HMP Liverpool

Inspection report

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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

Overall summary

We announced our intention to undertake a comprehensive inspection of health care services provided by Mersey Care NHS Foundation Trust on the 14 September 2018. The trust provided mental health services at HMP Liverpool from the 1 April 2018. We carried out our inspection of services provided by the trust at the prison between 9 and 12 October 2018.

Previously we had concerns about the quality of care provided at the prison by another registered healthcare provider. We decided to inspect healthcare services provided by the trust at the prison to determine if the trust was meeting the legal requirements and regulations under Section 60 of the Health and Social Care Act 2008, and that prisoners were receiving safe care and treatment.

We do not currently rate services provided in prisons.

At this inspection we found:

- The provider had effective systems for recording and acting on significant events and incidents. Learning from adverse events and the subsequent dissemination of information to improve safety across the service was embedded.
- The service had a comprehensive programme of quality improvement activity. This supported routine assessments and enhanced the effectiveness of care provided.
- Most of the time, prisoners were involved in their care and staff treated them with compassion, kindness, dignity and respect.
- Prisoners could access care and treatment within an appropriate timescale.
- There was a strong focus on continuous learning and improvement at all levels of the trust.

The areas where the provider **should** make improvements are:

- Staff should consider involving prisoners in their Care Programme Approach (CPA) review. The criteria and decision making for placing a prisoner on a CPA or a Non-CPA should be clarified.
- Staff from the trust should continue to formally gather feedback from people who use the service, and partner healthcare agencies.
- The trust should work with partners to ensure that all concerns are recorded and to improve the consistency of complaint responses.

Our inspection team

Our inspection team was led by a CQC health and justice inspector, accompanied by the manager for the health and justice team and a nurse specialist in mental health.

Before this comprehensive inspection we reviewed a range of information that we held about the service. Following the announcement of the inspection we requested additional information from the trust, which we reviewed. During the inspection we asked the provider to share with us further information, we spoke with healthcare staff, prison staff, commissioners and people who used the service, and sampled a range of records.

Background to HMP Liverpool

HM Prison Liverpool is a local category B prison that is located in Liverpool, England. The prison is operated by Her Majesty's Prison and Probation Service. The prison can accommodate up to 1176 adult male prisoners. However, at the time of this inspection the prison was holding up to 700 adult males.

Our last joint inspection with Her Majesty's Inspectorate of Prisons (HMIP) was in September 2017. At the same time we carried out an announced focused inspection of healthcare services to follow up on requirement notices that we had previously issued in respect of another registered healthcare provider. The joint inspection report can be found at: https://www.justiceinspectorates.gov.uk

From the 1 April 2018 mental health services at the prison had been subcontracted to Mersey Care NHS Foundation Trust. The trust provided healthcare services under an integrated model of care known as; 'Better Health Liverpool' and they worked closely with several other healthcare providers, commissioned by NHS England.

The trust is registered with CQC to provide the regulated activities of Diagnostic and screening procedures and Treatment of disease, disorder or injury at the prison.

Are services safe?

Safety systems and processes

- The provider had safeguarding systems in place. All staff received up-to-date safeguarding training appropriate to their role and they knew how to identify and report concerns. Mersey Care NHS Foundation Trust ensured all staff received appropriate safeguarding supervision in line with its policies and procedures.
- Healthcare staff worked with healthcare partners and custodial staff to support prisoners and protect them from neglect and abuse. A weekly safeguarding meeting was a new initiative established by the service manager. It was healthcare led and was attended by a range of healthcare partners, including prison staff at deputy governor level. Prisoners at risk of abuse were discussed. Actions to help and support the prisoner were agreed and managed jointly by healthcare and custodial staff.
- The provider carried out appropriate pre-employment checks on staff at the time of recruitment. Disclosure and Barring Service (DBS) checks were undertaken where required. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).

