development of a pressure ulcer app, in conjunction with Liverpool John Moores University, using augmented reality to support assessment and grading of pressure ulcers across district nursing and skin teams.
- The identification and implementation of AMaT – an innovative software system designed to make auditing easier, faster, and more effective within clinical audit.
- The use of augmented reality to deliver digital welcome packs for Rowan View and Hartley Hospital, aimed at service users and their families.
- The introduction of immersive reality spaces for therapeutic engagement with service users as well as training and wellbeing opportunities for staff.

The trust's Telehealth service originally started as a small project that supported around 50 patients in Liverpool with chronic obstructive pulmonary disease (COPD) and heart failure. The Telehealth team delivered remote monitoring services across Cheshire and Merseyside, and West Lancashire, and was supporting around 2,000 patients a day at the time of inspection with long-term conditions like COPD, diabetes, and heart failure. The service developed virtual wards for patients requiring urgent and close monitoring at their homes, with oversight from a consultant. Outcome measures identified a 40% reduction in emergency admissions and an estimated 3,900 bed days saved in total.

Individual staff and teams received awards for improvements made and shared learning. External organisations had also recognised the trust's improvement work. The trust had won awards for innovation and research for their 'Life Rooms' model:

- Innovation in Community Health – 2018 (National Positive Practice in Mental Health Collaboration)
- Partnerships in Innovation – 2018 (North West Coast Research and Innovation Award)
- Outstanding contribution to patient and public involvement (PPI) in research - 2018 (North West Coast Research and Innovation Awards)
- Innovation in Mental Health Award – 2021 (NHS Business Awards)
- Best Larger Social Prescribing Project - 2022 (Social Prescribing Network Awards)

They had also been shortlisted for the Health Services Journal 'Mental Health Innovation of the Year' Award in 2019.

All clinical teams within the trust were working towards internal accreditation. The trust had developed a proposal that accreditation became an extension of the Quality Review Process (QRV). All teams were identified at a stage 1, 2 or 3 of accreditation, linked to their QRV performance. To gain stage 3 accreditation a team must have received a 'good plus' rating in all five domains of the QRV, not have 'red flags' within their individual action plans, maintained the QRV result at the next 12-month review and completed and presented to a panel a quality improvement project with evidence of improvement in patient experience.

Some teams had received external accreditation, such as the Brain Injuries Unit which was a Headway Approved Provider and the Core 24 and LLAMS Warrington / St Helens team which were accredited by the Psychiatric Liaison Accreditations Network (PLAN).

The trust was actively participating in clinical research studies. There was a visible and proactive approach to offering and delivering research within the trust. The Medical Director was the board member responsible for research. The

Our findings

trust's research and development team had supported National Institute for Health Research (NIHR) adopted studies. Student, staff, internally generated research studies and service evaluations have also been facilitated. Studies included both observational and interventional research covering a range of areas such as trials of new therapeutic drugs, testing the effectiveness of online support tools and questionnaire based studies. They were conducted across all ages and in areas such as dementia, schizophrenia, psychosis, perinatal mental health, COVID-19, learning disability, infant feeding, tissue viability, anxiety and depression.

In 2021/2022, the trust had recruited 731 patients to participate in research. The Trust continued to support several studies within the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH) programme and had worked collaboratively with Liverpool Health Partners (LHP) and partnered in a recent bid for the biomedical research centre. Mersey Care had also established the first NHS led Global Centre for Research on Mental Health Inequalities.

The trust had a planned approach to take part in national audits, such as the National Audit of Inpatient Falls, National Clinical Audit of Psychosis and The National Asthma and COPD Audit.

The trust actively sought to participate in national improvement and innovation projects. The trust had been the North West winner for the NHA Parliamentary Award for 'Excellence in Mental Health' in 2019 and 2020 and the national winner in 2021. The trust's guide to reducing restrictive practice had been adopted by the World Health Organisation. Since our last inspection, the trust had continued to refine and roll out 'No Force First' across all of its mental health and learning disability services.

Key to tables

Ratings	Not rated	Inadequate	Requires improvement	Good	Outstanding
Rating change since last inspection	Same	Up one rating	Up two ratings	Down one rating	Down two ratings
Symbol *	➔➔	↑	↑↑	↓	↓↓

Month Year = Date last rating published

* Where there is no symbol showing how a rating has changed, it means either that:

- we have not inspected this aspect of the service before or
- we have not inspected it this time or
- changes to how we inspect make comparisons with a previous inspection unreliable.

Ratings for the whole trust

Safe	Effective	Caring	Responsive	Well-led	Overall
Requires Improvement ↓ Apr 2023	Requires Improvement ↓ Apr 2023	Outstanding ↑ Apr 2023	Good ➔➔ Apr 2023	Outstanding ➔➔ Apr 2023	Good ➔➔ Apr 2023

The rating for well-led is based on our inspection at trust level, taking into account what we found in individual services. Ratings for other key questions are from combining ratings for services and using our professional judgement.

Ratings for a combined trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Adult social	Requires Improvement	Good	Good	Good	Requires Improvement	Requires Improvement
Mental health	Requires Improvement	Requires Improvement	Outstanding	Good	Good	Good
Community	Requires Improvement	Requires Improvement	Good	Good	Requires Improvement	Requires Improvement
Overall trust	Requires Improvement ↓ Apr 2023	Requires Improvement ↓ Apr 2023	Outstanding ↑ Apr 2023	Good →← Apr 2023	Outstanding →← Apr 2023	Good →← Apr 2023

The rating for the well-led key question is based on our inspection at trust level, taking into account what we found in individual services. Ratings for other key questions take into account the ratings for different types of service. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Rating for acute services/acute trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Liverpool Walk in Centre	Requires improvement Apr 2019	Requires improvement Apr 2019	Good Apr 2019	Good Apr 2019	Requires improvement Apr 2019	Requires improvement Apr 2019
Overall trust	Requires Improvement ↓ Apr 2023	Requires Improvement ↓ Apr 2023	Outstanding ↑ Apr 2023	Good →← Apr 2023	Outstanding →← Apr 2023	Good →← Apr 2023

Ratings for the trust are from combining ratings for hospitals. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Rating for Liverpool Walk in Centre

	Safe	Effective	Caring	Responsive	Well-led	Overall
Overall	Requires improvement Apr 2019	Requires improvement Apr 2019	Good Apr 2019	Good Apr 2019	Requires improvement Apr 2019	Requires improvement Apr 2019

Rating for mental health services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Forensic inpatient or secure wards	Requires Improvement → ← Apr 2023	Good → ← Apr 2023	Good → ← Apr 2023	Good → ← Apr 2023	Good → ← Apr 2023	Good → ← Apr 2023
Long stay or rehabilitation mental health wards for working age adults	Good Apr 2019	Good Apr 2019	Good Apr 2019	Good Apr 2019	Good Apr 2019	Good Apr 2019
Acute wards for adults of working age and psychiatric intensive care units	Requires Improvement ↓ Apr 2023	Requires Improvement ↓ Apr 2023	Outstanding ↑ Apr 2023	Requires Improvement ↓ Apr 2023	Good → ← Apr 2023	Requires Improvement ↓ Apr 2023
Wards for older people with mental health problems	Good Apr 2019	Good Apr 2019	Good Apr 2019	Good Apr 2019	Good Apr 2019	Good Apr 2019
Community-based mental health services for older people	Good Oct 2015	Good Oct 2015	Outstanding Oct 2015	Good Oct 2015	Good Oct 2015	Good Oct 2015
Wards for people with a learning disability or autism	Good → ← Apr 2023	Good → ← Apr 2023	Good → ← Apr 2023	Good → ← Apr 2023	Requires Improvement ↓ Apr 2023	Good → ← Apr 2023
Community-based mental health services of adults of working age	Requires improvement Apr 2019	Requires improvement Apr 2019	Good Apr 2019	Good Apr 2019	Good Apr 2019	Requires improvement Apr 2019
Mental health crisis services and health-based places of safety	Good Oct 2015	Good Oct 2015	Good Oct 2015	Good Oct 2015	Good Oct 2015	Good Oct 2015
Community mental health services for people with a learning disability or autism	Good Oct 2015	Good Oct 2015	Good Oct 2015	Good Oct 2015	Requires improvement Oct 2015	Good Oct 2015
Substance misuse services	Good Jun 2017	Good Jun 2017	Good Jun 2017	Good Jun 2017	Good Jun 2017	Good Jun 2017
High secure hospitals	Good → ← Apr 2023	Requires Improvement ↓ Apr 2023	Outstanding ↑ Apr 2023	Good → ← Apr 2023	Good → ← Apr 2023	Good → ← Apr 2023
Overall	Requires Improvement	Requires Improvement	Outstanding	Good	Good	Good

Overall ratings for mental health services are from combining ratings for services. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Rating for community health services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community dental services	Good Apr 2019	Good Apr 2019	Good Apr 2019	Good Apr 2019	Good Apr 2019	Good Apr 2019
Community health services for adults	Requires improvement Apr 2019	Requires improvement Apr 2019	Outstanding Apr 2019	Good Apr 2019	Requires improvement Apr 2019	Requires improvement Apr 2019
Community health services for children and young people	Good Apr 2019	Good Apr 2019	Good Apr 2019	Good Apr 2019	Good Apr 2019	Good Apr 2019
Community end of life care	Good ↑ Apr 2023	Good ↑ Apr 2023	Good → ← Apr 2023	Good → ← Apr 2023	Requires Improvement → ← Apr 2023	Good ↑ Apr 2023
Community health inpatient services	Good Apr 2023	Good Apr 2023	Good Apr 2023	Good Apr 2023	Good Apr 2023	Good Apr 2023
Overall	Requires Improvement	Requires Improvement	Good	Good	Requires Improvement	Requires Improvement

Overall ratings for community health services are from combining ratings for services. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

High secure hospitals

Good

Is the service safe?

Good

Our rating of safe stayed the same. We rated it as good.

Safe and clean care environments

All wards were safe, well equipped, well furnished, well maintained and fit for purpose.

Safety of the ward layout

Staff completed and regularly updated thorough risk assessments of all wards areas and removed or reduced any risks they identified. Staff carried out regular physical checks of the ward environment. Staff completed a security checklist at the start of every day and night shift. The checklist included doing a count of sharp objects on the ward such as cutlery and ligature cutters and a patient count. We reviewed the security procedures on all wards we visited and saw security checklists were completed at every shift handover.

Outdoor areas, such as ward garden areas were included in the risk assessments, and patients could access these areas without staff supervision following a risk assessment and if they had leave or parole to do so.

Staff knew about most potential ligature anchor points and mitigated the risks to keep patients safe. Each ward had an up to date environmental suicide risk assessment (ESRA). These were updated annually, or when the ward environment was changed. The risk assessments clearly highlighted which areas of the ward were high risk. All bedrooms and bathrooms were considered the highest risk areas due to being used unsupervised by patients, but this was mitigated through observation protocols for these areas when in use by patients.

Staff we spoke with were well informed about ligature anchor point risks. Staff mitigated risks by positioning themselves at key points on the ward, such as the night station which gave a clear view of all bedroom doors and nurse call indicator lights.

Staff could not always observe patients in all parts of the wards. Not all areas of the wards could be observed from the nursing station, this was mitigated by using parabolic mirrors on corridors and in rooms where there were blind spots. Closed circuit television (CCTV) was used in patient communal areas, corridors, and seclusion rooms. The CCTV was not live monitored and there were protocols in place governing video review. For example, staff advised a review could be requested following an incident. Closed circuit television was not used in the seclusion rooms and staff monitored patients by direct regular observations of patients when they were in the seclusion room.

We saw that patient doors were designed to prevent holding, barring, and locking on all wards we visited. During the day patients had access to their bedrooms, which were not locked. During night-time confinement bedrooms were locked by 21:15 pm and reopened at 07:15 am as per the trust policy.

We saw evidence that relational security was reviewed for each patient at least every six months, although some were reviewed more frequently than this. Relational security is the knowledge and understanding that staff have of patients. An important part of relational security is the ability for staff members to maintain professional boundaries whilst maintaining a therapeutic relationship. Staff understood the importance of relational security.

Staff completed incident forms when security procedures were breached.

The ward complied with guidance and there was no mixed sex accommodation.

Staff had easy access to alarms and there were enough alarms for all staff. Each ward had an alarm system in place with panels which identified the location of the person who activated it.

Each ward had their own supply of alarms which were kept on permanent charge in the staff offices. The alarms were used to seek assistance during incidents and emergencies. Staff could use the alarm to call on staff from neighbouring wards or from across the site, depending on the level of response that was required.

Staff told us that other staff responded quickly when alarms were activated. The hospital security team was responsible for the testing and maintenance of the alarms. Alarms on each ward were tested weekly to ensure they were functioning correctly. Alarms that were used in other areas of the hospital site were tested every three months.

Patients had easy access to nurse call systems in their bedrooms. A nurse call system was in place that patients used when in their bedrooms, this made a sound and lit up a light above the relevant bedroom door. Patients told us staff responded to the nurse call system and incident reports recorded that staff responded to the nurse call system, for example, at night-time if patients needed assistance.

Maintenance, cleanliness, and infection control

Ward areas were clean. The housekeeping team visited the wards every day and completed a weekly deep clean of the ward areas and patient bedrooms. Cleaning audits were completed of both on and off ward areas. Patient bedrooms were included on the weekly housekeeping cleaning schedule.

Most wards were fit for purpose. All the wards we visited had an en-suite toilet and a sink in their bedroom. However, not all patients had access to en-suite shower facilities. Only Macaulay ward had en-suite bathrooms with showers. Patients had to share communal bathing facilities, with access to two bathrooms with a shower and a bath, which were ligature free. Dickens ward staff told us the lack of individual bathing facilities presented many challenges in an era of enhanced infection prevention and control. We spoke to the modern matron about plans to refurbish wards with en suite bathrooms and toilets. We were told that the trust was looking at a future new build, with patients involved in early consultation on what this would look like, though there were no agreed timescales when new build facilities would be available.

Some wards were well maintained and well furnished. All ward areas were visibly clean, and we saw evidence of ongoing maintenance and re-decoration of areas during our inspection. However, many staff told us that areas of the hospital were overdue for refurbishment, and we observed this was evident in some wards we visited, for example on Carlyle ward there was an ongoing issue of the sluice not draining appropriately. On Carlyle and Johnson wards the bedrooms were in a poor state of repair. These matters had been reported to the estates department for planned maintenance. Between April and September 2022 there were no reported incidents of blocked drains related to Carlyle ward.

Staff followed infection, prevention and control procedures, including hand washing. Personal protective equipment (PPE), including aprons, gloves and face masks were available at entry points to each ward. Masks were compulsory within clinical areas or wards that had patients who were clinically vulnerable to COVID-19, these wards had a notice on the door to inform visitors that they must wear a face mask. The trust regularly reviewed national guidance about wearing PPE in clinical areas and wearing face masks. Mask wearing was relaxed at the time of our inspection as risks had decreased.

PPE was available throughout the hospital. The Health Centre reported that there had been no PPE supply chain problems even at the peak of the pandemic. However, the hospital was not well equipped to store as much PPE, so this meant that some rooms were out of commission, for example, in the Health Centre as they were used for PPE.

Staff described a pro-active procurement team which helped them find solutions for national problems, such as shortages of blood test bottles. This had prevented any disruption for patients.

In June 2022, the trust infection control team completed an audit of 12 inpatient wards (sample size), four wards of which were at the Ashworth site. The overall compliance rate of the sample size was 90% with some improvements identified, which were addressed at the time, for example, the availability of laminated wipe clean posters. We saw the trust had addressed this and wipe clean posters were available on all wards we visited at the time of inspection.

Seclusion room (if present)

Seclusion rooms allowed clear observation and two-way communication. All seclusion rooms had en-suite bathroom facilities. Staff were able to view the seclusion room through a glass pane in the door and a viewing window in the en-suite bathroom area. Each seclusion bedroom area was covered by CCTV. Blind spots in bedrooms and en-suite bathrooms were mitigated using parabolic mirrors allowing staff to view all areas of seclusion rooms.

All seclusion rooms had a clock that patients could clearly see from their bedroom. We noted that there was not a clock in the seclusion room on Johnson ward, but a clock was located outside of this that was visible to a patient using the seclusion room.

Clinic room and equipment

Clinic rooms were fully equipped, with accessible resuscitation equipment and emergency drugs that staff checked regularly. Each ward had an emergency bag containing emergency medicines which were checked regularly. Emergency bags were in clinic rooms and contained a defibrillator, emergency medicines and resuscitation equipment. The contents of emergency bags were checked weekly by the physical healthcare staff. Emergency bags were closed with a security strip, which had an expiry date on it. Staff could view the expiry dates of emergency drugs as these were detailed and stored in a clear panel within the bag.

Staff always checked and maintained equipment. Fridge temperature monitoring records for clinic rooms on all wards recorded between August to November 2022 were completed. Clinic rooms were also temperature controlled.

Clinical waste at the Health Centre was bagged, tagged, and stored securely until collection. Sharps bins were used appropriately, they were dated and not over-full.

Safe staffing

High secure hospitals

The service did not always have enough nursing staff; however, staff knew the patients well and received basic training to keep people safe from avoidable harm.

Nursing staff

The service maintained minimum safe staffing levels to ensure patient's care and treatment needs were met, but staff were deployed across the site to maintain safe staffing levels.

All staff and patients we spoke with told us that staffing was the main challenge the service faced. Staffing shortages were impacted by short notice staff sickness and bank staff not arriving for shift or arriving late. Ashworth also had several staff absent due to long COVID. At the time of inspection, there was a national shortage of staff working in high-secure hospitals, which also impacted on Ashworth.

Ashworth Hospital had seen a significant impact of the COVID-19 pandemic on staffing levels, and as a result had been placed into business continuity by the trust on five occasions since 15 January 2021, the most recent period ending on 14 September 2022.

During these periods of business continuity, the trust had reduced patient capacity and closed wards as needed to maintain safe staffing levels. For example, during one period Lawrence ward remained open only to five patients who were in long term segregation at the time and was closed to admissions, meaning some staff could be released to support other wards. Ruskin ward was closed to admissions and transfers between December 2021 and February 2022, and Tennyson ward between January 2022 and May 2022. Turner ward was also closed on more than one occasion and at the height of a significant COVID-19 outbreak, the purpose of some wards was changed to manage infection levels and focus on supporting patient's physical healthcare needs.

Whilst patients in high secure hospitals are subject to night-time confinement in their bedrooms as part of security procedures, patients were not confined to their bedrooms as a response to staffing pressures.

The service had enough staff on each shift to carry out any physical interventions safely. Despite staffing pressures across the hospital, staff were able to attend other wards to respond to emergencies when the alarm was raised.

Staff were supported by site managers to keep patients safe. Site managers attended a daily risk/capacity meeting to look at staffing levels across the hospital. This was reviewed three times a day to ensure the highest risk wards had enough staff to maintain patient safety. Actions taken if staffing shortages were due to exceed safe staffing levels on wards included redeploying modern matrons, senior managers, positive intervention programme service staff (PiPs), recreational, therapy staff, educational and social care staff to wards.

The service had decreasing vacancy rates. The trust provided us with the latest vacancy rates for ward-based staff. The current qualified vacancy rate for staff nurses had decreased from 35% August to 28% in November. The trust had ongoing mitigation and recruitment plans in place. The trust had recruited eighty-eight registered nurses to the secure division through an ongoing recruitment process. Forty-three of these staff had applied to work at Ashworth. Twelve of these recruits were expected to start by the end of March 2023. In addition, the service was involved in international nurse recruitment, with five international nurses planned to join the secure division before the end of March 2023 and an anticipated twenty additional international nurses recruited and expected to join the secure division between April and November 2023. The high secure service had filled the health care support staff vacancies and has an additional pool of bank health care assistants to provide additional support to the wards at Ashworth.

We were told how the service had instigated measures to keep shortlisted applicants and successful candidates interested during the recruitment process, such as inviting them to question and answer sessions with a nurse who had recent experience on the wards. The trust attended recruitment fairs and similar events and involved staff who had recent ward experience so they could share their experience of working in a high secure environment. The trust had also recruited a staff member for 12 months to focus only on recruitment for the high secure service.

The service had increased rates of bank nurses and nursing assistants. In quarter one 2022, 17% of all shifts were covered by bank staff. In quarter three this had increased to 21%. The trust did not use agency staff and offered staff overtime or if required mutual aid from within the secure service division. All bank staff were regularly employed by Ashworth, so they were familiar with the site.

Managers made sure all bank staff had a full induction and understood the service before starting their shift. All new staff members at Ashworth received an induction to the hospital. This included security and key training. New members of staff were assigned a mentor on their ward. We spoke with two recently employed staff, a post registration preceptorship nurse and three student nurses completing their degree course. All spoke positively about the induction they had to complete before they could work or have a placement on a ward.

The service had reducing turnover rates. The trust provided us with staffing figures for the whole secure division which indicated low staff turnover rates. However, Ashworth was only a part of this division, so we were unable to see the turnover rate just for Ashworth. Leaders and staff at Ashworth told us turnover rates were low. The trust had put in place incentives to retain staff and had implemented a flexible staffing roster in response to staff feedback, which made Ashworth a more attractive place to work.

Managers supported staff who needed time off for ill health. Staff had access to the trust employee assistance programme and occupational health and ward managers undertook welfare checks on staff. Levels of sickness were still high but were decreasing. Sickness rates across the high secure service between April and June 2022 were 12% and had decreased to 10% between July and October 2022.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants for each shift. Shifts operated at safe staffing levels but did not always meet their desired staffing establishment levels to enable therapeutic care and treatment. Ward managers used the safer nursing care tool for monitoring and reviewing staffing levels. This included reviewing the acuity and dependency of patients to set minimum staffing levels for the wards. Safer staffing reviews were completed on an annual basis. In addition, staffing levels were reviewed three times a day at risk/capacity meetings to review the number and skill mix of staff needed for each ward.

Patients had a regular one to one session with their named nurse. Patients told us they had a regular one to one session with their named nurse and this included reviewing and contributing to their care plan and positive behaviour support plans. The named nurse audit provided by the trust demonstrated regular named nurse sessions took place on all wards. For example, a patient admitted mid-October 2022 had five named nurse session by mid-November 2022. Another patient admitted late September 2022 had 17 named nurse sessions by mid-November.

Patients had on and off ward activities cancelled or delayed when the service was short staffed. Staff and patients on all wards told us that on and off ward activities were regularly cancelled due to staffing. Each ward had access to a therapy and education centre but both patients and staff told us that they were often unable to attend this as the staff who normally ran activities at these centres were redeployed to work on wards due to low staffing. Nursing staff on wards told us that they tried to deliver recreational and physical activity sessions but told us they were often limited in what they were able to provide for patients.

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From March 2020 to October 2022 during COVID-19 and periods of business continuity the service followed government guidelines in promoting meaningful activities and introduced health and wellbeing packs and resources to reduce self-isolation for patients. Materials included mindfulness, emotional regulation materials, physical exercise, puzzles, quizzes and COVID-19 updates. Packs were tailored for patients in long term segregation and seclusion. In the October review of the service COVID-19 response, feedback from patients about the activity packs was positive.

During this period there were no reported complaints received from patients related to meeting the required staffing levels. Patients we spoke with reported they felt safe on the wards, however, most patients stated they had experienced therapy and rehabilitation sessions being cancelled. Managers were supporting therapy staff to provide therapy sessions on the ward when they needed to be deployed there, to make best use of their time in supporting patients. Senior leaders were aware of the impact on both staff and patients and were keen to see a return to the levels of therapeutic activity provided prior to the COVID-19 pandemic. Staff hoped the opening of the Life Rooms in January 2023 and the recruitment campaign would improve the position for both staff and patients.

Managers had begun to document the impact of these cancelled sessions and recorded that in October 2022, there were only nine out of thirty-one days when therapy and rehabilitation staff were not deployed to support ward staff. On every ward we visited patients and staff raised concerns about limited access to meaningful activities off the ward or access to ward-based facilities due to staffing pressures.

Staff shared key information to keep patients safe when handing over their care to others. Staff shared essential information about patients' needs and risks during daily handover meetings.

Medical staff

The service had enough daytime and night-time medical cover and a doctor available to go to the ward quickly in an emergency. There was one on call doctor on every day and night shift, supported by one on call consultant. There was good physical health medical cover from three part-time GPs (general practitioners) who worked together to ensure availability.

Psychiatrists confirmed that there was enough skilled support from other members of the MDT (multidisciplinary team) to enable them to focus on the core aspects of their role.

Managers could call locums when they needed additional medical cover. Managers made sure all locum staff had a full induction and understood the service before starting their shift.

Other staff

The psychologist and social work staff we interviewed told us their professions never had any difficulty with recruitment. This was confirmed by medical personnel.

The service had done well at encouraging retirees to return to work part-time. For example, the physical activity workers (PAWs) team comprised staff who had retired and returned. This team was ward based and supported wards when short staffed. This was not the case for all other off-ward teams. Many staff complained to us about the impact this had on off-ward patient activities.

Mandatory training

High secure hospitals

The mandatory training programme was comprehensive and met the needs of patients. Staff had completed it or kept up to date with it. The mandatory training programme included courses such as safeguarding adults and children, conflict resolution, equality, and diversity, preventing radicalisation, Basic and immediate lifesaving, fire safety and moving and handling. All wards had a compliance rate of above 90%.

Managers monitored mandatory training and alerted staff when they needed to update their training. The trust provided us with training compliance data for the whole secure division, inclusive of Ashworth. Core mandatory training compliance for the nine training subjects was 95% or above. Core mandatory training included safeguarding children and adults. Role specific mandatory training included basic and immediate life support and safeguarding children specialist level 3.

Assessing and managing risk to patients and staff

Staff assessed and managed risks to patients and themselves well. They achieved the right balance between maintaining safety and providing the least restrictive environment possible to support patients' recovery.

We saw that physical health needs were assessed at or soon after admission using recognised tools. For example, the Malnutrition Universal Screening Tool (MUST) and the Multi-factorial Falls Risk Assessment. Each patient had a Health Passport which was updated at least annually and incorporated the Lester tool.

Staff on the admissions ward told us that they sought to have a good understanding of patients' needs prior to admission so they could minimise the use of seclusion on arrival at the hospital. Patient records confirmed that not all patients were secluded during that transition period.

Staff had the skills to develop and implement good positive behaviour support plans and followed best practice in anticipating, de-escalating, and managing challenging behaviour. All staff we met had a good working knowledge of the risks presented by their patients and the ward environment. They answered questions about both without needing to look at written records and whenever we checked we found corroboration for what they told us.

Assessment of patient risk

Staff completed risk assessments for each patient on admission or transfer, using a recognised tool, and reviewed this regularly, including after any incident.

Staff used a recognised risk assessment tool. We reviewed 46 care records and saw that staff had completed a risk assessment for each patient when they were admitted, and these were updated regularly.

Management of patient risk

Staff knew about any risks to each patient and acted to prevent or reduce risks. Staff told us they felt safe at work and felt able to ask for help when this was not the case. Some staff at the Health Centre said they felt safer than in the community teams because risks were known. Staff told us they were aware of or had experienced assaults from patients, but this had decreased with the ward-based PIPs (Positive Intervention Programme) supporting them. We saw from patient records that staff benefited from additional support, especially when working with patients whose responses may be unpredictable. Input from the PIPs team and the HOPE(S) team was valued. The HOPE(S) model was a human rights-based model that encouraged teams to **H**arness the system through key attachments and partnerships;

created **O**pportunities for positive behaviours, meaningful and physical activities; identified **P**rotective and preventative risk and clinical management strategies; and built interventions to **E**nhance the coping skills of both staff and patients, while the **S**ystem was managed and developed. Patients we spoke with on all the wards we visited said they felt safe on the ward and staff responded to risk positively.

Risk assessments were developed by psychologists with input from the multidisciplinary team (MDT). They were detailed and contained useful guidance about potential triggers for behaviours, how to mitigate the risks and how best to respond.

Psychology led group work with patients had been suspended due to COVID-19 and was now gradually being reinstated.

Staff identified and responded to any changes in risks to, or posed by, patients. On each shift a staff member on each ward was available to respond to radio calls to help with other wards when an incident took place. We were told in certain circumstances body worn cameras were used in Ashworth during incidents or restraints to provide a safeguard against allegations of misconduct by staff and to maintain patient safety. The use of body worn had to be agreed through a governance process and with the MDT.

Some patients had a positive behaviour support (PBS) plan which was personalised and developed by the ward psychologist with MDT input. PBS was used to support people to end seclusion or long-term segregation and for those who had difficulty engaging with talking therapies.

The Health Centre triaged all referrals and reviewed and added information about existing conditions to ensure patients were directed to the right clinician in a timely way. Decisions were discussed in a daily meeting where the day's activities were confirmed. Health Centre staff described close liaison with ward staff to find ways to work with patients who may be uncooperative or distressed.

The range of audits carried out by Health Centre staff had reduced during COVID-19. However, those required to maintain patient safety had been retained, for example, the sharps audit.

The Health Centre maintained a vaccine tracker which showed which patients had received COVID-19 or flu vaccinations. Patients were also offered age-appropriate universal vaccinations and health screening.

Staff followed procedures to minimise risks where they could not easily observe patients. We reviewed patient observation records. Observation records showed that staff followed the trust policy and observed patients at the minimum observations levels for the ward and maximum levels identified for individual patients.

Staff followed trust policies and procedures when they needed to search patients or their bedrooms to keep them safe from harm. The trust search policy covered routine and random searching without cause as is indicated through the provision of the National Clinical Security Framework.

Staff completed a monthly search of each patient's room, its contents and any locker used by that patient. Searches were random, so not predictable by patients. Security searches included a rub down search of a patient when a patient's room and/or his locker was searched unless an exemption was given by the Medical and Director and approved by the Security Director.

For patients assessed by the MDT as presenting a high risk of assault if they or their possessions were searched without consent, for example, patients in seclusion or segregation, attempts to perform the search were made each month. After three months if a search was not completed the MDT arranged for searches to be done with the support of the personal safety team (PSS).

Several routine searches took place for patients moving around in the secure area when at least one patient from any group of up to nine patients, or 10% of any group of 10 or more patients were subjected to a rub-down search. This was dependent upon the number of patients from the ward.

All parts of the ward areas other than patients' rooms were searched at least once a week. Therapy, workshop, recreations and leisure facility areas and other non-ward areas where patients visited were searched as least once every three months. Other searches included rub down pre and post leave of absence, external visits, pre and post off ward activities and locked box searches. Personal searches were only completed as and when required, for example on admission, prior to leave of absence or if a patient was believed to be a danger to self or others. Each patient had a security risk assessment and emergency escape procedure in place, which was reviewed regularly.

Use of restrictive interventions

Levels of restrictive interventions were reducing. We saw ongoing evidence of commitment to improvement and innovation in the reduction of restrictive interventions. The use of the Positive Intervention Programme Service (PIPS) team was observed assisting on the wards. The team directed staff in building positive relationships and engaging patients in strategies to support and challenge them on moving out of long-term segregation. The team used the HOPE(S) model to empower patients and staff to carry out their work together and build confidence, without relying on the team to do it for them.

Night-time confinement was operational practice across high secure services, with all patients being locked in their rooms from 9.15pm until 7.15 the following morning. The practice was initiated in 2011 under the High Security Psychiatric Services (Arrangements for Safety and Security) Directions. The policy was updated for all high secure hospitals by the Department of Health in 2013. Staffing levels at night were, consequently, lower than during the day. We saw that night-time confinement was a standing item agenda on patient forums in high secure services

Staff participated in the provider's restrictive interventions reduction programme, which met best practice standards. The trust reducing restrictive practice guide was relaunched on the 25th of May and 8th of June 2022. This re-focused staff on reducing restrictive practices including No Force First and the HOPE(S) model. The re-launch was an opportunity to ensure staff in the Mid-Mersey division (former North West Boroughs NHS trust) acquired by Mersey Care in June 2021 were all refreshed on the guidance.

Staff understood the Mental Capacity Act definition of restraint and worked within it. No Force First is a restraint reduction strategy that aims to reduce conflict and restrictive practices which can lead to physical, psychological harm and traumatic experiences. Staff were committed at all levels to the reducing restrictive practice model. It was well integrated into the culture and narrative of staff. We observed the pride, commitment, and positive approach in improving the quality of life for patients receiving care at Ashworth Hospital. There were clear links between the overarching HOPE(S) model, a human rights approach for autistic patients or those with a learning disability and the reducing restricted practices for all patients at Ashworth. The Positive Intervention Programme (PIP) was a clear example of how this approach was working for patients at ward level.

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The trust provided data on incidents on the number of times restraint was used across the service from August to November 2022. A total of three restraints was reported across the service during this period.

We reviewed patients subject to the highest levels of restriction at Ashworth Hospital. On the first day of inspection, there were 3 patients subject to seclusion and 27 subject to long-term segregation (LTS), which was a reduction from 28 patients in July 2022. Of those, we visited wards where two patients were in seclusion and 16 were in LTS. We spoke with fourteen patients and greeted or observed eight more who were held in seclusion or LTS. We reviewed 10 sets of patient notes, two in seclusion and eight in LTS.

We found reviews that corresponded with the MHA Code of Practice requirements at Chapter 26. We noted that the seclusion and segregation policy reflected these requirements. The rationale for commencement and continuation of seclusion was found on each record. There was evidence that LTS care plans were comprehensive and up to date. Barriers to Change care plans were comprehensive and optimistic for the future. The LTS re-association pathway chart was helpful to patients working towards ending LTS/seclusion. There was evidence of seclusion and segregation care plans that included plans to end seclusion and barriers to change. There was evidence that patients were involved in co-production of care and positive behaviour support plans and their preferences of activities was noted, their triggers and stresses identified, and their views were recorded.

The trust completed an annual review of restrictive practice and there was an ongoing quality improvement project at the hospital to improve access to debriefs following the use of restrictive practice.

The use of long-term segregation was regularly reviewed. The trust completed a review of all patients in long term segregation every three months. Each of the High Secure Hospitals in England completed a peer audit of the use of long-term segregation every three months in line with the Mental Health Act code of practice.

When a patient was placed in seclusion, staff kept clear records. We reviewed the seclusion records for two patients. We found no gaps in seclusion observation records and saw that nursing and medical reviews took place regularly, in line with the Mental Health Act Code of Practice.

Staff attempted to avoid using restraint by using de-escalation techniques and used restraint only when de-escalation had failed. This practice was in line with best practice guidelines. The trust policy on seclusion and long-term segregation included a section on patient discretional confinement as an alternative to seclusion or LTS.

Staff followed the National Institute for Health and Care Excellence (NICE) guidance when using rapid tranquilisation. We found that staff consistently monitored patients' physical health after rapid tranquilisation was used. Information provided by the trust was that there were no incidents of the use of rapid tranquilisation between April and September 2022.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

The trust had a trust wide safeguarding team, with a single point of access for all services. Ashworth hospital had a designated safeguarding lead who was specifically assigned to provide safeguarding advice and support to staff at Ashworth. Social workers took the lead for safeguarding within the hospital, but it was recognised it was everyone's responsibility.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Information we received from the trust was that four safeguarding referrals were made between April and September 2022, which were also incident reported.

The hospital had a designated safeguarding lead who took the lead responsibility for the protection of patients. Social workers were visible on the wards and provided advice and support to nursing staff and patients.

Managers took part in serious case reviews and made changes based on the outcomes.

The local authority had given delegated authority to Mersey Care to carry out all Section 42 enquiries at Ashworth, supported by a Memorandum of Understanding. Oversight was by a weekly strategy meeting and all safeguarding was reported weekly into the divisional safety huddle.

The high secure commissioner also reviewed safeguarding incidents, responses, and investigations. The safeguarding lead attended the commissioner-led incident review meetings which provided a forum to challenge the safeguarding process. The commissioner highlighted this approach as having improved the reporting of safeguarding. The process could involve reviewing patient records and CCTV to determine whether allegations from patients were made in the context of their mental health or not. The commissioner was assured by the processes in place as part of their oversight of the service.

Staff had access to training on how to recognise and report abuse, appropriate for their role and staff were up to date with it. All nurses and healthcare assistants were required to complete level three Safeguarding Children and Adults training. The overall compliance rate for Safeguarding Adults' level one and three training was 96%.

Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them

Staff could give clear examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. For example, staff referred to reporting racial discrimination when culturally inappropriate language was used.

