Mersey Care NHS Foundation Trust

Quality Report

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

Date of inspection visit: 20 March 2017 to 23 March 2017
Date of publication: 27/06/2017

Core services inspected	CQC registered location	CQC location ID
Other specialist services: high secure services	Ashworth Hospital	RW404
Forensic inpatient/secure wards (medium and low secure)	Scott Clinic Rathbone Hospital	RW493 RW401
Learning disability and autism secure services	Specialist Learning Disability Division Gisburn Lodge Inpatient secure Daisy Bank Inpatient secure North Lodge	RW41P RW4X6 RW4X8 RW4X9
Wards for older people with mental health problems	Mossley Hill Hospital Boothroyd Ward Heys Court Clock View Hospital	RW438 RW449 RW435 RW41E
Wards for people with learning disabilities and autism	Rathbone Hospital Olive Mount Hospital	RW401 RW453
Substance misuse services	Liverpool Community Alcohol services Windsor Clinic/Kevin White Unit Ambition Sefton (Bootle) Ambition Sefton (Southport) Community Drugs team	RW412 RW412 RW41R RW41T RW439

Summary of findings

This report describes our judgement of the quality of care at this provider. It is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from people who use services, the public and other organisations.

Summary of findings

Ratings

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

Overall rating for services at this Provider	Good 
Are services safe?	**Requires improvement** 
Are services effective?	**Good** 
Are services caring?	**Good** 
Are services responsive?	**Good** 
Are services well-led?	**Good** 

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

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

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

Summary of findings

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Overall summary

We rated the trust as good overall because:

- The trust's restrictive practice reduction programme was effective. There was a clear commitment to safeguarding. Almost all of the individual patient risk assessments we reviewed were thorough and up to date. The trust was compliant with duty of candour requirements and had taken potential risks into account when planning services. Trust buildings and clinical equipment were mostly clean and well-maintained. Security arrangements and environmental risk assessments were effective. Most teams had put measures in place to reduce the impact of low staffing, and staffing was discussed regularly at all levels of the trust. Overall compliance with mandatory training was good. Medicines management on most of the wards was good. Staff reported and learned from incidents.
- Within high secure services, there was a clear aspiration to reduce the use of seclusion and long-term segregation. The trust had recruited an additional 19 psychology staff since our last inspection, which had improved access to psychological therapies in the local division. The quality and range of psychological and occupational therapies in learning disability and autism secure wards was excellent. Therapeutic intervention and treatment provided in most of the core services was in line with best practice guidance. Staff evaluated the effectiveness of their interventions using standardised outcome measures and clinical audit. Care planning and record keeping was mostly effective throughout the trust. The majority of staff were experienced and skilled, and compliant with trust requirements for supervision and appraisal. Multidisciplinary meetings and handovers were patient-focused and effective. The majority of staff understood and applied the Mental Health Act and Mental Capacity Act.
- Almost all of the patients and carers we spoke with were positive about staff and the service. Patients said that staff were supportive, helpful and kind. All of the interactions we observed in five of the six core services we inspected were caring and respectful. Staff involved patients and carers in the care they received. Patients were oriented to the wards on their arrival. There were many opportunities for patients and carers to give feedback and help develop services.
- The trust's services were planned and delivered to meet the diverse needs of the population. There were good escalation procedures in place for delayed discharges. Staff took active steps to understand and engage people from disadvantaged groups and those with protected characteristics under the Equality Act 2010. Food provided to patients had improved since our last inspection. Patients on all but two of the wards we inspected had access to at least 25 hours of activity each week. Services met people's individual needs, including disability, spiritual and dietary needs. The trust listened to and learned from complaints.
- The trust had a clear vision, values and strategy. Safety and quality were paramount. The trust was financially stable and secure. Non-executive directors and the council of governors were effective in holding the trust to account. The trust had an up to date risk register and there were clear risk identification and review processes in place for risks at corporate and divisional level. There were effective surveillance systems in place and each division had a clear governance structure. Leadership at all levels was visible and effective. The trust was committed to its goal of developing a fair and just culture. Staff were aware of the whistleblowing policy and felt able to raise concerns. Overall, staff morale was good despite service pressures. Staff and patients were engaged in all aspects of strategy delivery.

However:

- There was an infection control risk in patients' laundry rooms on four of the medium secure wards. On the STAR unit, staffing was not sufficient to manage the level of need. There was low compliance with training in basic and immediate life support on three wards for older people with mental health problems and one ward for people with learning disabilities and autism. Medicines were not always managed safely in wards for older people with mental health problems and on the STAR unit.

Summary of findings

- Five trust policies referred to the out of date 2008 Mental Health Act Code of Practice, which meant staff were not following current guidance. The trust had not notified CQC of authorised Deprivation of Liberty Safeguards applications. This is a requirement of their registration. At Wavertree Bungalow, care plans for patients who were not independently mobile did not include a detailed moving and handling risk assessment. Also at Wavertree Bungalow, there was insufficient information in care records to enable staff to safely support two patients with epilepsy.
- We observed negative interactions on wards for people with learning disabilities or autism. On Wavertree Bungalow, we saw staff ignoring patients, talking about patients in front of other patients, and failing to provide verbal reassurance during moving and handling.
- There was a lack of meaningful activity on wards for people with learning disabilities or autism. On STAR unit we found that staff did not always use patients' communication aids and could not control the level of noise in the environment to make it suitable for patients with sensory needs.
- Some ward staff told us that low staffing levels were affecting their morale and making it difficult for them to perform their roles safely. The proportion of staff who would recommend the trust as a place to work was worse than the national average for mental health trusts. Governance at local level was not always effective.

Summary of findings

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

We always ask the following five questions of the services.

Are services safe?

Requires improvement

We rated safe as requires improvement because three of the core services we inspected on this occasion, and two core services we inspected previously, were rated requires improvement for this key question.