Risks to patients

- There were arrangements for planning and monitoring the number and skill mix of staff required to provide care and treatment for prisoners with mental health needs. A rota system ensured that sufficient staff were on duty to meet the needs of prisoners. At the time of the inspection staffing levels were appropriate, gaps were covered, which included staff from the integrated mental health team (IMHT) providing temporary support to the staff group with responsibility for the inpatient unit. This provided consistent nurse contact with prisoners. Agency staff were not used, though one bank nurse was.
- The service manager and the deputy chief operations officer for the secure division within the trust confirmed there were plans to increase staffing numbers by employing 11 new members of staff, this included three learning disability nurses and a second psychologist. New posts had been developed as part of a staffing model and included an occupational therapist and a social worker. It was envisaged that these posts would provide support while a prisoner was detained and following release from the prison.
- Risks to prisoners were identified and managed. For example, systems were in place to follow up prisoners at risk of suicide and self-harm who failed to attend appointments with nurses and psychiatrists. The clinical and nursing improvement lead for the trust, confirmed that improvement work was in progress and this included the development of individual prisoner healthcare safety plans.
- A quality improvement plan (QIP) was in place, to which all healthcare partners contributed was regularly updated. The QIP included identified concerns and ongoing actions in relation of several aspects of service delivery, including safeguarding and deaths in custody with each area having a separate and focused action plan. Trust staff were sighted on the QIP, and contributed to its up keep with partner agencies.
- Actions from deaths in custody reviews were monitored with healthcare partners and custodial staff to reduce risks and keep prisoners safe.

Information to deliver safe care and treatment

- Staff had the information they needed to deliver safe care and treatment to prisoners. This was recorded in care records and risk assessment documents.
- The service had systems for sharing information with staff and other healthcare partners. This helped enable staff to deliver a seamless service.

Track record on safety and lessons learned and improvements made

- There was a system for recording and acting on significant events and incidents. Staff worked with healthcare partners to help ensure that incidents were reported, investigated and reviewed.
- Staff understood their duty to raise concerns and report incidents and near misses. Staff raised incidents through an IT reporting system and had received appropriate training.
- There was evidence of effective learning from adverse events and the subsequent dissemination of information to improve safety across the service. Staff told us they received feedback from incident reports, this happened in team meetings, clinical supervision sessions and reflective practice sessions.

Are services safe?

- Incidents were reviewed monthly and a report on all incidents was produced under the 'Better Health Liverpool' arrangement. Incidents were graded and reviewed by type. For example, aggression towards staff or other prisoners located in the inpatient unit. Learning from reviews were shared with all healthcare partners through a 'learning round up' bulletin.

Are services effective?

Effective needs assessment, care and treatment

- Clinicians including registered mental health nurses, assessed needs and delivered care and treatment to prisoners in line with current legislation, standards and guidance supported by a range of clinical pathways and protocols. Clinical staff had access to guidelines from the National Institute for Health and Care Excellence (NICE) and used this information to help ensure that prisoners' mental health care needs were met.
- Prisoners' health care needs were fully assessed when they were first received into the prison; an initial healthcare assessment was completed by a healthcare partner responsible for providing primary healthcare services. Mersey Care nursing staff were responsible for completing a secondary health assessment within the first seven days of a prisoner's reception into the prison.
- Prisoners were admitted to the inpatient unit based on clinical need following an assessment. Clinical monitoring was completed on the unit by registered general nurses and registered mental health nurses with security oversight and support from prison officers. This meant that prisoners who required treatment and/or clinical observations had effective access to inpatient care and treatment.
- Well defined care pathways to support prisoners to access mental health services were in place. New referrals were managed by the Integrated Mental Health Team (IMHT) and were discussed at the single point multidisciplinary team meeting, which were held several times during the week. The IMHT saw prisoners with urgent needs due to risk/self-harm immediately or within 24 hours, dependent on their needs and in accordance with the mental health care pathway.
- IMHT nurses provided support to prisoners with diagnosed enduring mental illness and provided support and signposting to prisoners experiencing lower level mental health concerns. For example, mild depression. Nurses' caseloads were capped at 12 patients, although the composition of individual caseloads was adjusted according to need and staff's capacity. An allocations meeting had been introduced to ensure effective monitoring of caseloads.
- Access to patients' records for prisoners who had received mental health services in the community had been facilitated and this supported timely access to information for some patients. However, some delays still occurred despite repeated requests. The trust was aware of this and was addressing it through its monitoring arrangements and its links with community partners.
- Prisoners with mental health needs that were known to either the IMHT or were located on the inpatient unit had a care plan. We looked at a sample of 18 care records and found they contained up to date care plans that clearly set out the support and treatment prisoners received. A comprehensive care planning template had been developed and completed for all inpatients with diagnosed mental health needs. Care plans contained evidence of patients' involvement in planning their care and a prompt to offer patients a copy of their plan. Prisoners told us they held a copy of their care plan.
- A nurse led project was in progress to develop wellbeing plans for all inpatients to support them to increase their emotional resilience. Emotional resilience refers to one's ability to adapt to stressful situations or crises.
- Risk assessments were in place for prisoners located on the inpatient unit and effectively identified individual risks. However, we found that risk assessments could be stored in one of several places within the patient record system and we were concerned that nursing staff and other healthcare staff may not be able to locate them. We raised this with the trust, they told us they were aware of this and had plans to provide training for staff on the use of the patient record system, to help ensure they used the system appropriately.
- The prison and the trust under the 'Better Health Liverpool' integrated approach worked together with prisoners located on J wing. J wing provided a facility for prisoners who wanted to improve their wellbeing. For example, mental health, physical health, diet, fitness and addictive behaviour including substance misuse. Everyone located on the wing had a prison wellbeing action plan that included the details of healthcare partners involved in a prisoner's care. Prisoners on J wing told us they were supported by nursing staff from the IMHT, including regular one to one meetings with a named nurse.
- The specialist learning disability division within the trust was involved in developing a new pathway to run alongside mental health pathways. The plan was to focus on the early identification of learning disabilities at the point of reception into prison, and to provide ongoing support with a focus on post release planning.