Staff followed clear procedures to keep children visiting the ward safe. Social workers had to approve all child visits to the hospital. Children were not allowed to visit patients on wards, instead visits with children took place in designated visiting rooms off the ward.

Ashworth had provided information to patients about the CQC closed cultures guidance. CQC define a closed culture as 'a poor culture that can lead to harm, including human rights breaches such as abuse'. In these services, people are more likely to be at risk of deliberate or unintentional harm. The wards had information about the indicators of a closed culture posted on notice boards.

Patients told us the information on closed cultures was empowering and reported feeling confident to challenge staff about the use of language they believed was inappropriate. Staff also reported they felt able to challenge patients about potentially racist or culturally inappropriate language.

Staff access to essential information

Staff had easy access to clinical information, and it was easy for them to maintain clinical records.

Records were stored securely. Patient notes were comprehensive, and all staff could access them easily. We saw that wards used a one-page profile for each patient which contained basic information about patients' risks and de-escalation strategies. On the wards it was easy for relevant professionals to access the patient electronic record system and to navigate the system to find the correct document.

The Health Centre used a different electronic record system to the one in the wards. There was no duplication of information between the two systems as information was transferred automatically to the ward based system three times a day, and maintained accurate information about patient's health conditions, for example diabetes. The Health Centre was awaiting recognition from the NHS spine. This would make it easier to refer to external clinicians and receive updates from them. Clinical staff were optimistic this would happen soon.

When patients transferred to a new ward, there were no delays in staff accessing their records.

Medicines management

The service did not always use systems and processes to safely prescribe, administer, record and store medicines. Staff regularly reviewed the effects of medications on each patient's mental and physical health.

Allergy status was completed on all but one of the electronic prescription records examined. A patient with a penicillin allergy was prescribed an alternative antibiotic. The off licence prescribing of an antipsychotic was through a documented approval process.

Staff completed medicines records accurately and kept them up to date.

The controlled drugs register (CD) against stock was checked three times daily by staff on wards. Prescription records checked on inspection did not have any missed administration doses. Staff reviewed patients' medicines at multidisciplinary meetings and ward round meetings. Patients were invited to attend the ward round meeting and we saw that doctors spoke with patients about their medicines. Pharmacists completed regular reviews of patient prescription charts. Staff told us that they could contact the pharmacist when needed.

Staff stored and managed most medicines and prescribing documents safely.

Medicine management audits on storage were completed. When temperatures medicines were stored at fell outside the normal range, there were documented appropriate actions completed. Emergency medicines were available for administration and signposted to where they were stored.

However, the opening dates of some medicines, such as eye drops, medicated cream and liquids were not always completed. Medicines with reduced expiry dates on opening risked being ineffective when used past their manufacturer recommended expiration dates.

Some of the services run by other providers and operating out of the Health Centre under a service level agreement had their own storage areas for clinical supplies. We found a few low risk items in these areas were well beyond their expiry dates, such as cotton wool dental rolls and hand softener. There was no oversight of these stores by Mersey Care staff.

Staff learned from safety alerts and incidents to improve practice.

Staff had access to incident reporting systems to be able to report medicine issues. Incidents involving medicines were discussed regularly at the trust medicines optimisation group. We saw that learning from safety incidents across the trust was shared with ward managers for discussion in team meetings.

The service ensured people's behaviour was not controlled by excessive and inappropriate use of medicines. Administration of oral medicines were included as part of a one-page care plan covering the behavioural management of patients. Where a medicine was administered regularly, such as a benzodiazepine, we observed a separate care plan was in place to manage this administration. However, we did find that the reason for administration was not always recorded in a patient's progress notes.

Staff reviewed the effects of each patient's medicines on their physical health according to NICE guidance. There was evidence of care planning for patients with diabetes, asthma, chronic kidney disease and sickle cell crisis. Staff then carried out the necessary physical health monitoring tests for each patient and the appropriate medicines were seen to be prescribed.

Staff monitored the side effects of constipation for the patients prescribed antipsychotic medicines. Staff developed care plans for clozapine constipation side effect management and used bowel charts for some patients along with various laxative medicines prescribed. Staff had completed a falls risk assessment for a patient prescribed a benzodiazepine.

Track record on safety

The service had a good track record on safety.

Reporting incidents and learning from when things go wrong

The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

Staff knew what incidents to report and how to report them. Staff raised concerns and reported incidents and near misses in line with trust/provider policy. Between April and September 2022, the service reported 459 incidents by all types. For example, medicine errors, LTS, IT failures, infection control, aggression toward staff or patient to patient.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation when things went wrong.

Managers debriefed and supported staff after any serious incident. Staff told us that they received support after incidents, from managers and the PIPS team.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations.

Staff received feedback from investigation of incidents, both internal and external to the service. Staff received information about incidents that occurred in parts of the trust in a monthly bulletin that was shared with all staff.

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Staff meet to discuss the feedback and look at improvements to patient care. Staff told us they knew what to report and how to report it. De-briefs were held following incidents and they were further discussed in several forums when appropriate, such as the MDT or reflective practice, which had recommenced after being paused during COVID-19.

Is the service effective?

Requires Improvement 

Our rating of effective went down. We rated it as requires improvement.

Assessment of needs and planning of care

Staff assessed the physical and mental health of all patients on admission. They developed individual care plans which were reviewed regularly through multidisciplinary discussion and updated as needed. Care plans reflected patients' assessed needs, and were personalised, holistic and recovery oriented. They included specific safety and security arrangements and a positive behavioural support plan.

Staff completed a comprehensive mental health assessment of each patient either on admission or soon after. Whenever staff gathered comprehensive assessment information prior to each patient's admission. If this was not an option, assessments took place promptly following admission. All assessments were updated in response to changes in patient's mental state and patients had the opportunity to contribute to their assessment. If patients were too unwell or did not wish to engage with care planning this was recorded on the forms. We reviewed 46 patient care records and saw that staff completed a mental health assessment for each patient after their admission.

All patients had their physical health assessed soon or after admission and regularly reviewed during their time on the ward. These physical health assessments contained the appropriate additional checks if they had co-morbid conditions or were in receipt of certain medicines.

Staff developed a comprehensive care plan for each patient that met their mental and physical health needs.

Patients were supported to set realistic goals to improve their physical health across the Lester tool parameters. The Lester tool helps clinicians to assess the cardiovascular health of patients with severe mental illness and recommends the best course of intervention and treatment. This was included within the patients' physical health passport.

The service delivered the FITTER programme run by the dietetic team, which supported patients to understand the relationship between a healthy lifestyle and improved physical health and involves developing an individual exercise plan. The programme provides an eight-week nutrition and fitness programme for patients with obesity with or with co - morbidities at the time of inspection this was not being run due to staffing pressures and there were 170 eligible patients on the waiting list, who has been seen by a dietician. The programme had not been delivered since February 2022.

All patients with long term health conditions, for example, asthma and diabetes were on the chronic disease register, their conditions were reviewed annually, and they were encouraged to follow an individual treatment plan to improve their outcomes. Some patients had a care plan developed with speech and language therapist (SALT) to encourage them to manage their health conditions and symptoms. Diagnosed asthmatics were shown inhaler techniques by health centre staff and provided with prompt cards to support their self-administration of medicines.

Screening programmes were adhered to and health centre staff offered education on how to self-examine and report any concerns.

Care plans were personalised, holistic and recovery orientated. Staff regularly reviewed and updated care plans when patients' needs changed. Patients had a range of care plans in place to address their needs. Overall, the care plans we reviewed showed evidence of patient involvement. They included individualised coping strategies and reflected patient's individual needs. However, several physical healthcare, night-time confinement and mental health care plans had generic content recorded and did not reflect the patient's individual needs. The quality team was engaged in a quality improvement project to revise care planning, including documentation, to make it more integrated. At the time of inspection, as each care plan was 'stand-alone'. The integrated plan was a new development to further enhance care planning to make it more engaging and user friendly for patients, which had led to some being standardised.

Patients also had a positive behaviour support plan in place which provided information about strategies staff could use to prevent or respond to incidents. Staff had developed one-page positive behaviour support profiles which were accessible by staff on the patient records system. Patients that wished to have a copy of their care plans and one-page profile, were provided with a paper copy, and retained these themselves.

Staff told us that patients could be referred for autism and other assessments only when well enough. We looked at the care plans for a patient diagnosed with autism. Most of them took full account of his autism. Staff told us of other patients they thought may be autistic who had not been formally assessed or diagnosed for a variety of reasons. For example, because they were too mentally unwell. We were advised that patients could be referred for autism and other assessments only when stable.

We looked at the care plans for a patient diagnosed with autism and found that they took account of his individual needs.

Staff recorded evidence of advance decisions in patient care plans where this was relevant.

Each patient had a risk management care plan, which contained information about patients' risk to self, others, and any identified risk of breaching security or attempting to escape.

Best practice in treatment and care

Staff provided a range of treatment and care for patients based on national guidance and best practice; however, care was not always delivered in line with NICE guidance. Staff ensured that patients had good access to physical healthcare and supported them to live healthier lives. Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, bench marking, and quality improvement initiatives.

Patients had access to the Life Rooms team as part of the rehabilitation service. This offered a range of activities which included horticulture skills in outdoor classrooms, maths and English refresher and advanced courses, shared reading, graphics and information technology skills, art, expressive art, music confidence through drama and peer tutoring. Life Rooms helped patients to develop hobbies and leisure interests. At the time of inspection, the building was being refurbished and due to reopen in January 2023. Life Room activities that could be offered outside were taking place, for example horticulture. Other activities were offered with a ward-based activity timetable available to patients.

Staff provided a range of care and treatment suitable for the patients in the service. The hospital offered various interventions depending on patients' needs, such as cognitive behavioural therapy (CBT) and trauma informed care.

High secure hospitals

Staff did not always deliver care in line with best practice and national guidance (from relevant bodies e.g. NICE). We checked 14 electronic records for patients who had underlying co-morbid physical health conditions against NICE guideline NG89, Venous thromboembolism in over 16s: reducing the risk of hospital-acquired deep vein thrombosis or pulmonary embolism (VTE). The lack of activity and prolonged confinement may cause an increased risk of deep vein thrombosis (DVT).

In NG89 section 1.9 Interventions for people with psychiatric illness. Section 1.9.1 referred to 'assess all acute psychiatric patients to identify their risk of VTE and bleeding. We found that VTE risk assessments were not always completed on admission. Five patients with underlying health conditions had no VTE assessment in their records. These patients were recorded as having conditions such as diabetes, chronic kidney disease and hypertension. We also found a further three patients whose VTE assessments had missed their review date and were no longer being completed. One patient had an ongoing VTE assessment and DVT plan, with monthly reviews set. From the assessment record it was not apparent which nationally recognised tool the ward staff were using, and the trust clarified ward staff do not utilise a VTE risk assessment tool.

The trust provided us with their venous thromboembolism diagnosis and anticoagulant treatment pathway based on NICE guideline NG158 published March 2020. This covered diagnosis and management of venous thromboembolic diseases in adults. It aimed to support the rapid diagnosis and treatment for people who develop deep vein thrombosis (DVT) or pulmonary embolism (PE) and testing for other risk factors. However, this pathway did not cover the longer-term assessment and review post admission of VTE. The trust provided us with a copy of the October 2022 audit of the VTE assessment compliance report. This highlighted that Arnold, Lawrence and Turner wards had completed a VTE assessment of a patient on each of these 3 wards on admission, then after 24 and 72 hours. The trust did not provide us with a specific VTE policy to clarify the longer-term management of VTE.

The trust revised the PIP model in October 2022, changing it to an in-reach model and increasing the number of practitioners. This meant there were six practitioners based on the high dependency wards, leaving a smaller outreach team based in the pavilion. The changed model enabled all patients in both LTS and seclusion to have consistent input with the same practitioner, resulting in an increase in meaningful activities offered daily. Practitioners worked collaboratively with ward staff in improving their confidence and skills when working with patients in crisis.

Patients and staff were supported to develop transition exit plans with the MDT to support patients back into the ward community in as timely a manner as possible. PIP staff were able to support in the removal of restrictive practices on the ward, and attend patient care team meetings, barrier to change meetings, and Care Programme Approach meetings.

Although the new model had only been introduced recently, there had been positive feedback from patients, staff, and MDT members in improved frequency to activities, which led to a reduction in incidents and patients feeling hopeful about their future and moving out of LTS and seclusion. Patients reported the benefits of working with staff familiar to them.

On Lawrence ward, staff took a quality improvement approach to supporting a patient with high complex needs and poor response to previous antipsychotic medicine. The patient had a history of treatment resistant schizophrenia with unpredictable and impulsive episodes leading to assaults on staff and patients. The care team followed NICE guidelines QS80, Psychosis and Schizophrenia in Adults in developing a plan to help improve the patient's compliance with medicine and plan interventions in the least restrictive way. Over time, the patient's compliance with medication improved and their level of engagement on the ward increased.

High secure hospitals

In March 2022, Lawrence ward reduced its capacity to five patients due to business continuity, four of whom were in LTS and one in seclusion. Staff used this opportunity to take a quality improvement approach with the aim of reducing the patients time in LTS. Staff were able to provide more intense one to one session with patients and with less patients on the ward, encourage them back into the main ward environment. During this brief period, the ward team were able to reduce time spent in LTS and reduce the patient's isolation.

On wards we saw the Triangle of Care (TOC) was embedded. The TOC was a partnership between the patient, staff member and carer, which gave carers the recognition as key people in a patients' mental health care. The carers lead supported wards to implement and complete the self-assessment and TOC tool kit. We saw TOC information displayed at ward level on performance against the self-assessment and it was discussed in patient community and ward staff meetings. The tool provided carers with a voice, where they cannot be present in the ward environment. A TOC quarterly report was completed to capture data and presented to the senior leadership team and commissioners.

We saw that the HOPE(S) model and barriers to change checklist had been embedded into practice to reduce long-term segregation and had been incorporated into the trust's independent monthly monitoring reviews. The HOPE(S) model was a national project led by the trust in conjunction with NHS England which aimed to support patients out of long-term segregation. The model was established from a review of factors found to be efficient in reducing seclusion and restrictive practice. Data was generated via the Positive Intervention Programme team, supported by research from a clinical psychologist who did a small pilot study at Ashworth.

Staff usually identified patients' physical health needs and recorded them in their care plans. Staff ensured that patients with known physical healthcare needs had a physical health care plan in place and covered essential information about how to manage patients' physical health needs.

Staff made sure patients had access to physical health care, including specialists as required. Staff referred patients to the physical healthcare service when this was needed. The physical healthcare services offered a variety of services including speech and language assessments, dietician assessment, wound management, and a routine GP clinic. Bowel checks, vaccinations, and blood tests were also offered.

The Health Centre staff had working relationships with most specialist external health services that patients were likely to use, for example, general surgery or cardiology. Some specialisms had been able to increase their input to Ashworth as their work elsewhere had been suspended for part of the COVID-19 pandemic. Patients had good access to a range of physical healthcare specialists. In addition, the hospital had arranged for a mobile MRI (Magnetic Resonance Imaging) scanner to attend the premises so patients waiting for scans could receive them.

There were service level agreements in place for regular dental, chiropody, and optician clinics on site.

Due to staff shortages, although ward staff attempted to involve patients in some light physical activities, on the medium dependency wards the input of the physical activity workers (PAWs) team was critical in the afternoons and early evenings. For example, subject to appropriate risk assessments, they took less motivated patients for walks in the grounds or to a small gym for up to 90 minutes a week. A patient who had lost confidence in walking following a fall had been supported to improve their confidence and extend their walks.

High secure hospitals

Previously, the Health Centre had bench marked its performance with the Health Centres in the other High Secure Hospitals. During the COVID-19 Pandemic the service increased contact with the other high secure hospitals, including weekly calls with senior clinicians, wider discipline meetings and bench marking additional activity including post COVID-19 increase in general hospital admissions. An annual conference for the high secure health centres was completed virtually in 2021 and there were plans for the 2023 conference to be a face to face event.

Health Centre staff liaised positively with link nurses on each ward about general physical health matters and identified when errors were made by ward staff when completing National Early Warning Scores (NEWS2) to monitor patients' physical health forms. The potential seriousness of this was discussed with individual staff in supervision with their ward managers.

Staff met patients' dietary needs and assessed those needing specialist care for nutrition and hydration. Staff included information about patients' dietary needs within their care plans. Patients had support from dietitians and speech and language therapists where needed. When services were not available at Ashworth hospital, patients were referred to services at the local acute trust for further support and assessment.

Staff helped patients live healthier lives by supporting them to take part in programmes or by giving advice. The Health Centre staff delivered health promotion sessions and supported patients to learn about self-examination. The link nurses offered all the patients on their linked ward a monthly well man check. This included NEWS2, nutritional and body mass index screening and waist circumference, which were reported at least monthly. If patients were uncooperative the expectation was that, at a minimum, respiration and level of consciousness was recorded were possible.

Staff used recognised rating scales to assess and record the severity of patients' conditions and care and treatment outcomes. Staff used rating scales such as the Health of the Nation Outcome Scale (HONOs), Model of Human Occupation Screening Tool (MOHOST), the Historical Clinical Risk management (HCR-20) scale, and the Tilt high risk rating for patients in high secure service environments.

Staff took part in clinical audits, bench marking, and quality improvement initiatives. Modern matrons undertook audits of staff recording of physical observations and of the malnutrition universal screening tool (MUST) and shared these results with ward managers. Ward managers completed regular audits of patient care plans and risk assessments. Other audits included the use of the Mental Health Act section 58 and 132, continuous positive airway pressure for treatment of sleep apnoea/hypnoea syndrome, Mental Capacity Act, sharps audits, Duty of Candor, Care Programme Approach, chronic disease trackers, pharmacy audits and infection prevention and control audits. We also saw evidence of ward-based audits being completed. For example, on Turner ward we saw reflective practice records, handover and MDT minutes audits taking place throughout 2022.

Managers used results from audits to make improvements. An example of this was a quality improvement project that was in progress to include patients further in the personalisation of their care plans.

Staff used technology to support patients. Patients could have virtual meetings with families using ward laptops. The service used a wall-mounted tablet, which was a shopping application based on the ward (not internet enabled). This allowed patients access to shopping sites to purchase their own clothes, electrical and other personal items that were not restricted. The tablet did not allow patients to access outside unmonitored web sites. The tablet was available in a range of languages, so patients whose first language was not English could buy items. There was an approval process, so patients bought items within their disposable income.

High secure hospitals

Skilled staff to deliver care

The ward teams had access to the full range of specialists required to meet the needs of patients on the ward(s), however vacancies were high in the occupational therapy team. Managers made sure they had staff with the range of skills needed to provide high quality care. They supported staff with appraisals, supervision, and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.

The multidisciplinary team was made up of registered nurses, health care assistants, medical staff, security staff. PIP's team, occupational therapists, psychologists, social workers and domestic staff. In addition, other health professionals supported the wards-based team, for example, Health Centre staff, speech and language therapists, GPs, and social therapy staff.

However, from April to September 2022, there had been 34 incident reports of wards not meeting the required levels of staffing to meet patients' needs across the 13 wards. Incident reports referred to insufficient staffing figures directly impacting on ward and off ward-based activities, for example going to the gym, or patient shop. The incident reports also noted that staff had to lock off some communal ward areas at times to maintain safe observations or during medication administration.

Managers ensured staff had the right skills, qualifications, and experience to meet the needs of the patients in their care, including bank staff. We met many staff who were passionate about their role and determined to make sure their patients were fully supported in their recovery. They described the training opportunities available to them, including university level courses. Training specific to their work included training on relational security and the HOPE(S) model.

Consultant psychiatrists had received training in attention deficit hyperactivity disorder (ADHD). Staff completed a full day learning disability and autism training on induction and well as a learning disability awareness e-learning package that includes autism awareness. In the secure division 99% of the division had completed this training. Two staff had completed more advanced specific training in autism, with plans for further staff to undertake it. The Health and Care Act 2022 introduced a new legal requirement on 01 July 2022 for all registered health and social care providers to ensure staff received training in learning disability and autism, at a level appropriate to their role. The trust had a plan in place to achieve this that was in progress at the time of inspection.

The roll out of the role specific training would include more advanced autism training from July 2023. In addition, the trust has registered professionals including registered doctors. learning disability nurses who have a master's degree in learning disability. Allied health professionals who have specialised to work in learning disability services, including, clinical psychologists, and associate director for learning disabilities. These staff support and training, to ensure the high secure services meet national requirements and guidelines.

Speech and language therapists were working closely with ward and Health Centre staff to support patients with, or at risk of, swallowing difficulties and all clinical staff had received awareness training, so they knew when to refer to the speech and language therapists.

Patients benefited from a wide range of therapies, much of which had had to be delivered individually during COVID-19, but some groups had restarted. For example, psychology offered cognitive behaviour therapy (CBT) for psychosis, schema therapy (ST) and cognitive analytic therapy (CAT).

High secure hospitals

The service had access to a full range of specialists to meet the needs of the patients on the ward, however vacancies were high in the occupational therapy (OT) team. Patients told us that activities were often cancelled and spoke about the impact this had on their care and treatment. Staff were frustrated by the cancellation of activities and had begun to monitor the frequency of cancelled activities and the number of patients this impacted.

At the time of inspection, access to OT was through a referral process due to the vacancies for occupational therapists (OT) and occupational therapy assistants. The vacancies within the OT service were 3.6 band 6 posts and six band 5 posts due to additional funding. In addition, there were band 5 educational tutor vacancies and a head of rehabilitation secondment post vacancy. The sensory integration lead had left so OT's could not complete a sensory integration assessment. Therapy staff, including technical and physical health instructors who supported patients to complete activities, were often re-deployed due to low staffing levels across the hospital.

The service had paused the collection of 25 hours of meaningful activity data through the COVID-19 pandemic and this had not re-started at the time of inspection. Under Department of Health guidance Positive and Proactive Care: Reducing the Need for Restrictive Interventions, services must record all meaningful and restrictive practices. We saw that the numbers of activities patients were involved in on the ward, the use of outdoor space, ground leave within the perimeter and visits to the GP or from the Health Centre team or other professionals were not routinely recorded as part of meaningful activities.

The trust told us they planned to start recording this data again from 01 December 2022 and it would be recorded differently using handheld devices, although no time frame was given for this. Training on what was meaningful activity and using the handheld devices had commenced.

Throughout COVID-19 pandemic from March 2020 to the time of inspection, a suite of alternative ward based activities had been provided through life rooms to ensure patient had access to meaningful activities. This was enhanced by the addition of PAWs workers. The life rooms, and allied health professional workforce continued to deliver services, for example the moving on group continued to meet.

The OT staff were also transitioning from the MOHOST (an overview of an individual's occupational functioning) to the Montreal cognitive assessment (MoCA). MoCA was designed as a rapid screening tool for mild cognitive dysfunction and assessed different cognitive domains, for example attention, concentration, executive functions, memory, language and thinking.

In the Health Centre, registered nurses worked alongside nursing assistants to provide physical healthcare to patients at Ashworth. Work had recently been carried out to improve career pathways, but Band 6 registered nurse posts were particularly hard to fill, and an advert had been out for 2 years to fill these posts. The nursing team in the Health Centre was over-stretched with staff describing how they liaised in the evenings to plan for the next day. The biggest impact on patients was the reduction of health promotion activity. Nursing staff in the Health Centre were all immediate life support (ILS) trained but these skills were rarely used.

Managers gave each new member of staff a full induction to the service before they started work. New apprentice nurses and health centre staff described a thorough induction process. The trust was actively supporting the training of nurse associates.

Managers supported staff through regular, constructive appraisals of their work. Staff told us they received regular supervision and an annual appraisal. Staff availability impacted on attendance at reflective practice sessions, which were suspended during COVID-19 but had restarted.

Managers supported all staff through regular, constructive clinical supervision of their work. A refreshed version of the trust appraisal process was launched in 2022. The key performance indicator (KPI) target for compliance set by the Trust was 90% of staff were required to have an appraisal between 01 May and 31 December and there was a monthly trajectory set to support this achievement. The appraisal window for this year ran from 01 May 2022 to 31 December 2022. On 03 November 2022, the secure division had achieved 77% compliance of the months, trajectory and overall appraisal compliance was 69%. The service was on target to meet the 90% trust target by 31 December 2022. Feedback from staff in the service on their experience of appraisal in November 2022 was 91% were either very satisfied or satisfied with their appraisal.

Managers made sure staff attended regular team meetings or gave information from those they could not attend. We reviewed team meeting minutes for all the wards we visited and found that regular team meetings were held.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills, knowledge, and specialist training for their role. Therapeutic staff had the opportunity to develop specialist skills within their specialism, alongside their core work.

Managers recognised poor performance, could identify the reasons, and dealt with these.

Managers recruited, trained, and supported volunteers to work with patients in the service. The hospital had a volunteering befriending service, who contacted patients who did not have any other visitors.

Multi-disciplinary and interagency teamwork

Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. The ward team(s) had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.

Staff held regular multidisciplinary meetings to discuss patients and improve their care. We observed a multidisciplinary meeting on three wards and saw that these included consultants, nurses, psychologists, occupational therapists, managers, and security liaison. All participants had the opportunity to share information and express their views and a contemporaneous record was kept. We observed that patients were invited to attend their ward round review and were encouraged to contribute to this. Patients were discussed in a respectful way.

Each patient had a regular CPA review meeting. Members of the MDT such as psychologists and speech and language therapists each prepared reports of patients progress for CPA meetings.

Patients also requested advocacy and/or their solicitors to attend CPA meetings to support them. Family members/ carers were invited where permission was given by the patient. From January to September 2022 the average patient attendance at CPA's was over 65%, with some patients choosing not to attend and others just requesting feedback from the meeting.

Ward teams had effective working relationships with other teams in the organisation, for example the PIPS team, security staff, social workers, therapy staff and clinical leads. Wards based staff told us they valued the relationship within the secure service and there was a positive culture of support. There were mixed views within the Health Centre about how integrated they were with the ward teams. Some said an unintended consequence of COVID-19 was much closer working relationships, but more work to understand and value their role was needed across the high secure site.

High secure hospitals

Staff made sure they shared clear information about patients and any changes in their care, including during handover meetings. Handover meetings took place on each ward at least twice a day. Handover meetings detailed and staff shared essential information about patient needs, risks, and observation levels. Staff worked with other disciplines within and outside the secure service. For example, psychologists were involved in the formulation and treatment plans of patients and supported staff with reflective practice. Social workers worked with families to maintain support and contact with patients and therapy staff provided ward based activities, including education.

Ward teams had effective working relationships with external teams and organisations. Ward teams invited care coordinators and other providers to review meetings to plan patient's discharge from the hospital. Health Centre staff reported that there were efficient and effective systems in place with an external provider to get blood test results back within 24 hours or 2 hours if urgent.

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

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and discharged these well. Managers made sure that staff could explain patients' rights to them.

Staff kept up to date, with training on the Mental Health Act and the Mental Health Act Code of Practice. Ninety per cent of all ward staff had completed Mental Health Act training.

Staff had access to support and advice on implementing the Mental Health Act and its Code of Practice. Staff knew who their Mental Health Act administrators were and when to ask them for support. Staff could get advice from the hospital's mental health act administrators. This team reminded ward teams when patients needed to have their mental health act rights repeated to them.

However, 5 patients out of 35 patients' records checked did not have authority in their Mental Health Act certificates for at least one of their prescribed medicines, for example an antihistamine or anxiety reducing medicine, not covered by a T2. Staff on wards were checking the Mental Health Act certificates as part of an audit. These audits had not alerted staff to the discrepancies.

Staff made sure patients could take section 17 leave (permission to leave the hospital) when this was agreed with the Responsible Clinician and/or with the Ministry of Justice. Patients had leave for medical appointments and treatment.

The service had clear, accessible, relevant, and up-to-date policies and procedures that reflected all relevant legislation and the Mental Health Act Code of Practice. Ashworth had a policy for the management of incoming and outgoing mail, this included guidance on withholding and monitoring mail. The service also had a policy and procedure for monitoring telephones call to and from patients at the hospital. We were informed that there had been no appeals under section 134 of the Mental Health Act (MHA) to the Care Quality Commission (CQC) against the withholding of mail in the 12 months prior to our visit. During the inspection we spoke with five staff including a security manager, the security intelligence analyst, security liaison nurse, two postal monitors and visited the mail room.

A specific drugs protocol that involved additional procedures in mail handling was in place. The policy also appropriately stated that withheld items would be kept for 12 months in case of section 134 MHA appeal by the patient to the CQC.

High secure hospitals

All the patients who we spoke with understood that they were subject to mail and telephone monitoring and understood the reasons for it, although not all agreed with it. Some patients were unhappy about only being able to use the telephone at pre-booked times for a certain duration, for example, if they could not get through to the person they were contacting, there was no flexibility to allow an additional call.

We saw a detailed telephone care plan stating the reasons for the pre-booking of calls and the justification for live telephone monitoring for all but one of the relevant patients records we reviewed. Some mail monitoring related to patients having been recently found in possession of illicit substances and related to the nature of their history or index offence.

The policy and guidance for the management of incoming and outgoing mail could be improved if descriptions of withheld items were more detailed. This would help CQC to evaluate any appeals about monitoring of patient's mail. The service should consider taking photographs of any items, letters, and emails printouts, especially those with photographs of children attached. The relevant documents for monitoring mail were valid for the maximum allowed time of 12 months and reviewed weekly by the MDT. The photograph policy made no mention of photographs sent to patients to patients by emails and was not cross referenced to the mail policy. The process could be further improved if sections of the photographic policy on the procedure for giving photographs of children to patients and disclosure of photographs were adapted to the sending of photographs by email.

Patients had easy access to information about independent mental health advocacy and patients who lacked capacity were automatically referred to the service. Patients told us that they knew how to access support from an advocate if they needed this and could name the advocates that visited their ward. Advocates completed a minimum monthly drop in visit to each ward and attended community meetings. Independent Mental Health Advocates from an external organisation were a regular presence on the wards. They attended most community meetings and all patients had their number of their phone lists. The IMHAs were also trained as appropriate adults and could assist in interviews where one was required.

Staff explained to each patient their rights under the Mental Health Act in a way that they could understand, repeated as necessary and recorded it clearly in the patient's notes each time. We saw evidence in patient's records that staff discuss with patients their rights under the Mental Health Act and recorded this.

Good practice in applying the Mental Capacity Act

Staff supported patients to make decisions on their care for themselves. They understood the trust policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly for patients who might have impaired mental capacity.

Staff received, and were consistently up to date, with training in the Mental Capacity Act. We reviewed training data and found compliance with Mental Capacity Act training was compliant with the 90% target.

There was a clear policy on Mental Capacity Act, which staff could describe and knew how to access.

Staff gave patients all support to make specific decisions for themselves before deciding a patient did not have the capacity to do so. Some of the patient records we viewed contained evidence that the patient's capacity to make decisions about their care and treatment had been appropriately considered, but in each case, it was concluded that their capacity was not impaired so there was no further action in this regard.

High secure hospitals

Is the service caring?

Outstanding ☆ ↑

Our rating of caring improved. We rated it as outstanding.

Kindness, privacy, dignity, respect, compassion, and support

Staff treated patients with compassion and kindness. They truly respected and valued patients as individuals and patients were empowered as partners in their care, and emotionally, by a distinctive service. There was a strong, visible person-centred culture based on respectful, caring, and compassionate interactions between patients. Patients privacy and dignity was always understood by staff regarding patient's individual needs. Staff supported patients to understand and manage their care, treatment, or condition.

Staff consistently spoke about patients with compassion and were highly motivated and inspired to offer care that was person centred and co-produced with patients. Relationships between staff and patients were strong and most patients we spoke with told us they had no complaints about staff, except they were always very busy. Patients told us they related positively to staff and liked some more than others, but these preferences were not related to staff gender, ethnicity, competence, or attitude.

Patients told us staff were respectful and responsive when caring for them. Patients said staff treated them well and behaved kindly. Patients told us that staff were kind. We observed that staff were respectful in their interactions with patients on the wards we visited. Patients recognised that staff were not always available to offer support for off ward activities, due to minimum staffing levels, though patients told us staff were able to give them help, emotional support and advice when they needed it.

Staff supported patients to understand and manage their own care treatment or condition. Staff involved patients in discussions about their care and treatment in ward round meetings and patients were able to discuss their medicines with consultants.

Psychology staff worked with patients in developing a trauma informed care formulation that incorporated patients' past trauma into their current difficulties, which was in addition to their other psychological difficulties and offence histories. A research project was undertaken across Ashworth, led by psychological services, to understand the prevalence and experience of patients' past trauma. This research was used to guide the development of more trauma informed care. The research gave patients a voice and a forum to highlight their trauma from their remote past. Patients were regularly consulted with, and their views sought on their experiences of undertaking group interventions, along with their thoughts on how the delivery and content of the group intervention could be modified to enhance their experience.

Patients were consulted on choosing between available options for psychological treatment. Psychological services had information leaflets setting out the various group and individual interventions available for patients to progress through their care pathway. Patients were provided with leaflets to support them to make informed choices as to their preferred treatment. This helped patients become active participants in their treatment their care.

High secure hospitals

Patients were active partners in their care and staff were fully committed to working in partnership with patients in collaboration on assessing and explaining their risks, so they actively participated in their assessment and treatment pathway. Where appropriate and through the care programme approach (CPA), families were encouraged to participate in the risk assessment and recovery pathway process.

Staff directed patients to other services and supported them to access those services if they needed help. Staff directed patients to the advocacy service and social workers if needed.

Staff always took patients' personal, cultural, social, and religious needs into account, and found innovative ways to meet them. Staff understood and respected the individual needs of patients. Patients care plans included information about patients' personal, gender, cultural, sexual, and religious needs. Staff ensured they shared information on the needs of patients with other staff members who were unfamiliar with these. For example, three student nurses and an apprentice trainee told us they had a full induction before their placements on wards commenced and this included patients' individual communication styles, signs, and triggers that patients' mental health was deteriorating in recognising key references or words patients used.

Staff felt that they could raise concerns about disrespectful, discriminatory, or abusive behaviour or attitudes towards patients. All staff we spoke with were aware of the need to recognise and respond to concerns about disrespectful and discriminatory comments and referred to the use of the safeguarding policy or complaints policy which they would direct patients to.

Staff followed policy to keep patient information confidential.

Involvement in care

Staff involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided. They ensured that patients had easy access to independent advocates.

Involvement of patients

Staff introduced patients to the ward and the services as part of their admission. Patients told us that they had received information about the ward when they were admitted, and staff had showed them around.

Staff involved patients and gave them access to their care planning and risk assessments. On all the patient records reviewed we saw that patients had been given the opportunity to express their views on their care and treatment and copies of care plans had been offered but usually refused. Family involvement had also been discussed with patients and their views on contact were also clearly recorded.

Staff made sure patients understood their care and treatment (and found ways to communicate with patients who had communication difficulties). Staff made sure patient's communication needs were understood and followed best practice guidance, for example staff developed a one-page profile with patients to help patients and staff to plan what they wanted to discuss during their ward round meeting. Staff made sure patients had access to an interpreter for ward rounds and review meetings.

Patients in long-term segregation were involved in the goal setting process of the barriers for change checklist. This was fed back to the patient and the care team and encouragement given for it to be shared with the patients' family where appropriate.

High secure hospitals

Staff involved patients in decisions about the service, such as the development of the Life Rooms. Staff empowered patients to have a voice and to realise their potential. Patients' individual preferences and needs were always reflected in how care was delivered. Patient representatives were also invited to sit on the interview panel for new staff members. Previous high secure patients had worked directly with current high secure patients in long term segregation to improve professionals understanding of the impact of restrictive practices. Patients were involved in the co-production of policies and procedures where appropriate. The co-production group had recently designed their own logo and any documentation that had been co-produced was being stamped with the logo.

Patients were supported by a lived experience practitioner in co-designing, co-creating and co-delivering training. The practitioner felt that working in co-production had supported the reduction in the use of restrictive interventions and all other forms of physical restraint and brought an understanding of the patient voice.

Ashworth was engaged in a programme to review and plan the future clinical environment to ensure wards and clinical areas would be modernised and fit for future use. A patient/governor from the wider trust who was involved in a new build service was leading on engagement with patients in high secure, including visiting every ward and attending every patient forum. The aim was for the trust to obtain as much patient feedback as possible and ensure they contribute to plans as patients would then be involved in the cycle of reviews.