- Four of the wards in medium secure services included rooms that were used for patients' laundry and disposal of dirty mop water. This presented a risk of cross-infection, which had not been adequately mitigated by the trust.
- Staff vacancy and sickness rates were higher than the average for mental health trusts in England. Staffing on STAR unit, a ward for people with learning disabilities and autism, was not sufficient to manage patients' level of need.
- There was low compliance with training in basic and immediate life support on three wards for older people with mental health problems and one ward for people with learning disabilities and autism.
- Staff did not always manage medicines safely in wards for older people with mental health problems and on the STAR unit.
- Seclusion rooms on three wards in medium secure services had the potential to breach patients' privacy and dignity due to the positioning of their windows.
- The trust's systems did not allow them to accurately report on all safeguarding indicators.

However:

- The physical environment at core service locations was mostly clean and well maintained. Clinic rooms were well-equipped and staff ensured that all clinical equipment was checked and maintained according to manufacturers' standards. All of the trust's inpatient and supported living areas had a ligature point risk assessment completed within the last 12 months. (A ligature point is something to which a person at risk of self-harm could attach a cord, rope or other material for the purpose of hanging or strangulation.)
- Security arrangements worked well. Staff managed alarms and keys safely. The trust had an effective restrictive practice reduction programme called No Force First. Use of prone restraint had decreased significantly since our previous inspection.

Summary of findings

- Most teams had put measures in place to reduce the impact of low staffing. Staffing was discussed regularly at all levels within the trust. Overall compliance with mandatory training across the core services was high at 89%.
- The trust had a safeguarding strategy and a clear commitment to safeguarding. Almost all of the individual patient risk assessments we reviewed were thorough and up to date. There was evidence of good medicines management across all of the core services and most of the wards.
- Staff reported incidents appropriately and in a timely manner. The trust had acted to reduce incidents and promote reporting since our last inspection. Learning from incidents was fed back to staff through team meetings, supervision and quality practice alerts. The trust had a 'being open' policy, which included duty of candour. The trust monitored adherence to duty of candour legislation.
- The trust had an effective estates strategy and had taken potential risks into account when planning services.

Are services effective?

Good

We rated effective as good because four of the core services we inspected on this occasion, and all of the core services we inspected previously, were rated at least good for this key question.

- We saw many examples of best practice being implemented across the core services. NHS England's recommendation to 'stop the overmedication of people with a learning disability' was reflected in trust policy and practice. There was a clear aspiration across high secure services to reduce the use of seclusion and long-term segregation. Staff evaluated the effectiveness of their interventions by using standardised outcome measures and clinical audit.
- The trust had recruited an additional 19 psychology staff since our last inspection, which increased the availability of psychological therapies. The quality and range of psychological and occupational therapies in learning disability and secure services was excellent.
- Care planning and record keeping were mostly good throughout the trust. All patients with a learning disability or autism who presented with challenging behaviour had high-quality positive behaviour support plans. Staff could easily access the information they needed to be able to deliver safe and effective care. Staff assessed, monitored and met patients' physical health needs,
- Overall, staff were experienced and skilled. All had received additional training to support them in their role. The majority of

staff in high secure, medium secure, low secure, learning disability and autism secure and substance misuse services were compliant with trust policy requirements for supervision and annual appraisal. The trust had a leadership development pathway that was open to all staff.
- There were policies and support in place to address staff poor performance. The trust was in the process of implementing a 'fair and just culture' based on feedback from staff.
- Multidisciplinary meetings and handovers were patient-focused and effective. All of the teams worked collaboratively with external organisations.
- Most staff had completed Mental Health Act and Mental Capacity Act training. There were effective systems in place to ensure that the requirements of the Mental Health Act and Code of Practice were met. Most staff understood the application and principles of the Mental Health Act and Mental Capacity Act.

However:

- Five trust policies referred to the out of date 2008 Mental Health Act Code of Practice, which meant staff were not following current guidance.
- The trust had not notified CQC of authorised Deprivation of Liberty Safeguards applications. This is a requirement of their registration.
- At Wavertree Bungalow, care plans for patients who were not independently mobile did not include a detailed moving and handling risk assessment. Also at Wavertree Bungalow, there was insufficient information in care records to enable staff to safely support two patients with epilepsy.
- Psychological therapies and dementia-appropriate environments were not consistently available across all wards for older people with mental health problems.
- Compliance rates for supervision and/or appraisal were low on three wards for older people with mental health problems and one ward for people with learning disabilities or autism.
- Staff on the STAR unit (a ward for people with learning disabilities and autism) had not received training in autism, learning disability, epilepsy and communication skills.
- Only 56% of staff on wards for older people with mental health problems had completed Mental Health Act training.
- Only 30% of staff in medium and low secure services and 57% of staff in wards for older people with mental health problems had completed Mental Capacity Act training.

Summary of findings

Are services caring?

Good

We rated caring as good because five of the core services we inspected on this occasion, and all of the core services we inspected previously, were rated at least good for this key question.

- Almost all of the patients and carers we spoke with were positive about the staff and the service. Patients said that staff were supportive, caring, respectful, helpful and kind.
- All of the interactions we observed in five of the six core services were caring and respectful. Staff were good at recognising and responding to patients' needs.
- The trust involved patients and carers in the care they received. Ninety-five per cent of patients who completed the trust's patient experience survey reported that they had been involved in the development of their care plan. Trust policies and strategies were in place to ensure carers were meaningfully involved in care planning. Patients had been involved in many different projects across the trust.
- Advocates and the patient advice and liaison service visited wards regularly to support patients and help facilitate community meetings. All mental health wards held community meetings at least monthly. High secure services and learning disability and autism secure services also held monthly forums attended by patient representatives. The patient representatives felt valued in their role and able to make changes on behalf of their peers.
- Staff oriented patients to the wards on patients' arrival. Some wards gave patients an information pack that was specific to the ward. Patients from learning disability and autism secure services had been involved in making videos to help new patients know what to expect from admission.
- The trust had employed seven peer support workers, who were people with direct experience of using trust services.