Are services effective?

Monitoring care and treatment

- Healthcare managers within the trust had developed and put in place a comprehensive programme of quality improvement activity. This enabled staff to routinely assess the effectiveness and appropriateness of the care provided. For example, monthly reports on waiting times for mental health clinics, including reporting on areas of concern.
- Improvements were made using audit findings. Clinical audits had a positive impact on quality of care and outcomes for prisoners. In August 2018 a clinical audit was completed to gain a baseline of the quality of care plans. Data and findings were analysed and an action plan was agreed. Work remained ongoing at the time of the inspection; however, care plans that we reviewed were of a good quality and addressed identified needs.
- Healthcare managers used a range of national monitoring processes to review the service and patient outcomes including the monitoring and review of performance indicators, known as health and justice performance indicators (HJiP). This was reported on through contract meetings with NHS England. We reviewed HJiP data for the period April to September 2018 and observed that there had been a sustained improvement in the number of secondary health screens completed within the target of seven days.
- Waits for secondary health screens, referred to as, 'Wellman' assessments were effectively monitored. At the time of our inspection 27 prisoners were on the waiting list and seven of these had waited over seven days. The reasons for the delay were recorded. For example, prisoner refused, prisoner under the influence. These refusals were discussed at single point meetings where actions were agreed to engage people in the process.
- Prisoners with mental health needs were monitored through nurse led clinics and a range of multidisciplinary meetings (MDT). For example, an inpatient ward round was held weekly as was a MDT with the IMHT. Both meetings were well attended by partner healthcare colleagues and prison staff. These arrangements meant there was effective sharing of information amongst partners with a clear focus on outcomes for people.
- Physical health checks including blood tests and ECG's were completed in respect of prisoners prescribed anti-psychotic medicines. These measures helped ensure prisoners' health care needs, care and treatment was effectively monitored.
- A review of the electronic patient record system showed patients received timely reviews by psychiatrists. There were four people waiting t to be seen by a psychiatrist.
- There was some confusion around the application of the Care Programme Approach (CPA). At the time of the inspection there were 29 prisoners under CPA and 74 under non-CPA. The reasons for the use of this distinction were unclear, particularly as some of the care records for prisoners on non-CPA showed that the person met the classification for being monitored under CPA. Clarity on the use of the two terms would be helpful.
- CPA reviews were completed annually. We were told prisoners didn't usually attend CPA reviews, as would be the practice in the community, but were assessed by their care coordinator. The trust should consider involving prisoners in their CPA review and the criteria and decision making for placing a prisoner on a CPA or a Non-CPA should be clarified.
- The management of prisoners who failed to attend for appointments was effective including arrangements for following up those who did not collect prescribed medicines. Staff followed up on all prisoners who failed to attend an appointment. Those most at risk, such as, prisoners prescribed critical medicines were followed up immediately on the day by the duty nurse, or within two days for missed depot injections. Those on non-critical medicines were followed up after three missed doses.
- Information shared by the trust showed there had been an increase in recent weeks of prisoners not attending healthcare appointments. The reasons behind this increase were unclear. In response to this, the service manager undertook a 'dip' sampling exercise of the records of prisoners who had not attended. It was reported by some prisoners that they had not been called by prison officers for their appointment. Partnership work between all healthcare providers and the prison, under 'Better Health Liverpool', was taking place to address and reduce the number of missed

appointments. There were plans for 12 dedicated healthcare prison officers to work with healthcare providers and help ensure prisoners were escorted to appointments from the 1 November 2018.