Patients at the service were given a welcome pack that outlined the ward the patient was being admitted to. Each patient had an assessment prior to or soon after admission, with at least one visit to the ward. A named nurse spoke with the patient by way of introduction. Each ward had a patient representative who attended monthly patient forums on behalf of the ward and minutes were available for all patients

Patients could give feedback on the service. There was an annual patient survey, which included a survey tracker, to monitor progress on improvements on wards when patients identified shortfalls in the ward, for example issues arising out of communal living.

Patients could also give their feedback in community meetings on each ward, which took place regularly. The meetings included the review of the patient's survey tracker. This rated progress on improvements as red, amber, or green. In August, the amber issues were around care plans, cleanliness, effective care, friends and family and medication.

The restrictive practice monitoring group met every month and viewed patient input. The trust also took a 'You Said, We Did' approach to patient engagement, with actions recorded in community meetings.

Staff supported patients to make advanced decisions on their care. Numerous staff members described the exceptional care that had been delivered to a patient at the end of their life. The hospital had worked closely with external palliative care and district nursing teams to provide end of life care on the ward as the patient considered to be his 'home.' The trust had put arrangements in place to support staff and fellow patients at this time.

Staff made sure patients could access advocacy services. Patients we spoke with were positive about their access to and relationships with advocates. Patients told us advocates were a visible presence on the ward and attended community meetings. Staff recognised patients needed to have access to their advocacy and support network and supported patients to do this.

Involvement of families and carers

Staff informed and involved families and carers appropriately.

High secure hospitals

Staff supported, informed, and involved families and carers. Social workers for each ward took the lead on maintaining contact with carers. The trust shared examples of how families and carers were being involved in all decisions that affected them and patients, including designing, planning, delivering, and reviewing of services.

A collaborative project with University of Central Lancashire and Ashworth was being progressed to explore physical health problems, namely diabetes, evident in patients within secure services. Five carers were identified from high and medium secure services to contribute to the planning and pilot of this study.

A further project was being progressed with carer involvement on shared decision making focusing on whether carers felt involved in decisions about their family members. A reducing restrictive practices (RRP) guidance was being co-produced with carers and the RRP team.

Relatives were invited to a roadshow on digitalisation earlier in 2022 on the use of nature to promote well-being and quality of life in mental health. This was going to be an ongoing forum to involve relatives in the development of the current and future Ashworth site using digital technology and architecture.

Due to COVID-19 restrictions, some carers had been unable to complete face to face visits. The hospital had arranged for each ward to be able to facilitate video calls between patients and carers. These had been well received by patients and carers.

Staff helped families to give feedback on the service. A carers lead was employed to support carers and the carers agenda. Staff collected feedback from carers after engagement events. A carers forum was facilitated by the carers lead, however due to COVID-19 the forums were moved to an online platform to enable support to be delivered during the pandemic. Plans were underway to return to a face-to-face forum whilst keeping the virtual offer for those who preferred it.

The forum agenda varied and was used to provide advice, support, and information. Guest speakers and topics were varied and ranged from care pathways, reducing restrictive practice, pharmacy, psychology, psychiatry, and security as some examples. A bi-monthly carers newsletter was produced and provided general updates related to the service. Work was progressing to develop carers and visitor information videos and interactive information packs for carer visit Ashworth.

A task and finish group was established to review the secure carers tool kit, a collaborative initiative developed with NHS England and the University of Central Lancashire, with input from the carers lead. This toolkit aimed to provide information for carers, patients, service providers and commissioners about how carers of people who use secure mental health services should be engaged with, supported, involved, and empowered. Copies of the toolkit had been shared with carers of patients.

Staff gave carers information on how to find the carer's assessment. Each patient had an allocated hospital based social worker who acted as a liaison for carers, including advising carers of their rights in relation to the MHA and referrals for carers assessments.

Is the service responsive?

Good ➔➔

High secure hospitals

Our rating of responsive stayed the same. We rated it as good.

Access and discharge

Staff planned and managed patient discharge well. They worked well with services providing aftercare and managed patients' moves to another inpatient service or to prison. As a result, patients did not have to stay in hospital when they were well enough to leave.

Bed management

In April 2022, bed occupancy was 92% and had risen to 97% by September 2022 across Ashworth hospital. Turner Ward had been temporarily closed for a period during the COVID-19 pandemic to manage safe staffing across the hospital.

The national target for high secure services for 'referral to initial assessment' was 21 days when in receipt of all information and 'from assessment to initial treatment' the national target was 168 days. The high secure service met all national targets for referral to initial assessment and assessment to treatment. Psychiatrists told us that there were currently no delays to admissions and patients accepted for treatment were usually admitted within 2 weeks of referral.

Patients were moved between wards only when there were clear clinical reasons, or it was in the best interest of the patient. The service used the bed management system flexibly during the COVID-19 pandemic to enable them to meet the patients' needs while managing the outbreaks and flow across wards. They saw advantages in referring patients from high to medium dependency at an earlier stage, enabling the accepting ward to set objectives and personal goals with the patient prior to transfer. This helped motivate patients to progress as they felt their care pathway was being actively discussed, meaning transfers were less likely to break down. Staff were able to complete short term goals in collaboration with the patients, helping patients to gain more independence and provide them with transferable skills to utilise on medium dependency wards. Wards were able to transition patients, utilising short to longer periods of orientation to the receiving ward to alleviate any anxieties should they be present. The trust had seen more successful transfers of patients with complex needs because of this approach and were taking that learning into the review of their bed management policy and process.

Managers regularly reviewed length of stay for patients to ensure they did not stay longer than they needed to. The current average length of stay in Ashworth patients was 6.46 years, the median length of stay was 4.43 years. The NHS national figures for high secure hospitals in England specifies the average length of stay as being typically 5 to 6 years.

The service had high out-of-area placements due to the commissioning arrangements of Ashworth. The hospital provided regional mental health and personality disorder services; therefore, patients were admitted to these wards from across the country. From April 2022 to September 2022, Ashworth hospital received 37 referrals. Five referrals were accepted for admission, 25 routine and one urgent referral were seen within the specification requirement and a patient known to the service accepted without requiring referral. Of the remaining 11, some were either not accepted for referral or referrals were ongoing. Some patients not accepted for referral were referred to either Rampton or Broadmoor or returned to prison.

Managers and staff worked to make sure they did not discharge patients before they were ready.

When patients went on leave there was always a bed available when they returned. On 30 September 2022, there were 10 patients on active leave of absence from Ashworth, where their bed was available to them should they need to return.

High secure hospitals

Discharge and transfers of care

Managers monitored the number of patients whose discharge was delayed, knew which wards had the most delays, and took action to reduce them. In every patient's electronic record there was a basic discharge plan which was first completed on admission and indicated the overall discharge aims.

Information provided by the trust was that since April 2022, out of 25 patients to be discharged, 84% were delayed. Six patient discharges were delayed due to the receiving medium secure hospital being closed to admissions and a further eleven were delayed due to the demand on the system and availability of medium secure beds. Two direct transfers went ahead during this period. One patient's transfer to a low secure hospital was delayed due to capacity and demand on the system and five patients' remissions to prison were delayed.

The service was doing all it could to process patient discharges and these figures were outside the trust's control. The national picture for High Secure Hospitals showed that these figures were better than some other High Secure Hospitals. Staff worked with medium and low secure facilities to find suitable placements and to identify actions needed when discharges were delayed. At the time of inspection there were four delayed discharges awaiting beds in medium secure hospitals. All four patients had been escalated with commissioners and liaison with the new providers continued. Delayed discharges for Ministry of Justice patients varied from 1 – 6 weeks.

Staff carefully planned patients' discharge and worked with care managers and coordinators to make sure this went well. Staff had regular meetings with external teams to plan and monitor the progress of patients' discharge. We saw examples of positive discharge planning for patients who were with the service for several years. The patients care teams had worked creatively with the patient to provide opportunities for them to have leave within the community, such as visiting a seaside town or shopping in local areas. Access to the community was planned around designated times and dates, for example, avoiding school holidays.

Staff supported patients when they were referred or transferred between services. For example, staff supported patients to identify goals they could achieve as part of their transfer plan. During COVID-19 the bed management system had also been revised to support patients to move between services quickly.

The service followed national standards for transfer. Ashworth ensured any transfer decisions were based on a detailed psychiatric assessment and assessment of risk.

The design, layout, and furnishings of the ward supported patients' treatment, privacy, and dignity. Each patient had their own bedroom with an en suite toilet, some with showers and patients could keep their personal belongings safe. There were quiet areas for privacy. The food was of good quality and patients could make hot drinks and access snacks at any time.

Each patient had their own bedroom, which they could personalise. We saw that some patients had been able to personalise their bedrooms with photos and personal belongings. Patients had a secure place to store personal possessions. Each patient had access to a locker on the ward where they could store some personal items. Patients were limited to the number of personal items they could have on a ward at a time and any additional belongings were stored in a secure storage facility located on the hospital site. Staff supported patients to visit the storage facility to store or collect items. Observation panels on bedroom and clinic doors in some wards, for example, Turner ward, were covered by material applied to the panel externally to protect privacy and dignity.

The service had a full range of rooms and equipment to support treatment and care. Most patients had access to gym equipment on each ward and in the garden area, plus a large and a small central gym as well as a swimming pool. There was a large football pitch and a horticultural area outdoors. Patients had access to activities such as arts, crafts, and woodwork. However, staffing pressures limited access to these facilities for patients.

All ward facilities were ground floor and level access. The service could provide care for patients who required medical or mobility aids, and adapted bedrooms to accommodate patient physical health needs. On Newman ward, patients had access to a bariatric bath. If patients needed adaptations and equipment these were assessed and provided on an individual basis, for example, a portable hoist was referred to as being available on Lawrence ward.

Patients could make phone calls in private. We observed that patient telephones were located on the ward corridor, in a separate enclosed booth, which afforded patients to speak in private.

The service had an outside space that patients could access easily. All wards had access to outdoor space. Patients were individually risk assessed to access these areas. However, patients were also considered for grounds access. We saw patients walking around the areas between wards. Information provided by the trust was 50 patients had leave or parole to access the grounds out of a population of over 200 patients.

Patients could make their own hot drinks and snacks and were not dependent on staff. On Macaulay ward for example patients had access to a kitchen area to make their own drinks. On other wards, drink making facilities (vacuum dispensing flasks) and tea, coffee and sundries were available to patients.

The service offered a variety of food, and feedback from patients on the quality of food was variable. Some patients we spoke with told us that meals could be improved, though most patients said the variety and choice of food was good and culturally appropriate for their needs. Mealtimes were protected to ensure nursing staff could focus on patients' nutritional and safety needs. We saw that patients regularly raised the quality and variety of food provided in community meetings and the trust was taking a 'You Said, We Did' approach to the quality of food. The hospital provided a takeaway service, which patients could order different world food items from. Patient representatives were involved in what food items were sold in the hospital shop and attended meetings between hospital catering and operational managers and dietitians to resolve some of the issues raised.

Patients' engagement with the wider community

Staff supported patients with activities outside the service, such as work, education, and family relationships.

Patients had limited access to opportunities for education and work due to staffing pressures. The trust were in the process of renovating the therapy and education area with the development of the Life Rooms, which was due to open in January 2023. The Life Rooms model was given clinical recognition in 2021 and was also provided by the trust in community settings. Patients at Ashworth also had access to The Recovery College, which had been adapted to meet the needs of people in inpatient settings, including secure care. The Recovery College prospectus had been co-designed with patients and included sessions on drama, horticulture and music. Patients detained at Ashworth whilst studying for qualifications were supported to complete these whenever possible.

Staff helped patients to stay in contact with families and carers. During COVID-19, patients could contact families by telephone and using an online platform through ward-based laptops.

Staff encouraged patients to develop and maintain relationships both in the service and the wider community. Social Workers were instrumental in helping patients and their families stay connected with each other. We heard about complex work being undertaken by one social worker who was supporting a patient to complete all the personal administration required following their sudden detention in hospital. Restrictions on patient phones and internet access made this particularly difficult.

Meeting the needs of all people who use the service

The service met the needs of all patients, including those with a protected characteristic. Staff helped patients with communication, advocacy, and cultural and spiritual support.

The service could support and adjust for disabled people.

Staff told us that it was a challenge to get patients engaged in activities or to appointments in the mornings. They attributed it to their medication. The physical activity workers (PAWs) took this into account and started their work after lunch.

If patients were known to be a member of the LGBT+ community, they received a discreet visit from an in-house advisor to reassure them they would not be discriminated against by staff and would be protected from other patients' prejudices if required. If further discussion was needed, they were encouraged to engage with psychology. The same advisor was also involved in supporting staff and linked with the LGBT+ staff network and other trust initiatives in this area.

Patients from the LGBT+ community had also been involved in developing policies related to their care and treatment based on their lived experience. The service set up the High Secure 'recovery champions group' to influence practice and developments using patients as experts by experience.

Patients had access to easy read resources to help them to understand their care and treatment. The service had information leaflets available in languages spoken by the patients and local community. Staff could order information leaflets in different languages if patients needed them. Patients attending the Health Centre had access to a range of leaflets covering common health conditions in different languages and easy-read format. Hospital passports were available in standard and easy-read versions. Where possible, patients were invited to the Health Centre for appointments as this normalised the experience, but this had stopped due to COVID-19 and was now impacted by staff availability for escort duties. Health Centre staff adapted to provide most interventions on the ward as well as in the Health Centre so patients' needs could be met.

Some patients had received or been referred for sensory assessments on account of their autism. The high secure commissioner clarified that patients access to assessments for autism/neurodiversity assessments depended upon how each patients care was commissioned and referrals for assessments were on an individual patient basis. The trust was developing an autism/neurodiversity pathway to enhance the current treatment pathways on offer at Ashworth. This would involve recruitment of additional occupational therapists, using specialist staff from the learning disability service.

Staff made individual adaptations where they could and escalated for reasonable adjustments to be made. However, staff could do little to minimise the sensory overload from banging doors, alarms, universal heat and light controls and doorbells.

Managers made sure staff and patients could get help from other interpreters when needed. On Lawrence ward we saw an example, were a patient was also supported by a patient who shared the same first language and acted as an interpreter.

Patients had access to spiritual, religious, and cultural support. The chaplaincy service offered a range of religious and spiritual support. For example, we saw that Muslim patients had access to prayer mats and religious texts. Religious leaders for a variety of faiths attended wards to lead on ceremonies and prayer. The hospital also had a chapel within the secure perimeter and wards used rooms as a multi-faith room for patients to access. Staff ensured that religious and cultural information was included within patients' care plans. The service provided a variety of food to meet the dietary and cultural needs of individual patients.

Listening to and learning from concerns and complaints

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and wider service.

Patients, relatives, and carers knew how to complain or raise concerns. Staff supported patients to make formal complaints and to give their feedback about their experience. Patients told us they knew how to raise complaints and we saw information on how to complain was displayed on all wards we visited.

Staff protected patients who raised concerns or complaints from discrimination and harassment. Patients told us they were confident to raise concerns formally and informally on a one to one basis or in a community meeting.

Patients told us that two themes were regularly discussed in community meetings, which were missing property and insufficient access to activities. Patients told us these concerns were not always resolved to their satisfaction. A patient told us how the advocacy service was helping them with a complaint around damage to personal property and described the advocacy service as 'battling' for them. They identified the advocate as making progress on property damage, but the issue was the length of time the complaints team took to deal with their complaint. The complaints team had recognised the issue and recently changed the process about how missing property claims were managed, which they hoped would improve things for patients.

The service clearly displayed information about how to raise a concern in patient areas.

Staff understood the policy on complaints and knew how to handle them. Managers investigated complaints and identified themes. Managers kept a log of complaints on their wards. Complaints across the hospital were overseen by the trust's complaints department. Complaints were investigated by senior members of staff. From April to November 2022 the service had received 15 complaints, which had been referred by patients themselves, advocacy or through the CQC. Three complaints were upheld, two were resolved and the others were being investigated or for sign off.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. Patients received feedback in a formal letter which contained information about what they should do if they were not satisfied with the outcome of the complaint.

Managers shared feedback from complaints with staff and learning was used to improve the service. Staff discussed complaints during team meetings. Staff could view information about lessons learnt from complaints on the trust intranet.

High secure hospitals

The service used compliments to learn, celebrate success and improve the quality of care. We saw that staff had arranged for an advocate to meet and support a patient who made complaints about their care. Staff had liaised with the trust's facilities management team about improvements in ventilation in bedrooms in response to the complaint.

Is the service well-led?

Good

Our rating of well-led stayed the same. We rated it as good.

Leadership

Leaders had the skills, knowledge, and experience to perform their roles. They had a good understanding of the services they managed and were visible in the service and approachable for patients and staff.

Most staff were complimentary about local and trust-wide leaders' skills, knowledge, visibility, and approachability. Managers were described as hands on when needed.

The clinical leadership in the Health Centre had been consistent for 19 years. Leaders in this area were approachable and visible to their staff team and the wider hospital. GPs kept up to date through their other GP work outside the hospital, so patients were assured of a service equitable with a GP service in the community.

Staff had opportunities to progress, we saw that some experienced staff had been successful in obtaining modern matron posts. The trust had also recruited through staff retiring and returning to support and mentor staff as part of their personal development.

Staff told us that operational managers, modern matrons and ward managers were visible, approachable, and supportive. We saw senior staff and ward managers stepped into ward numbers to help when wards required staffing cover. Staff told us that senior leaders were visible, approachable and they often saw operational and clinical managers on the wards.

Vision and strategy

Staff knew and understood the provider's vision and values and how they applied to the work of their team. Staff we spoke with were aware of the trust's values of continuous improvement, accountability, respect, enthusiasm, and support. Information about the trusts vision and values were displayed throughout the hospital. The trust vision was to strive for perfect, whole-person care that helps people live happier, healthier lives.

Culture

Staff felt respected, supported, and valued. They said the trust promoted equality and diversity in daily work and provided opportunities for development and career progression.

Staff knew who the Freedom to Speak Up guardians were at the hospital. Staff said they could raise concerns with ward and more senior managers and their concerns were listened to and acted upon.

High secure hospitals

Several Health Centre staff described their immediate team as a second family. Staff on wards said they could rely on colleagues to 'have their back.' Everyone described positive working relationships between hospital teams, and, where applicable, with external teams, such as those based in local acute hospitals.

Staff said they felt listened to by senior leaders. Long-standing staff said there had been a 'massive' cultural change within the hospital and the wider trust in the last few years. A psychiatrist described a new learning culture and clear lines of accountability.

We spoke with a staff member who was dyslexic and who had received good support from the trust and their line manager to minimise the impact of this on their work. They were particularly pleased that it was understood that dyslexia can affect more than just reading and writing.

Members of the MDTs spoke very positively about the skills and resilience of the nursing staff on the wards.

Staff spoke positively about the role of modern matrons who were leading on several quality improvement projects in the hospital.

The Culture of Care Barometer (CCB) was an evidence-based survey tool used at the service to gauge the culture of care provided. This was used in conjunction with the annual staff survey. The service ran the CCB three times a year, which asked staff for their views and experience of working in the service. This helped senior leaders measure staff experience and engagement. The survey was anonymous and provided team level data when a minimum of 11 staff completed the survey.

Reports were available for each ward at Ashworth, divisional level and trust wide. Results were used in discussion around the team canvas, which considered the key principles of high performing teams: what they did and how they did it. The CCB provided a regular measurement of staff engagement and staff experience at team level. The service used this to identify areas of concern or good practice. For example, we saw the results of the last two quarterly reports for the CCB being used for a quality improvement project. The results reflected positive engagement with staff and showed that staff commitment to patient care and treatment was their top priority.

We saw information displayed on all wards we visited about indicators of what could contribute to a closed ward culture. Patients referred to this information in conversations with us and gave examples of challenging staff over the use of appropriate language. Patients said this empowered them to challenge perceived negative language and staff said this helped them to raise concerns about racist language used toward them by patients.

Patients and carers were informed and involved about decisions and were able to give their feedback about the service and were able to raise concerns.

Managers made sure that they provided patients and carers with a response to complaints. Senior managers attended monthly patient involvement meetings.

Governance

Our findings from the other key questions demonstrated that governance processes usually operated effectively at team level and that performance and risk were managed well.

High secure hospitals

The high secure service had a strong system of governance in place. Senior leaders felt they had good oversight, backed up with data, which was triangulated, of all aspects of the service. Staff undertook or participated in local clinical audits. However, we found examples on four wards when on six occasions, Mental Health Act certificates did not cover prescribed and administered medicines and an audit had not identified this. We also found in nine out of 14 patient records we reviewed that venous thromboembolism assessments were not completed in line with trust and national guidance.

There was a clear framework of what must be discussed at a ward, team, or directorate level in team meetings to ensure that essential information, such as learning from incidents and complaints, was shared.

The trust Board had oversight of security at the site and the assurance process was led by the Executive Director with responsibility for High Secure Services, who managed the Director of Security. Any incidents that were relevant to the security directions were reported through the patient safety system. Exemptions were agreed through the incident management process.

The Chief Executive Officer (CEO) represented the trust on a quarterly basis at the National Oversight Group, which monitored the three High Secure Hospitals. Planned and unplanned site visits both day and night took place by Executive and Non-Executive Directors along with peer audit security reviews. Quarterly updates were provided to the Quality Committee on night-time confinement.

The Executive Director with responsibility for High Secure Services and the Director of Security gave updates to the Board on a regular basis. There was also a biannual report produced to the Board, which included safeguarding quarterly reports, number of independent reviews of long-term segregation and outcomes, complaints activity, monitoring of the use of Section 134, night-time confinement, staffing levels, and access to a minimum of 25 hours meaningful activity.

Staff had implemented recommendations from reviews of deaths, incidents, complaints, and safeguarding alerts at service level. Staff shared key learning from incidents within the hospital and wider trust with staff. In November 2021, a peer review of security of Ashworth was undertaken. The findings of the review were that good controls were in place to mitigate key risks across the functions.

The COVID-19 pandemic had not impacted staff training and the provision of training for staff was tailored according to role, capability or need. Hospital staff demonstrated a good understanding of their role and responsibilities and engaged fully with the audit process. Minor identified improvements were completed in the trust action plan between December 2021 and January 2022.

Staff understood the arrangements for working with other teams, both internal and external, to meet the needs of the patients. The service's physical healthcare and PIPS teams were both accessible and visible.

The trust had a reducing violence and restrictive intervention strategy, which set out the trust's aims to reduce restrictive interventions. The trust also had a restrictive interventions strategic oversight group which was attended by Ashworth's designated lead for restrictive practices.

Patients in long term segregation were subject to a monthly internal independent review and were discussed monthly at the reducing restrictive practice (RRP) monitoring group. An external independent review process was supported by

NHSE (NHS England) commissioners and involved an independent multi-disciplinary team conducting a review of patients in long-term segregation every three months. This followed a standardised process of confirm and challenge with professionals in other High Secure Services. In addition, patients in long term segregation were regularly discussed as part of a peer review process in the medical audit meeting.

Data relating to reducing restrictive practices was reviewed at divisional level in the RRP monitoring group, performance report, safety huddles, strategic quality improvement group, and strategic safety and improvement group quality committee. The Board received information around RRP (Use of Force Act), segregation and seclusion, restraints, blanket restrictions, rapid tranquilisation, and assaults through the safety report.

The RRP team was effective in identifying hot spots through data analysis and effectively supported teams to make improvements. In response to growing concerns over the use of long-term segregation, the RRP team and Centre for Perfect Care were able to respond to the data and implement an improvement plan that had led to greater focus and monitoring from Board, resulting in reductions in its use.

The trust response to the Mental Health Units (Use of Force) Act was prompt. Staff and patient engagement and assurance that the criteria were met and embedded was closely monitored by the Board and assurance given through the strategic quality improvement group and the strategic safety and improvement group.

The trust quality review process (QRV) was a self-assessment of the clinical environment by the clinical team and formed part of the trust governance process. This was based on the CQC five key questions and took place at least annually. The QRV was overseen by operational and divisional staff and an opportunity for clinical teams to demonstrate and reflect good practice and highlight areas for improvement. Wards were supported by the trust quality and compliance team to make identified improvements as part of an internal peer review system.

Ashworth held night-time confinement (NTC) meetings. We reviewed the minutes from August 2021 to August 2022. Wards were represented and discussed individual issues regarding NTC, for example risk assessment, patient physical observations and patients delaying going to their bedroom. A recent survey of NTC was completed and discussed in the November NTC meeting. This information was to be used as part of a five-year demand and capacity review by the service.

Management of risk, issues, and performance

Teams had access to the information they needed to provide safe and effective care and used that information to good effect.

Ashworth hospital had a risk committee, which reported directly to the Board. A board level risk report highlighted that sufficient funding needed to be maintained for the continued improvement, installation, maintenance, and upgrade of the high secure service security systems, to maintain the integrity of the physical security infrastructure and meet the terms of the high secure license.

Staff maintained and had access to the risk register at service level. Ashworth had its own risk register; the hospital escalated the most serious risks to the trust's risk register. Staff concerns matched those on the risk register.

Staffing levels featured on the risk register as an elevated risk, and we saw action had been taken to improve recruitment and retention. A task and finish group had been established to better understand recruitment and retention issues in nursing and therapies staff. A vacancy review group was established in June 2022 and presented the short,

medium, and long-term actions that had been identified to reduce the vacancy gap. Since the establishment of the group, five actions had been prioritised as short-term actions, including aligning recruitment teams to ensure standardisation of approaches, aligning recruitment systems, trust wide recruitment campaign, specific divisional recruitment campaigns and specific incentive offers.

Staffing in High Secure Hospitals was a challenge nationally. There was a national and centrally funded solution expected to address these issues, but this could also impact on the wider trust should staff wish to move to the secure division. Members of the Executive team had escalated through committee meetings and to Board the staffing concerns at Ashworth Hospital. The trust board meeting in September recognised the risk which was on the high secure risk register with a risk rating score of 20.

We saw staff had been redeployed to protect patients. Senior managers had a good oversight of the staffing issues and had a staffing contingency plan in place which enabled staff to identify and respond to the highest risk areas of the hospital.

Managers collected and reviewed data about performance, staffing, patient care and ward security. Each ward had its own quality improvement plan. Staff had access to the equipment and information technology they needed to do their work.

Health Centre staff identified trends, such as a rise in admissions of patients with epilepsy, and they took steps to make sure the relevant policies, procedures and training were fit for purpose, even when a review was not due.

The service had plans for emergencies. The hospital had developed and implemented business continuity plans related to low staffing levels and COVID-19. These clearly identified how non- essential services would be paused to enable staff to manage risk at times of low staffing and in the event of a COVID-19 outbreak.

Information management

Staff collected analysed data about outcomes and performance and engaged actively in local and national quality improvement activities.

Staff knew how to access the incident reporting system. Information was in an accessible format and was timely, accurate and identified areas for improvement. Team managers had access to information to support them with their management role. This included information on the performance of the service, staffing and patient care.

Staff made referrals to external bodies as needed, including the police and CQC.

The Health Centre used a different electronic record system to the one in the wards. There was no duplication of information between the two systems as information was transferred automatically to the ward based system three times a day and maintained accurate information about patient's health conditions, for example diabetes. Electronic prescribing and medicines administration was also in place and working well.

Engagement

Managers engaged actively with other local health and social care providers to ensure that an integrated health and care system was commissioned and provided to meet the needs of the local population and for England and Wales. Managers from the service participated actively in the work of the local transforming care partnership.

High secure hospitals

Managers had good relationships with external professionals, including the NHS England high secure commissioner and local commissioning teams. The hospital provided a weekly update to NHS England to report on the impact of COVID-19 and weekly updates to the CQC on COVID-19 outbreaks across the trust locations. The hospital met regularly with the other High Secure Hospitals and participated in a peer review programme.

Staff and patients had access to up to date information about the work of the hospital and the services they used. Managers shared feedback and information about lessons learned through emails, the staff intranet and trust wide staff newsletter. Leaders shared service development updates with patients during patient involvement meetings. Staff and patients had co-produced a quality improvement plan which focused on patient experience. The hospital ran regular carer engagement events. Although these had been moved to online sessions, the hospital was planning its first face to face carer event since COVID-19.

There was a system in place for patients on each ward to give regular feedback on their care and treatment and their involvement in this process was actively encouraged. Their responses were analysed and rated centrally, and the ward team received feedback on the patient experience and were expected to make improvements where needed.

Visits to patients took place every day of the week with visits by children limited to weekends. They were supervised by appropriately trained staff.

Leaders described close working relationships with the other High Secure Hospitals which they said were better than ever. The Health Centre's links with other High Secure Health Centres had been maintained during COVID-19 with a physical health conference planned for 2023.

Learning, continuous improvement and innovation

Staff had opportunities to participate in research. We saw that there were several active research and quality improvement projects that staff were participating in. The research department completed an impact statement produced for the Research Excellence Framework (REF 2021), a national assessment of how universities had performed. The statement captured the impact of the research, which was rated as world leading. The impact from the Ashworth research centre included the work on Life Minus Violence (LMV), a programme of cognitive behavioural therapy focused on reducing the risk of aggression in individuals who have a history of habitual aggression or violence. This was written and evaluated at Ashworth as part of crisis negotiation and aggression policy work.

The Ashworth research unit had also published a paper on healthy sleep, which led to the development of a new project on healthy sleep for patients with psychosis. Work had also been undertaken on victim empathy and cognition. Some professions, notably psychiatry and psychology, told us how they valued the input of the trust's research centre. It helped them keep up to date with new developments in their fields.

Following work to support a patient at the end of their life, the Health Centre was developing a service level agreement with external teams to set out arrangements for the future, based on the lessons recently learned about best practice and mutual support.

The quality team was leading improvements to care planning documentation to integrate the information. This would reduce the number of documents staff needed to look at to get a holistic view of the patient's care needs, as well as the time spent duplicating information across different care plans.

High secure hospitals

The trust had achieved the Navajo Merseyside & Cheshire Charter Mark, a regional equality mark which was a signifier of good practice, commitment and knowledge of the specific needs, issues and barriers facing LGBT+ people in the local area.

Patients were incredibly positive about the system that was introduced to enable them to order clothes and other permissible items via a wall-mounted tablet (not internet enabled) where they could view a catalogue and make their selection.

Community end of life care

Good ↑

Is the service safe?

Good ↑

Our rating of safe improved. We rated it as good.

Mandatory training

The service provided mandatory training in key skills to all staff and made sure everyone completed it.

Nursing staff received and kept up to date with their mandatory training. When we spoke with staff, they told us they had protected time to complete training and they were up to date with it. The trust monitored training at team and divisional level, as well as for the trust overall. As of December 2022, trust data showed that for the three palliative care teams, compliance with core mandatory training was 100% for two teams and 98.4% for the Knowsley team. Compliance with mandatory data security awareness training was 100% for all three teams.

Together, the mandatory and role specific training included courses such as conflict resolution, infection control, moving and handling and basic life support. Staff received training in learning disability awareness and dementia awareness on induction and they were up to date with this. However, clinical staff did not complete further role specific mandatory training on recognising and responding to patients with mental health needs, autism, learning disabilities and dementia. Staff consulted specialist colleagues within the trust, as necessary when working with patients with mental health needs. We spoke with managers to confirm the team had worked well with patients with learning disabilities and dementia, and all staff received mandatory training in suicide prevention. We received positive feedback from one patient with a history of mental health problems and they said the team had responded well to their needs.

Managers monitored mandatory training and alerted staff when they needed to update their training. We could see from team meeting minutes and staff told us that managers reminded them to complete any mandated training.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Nursing staff received training specific for their role on how to recognise and report abuse. The trust reported that all nursing staff were required to complete level one and level two in both adult and child safeguarding. As of December 2022, training for Safeguarding Level 2/3 was 100% for the combined Liverpool and South Sefton team and 85.7% for the Knowsley team. Staff also received training in PREVENT (aimed at safeguarding people becoming radicalised or from supporting terrorism).

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. Staff undertook mandatory training in equality and diversity and all teams were 100% compliance with this as of December 2022.

Community end of life care

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. We looked at records and spoke with staff about how they worked with the police and social care agencies to protect adults and children at risk. Safeguarding concerns were included as a standard agenda item in the team handover that all staff attended at the start of every day.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff demonstrated a good knowledge of how to identify abuse, neglect and other safeguarding concerns when we spoke with them. In the last 12 months, the service had made only one safeguarding referral, but staff told us that, often, safeguarding referrals were made by the district nursing teams who usually saw patients more frequently and earlier on in their care.

Cleanliness, infection control and hygiene

The service controlled infection risk well. They used control measures to prevent the spread of infection before and after the patient died.

Staff followed infection control principles including the use of personal protective equipment (PPE). We observed a patient visit and spoke with staff to confirm that all the palliative care team carried hand gel, and had access to personal protective equipment, including gloves and aprons. We observed that staff decontaminated their hands frequently, which reduced the potential risk of infection being spread.

Environment and equipment

Equipment was well maintained, but not all staff had the equipment they needed to treat patients. Staff managed clinical waste well. When providing care in patients' homes staff took precautions and actions to protect themselves and patients.

We looked at audits to confirm that staff carried out regular safety checks of any specialist equipment they used. Managers kept a log of when equipment was due for servicing. We checked the records for the maintenance of syringe drivers, and found it was up to date.

Some staff told us they did not have had enough suitable equipment to help them care for patients, for example, blood pressure monitors, stethoscopes, thermometers and saturation probes, which are used to measure oxygen saturation in the blood. The trust told us that they had ordered the equipment on the 25 October 2022, and they were awaiting delivery. They had mitigation in place including joint visits with district nurses, who did have all their equipment, a triage system so they could identify any visits where patients might require physical health monitoring and allocation of visits to staff that had sufficient equipment. We did not find evidence of any adverse impact on patients because staff did not have access to the equipment they needed.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration. Risk assessments considered patients who were deteriorating and in the last days or hours of their life.

Staff identified deteriorating patients and escalated them appropriately. We spoke with staff and looked at care records to confirm that there was an escalation process in place with district nursing teams who could call a single point of

access and speak directly with specialist palliative care staff seven days a week in Liverpool and South Sefton. However, staff reported that not all district nurses were aware of the single point of access number and managers had planned further awareness raising events. Staff from the specialist palliative care team could escalate concerns to a consultant where needed including at weekends, and there was evidence that this happened when required.

The specialist palliative care team used a variety of assessments to identify deteriorating patients, but these were not yet standardised across the service. Staff were in the process of doing this and were also developing a triage tool to help highlight the main concerns. We attended a daily handover where staff discussed plans for those patients that had been identified through the escalation process.

Staff completed risk assessments for each patient where necessary, if this had not already been completed by the district nursing teams. We looked at a sample of patient records to confirm that, where necessary, staff completed falls and pressure ulcer risk assessments.

Staff knew about and dealt with any specific risk issues. We looked at a sample of patient records and saw that the specialist palliative care team worked in partnership with district nursing teams to ensure appropriate care for patients with specific risk issues like pressure ulcers.

The service had 24-hour access to mental health liaison and specialist mental health support (if staff were concerned about a patient's mental health). Staff worked closely with the trust's mental health teams and had access to community mental health and crisis services for patients where needed.

Staff shared key information to keep patients safe when handing over their care to others. All specialist care team staff and district nursing teams had access to the same electronic patient record and carried out visits together where needed. The specialist palliative care team only stayed involved with the patient where their input was needed but could see input from other professionals in the patient's care record.

Handovers included all necessary key information to keep patients safe. We attended one of the daily handover meetings and observed that it followed a standard agenda and included information about safeguarding issues, incidents and patients with urgent needs.

Nurse staffing

The service had enough nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.

The service had enough nursing and support staff to keep patients safe. The service employed 18.6 whole time equivalent, (wte) staff, which represented an uplift of three wte staff since the service had become part of the Integrated Mersey Palliative Care Team, (IMPaCT). This was to ensure there were sufficient staff to support the single point of access line. Patients could call for palliative care advice and support 24 hours a day, seven days a week, and specialist nurses worked on a rota to offer the specialist palliative care service from 8.30am to 5pm, seven days a week. Outside these hours, the district nursing team saw patients as needed but had access to telephone support to escalate concerns about patients.