However:

- We observed negative interactions on wards for people with learning disabilities or autism. On Wavertree Bungalow, we saw staff ignoring patients, talking about patients in front of other patients, and failing to provide verbal reassurance during moving and handling.

Are services responsive to people's needs?

Good

We rated responsive as good because five of the core services we inspected on this occasion, and all of the core services we inspected previously, were rated at least good for this key question.

Summary of findings

- Patients in learning disability and autism secure services had 'moving on' care plans to prepare them for discharge. Trust staff had done exemplary work with local placement providers to ensure that transition to the community was as successful as possible.
- Staff took a proactive approach to understanding the needs of different groups of patients. All of the wards provided access to separate rooms where patients could practise their faith. Wards were also able to cater for specific dietary needs. We saw good examples of compliance with NHS England's accessible information standard.
- All of the core services had a full range of rooms and equipment to support treatment and care. Trust premises were accessible to people who used wheelchairs or who had mobility difficulties. The trust's patient-led assessment of the care environment scores for food had improved since our last inspection. Patients on all but two of the wards we inspected had access to at least 25 hours of activity each week. All patients were able to make private telephone calls (with limitations for some patients in high secure services).
- All of the core services provided information on treatments, local services, patient rights and how to complain. The trust listened to and learned from complaints.
- The trust's services were planned and delivered to meet the diverse needs of the population. The trust's three priorities for improvement were identified in consultation with stakeholders.
- The trust had a five-year plan to integrate the community physical health services they were due to take over from 1 June 2017.
- The trust took active steps to engage people who found it difficult to engage with mental health services.
- There were good escalation procedures in place for delayed discharges.

However:

- There was a lack of meaningful activity on wards for people with learning disabilities or autism.
- On STAR unit, a ward for people with learning disabilities and autism) we found that staff did not always use patients' communication aids and could not control the level of noise in the environment to make it suitable for patients with sensory needs.
- The trust was not meeting its own targets for timeliness of response to complaints.

Summary of findings

Are services well-led?

Good

We rated well-led as good. Four of the core services we inspected on this occasion, and five of the core services we inspected previously, were rated good for this key question. However, two of the core services we inspected on this occasion and two of the core services we rated previously were rated requires improvement for well led. We made a decision to deviate from our aggregation tool in this case because one of the core services rated as requires improvement for well-led (wards for people with learning disabilities and autism) represented only 14 of the trust's 672 beds. We also found evidence that the trust overall was well led. It would therefore have been disproportionate for us to rate this key question as requires improvement.

- The trust had a clear vision underpinned by four values. Staff knew and understood the vision and values. It was clear from the trust's strategy that safety and quality were paramount. The trust had developed their overarching strategic goal following consultation with staff. Staff and patients were engaged in all aspects of strategy delivery.
- The trust was financially stable and secure. The trust non-executive directors and council of governors were effective in holding the trust to account. The trust minimised the impact of pressures and efficiency changes on the quality of care.
- Each division had a clear governance structure from ward or team level up to the board. There were thorough surveillance systems in place. There was evidence from the assessment of core services that the trust governance framework was effective, with some exceptions. The trust had an up to date risk register and there were clear risk identification and review processes in place for risks at corporate and divisional level.
- At core service level, managers had access to 'dashboards' to monitor their team's performance. The trust completed internal quality review visits to assess safety and quality at individual wards and locations.
- Leadership at all levels of the trust was visible and effective. Leaders encouraged collaborative and supportive relationships among staff. Senior staff visited the core services. Staff were aware of the whistleblowing policy and felt able to raise concerns. Staff described the new 'freedom to speak up guardian' as visible and approachable. The trust was committed to its goal of developing a fair and just culture
- Overall, staff morale was good despite service pressures. Many staff said that they enjoyed their work and felt valued by their teams. Staff in core services facing organisational change felt

supported, and most said that communication was good. Staff were able to give feedback and suggest ideas for service improvement. The trust leadership development pathway was open to all staff.

- Poor staff performance was addressed promptly and effectively. The trust had analysed the causes of staff sickness, and put plans in place to address it. The trust was compliant with the workforce race equality standard, and working to address shortfalls.
- The trust had refurbished a popular local building to provide a well-used community hub. The trust offered volunteering opportunities to patients, staff, trust members and the public through its 'people participation programme'. The trust had employed eight service users to help train staff and support patients through their recovery. The trust was also running a public campaign to encourage people to talk about mental health problems.

However,

- Some ward staff told us that low staffing levels were impacting on their morale and making it difficult for them to perform their roles safely. The proportion of staff who would recommend the trust as a place to work was worse than the national average for mental health trusts. Staff sickness across the trust was high. Some staff expressed frustration about the lack of clarity for band 2 healthcare assistant roles, particularly in the local division.
- Governance at local level was not always effective. Learning from the specialist learning disability division (about care plans for patients with epilepsy) was not transferred for people with learning disabilities accessing inpatient beds in the local division.
- Some patients felt that it was unfair that the trust did not pay volunteers for their work.

Summary of findings

Our inspection team

Our inspection team was led by:

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

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

The team included nine CQC inspectors, two pharmacist inspectors, two assistant inspectors, an inspection planner, a third inspection manager, two Mental Health Act reviewers, and a variety of specialist advisors. The specialists were: a director of nursing, a consultant forensic psychiatrist head of forensic services, a forensic consultant psychiatrist, a consultant psychiatrist in learning disabilities, a consultant psychologist in learning disabilities, a clinical psychologist, a speech and language therapist, a security manager and five specialist nurses. Five experts by experience (people who had either used services or cared for someone who used services) were also part of the inspection team. Three of the experts by experience had used services, and two had cared for people using services.