Effective staffing

- A comprehensive training matrix was in place and demonstrated good staff compliance. 100% of staff had completed mandatory training requirements in safeguarding adults and children, information governance, infection control, and equality, diversity and human rights. Staff had the skills, knowledge and experience to carry out their roles.
- Healthcare managers provided staff with ongoing support. This included regular clinical supervision, one-to-one meetings, appraisals, and support for revalidation.
- Supervision arrangements for the staff team were effective and 100% of staff had received an annual appraisal. Clinical and managerial supervision was in place across all levels of the team. Staff confirmed they had received formal clinical supervision, that good informal supervision arrangements were in place and they felt supported and could approach any of the senior healthcare managers located within the prison.
- Weekly reflective practice sessions had been introduced and were well received by staff from the IMHT. There were plans to provide reflective practice sessions to nursing and healthcare staff from the inpatient unit.
- Healthcare managers ensured that all staff worked within their scope of practice and had access to clinical support when required. Staff were encouraged and given opportunities to develop and all members of the IMHT had been put on a leadership development programme.
- A new induction pack had been developed to provide staff joining the trust with a base level of knowledge about the service and the wider prison. However, it was too soon to assess the impact of this process at this inspection as recruitment was ongoing.

Coordinating care and treatment

- Staff worked well together and with other healthcare professionals to deliver effective care and treatment. The weekly inpatient ward round meeting provided a multi-disciplinary forum to discuss people who used the service and made robust decisions about people's care and treatment with all relevant teams.
- The IMHT facilitated a weekly multi-disciplinary team (MDT) meeting, attended by representatives of other teams, such as substance misuse, talking therapies and advocacy services staff. Partnership working was effective with a joined response to meet prisoner's healthcare needs being evident.
- When prisoners known to the IMHT were admitted to the inpatient unit, the responsible care coordinator or lead nurse liaised with inpatient staff to help ensure continuity of care. It was the expectation of the trust that the care coordinator maintained contact with the prisoner. However, this did not always happen or there was confusion around who was responsible for the patient. Nurses told us that sometimes there was insufficient collaboration between these teams. The trust was aware of this and had put measures in place to improve communication and joint working arrangements between the two teams, including regular attendance from the IMHT team manager at the weekly ward meeting.
- The IMHT provided support to Assessment, Care in Custody, and Teamwork (ACCT) meetings and reviews. ACCT is a prison led care planning system used to help identify and care for prisoners at risk of suicide or self-harm. The team prioritised attendance at ACCT reviews with a nurse from the IMHT attending the first ACCT review. Attendance at subsequent ACCT reviews occurred when the prisoner was known to the team and following joint working with the prison's safer custody team. The clinical and nursing improvement lead confirmed the trust was working collaboratively with prison staff and partners around the management of the ACCT process and they had introduced safety plans, to support prisoners during periods of ill health to work on their recovery.
- Care records and minutes from meetings showed that all relevant staff, including those in different teams and from different organisations, for example, primary healthcare nurses, were involved in assessing, planning and delivering coordinated care and treatment.
- Processes were in place to help ensure information was shared with community services when prisoners were released from prison. This included monthly meetings with Shelter, focussing on prisoners placed on CPA, which enabled early discussions about people's accommodation needs. External partners including local criminal justice liaison teams attended some of the weekly single point referral meetings.

Are services effective?

- The IMHT attended key prison-led meetings, which demonstrated positive partnership working and prisoner focus. Examples were the over-50s forum, Enhanced Care and Safer Liverpool meetings. The prison's discharge forum, to which men were invited 12 weeks before their planned release from the prison, was a useful opportunity to inform prisoners about community services and to agree arrangements for transferring patients' care.