The service had low and/or reducing vacancy rates. In November 2022, the trust supplied data to show that the service had 2.8 wte vacancies across the team, and this was for nursing staff.

Community end of life care

The service had low turnover rates. Most of the staff we spoke with had been with the service for several years, and in some cases many years. No members of staff had left the service in the period April to October 2022.

The service had high sickness rates, but they were reducing. According to data supplied by the trust, the service had high rates of sickness absence in the Liverpool and South Sefton team in April and May 2022, but these had fallen to much lower levels by September 2022. In April and May, the sickness absence rate for specialist nurses was 25%, but in August, it had fallen to 8%, and, in September, it was 0%. There was limited cover for staff sickness, so staff had increased workloads when sickness levels were high. There was a contingency plan for when sickness absence was high in the team and this involved staff cancelling non-urgent meetings and offering staff overtime payments. Some staff told us their supervision and appraisal meetings had been cancelled or re-arranged because of high levels of sickness in the team. The trust told us this was to ensure safer staffing levels could be maintained during periods of high sickness absence. In the Knowsley service, sickness absence levels were not as high.

The service had low rates of bank staff. There was only one staff member employed as bank, and this was someone that had worked for the service previously for many years. The service did not use agency staff.

Medical staffing

The service did not employ medical staff but was part of the Integrated Mersey palliative Care Team, (IMPaCT). This meant patients and staff had access to medical staff including consultants and GP's as they were part of the IMPaCT delivery model.

The IMPaCT service had a consultant on call during evenings and weekends. Staff could escalate concerns to a consultant when they were on duty and, out of hours, partner agency staff that were on duty could do the same.

Records

Staff kept detailed records of patients' care and treatment. Records were clear, up to date, stored securely and easily available to all staff providing care.

Patient notes were comprehensive, and all staff could access them easily. Staff used a combination of an electronic and paper record, which all staff had access to. Care records were completed in the patient's home and information was uploaded onto the electronic system reporting system. Staff had access to tablet computers for this purpose.

When patients transferred to a new team, there were no delays in staff accessing their records. The electronic record was shared by other trust teams, including the district nursing teams. Staff including consultants that were part of the IMPaCT hubs could also access this system, but in the North Liverpool and South Sefton hub, partner agency staff had not yet received the necessary training to access the system. We did not see any negative impact on patient care because all the Mersey Care staff could access the system.

Records were stored securely. Each member of the team had a personal log-on to the electronic recording system which was secure. Staff had to complete information governance training before they could use it.

Medicines

The service used systems and processes to safely prescribe, administer, and record medicines.

Community end of life care

Staff followed systems and processes to prescribe and administer medicines safely. The specialist palliative care team worked with GPs and the community district nursing team to provide the management and administration of medication for palliative care patients with complex needs. The team had specially trained nurse prescribers and appropriate medicines management standard operating procedures to follow. In the last 6 months, there were 4 prescribing errors and none of them resulted in serious harm to patients.

Staff reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines. We saw in care records that medicine was available for patients and regularly reviewed. We observed a daily handover meeting where staff met to discuss all the patients that were due to be seen that day, and this included a review of any medicines they were prescribed if needed. The patients and carers we spoke with told us staff provided them with appropriate medicines information and advice. The service was introducing several new medicines advice leaflets for patients and their families, and these were under review by patient consultation groups in the trust.

Staff completed medicines records accurately and kept them up to date. Staff completed records at the same time they saw patients in the place where they lived.

Staff learned from safety alerts and incidents to improve practice. Some staff attended weekly divisional medicines incidents meetings and fed back learning from medicines incidents to the team in daily handovers and team meetings.

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

Staff raised concerns and reported incidents and near misses in line with trust policy. When we spoke with staff, they confirmed they knew what incidents to report and how to report them. We looked at some quarterly incident reports and minutes from the meetings where staff discussed medicines incidents.

Staff reported serious incidents clearly and in line with trust policy. In the 12 months prior to our inspection there were no serious incidents reported by this service. Staff reported all deaths in the service as incidents so that lessons could be learned.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if things went wrong. Staff demonstrated a good knowledge of the duty of candour and received specific guidance on it, but in the last 12 months, there had been no incidents in the service that met the legal threshold for the duty to be applied.

Staff received feedback from investigation of incidents, both internal and external to the service. Staff confirmed that they received feedback about incidents through short briefings circulated at team meetings. Staff attended medicines incidents meetings and fed back to colleagues through daily handover meetings.

Staff met to discuss the feedback and look at improvements to patient care. There was evidence that changes had been made as a result of feedback. For example, we saw how staff were making changes to the medicines training programme for district nurses following a medicines error.

Community end of life care

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations. We looked at one serious incident report from 2021 involving the district nursing service caring for a patient with a life limiting condition. We saw that the lead investigator involved the patient and offered to feedback the findings.

Managers debriefed and supported staff after any serious incident. Although the service had not reported any serious incidents, the emotional impact of caring for people at the end of their lives was high. Staff had group and individual access to a psychologist to help them manage the emotional impact of the job, and this was something they valued highly. Nursing staff also had weekly access to peer group supervision and used this for emotional support.

Is the service effective?

Good ↑

Our rating of effective improved. We rated it as good.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Staff protected the rights of patients in their care.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. We looked at a range of policies and procedures, which were based on recognised quality standards, such as the National Institute for Health and care Excellence, (NICE). However, the trust's end of life care policies should have been reviewed in December 2021 and February 2022.

At handover meetings, staff routinely referred to the psychological and emotional needs of patients, their relatives and carers. When we shadowed staff, attended meetings with them and looked at care records, we saw that staff placed great emphasis on supporting patients and their families with their emotions and feelings.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain, and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

Staff assessed patients' pain, but they did not use a recognised tool. They gave pain relief in line with individual needs and best practice as outlined in guidance produced by the National Institute for Health and care Excellence, (NICE).

Patients received pain relief soon after requesting it. Patients and their families had access to an advice line 24 hours a day, 7 days a week to request pain relief. Staff from the specialist palliative care team visited patients quickly, and sometimes the same day where this was needed. This included weekends. We spoke with some patients and carers about pain relief, and they had no concerns.

Staff prescribed, administered and recorded pain relief accurately. We looked at a sample of care records to confirm this.

Patient outcomes

Community end of life care

Staff monitored the effectiveness of care and treatment, and took some local action to make improvements, but they did not do this consistently across all teams. It was not always possible to identify if they achieved consistently good outcomes for patients.

The service participated in relevant national clinical audits, but across the services, there was inconsistency about how outcomes were monitored. For example, the services in Liverpool and South Sefton did not routinely monitor whether patients achieved their preferred place of death. In the Knowsley and St Helens services, the trust provided data to show that from the period April 2022 to September 2022, 78% of patients achieved their preferred place of death, but there was no narrative to say whether this had improved or declined over the years, or whether this met relevant standards.

In the Liverpool and South Sefton services, managers monitored staff compliance with the electronic end of life care plan, but their most recent audit only achieved an overall compliance rate of 78%. This meant there was only a moderate level of assurance that service standards, such as care after death, and information provided for bereaved people, were consistently being achieved.

Outcomes for patients were largely positive but were not consistent. Staff carried out audits differently in the different teams and it was therefore difficult to identify whether they met expectations, such as national standards. However, in the services across both geographical areas, the audits identified that further work was needed to ensure services met objectives consistently.

Managers and staff used the results from audits to improve patients' outcomes. The service had undergone a transformation so that services across Liverpool and South Sefton were part of a multi-agency hub designed to provide a single point of contact for people requiring access to specialist palliative care. Managers had made these changes partly because, on average, people in Liverpool were more likely to die in hospital than in the rest of England. In addition, managers identified that services in this geographical patch were fragmented and poorly co-ordinated.

Services in St Helen’s and Knowsley were still operating under a different model, but they had a detailed action plan to improve the areas they identified as below the required standard.

Managers did not always share and make sure staff understood information from the audits. Many of the staff we spoke with in the Liverpool and South Sefton teams told us that they did not know what audits had been carried out to evaluate the IMPaCT model. However, they were aware of routine audits carried out within the service, such as infection control and care records audits. Staff shared these in team meetings and staff development sessions.

Competent staff

The service made sure staff were competent for their roles, but managers did not always appraise staff’s work performance in a timely way. Managers provided access to clinical supervision and support.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. Most staff we spoke with had many years of experience in the service, and most of them were band 7 nurses who had completed nurse prescriber training. We looked at data to confirm that nurse prescribers completed an annual declaration to show they kept up to date with their competence and skills in this area.

Managers supported nursing staff through regular, constructive clinical supervision of their work. The trust told us that nursing staff should have had access to managerial supervision at least every 8 weeks and clinical supervision on a quarterly basis. The trust supplied us with data to show that in the previous 12 months, nursing staff were between 95%

and 100% compliant with supervision arrangements, except on 7 occasions where they were between 80 and 90% compliant and this was due to sickness absence in the team. Several staff told us their managerial one-to-one sessions were often cancelled or re-arranged due to work pressures and that clinical supervision often took place in a peer group. Staff told us they would have liked more regular one-to-one supervision sessions, but the trust provided us with evidence that over the last 12 months, staff had, on average attended 12.4 one-to-one supervision sessions per person. This was in addition to peer group supervision and reflective practice. The trust supplied us with data to show that staff in the Knowsley service were 100% compliant with their supervision arrangements.

Managers supported staff to develop through yearly, constructive appraisals of their work, but not all staff were up to date with them. The staff in Knowsley were 85% compliant, but due to sickness absence, and the need to prioritise patient care, the staff in Liverpool and South Sefton were only 44% compliant. The trust showed us data to evidence that staff that did not have an up to date appraisal had been booked to complete them by the middle of December 2022.

Managers made sure staff attended team meetings or had access to full notes when they could not attend. We looked at a sample of team meeting minutes to see that they were held regularly and documented adequately.

Staff had the opportunity through the appraisal process and supervision to discuss training needs and were supported to develop their skills and knowledge. The service had secured additional funds to enable staff to attend relevant conferences and other external courses relevant to palliative care. Nine staff were due to attend training in advanced pain management.

Managers made sure staff received any specialist training for their role, and compliance as of December 2022 was 97.8% for the Liverpool team, 94.7% for South Sefton and 85.7% for Knowsley.

Multidisciplinary working

All those responsible for delivering care worked together as a team to benefit patients. They supported each other to provide good care and communicated effectively with other agencies.

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. Each day, clinical nurse specialists from the team met with partner agencies across the Liverpool and South Sefton area to discuss any urgent new referrals and existing patients that required specialist input from the palliative care service. The meetings, located in two hubs across the patch, were designed to ensure patients got the right level of care by bringing together key professionals involved in delivering end of life care across the system. We observed one of these meetings and saw how hospice staff, consultants, and in-patient end of life care staff worked together to identify which patients needed what level of support. On a weekly basis, the teams met for longer to review patient care in more depth, particularly those with complex support needs. Managers from Mersey Care were identifying ways that district nursing staff could attend these meetings more consistently.

Staff worked across health care disciplines and with other agencies when required to care for patients. Staff worked collaboratively with therapy staff, for example physiotherapists and occupational therapists from 2 hubs across Liverpool and South Sefton. They worked closely with district nursing teams and carried out joint visits where appropriate. Staff from 2 local hospices were part of the hubs and could identify when specialist in-patient beds were available.

Staff referred patients for mental health assessments when they showed signs of mental ill health, depression. We spoke with staff to confirm that they had access to these where needed.

Community end of life care

Health promotion

Staff gave patients practical support to help them live well until they died.

Staff assessed each patient's health when admitted and provided support for any individual needs to live a healthier lifestyle. Staff across the palliative care teams encouraged patients to make healthy lifestyle changes and promoted ways for patients to manage their own health. We confirmed this when we spoke with patients and when we examined care records.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. We spoke with staff and looked at records to confirm that staff had a good understanding of the principles of the Mental Capacity Act and when to carry out an assessment of capacity.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. We looked at care records and a recent records audit to evidence that staff gained consent from patients and recorded this correctly in their care record. A recent care records audit showed that staff in the Liverpool and South Sefton teams had recorded consent in 100% of the records sampled. However, there was no similar audit data for the services in Knowsley.

Staff clearly recorded consent in the patients' records. Staff had created a specific template to record capacity and consent on the electronic patient record system. This meant staff were more consistent in completing this information for all patients.

Nursing staff received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards. Training in this was mandatory at Level 2 and the compliance rate was 100% across the teams.

We did not see any evidence that the services in Liverpool and South Sefton were supporting any patients subject to a deprivation of liberty.

Staff could describe and knew how to access policy and get accurate advice on Mental Capacity Act and Deprivation of Liberty Safeguards. An up-to-date policy was on the trust website and staff knew how to access it. The policy contained information about who to contact for advice.

Managers monitored how well the service followed the Mental Capacity Act but did not make changes to practice when necessary. A recent audit carried out by managers in the Liverpool and South Sefton teams showed that staff recorded patients' mental capacity status in only 66% of records audited. The trust supplied an action plan for the teams, but we could not see any actions aimed at improving performance in this area. The trust could not provide similar data for services in Knowsley.

Community end of life care

Is the service caring?

Good 

Our rating of caring stayed the same. We rated it as good.

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. We spoke with 5 patients and 2 family members who confirmed that staff had time for them and were always respectful and considerate. The responses we received were overwhelmingly positive and many of the patients we spoke with said staff went out of their way to provide responsive care that was tailored to their individual needs.

Patients said staff treated them well and with kindness. The feedback we got from patients and their families was that staff were compassionate, and extremely caring. When we spoke with staff, they demonstrated an empathic approach and genuinely cared about ensuring that patients and their families experienced the highest quality care they could provide.

Staff followed policy to keep patient care and treatment confidential.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. When we spoke with staff, they demonstrated a highly person-centred approach, tailored to individual need. They gave us examples of how they listened to patients and their families about what they needed and did their best to provide this.

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgemental attitude when discussing patients with mental health needs. We interviewed staff and asked them specifically about caring for patients with mental health needs. We spoke with one patient who felt their mental health needs had been met fully by staff.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs, but they did not always ensure that written information about coping with dying was shared with patients and their families.

Staff gave patients and those close to them help, emotional support and advice when they needed it. All the patients and family members we spoke with confirmed that the teams provided emotional support as well as appropriate advice in a timely way. The trust kept a record of feedback from patients, and we saw many examples where people had cited examples of the type of positive support and advice they had received.

Community end of life care

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them. However, a recent audit showed that that leaflets explaining about coping with dying and what to do when someone dies, were only evident in 34% of the care records audited. The teams planned to improve training and communication to district nurses to ensure that appropriate written information was given at the end of life care planning stage.

Understanding and involvement of patients and those close to them

Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. The teams carried out regular patient experience surveys, but in Knowsley and St Helens, specialist palliative care was delivered in a different way such that it was not possible to discern any specific feedback about specialist palliative care nursing staff employed by this provider. The trust planned to improve their patient feedback mechanisms by developing standardised community specialist palliative care patient experience survey across the organisation by the end of March 2023.

Staff made sure patients and those close to them understood their care and treatment. The teams carried out patient experience surveys and a recent survey carried out in 2022 showed that 90% of respondents in Liverpool and South Sefton though that staff gave them all the information they needed about care and treatment. There was no data to compare from the Knowsley service.

Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary. When we spoke with patients and families, they told us that staff spoke with them in a way they could understand and, where appropriate, they enlisted help from the patient's family for patients with specific communication needs. In some cases, staff linked in with other professionals, such as occupational therapists, and speech and language therapists to help patients communicate their needs.

Staff supported patients to make advanced decisions about their care, but the trust did not have a consistent approach to monitoring this so they could not be sure to what extent all patients had been asked about their wishes and preferences for future care. In the Liverpool and South Sefton teams, staff audited whether a 'unified do not attempt cardiopulmonary resuscitation form' had been completed but there was no qualitative data to evidence whether patients had been given opportunities to discuss and review their wishes and preferences prior to or at the end-of-life stage. The audit, carried out in the Knowsley team, could evidence that wishes and preferences about care at the end of life had been discussed consistently with patients.

Patients gave positive feedback about the service. The teams in Liverpool and South Sefton carried out a patient experience survey in 2022 with a sample of 20 service users. It showed that all 20 respondents were likely or extremely likely to recommend the service to family or friends if they needed similar care or treatment. We looked at log of compliments received from service users since the start of 2022 and saw it contained many examples of highly positive feedback about staff and the service they had provided. All the patients and families we spoke with as part of our inspection, gave very positive feedback.

Patient surveys had been carried out in Knowsley, but none of the feedback related to Mersey Care specialist palliative care services.

Community end of life care

Is the service responsive?

Good 

Our rating of responsive stayed the same. We rated it as good.

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Managers planned and organised services, so they met the needs of the local population. Managers in the Liverpool and South Sefton services had implemented a new model called the Integrated Mersey Palliative Care Team, (IMPaCT), in response to a lack of coordinated care for people with a life limiting progressive condition in the Liverpool and South Sefton areas. The model, which was consultant led, was a partnership between the trust, acute hospitals operating across the patch and 2 local hospices. This meant that patients and other professionals had access to a single point of contact for palliative care assessment and advice, and pathways were streamlined when patients were transferred between in-patient and community care. The model aimed to ensure that people were put in touch with the right service at the right time to meet their needs. The model was still under development and had not been evaluated fully.

Experienced nurses from the specialist palliative care team staffed the advice line Monday to Friday from 9am to 5pm and, at other times, a 24-hour advice line was in operation. The specialist palliative care team were available on a rota to work at weekends during the day, which meant that if patients with complex needs required specialist input, including admission to a local hospice, this could be facilitated. The model was under review with a view to improving out of hours provision including on bank holidays.

Staff could access emergency mental health support 24 hours a day 7 days a week for patients with mental health problems, learning disabilities and dementia. We spoke with staff to confirm they could access this when needed. Out of hours, patients could contact the 24-hour palliative care advice line where they would be directed to the trust's emergency mental health support services.

The service had systems to help care for patients in need of additional support or specialist intervention. The specialist palliative care team in Liverpool and South Sefton were part of a city-wide multi-agency, multidisciplinary meeting where they discussed all patients that required, or were in receipt of palliative care across the patch. This meant patients that needed additional or specialist input could be identified and seen quickly by the most appropriate service.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. The trust had an appropriate policy in place which staff confirmed they understood and knew how to access. Staff asked patients about communication needs when they saw them.

Community end of life care

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. Staff had access to a language line which provided translation services for patients and relatives. Staff also had good access to sign language interpreters.

Access and flow

Patients could access the specialist palliative care service when they needed it. The provider did not routinely monitor waiting times from referral to achievement of preferred place of care and death.

Managers did not monitor waiting times but made sure patients could access services when they needed them. The specialist palliative care teams in Liverpool and South Sefton did not monitor waiting times, but patients could access services 7 days a week through a dedicated palliative care advice line. The trust said they did not specifically monitor whether patients received treatment within agreed timeframes, but they monitored complaints, patient feedback and incidents as an indicator of service performance in this area. The trust told us that staff could respond to urgent patients within 24 hours and more routine assessments within 10 working days but the trust did not monitor whether patients were responded to within these timescales.

Staff supported patients when they were referred or transferred between services. One of the main purposes of the integrated palliative care hubs was to ensure patients could be supported to access and transfer between the different services involved in their journey. Staff gave us examples of how patients were supported to access a hospice at the weekend and how they supported patients from hospital to die in their chosen place.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

Patients, relatives and carers knew how to complain or raise concerns. All the patients and carers we spoke with said staff had provided them with an information pack containing, details of how to make a complaint and the relevant contact details for the service.

Staff understood the policy on complaints and knew how to handle them. We did not speak with any service users who had raised a complaint, but staff told us they knew how to handle complaints and had access to the trust's policy.

Managers investigated complaints and identified themes. In the last 12 months, the specialist palliative care service in Liverpool and South Sefton, did not receive any complaints directly about their service, but there were 5 complaints about the quality of end-of-life care provided by the district nursing teams. The themes were about communication with family members, carers and other associated health professionals, the assessment of pain, documentation and systems and processes supporting communication. Three of these complaints had been investigated and responded to and 2 were still on-going. In the same period, there was one complaint about the service in Knowsley and St Helens, and this had been investigated.

Managers shared feedback from complaints with staff and learning was used to improve the service. Staff told us they discussed complaints in team meetings but because the service received so few complaints, we could not see evidence of this in the meeting minutes we looked at. There was evidence that staff had made improvements in response to a complaint about communication with families.

Community end of life care

Staff could give examples of how they used patient feedback to improve daily practice. Following from a complaint about communication with a family, staff had developed two new patient information sheets about syringe drivers and the use of anticipatory medicines in the end of life. These were with patient reading groups for feedback before being given out.

Is the service well-led?

Requires Improvement 

Our rating of well-led stayed the same. We rated it as requires improvement.

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

The operational managers of the service were all highly experienced in end-of-life care, knowledgeable about the issues faced by staff and patients, and very visible in the service. The service was overseen by a head of operations who was also an experienced manager and highly visible in the service. Most of the staff we spoke with thought that managers were approachable, but a small number of staff did not think so. The team had gone through a transformation and there were some tensions between leaders and some of the staff team. Managers were responding to these issues but not all staff agreed that their concerns had been fully resolved.

As a result of the transformation, the teams in Liverpool and South Sefton had increased in size by 3 full-time clinical nurse specialists, and there had been an increase in the amount of training offered to staff. We spoke with many staff who had been given the opportunity to attend specialist courses, for example, in advanced pain management. The staff we spoke with confirmed there were opportunities for professional development.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

The trust had a specific vision and strategy for end-of-life care, which they planned to implement across all the palliative care services that the provider was responsible for. The strategy was in the process of being implemented across the Liverpool and South Sefton teams where the specialist palliative care staff worked in partnership with other hospitals and hospices to deliver more joined up and responsive care. However, some staff in the specialist palliative care teams thought the new strategy and operating model, would impact negatively on patient care, because patients might not always see the same specialist nurse and there was not as close a connection with GP's and district nurses as they had before. At inspection, we did not find any negative impact on patient care because of the new model and managers reported there were positive outcomes for patients, including reduced unplanned hospital admissions and increases in the number of people supported to die at home or in their preferred place. Managers planned to improve the pathways between the specialist palliative care team and the district nursing team by having some district nurses on short term secondment to the team. They would then be able to act as link nurses once back in their district nursing teams.

Many of the staff we spoke with in the team had not been informed about the improvements in patient outcomes that were being achieved by the new model. In team meeting minutes, we saw that staff did not feel they were kept informed about significant organisational changes, for example, the acquisition of palliative care services in Knowsley.

Culture

Not all staff felt respected, supported and valued, but they were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work, and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

Most of the staff we spoke with felt respected, supported and valued, but there was a small cohort of staff that did not, because they did not feel there was enough of a work-life balance. We raised this with managers who told us they would remind staff of the correct escalation process if they had concerns, for example, about not being able to finish work when they should. All the staff and managers we spoke with were focused on the needs of patients and were motivated to deliver high quality care. The trust carried out staff surveys and culture of care barometers, but the results were not available for teams that only had a small number of responses. The trust said they were in the process of reviewing how smaller sized teams could be incorporated.

The service had an open culture where staff could raise concerns, and some staff in the Liverpool and South Sefton team, had raised concerns through the trust's freedom to speak up guardian in April 2021. Staff thought the new model of delivering care was impacting on their well-being and posing risks to patients. We looked at records of meetings between staff and managers and there was an action plan in place to address concerns. Managers had put a 'you said, we did' chart in the team office to record what action they had taken as a result of concerns. The actions included, appointing additional staff to help with answering the advice line, replacement IT equipment and enlisting support from the wider partnership to ensure calls to the advice line were not stacking up. At the time of our inspection, the freedom to speak up guardian was still involved because staff were not satisfied that the issues had been fully resolved.

None of the patients we spoke with raised any concerns about the care they received from the specialist palliative care team, though they felt they could raise concerns with the trust if needed. They had been provided with written information about how to raise concerns and complaints.

Governance

Leaders did not always operate effective governance processes, throughout the service, and staff were not always clear about which managers they should report their concerns to. Staff and managers did not always have enough opportunities to meet, discuss and learn from the performance of the service.

Overall, the governance arrangements for the service were not consistent or clear. When we last inspected the service in 2018, we found that managers did not always have sufficient oversight of all their community palliative care services, and, at this inspection, we found there were still some issues with governance and oversight of services. There were divisional governance meetings but the last six meeting minutes we looked at did not have any representation from the managers of the specialist palliative care team. The trust told us this was because their attendance was not always considered necessary due to their attendance at other divisional meetings. The services in Knowsley operated differently to the services in Liverpool and South Sefton but the staff we spoke with were unaware of specific action plans to align the services. There was an inconsistent approach to outcome monitoring and audit, so we could not be

sure that all services were operating to the same standards. Some audits were of poor quality, and we could not always see what actions had been taken to improve performance where audits identified deficits. Outcomes and waiting times were not consistently monitored so the trust could not be sure whether services were delivering improved performance in these areas.

Not all staff felt supported by managers and within the Liverpool and South Sefton teams, and staff were not always clear which manager to report to as there were three different managers that all had some level of operational responsibility. In Liverpool and South Sefton staff did not have protected time to carry out quality improvement within their team.

However, patient feedback was positive, the care was safe, and staff provided responsive care. Managers and staff had worked hard to improve the system across Liverpool and South Sefton so that patients' needs for specialist palliative care could be responded to more consistently, including out of hours.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

Staff managed risks to patients and staff well and, incidents were appropriately reported and investigated.

The service had a risk register in place, but staff were not always clear where risks should be recorded. The service in Liverpool and South Sefton had a risk register that identified some risks relating to all the end-of-life care services, but the specific risks identified for the Knowsley service were recorded separately on the risk register for the wider trust.

Both services had an appropriate business continuity plan in place which we looked at following our inspection. Not all staff felt they could contribute to decision making, but the service had increased resources to the Liverpool and South Sefton team to ensure the implementation of the new model did not compromise the quality of care.

Information Management

The service did not always collect reliable data, but staff could find the data they needed to understand performance, make decisions and improvements. The information systems were not yet integrated, but data or notifications were consistently submitted to external organisations as required.

Overall data systems were inconsistent and sometimes of poor quality. The trust told us that the services in Liverpool and South Sefton did not monitor whether patients achieved their preferred place of death, but managers in the service reported that the new service model had increased the numbers of people dying in their preferred place. Data collection was inconsistent across the services and some audits were of poor quality. For example, in the quality review process, Liverpool and South Sefton teams, staff audited whether a 'unified do not attempt cardiopulmonary resuscitation form' had been completed but there was no qualitative data to evidence whether patients had been given opportunities to discuss and review their wishes and preferences prior to or at the end-of-life stage.

Engagement

Community end of life care

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

In Liverpool and South Sefton, managers collaborated effectively with partner organisations and commissioners to plan and develop the Integrated Mersey palliative Care Team, (IMPaCT). They participated in steering groups to help manage performance and develop the model to improve services for patients. Managers acknowledged there was further promotional work to be done with district nursing teams and they were planning this.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

Some of the staff we spoke with were involved in quality improvement projects and acted as peer reviewers for other services in their quality review processes. However, they did not always get protected time to do this, which some members of the team thought stifled innovation, because they were too busy delivering direct care to patients. The team had raised the issue at team meetings, and managers acknowledged that staff sickness had been a concern, but attendance had improved recently. Staff had access to a dedicated website and a team to support staff carrying out quality improvement, audit and research.

Wards for people with a learning disability or autism

Good

Is the service safe?

Good

This was the first inspection of this service at this Trust. We rated it as good because:

Safe and clean care environments

- People were cared for in wards that were mostly safe, clean well equipped, well furnished, well maintained or fit for purpose. The premises were clean and there was a cleaning schedule in place which was reviewed by staff, however some of the bathrooms on Byron ward were poorly maintained making them difficult to clean. There was a programme of work taking place on the bathrooms and one of the bathrooms had been fully refitted.
- People were cared for in wards where staff had completed thorough risk assessments of the environment. Environmental risk assessments on Byron ward were up to date and mitigations were in place where appropriate. Staff regularly completed infection prevention control checks and actioned any concerns identified. Staff had completed a fire risk assessment which was up to date and each person had a personal emergency evacuation plan in place. Staff had carried out ligature risk assessments and there were ligature cutters available.
- The service's infection prevention and control policy was up to date. Staff regularly completed infection prevention control checks and actioned any concerns identified.
- People had easy access to nurse call systems and staff had easy access to alarms. The ward was a mixed sex ward. It contained a separate female lounge. Managers were aware that mixed sex wards could present risks and this was on the risk register.

Clinic rooms and equipment

- The clinic room was fully equipped with accessible resuscitation equipment. The clinic room was clean and tidy and staff monitored the temperatures of the fridge and the room to ensure medication was store safely.
- Staff maintained equipment in line with manufacturer's instructions and equipment was clean, safe and in date.

Safe staffing

- The service had enough staff to keep people safe from avoidable harm. There were 11 staff on the early and late shifts during the day, consisting of 9 support workers and 2 qualified nurses. There was 1 qualified nurse and 6 support workers at night. There were also 3 extra staff on a twilight shift which covered the period between 4:30p.m. and 12a.m.
- There were not always enough qualified nurses, but there were clear procedures in place for accessing nurses from other services when there were absences. The service always had at least one qualified staff member on duty. Managers used regular bank nurses who knew the service and 1 regular agency nurse who worked full time hours.
- The service had enough staff for people to take part in activities. Byron ward had enough staff to take people out on activities and to have one to one sessions. Some people on Byron ward had structured routines which were important to them and staff ensured these routines were kept to.

Wards for people with a learning disability or autism

Mandatory Training

- Staff had completed and kept up to date with their mandatory training. Staff training compliance levels were: 97% core mandatory training; 96% security awareness training; 87% role specific training; 93% divisional training and 97% continuous professional development. The training programme met most of the needs of people and staff.

Assessing and managing risk to patients and staff

Assessment of people's risk

- The service helped keep people safe through formal and informal sharing of information about risks. We looked at 3 people's records. Everyone had a risk assessment which was up to date and staff updated these plans when new risks were identified.

Management of people's risk

- People's care records helped them get the support they needed. Staff mostly kept accurate, complete, legible and up-to-date records, and stored them securely. We reviewed 3 sets of care records and found risk assessments and care plans were mainly up to date and corresponded with one another. However, two of the care records we reviewed did not have a one-page profile in the file, which meant that staff did not have quick access to information about those people.
- Staff managed the safety of the living environment and equipment in it well and took action to minimise risk.
- Staff knew about any risks to each person and prevented or reduced risks. For example, staff managed the risk from inappropriate use of water by managing access to water. However, they recognised that this was due to sensory needs and had devised care plans to ensure people with this need had regular supervised access to water therapy.

Restrictive Practice

- People's freedom was restricted only where they were a risk to themselves or others, as a last resort and for the shortest time possible. Restrictive practices and blanket restrictions were reviewed monthly and staff assessed banned items on an individual basis.
- Staff made every attempt to avoid restraining people and did so only when de-escalation techniques had failed and when necessary to keep the person or others safe. Restraint incidents on Byron ward were monitored and the average number of restraints was 11 per month. There was no use of face down restraint and no use of rapid tranquilisation. We observed staff on Byron ward redirecting people and using de-escalation techniques. Managers told us that staff used forward planning in situations people might find difficult, referred to people's positive behavioural support plans, and prioritised people's routines to reduce the likelihood of people becoming distressed.
- Staff rarely used seclusion and there was no seclusion room on Byron ward. Managers told us there had been one incident of seclusion and which was for 6 hours. A seclusion room had been used on another ward on the same site for this purpose. There was no use of long-term seclusion.

Safeguarding

- Staff had received training on how to recognise and report abuse and they knew how to apply it. Staff had received level 3 safeguarding training which was appropriate for the needs of the service.

Wards for people with a learning disability or autism

- Staff understood how to protect people from abuse and the service worked well with other agencies to do so. Managers made safeguarding referrals where they had concerns about people safety and welfare and followed up safeguarding referrals to ensure were aware of any outcomes.
- Staff followed clear procedures to keep children visiting the ward safe. There was a family room off the ward where people could spend time with their families including children.

Medicines management

- Staff followed systems and processes to prescribe and administer medicines safely. The ward had an electronic system for prescribing and administering medicines. Where needed the appropriate Mental Health Act authorities for prescribing were in place. Arrangements were in place to support people with their medicines when away from the wards.
- Pharmacy team support to Byron ward was limited due to capacity at the Hollins Park site. A weekly medicines stock top up service was provided but there was no nominated clinical pharmacist support to the ward. Nurses explained that they had a range of easy-read leaflets for patients and access to Speech and Language Therapy to help with sharing medicines information within a story, if needed. However, there was less opportunity for people or their advocates to discuss their medicines and side-effects with a pharmacist.
- People's medicines on Byron ward, including the use of 'when required' medicines, were reviewed every two weeks at the Consultant ward round. There was a strong focus on deprescribing and achieving the aims of STOMP (Stop Over Medicating People with a learning disability). A structured form for capturing these reviews had been shared with the ward following a pilot at a different trust site.
- Staff followed national practice to check patients had the correct medicines when they were admitted, or they moved between services. However, medicines information within people's hospital passports was not always up to date.
- However, annual heath checks to identify cardio-vascular risk, had not been completed for people who had stayed at Byron ward for more than a year. This was contrary to Trust policy.
- Staff carried out physical checks such as recording people's weight. They also reviewed the effects of each people's medicines on their physical health and supported people to use a self-rating scale for measuring the side-effect of antipsychotics.

Track record on safety

- The service managed incidents affecting people's safety well. Staff recognised incidents and reported them appropriately and managers investigated incidents and shared lessons learned. We reviewed 1 incident. Managers investigated the incident effectively and put actions in place to reduce the likelihood of recurrence. Staff and people living on Byron ward received debriefs following incidents and learning was shared with staff through team meetings and reflective practice.
- When things went wrong, staff apologised and gave people honest information and suitable support.
- Staff reviewed all use of restraint and used the examples as learning in their restrictive intervention's reduction programme.

Is the service effective?

Good 

Wards for people with a learning disability or autism

This was the first inspection of this service at this Trust. We rated it as good.

Assessment of needs and planning of care

- Staff had not always completed a comprehensive assessment of each person's physical and mental health either on admission or soon after. We found 2 of the 3 records we looked at did not contain an initial assessment although information had been gathered about people's needs.
- Staff mainly ensured people had up-to-date care and support assessments, including medical, psychological, functional, communication, preferences and skills. Staff completed a range of care plans that were used to detail people's individual needs. Care plans contained detailed, up to date information about people's needs and how to support them including joining in and having a good life, friends and family care plans and maintaining physical health. In addition, some people had a behavioural support plan and sensory care plans where this was needed. We found 2 care plans did not contain up to date information about life events that would have helped staff support people appropriately and sensitively. However, these life events were shared with staff during handovers.

Best practice in treatment and care

- Staff supported people with their physical health and encouraged them to live healthier lives. People had access to occupational therapy support and were supported to take exercise including using the gym and going on bike rides. Staff provided healthy eating sessions and cooking sessions on the ward. Staff carried out physical health observations, when required and recorded these in people's records.
- Staff understood people's positive behavioural support plans, provided the identified care and support. Some people had detailed positive behavioural support plans and some people also had sensory care plans which provided guidance to staff to support their needs.
- People were not always supported by staff in line with their moving and handling risk assessments and care plans. We found 1 falls risk assessment that had not been completed.
- Staff took part in clinical audits, bench marking and initiatives. Managers carried out regular record keeping audits to make sure records were accurate, contained appropriate information and were up to date.

Skilled staff to deliver care

- People received good care as managers supported staff through regular, constructive clinical supervision of their work. Supervision compliance was 100%.
- People were supported by staff who had received relevant and good quality training in evidence-based practice. Staff had attended a range of training which was specific to the needs of the people living there. For example, staff attended courses on working with developmental trauma and behaviours that challenge; supporting service users with complex interpersonal needs and an understanding behaviour workshop. However, staff had only received a basic level of autism training, contained in the learning disability training carried out on induction. This was concerning due to the complex needs of some of the people on the ward.
- The service had clear procedures for team working and that promoted good quality care and support. Managers held regular team meetings which were inclusive and constructive and based on Trust values and team objectives. Managers also held reflective practice sessions to support staff to reflect on and improve their practice.