Why we carried out this inspection

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

We also planned this inspection to include high secure services (a new core service) and to assess if the trust had addressed some of the areas where we identified breaches of regulation at our previous inspection in June 2015 (published October 2015). At the June inspection, the trust was found to be in breach of regulations of the Health and Social Care Act (Regulated Activities) Regulations 2014 in the following core services:

Acute wards for adults of working age and psychiatric intensive care units

- Regulation 12 (safe care and treatment)

Community mental health services for people with learning disabilities or autism:

- Regulation 17 (good governance)

Long stay/rehabilitation mental health wards for working age adults

- Regulation 12 (safe care and treatment)
- Regulation 18 (staffing)

Wards for older people with mental health problems

- Regulation 10 (dignity and respect)
- Regulation 12 (safe care and treatment)

Wards for people with learning disabilities or autism

- Regulation 11 (need for consent)

We also found trust-wide breach of regulation 18 (staffing). We last inspected Calderstones NHS Foundation Trust in February 2016 and found one breach of regulation 18 (staffing) for wards for people with learning disabilities or autism.

Following the inspections in June 2015 and February 2016 each trust submitted a comprehensive action plan to improve and address breaches of regulation. Mersey Care NHS Foundation Trust gave a presentation to CQC in May 2016 to update us of their progress.

During this inspection we found that in the core services we inspected the trust had met the regulation requirements outlined above.

Summary of findings

How we carried out this inspection

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

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

Before visiting, we reviewed a range of information we held about Mersey Care NHS Foundation Trust and asked other organisations to share what they knew. We carried out announced visits between 20 March 2017 and 7 April 2017. We held focus groups with a range of staff who worked within the service, such as nurses, nursing assistants, doctors, allied mental health professionals and psychologists. We talked with people who use services and carers and family members. We observed how people were being cared for and reviewed care or treatment records of people who use services. We carried out unannounced visits on 30 March 2017.

Information about the provider

Mersey Care NHS Foundation Trust provides specialist inpatient and community mental health, learning disability and substance misuse services for adults in Liverpool, Sefton and Kirkby. It provides specialist high secure and learning disability and autism secure beds to a much wider population encompassing North West England, parts of central England, and Wales. Mersey Care NHS Trust was established on 1 April 2001 and was granted NHS Foundation Trust status in May 2016. The trust currently employs over 5000 staff and serves a population of almost 11 million people. In July 2016, Mersey Care completed the acquisition of Calderstones Partnership NHS Foundation Trust. Mersey Care NHS Foundation Trust has an annual turnover of £240 million, and over 12,000 members.

The trust's services were delivered through three divisions:

- Secure division comprised high secure services at Ashworth Hospital, medium secure services at Scott Clinic and low secure services at Rathbone Hospital.
- Specialist learning disability division comprised the wards and individualised packages of care previously provided by Calderstones NHS Foundation Trust.
- Local division comprised the remaining mental health, learning disability and some social services provided to the population of Liverpool, Sefton and Knowsley.

The trust's services were commissioned by:

- NHS England and NHS Wales
- Liverpool, South Sefton, Southport and Formby, Knowsley, St Helens, Halton, and West Lancashire clinical commissioning groups
- Liverpool City Council, Sefton Metropolitan Council, Knowsley Metropolitan Council, and Halton Borough Council.

Mersey Care NHS Foundation Trust currently has 23 active locations registered with CQC. During this focused inspection we looked at the following core services provided by the trust:

- Other specialist services: high secure services (Ashworth Hospital)
- Forensic inpatient/secure wards (medium/low secure)
- Wards for older people with mental health problems
- Wards for people with learning disabilities and autism.

We also looked at two additional non-core services:

- Learning disability and autism secure services
- Substance misuse services.

We did not inspect the following core services and locations provided by the trust:

- Acute wards for adults of working age and psychiatric intensive care units
- Community mental health services for people with learning disabilities or autism

Summary of findings

- Community-based mental health services for adults of working age
- Community-based mental health services for older people
- Long stay/rehabilitation mental health wards for working age adults
- Mental health crisis services and health-based places of safety
- Rufford Road and Morley Road; two adult social care homes each providing four beds for people with a severe learning disability.

We inspected Rufford Road and Morley Road separately in January 2017. We rated both 'good' overall, with no requirement notices. The other six core services were last inspected in June 2015. We have aggregated ratings for these locations and core services along with ratings from the current inspection to give an overall provider rating.

Mersey Care NHS Foundation Trust has previously been inspected once and Calderstones NHS Foundation Trust has previously been inspected twice under the new methodology. We last inspected the trusts in June 2015 and October 2015 respectively. Reports were published in October 2015 and February 2016. Overall, both trusts were rated as good.

What people who use the provider's services say

We spoke with 175 patients and 24 carers during our inspection. We also received 55 completed comment cards. Almost all of the patients and carers we spoke with were positive about the staff and the service. Patients said that staff were supportive, caring, respectful, helpful and kind. Patients with specific individual needs (for example dietary requirements, personal care needs or communication needs) told us that that staff assisted them appropriately. Some patients said that staff were genuinely interested in their wellbeing. Others told us that they felt safe on the wards. Many of the carers told us that they felt involved in their family member's care and that communication was good. Two carers said that the care provided to their family member on learning disability and autism secure wards was excellent.

Only a small number of the patients and carers we spoke with had negative things to say about the service. Some of the patients at high secure services were unhappy about aspects of the care and/or future plans for their care. When we reviewed these patients' care records we were satisfied with the actions that high secure services had taken. Several patients on learning disability and autism secure wards said that staff were not always respectful and polite.

Thirty-one responses on comment cards were positive, 11 were negative, a further 11 were mixed and two were unclear. The majority of comment cards described staff as helpful, friendly, pleasant or caring. The main theme of the negative comments was staffing. Many respondents said that more staff were needed.

Good practice

Staff in learning disability and autism secure services and staff in substance misuse services were facing uncertainty and organisational change. There was an NHS consultation in progress regarding the future of the trust's learning disability and autism secure site, the outcome of which was expected the week following our inspection. Commissioning for substance misuse services had changed, meaning that the trust needed to make significant efficiency savings. Despite this, most of the staff in these services told us that they felt positive about coming to work. Many said that they appreciated the trust's efforts to keep them informed of any changes, and that the trust and their managers were 'doing everything they can' to ensure that jobs were safe and that services continued to provide quality care.