Helping patients to live healthier lives

- Staff were proactive in empowering patients, and supporting them to manage their mental health and maximise their independence.
- A range of health promotion and wellbeing information was available to prisoners about services available to support positive mental health, including access to counselling and psychology services.
- The trust had recently subcontracted the services of an advocacy agency to assist prisoners who needed this support. It was planned that prisoners located on the inpatient unit would be offered the support first and then those on CPA.
- During the inspection, world mental health day was celebrated. Staff from the IMHT visited the wings and promoted the event as well as taking part in a question and answer session on prison radio within HMP Liverpool.
- The trust had identified several goals to support prisoners. These included 'reducing deaths by suicide of the people in our care to zero by 2020' and 'eliminating physical and medication-led restraint by 2020'. The trust promoted 'save life' training, a free suicide prevention training course accessible to all staff and the public.

Consent to care and treatment

- Nurses supported prisoners to make decisions about care and treatment.
- Nursing staff who completed secondary health screening asked prisoners to consent to information sharing. Clinicians obtained consent to care and treatment in line with legislation and guidance. They understood the requirements of the legislation and guidance when considering consent and decision making.

Are services caring?

Kindness, respect and compassion

- Nursing staff treated prisoners with kindness, respect and compassion. During our inspection we observed nursing staff being courteous when interacting with prisoners.
- Staff demonstrated an understanding of prisoners' personal, cultural, social and religious needs. They displayed a non-judgmental attitude to all prisoners and people who engaged with the service.
- People who used mental health services spoke positively about the care and treatment they received from trust health care staff.

Involvement in decisions about care and treatment

- Nursing staff helped prisoners to be involved in decisions about their care and treatment.
- Prisoners told us they felt involved in decision about their treatment, they fully understood their planned treatment and told us they held a copy of their care plan.
- Prisoners felt listened to and supported by staff and commented that their confidentiality had never been breached.
- Information leaflets were available about healthcare services provided within the prison including mental health services. Information was also available as an audio version to help prisoners to be involved in decisions about their care.
- Interpretation services were available and used to support communication during consultations for people whose first language was not English.

Are services responsive to people's needs?

Responding to and meeting people's needs

- Healthcare managers took account of prisoners' needs and preferences. They understood the needs of the prison population and tailored services in response to those needs.
- Senior managers aimed to improve services in response to unmet needs. For example, there had been an increase in the number of psychiatrist clinics with the appointment of a new psychiatrist who would provide a service across four working days, including the provision of emergency appointment slots.
- Care pathways were appropriate for prisoners with mental health needs, including those in need of urgent care and treatment, for example, urgent referrals were seen immediately or within 24 hours, dependent on their needs in accordance with the mental health pathway.
- The service was responsive to the needs of people in vulnerable circumstances. For example, prisoners held in the prison's care and separation unit and who were known to the IMHT were seen daily by a nurse from the IMHT. It is a prison requirement that a member of healthcare staff must assess the physical, emotional and mental wellbeing of prisoners and if there are any clinical reasons to advise against the continuation of segregation.
- Since Mersey Care NHS Foundation Trust was subcontracted to provide mental health services at the prison senior trust managers had been committed to developing a clinical psychology service to meet the needs of prisoners. The clinical psychology and talking therapies (CPTT) service ensured that prisoners with psychological needs were able to access psychological interventions as available to people in the community.
- The prison was responsible for the therapeutic environment of the inpatient unit and not the trust. The lead prison officer for inpatients had developed and put in place a 'Healthcare Meaningful Activities Timetable', which included access to the gym, education, self-help work books, art materials and attendance at monthly patient forum group.
- The prison was responsible for the therapeutic environment of the inpatient unit. Partnership working between all healthcare providers and the prison under Better Health Liverpool had led an improved inpatient regime.

Timely access to the service

- The IMHT provided a service to prisoners seven days a week between 8.30am and 4:30pm and offered a range of support including services for people with anxiety, depression and other enduring mental illnesses. For example, bipolar affective disorder. Outside of these hours nursing staff were on site from 7.30am to 9pm, Monday to Friday with reduced hours at weekends and responded to urgent referrals, through a duty call system.
- Prisoners had timely access to nursing staff from the IMHT. There were no prisoners waiting to see nurse from the IMHT and there were no prisoners waiting to access an inpatient bed at the time of the inspection.
- Information for prisoners about the service was available in a healthcare services booklet. The booklet advised that its contents could be translated into other languages, large print, audio or braille. Work was under way to develop information in easy read format for prisoners with a learning disability; this was led by senior managers within the learning disability division.
- Referral into mental health services was through the integrated mental health team and referrals came from several sources. These included prison staff, other health care practitioners, reception health screening, external sources including the trusts criminal justice liaison teams, and prisoner self-referral.
- The Clinical Psychology and Talking Therapies (CPTT) service was not a crisis service and prisoners self-referred to the team. The team provided a range of therapies. For example, cognitive behavioural therapy, eye movement desensitisation and reprocessing therapy and counselling. The team included one part-time psychologist and two psychological well-being practitioners. The service was in demand with a waiting list for the service was 66.
- The length of time prisoners waited to be transferred to a secure mental health hospital varied. Delays were predominantly due to community bed availability and suitability. This had resulted in four people being detained under the Mental Health Act immediately on release. A mental health summit was held in June 2018 with partners from the prison, trust community services, and NHS England commissioners to address the challenges faced when transferring prisoners to secure mental health hospitals.
- It was anticipated that future mental health transfers would happen much quicker as the community