Multi-disciplinary and interagency team work

Wards for people with a learning disability or autism

- .Staff from different disciplines worked together as a team to benefit people. These included the psychiatrist, clinical psychologist, nursing lead and occupational therapy staff. They supported each other to make sure people had no gaps in their care. Staff demonstrated effective multi-disciplinary working. The ward held regular multi-disciplinary team meetings to discuss people's care and support. A range of professionals were involved in these meetings including professionals external to the ward such as social workers and advocacy staff. People, their carers and families also attended these meetings. Staff completed a prompt sheet with people, prior to the ward rounds and multi-disciplinary team meetings to help prepare them for these meetings.
- The ward team had effective working relationships with staff from services that would provide aftercare following people's discharge and engaged with them early on in people's admission to plan discharge.
- Staff shared clear information about people and any changes in their care, including during handover meetings. Staff shared detailed information at handover meetings.

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

- Staff understood their roles and responsibilities and were able to explain people's rights to them. Staff had access to policies relating to the Mental Health Act and code of practice and could access support from the Trust's Mental Health Act administrators when required.
- Staff explained to each person their rights under the Mental Health Act in a way that they could understand, repeated it as necessary and recorded it clearly in the people's notes each time. This was audited monthly.
- Staff made sure people could take section 17 leave (permission to leave the hospital) when this was agreed with the Responsible Clinician or the Ministry of Justice or both.
- People had easy access to information about independent mental health advocacy, and people who lacked capacity to make decisions for themselves were automatically referred to the service. The mental health advocate visited the ward twice a week and saw all people who were newly admitted to the ward.

Good practice in applying the Mental Capacity Act

- Staff supported people to make decisions on their care for themselves. They assessed and recorded capacity clearly for people who might lack the mental capacity to make certain decisions for themselves. We saw examples of capacity assessments which were specific to individual decisions and saw evidence of best interest decisions being made.
- Staff gave people all possible support to make specific decisions for themselves before deciding they did not have the capacity to do so. Staff used easy read information and social stories and worked with speech and language staff to help people understand information and make decisions.
- People's freedom was restricted only when necessary and staff made applications for a Deprivation of Liberty Safeguards authorisation where needed, or a deprivation of liberty was made through a court process.

Is the service caring?

Good ➔➔

This was the first inspection of this service at this Trust. We rated it as good.

Kindness, privacy, dignity, respect, compassion and support

Wards for people with a learning disability or autism

- People received kind and compassionate care from staff who mostly used positive, respectful language at a level people understood and responded well to. People told us they liked the staff and that all the staff were nice. One person told us that night staff did not always help them. Families told us that staff were amazing, responsive and really helpful and caring.
- Staff were patient and used appropriate styles of interaction with people. They were calm, focused, and attentive to people's emotional and other support needs and sensory sensitivities.
- Staff mostly showed warmth and respect when interacting with people. We mainly observed caring interactions which showed staff understood the people's needs and preferences well. For example, we observed staff chatting, singing and dancing with people and providing support when people were distressed. However, we observed 2 occasions where staff did not respond in a timely way to people's needs or distress. Although this occurred when staff were engaged in other duties this increased people's distress.
- Staff directed people to other services and supported them to access those services if they needed help.

Involvement in care

- Staff involved people in care planning and risk assessment and sought their feedback on the quality of care provided. They ensured that people had easy access to independent advocates. We found care plans were person centred and focused on what was important to people, their strengths and their skills and their goals. Most people had access to advocacy. Some people were subject to an urgent Deprivation of Liberty Safeguard because they were no longer a detained patient but their new home was not ready for them to move to, and it would not be safe for them to leave the ward. This meant they did not have the same access to advocacy as people who were detained under the Mental Health Act.
- People were listened to, given time and supported by staff to express their views using their preferred method of communication. For example, 2 patients had Picture Exchange Communication Systems to help them to communicate with staff.
- Staff respected people's choices and wherever possible, accommodated their wishes, including those relevant to protected characteristics such as cultural or religious preferences.
- Staff informed and involved families and carers appropriately. All families and carers we spoke to told us staff kept in touch regularly and contacted them if they had any concerns about their loved one. Families and carers were invited to regular multi-disciplinary meetings and families told us they were involved in putting together care plans.

Is the service responsive?

Good 

This was the first inspection of this service at this Trust. We rated it as good.

Access and discharge

- Most people were admitted from the local area. Managers always met with people prior to admission where possible. Managers provided recommendations to commissioners if they felt the ward would not meet people's needs.

- Staff planned and managed discharge well. They liaised well with services that would provide aftercare and were assertive in managing the discharge care pathway. However, people were expected to be on the ward for 3-6 months and there were several people who had been on Byron ward for longer. This was due to the availability of suitable placements for move people onto. 2 people had been allocated placements but these were not ready for them to move to.

Discharge and transfers of care

- Staff carefully planned people's discharge and worked with care managers and coordinators to make sure this went well. Discharge was considered at admission and throughout a person's stay. Staff worked with people and their families to identify appropriate discharge placement. Some people needed bespoke placements in order to meet their needs and this was causing delays in discharge. Staff carried out work with people to prepare them for discharge. Staff also carried out environmental assessments on new placements and supported the training of new staff. Staff followed a 12-point discharge plan to make sure discharges were carried out in a structured way.

Facilities that promote comfort, dignity and privacy

- The service's design, layout and furnishings met people's individual needs and the service was appropriately designed to meet the needs of the people on the ward. The ward contained quiet areas including a separate lounge and sensory room and had been made more welcoming with murals and decoration on the walls. Some of the information and pictures on the walls had been taken down at the time of our inspection because of the sensory needs of some of the people who lived there. People had access to a garden and could also access a gym onsite.
- The design, layout, and furnishings of the premises supported people's treatment, privacy and dignity. Although each person on Byron ward had their own bedroom with an en-suite bathroom containing a toilet and a sink, the shared bathrooms were in a poor state of décor and difficult to keep clean. The Trust had started a programme of work to improve the bathrooms on the ward and one new bathroom had completed.
- The service had quiet areas and a room where people could meet visitors in private.
- The food was generally of good quality and people had access to hot drinks and snacks at any time. People told us they could access drinks and snacks when they wanted them but that the choice at lunchtime was very limited and they had the same food every day. This had been raised at a residents meeting but had not been changed.

Patients' engagement with the wider community

- Staff supported people to take part in their chosen social and leisure activities on a regular basis. Staff supported people to take part in activities including cycling, using the gym, woodwork courses for trips such as going to Blackpool and going trampolining. People told us they were involved in swimming, craft activities, drawing, cooking and shopping trips.
- Staff gave people person-centred support with self-care and everyday living skills. People had detailed person-centred support plans which provided staff with guidance about how to encourage people to take part in their self-care routines. Some people were supported to cook their own meals.
- Staff helped people to stay in contact with families and carers. Carers told us that they had good contact with their family member including regular phone calls and visits.

Meeting the needs of all people who use the service

Wards for people with a learning disability or autism

- The service did not always meet the needs of all people. People had a range of needs, particularly in relation to noise tolerance. We observed times when some people found loud music, banging doors and raised voices from other people on the ward distressing. Although staff attempted to manage this through redirection and diversion, this was not always effective.
- Wards were accessible for people with a disability and people had information available in an accessible format. The ward had an assisted bathroom and bedroom and managers told us that they would obtain equipment based on individual's needs.
- Staff offered choices tailored to individual people using a communication method appropriate to that person One person had a communication board, to help them communicate and there was some easy read information available for people including some easy read care planning information. We were told that some of the easy read information that was on the ward had been taken down as some people living there struggled with having information on the walls. Some staff had received Makaton training which is a language programme that uses symbols, signs and speech to enable people to communicate. We saw staff signing Christmas songs with one of the people on the ward. Staff used signers and interpreters when they needed them.
- People had access to spiritual, religious and cultural support. People used a multi faith room which was off the ward but in the same building and staff had supported 1 person to attend church services each week. The service met people's dietary needs when required.

Listening to and learning from concerns and complaints

- People and those important to them could raise concerns and complaints easily, and staff supported them to do so. Any themes from complaints were discussed in team meetings, for example managers reviewed complaints and identified a need for all staff to engage people in activities
- Staff were committed to supporting people to provide feedback so they could ensure the service worked well for them. Staff held community meetings with people to discuss any issues on the ward and gather feedback. The family and carer lead carried out drop in events to gain feedback from families.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and wider service. We reviewed one complaint which had been investigated thoroughly and in line with the providers policy.
- Managers shared feedback from complaints with staff, and learning was used to improve the service.

Is the service well-led?

Requires Improvement 

This was the first inspection of this service at this Trust. We rated it as requires improvement.

Leadership

- Leaders had the skills, knowledge and experience to perform their roles and had a clear understanding of people's needs. Managers knew people well and had a good understanding of people's needs.
- Managers were visible in the service, approachable and took a genuine interest in what people, staff, family, advocates and other professionals had to say.

Wards for people with a learning disability or autism

- Managers worked directly with people and led by example. Managers knew people at the service, their families and carers well and spent time working directly with people so they understood people's individual strengths and support needs.

Vision and strategy

- Staff knew and understood the provider's vision and values and how to apply them in the work of their team.
- The provider had a clear vision for the direction of the service that demonstrated ambition and a desire for people to achieve the best outcomes possible. Staff were involved in developing and understood the vision for Byron ward. The team purpose was to support service users along their care pathway ensuring appropriate assessment, engagement and therapeutic activity. This was broken down into objectives, who was going to carry out the objectives and how they were going to do this.

Culture

- Staff felt respected, supported and valued. They said the service promoted equality and diversity in daily work. Staff told us they knew who their senior managers were and felt they were approachable. Staff told us they felt listened to and knew about the role of freedom to speak up guardian.
- Staff had regular opportunities to feedback about the running of the ward. Staff had been involved in an away day to provide them with an opportunity to discuss and reflect on improvements to the service.
- Staff felt able to raise concerns with managers without fear of what might happen as a result.

Governance

- Governance processes were not always effective. Although there was a clear procedure for admission to the service, we found that assessments were not always carried out prior to people coming into the service. Important information was missing from 2 care plans and 2 people did not have a one-page profile in their files, which meant staff could not access useful information about them quickly. Annual health checks had not been carried out and people did not always have up to date hospital passports or advice about their medicines. However, people had a range of care plans which provided important information about key aspects of their care and quality of life and which linked in with up to date risk assessments.
- Governance processes generally helped to hold staff to account, kept people safe, protected their rights. Managers had monthly leadership meetings where they reviewed key issues linked to the running of the service including incidents, staffing and environmental concerns. Relevant information from these meetings were then fed into the team meetings for the service. Managers were aware of the staffing challenges within the service and there were plans in place to manage this. Managers reviewed strategies to improve the service and identified continued improvements, for example, managers had identified that debriefing was not always occurring and had implemented a plan to improve this which included way to overcome barriers.
- Regular team meetings took place. These were structured, recorded appropriately and held at a time to ensure that night staff were included in the meeting.
- The provider kept up to date with national policy to inform improvements to the service. Registered nurses attended weekly quality meetings and shared information including updates to National Institute for Health and Care Excellence guidance, restrictive practice updates and best practice.
- Managers monitored risks around the environment and equipment appropriately. Regular environmental audits took place to monitor the safety of the environment and concerns were escalated and actioned.

- Managers carried a range of audits of records including supervision audits and record keeping audits. Although we saw some in depth audits of records which focused on ensuring the records were person centred and meaningful for people living there, these were not always effective because lack of admission assessments and annual health checks not been identified. Audits were discussed at leadership meetings.

Management of risk, issues and performance

- Teams had access to the information they needed to provide safe and effective care and used that information to good effect. Managers at the service had started a process of reviewing and updating information to ensure it met the needs of the people staying at the service.
- Staff were able to explain their role in respect of individual people without having to refer to documentation. Most staff knew the people they cared for well and understood their needs.
- There was a risk register in place for the service. The risk register was discussed at team meetings and contained key risks for the ward for example the poor state of the showers and risks associated with the ward being a mixed gender ward.

Information management

- Staff had access to the equipment and information technology to do their work. Systems were accessible to staff. Information governance systems included confidentiality of patient records. Staff could access team meetings online if they were unable to make them in person.

Engagement

- People and those important to them worked with managers and staff to develop and improve the service. For example, staff and people worked together to put on a learning disability and autism awareness day including a cake sale. This helped raise awareness and raised some money for the ward. Staff had regular meetings with people who lived there to discuss any issues and improvements to the service, however not everyone attended these and we noted there were some issues such as the lunch menu, where improvements had not been made.
- The service worked well in partnership with advocacy organisations/ other health and social care organisations, which helped to give people using the service a voice/ improve their health and life outcomes.
- Staff engaged in local and national quality improvement activities such as reducing restrictive practice and the safer wards initiative.

Learning, continuous improvement and innovation

- The provider kept up to date with national policy to inform improvements to the service.
- The provider had invested in the service, embracing change and delivering improvements. There was evidence of improvements being made, such as the development of a sensory room for people to use when they needed some quiet time and the improvements that were being made to the bathrooms on the ward.

Forensic inpatient or secure wards

Good  

Is the service safe?

Requires Improvement  

Our rating of safe went down. We rated it as requires improvement.

Safe and clean care environments

All wards were safe, clean, well equipped, well furnished, well maintained and fit for purpose.

Safety of the ward layout

Staff completed and regularly updated thorough risk assessments of all wards areas and removed or reduced any risks they identified. Staff worked with the relevant trust departments to ensure that annual health and safety and fire risk assessments were completed. Each of the wards we visited had up to date assessments in place. In addition, staff completed daily, weekly and monthly checks of the environment as well as security and fire safety systems.

Staff knew about any potential ligature anchor points and mitigated the risks to keep patients safe. Staff worked with the relevant trust department to complete environmental suicide risk assessments (ESRA). These were reviewed annually or in response to incidents or a change in the environment. Each of the wards we visited had an up to date assessment in place. Assessments were comprehensive and captured relevant risks and potential ligature points. Identified concerns had actions to either mitigate, reduce or remove the risk. These included the use of individual risk assessment, observations and supervised access to specific rooms such as the laundry room. Staff we spoke with were able to access a copy of their ward's assessment and were knowledgeable about the environmental and security risks that were present.

Staff could not always observe patients in all parts of the wards. Not all areas of every ward could be observed from the nursing station or main communal area. Staff mitigated this risk through individual assessment and use of observations, including zonal observations. Some wards also utilised CCTV and some wards used parabolic mirrors to further manage risk. CCTV was only used in communal areas.

The ward complied with guidance and there was no mixed sex accommodation. All wards were single sex facilities.

Staff had easy access to alarms. There were processes to manage, monitor and check staff alarms. Patients had easy access to nurse call systems.

Maintenance, cleanliness and infection control

Ward areas were clean, well maintained, well-furnished and fit for purpose. Wards we visited ranged from newly developed modern wards to older adapted accommodation. However, we found that décor and furnishings were appropriate in each location. Some wards at Hollins Park were due to undergo redecoration.

Forensic inpatient or secure wards

Staff made sure cleaning records were up-to-date and the premises were clean. Wards we visited were visibly clean. During our inspection we saw that cleaners were a constant presence on the ward. Cleaning records we reviewed were up-to-date and evidenced daily cleaning of the environment. Staff we spoke with told us that cleaning staff were responsive and quick to address any spillages or concerns that did arise. We spoke with two cleaning staff during the inspection. They told us they were fully resourced and supported in their role.

We reviewed cleaning rotas and spoke with cleaning staff; they were able to show us up to date and comprehensive records. During the inspection we saw continuous cleaning activity, and patients told us that the wards were always clean and tidy, especially bathrooms and eating areas.

Staff made sure equipment was well maintained, clean and in working order. There were records of regular checks, maintenance and cleaning of equipment. Staff completed daily checks on the temperature of fridges containing medicines.

Staff followed infection control policy, including handwashing. During our inspection we observed staff complying with infection control protocols. Staff had access to training, policies and a trust team to support them with infection control.

Seclusion room (if present)

Wards had access to either a dedicated or shared seclusion room. Seclusion rooms allowed clear observation and two-way communication. Seclusion rooms had appropriate viewing panels and two-way intercoms in place. Furniture and fittings within seclusion rooms were fit for purpose and appropriate for such facilities.

Seclusion rooms had a toilet and en-suite bathroom facilities. Toilet and bathroom facilities could be freely accessed by patients in seclusion. Observation panels allowed staff to observe patients within the en-suite area.

Seclusion rooms had a clock. Clocks were visible to patients within seclusion and also displayed the day and date.

Clinic room and equipment

Clinic rooms were fully equipped, with accessible resuscitation equipment and emergency drugs that staff checked regularly. Each ward had an emergency response bag. These contained emergency medicines and resuscitation equipment including a defibrillator. Emergency bags were subject to weekly checks. We reviewed records in the clinic rooms we visited and found that emergency bags had been checked as required. All wards had equipment and space to undertake physical observations as required.

Staff checked, maintained, and cleaned equipment. Staff monitored the temperature of clinic rooms and fridges containing medicines. Equipment that required regular maintenance, checks or calibration had been identified. Records we reviewed showed that the relevant checks were up to date. Equipment had stickers on them to show when they were last checked.

There were appropriate policies and procedures for the management of clinical waste. Clinic rooms had sharps bins in place which were in date and not overly full.

Safe staffing

Forensic inpatient or secure wards

The service had enough nursing and medical staff, who knew the patients and received basic training to keep people safe from avoidable harm. However, staffing pressures meant there was not always sufficient staff to enable compliance with the trust policy requiring staff spend no longer than 2 hours on continuous observation. Staff told us they were not always able to take regular breaks.

Nursing staff

Staff and patients we spoke with all identified staffing as the biggest challenge facing the service. Although some patients told us they had had activities or escorted leave cancelled in the past the main impact was on staff. Staff we spoke with told us they were not always able to take scheduled breaks and that they regularly breached the trust observation policy. The trust observation policy stated that staff should not complete more than two hours continuous observation. We reviewed shift planners across most of the service's wards for the month of November. This showed that staff completed more than two hours continuous observations on 41 shifts. This excluded data for Eden ward and wards at the Whalley location which were not provided. Staff told us that the expectation was that they would record such issues via the electronic incident reporting system. However, staff told us this not always happen due to capacity and that often only more serious concerns were reported. We reviewed adverse incident data from the previous 12 months. We found three incidents where there was temporarily no registered nurse on duty for a short time. In each instance this had been escalated to unit management and a nurse was moved from another ward. There was no harm as a result of the incidents. Two of these incidents were at Rowan View. We also identified four additional reports of low or unsafe staffing. Three of these were at Rowan View.

The service had processes and strategies in place to help mitigate the risk of staffing. The service completed an annual safe staffing review using the Telford Model of Professional Judgement to agree the size and staff mix on each ward. The most recent review had been completed in November 2022 and included plans for further investment into inpatient staffing.

At the time of our inspection the service had high vacancy rates for qualified nurses. The service had 195 whole time equivalent posts and 43.43 whole time equivalent vacancies. This meant there was a registered nurse vacancy rate of 22%. The service partly mitigated this by over recruitment of health care assistants and utilising the support of wider members of the multi-disciplinary team.

The service had low and or reducing turnover rates. The turnover rate for October 2022 was 2%.

Ward managers could adjust staffing levels according to the needs of the patients. Each location held regular safety huddles which enabled senior managers and ward managers to assess staffing levels on each ward against acuity and activity. Managers could 'mobilise' staff between wards to ensure wards met safe staffing levels. We discussed the process of mobilisation with staff we spoke with. Some staff at Rowan View told us they did not like being mobilised between mental health and learning disability wards. However, some of staff told us they considered this a positive and chance to develop their skill sets. Senior managers had taken steps to support staff moving between ward types. This included awareness training on learning disabilities and mental health as well as one to one support.

The service had high rates of bank and agency nurses. Managers prepared rotas six weeks in advance and submitted requests for bank and agency staff to a central trust team. Where the service was not able to fill gaps with bank and agency staff managers addressed this with the mobilisation of staff across wards, increasing the numbers of health care assistants and by utilising senior managers at locations in ward numbers. Overall, the service had an 87% fill rate for qualified staff and 122% fill rate for non-qualified staff. The overall shift fill rate was 105%.

Forensic inpatient or secure wards

Managers requested bank and agency staff familiar with the service. Managers made sure all bank and agency staff had a full induction and understood the service before starting their shift. We spoke with bank and agency staff during our inspection. They told us they were familiar with the service and the wards. Managers made sure all bank and agency staff had a full induction and understood the service before starting their shift. Bank and agency staff told us that they were able to access information on patients through handovers and one-page profiles of patients that were on each ward. Bank and agency staff we spoke with were confident in their role and able to answer questions about the patient group and associated risks.

Patients rarely had their escorted leave or activities cancelled, even when the service was short staffed. We spoke with 34 patients and 11 carers. Four patients and two carers told us that patients had had escorted leave rearranged due to staffing pressures. However, in general we found that staff prioritised the delivery of leave, activities and one to one named nurse sessions. Escorted leave was planned in advance to ensure sufficient staff to facilitate it. Staff members of the wider multi-disciplinary team including occupational therapists were utilised to facilitate leave when required. Patients had regular one to one sessions with their named nurse. Staff and patients we spoke with told us that one to one named nurse sessions took place as scheduled. Care records we reviewed evidenced that sessions were occurring on a weekly basis.

Managers supported staff who needed time off for ill health. Staff had access to trust services including an employee assistance programme and occupational health team. Managers had policies and procedures to support them in the management of staff sickness and the utilisation of processes such as phased returns.

Levels of sickness were low and reducing. Sickness rates across the service in September 2022 were 10%.

The service had enough staff on each shift to carry out any physical interventions safely. Shift rotas were prepared six weeks in advance and included information on staff training in restraint. This ensured there was always enough staff on shift who were appropriately trained. Additional support could be accessed from other wards in each location.

Staff shared key information to keep patients safe when handing over their care to others. Staff shared information in safety huddles and in shift handovers. We attended two handovers and found they were comprehensive and included the sharing of key information around patients, changes to risk and ward atmosphere.

Medical staff

The service had enough day-time and night-time medical cover and a doctor available to go to the ward quickly in an emergency. Doctors were allocated to each ward. Staff we spoke with told us they were able to access medics when they needed to. Patients we spoke with told us that medics were accessible and available. The service had on call rotas to provide cover out of hours.

Managers could call locums when they needed additional medical cover. Managers made sure all locum staff had a full induction and understood the service before starting their shift.

Mandatory training

Forensic inpatient or secure wards

Staff had completed and kept up to date with their mandatory training. Across the forensic service average ward compliance with the trust's core mandatory training was 98%. There was no ward with mandatory training compliance below 75%. The mandatory training programme was comprehensive and met the needs of patients and staff. The mandatory training programme included safeguarding, infection control, conflict resolution and equality and diversity training.

In addition to core mandatory training staff had access to role specific, division specific and continual personal development mandatory training. Role specific training included courses on basic and immediate life support, personal safety and breakaway and additional higher-level safeguarding. Across the forensic service average ward compliance with role specific mandatory training was 90%.

Division specific mandatory training included courses on the care programme approach, falls prevention, suicide awareness and divisional security. Across the forensic service average ward compliance with division specific mandatory training was 94%.

Continual personal development mandatory training included courses on the management of adverse incidents, dementia awareness and the triangle of care / carers awareness. Across the forensic service average ward compliance with continual personal development mandatory training was 99%.

There was no ward with, mandatory, role specific or continual personal development mandatory training compliance below 75%.

Managers monitored mandatory training and alerted staff when they needed to update their training. Managers had access to up-to-date training data. Staff were alerted by email when training was coming up for renewal.

Assessing and managing risk to patients and staff

Staff assessed and managed risks to patients and themselves well. They achieved the right balance between maintaining safety and providing the least restrictive environment possible to support patients' recovery. Staff had the skills to develop and implement good positive behaviour support plans and followed best practice in anticipating, de-escalating and managing challenging behaviour. As a result, they used restraint and seclusion only after attempts at de-escalation had failed. The ward staff participated in the provider's restrictive interventions reduction programme.

Assessment of patient risk

Staff completed risk assessments for each patient during transfer or on admission, using a recognised tool. Staff used the historical, clinical and risk management tool – 20 (HCR-20) during the assessment process. We reviewed 40 clinical records during our inspection. All records had a full risk assessment in place that had been completed either during transfer or on admission. Risk assessments were comprehensive and multi-disciplinary. Staff reviewed the risk assessment regularly. Risk assessments were reviewed a minimum of monthly or in response to an incident or change in presentation. Records we reviewed demonstrated regular review of risk assessments including in response to incidents.

Management of patient risk

Staff identified and responded to any changes in risks to, or posed by, patients. Staff identified changes through regular staff patient engagement, such as one-to-one named nurse sessions and through ongoing assessment and monitoring. Staff shared updated information on patient risk during handovers.

Staff followed procedures to minimise risks where they could not easily observe patients. This included individual risk assessments and the use of zonal observations where appropriate.

Staff followed trust policies and procedures when they needed to search patients or their bedrooms to keep them safe from harm.

Use of restrictive interventions

The service had an embedded culture of least restrictive practice. Staff participated in the provider's restrictive interventions reduction programme, which met best practice standards. The trust had developed a reducing restrictive practice approach centred around the concepts of least restrictive practice, no force first and the HOPE(S) model. No force first was a restraint reduction strategy. The HOPE(S) model was a psychology-led clinical model developed by the trust which takes a human rights approach to working with patients in seclusion. It involved harnessing the system and engaging with the individual, creating opportunities for positive and meaningful activities, identifying protective and preventative risk management strategies and enhancing the coping skills of both patients and staff. It has an ethos on working as a system to create relationships and partnerships to support the patient through their care and treatment. The model aims to reduce the use of long-term segregation.

Staff received training around restraint, least restrictive practice and the trust strategy as part of their induction and on-going training requirements. Staff worked with the trust team and the service's dedicated reducing restrictive practice lead to reduce restrictive practices on their ward. This included reviewing environments, working with patient groups and working with individual patients. The team were also involved in reviewing incidents to look at whether restrictive practice contributed to the incident occurring. Examples of work around reducing restrictive practice that we observed included the development of specialist care plans and positive behavioural support plans, the opening of rooms that had previously been locked or restricted access and ensuring the provision of activities at times that had been identified as periods of high incidents occurrence.

Staff made every attempt to avoid using restraint by using de-escalation techniques and restrained patients only when these failed and when necessary to keep the patient or others safe. Staff utilised verbal de-escalation and diversionary activities identified in care plans for each patient. Patients also had access to quiet rooms. Patients on learning disability wards could access sensory rooms as part of their de-escalation plans.

The service had a restrictive practices register in place which detailed existing restrictive practice on each ward. The register included a rationale and justification for each restrictive practice and a timescale and process for review. The register was discussed in community meetings with patients and reviewed by ward staff and the reducing restrictive practices group. Where individual restrictive practices were in place these had been appropriately care planned. For example, the use of handcuffs during transfer.

Levels of restrictive interventions were low and reducing. In the 12 months prior to our inspection there had been 185 incidents of seclusion across the 15 wards. There had been five instances of long-term segregation. We reviewed seclusion and long-term segregation records during our inspection. When a patient was placed in seclusion, staff kept clear records and followed best practice guidelines. Staff followed best practice, including guidance in the Mental Health Act Code of Practice, if a patient was put in long-term segregation. We found decisions to seclude or segregate had been made by a multi-disciplinary team and where feasible had involved the patient. Rationales for instigating seclusion or long-term segregation were justified. Episodes of seclusion and long-term segregation were subject to regular multi-disciplinary review.

Forensic inpatient or secure wards

In the 12 months prior to our inspection there had been 1,419 instances of restraint across the 15 wards and five independent packages of care houses. Individual package of care houses were single occupancy houses where patients were supported by staff. Staff understood the Mental Capacity Act definition of restraint and worked within it. Incidents of restraint were reviewed by ward managers and a trust team to ensure they were appropriate and utilised correct holds. Learning was shared with staff.

Staff followed NICE guidance when using rapid tranquilisation. There had been 16 instances of rapid tranquilisation in the 12 months prior to our inspection.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Staff received training on how to recognise and report abuse, appropriate for their role. Staff were kept up to date with their safeguarding training. The trust provided us with training compliance across the secure division. The secure division includes separate high secure provision. Training compliance for the division with level one adult safeguarding training was 97%. For combined level two and three adult safeguarding training the compliance was 92%. Training compliance for level one safeguarding children training across the division was 97%. Compliance with level two safeguarding children training was 96%. Compliance with level three safeguarding children training was 90%. All of the staff we spoke with during the inspection had completed relevant safeguarding training. There were systems in place to prompt staff members and ward managers if safeguarding training was due for renewal or was overdue.

Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them. Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff we spoke with were knowledgeable around safeguarding and associated issues. Staff had access to support from a trust wide safeguarding team as well as safeguarding leads within the division. Each ward had an allocated social worker who led on safeguarding. Staff had access to safeguarding policies and procedures to guide their practice. We saw evidence of appropriate safeguarding within care records we reviewed. Care records included examples of safeguarding concerns being identified, reported and managed as well as evidence of multi-agency working and liaison with relevant stakeholders and local authorities to safeguard individuals. Safeguarding was discussed in safety huddles and at shift handovers.

Staff could give clear examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. Staff we spoke with gave examples of how patients had been protected including the separation of patients where required, the reporting of incidents to police and the development of safeguarding care plans. Staff we spoke with had an understanding of safeguarding concerns in relation to patients protected characteristics and gave examples of concerns they would raise including racially discriminatory language or behaviour.

Staff followed clear procedures to keep children visiting the ward safe. Child visits were individually risk assessed by a multi-disciplinary team and held away from ward environments. Child visits were supervised where appropriate.

Managers took part in serious case reviews and made changes based on the outcomes.

Staff access to essential information

Staff had easy access to clinical information and it was easy for them to maintain high quality clinical records – whether paper-based or electronic.

Patient notes were comprehensive and all staff could access them easily. Records were clear, up-to-date and easily available to all staff providing care. Staff had easy access to clinical information and were able to maintain and access clinical records. Clinical records were both paper and electronic. Records were stored securely. Paper records were kept in locked rooms or cupboards and electronic records were password protected.

When patients transferred to a new team, there were no delays in staff accessing their records. When patients were transferred within the service staff had access to records on the electronic care records system. There were policies and processes in place to support the sharing of information for patients transferring into, or from external services.

Medicines management

The service used systems and processes to safely prescribe, administer, record and store medicines. Staff regularly reviewed the effects of medications on each patient's mental and physical health.

Staff followed systems and processes to prescribe and administer medicines safely. Staff involved in the administration of medicines received training and completed a competency assessment before they were able to start administering medicines. The relevant legal authorities for treatment were in place and checked by nurses. Patients were supported to use formal side-effect rating tools for reporting and monitoring side effects so these could be managed effectively. Therapeutic drug monitoring was carried out and recorded when needed. The use of 'when required' medicines was reviewed at consultant wards rounds. However, we found on Eden ward that blood glucose readings were not being recorded consistently. We reviewed the previous seven days records but found that some readings had not been recorded. Directions provided to staff stated that blood glucose levels should be recorded prior to administering insulin.

Patients medicines needs were considered when they were away from the ward. The trust had a medicines self-administration policy. However, this had not been fully implemented and was under review at the time of our inspection. Self-administration within safe, secure parameters can support independence and confidence with medicines in preparation for discharge.

Staff reviewed the effects of each patient's medicines on their physical health according to NICE guidance. Staff completed monitoring of patients on medication including the use of electro-cardiograms, blood tests and regular monitoring of patients weight.

Staff followed national practice to check patients had the correct medicines when they were admitted or they moved between services. Medicines reconciliations were completed by pharmacists on admission.

Staff reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines. Medicines were reviewed within ward rounds or in response to an incident or change in presentation. Patients had access to medicines information leaflets. Some of the patients we spoke with told us they had discussed medication with their care team.

The service ensured people's behaviour was not controlled by excessive and inappropriate use of medicines. Rapid tranquilisation (intramuscular injections for the management of severe agitation and aggression) was only used as a last resort. In the period between 1 January 2022 and 30 November 2022 there had been 16 instances of the use of rapid tranquilisation across the forensic wards.

Forensic inpatient or secure wards

On the wards for people with a learning disability there was a strong focus on de-prescribing and achieving the aims of STOMP (Stop Over Medicating People with a learning disability). We saw examples within care records of the effective implementation of STOMP principles where the use of psychotropic medicines had been reduced or stopped completely. Staff we spoke with on learning disability wards were knowledgeable about STOMP and its objectives.

Staff stored and managed all medicines and prescribing documents safely. Staff completed medicines records accurately and kept them up-to-date. Medicines were stored within dedicated clinic rooms. Staff monitored the temperature of fridges storing medication and the ambient temperature of the rooms in which they were located. Staff completed regular stock checks and audits. However, we found one box of medication on Allerton ward and one on Eden ward that had been dispensed by the pharmacy which had a cut strip of tablets with no expiry date. This meant that ward staff could not be sure the medicines were in date. Staff stored controlled drugs securely. Controlled drugs are medicines which have additional storage and recording requirements. The trust pharmacy team undertook monthly audits of controlled drugs and reported findings to the ward.

Staff learned from safety alerts and incidents to improve practice. Safety alerts were circulated to wards and staff via email. Copies of relevant safety alerts were available on each ward. Safety alerts were discussed in team meetings.

Staff we spoke with felt supported around the management of medicines. However, there was only limited trust pharmacist capacity to support medicines optimisation. Staff told us that the trust pharmacy team were accessible via email and telephone if needed. However, pharmacists were not routinely part of multidisciplinary team meetings and did not have capacity to attend consultant ward rounds. At Hollins Park pharmacy staff used daily reports from the electronic prescribing system to target pharmacist activity. One ward had established a weekly meeting between the pharmacist and ward consultant. This was reported to work well but had not been extended across the site or division.

Track record on safety

The service had a good track record on safety.

Staff reported serious incidents clearly and in line with trust policy.

The service had no never events on any wards.

Reporting incidents and learning from when things go wrong

The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

Staff knew what incidents to report and how to report them. Staff raised concerns and reported incidents and near misses in line with trust policy. Staff reported incidents electronically. Staff we spoke with were aware of the trust's incident reporting policies and processes. Staff reported incidents such as health and safety incidents, prescribing or medication errors, the use of seclusion or long-term segregation and incidents of aggression.

Adverse incidents were reviewed by ward managers and senior staff within the locality and service. Incidents were discussed within team meetings and at safety huddles. Governance forums monitored adverse incident reporting for trends and themes.

Forensic inpatient or secure wards

Managers debriefed and supported staff after any serious incident. Psychology teams led debrief sessions and provided regular reflective practice sessions for staff. Staff we spoke with who had been involved in incidents told us that they felt supported post incident.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations. Managers reviewed incidents and identified those that required further investigation. This took the form of a 72-hour review and if required comprehensive root cause analysis investigations. Managers we spoke with had received training in conducting investigations. There were governance processes in place to ensure investigations were reviewed and ratified. Processes were in place to monitor the implementation of identified actions.

Staff received feedback from investigation of incidents, both internal and external to the service. Staff met to discuss the feedback and look at improvements to patient care. Staff discussed the outcome of investigations in team meetings and one to one supervision sessions. Information on identified learning was also shared via email and in quarterly learning bulletins that were circulated to staff and available both on the ward and via the trust SharePoint system.

There was evidence that changes had been made as a result of feedback. Staff we spoke with gave examples of post incident improvements including in relation to the use of plastic handcuffs during patient transfer, the use of emergency contact numbers and the management of sensory items on learning disability wards.

Staff understood the duty of candour. They were open and transparent, and gave patients and families a full explanation if and when things went wrong. Incidents requiring duty of candour were flagged on the electronic system. Staff we spoke with understood the principles of duty of candour and were able to give examples where it had been implemented.

Is the service effective?

Good 

Our rating of effective stayed the same. We rated it as good.

Assessment of needs and planning of care

Staff assessed the physical and mental health of all patients on admission. They developed individual care plans which were reviewed regularly through multidisciplinary discussion and updated as needed. Care plans reflected patients' assessed needs, and were personalised, holistic and recovery-oriented. They included specific safety and security arrangements and a positive behavioural support plan.