In high secure services, staff were striving to reduce restrictive practice. They had already succeeded with 'No Force First' and were developing and piloting other models to build on this. Staff from high secure services had been contracted to provide training and supervision to staff in three high secure prisons.

Summary of findings

In learning disability and autism secure services, there was excellent use of positive behaviour support to reduce restrictive practice. There was a human rights based approach to risk assessment, and the service promoted equality and diversity. Patients were seen as experts in their own care. Patients had been involved in filming a number of short videos about the wards with the trust's media team. These videos were available online to help new patients know what to expect from admission and the transforming care agenda.

On wards for older people with mental health problems, multidisciplinary frailty reviews took place weekly or fortnightly. At the reviews, staff discussed patients' fall risk, physical health conditions, infections and delirium, continence, modified early warning system score, weight, and diet and fluid intake. Activities on the wards included weekly visits from the Philharmonic Orchestra and a dance and movement organisation.

Four times a year, Wavertree Bungalow respite unit (a ward for people with learning disabilities and autism) closed for two days. This allowed staff to hold a whole team away day for training, good practice sessions and team meeting on one of the days. On the other day, staff from Wavertree Bungalow would cover STAR unit (the other ward for people with learning disabilities and autism) so that the STAR unit team could do the same thing.

In substance misuse services, managers had set up a partnership project to provide support for veterans and reservists seeking military-specific addiction treatment across the UK. Staff had also run clinical studies, and used findings to support successful applications for funding for a community blood-borne virus clinic.

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that all policies referring to the Mental Health Act cite the current Code of Practice.
- The provider must ensure that they comply with regulation 18, of the Care Quality Commission (Registration) Regulations 2009 which make requirements that the trust notify CQC of all Deprivation of Liberty Safeguards authorisations.

Forensic inpatient/secure wards (medium and low secure)

- The provider must ensure that good infection control measures are in place to ensure the separation of clean and dirty areas of the laundry and sluice on the four wards identified.

Wards for older people with mental health problems

- The provider must ensure that medicines are managed safely including the inclusion of allergies on all prescription cards for patients and the creation of covert medicines care planning and instructions to staff at Irwell ward.
- The provider must ensure that there is prompt action taken if the clinic fridge temperatures are not within range.
- The provider must ensure that staff clean all equipment according to policy and records are completed to reflect this has taken place.
- The provider must ensure that staff complete all training necessary to ensure they are able to deliver safe and effective care. Required training includes basic life support, immediate life support, moving and handling of people and dysphagia training.
- The provider must ensure that staff receive supervision and appraisal as per the trust's policy.
- The provider must ensure they submit notifications to CQC of Deprivation of Liberty Safeguards authorisations for patients.

Wards for people with learning disabilities and autism

- The provider must ensure that staffing levels are sufficient to manage levels of patient observation at the STAR unit.
- The provider must ensure that staff complete observations as per the trust policy in terms of duration and recording at the STAR unit.

Summary of findings

- The provider must ensure sufficient qualified staff complete immediate life support training at the STAR unit.
- The provider must ensure there is a system to monitor clinical stocks and expiry dates at the STAR unit.
- The provider must ensure that moving and handling plans are completed for all patients with moving and handling needs at Wavertree Bungalow.
- The provider must ensure that sufficiently detailed epilepsy care plans are completed for all patients with epilepsy at Wavertree Bungalow.
- The provider must ensure all staff have an appraisal.
- The provider must ensure that all staff receive regular supervision as per the trust policy.
- The provider must ensure that specialist training required to enable them to carry out their role is available to staff.
- The provider must ensure that positive behavioural support plans are followed.
- The provider must consider how to safely manage patient-initiated physical affection at Wavertree Bungalow.
- The provider must ensure that all patients have access to meaningful activities and planned community leave as part of their weekly programme.
- The provider must ensure that where communication aids are required, these are accessible to the patient and staff.
- The provider must ensure there is a system of recording additional training including when this has taken place and who attended.
- The provider must review the monitoring systems for recording training data and deprivation of liberty applications and authorisations.
- The provider must submit notifications to CQC to advise of authorised Deprivation of Liberty Safeguards applications.

Action the provider SHOULD take to improve

- The trust should continue with plans to improve systems to ensure accurate and prompt safeguarding reporting.
- The trust should continue with plans to understand and improve staff sickness rates.
- The trust should continue to implement and develop its recruitment and retention strategy.
- The trust should continue to work with stakeholders to try to reduce delayed discharges.
- The trust should continue to improve its response times for complaints.
- The trust should continue to work with staff to ensure all, including those at band 2, feel valued and able to fulfil their role safely.
- The trust should review governance systems to ensure that there is sufficient oversight of the application of the Mental Capacity Act and that the training compliance at ward level matches data held at trust level.
- The trust should ensure that all relevant learning is shared across divisions.

Other specialist services: high secure services (Ashworth Hospital)

- The provider should ensure that the Mental Health Act policy is updated, and remove references to the out of date Code of Practice.
- The provider should ensure that the central records of how many staff have undertaken mandatory training accurately reflects the true figures.

Forensic inpatient/secure wards (medium and low secure)

- The provider should ensure that the privacy and dignity of all service users while they are in seclusion at Scott Clinic is maintained and monitored at all times.
- The provider should ensure that there are systems in place to ensure that the staffing levels support the needs of the patients and that monitoring of rescheduled leave as well as cancelled leave should be considered to support this.

Summary of findings

- The provider should consider the necessity and rationale of the frequency of the drug detection dogs attending all of the wards we inspected.
- The provider should ensure that patients who are using seclusion cannot see the computer screens in the staff offices at the Scott Clinic.