hospitals to which prisoners could be transferred were the responsibility of the trust. We were unable to assess the full impact of this at the time of our inspection. Data on mental health transfers from the trust showed that two transfers in July 2018 had been timely and at the time of our inspection five prisoners were waiting to be transferred under the Mental Health Act.

Listening and learning from concerns and complaints

- Prisoners knew about the complaints procedure and how to raise a complaint. Information on how to complain was publicised on most wings and in the healthcare centre.
- The management of complaints was coordinated by the lead provider in line with an agreed integrated partnership model know as, 'Better Health Liverpool'. Prisoners had good access to 'Have your say about our services' forms, which were managed confidentially. All complaints, compliments and suggestions were logged electronically, as were all letters of response to complainants.
- Individual complaints were forwarded to the appropriate team leader within Mersey Care for a response. On receipt, staff met with complainants promptly to discuss the issues raised and agreed a resolution. These contacts were followed up with a letter confirming the outcome of the discussion. The complaints log showed that most responses were produced within the stated timeframe. We found some variation in the quality of response letters, including whether they addressed all the concerns raised by the complainant.

Are services well-led?

Leadership capacity and capability

- Healthcare managers had the capacity and skills to deliver good quality, sustainable care. They were knowledgeable about issues and priorities relating to the service and they understood the challenges and were addressing them. They worked closely with staff and healthcare partners, prioritising inclusive leadership.
- Healthcare managers and senior managers within the trust were visible and approachable. They were focused on staff and service development. However, we were unable to fully test the impact of this and how improvements were being sustained at the time of this inspection as the trust had only been delivering services for six months. Despite this, early indications were positive.
- Most trust staff had previously been employed at the service by another healthcare provider and had transferred over to Mersey Care on the 1 April 2018. Prior to transferring the staff's terms and conditions of employment, the trust set up a series of staff consultations. This ensured that staff were both involved in, and fully apprised of, changes and how they might be affected.
- Staff spoke positively about the support they had received from the trust since April 2018. They told us there was a strong focus on personal and professional development and many said they felt 'valued' by senior healthcare managers.
- The trust both recognised and fully embraced the importance and value required under the 'Better Health Liverpool' integrated partnership model. One way in which they did this was through the shared ownership of the quality improvement plan (QIP).

Vision and strategy

- Healthcare managers and senior managers across the trust had a clear vision and strategy on delivering high quality care and promoting positive outcomes for people.
- A two-year mental health transformation programme was in place that had a clear focus on service development to address the mental wellbeing of the prison population, which included the adoption of a multidisciplinary approach to working with partners.
- The trust strategy was in line with mental health priorities across the region and the needs of the prison population. Critical to changes introduced since 1 April 2018 was a revised clinical model including several new posts, for example, the appointment of a service manager, a perfect care practitioner and plans to establish a learning disability team.
- Staff were aware of and understood the vision, values and strategy and their role in achieving them, in relation to both the trust and the 'Better Health Liverpool's' integrated care model. Staff were positive, passionate and optimistic about the plans introduced so far and about proposed future changes
- Senior trust managers ensured that the prison was firmly on their agenda at board level, was of equal importance and value in comparison to other services such as community services. They ensured that staff who worked in the prison, were included and felt part of the wider trust.