Staff completed a comprehensive mental health assessment of each patient either on admission or soon after. We reviewed 40 clinical records during our inspection. Each record had a comprehensive and multi-disciplinary assessment in place. Assessments were holistic, completed in a timely manner and subject to regular review. In addition to nursing assessments patients were also assessed by the wider multi-disciplinary team including psychology, occupational therapy and where appropriate specialists such as speech and language therapists and dietitians.

Forensic inpatient or secure wards

All patients had their physical health assessed soon after admission and regularly reviewed during their time on the ward. We reviewed 40 clinical records. Each patient had a physical health assessment completed on, or soon after admission. Staff completed monthly physical health reviews as a minimum. Where patients required additional monitoring, for example due to medication or an existing physical health concern this was completed.

Staff developed a comprehensive care plan for each patient that met their mental and physical health needs. We reviewed 40 clinical records during our inspection. Each record contained a range of care plans covering treatment and needs identified through the assessment process. Patients had specialist care plans in place where appropriate, for example in relation to the risk of choking or the management of epilepsy. Care plans were generally personalised, holistic and comprehensive. Care plans demonstrated specialist input where appropriate, for example care plans developed with the reducing restrictive practices team. Where appropriate patients had positive behavioural support plans in place. Positive behavioural support plans we reviewed were collaborative in nature, comprehensive and subject to regular review.

Staff regularly reviewed and updated care plans when patients' needs changed. 38 of the 40 clinical records we reviewed had in date care plans. The remaining two care plans were due for review. Care plans were reviewed as a minimum of monthly or in response to an incident or change in circumstance. We saw examples where care plans had been reviewed and updated following incidents.

Best practice in treatment and care

Staff provided a range of treatment and care for patients based on national guidance and best practice. They ensured that patients had good access to physical healthcare and supported them to live healthier lives. Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives.

Staff provided a range of care and treatment suitable for the patients in the service. Staff delivered care in line with best practice and national guidance (from relevant bodies such as the National Institute for Health and Care Excellence). The service offered a range of interventions framed by a trauma informed approach and dependent upon patient need. This included psychological therapies such as cognitive behavioural therapy, psychotherapy, dialectical behaviour therapy and cognitive analytic therapy. The service had introduced a trauma informed approach since 2015 and had a division-wide commissioning for quality and innovation (CQUIN) target in relation to this.

Staff identified patients' physical health needs and recorded them in their care plans. Staff made sure patients had access to physical health care, including specialists as required. We reviewed 40 clinical records during our inspection. We found evidence that physical health concerns had been identified during initial and ongoing assessment processes. Records contained a range of specific care plans detailing the management of physical health concerns such as diabetes, epilepsy and asthma. Physical health care plans we reviewed were of a good quality, comprehensive and evidenced involvement of relevant physical health specialists. Patients had access to physical health care services including GPs, podiatry and physiotherapy. Patients had access to a nurse led health centre within the high secure services. Staff supported patients to attend external medical and hospital appointments as required. Wards ran monthly well-man or well-woman clinics.

Staff met patients' dietary needs, and assessed those needing specialist care for nutrition and hydration. Care records we reviewed showed evidence of the involvement of speech and language therapists and dietitians where appropriate. Care records demonstrated the use of tools such as the malnutrition universal screening tool (MUST) and fluid intake charts.

Forensic inpatient or secure wards

Staff helped patients live healthier lives by supporting them to take part in programmes or giving advice. Patients had access to gym facilities both on and off the ward. There were gym instructors who supported patients to use those facilities and worked with patients and staff to develop individual personal fitness programmes. Patients at Rowan View also had access to other exercise facilities including an indoor sports hall and an outside all-weather facility. Staff and dieticians supported patients around healthy eating and meal planning. The service provided nicotine replacement products to patients who required them.

Staff used recognised rating scales to assess and record the severity of patients' conditions and care and treatment outcomes. The service utilised mental health clustering as well as a range of specialist outcome measures dependant on the professional involved and the patient. These included psychological outcome measures such as the Becks depression inventory, the general anxiety disorder assessment and the goal attainment scale as well as occupational therapy assessments such as the health of the nation outcome scale and the occupational self-assessment tool. In addition, staff used tools such as the Liverpool university neuroleptic side effect rating scale to monitor medications side effects.

Staff used technology to support patients.

Staff took part in clinical audits, bench marking and quality improvement initiatives. There was a programme of audit at ward, divisional and trust level covering areas such as care planning, record keeping, infection control, medication, the involvement of carers and adherence to the Mental Health Act. In addition, staff completed peer quality review visits of wards. Managers used results from audits to make improvements. Action plans were developed from audit findings and shared through email, team meetings and supervision sessions. Delivery of action plans was monitored through the governance framework.

Skilled staff to deliver care

The ward team(s) included or had access to the full range of specialists required to meet the needs of patients on the ward(s). Managers made sure they had staff with the range of skills needed to provide high quality care. They supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.

The service had access to a full range of specialists to meet the needs of the patients on the ward. This included psychiatrists, psychologists, occupational therapists, social workers, speech and language therapists and a drug and alcohol practitioner. Specialists worked effectively and collaboratively with ward and nursing staff. In addition, patients and staff had access to specialist positive behavioural support and reducing restrictive practice practitioners.

Managers ensured staff had the right skills, qualifications and experience to meet the needs of the patients in their care, including bank and agency staff. At Rowan View there was an induction programme that covered both mental illness and learning disability awareness to help support staff who may mobilise between the wards.

Managers gave each new member of staff a full induction to the service before they started work. There was a full induction programme in place for new staff. The induction programme was two weeks long and ran monthly. The induction programme covered areas such as security and key management, trauma informed approach, supportive observations and positive behavioural support. The induction programme also included space for new staff to visit and orientate to their ward and to complete mandatory training within 28 days of taking post.

Managers supported staff through regular, constructive clinical supervision of their work. Staff we spoke with told us they had regular supervision. Supervision trees were in place and on display in ward office areas. At the time of our inspection the average ward compliance with supervision was 95%. Staff told us that they felt supported and were able to access advice when they required it. Formal supervision sessions were supported by regular thinking space and reflective practice sessions supported by psychology staff.

Managers supported staff through regular, constructive appraisals of their work. The service used the trust's PACE annual review process which aligned with the trust and wards vision and objectives. PACE allowed staff to reflect on what they had done well, how they had reflected the trust values and areas for development. At the time of our inspection the average ward compliance with annual appraisal was 93%. The 12-month monitoring period had not yet finished and ran until the end of 2022.

Managers made sure staff attended regular team meetings or gave information from those they could not attend. Team meetings were held monthly and generally facilitated by the ward manager or modern matron. Team meetings were used to update staff, share positive performance as well as lessons learnt and to review ward canvas documents.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Managers made sure staff received any specialist training for their role. Staff we spoke to had undertaken training around areas such as epilepsy, dual diagnosis, learning disabilities and dysphagia. We spoke to staff who had been supported to undertake nursing qualifications as well as health care degree and masters qualifications.

Managers recognised poor performance, could identify the reasons and dealt with these. Poor performance was managed in the first instance through supervision and enhanced support. Managers could access support from the trust human resources team. There were appropriate policies in place to support the management of poor performance and disciplinary procedures.

Multi-disciplinary and interagency team work

Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. The ward team(s) had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.

Staff held regular multidisciplinary meetings to discuss patients and improve their care. Staff held weekly multi-disciplinary reviews of each patient. We observed two multi-disciplinary reviews during our inspection. Reviews were well structured and considered all relevant information. Staff from relevant disciplines attended and discussions were multi-disciplinary in nature.

Staff made sure they shared clear information about patients and any changes in their care, including during handover meetings. We observed two handovers during our inspection. Handovers were well structured and covered relevant information. This included a review of each patient, activities, incidents and ward atmosphere. Identified tasks for the on-coming shift were allocated. The service completed handover audits to assure their quality.

Ward teams had effective working relationships with other teams in the organisation. There were pathways in place between relevant services. There were good links with trust-wide teams including infection control, safeguarding and human resources.

Forensic inpatient or secure wards

Ward teams had effective working relationships with external teams and organisations. Staff maintained contact with care co-ordinators, commissioners and other providers to share information and facilitate transfers. There were good links and pathways with other services including prisons and other mental health providers.

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

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and discharged these well. Managers made sure that staff could explain patients' rights to them.

Staff received, and kept up-to-date, with training on the Mental Health Act and the Mental Health Act Code of Practice and could describe the Code of Practice guiding principles. Staff we spoke with were knowledgeable about the Mental Health Act. They were able to discuss how the Mental Health Act was implemented on their ward and how the ward and service met the requirements of the Act.

Staff had access to support and advice on implementing the Mental Health Act and its Code of Practice. Staff knew who their Mental Health Act administrators were and when to ask them for support. There was a Mental Health Act administration team in place at divisional level that supported staff. Staff we spoke with were aware of the team and how to contact them. The service had clear, accessible, relevant and up-to-date policies and procedures that reflected all relevant legislation and the Mental Health Act Code of Practice.

Patients had easy access to information about independent mental health advocacy and patients who lacked capacity were automatically referred to the service. Advocacy services were advertised on each ward we visited and attended the ward regularly. We spoke with one advocate during the inspection who told us that ward staff were supportive and made referrals to the advocacy service when appropriate.

Staff explained to each patient their rights under the Mental Health Act in a way that they could understand, repeated as necessary and recorded it clearly in the patient's notes each time. Staff were sent reminders by the Mental Health Act administration team when rights were due to be read.

Staff generally made sure patients could take section 17 leave (permission to leave the hospital) when this was agreed with the Responsible Clinician and/or with the Ministry of Justice.

Staff requested an opinion from a Second Opinion Appointed Doctor (SOAD) when they needed to. Staff stored copies of patients' detention papers and associated records correctly and staff could access them when needed. We reviewed 40 care records during our inspection and found that patient's prescription charts and related mental health documents were present and up to date. Where appropriate staff had requested opinions from Second Opinion Appointed Doctors. Paperwork in relation to this was fully complete and stored with patient records for easy access and reference.

Care plans included information about after-care services available for those patients who qualified for it under section 117 of the Mental Health Act.

Managers and staff made sure the service applied the Mental Health Act correctly by completing audits and discussing the findings. As well as ward staff, staff from the Mental Health Act administration team completed audits.

Good practice in applying the Mental Capacity Act

Forensic inpatient or secure wards

Staff supported patients to make decisions on their care for themselves. They understood the trust policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly for patients who might have impaired mental capacity.

Staff received, and were consistently up to date, with training in the Mental Capacity Act and had a good understanding of at least the five principles. Staff we spoke with demonstrated a good understanding of the application of the Act in their day-to-day work with patients. They were able to describe each of the five principles that underpin the Act and give examples of how the Act had been used with individual patients.

There was a clear policy on the Mental Capacity Act and Deprivation of Liberty Safeguards, which staff could describe and knew how to access. Staff knew where to get accurate advice on the Mental Capacity Act and deprivation of liberty safeguards. Staff we spoke with told us policies were accessible on the trust intranet and support was available from service and trust Mental Capacity Act leads.

Staff gave patients all possible support to make specific decisions for themselves before deciding a patient did not have the capacity to do so. Staff assessed and recorded capacity to consent clearly each time a patient needed to make an important decision. Care records we reviewed included capacity assessments where concerns had been identified. Assessments were decision specific and subject to regular review. When staff assessed patients as not having capacity, they made decisions in the best interest of patients and considered the patient's wishes, feelings, culture and history. We saw examples of best interest decisions in the care records we reviewed. Best interest meetings and decisions were multi-disciplinary and where feasible included input from carers and family members. They were decision specific and subject to regular review.

The service monitored how well it followed the Mental Capacity Act and made changes to practice when necessary. Staff audited how they applied the Mental Capacity Act and identified and acted when they needed to make changes to improve.

Is the service caring?

Good

Our rating of caring stayed the same. We rated it as good.

Kindness, privacy, dignity, respect, compassion and support

Staff treated patients with compassion and kindness. They respected patients' privacy and dignity. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.

Staff were discreet, respectful, and responsive when caring for patients. Staff we spoke with discussed patients under their care with compassion and in a respectful manner. We observed staff discussing patients in a respectful manner in care reviews, multi-disciplinary meetings and handovers. Patients said staff treated them well and behaved kindly. We spoke with 34 patients and 11 carers during our inspection. The vast majority of patients and carers we spoke with were positive about staff. They reported staff were kind, caring and considerate. Three patients we spoke with told us there were individual staff they did not like or had issues with. We discussed this with the relevant ward managers who reported they were aware of issues or complaints that had been made and that these were being reviewed. Staff gave patients help, emotional support and advice when they needed it. Staff understood and respected the individual needs of each patient. Patients we spoke with gave examples of when staff had supported them when the patient was

distressed as well as examples of how staff had helped them to achieve objectives or goals. Patients generally described positive relationships with both nursing staff and wider members of the multi-disciplinary team such as occupational therapists and psychologists. They told us that staff showed a genuine interest in them and their well-being. However, although patient gave positive feedback about staff, staff attitude and staff support some patients on the Rowan View site felt that there were not always enough staff on the ward to respond promptly to requests. Some patients on the Rowan View site also told us that staff often changed and that they did not like the inconsistency in staffing.

Staff supported patients to understand and manage their own care treatment or condition. Patients were involved in discussions about their care and treatment in one-to-one sessions with their named nurse as well as in ward rounds and care reviews. Care plans we reviewed during the inspection demonstrated patient involvement and showed staff working with patients to develop care plans. Patients were able to discuss their medicines with their consultant and if required with a pharmacist. Patients had access to patient information leaflets around medicines as well as other aspects of care and treatment.

Staff directed patients to other services and supported them to access those services if they needed help. We saw examples of patients being referred into a third sector organisations that supported the development of personal skills and offered employment opportunities. We spoke with patients who were working towards a transfer to a different service or who were due to be transferred. They told us how staff had supported and reassured them during this process including providing information on, and facilitating visits to, onwards services.

Staff felt that they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients. Staff that we spoke to demonstrated an awareness of issues or concerns to be aware of and told us they would be confident to raise a concern if it was appropriate.

Staff followed policies to keep patient information confidential. Staff completed training around information governance and confidentiality. Conversations in rooms used for care reviews and one-to-one conversations could not be overheard in other rooms or the main ward corridor. Patient information within nurses offices was not visible through windows. Client records were stored securely, and computer systems were password protected.

Involvement in care

Staff involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided. They ensured that patients had easy access to independent advocates.

Involvement of patients

Staff introduced patients to the ward and the services as part of their admission. Patients we spoke with told us they had been orientated to the ward on admission or as soon as they were well enough to do so. Patients and carers we spoke with told us they had been provided with information on the ward and service as part of the admission process.

Staff involved patients and gave them access to their care planning and risk assessments. Care records we reviewed demonstrated that staff had sought to involve patients and carers in both the assessment and care plan processes. We saw evidence of patients helping to identify treatment or intervention goals and agreeing the support and actions required to achieve them. Care records demonstrated that patients had been offered copies of relevant documentation but it was not always clear that this had been accepted. Patients we spoke to were generally aware of the contents of their care plan and the objectives of their treatment. Some patients we spoke with told us they had copies of their care plan but others told us they did not want one.

Forensic inpatient or secure wards

Staff made sure patients understood their care and treatment (and found ways to communicate with patients who had communication difficulties). Staff working on learning disability wards had access to, and training in communication tools such as picture boards and easy read documentation.

Staff involved patients in decisions about the service, when appropriate. Patients could give feedback on the service and their treatment and staff supported them to do this. Patients had access to monthly patient tracker surveys which captured feedback on a range of key issues. Feedback form patients for each ward over the last three months was largely positive. Patients also had access to weekly community meetings on each ward. We reviewed minutes of four community meetings across three wards. Minutes demonstrated that patients were able to raise concerns at these meetings and that feedback on actions taken was provided.

Staff supported patients to make advanced decisions on their care.

Staff made sure patients could access advocacy services. Advocacy services were advertised on each ward. Patients we spoke with were aware of the independent advocate that visited their ward. We spoke to one independent mental health advocate during our inspection. They told us that staff promoted their service on the wards and completed referrals for patients when required. They told us that staff were generally supportive and responsive to issues that they raised.

Involvement of families and carers

Staff informed and involved families and carers appropriately.

Staff supported, informed and involved families or carers. We spoke with 11 carers during our inspection. Carers that we spoke with told us they were involved in decisions about the care of their loved one. They told us that staff kept them informed about their loved one and notified them if they had been involved in any incidents, had a change in presentation or were subject to restrictions such as long-term segregation or seclusion. Carers told us that staff would return calls and were responsive but that sometimes it could take a while to get a return call dependent upon staff capacity.

Staff helped families to give feedback on the service. Carers and family members were able to complete satisfaction surveys. The service was part of the triangle of care project. Triangle of care is a national initiative originally launched on acute mental health wards that focuses on the principle of carers, patients and staff working in equal partnership. It encourages carer participation and the development of processes and forums for their involvement. Wards had completed triangle of care self-assessments and developed action plans from the findings. The secure division (including high secure services) had a carers lead in place to support carers and the carers agenda.

Staff gave carers information on how to find the carer's assessment. Each ward had an allocated social worker who led on carer liaison, provided advice around their and their loved ones rights under the Mental Health Act and completed referrals for carers assessments.

Is the service responsive?

Good 

Forensic inpatient or secure wards

Our rating of responsive stayed the same. We rated it as good.

Access and discharge

Staff planned and managed patient discharge well. They worked well with services providing aftercare and managed patients' moves to another inpatient service or to prison. As a result, patients did not have to stay in hospital when they were well enough to leave.

Bed management

Managers regularly reviewed length of stay for patients to ensure they did not stay longer than they needed to. Excluding the single occupancy individual package of care houses, bed occupancy across the wards between June 2022 and November 2022 was 85%. Individual package of care houses were single occupancy houses where patients were supported by staff.

The service had no out-of-area placements. Since 1 November 2021 NHS England had devolved commissioning of low and medium secure services to Mersey Care. The trust worked collaboratively with commissioners and other local providers to manage the regional secure bed base as a single stock to improve patient flow and avoid out of area placements where possible.

Managers and staff worked to make sure they did not discharge patients before they were ready. Discharge planning began on admission and was carried out collaboratively with the patient and other stakeholders. Discharge and discharge plans were reviewed and updated on a regular basis. Staff had policies and procedures to support them with facilitating discharge

Patients were moved between wards only when there were clear clinical reasons or it was in the best interest of the patient. During our inspection we saw examples of patients having been moved appropriately between wards due to safeguarding concerns.

Staff did not move or discharge patients at night or very early in the morning. Discharge was planned in advance and took place at a time agreed with the patient.

Discharge and transfers of care

Managers monitored the number of patients whose discharge was delayed, knew which wards had the most delays, and took action to reduce them. At the time of our inspection there were 12 delayed discharges across the wards. In general, patients did not have to stay in hospital when they were well enough to leave. However, staff we spoke with told us that delays could occur due to a lack of community or onward provision or Ministry of Justice restrictions

Staff carefully planned patients' discharge and worked with care managers and coordinators to make sure this went well. Care records we reviewed evidenced a collaborative approach to planning and facilitating discharge. Discharge plans were reviewed and updated in ward rounds and multi-disciplinary meetings.

Staff supported patients when they were referred or transferred between services. This included the provision of information and also one to one work with members of the multi-disciplinary team including psychology to help address patients concerns or uncertainty. The service followed national standards for transfer.

Forensic inpatient or secure wards

Facilities that promote comfort, dignity and privacy

The design, layout, and furnishings of the ward supported patients' treatment, privacy and dignity. Each patient had their own bedroom with an en-suite bathroom and could keep their personal belongings safe. There were quiet areas for privacy. The food was of good quality and patients could make hot drinks and snacks at any time.

Each patient had their own bedroom, which they could personalise. We saw examples on every ward we visited where patients had personalised their bedrooms with photographs, artwork and personal belongings. Patients had a secure place to store personal possessions.

The service had a full range of rooms and equipment to support treatment and care. Staff and patients could access the rooms. Where rooms were locked or subject to supervised access this had been assessed as a potential restrictive practice and appropriately care planned. Patients had access to lounge areas, quiet rooms, activity rooms and games rooms. Patients at Rowan View had access to shared facilities including a sports hall and all-weather outdoor pitch. Rowan View also had an immersive sensory room. However, this was not in operation. We discussed this with senior managers who were able to explain that this was due initially to COVID restrictions, the need to have the system rebooted and conforming with infection control requirements. Work was ongoing to ensure that the immersive room could be opened.

The service had quiet areas and a room where patients could meet with visitors in private. Visiting arrangements were individually assessed and where appropriate patients could meet visitors in off ward café areas within the building.

Patients could make phone calls in private. Wards had telephone rooms. Patients also had access to a 'kiosk' in their bedrooms. The kiosk was a computer based system that allowed patients to make phone calls to a list of pre-approved numbers as well as accessing agreed websites for shopping purposes.

The service had an outside space that patients could access easily Outdoor spaces were well maintained.

Patients could make their own hot drinks and snacks and were not dependent on staff. Each ward had a drinks station that patients could access. There were also additional kitchen areas that could be accessed with staff

Patients' engagement with the wider community

Staff supported patients with activities outside the service, such as work, education and family relationships.

Staff made sure patients had access to opportunities for education and work, and supported patients. The service worked with a third sector organisation to provide access to volunteering roles and support opportunities for further education and paid employment. At Rowan View we spoke with patients who had been volunteering at the on-site café.

Staff helped patients to stay in contact with families and carers. Patients were able to contact their families via phone or the 'kiosk' within their bedrooms. Staff supported patients where required. Families and carers were invited to care review meetings where appropriate.

Staff encouraged patients to develop and maintain relationships both in the service and the wider community. Staff worked one to one with patients where support was needed. Patients had access to the community through agreed section 17 leave.

Forensic inpatient or secure wards

Meeting the needs of all people who use the service

The service met the needs of all patients – including those with a protected characteristic. Staff helped patients with communication, advocacy and cultural and spiritual support.

The service could support and make adjustments for disabled people and those with communication needs or other specific needs. All wards were accessible to patients with mobility needs and included appropriate facilities such as adapted bathrooms.

Staff made sure patients could access information on treatment, local service, their rights and how to complain. Information was displayed in communal areas on the wards. Additional leaflets were available and staff also provided verbal information as required.

The service had information leaflets available in languages spoken by the patients and local community. Information on display within wards was predominately in English. However, staff had access to translation services that could provide translated versions of documentation and information leaflets as required. Managers made sure staff and patients could get help from interpreters or signers when needed. The same translation services could provide translators either in person or via telephone or video link. Staff we spoke with knew how to access translation services and told us they were responsive to requests. We saw examples of where translation services had been used to support patients or carers whose first language was not English or who were unable to converse to the required level in English.

The service provided a variety of food to meet the dietary and cultural needs of individual patients. This included appropriate meals for those who were vegetarian or vegan or who suffered from specific food intolerances. The service provided culturally appropriate meals such as halal meat

Patients had access to spiritual, religious and cultural support. There was a chaplaincy service that offered a range of religious and spiritual support. Patients had access to multi-faith rooms and items such as holy books for different religions and prayer mats. Staff captured patients spiritual and cultural information and needs during the assessment process and from ongoing reviews..

Listening to and learning from concerns and complaints

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and wider service.

Patients, relatives and carers knew how to complain or raise concerns. Staff protected patients who raised concerns or complaints from discrimination and harassment. Patients and carers we spoke to told us they would not have any concerns about raising a complaint if they felt it was necessary. Most patients and carers we spoke with told us they would raise a concern with the ward manager in the first instance. The service clearly displayed information about how to raise a concern in patient areas. Wards displayed posters advertising the advocacy service, trust patient advice and liaison service and the trust complaints team. There were also posters advising patients how to contact the Care Quality Commission

Staff understood the policy on complaints and knew how to handle them. Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. Staff would attempt a local

resolution as a first step and move to a formal complaint if this was unsuccessful. Staff knew how to contact the trust complaints team and how to support patients to do so. Patients and carers who complained received feedback in the form of a formal response letter and a face to face meeting if requested. The complaints response letter included information on what they should do if they were unhappy with the outcome.

Managers investigated complaints and identified themes. Formal complaints were managed by the trust complaints team and investigated by a manager independent of the ward. Managers had been trained to complete complaint investigations. The findings of completed complaint investigations were reviewed within the division's governance structure and analysed for themes. Managers shared feedback from complaints with staff and learning was used to improve the service. Feedback from complaints was shared with staff in one to one meetings and supervision. Findings and recommendations from complaints were discussed within team meetings.

The service used compliments to learn, celebrate success and improve the quality of care.

Is the service well-led?

Good 

Our rating of well-led stayed the same. We rated it as good.

Leadership

Leaders had the skills, knowledge and experience to perform their roles. They had a good understanding of the services they managed and were visible in the service and approachable for patients and staff.

Leaders within the service had the skills, knowledge and experience to perform their roles. They were able to describe how the teams were working to provide high quality care. Leaders we spoke with demonstrated an excellent understanding of the patient group they cared for and were able to identify challenges the service faced as well as discuss plans to address those challenges.

Staff we spoke with told us that senior managers within the service were visible, approachable and supportive. Managers had helped to make up staffing numbers on wards during staff shortages and were a regular presence in ward areas.

Staff and leaders had access to specialised training, development and leadership courses. The trust ran a range of course depending on the staff members position and banding. Ward managers we spoke with told us they felt supported in their development.

Vision and strategy

Staff knew and understood the provider's vision and values and how they (were) applied to the work of their team.

Forensic inpatient or secure wards

Staff knew and understood the provider's vision and values and how they applied to their ward. Staff we spoke with were able to describe the trust's vision of striving for perfect, whole-person care that helped people live happier, healthier lives. Staff were able to describe the trust's values and how they fitted into this vision and their own work on their ward. The trust's values were centred around continuous improvement, accountability, respect, enthusiasm and support. Information on the trust's vision and values was displayed on each ward.

Staff on each ward had developed a 'team canvas'. Team canvas' identified the purpose and objective of the ward as well as how these could be achieved and reviewed. They provided a framework for implementing the trust's vision, strategy, objectives and culture from board to ward. The document was regularly reviewed and provided a team space to consider what wasn't going as expected and to replicate and maximise what was. Staff we spoke with were able to describe and discuss their team's canvas as well as their input into it.

Culture

Staff felt respected, supported and valued. They said the trust promoted equality and diversity in daily work and provided opportunities for development and career progression. They could raise any concerns without fear.

Staff we spoke with felt respected, supported and valued. Although staff discussed the pressures of staffing they spoke positively about the trust, the secure division and senior management. Staff appraisals and supervision included conversations about career development. Several staff members we spoke with had undertaken additional training, qualifications or carer development opportunities.

Staff felt empowered and supported to do their job. Staff had access to an employee assistance service for additional support. Staff felt able to raise concerns without fear of reprisal. Staff described an open and honest culture. They felt managers were supportive and approachable.

There was an embedded culture of quality improvement and staff felt empowered to suggest improvements or changes to the service and felt managers were receptive to ideas.

Staff teams worked well together. There was strong collaboration, team-working and support across wards, locations and clinical pathways. Staff spoke positively about their colleagues at ward, location and divisional levels. They described collaborative team working and a supportive environment. There were good relationships with managers and senior staff within the multidisciplinary team. There were no cases of bullying or harassment reported.

We saw no evidence of a closed culture at the service. Managers we spoke with were aware of the risk of closed cultures and were able to discuss actions they took to mitigate those risks. This included senior managers being a regular presence on the wards, regular peer to peer and external reviews of wards, the mixing of staff through planned staff rosters and the promotion of the Trust's whistleblowing and Freedom To Speak Up Guardian processes.

Governance

Our findings from the other key questions demonstrated that governance processes operated effectively at team level and that performance and risk were managed well.

Our findings from the other key questions demonstrated that governance processes operated effectively at service level.

Forensic inpatient or secure wards

There was an effective governance structure in place at ward, location and divisional levels. Performance and risk were managed well. There were processes in place to monitor the safety and quality of premises, equipment and the delivery of care and treatment. Staff discussed incidents, performance, risk and quality improvement in governance meetings. There was a clear framework of what was to be discussed in meetings at all levels and processes to escalate concerns and inseminate feedback. Action plans were monitored and delivered.

Managers had effective oversight of the service and performance. They had access to different performance dashboards and data to support decision making and service development. Despite staffing pressures managers ensured wards met safe staffing levels and that patient care was prioritised. Managers promoted quality improvement and ensured relevant learning from incidents and complaints was shared with staff and used to generate service improvement.

Staff were well supported and had access to regular supervision and appraisal. The service supported staff's professional development. Staff had access to a suite of policies and procedures to support them in their work. Policies and procedures were appropriate and up to date.

Staff understood the arrangements for working with other teams, both within the provider and externally. The service submitted data and appropriate notifications to external bodies when required.

Management of risk, issues and performance

Teams had access to the information they needed to provide safe and effective care and used that information to good effect.

There was a strong commitment to best practice performance and risk management with problems identified and addressed quickly and openly. There was a clear quality assurance and performance framework in place. Managers had access to up-to-date performance data.

The service had a risk register and improvement plans. Staff were able to raise issues for inclusion on the risk register. Staff concerns matched those on the risk register. Managers we spoke with demonstrated a good understanding of the risks the service faced and could describe actions in place to mitigate them. Managers discussed and monitored risk during safety huddles and risk was regularly discussed at clinical governance meetings.

The service had a positive culture of continuous improvement. Each ward had quality improvement plans and projects in place. Learning around best practice and service development was disseminated across all wards.

The service had plans for emergencies such as adverse weather, loss of information technology systems or closure of premises. The service had managed its response to the Covid-19 pandemic to minimise disruption to the service and patients.

Information management

Staff collected analysed data about outcomes and performance and engaged actively in local and national quality improvement activities.

Staff had access to the information they needed to provide safe and effective care and used that information to good effect. The service used systems to collect data from wards, which were not onerous for front line staff. Managers had access to performance data that enabled them to support the service and identify areas for improvement.

Staff had access to the equipment and information technology needed to do their work. Electronic documents were password protected. Paper records were stored securely. Staff followed policies and procedures to protect patient confidentiality.

Engagement

Managers engaged actively with other local health and social care providers to ensure that an integrated health and care system was commissioned and provided to meet the needs of the local population. Managers from the service participated actively in the work of the local transforming care partnership.

Staff, patients and members of the public had access to up to date information. Information was available via the trust's website and social media channels. Information was also displayed on site.

Staff attended regular meetings at all levels and information was also shared via email and through lessons learnt bulletins, quality practice alerts and blogs by senior trust staff.

Patients and carers could give feedback on the service by completing surveys or through community meetings and ad-hoc groups. Staff could give feedback on the service through a staff survey and during supervision sessions and learning events.

The service worked closely and collaboratively with other local providers. Since 1 November 2021 the trust had assumed responsibility for commissioning low and medium secure services within the North West. The trust and service worked with other providers, stakeholders and commissioners to manage the regional bed base as a single stock.

Learning, continuous improvement and innovation

The service had an embedded and systematic approach to improvement and was committed to learning, continuous improvement and innovation. There was evidence of learning from when things had gone wrong. Shared learning was disseminated through the governance structure.

The service identified learning and improvement opportunities through adverse incident and complaint investigations, audits and staff and client feedback. Managers developed action plans which were monitored through the governance framework.

Each ward had quality improvement projects in place and were supported by the trust's Perfect Care team in developing and delivering quality improvement projects. Examples we saw on inspection included projects to reduce the use of observation, the piloting of nurse led positive behavioural support formulation and the development of sensory boxes.

Acute wards for adults of working age and psychiatric intensive care units

Requires Improvement ↓

Is the service safe?

Requires Improvement ↓

Our rating of safe went down. We rated it as requires improvement.

Safe and clean care environments

All wards were safe, clean well equipped, well furnished, well maintained and fit for purpose.

Safety of the ward layout

Staff in most locations completed and regularly updated thorough risk assessments of all wards areas, and removed or reduced any risks they identified. During the inspection we reviewed both environmental and ligature risk assessments. These were generally well written. Staff on most of the wards we visited knew about any potential ligature anchor points and mitigated the risks to keep patients safe. For example, all staff conducting observations were able to tell us what and why they were conducting observations.

On most wards, staff knew about any potential ligature anchor points and mitigated the risks to keep patients safe. We saw staff on static observation points such as communal areas to mitigate known ligature anchor points. However, on one ward Windsor House there was an alcove in the garden not directly observable. Within the ward ligature assessment this was mitigated by staff observing CCTV within the nurse's station and being staffed or locked when not in use. We observed incidents where staff were either not in the office or in the office but not observing the CCTV. We also saw that patients had free access to the garden area and saw patients in the garden without staff. When this was pointed out managers immediately placed a static observation point within the garden area and increased the staff numbers to reflect the increase in observation points. There had been no incidents of self harm at Windsor House relating to this area.

Staff had completed fire risk assessments for all buildings, and there were fire evacuation plans specific to each ward. All patients that needed them had personal emergency evacuation plans (PEEP) in place.

In all but one ward, Windsor House, staff could observe patients in all parts of the wards. Where this was not possible, parabolic mirrors were placed in bedrooms and communal areas so staff could view areas not possible to observe by direct line of sight. All patients not on close observations were observed every hour to ensure their safety.

The core service had five mixed sex wards and four wards with dormitory accommodation. Two of the mixed sex wards also contained dormitories. The other mixed sex wards complied with national guidance.

Each dormitory contained only male or female patients and we saw staff stationed on static observation points to ensure safety. We looked at incidents across the service and could find no increase in incidents on the mixed sex or dormitory wards. We reviewed one incident of a male patient behaving inappropriately towards a female after admission and they were immediately transferred to an all-male ward. Patients on all five mixed sex wards told us they felt safe.

Staff had easy access to alarms and patients had easy access to nurse call systems. All bedrooms were fitted with alarms. Staff always carried personal alarms on them.

Maintenance, cleanliness and infection control

Most ward areas were clean, well maintained, well furnished and fit for purpose. There was a mixture of accommodation from newly designed and modern buildings to older adapted accommodation. All wards were well furnished with furniture that was well maintained and fit for purpose.

However, we found that the environment was in a poor state of repair at Windsor House. This was a standalone ward in a large Victorian style house, which meant there were no other resources close by to support the ward quickly if needed. The trust had a standalone unit protocol in place to manage admissions that present with increased risk.

We found that maintenance standards had not been maintained to the standards we found elsewhere. The ward had not been decorated for several years. Walls needed repair with plaster missing and doors had paint missing from constant use. We saw skirting boards in communal areas which were rotten in places. We raised our concerns and were told the ward was having new anti-ligature alarms fitted to doors and we saw evidence that a full refurbishment of the ward was planned to commence shortly after our visit.

Clock View Hospital was a newly designed building with a staff car park in between it and a busy main road. If you stood in the staff car park, to which the public had access, you could clearly see into the hospital wards through large windows and see through them into the green exercise areas. There was no privacy screen on the glass preventing people on the outside seeing into the wards. None of the rooms were in use and staff had failed to draw blinds to protect the privacy and dignity of patients.

Staff made sure cleaning records were up-to-date and the premises were clean. We reviewed cleaning rotas and spoke with cleaning staff; they were able to show us up to date and comprehensive records. During the inspection we saw continuous cleaning activity, and patients told us that the wards were always clean and tidy, especially bathrooms and eating areas.

Staff followed infection control policy, including handwashing. The trust's COVID-19 policy did not include wearing face masks at the time of inspection; however, some staff were still wearing them as a personal choice.

Seclusion room

The seclusion rooms allowed clear observation and two-way communication. They had a toilet and a clock. The viewing panel in the seclusion room door permitted staff to carry out observations. The taps in the sink of the seclusion suites were anti-ligature. Strong seclusion type mattresses, which afforded comfort especially during longer periods of seclusion, were used in each seclusion room.

Seclusion rooms were not used for any other purpose and were ready to be used.

Clinic room and equipment

Clinic rooms were fully equipped, with accessible resuscitation equipment and emergency drugs that staff checked regularly. All wards had their own clinic rooms, some had an additional room just for physical observations. All wards had equipment and space to undertake physical observations, venepuncture and electrocardiogram monitoring.

Medication cupboards were not over-stocked and medication was in date. Emergency drugs were available and within date. Oxygen and resuscitation equipment, including defibrillators, were all maintained and recently checked.

Staff checked, maintained, and cleaned equipment. Clinics were clean, tidy, and equipment requiring calibration had stickers to show when it was last checked. Sharps boxes were all in date, and not overly full.