Wards for older people with mental health problems

- The provider should review the blanket restrictions in place and ensure they are individually assessed.
- The provider should ensure that they reassess the capacity to consent to admission for patients at Heys Court and review their care plans to ensure the least restrictive practice is in place.
- The provider should review the activities available to patients, and communicate to patients when there are changes to the planned activities.
- The provider should review the arrangements for facilitating community and section 17 leave at Heys Court.
- The provider should review the information that is available to patients and ensure that it is in accessible format for patients.
- The provider should ensure that there is a working patient phone on Boothroyd ward.
- The provider should review the environment of the wards caring for people with dementia to ensure it is appropriate to their needs in accordance with current guidance.
- The provider should review the disciplines working on each ward to ensure equity of access and provision to patients, including psychology and occupational therapy.
- The provider should consider the creation of a welcome pack or information available to patients and carers on admission to the ward to assist with orientation.
- The provider should ensure that they give the opportunity to the patient or their family to be involved in the care planning process.
- The provider should ensure they offer patients a copy of the care plan and document this within care records.

Wards for people with learning disabilities and autism

- The provider should ensure that community meetings at the STAR unit are meaningful by recording attendees and acting on patient feedback.
- The provider should consider how they might better meet the sensory needs of people with autism on the STAR unit.

Substance misuse services

- At the Windsor Clinic, the fire risk assessment should be updated and actions completed.
- Each patient should have a clear risk management plan that is regularly reviewed.
- All care records should be comprehensive, holistic and recovery focused and reviewed regularly. They should take account of patients' views.
- All care records should contain individual plans for unexpected exit from services.
- Ensure all patients at Ambition Bootle have a review as per trust policy.
- There should be effective systems for audit and review in relation to care records.
- Ensure the action plan to ensure the completion of risk management plans and care records at Ambition Bootle is implemented.

Mersey Care NHS Foundation Trust

Detailed findings

Mental Health Act responsibilities

Mental Health Act training was mandatory for all trust staff. Local records indicated that the majority of staff in the following core services had completed Mental Health Act training at the time of inspection: wards for people with learning disabilities and autism; learning disability and autism secure services; high secure services; medium and low secure services. However, only 56% of staff in wards for older people with mental health problems were compliant.

We did not review adherence to the Mental Health Act and the Mental Health Act Code of Practice at substance misuse services because these services did not accept patients who were detained.

We were satisfied that the specific powers and duties of the hospital managers were being discharged according to the provisions of the Mental Health Act. Their role was embedded within the trust. They were able to contact the Mental Health Act lead, director of patient safety or responsible non-executive director at any time. Several training sessions were provided by the trust solicitors each year, with additional training for high secure services. Hospital managers were assessed, appraised and reviewed annually before re-appointment. They fully understood the responsibilities and requirements of their role.

Staff we spoke with, including staff from areas where compliance with training was low, were able to tell us how they applied the Mental Health Act within their role. This included facilitating section 17 leave and ensuring that legal paperwork was present and up to date. Staff received regular legal and practice updates through the Mental Health Act lead bulletin. They felt supported by Mental Health Act administrators, and knew who to contact for legal advice when needed. Mental Health Act administrators were based on site at all of the secure services.

Mental Health Act documentation was received by a qualified nurse and scrutinised by a Mental Health Act administrator prior to patients' admission. Patients had their rights under the Mental Health Act explained to them initially and routinely thereafter. Easy read versions of Mental Health Act leaflets were available for patients with a learning disability or who needed these.

Consent to treatment and capacity requirements were adhered to, and copies of consent to treatment forms were attached to medication charts where applicable. Detention paperwork was up to date and filled in correctly. There were efficient systems in place to prompt staff to complete section renewals, section 132 checklists and tribunal reports. Mental Health Administrators audited documentation and escalated any concerns through the Mental Health Act law governance groups.

All patients in high secure services who were cared for in long-term segregation were reviewed on a daily basis, consistent with the requirements of the current Code of Practice. Segregation care plans were up to date and comprehensive.

There was an inter-agency working group including hospitals, approved mental health professional services, police and ambulance which considered the implications of sections 135 and 136. These services had a joint policy.

Their work was monitored and reported in to the trust Mental Health Act law governance group. There was also a street car triage system provided jointly with police, which had reduced the use of section 136 by 40%.

At the time of inspection, a number of trust policies referred to the 2008, rather than 2015, Mental Health Act Code of Practice. These policies included:

- Mental Health Act 1983 overarching policy
- Consent to treatment policy
- Leave for an informal patient and equality and human rights analysis
- Section 117 – aftercare under the Mental Health Act 1983
- Seclusion.

This meant that staff were not following current guidance, and is a breach of regulation. The trust updated all of these policies in April 2017 to refer to the 2015 Mental Health Act Code of Practice.

Mental Capacity Act and Deprivation of Liberty Safeguards

CQC have made a public commitment to reviewing provider adherence to MCA and DoLS.

Staff compliance with training in the Mental Capacity Act was below 75% on medium and low secure wards (30%) and wards for older people with mental health problems (57%). However, most staff we spoke with in all core services showed a good understanding of the principles and application of the Act. Some staff in high secure services carried the five principles on a small folding card. We saw some very good examples of Mental Capacity Act assessments and best-interest decision making in high secure services, learning disability and autism secure wards, wards for older people with mental health problems and wards for people with learning disabilities and autism.

Staff at Heys Court, a ward for older people with mental health problems, did not always understand the principles and application of the Mental Capacity Act. There was one patient on the ward waiting for a Deprivation of Liberty Safeguards assessment from the local authority. We could not find any evidence that his capacity had been assessed or reviewed since November 2016. We also observed that staff did not have a system in place to prompt them well in advance of when an existing Deprivation of Liberty Safeguards authorisation was nearing time for renewal.

Two core services had applied to the local authority for Deprivation of Liberty Safeguards in the past 12 months – wards for older people with mental health problems and wards for people with learning disabilities and autism. The trust is required to notify CQC of any Deprivation of Liberty Safeguards authorisations granted. Wards for older people had failed to notify us of eight of 26 approved applications, wards for people with learning disabilities had failed to notify us of their one single approved application.