Culture of the organisation

- Staff reported that they felt listened to and involved in the day to day management of the service. Staff felt respected, supported and valued. They told us they were proud to work for the trust.
- Staff confirmed they could raise concerns and were encouraged to do so. They had confidence that their concerns would be addressed and outcomes of incidents and concerns were shared with staff.
- Staff reported positively about how they were supported by improved training, management support and clinical supervision. Weekly reflective practice sessions were taking place with the IMHT and were well received. There were plans to extend these to other staff groups.
- There were processes for providing all staff with the development they need. This included appraisal and career development conversations. All staff had received their annual appraisal. Staff were supported to meet the requirements of professional revalidation where necessary.
- Measures were in place to identify concerns about staff performance and none had been reported at the time of the inspection.
- Systems to ensure compliance with the requirements of the duty of candour were embedded. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment), though none had been reported at the time of our inspection

Are services well-led?

Governance arrangements

- Systems and processes to support good governance and management were clearly set out, understood and effective, and linked directly to the wider trust. The governance and management of partnerships, joint working arrangements and shared services promoted interactive and co-ordinated person-centred care.
- Healthcare managers and senior managers within the trust gathered appropriate information through their quality, performance and contract reporting arrangements. The information was used to monitor the service and trends, and provide an overview of quality performance issues. The information was regularly reviewed to inform service delivery and ongoing development.
- A range of shared policies, procedures and activities were in place under the 'Better Health Liverpool' integrated model and this helped ensure all partners were operating as intended.

Managing risks, issues and performance

- Processes for managing risks, issues and performance were effective. Monitoring systems supported processes to identify, understand and address risks. This included monitoring of prisoners who missed appointments, clinic waiting times and mental health transfers.
- A risk assessment was in place under the 'Better Health Liverpool' integrated service model which was regularly reviewed by all healthcare providers.
- A quality improvement plan (QIP) was in place and jointly managed by all healthcare providers. The QIP included, a quality plan, external recommendations, and death in custody actions. This provided shared monitoring and oversight of all healthcare services within the prison.
- Staff understood their role and accountabilities including in respect of safeguarding. The development of a health led safeguarding meeting to discuss referrals and concerns within the prison was a positive initiative.

Engagement with patients, the public, staff and external partners

- Measures were in place to seek feedback from people who used the service, staff and other healthcare partners. The trust had provided mental health services since the 1 April 2018 and at the time of the inspection it was too soon to fully assess the impact of engagements arrangements and how this was shaping the service.
- Mersey Care NHS Foundation Trust gathered feedback from prisoners through the use of 'Have your say about our services' forms, reviewing compliments and concerns and the use of advocacy services.
- The trust had recently involved prisoners in the recruitment of staff. Collectively these new initiatives required further opportunities to embed before the full impact on healthcare services could be assessed.
- Alongside these several prison led engagement meetings provided useful feedback on the quality of healthcare services. For example, monthly inpatient healthcare forums, which the trust reviewed and considered.
- Incidents and complaints were routinely reviewed at team meetings and provided an opportunity for staff to consider and reflect on prisoner and partnership feedback. Team meetings provided an opportunity for staff to discuss areas for improvement, for example, services for prisoners who may have dementia.
- The electronic log showed that 'Better Health Liverpool' had received 112 'Have your say' forms since 1 April 2018, of which 15 were complimentary about staff or services, or contained suggestions for service improvements. None of the 97 complaints had required escalation to a more formal process and those completed had been resolved locally. Common themes were, access to medicines, staff attitude, access to treatment or services, although no single service was highlighted. Some analysis of trends was taking place and being reported to the monthly Risk and Quality Group. However, concerns raised verbally were not being recorded, which was a missed opportunity to inform service improvement.

Continuous improvement and innovation

- There was a focus on continuous learning and improvement at all levels within the service. The service made use of internal and external reviews of incidents and complaints, or example, previous joint HMIP/CQC reports and reports from the Kirkup review of healthcare services at HMP Liverpool. Learning was shared and used to make improvements.
- There was a strong culture of innovation evidenced by the number of identified areas for improvement as part

of the mental health transformation programme for the next two years. These included a review of care pathways, to improve access to secure hospital beds and services across the trust and links with community services, for example health and justice criminal and liaison and diversion services to provide support to prisoners upon release.

- The use of monthly learning rounds ups provided an ideal opportunity to share learning from incidents, risks and complaints.
- The service manager and the clinical and nursing improvement lead told us about the 'Prospect' model of care that was being piloted and was in line with the stepped care model as applied to community mental health services. The model addressed the development of comprehensive discharge planning arrangements for prisoners, including a focus on the development and implementation of plans for the treatment and remission of prisoners who required transfer to secure hospitals on release.