Safe staffing

The service did not have enough nursing and medical staff with high vacancy rates in particular for nurses.

Nursing staff

The service did not have enough nursing and support staff due to high vacancy and sickness rates, but managed staffing to ensure patients were kept safe.

The trust followed national guidance to establish safe staffing levels. Managers calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants for each shift. The ward manager could adjust staffing levels according to the needs of the patients. Each location held daily safety huddles to assess staffing on each unit and consider any shortfalls. This enabled management at the locations to move staff where necessary or request additional staff to attend.

The service had high vacancy rates. The service had 617.61 whole time equivalent posts and 104.27 equivalent vacancies. This was a vacancy rate of 16.88%. Nursing vacancies were high, there was a working time equivalent of 198.37 posts with 51.5 vacant, meaning the vacancy rate for nurses was 26%. Weaver ward was carrying six and a half vacancies, Grasmere six and Newton five vacancies.

Managers supported staff who needed time off for ill health. However, sickness was high with an average sickness rate across all wards of 11% at the time of inspection. Sickness rates were above 20% on Harrington, Morris, Pine and Windsor wards.

Staff told us that they had vacancies but felt they were coping. We saw that modern matrons and clinical leads were covering wards and were included in staff numbers. Staff were creative with the rotas to ensure there was always enough staff on duty to meet safe staffing levels. The trust recorded through datix if wards were below safe staffing levels and no incidents had been recorded. The trust also reported it as a never event if a shift started without a qualified nurse, which had not happened. However, on one ward we visited the nurse in charge was still in their preceptorship although there was a clinical lead nurse supervising them on the ward.

The service had high rates of bank and agency nurses and nursing assistants. Managers prepared rotas and then requested bank and agency staff to cover for either extra duties such as additional observations or cover for leave. A central team then tried to fill those vacancies with bank or agency staff. Shifts they could not fill were then sent back to managers who filled them by using staff from different sites, modern matrons or clinical governance leads or approaching staff directly to work overtime.

Acute wards for adults of working age and psychiatric intensive care units

Despite having vacancies and some high levels of sickness the trust monitored how many shifts were filled per ward, which roles either qualified and non-qualified were filled, and which shifts were covered either days or nights. Overall, the service had a 93.17% fill rate for qualified staff and 117.33% fill rate for non-qualified staff. The trust target was 90%. The trust had filled extra shifts with health care assistants to support nursing staff. Out of the 17 wards only one did not have a fill rate over 100% for non-qualified staff.

We cross referenced the fill rate data with incident, rapid tranquilisation and seclusion data and could find no correlation to wards that had reported lower fill rates. Patients mostly told us that activities or leave were not cancelled and advocates told us patients were not complaining about activities and leave being cancelled. We saw activities taking place, as well as patients going on leave and community assessments.

Managers requested bank and agency staff familiar with the service. Managers made sure all bank and agency staff had a full induction and understood the service before starting their shift. The bank staff we spoke with told us they were regulars on the ward and when questioned about patient need, they could answer questions about risk and patient preference.

The service had low turnover rates. There were very low turnover rates, nearly every ward had maintained the same staff over the last six months.

Patients had regular one to one session with their named nurse. We saw patients who confirmed they spoke to their named nurse and we saw patients who had copies of their care plans in their bedrooms.

Patients rarely had their escorted leave or activities cancelled, even when the service was short staffed. We saw that other staff such as Occupational Therapists, their assistants and activity co-ordinators escorted patients on leave. We did not see these being cancelled. There was only one recorded incident on datix where leave had been cancelled due to staff shortage.

The service had enough staff on each shift to carry out any physical interventions safely. The service had low levels of restraint with 1252 incidents over 12 months.

Staff shared key information to keep patients safe when handing over their care to others. Staff attended huddles at the start of each shift to ensure they were aware of the current key information in relation to each patient on the relevant ward. Staff were well briefed with a daily briefing note and a risk register for each patient. Staff completing patient observations were given a document which outlined the risk each patient presented and how they could recognise triggers and action to take that supported the patient.

Medical staff

The service had enough daytime and night-time medical cover and a doctor available to go to the ward quickly in an emergency. We reviewed eight seclusion records and found that doctors had been available to conduct medical reviews at the right time.

Managers could call locums when they needed additional medical cover.

Managers made sure all locum staff had a full induction and understood the service before starting their shift.

Mandatory training

Acute wards for adults of working age and psychiatric intensive care units

Staff told us they had completed and kept up to date with their mandatory training. The trust recorded training in six different categories.

Core mandatory training which included fire safety, infection control and safeguarding. The trust had a 95% target and 96.6% of staff had completed the training.

Mandatory data security awareness which included information governance. The trust had a 95% target and 95.9% of staff had completed the training.

Role specific mandatory training which included life support, breakaway and higher levels of safeguarding training. The trust target was 90% and 90.2% of staff had completed the training.

Core service training for the mental health division which included mental health act training, medicines and suicide prevention awareness. The trust target was 90% and 92.9% of staff had completed the training.

There was also a continuing professional development category which included dementia and learning disability training. The trust target was 90% and 98.9% of staff had completed the training.

New training courses were recorded separately. There were two new courses, freedom to speak up for senior managers (57.3%) and search training (78.7%) with a target of 95%. These were ongoing courses for which staff were allocated training dates in the near future.

Assessing and managing risk to patients and staff

Staff assessed and managed risks to patients and themselves well and followed best practice in anticipating, de-escalating and managing challenging behaviour. Staff used restraint and seclusion only after attempts at de-escalation had failed. The ward staff participated in the provider's restrictive interventions reduction programme.

Assessment of patient risk

We reviewed 92 care records. Staff completed risk assessments for each patient on admission, using a recognised tool, and reviewed this regularly, including after any incident. Out of the 92 records we found two that had risk assessments that had not been updated after incidents, both were on Brunswick ward. Other risk assessments on Brunswick ward had been updated. On other wards we saw good examples of incident management which included de-briefs with patients and changes in observation practice individualised to the patient's risk.

Staff used a risk assessment tool, a Risk Assessment Management Plan (RAMP) to assess patient risk. Patients also completed their own 'My Safety Plan' within which each patient identified their own triggers and early warning signs. It also included positive goals for the future.

Management of patient risk

Staff knew about any risks to each patient and acted to prevent or reduce risks. All staff we spoke with could identify what risks each patient presented. When conducting general observations, staff carried a folder within which was an individualised profile of each patient.

Staff were aware of least restrictive practice and applied blanket restrictions on patients' freedom only when this was justified. Each ward had some items that were not allowed on the ward, but many items were individually risk assessed.

Staff identified and responded to any changes in risks to, or posed by, patients. Staff also received a risk briefing at the start of each shift and there was also a morning huddle where risk was reviewed. We saw evidence of levels of observation being changed to reflect the current needs of each patient.

Staff could not observe patients in all areas of the wards but followed procedures to minimise risks where they could not easily observe patients, including through individually risk assessed patient observations and placement of mirrors.

Staff followed trust policies and procedures when they needed to search patients or their bedrooms to keep them safe from harm. There was an intelligence led approach to searching patients' rooms.

Use of restrictive interventions

Levels of restrictive interventions were low across the service.

Staff made every attempt to avoid using restraint by using de-escalation techniques and restrained patients only when these failed and when necessary to keep the patient or others safe. This service had 1252 incidences of restraint between October 2021 – November 2022, with 37 instances of prone restraint. The incidents of prone restraint were spread evenly across the service. Managers told us that restraints could occasionally result in prone restraint being used unintentionally, for example if a patient manoeuvred into this position, but that staff were not trained in, and did not use prone restraint intentionally. If prone restraint did happen during a restraint staff were required to record this as part of an incident so it could be reviewed.

Sheridan ward had the highest incidents of restraint (265) and rapid tranquilisation (179) with the second highest seclusion rate (38). However, these incidents were clustered from February 2022 when they accepted a new patient. In September and October 2022 these rates had fallen to 12 restraints, three rapid tranquilisation incidents and no seclusions.

Staff participated in the provider's restrictive interventions reduction programme, which met best practice standards. Staff told us managers encouraged them to use least restrictive interventions with patients. We reviewed 16 incidents of restraint. Staff made every attempt to avoid using restraint by using de-escalation techniques and restrained patients only when these failed and when necessary to keep the patient or others safe. All staff we interviewed said that restraint was rare, and patients confirmed that incidents of restraint were rare. Staff told us they used verbal de-escalation techniques and that this was very effective. As a result of the restrictive interventions reduction programme we saw staff make positive decisions not to place restrictions on patient, for example we saw very few patients were on 1:1 observation.

Staff followed National Institute for Health and Care Excellence (NICE) guidance when using rapid tranquilisation. From October 2021 to November 2022, there had been 228 incidents of rapid tranquilisation, with 179 of them on one ward due to an acutely unwell patient. We found that physical health checks were being completed after each incident, but in one record we saw that one check had not been completed.

When a patient was placed in seclusion, staff kept clear records and followed best practice guidelines. There were 282 incidents of seclusion between October 2021 and November 2022. We examined the last eight incidents and we found that staff completed observations correctly and used the trust seclusion booklet to record all activity. In all but one record, two nurses completed reviews when required to do so and, in all records doctors completed their reviews in time.

There were no incidents of long-term segregation at the time of inspection.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Staff received training on how to recognise and report abuse, appropriate for their role. The trust had a target for 95% of staff to receive safeguarding training. There was training for safeguarding level one for adults (97.9% had completed this training) and children (98.1%). There was further training for staff who required a greater knowledge with 94.6% completing level two and three for adults and 97.3% for safeguarding children level two and 93.7% for safeguarding children level three.

Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them. Staff discussed any incidents in the previous 24-hours at daily safety huddles to ensure all safeguarding concerns were captured and reported. From December 2021 to October 2020 staff had made 61 safeguarding referrals.

Staff followed clear procedures to keep children visiting the ward safe. All sites had a specific visiting room which was available to book for visits with children which were separate from the wards.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Teams included staff who were safeguarding leads on the ward and acted as links between the ward and trust safeguarding team. Staff told us they felt confident to raise and report concerns and could give us examples of where they had done so.

Staff access to essential information

Staff had easy access to clinical information and it was easy for them to maintain high quality clinical records – whether paper-based or electronic.

Patient notes were comprehensive and all staff could access them easily. The trust had completed an acquisition of another trust in 2021, but all wards were using the same electronic record keeping system. All wards were using bank and agency staff, but we saw that these staff had access to the system and training on how to use it.

When patients transferred to a new team, there were no delays in staff accessing their records. All staff could access the trust computer systems and all records were stored securely.

Medicines management

The service used systems and processes to safely prescribe, administer, record and store medicines. Staff regularly reviewed the effects of medications on each patient's mental and physical health.

Acute wards for adults of working age and psychiatric intensive care units

Staff followed systems and processes to prescribe and administer medicines safely, in most cases. The service had an electronic system for prescribing and administering medicines and a contingency plan was in place if there were any IT issues that meant that this couldn't be used. There were systems in place for staff to get medicines prescribed including in an emergency and out of hours and emergency stock was available. Staff stored and managed all medicines and prescribing documents safely. Pharmacy staff attended the wards at regular intervals to ensure stock was managed appropriately and available when needed.

Staff reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines. Pharmacists attended the wards when required and met with patients to discuss and provide information around medicines. This included leaflets in easy read formats and different languages.

Staff completed medicines records accurately and kept them up-to-date. Of 25 records we reviewed for allergy information, we found that two did not contain accurate allergy information. Neither patient had been negatively affected by this and the trust took immediate action when we made them aware. This meant there was a risk that people could be prescribed medicines that they had previously reacted too. Records for people prescribed valproate who were of childbearing age did not always show that the requirements of the pregnancy prevention programme (MHRA drug safety update April 2018) had been met. The trust had begun to audit this and had identified this is an area for improvement and were working towards this.

Staff stored and managed all medicines and prescribing documents safely. Medicines were mostly safely administered. However, on one record we found that a medicine with a minimum required time between repeated doses, was given too closely together. We found they received too many doses in a day. We immediately raised this during the inspection in order that steps could be taken to monitor and address this. The trust did an immediate audit to assure itself this was an isolated incident.

Staff followed national practice to check patients had the correct medicines when they were admitted or they moved between services. Trust data showed that medicines reconciliation (admission medicines checks) across all wards inspected were at least 99% over the previous 3 months. However, we found that on one instance a prescribing error had occurred at the point of return to the ward from a medical service. This was immediately highlighted to a nurse during the inspection and rectified.

Staff learned from safety alerts and incidents to improve practice. We saw that safety alerts were sent to staff and that staff discussed these on daily briefing.

The service ensured people's behaviour was not controlled by excessive and inappropriate use of medicines.

Staff reviewed the effects of each patient's medicines on their physical health according to NICE guidance. We found that for patients prescribed medicines that required ongoing monitoring, this was carried out. However, for one person the physical observation records were incomplete for two days during the titration period of a medicine.

Track record on safety

The service had a good track record on safety.

Reporting incidents and learning from when things go wrong

Acute wards for adults of working age and psychiatric intensive care units

The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

Staff knew what incidents to report and how to report them. Incidents and concerns for safety were raised in the daily morning huddle to ensure incidents were reported appropriately.

Staff reported serious incidents clearly and in line with trust policy. The service reported 31 serious incidents between November 2021 to October 2022, 11 of which had been fully investigated and signed off by senior managers with actions agreed. Seven reviews were ongoing in partnership with the Integrated Care Board (ICB) and 13 were closed at 72-hour review stage in line with trust policy. Incidents involved allegations against staff, a media interest incident, damage, ligatures, absent without leave (AWOL), a patient under 18 being admitted and one patient requiring treatment at urgent care.

The service had no never events on any wards.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong. Out of the 31 serious incidents, the duty of candour threshold was met 21 times. We examined serious incidents and could see the trust had appropriately written to those involved fulfilling its obligations.

Managers de-briefed and supported staff after any serious incident. The service had developed 'seven minute' briefings which briefed staff on incidents and the learning from those incidents.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations. Patients told us they were given feedback when they complained and that they were aware how issues they had raised were resolved.

Staff received feedback from investigation of incidents, both internal and external to the service as well as looking at improvements to patient care. Staff told us they discussed incidents not only in team meetings but also as soon as practicable after incidents.

There was evidence that changes had been made as a result of feedback. Following incidents of ligatures over bathroom doors, the trust had changed all en-suite doors and was installing door top alarms. New guidance about the use of outdoor space and two staff accompanying those with an AWOL risk had been introduced. New safety huddles were created with staff given guidance on weekly reviews of care plans.

Is the service effective?

Requires Improvement ↓

Our rating of effective went down. We rated it as requires improvement.

Assessment of needs and planning of care

Acute wards for adults of working age and psychiatric intensive care units

Staff assessed the physical and mental health of all patients on admission. On all wards they developed care plans which were reviewed regularly through multidisciplinary discussion and updated as needed. However, while some care plans reflected patients' assessed needs, we found some were not personalised.

Staff completed a comprehensive mental health assessment of each patient either on admission or soon after. Patients had their physical health assessed soon after admission and regularly reviewed during their time on the ward. Care records showed that physical health assessments were on-going from admission, with weekly checks on weight, pulse, blood pressure and other aspects of physical healthcare, with the patient's consent. Some patients required blood sugar monitoring or other more detailed observations related to long term physical conditions, these were being carried out. Where patients refused to allow physical health checks these refusals were recorded and we saw where staff had recorded different approaches to encourage the patient to engage.

Out of the 92 physical health checks we examined all were complete apart from three records. In three there were checks recorded but the records were not complete.

Staff developed a comprehensive care plan for each patient that met their mental and physical health needs. The electronic record system allowed for more than one care plan to be prepared, and we saw that the care plans were comprehensive and being shared with patients. Each care plan fed into a different aspect of patient care, allowing a holistic approach to nursing. However, some patients care plans contained standard statements and were not individualised as others.

Staff regularly reviewed and updated care plans when patients' needs changed. There was a service policy that care plans should be reviewed every week and we saw patients care being discussed daily within the morning huddle.

Out of the 92 care plans we looked at, some were personalised, holistic and recovery-orientated. At Halton Brooker Centre, St Helens Hope and Recovery Centre, Hollins Park and Whiston Resource and Recovery Centre we found care plans to be individualised. Patients had care plans covering different issues. For example, one patient had care plans covering verbal/physical aggression, physical health, discharge and carers while another covered accommodation and social activities.

However, at Clock View Hospital, Broadoak and Windsor House (eight wards in total) we looked at 43 care plans from these wards. We found these records were not as holistic as on other wards with some use of standardised wording and not as personalised as plans we saw elsewhere.

Best practice in treatment and care

Staff provided a range of treatment and care for patients based on national guidance and best practice. They ensured that patients had good access to physical healthcare and supported them to live healthier lives. Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives.

Staff provided a range of care and treatment suitable for the patients in the service. Staff delivered care in line with best practice and national guidance. We saw a variety of activities for patients to engage with. There was a musician who provided entertainment, there were also pet therapy and gardening groups. We saw professional support with self-reflective groups which encouraged patients to understand how they regulated their emotions.

Staff identified patients' physical health needs and recorded them in their care plans. Nurses were using standardised tools to carry out an assessment of the patient to understand their physical health needs, including the effects and side effects of medication for mental disorder using recognised tools such as the Lester tool.

We saw from records that patients received a full medical within 24 hours of admission. This included, pulse, pulse oximetry, respiration, weight BMI, temperature, blood screening and ECG. If this was not possible the trust also had a Visual A-E Assessment for those patients who would not agree to physical health checks. This meant that staff were still checking patients for signs of cardio-vascular problems even when they refused tests such as pulse and blood pressure checks.

Health care assistants had been trained to complete physical health assessments.

Staff made sure patients had access to physical health care, including specialists as required. We saw that patients had accessed dentists and opticians.

Staff met patients' dietary needs and assessed those needing specialist care for nutrition and hydration. Patients told us that any religious or dietary needs were met with halal food and vegan diets supported.

Staff helped patients live healthier lives by supporting them to take part in programmes or by giving advice. The trust had a smoke free policy, although we observed patients smoking during our inspection. Staff offered smoking cessation and advice to patients' and 99.7% of staff had completed smoking cessation training.

Staff used recognised rating scales to assess and record the severity of patients' conditions and care and treatment outcomes. These health screening tools included NEWS2, Malnutrition Screening Tool (MUST), Waterlow Assessment as well as assessments for diabetes, cholesterol and hypertension.

Staff used technology to support patients through the use of phones and video calling facilities to contact family, especially when they were unable to visit in person.

Staff took part in clinical audits, benchmarking and quality improvement initiatives. Local audits took place such as audits of clinic room fridge temperatures, compliance with malnutrition screening, and infection control. Staff were also involved in trust-wide audits in areas such as care planning and record keeping.

Managers used results from audits to make improvements. The trust had implemented a new audit procedure in May to standardise the process following the acquisition of additional wards. Ward audits now covered reducing restrictive practice, Mental Health Act, record keeping, medicines management, inpatient discharge, Duty of Candour and research information.

Skilled staff to deliver care

The ward teams included or had access to the full range of specialists required to meet the needs of patients on the wards. Managers made sure they had staff with the range of skills needed to provide high quality care. They supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.

Acute wards for adults of working age and psychiatric intensive care units

The service had a full range of specialists to meet the needs of the patients on the ward. On each ward there were multidisciplinary teams. Occupational therapists and activity co-ordinators were based at each location. There was psychology provision which provided individual and group sessions, although there was no psychologist in post at the Brooker Centre. We were told that the service had appointed a psychologist but were completing employment checks. Patients requiring an assessment were referred for assessment from within the core service psychology provision.

Managers always ensured staff had the right skills, qualifications and experience to meet the needs of the patients in their care, including bank and agency staff.

Managers gave each new member of staff a full induction to the service before they started work. We saw induction checklists on each ward to ensure consistency.

Managers supported staff through regular, constructive appraisals of their work. Overall appraisals for the service were 55%. However, the trust had introduced a new appraisal system in May 2022 which meant not all staff had received an appraisal under this system. The trust was on trajectory to meet the target of 90% by the end of December 2022. Before the introduction of the new system appraisal rates had been 90%. All staff we spoke to told us they received appraisals and all staff felt supported.

Managers supported medical staff through regular, constructive clinical supervision of their work. As with appraisals a new system had been introduced at the same time for recording supervisions. The overall service compliance rate at the time of inspection was 78%. The trust was on trajectory to meet the target of 90% by the end of December 2022. Before the introduction of the new system supervision rates had been 90%. All staff we spoke to told us they received supervision and all staff felt supported.

Managers made sure staff attended regular team meetings or gave information from those they could not attend. There were monthly ward meetings, but we saw staff discuss various items of business in the morning meeting. Managers raised issues at these daily meetings and did not wait for the monthly ward meeting.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. They recorded continuous professional development courses individually so they could reassure themselves that staff were keeping up to date with new developments.

Managers made sure staff received any specialist training for their role. Staff told us they had attended additional training they had requested such as nurse prescribing, tissue viability and management courses.

Managers recognised poor performance, could identify the reasons and dealt with these.

Multi-disciplinary and interagency team work

Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. The ward team(s) had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.

Staff held regular multidisciplinary meetings to discuss patients and improve their care. Each ward had its own multidisciplinary meeting and these were structured around the needs of the patients on that ward. We attended patient reviews at Clock View and Broadoak hospital. We also attended daily huddles at all locations which also discussed patient welfare.

Staff made sure they shared clear information about patients and any changes in their care, including during handover meetings. We also attended daily huddles at all locations which also discussed patient welfare and staff were able to change observation levels immediately.

Ward teams had effective working relationships with other teams in the organisation.

Ward teams had effective working relationships with external teams and organisations.

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

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and discharged these well. Managers made sure that staff could explain patients' rights to them.

Staff received and kept up-to-date with training on the Mental Health Act and the Mental Health Act Code of Practice and could describe the Code of Practice guiding principles. The trust had a 90% target for all staff and currently 91.5% of staff had completed the training. Staff were knowledgeable and when asked could discuss the guiding principles.

Staff had access to support and advice on implementing the Mental Health Act and its Code of Practice. The trust employed Mental Health Act administrators and staff knew when to ask them for support.

Staff knew who their Mental Health Act administrators were and when to ask them for support. There was clear information about who the administrators were and how to contact them.

The service had clear, accessible, relevant and up-to-date policies and procedures that reflected all relevant legislation and the Mental Health Act Code of Practice. Staff confirmed these were available for them on the hospital's intranet.

Patients had easy access to information about independent mental health advocacy and patients who lacked capacity were automatically referred to the service. We saw advocates on the wards and spoke to them. Most told us they felt welcomed and that patients and staff understood their role. However, one did say that they felt the ward did not understand their role and that staff had responded negatively to their interventions.

Staff explained to each patient their rights under the Mental Health Act in a way that they could understand, repeated as necessary and recorded it clearly in the patient's notes each time. We saw that patients had their rights explained to them and this was clearly recorded in the patient record. Where patients refused or did not have capacity, we saw this clearly explained. We also saw that staff continued to explain patients' rights to those who had refused or reassessed capacity.

Staff made sure patients could take section 17 leave (permission to leave the hospital) when this was agreed with the Responsible Clinician and/or with the Ministry of Justice. We saw patients taking section 17 leave, patients told us that sometimes they may have to wait for a member of staff to take escorted leave but it rare for it to be cancelled.

Staff requested an opinion from a Second Opinion Appointed Doctor (SOAD) when they needed to. We saw evidence of this when we looked at consent documentation and medicines records.

Staff stored copies of patients' detention papers and associated records correctly and staff could access them when needed. We examined 44 patient's prescription charts and related mental health documents and found them to be correct.

Acute wards for adults of working age and psychiatric intensive care units

Managers and staff made sure the service applied the Mental Health Act correctly by completing audits and discussing the findings. We spoke with mental act administrators and examined their auditing records and saw staff on the wards were complying with the act.

Good practice in applying the Mental Capacity Act

Staff supported patients to make decisions on their care for themselves. They understood the trust policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly for patients who might have impaired mental capacity.

Staff received and kept up-to-date with training in the Mental Capacity Act and had a good understanding of the five principles. At the time of inspection, 95% of staff had completed their training. The staff we spoke with demonstrated a good understanding of the application of the Act in their day-to-day work with patients.

There was a clear policy on Mental Capacity Act and Deprivation of Liberty Safeguards, which staff could describe and knew how to access. Staff confirmed these were available for them on the hospital's intranet.

Staff gave patients all possible support to make specific decisions for themselves before deciding a patient did not have the capacity to do so. Staff assessed and recorded capacity to consent clearly each time a patient needed to make an important decision. Consent to treatment and a patient's capacity were clearly recorded in all patient records.

When staff assessed patients as not having capacity, they made decisions in the best interest of patients and considered the patient's wishes, feelings, culture and history. We saw examples of best interest decisions, the responsible clinician along with the multidisciplinary team had documented these decisions in line with the trust's policy.

Staff made applications for a Deprivation of Liberty Safeguards order only when necessary and monitored the progress of these applications. Staff told us they received training regarding Deprivation of Liberty Safeguarding applications and knowledge of these applications was spread across the service with five wards having made at least one application within the last 12 months.

There had been eight Deprivations of Liberty Safeguards applications made in the last 12 months, all of which had been granted by the local authority.

The service monitored how well it followed the Mental Capacity Act and acted when they needed to make changes to improve.

Is the service caring?

Outstanding ☆ ↑

Our rating of caring improved. We rated it as outstanding.

Kindness, privacy, dignity, respect, compassion and support

Staff treated patients with compassion and kindness. They respected patients' privacy and dignity. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.

Acute wards for adults of working age and psychiatric intensive care units

We spoke to 54 patients during this inspection.

Staff were discreet, respectful, and responsive when caring for patients. We interviewed patients across the service, all of whom were positive about the politeness and respectfulness of staff. They spoke positively about staff who they worked with. Staff were described as supportive, kind, respectful and caring.

On Taylor ward, the activity co-ordinator involved patients in the planning and inspiration for large scale celebrations of events such as Halloween and Christmas. Patients engaged together and made large decorations that were not only complex but vast in content and design. Together they transformed the ward to reflect the theme patients had decided upon.

This provided an opportunity for patients to work together towards a common goal providing meaningful activities. Patients told us these activities helped them focus on wellbeing and gave them a structure to the day as well as feeling empowered in the management of their environment.

Pictures of these themed decorations were shown on a social media site and an internationally renowned artist had seen these and donated several original inspirational artworks in support of the work.

The activity co-ordinator had also received trust wide recognition and had spoken at external conferences about how to engage patients in meaningful activity.

Staff gave patients help, emotional support and advice when they needed it. We saw that patients had copies of their care plans and understood the treatment they were receiving. There were several thank you cards from discharged patients on display. These included a patient from Scotland who had been admitted and their return to Scotland for treatment had taken some time. A nurse who had supported her through the process worked on a rest day to escort her back to Scotland. Another was from a patient who had made several complaints when first admitted but was now thanking the ward staff as they now understood those decisions were in her best interests.

Staff supported patients to understand and manage their own care treatment or condition. We saw that patients had copies of their care plans and understood the treatment they were receiving.

Staff directed patients to other services and supported them to access those services if they needed help. Patients told us they had no difficulty getting support both on and off the ward.

Patients said staff treated them well and behaved kindly. We saw staff speaking with patients, interacting in a caring, interested manner and patients appreciated this.

Staff understood and respected the individual needs of each patient. We saw in handovers that staff knew the patients well. Staff were able to tell us about patients and their histories, and how they recognised if patients were having a difficult time and how they would interact with those patients to support them.

Staff felt that they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients. Patients told us they knew how to complain, but felt they had no need to do so. Some had raised minor concerns and were happy that staff had taken them seriously and dealt with the issues raised.

Staff followed policy to keep patient information confidential. All patient details were securely stored in the electronic recording system, and any paper notes were held in the nursing station.

Acute wards for adults of working age and psychiatric intensive care units

Involvement in care

Staff involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided. However, some patients care records did contain standard statements. They ensured that patients had easy access to independent advocates.

Involvement of patients

Staff introduced patients to the ward and the services as part of their admission. Wards had admission packs or information that they gave to patients. They also had staff information boards with information and pictures of staff.

Staff involved patients and gave them access to their care planning and risk assessments. Care records showed that patients were always offered copies of care plans, and risk assessments showed evidence of patient involvement. We saw printed copies of care plans in patients' bedrooms.

Staff made sure patients understood their care and treatment and found ways to communicate with patients who had communication difficulties. Patients who did not speak English as their first language told us they had received translated information, including relating to their rights under the Mental Health Act.

Staff involved patients in decisions about the service, when appropriate. Community meetings were held on all wards, we saw minutes from meetings on notice boards. These showed consideration of patients' thoughts and outlined attempts to include patients on improving the service.

Patients could give feedback on the service and their treatment and staff supported them to do this.

Staff supported patients to make advanced decisions on their care.

Staff made sure patients could access advocacy services. Patients told us they were aware of advocacy services. We saw advocates on wards supporting patients.

Involvement of families and carers

Staff informed and involved families and carers appropriately.

We spoke to 8 carers.

Staff supported, informed and involved families or carers. Patients told us their loved ones were able to visit, including children where appropriate. Carers were able to attend ward rounds and meetings when patients wanted them to attend, including some carers whose attendance was worked around other commitments.

We saw family visiting patients and they spoke positively about the support their loved ones had received.

Staff helped families to give feedback on the service. We saw from minutes of multi-disciplinary meetings that those present were asked for their views on the care plans proposed.

Staff gave carers information on how to find the carer's assessment.

Acute wards for adults of working age and psychiatric intensive care units

Is the service responsive?

Requires Improvement 

Our rating of responsive went down. We rated it as requires improvement.

Access and discharge

Staff managed beds well. A bed was available when a patient needed one. Patients were not moved between wards except for their benefit. Patients did not have to stay in hospital when they were well enough to leave.

Bed management

Managers regularly reviewed length of stay for patients to ensure they did not stay longer than they needed to. Bed occupancy over the previous 12 months was 96.7%. Patients on overnight leave or absent without leave did have a bed to return too. We saw no evidence that other accommodation such as section 136 suites were used to accommodate patients.

The service had no out-of-area placements. The trust had successfully managed to nurse all patients as close to their home as possible and the service had no patients nursed outside the trust area.

Managers and staff worked to make sure they did not discharge patients before they were ready. Managers took part in a daily bed management meeting where length of stay and discharge was discussed.

Patients were moved between wards only when there were clear clinical reasons or it was in the best interest of the patient. We saw evidence in multi-discipline meeting notes that patients were only moved for clinical reasons. In one meeting a patient move from an acute to PICU ward was discussed because of their increasing acuity.

Staff did not move or discharge patients at night or very early in the morning.

Discharge and transfers of care

Managers monitored the number of patients whose discharge was delayed and took action to reduce them. In the previous 12 months there had been 127 delayed discharges which was less than three a week across all 17 wards. Of these, 92 were related to waiting for accommodation or social care provision, which were provided by organisations outside the trust, to be made available. The staff worked closely with community teams and care co-ordinators to plan discharge and all patients had a discharge plan.

Staff carefully planned patients' discharge and worked with care managers and coordinators to make sure this went well. Patients care and discharge was discussed in weekly multidisciplinary meetings with those involved in that decision-making present to support transitions of care.

Staff supported patients when they were referred or transferred between services. We saw one former patient who returned to the ward weekly to provide musical entertainment for the patients.

Acute wards for adults of working age and psychiatric intensive care units

Facilities that promote comfort, dignity and privacy

The design, layout, and furnishings of the ward did not always support patients' treatment, privacy and dignity. Not all patients had their own bedroom with an en-suite bathroom. There were quiet areas for privacy. The food was of good quality and patients could make hot drinks and snacks at any time.

Where patients had their own bedroom, they could personalise it. Patients had a secure place to store personal possessions.

Dormitory accommodation was still in place at two locations. At Broadoak Hospital, there were three wards with five dormitories containing four beds per ward and at Windsor House there were two four bed dormitories. These were for both male and female patients. Each bed in the dormitory had a locked cabinet and a separate wardrobe space. Sleeping areas were separated by anti-microbial disposable curtains. This meant the privacy and dignity of these patients could not always be maintained.

The trust was building a new hospital site which would eradicate these dormitories; however, this was not likely to be ready for almost two years. In the interim, the trust had an admission protocol for the wards with dormitory accommodation. During the gatekeeping process, the mental health and physical health needs of individuals was considered, taking into account their clinical presentation, and risks posed to both self and others. At any point during an admission, individuals could move out of shared bedrooms if clinically indicated or if an individual requested this if the shared accommodation is causing distress to the individual. If required, the clinical teams would consider internal ward transfers in order to offer individuals the most appropriate environment to meet their clinical needs.

Patients on all three dormitory wards expressed no concerns about sharing sleeping accommodation. One patient told us they had actively pursued being returned to that ward as it was their preference to share.

Staff used a full range of rooms and equipment to support treatment and care. Wards varied in terms of the layouts, size and rooms available. On some wards, there were quiet rooms, with sensory equipment. The facilities available on each of the wards varied, but patients had access to activity and clinic rooms. Some wards had separate rooms for physical examinations to the main clinic room. Ward activity timetables were clearly displayed, and patients had access to a variety of activities including gardening, exercise, and cooking.

The service had quiet areas and a room where patients could meet with visitors in private. Patients could make phone calls in private. Patients had access to their own mobile phones but for those that did not a telephone was available.

The service had an outside space that patients could access easily. All the wards had outdoor spaces that were open for patients to use. This varied from ward to ward, and some areas were only accessible by stairs. Accessibility to these gardens for disabled patients was either provided through lifts or a different garden area was available. These spaces contained outdoor seating and often outdoor exercise equipment. Some of the wards had developed sport areas for patients to use. Taylor ward had developed a secret garden space which contained a reflective environment for patients to enjoy the sound of running water or meditate.

However, at Broadoak two wards shared a communal garden space which meant those patients could only use the garden at specified times.

Patients could make their own hot drinks and snacks and were not dependent on staff. We saw that patients were individually risk assessed for access to kitchens and staff were available to make drinks on request. We also saw drink vending machines for patients to purchase different hot drinks.

The service offered a variety of good quality food. There was a changing menu and food was mostly prepared off the ward and brought ready for service. Most of the patients were positive about the food quality on the wards.

Patients' engagement with the wider community

Staff supported patients with activities outside the service, such as work, education and family relationships.

Staff made sure patients had access to opportunities for education and work, and supported patients. Patients were often in the service for short periods and therefore not on the ward long enough to engage in a meaningful work programme. Staff were able to signpost patients to support available around work and education for patients once discharged.

Staff helped patients to stay in contact with families and carers. Patients we spoke with told us they were able to use phones and computers to maintain contact with their families, and that their families were invited to attend their weekly multi-disciplinary meetings if this was something the patient wanted. There was information available across services for patients to get involved in and access in the wider community.

Staff encouraged patients to develop and maintain relationships both in the service and the wider community. There was information available across services for patients to get involved in and access in the wider community.

Meeting the needs of all people who use the service

The service met the needs of all patients – including those with a protected characteristic. Staff helped patients with communication, advocacy and cultural and spiritual support.

The service could support and make adjustments for disabled people and those with communication needs or other specific needs. Each ward had access to adapted bedrooms and bathrooms to support those with mobility needs. Staff told us that easy read information about medication and some other topics were available and were printed off for patients when required.

Staff made sure patients could access information on treatment, local services, their rights and how to complain. Patients had access to information on all the wards. There were notice boards and leaflet racks, which included a range of information. This included information about the ward, treatments, medication, advocacy and complaints.

The service had information leaflets available in languages spoken by the patients and local community. Managers made sure staff and patients could get help from interpreters or signers when needed. We spoke to two patients whose first language was not English. They reassured us that accommodations had been made to ensure they had understood the treatment and care they were receiving.

The service provided a variety of food to meet the dietary and cultural needs of individual patients.

Patients had access to spiritual, religious and cultural support. Patients told us that, if they wanted, they could access religious or cultural support. Staff told us this could be facilitated.

Acute wards for adults of working age and psychiatric intensive care units

Listening to and learning from concerns and complaints

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and wider service.