The trust had a Mental Capacity Act overarching policy, which included the new case law (Birmingham City Council) ruling about the application of the Act to young people aged 16 and 17. It also had a 'Management of the deprivation of liberty safeguards (DoLS) within the meaning of the Mental Capacity Act 2005' policy. This stated that copies of standardised authorisation should be forwarded to CQC.

Requires improvement

Are services safe?

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

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

Summary of findings

We rated safe as requires improvement because three of the core services we inspected on this occasion, and two core services we inspected previously, were rated requires improvement for this key question.

- Four of the wards in medium secure services included rooms that were used for patients' laundry and disposal of dirty mop water. This presented a risk of cross-infection, which had not been adequately mitigated by the trust.
- Staff vacancy and sickness rates were higher than the average for mental health trusts in England. Staffing on STAR unit, a ward for people with learning disabilities and autism, was not sufficient to manage patients' level of need.
- There was low compliance with training in basic and immediate life support on three wards for older people with mental health problems and one ward for people with learning disabilities and autism.
- Staff did not always manage medicines safely in wards for older people with mental health problems and on the STAR unit.
- Seclusion rooms on three wards in medium secure services had the potential to breach patients' privacy and dignity due to the positioning of their windows.
- The trust's systems did not allow them to accurately report on all safeguarding indicators.

However:

- The physical environment at core service locations was mostly clean and well maintained. Clinic rooms were well-equipped and staff ensured that all clinical equipment was checked and maintained according to manufacturers' standards. All of the trust's inpatient and supported living areas had a ligature point risk assessment completed within the last 12 months. (A ligature point is something to which a person at risk of self-harm could attach a cord, rope or other material for the purpose of hanging or strangulation.)
- Security arrangements worked well. Staff managed alarms and keys safely. The trust had an effective restrictive practice reduction programme called No Force First. Use of prone restraint had decreased significantly since our previous inspection.
- Most teams had put measures in place to reduce the impact of low staffing. Staffing was discussed regularly at all levels within the trust. Overall compliance with mandatory training across the core services was high at 89%.
- The trust had a safeguarding strategy and a clear commitment to safeguarding. Almost all of the individual patient risk assessments we reviewed were thorough and up to date. There was evidence of good medicines management across all of the core services and most of the wards.
- Staff reported incidents appropriately and in a timely manner. The trust had acted to reduce incidents and promote reporting since our last inspection. Learning from incidents was fed back to staff through team meetings, supervision and quality practice alerts. The trust had a 'being open' policy, which included duty of candour. The trust monitored adherence to duty of candour legislation.
- The trust had an effective estates strategy and had taken potential risks into account when planning services.

Our findings

Safe and clean environments

The physical environment at core service locations was mostly clean and well maintained.

Requires improvement

Are services safe?

The trust's scores on the 2016 patient-led assessments of the care environment for their hospital sites were 99 out of a possible 100 for cleanliness and 94 for condition, appearance and maintenance. Patient-led assessments of the care environment are self-assessments undertaken by teams of NHS and independent health care providers. The teams include at least 50% members of the public. The trust's scores were broadly in line with the 2016 England average of 98 for cleanliness and 95 for condition, appearance and maintenance. In 2015, the trust scored 95 for cleanliness and 82 for condition, appearance and maintenance. This shows that the trust had improved in both areas since 2015.

Staff adhered to infection control principles including handwashing and safe disposal of clinical waste. However, four of the wards at Scott Clinic (the trust's medium secure forensic unit) contained a risk of cross-infection, which had not been adequately mitigated by the trust. On these wards the room that was used for patients' laundry also contained the metal sink that was used for disposal of dirty mop water. This meant that patients' clean laundry could potentially become contaminated.

Clinic rooms were well-equipped and staff ensured that all clinical equipment was checked and calibrated according to manufacturers' standards. Refrigerators used to store medication were within the required temperature range with one exception. On Boothroyd ward (a ward for older people with mental health problems) there were six occasions in March 2017 when the temperature exceeded 8°C. We raised this with the ward pharmacist who took action to ensure that staff did not administer medications that had been compromised.

Almost all of the locations we visited had up to date environmental health and safety risk assessments. The fire risk assessment at the Windsor Clinic (a ward for people recovering from alcohol or substance misuse) was out of date.

All of the trust's inpatient and supported living areas had had a ligature point risk assessment completed between February 2016 and January 2017. A ligature point is something to which a person at risk of self-harm could attach a cord, rope or other material for the purpose of hanging or strangulation. When we visited ward environments we saw that ligature point risk assessments and action plans were up to date and available to staff. We also saw evidence of the trust making changes to ward environments following ligature point risk assessments, for example by fitting a cover to a television satellite point. Staff we spoke with knew where the ligature points on their wards were, and explained how they would use individual risk assessment and management plans to help keep patients safe. There were 893 ligature incidents across the trust between 1 January 2016 and 31 December 2016. Only 18 of these incidents were attached from a ligature point. Nine of these were from a door. There had been one death by hanging on one of the trust's hospital sites, Clock View Hospital.

All of the mental health wards we visited were compliant with the Department of Health mixed-sex accommodation guidelines. Most of the ward layouts did not have clear lines of sight to allow staff to easily observe all patient areas. Staff had reduced risks by using zonal observations and convex mirrors. Patients on wards had access to nurse call buttons from their bedrooms. On Boothroyd ward (a ward for older people with mental health problems) patients wore call buttons as wristbands to make it easier for them to get nurses' attention.

Security arrangements were effective. On the wards, there were procedures in place to ensure that staff alarms and keys were safely managed. In the community services for people recovering from substance misuse there were locked doors between patient and staff areas.

The trust had a 2016/17 to 2021/22 estates framework, which linked in with the overall trust strategic framework. We saw evidence of investment in estates during our site visits, for example a rolling programme of refurbishment in high secure services and a complete renovation of the 'Life Rooms' in Walton to provide a hub for the local community. At our last inspection, June 2015, we issued a requirement notice to the trust because the environment of Irwell Ward (a ward for older people with mental health problems) was not safe for patients. In June 2015 we observed that reflective glass in windows and doors on the ward was causing accidents and confusion to patients with dementia. When we visited Irwell ward during this inspection we found that the trust had made significant improvements to the environment in line with best practice guidance.