Patients, relatives and carers knew how to complain or raise concerns. In the last 12 months there had been eight complaints made across the service. All of these were fully or partially upheld. Patients told us that they knew how to complain but suggested that most complaints they raised were dealt with informally and quickly by staff.

The service clearly displayed information about how to raise a concern in patient areas. There were noticeboards with signs outlining the complaint process for patients on the wards, as well as in the communal areas where visitors might arrive.

Staff understood the policy on complaints and knew how to handle them. Staff told us that they tried to deal with complaints informally in the first instance and knew the policy and how to support patients in making a formal complaint.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint.

Managers investigated complaints and identified themes. At Clock View Hospital meals had been provided that were microwavable. There had been complaints about the quality of those meals and managers had responded by providing a trolley with freshly prepared meals which also contained healthy options.

Staff protected patients who raised concerns or complaints from discrimination and harassment.

Patients received feedback from managers after the investigation into their complaint. Managers shared feedback from complaints with staff and learning was used to improve the service.

Complaints were shared with staff at the daily morning meeting and in team meetings.

The service used compliments to learn, celebrate success and improve the quality of care. In the last 12 months, the service received 21 compliments. Compliments were also captured in other ways, for example, during community and staff meetings and thank you cards.

Is the service well-led?

Good  

Our rating of well-led stayed the same. We rated it as good.

Leadership

Leaders had the skills, knowledge and experience to perform their roles. They had a good understanding of the services they managed and were visible in the service and approachable for patients and staff.

Acute wards for adults of working age and psychiatric intensive care units

Managers at the service knew the names of the most senior managers in the provider. Leaders provided clinical leadership. We saw modern matrons and clinical leads all working alongside junior colleagues on the wards.

Local leaders had a good understanding of the services they managed. They could explain clearly how the teams were working to provide the appropriate care within the constraints of staffing challenges. They had clear plans to provide cover including working in wards to cover gaps in staffing.

They told us they had opportunities for leadership development and they had undertaken leadership training.

Staff told us that managers were visible and accessible. During the inspection we saw ward managers and senior management interacting with patients; managers knew the names of the patients and were approachable. Managers and matrons completed regular walk arounds of their services.

Vision and strategy

Staff knew and understood the provider's vision and values and how they were applied to the work of their team. The visions and values of the service were displayed around the ward. Staff we spoke to could tell us the visions and values and explain how they were followed to ensure all staff were working together.

Some staff had the opportunity to contribute to discussions about the strategy for their service, especially where the service was changing. Staff that had transferred over to the trust from another provider felt that good practice they had in place had been acknowledged and used by the rest of the service. Conversely, they had seen working practices change to accommodate good practice elsewhere.

Culture

Staff felt respected, supported and valued. They said the trust promoted equality and diversity in daily work and provided opportunities for development and career progression. They could raise any concerns without fear.

All staff we spoke with said they felt supported and valued at the service, with both management and staff saying they felt the staff team were happy. Staff told us the role could be stressful, but that they were managed and supported by colleagues and senior staff.

There were no reports of bullying or harassment at the service, and all staff we spoke to knew how to use the whistleblowing process. All staff told us that they felt they could raise concerns to management about the service without fear of retribution.

We saw no evidence of a closed culture at the service. Managers we spoke with had identified the risk of closed cultures and had put operating procedures in place. Rotas were prepared to prevent this. Most staff (there were a few who were accommodated for personal reasons) did not work more than one month a year on nights and staff were mixed to prevent the same staff always working together. Managers also did unannounced night visits. On this inspection we visited all wards at Clock View Hospital at the same time the night shift started. We found staff had a good knowledge of their patients and they confirmed they did not work nights permanently and were rotated as managers described.

Governance

Acute wards for adults of working age and psychiatric intensive care units

Our findings from the other key questions demonstrated that governance processes did not always operate effectively at team level and that performance and risk were not always managed well.

Staff undertook or participated in regular clinical audits to ensure quality, such as care plans, risk management plans and medicines audits. During the inspection we found medicine issues relating to allergy recording, valproate procedures, and meeting required time between repeated doses despite audits taking place. Audits had also not identified that care records where not all of the same standard in three locations.

There was a clear framework of what must be discussed at a ward level in team meetings to ensure that essential information, such as learning from incidents, was shared and discussed. The provider had policies to guide staff in the day-to-day operation of the service. There was a standard agenda to ensure consistency and items included lessons learnt, governance, staffing and safeguarding. Meetings served a clear purpose and were well managed.

Clear governance systems promoted good oversight. Governance was fundamental to service development and was informed by meetings of patients, carers and staff across the service, feedback from surveys, consistent audit and monitoring and following a 'ward to board' model.

Managers made necessary changes and ensured learning was disseminated. Governance and performance processes reflected best practice. They were effective and strong, they identified and addressed issues and were used to make improvements.

Managers, despite high vacancy figures and sickness levels had ensured the wards were staffed to safe levels and that patients were safe and treated kindly. They monitored staff fill rates for each ward, on a clinical and non-clinical staff level and also broke down the figures into day and night shifts.

Staff understood the arrangements for working with other teams, both within the service and external to it, to meet the needs of patients.

Management of risk, issues and performance

Teams had access to the information they needed to provide safe and effective care and used that information to good effect. However, the trust did not always take action to mitigate risk in a timely manner.

The trust had made improvements to their estates over recent years and the completion of the new hospital in August 2024 would eradicate dormitories and close both Windsor House and Broadoak. However, at the time of inspection, the trust had not taken timely action to ensure Windsor House had been maintained to an acceptable standard, as the ward had not been decorated in three years and repairs were not actioned when required. The trust told us this was delayed due to the installation of door top alarm systems, but that did not account for the level of deterioration in the environment.

The trust had not taken action to mitigate the impact of dormitory accommodation on patient's privacy and dignity. In the State of Care in Mental Health Services – 2014/2017, CQC said that 'in the 21st century, patients, many of whom have not agreed to admission, should not be expected to share sleeping accommodation with strangers – some of whom might be agitated'. The report of the review of the Mental Health Act 2019 recommended that 'all existing dormitory accommodation should be updated without delay to allow patients the privacy of their own room'. Despite this, the new build was still almost two years off completion and the trust had not considered other options to mitigate the impact on patients.

Managers recognised the issues the service faced. They had oversight of governance issues via electronic record keeping, for example, clinical notes, multidisciplinary team and service user meetings, physical health, safe staffing and risk. They used the dashboards routinely to monitor performance targets.

There was a risk register which demonstrated that individual wards had raised risks to be included within the service risk register.

Potential future risks were included, such as staffing. Weaver ward had raised risks around being over-reliant on preceptorship nurses. Austen ward had leadership roles vacant. Risk around psychiatric and psychology vacancies for the service were also identified.

Managers discussed and monitored risk daily at morning handover meetings, and risk was regularly discussed at clinical governance meetings.

The service had plans for emergencies – for example, adverse weather or a flu outbreak. There were continuity plans in place for all service areas.

Information management

Staff collected analysed data about outcomes and performance and engaged actively in local and national quality improvement activities.

The service used systems to collect data from wards, which were not onerous for frontline staff.

Leaders had access to information that supported them to adapt and develop performance. They used the information gathered to generate improvement.

Staff had access to the equipment and information technology needed to do their work. They used technology to update records, which meant current information was always accessible.

The service managed information via electronic dashboards, which held a range of information, such as care plans, risk assessments, physical health checks and daily activity, and were updated regularly.

Using the dashboards, the information could be evaluated in total across the service and any issues noted.

Staff were committed to sharing information so that choices and decisions were supported. Information governance systems included confidentiality of patients' records.

Information was in an accessible format, and was timely, accurate and identified areas for improvement.

Staff made notifications to external bodies as needed.

Engagement

Managers engaged actively with other local health and social care providers to ensure that an integrated health and care system was commissioned and provided to meet the needs of the local population. Managers from the service participated actively in the work of the local transforming care partnership.

Information was shared with staff, patients and carers about the work of the provider via the intranet, bulletins, newsletters, carers meetings etc. Staff had regular meetings and information was shared via monthly lessons learnt bulletins that included learning from other services.

Patients and carers gave feedback on the service via surveys, community meetings and carer events. Families said that they were always invited to meetings about their relatives' care and that they could approach the ward managers or social worker with any queries.

Learning, continuous improvement and innovation

The organisation had several quality improvement initiatives taking place across their wards and services.

Each ward had a quality improvement group which discussed how they could improve care on that individual ward. These included healthy lifestyle processes for example. There were also service wide quality improvement initiatives. These included 'Making Care Appropriate' and a falls improvement plan.

Making Care Appropriate was a new system which identified if patients were receiving the right care in the right setting and helped identify discharge needs.

Community health inpatient services

Good

Is the service safe?

Good

This was the first inspection of this service. We rated it as good.

Mandatory Training

The service provided mandatory training in key skills to all staff; however, not all staff had completed it.

Staff received mandatory and role specific training but not all staff were up to date. The service's compliance rate for mandatory training was 94.2%, just below the trust target of 95%. However, the compliance rate for some other required or role specific training was below 90%. These included Mental Capacity Act level 1 (82.9%), introduction to medicines management (86.7%), basic life support (66.0%), immediate life support (79.6%) and moving and handling of people (75.3%).

Training availability had been identified as a risk by the trust. Compliance had been affected by the employment of new nursing staff, staff returning from long term sick and the availability of classroom based sessions. In addition, some new courses had been added to the required training list in June 2022, so compliance with these courses was currently low.

Staff yet to complete their basic life support or immediate life support training were all booked onto classroom courses, with a planned completion date of February 2022. The trust told us they ensured there were always a high proportion of staff on duty who were compliant with this training.

The mandatory training was comprehensive and met the needs of patients and staff. Training was a mixture of e-learning and classroom based.

Managers monitored mandatory training and alerted staff when they needed to update their training. An electronic training matrix was used to monitor staff training and compliance.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Staff received training specific for their role on how to recognise and report abuse. Compliance with Safeguarding adults level 1 training was 96.7% and exceeded the trust target of 95%. Safeguarding children level 1 training was slightly lower than the trust target at 94.2%. Safeguarding level 2 training compliance was lower with adults at 82.4% and children at 92.0%.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff were aware of the trust's safeguarding adults from abuse and safeguarding children policies.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. The trust had a safeguarding team and staff were aware of who to contact for advice.

Staff followed safe procedures for children visiting the ward. The trust had a policy in place for children visiting their sites.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

Ward areas were clean and had suitable furnishings which were clean and well-maintained. Staff cleaned areas and furnishings regularly and cleaning records confirmed this.

Staff followed infection control principles including the use of personal protective equipment (PPE). Staff and visitors followed trust infection and prevention control and COVID-19 guidelines that were in place at the time. Hand sanitisers were mounted on walls throughout the premises.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.

The environment was appropriately designed to meet patients' needs. Patients' rooms were a mixture of single and double occupancy. They had ensuite toilet and showering facilities and met the privacy and dignity needs of the patients. An electronic falls alarm system was in place. Patients could reach call bells and staff responded quickly when called.

Facilities included a therapy and rehabilitation gymnasium, quiet lounges, purpose-built kitchens to support activities of daily living and reablement, and sanctuary rooms for prayer and spiritual needs. There were two bariatric enabled rooms with tracked ceiling hoists and large dining rooms with garden views.

Patient entertainment systems included televisions and tablet devices, that could be used to complete patient experience questionnaires.

The service had enough suitable equipment to help them to safely care for patients. Equipment was clean. Maintenance checks were regularly carried out and were up to date. Daily checks were carried out of mattresses and pressure cushions.

The service had suitable facilities to meet the needs of patients' families. There were rooms on each ward for families and visitors to use to relax and spend time with their relative. Single bedrooms were spacious, which meant families could stay overnight with their relatives.

Staff disposed of clinical waste safely. Safe clinical waste disposal was observed. Health and safety workplace inspections were carried out every six months. These included an audit of the storage of hazardous substances and the disposal of clinical waste. An action plan was put in place following each audit and actions were allocated to a named person.

Community health inpatient services

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration.

Staff used nationally recognised tools to identify deteriorating patients and escalated them appropriately. These included the National Early Warning Score (NEWS) 2, which improves the detection and response to clinical deterioration in adult patients, the Malnutrition Universal Screening Tool (MUST) and the Waterlow scoring tool that predicts the risk of developing pressure ulcers.

One of the wards was trialling the use of a sub-epidermal moisture (SEM) scanner. This was a device that measured differences in moisture under the skin of the heels and the sacrum. The scanner helped to identify the risk of pressure ulcers before visible signs of tissue damage developed. Staff reported a reduction in pressure ulcer deterioration since the trial commenced. Use of the scanner was due to be rolled out to the other wards.

Staff completed risk assessments for each patient on admission, using a recognised tool, and reviewed this regularly, including after any incident. Risk assessments were completed and were up to date in all of the care records we viewed. These included; MUST, Waterlow, skin bundle, nutrition and risk of falls. Staff signature sheets were in place to show that staff had read and understood the risk assessments.

Staff knew about and dealt with any specific risk issues. A multi-disciplinary team (MDT) 'Electronic SAFER' meeting took place every morning where any high risk patients were discussed and actions were allocated. This included patients at risk, for example, from falls, pressure ulcers, catheter care or any patients who had become unwell. Staffing numbers were reviewed and discharges were discussed. A further meeting took place during the afternoon to ensure all actions from the morning had been completed.

Following the opening of Longmoor House, managers and staff identified patient falls as a cause for concern. In response, a falls quality improvement plan was created. This had three themes; workforce, training and education, and patient safety. Safe staffing was reviewed and a new falls alarm system was implemented. On admission, each patient was provided with falls prevention information and assessed for their falls risk. A falls prevention video animation, developed by the clinical MDT and the trust communications team, was shown to patients that were identified as high risk of falls. The patient was also provided with a blue risk band and a 'call don't fall' sign in their bedroom. Risk assessments had been adapted to include this information. If a patient fell, the risk assessment was updated and the patient was discussed at safety huddles, which took place following every shift handover.

A falls alarm prevention pathway was applied to all patients, with their consent, that enabled staff to monitor each patient via a falls alarm. A 48 hour falls alarm review was then carried out for each patient and at the next MDT meeting, a decision was made whether the falls alarm should remain in place or be removed. Whenever possible, patients at high risk of falls were placed in bays next to the nurses' station.

The falls quality improvement plan had been a success. In June 2021, prior to implementing the plan, falls at the service were as high as 15.28 falls per 1000 occupied bed days. In 2022, falls had consistently been below the national average of 5.67.

Shift changes and handovers included all necessary key information to keep patients safe. A handover meeting took place at each shift change.

Community health inpatient services

Staffing

The service had enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank, agency and locum staff a full induction.

Nurse staffing

The service had enough nursing and support staff to keep patients safe. A daily staff allocation board had been designed to support the nurse in charge to coordinate staffing and ensure sufficient numbers of staff were allocated to each zone. Zones included tagged zones, which consisted of patients identified as being at the highest risk of falls. These zones required a staff member to be present at all times.

The trust had carried out an overseas nurse recruitment drive to fill gaps in staffing. 10 international nurse recruits were being supported by the leadership team and mentors, who supported them to complete a preceptorship portfolio. Practice education facilitators provided additional support with learning needs. This recruitment campaign meant there were no registered nurse vacancies at the service.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance.

The ward manager could adjust staffing levels daily according to the needs of patients. A patient acuity tool was used to determine the number of staff required based on patients' needs.

The number of nurses and healthcare assistants matched the planned numbers.

The service had low vacancy rates. A number of band 3 health practitioner assistants had recently applied for and been promoted to band 4 therapy instructors. The trust had recruited additional health practitioner assistants to fill the gaps and following a staffing review, additional band 3 posts had been identified and advertised.

The service had low turnover rates. The staff turnover rate was 1.54%, which was slightly above the trust target of 1.32%.

The service had a sickness rate of 9.02%, which was twice the trust target of 4.43%. Staff sickness had been identified as a priority action as part of the service's support plan. The action was to ensure sickness was managed effectively and managers to provide support when necessary. To cover sickness, the service used their own staff first and if they couldn't fill the shift, bank or agency staff were used. Managers told us permanent staff were "very flexible and accommodating". Ward managers also helped to cover shifts when required.

The service had reducing rates of bank and agency nurses used on the wards. Staff told us staffing had improved and agency nurse usage had reduced significantly in recent months. When required, managers requested agency staff familiar with the service.

Medical staffing

The service had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave locum staff a full induction.

Community health inpatient services

The service had enough medical staff to keep patients safe. Staff and patients reported no issues with accessing medical staff. Patients were reviewed according to medical need and clinical condition. GPs had medical oversight of all patients and worked closely with the advanced clinical practitioner (ACP). The GPs and ACPs attended SAFER board rounds daily as a part of the wider MDT. The GPs also attended weekly MDT meetings to discuss complex patient needs.

The service had a dedicated allied healthcare professional and social worker workforce, who were allocated to each ward for consistency of care and treatment.

The service had a good skill mix of medical staff on each shift, which was reviewed regularly.

The service always had a GP on call during evenings and weekends. Two GPs were on duty at the service Monday to Friday from 9am to 5pm. Out of hours arrangements were in place for evenings and weekends.

Records

Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.

Patient notes were comprehensive and all staff could access them easily. Electronic care records, charts and documentation were kept up to date, with evidence of involvement from patient, families and MDT staff. However, one person's care records out of the six we looked at lacked care plans for two identified areas of specific need. This was fed back to the management team, who agreed to action.

Records were stored securely and were easily available to all staff providing care. All records were stored on a secure electronic system.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines.

Staff followed systems and processes to prescribe and administer medicines safely. However, we found that a medicine with a minimum required time between repeated doses was sometimes given too closely together. This was evidenced in 4 of the 17 records we looked at. We raised this with the pharmacy team so that steps could be taken to monitor and address this.

Controlled drugs were safely stored and managed.

Patients' medicines were regularly reviewed. GP's provided medical cover on the wards Monday to Friday, with the normal GP practice out of hours service available in the evenings and at weekends. Ward rounds were supported by a consultant psychiatrist once per week. This provided a review of any mental health prescribing. Care plans were not always in place for medicines prescribed to control behaviour that could be challenging. However, templates and guidance were being developed and there was no evidence this had impacted on patient care.

People's medicines needs were considered on discharge from hospital and compliance aids were available, if needed

Staff completed medicines records accurately and kept them up-to-date. The service had an electronic system for prescribing and administering medicines, a plan was in place should IT issues mean that records were not available. There was a process for transcribing (copying) prescriptions into people's medicines records, so that medicines could be administered if they were admitted to Longmoor House, when no prescribers were on duty.

Staff followed national practice to check patients had the correct medicines when they were admitted or they moved between services. The service's designated pharmacist carried out clinical checks and completed medicines reconciliation (admission medicines checks) on weekdays. However, medicines reconciliation was delayed for people admitted over the weekend because there was no weekend pharmacy service. An on-call service was available out of hours for urgent medicines supply and for advice.

There was a pharmacist and a pharmacist technician on both floors. They worked closely with the MDT and attended relevant meetings.

Staff worked with the acute trust OPAT (Outpatient Parenteral Antimicrobial Therapy) team, so that medically stable patients who need intravenous antibiotics could receive their treatment whilst at Longmoor House. Although not widely used, there was policy to support patients to self-administer medicines.

Audits of antimicrobial prescribing for urinary tract infections (UTIs) were completed to monitor compliance with national guidance and trust formulary. Trust data showed the Commissioning for Quality and Innovation (CQUIN) target for appropriate antibiotic prescribing for UTIs in adults aged 16+ had been achieved, helping to improve the management of acute UTIs.

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

All staff knew what incidents to report and how to report them. Staff raised concerns and reported incidents in line with trust policy.

Incidents were discussed in handover, at safety huddles and team meetings, and briefings were circulated to all staff.

The service had no never events on any wards.

Managers and staff understood the duty of candour. They were open and transparent, and gave patients and families a full explanation if and when things went wrong. For example, during an outbreak of COVID-19 at the service.

Staff met to discuss the feedback and look at improvements to patient care. All incidents were reviewed at the electronic SAFER meeting every morning. Information was shared with staff through handovers and team meetings.

Managers investigated incidents thoroughly and debriefed and supported staff after any serious incident. One of the ward managers had completed a Masters qualification in safety and accident investigation, funded by the trust.

Community health inpatient services

Is the service effective?

Good

This was the first inspection of this service. We rated it as good.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Staff protected the rights of patients in their care.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. Trust policies were up to date and regularly reviewed.

Staff protected the rights of patients subject to the Mental Health Act and followed the Code of Practice. The service had mental health lead roles, who had developed a mental health strategy for the service. This included reviewing processes for working with local mental health services, the development of new mental health care plans and training for staff on anti-psychotic medicines. They had also reviewed the number of patients being admitted with mental health needs and whether they had been appropriately referred to mental health services.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients' religious, cultural and other needs.

Staff made sure patients had enough to eat and drink, including those with specialist nutrition and hydration needs. Mealtimes were observed to be peaceful and food was served in a timely manner. Staff offered patients a choice of food and drink. If patients had specific dietary needs or allergies, these were appropriately recorded and catered for. Patients could eat in the dining room or in their own room. Snacks and drinks were available throughout the day.

Staff fully and accurately completed patients' fluid and nutrition charts where needed. These were up to date.

Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition. MUST records were accurate and up to date.

Specialist support from staff such as dietitians and speech and language therapists was available for patients who needed it. Referrals were made to dietetic services when required. However, a business case had been put forward for a permanent dietitian post at the service.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain, and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. Appropriate pain assessment records and pain management plans were in place. Comfort rounds took place every two hours to make sure patients were comfortable, not in any pain and had everything they needed.

Patients received pain relief soon after requesting it. This was prescribed and recorded accurately.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients. The service had been accredited under relevant clinical accreditation schemes.

The service participated in relevant national clinical audits. These included the National Audit of Care at the End of Life (NACEL) and antimicrobial prescribing for urinary tract infections.

Outcomes for patients were positive, consistent and met expectations, such as national standards. Managers and staff used the results to improve patients' outcomes. Nursing and therapy assessments were carried out on admission to ensure personalised care plans and goals were in place. Patients and families were involved in planning their care and goals.

To improve patient outcomes, the service had developed a patient timetable board that would be visible on each ward. The aim of the board was to improve the patient's experience and demonstrate their journey, provide structure to the patient's day whilst staying on the ward and inform carers and families of their relative's journey when visiting the ward. The board was due to go live on one of the wards on 1 January 2023.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. Information from these audits was used to improve care and treatment, and was regularly analysed and monitored.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. Staff were proactively supported and encouraged to acquire new skills. Specific competencies had been reviewed and developed by the matrons for different roles. These included identifying what additional training was required. Staff told us they were supported to develop and progress.

The service had allied health professional developmental posts and were supporting a band 6 registered nurse to work towards becoming an advanced nurse practitioner.

Managers gave all new staff a full induction tailored to their role before they started work. This included bank and agency staff. Staff spoke positively about the quality of the induction and of the training available.

Managers supported staff to develop through yearly, constructive appraisals of their work. The trust launched a new appraisal system in May 2022. At the time of our inspection, 75% of staff had completed an appraisal on the new system. The trust target was 95% by 31 December 2022.

Managers supported staff through regular, constructive clinical supervision of their work. The compliance rate for staff supervisions was 80.7%. This was below the trust target of 90%. Managers were aware and working to improve compliance.

Managers made sure staff attended team meetings or had access to full notes when they could not attend. Ward managers held staff meetings monthly. Matrons carried out weekly quality meetings with ward managers.

Staff had the opportunity to discuss training needs with their line manager and managers made sure staff received any specialist training for their role. For example, syringe driver awareness, wound care, pressure ulcers, intravenous therapy training, and palliative care.

Managers recruited, trained and supported volunteers to support patients in the service. Prior to the COVID-19 pandemic, the service had recruited volunteers to support on the wards. However, the only volunteer at the service at the time of the inspection was working in the garden area.

Multidisciplinary working

All those responsible for delivering care worked together as a team to benefit patients. They supported each other to provide good care and communicated effectively with other agencies.

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. These included the twice daily electronic SAFER meetings and a weekly MDT that was attended by psychiatrists, geriatricians and other staff from the service. The electronic SAFER meetings were used to identify which patients needed to go to MDT. Every person who had a fall was automatically discussed at MDT for a post-fall review.

Patients had their care pathway reviewed by relevant consultants. Care records were regularly reviewed and any concerns were addressed at electronic SAFER meetings and MDTs.

Health promotion

Staff gave patients practical support and advice to lead healthier lives.

Staff assessed each patient's health when admitted and provided support for any individual needs to live a healthier lifestyle. Information promoting healthy lifestyles and support was available on wards. Patients could access information via their televisions or electronic tablets. Care records included information provided to patients on how to lead healthier lifestyles. For example, exercise and dietary advice.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Staff were trained in the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). Patients who lacked capacity to make specific decisions were referred onto social services.

Bespoke training packages were provided to staff for mental capacity, to enhance the mandatory on-line training. A matron and a ward manager had completed the Best Interests Assessor training. Patients' families were invited to attend best interests meetings.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. When patients could not give consent, staff made decisions in their best interest, taking into account patients' wishes, culture and traditions. These decisions were clearly recorded in patients' records.

Do not attempt cardiopulmonary resuscitation (DNACPR) decisions were in place in two of the records we looked at. These were appropriately completed.

DoLS were implemented in line with approved documentation. Managers and the MDT monitored DoLS via the daily SAFER board rounds. A mental capacity assessment and DoLS action plan was in place to monitor and ensure processes were being followed, with the oversight of the MCA lead.

Staff had access to advice on the Mental Capacity Act and DoLS and were following correct procedures. There was a backlog of DoLS authorisations with the local authorities. However, staff were following the correct process and were in regular contact with local authority DoLS teams to inform them of expiry dates and to request updates.

Is the service caring?

Good

This was the first inspection of this service. We rated it as good.

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. Staff were observed to be approachable, with a friendly, professional attitude towards patients.

Patients said staff treated them well and with kindness. One patient told us, "Staff are brilliant, very friendly and have a laugh." Another patient told us, "Everyone goes out of their way to ensure you are warm and fed."

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. Patient's individual needs were discussed on admission and documented in care records. Staff were aware, and could provide examples, of patient's individual needs. For example, one patient liked to go out for a walk around the hospital grounds at the same time each day.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.

Staff gave patients and those close to them help, emotional support and advice when they needed it. Staff were aware that by the time patients arrived at the service, they may be in need of emotional support as they may have already accessed many different services.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them. A ward manager told us, "Relatives are equally important, they are heavily involved in the patient journey."

Understanding and involvement of patients and those close to them

Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

Staff made sure patients and those close to them understood their care and treatment. Care records contained evidence of patient and family involvement, and described how they had been involved in making decisions about their care and treatment.

Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary. Families were involved in planning and reviewing their relative's care.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. Matron clinics took place once per week that staff, patients and relatives could book to discuss their care and any concerns they had. Regular feedback was obtained from patients. Patients could use smart phones and a patient experience app to provide feedback. Other methods and options were provided. Responses to feedback were posted on message boards on ward walls. A ward manager told us, "It's important we read the feedback every month as it may be something we can change."

Information was collected from patients on admission about their aspirations and goals, and reviewed on discharge to see whether the goals had been met.

Staff supported patients to make advanced decisions about their care. Staff supported people with end of life care needs. If a patient developed end of life care needs whilst using the service, conversations took place between families, staff and other healthcare professionals to determine whether it was in the person's best interests to remain on the ward.

Staff supported patients to make informed decisions about their care. These were clearly documented in care records.

Patients gave positive feedback about the service. Regular feedback was obtained from patients, families and carers. Positive feedback was on display on the wards. Patients we spoke with spoke positively about the service and their care and treatment.

Community health inpatient services

Is the service responsive?

Good

This was the first inspection of this service. We rated it as good.

Service planning and delivery to meet the needs of the local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Managers planned and organised services so they met the changing needs of the local population. The service had been developed to meet the needs patients in the local area. The design and effectiveness of the service had been regularly reviewed since it opened to ensure it continued to meet patient's needs.

Facilities and premises were appropriate for the services being delivered. Patients spoke positively about the environment and said the wards were "private" and a "relaxed environment".

The service had systems to help care for patients in need of additional support or specialist intervention. The service had good links with health and social care professionals. For example, social workers, dietitians and the learning disability team.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

Wards were designed to meet the needs of patients living with dementia. Dementia friendly signage was in place and specific objects and sensory items were available.

Staff supported patients living with dementia and learning disabilities by using 'This is me' documents and patient passports. A dementia training programme was in place for staff. One of the matrons had liaised with the Alzheimer's Society who were planning to visit the unit and offer additional support and training. The Royal Liverpool Philharmonic Orchestra were due to visit to perform a dementia friendly concert.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. The service supported patients with a learning disability. Easy read documentation was provided and there were good links with the local learning disabilities team, who provided advice and guidance. Assistive listening devices, such as induction loops, were in place and leaflets were available in different languages if required.

The service had information leaflets available in languages spoken by the patients and local community. Interpreters or signers were available if required. Patients were signposted to other agencies and volunteer services.

Patients were given a choice of food and drink to meet their cultural and religious preferences. A "sanctuary room" was available to use for patients with religious or spiritual needs.

Access and flow

People could access the service when they needed it and received the right care in a timely way.

Managers monitored waiting times and made sure patients could access services when needed and received treatment within agreed time frames and national targets. The Trust aimed to transfer appropriate patients into Longmoor House as quickly as possible. Sometimes, for clinical and operational reasons, this didn't happen on the same day. The average time from referral to admission was 4.2 days. Admissions processes were being managed by the matrons and ward managers via an admission coordinator rota. However, this was under review and a business case had been submitted for three admissions/discharge coordinators.

An admissions phone was used for direct contact with the acute hospitals. The coordinator reviewed referrals each morning and a decision was made whether the referral was appropriate. Once the referral was confirmed, transport was arranged for the patient to be admitted to the service.

There was a detailed admissions and triage process but occasionally an inappropriate admission took place. A new transfer of care process and handover document had been put in place to improve the process. One of the aims of the new admissions/discharge coordinator role was to reduce the number of inappropriate admissions at the referral stage.

Managers and staff worked to make sure patients did not stay longer than they needed to. The service monitored the length of stay of patients weekly to ensure they were responsive to patient's needs and system pressures. The average length of stay for the previous 12 months was 22 days, which was higher than the trust target of 14 days. However, this had reduced from a peak of over 40 earlier in the year and had consistently been below the 22 days average in recent months. Length of stay was affected by the admission of patients with complex needs and delayed discharges due to lack of community care packages and nursing care home beds.

Managers monitored the number of patients whose discharge was delayed, knew which wards had the most delays, and took action to reduce them. A daily discharge situation report was produced that identified the number of patients no longer meeting the criteria for a bed and reasons why a discharge had not taken place. A fortnightly multi-agency meeting took place to review themes such as lack of care packages in the community.

Staff supported patients when they were referred or transferred between services. Staff described an effective process for prioritising the admission of patients with frailty needs.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

Patients, relatives and carers knew how to complain or raise concerns. The service clearly displayed information about how to raise a concern in patient areas. The process for making a complaint was discussed with patients on admission. Information on how to make a complaint was available on patient televisions and electronic tablets, and on ward walls.

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All complaints were acknowledged. Managers investigated complaints and identified themes. There had only been two formal complaints raised about the service in the previous 12 months. Both had been thoroughly investigated. One of the complaints was withdrawn by the complainant, the other was not upheld.

Managers shared feedback from complaints with staff and learning was used to improve the service. During the investigation of one of the complaints, inconsistencies were identified in the completion of paperwork. Although this did not influence the outcome for the patient, recommendations were shared with staff to ensure best practice.

Is the service well-led?

Good

This was the first inspection of this service. We rated it as good.

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

The service was overseen by two matrons, who specialised in physical health and mental health. Each ward was led by a ward manager. The leadership team were visible on the wards and were supported by occupational therapy and physiotherapy team leads, who each led their own team of therapists.

The service worked closely with the local acute trust to support occupational therapist and physiotherapist rotation at the service and with staff training sessions.

Four social workers, supported by a team leader, worked with the MDT for social care and discharge planning assessments, to ensure that their assessments reflected the needs of the patients to safely discharge them.

MDT meetings took place regularly and were well attended by all disciplines. Matrons and ward managers were open and transparent throughout the inspection visit. They had a good knowledge of the service and how the teams worked together. Staff told us matrons and ward managers were visible, approachable and supportive.

There were good opportunities for staff development at all levels and this was encouraged and supported by managers. For example, new band 4 therapy instructor roles had been created that existing band 3 health practitioner assistants had applied for.

The therapy team leaders had developed therapy instructor and reablement worker competency booklets to ensure they had the skills and competencies to deliver care safely.

Staff were consulted about shift patterns and could submit requests. Family friendly policies were in place and adjustments were made for staff who needed them.

Vision and Strategy

Community health inpatient services

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

Managers and staff were aware of the trust's visions and values. Information on these was posted on notice boards on all the wards. Ward managers described how they and their teams fitted into the trust's vision and values and how their quality improvement projects fed into them.

The trust's organisational effectiveness team used staff surveys and appraisal and supervision completion rates to develop a support plan for the service. Areas identified for improvement included; addressing staff shortages and creating stability within the team, building confidence in the skills and knowledge required to work at the service, developing ongoing leadership skills and encourage the celebration of achievements and continuous improvement. Progress with the action plan had been recently reviewed and was on track. The review identified staffing and recruitment had improved and staff survey responses showed increased levels of engagement.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work, and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

Staff knew how to escalate concerns and were aware of the trust whistleblowing policy. Freedom to speak up guardians had supported staff on the unit. Training on freedom to speak up was provided, although not all staff had completed this training. Effective speaking up arrangements help to protect patients and improve staff experiences.

There was a positive staff culture. Staff respected each other and worked together as a team. One staff member told us the best part of the job was how the team supported each other.

Regular staff surveys and staff meetings took place.

Ward managers told us they were confident staff would come to them with any issues or concerns. Staff we spoke with confirmed this.

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

The service was supported by a senior leadership team. Systems and processes were in place to assess and monitor the quality of the service. A comprehensive auditing schedule was in place. Ward manager audits were carried out weekly. These included reviewing care plans, risk assessments and other care documentation. Monthly audits included infection prevention and control.

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A quality review visit (QRV), which is the trust's internal quality assurance and improvement process based on CQC domains and ratings, was completed quarterly. This was completed with the service's leadership team to identify good practice and areas where improvement was needed. 3 wards received 'good plus' on their last QRV. One ward was still waiting for their result at time of the inspection.

Staff at all levels were clear about their roles and were involved in quality assurance processes.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

Risks to patients, staff and others were well managed within the teams. Incidents were appropriately reported and investigated.

Each ward had an up to date fire risk assessment in place. Each ward also had an up to date security risk assessment, completed by the trust health and safety team and the clinical manager for the service. These were completed on an annual basis as a minimum or more frequently if required. This included; internal and external security profiles, access controls, key management, staff training and awareness, and lockdown procedures. An action plan was put in place for any identified remedial actions.

An up to date environmental suicide risk assessment was in place for the service. This was reviewed annually.

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

Patient information was stored on a secure electronic record system, which all staff could access. This system was used throughout the trust which helped teams to effectively communicate and manage a service user's care and treatment journey.

Information governance and data security awareness were included in staff mandatory training. Compliance with information governance training was 100% and data security awareness was 94.5%.

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

Managers and staff engaged well with other healthcare professionals. They described how they worked with coordinators at the local NHS acute trust to improve the transfer of patients and the quality of care documentation.

The service's advanced nurse practitioners were working alongside the local acute trust to help reduce hospital acquired chest infections.

The service was supporting Liverpool School of Tropical Medicine with their research on anti-microbial resistance.

The service's garden area was previously waste ground but had been transformed by staff and volunteers into a popular place for patients and staff to access.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

Quality improvement processes were embedded in the service. For example, the falls quality improvement plan and the SEM scanner trial. Weekly quality meetings took place. Ward managers and staff had autonomy to introduce their own projects and audits. If they were successful, they were rolled out to the other wards.

Electronic care records had been reviewed to make them more appropriate to the service's needs. For example, if a MUST template was completed, it had been adapted to automatically produce a care plan.

New patient information leaflets had been designed and a video version was planned.

The service had been nominated for two star awards at the trust awards evening. These were for the falls quality improvement work and the international nurse recruitment programme.