However we also saw that the quality of some of the existing estate, especially at the Scott Clinic (medium secure unit), was making it difficult for staff to deliver safe and effective care. At our last inspection in June 2015, we

found that the seclusion ward on Myrtle ward did not comply with the standards set out in the Mental Health Code of Practice. At this inspection we found that this seclusion room had been moved to a different location within the ward. We still had concerns that seclusion rooms on Myrtle, Ivy and Hawthorn wards had the potential to breach patients' privacy and dignity because of the positioning of their windows. Staff added additional curtains to the windows following our inspection.

Safe staffing

The trust was experiencing difficulties with staff recruitment, retention and sickness. There were 12 risks on the trust's February 2017 risk register relating to safe staffing. Nine of these risks had a current rating of 12 (moderate and likely) with the remaining three risks rated lower. Two of the risks (unsafe staffing and high sickness absence) had been escalated to the board assurance framework and discussed at board meetings.

Information provided by the trust showed that, on 31 December 2016, they had 4325 whole time equivalent substantive staff. Between 1 January 2016 and 31 December 2016, 19% of staff left the trust. The percentage of staff leaving learning disability and autism secure wards was higher at 31%. This was due to uncertainties about the division's future. The trust had 7% staff vacancies and 8% staff sickness absence during the same period. The trust's vacancies and sickness rates had increased since our last inspection. On 31 January 2015 vacancies were at 5% and average sickness between 1 February 2014 and 31 January 2015 was 6%. We also looked at the average sickness rates for a three-month period so that we could compare the trust with the national average for mental health and learning disability trusts. According to NHS Digital, Mersey Care NHS Foundation Trust's average sickness absence rates from October to December 2016 were 7% while the national average was 5%.

High secure services had establishment staffing levels, and then a lower 'safe staffing' quota which the trust considered to be the minimum number of staff to ensure safety on the ward. We found that wards were meeting the 'safe staffing' levels. Keats ward and Ruskin ward had high levels of sickness (19% each) and turnover (19% and 18% respectively) between 1 January and 31 December 2016. Over the same period 20132 shifts could not be covered by substantive staff due to sickness, absence or vacancies. Sixty-two per cent had been filled by bank staff and 38% went unfilled. We saw that additional healthcare assistants were often brought in to cover qualified nurse absences.

Learning disability and autism secure wards had a 35% vacancy rate for qualified nurses, which is significantly higher than the trust average of 7%. This amounted to 38.3 whole time equivalent posts. When we visited this core service, we found that this vacancy rate was being managed well. There were enough staff on the wards to meet patients' needs. All bank and agency staff had had a local induction and were familiar with the wards and patients. Patients had access to regular activities and time with their named nurse. However, 30% of shift hours over the previous twelve months had gone unfilled by bank or agency staff, and some of the healthcare assistants told us that the loss of experienced colleagues was making it more difficult for teams to support patients with complex needs.

Wards for older people with mental health problems had the highest sickness absence rate with 14.5%. Within wards for older people, Oak ward and Heys Court had particularly high rates with 23% and 20% respectively.

In medium and low secure services, staff vacancies were lower than trust average at 2.2% but staff sickness absences were higher at 10.7%. When we visited the wards, staff and patients both told us that escorted leave was often postponed due to lack of staff. We could not check exactly how often this happened or how many patients were affected because the trust did not centrally record this information.

On wards for people with learning disabilities or autism, staff vacancies and sickness rates were both lower than the trust average at 2.7% and 0.1% respectively. However, we found that there were still not enough staff to cover patient observations at the STAR unit. Some staff were being asked to do up to seven hours of continuous observations, when the trust policy advised that two hours should be the maximum. We were concerned that staff were not getting breaks and that the effectiveness of their observations and therefore safety of their patients could be affected.

Many of the nurses, healthcare assistants and student nurses that we spoke with told us that staffing on the wards

was insufficient. Student nurses said that they could often feel pressured to cover healthcare assistant tasks on the wards, which made it difficult for them to complete their learning outcomes.

At the time of inspection a large number of trust staff in substance misuse services were about to undergo organisational change as a result of reduced funding. The trust had chosen to keep some vacancies available for these staff, which meant that community teams had been understaffed for some time and individual caseloads were high. Teams had put measures in place to monitor staff caseloads and plan frequency of appointments according to individual patients' risks.

The trust used the Telford Professional Judgement Model to calculate their ward establishment staffing levels. Ward staffing levels were formally reviewed twice a year at staff review panels chaired by the divisional head of nursing and senior managers. Each ward manager presented figures for their ward including patient acuity and use of bank and agency staff. The panel would then discuss whether the current staffing establishment met the needs of the ward. At team level, quality dashboards allowed for the tracking of patient experience (for example, provision of meaningful activity) against staffing.

The trust had recognised the risk of being unable to meet the staffing requirements on mental health wards at time of increased clinical need, which could impact on safety. The trust had agreed a recruitment and retention map and established a task and finish group to address the high number of vacancies. The trust had a recruitment and retention strategy in place, which included a rolling scheme to recruit more staff than were needed to fill current vacancies. For example, 53 new staff had been recruited to fill 42 vacant posts at high secure services. This reduced the impact of high staff turnover.

Staffing was discussed regularly at the trust executive committee, quality assurance committee, and divisional quality surveillance groups. We reviewed the monthly safer staffing report submitted to the executive committee for December 2016. It provided assurance that the trust was reviewing actual against clinically required staffing levels, and assessing the impact (for example by monitoring the percentage of incidents and complaints relating to staffing). Each division had a detailed action plan to address the impact of, and reasons for, staffing shortfalls.

Ward managers were able to request additional staff according to clinical need (for example, if multiple patients were being cared for under enhanced observation). We saw that, where shifts for qualified nurses could not be filled, additional healthcare assistants, occupational therapy staff and ward managers themselves completed clinical duties to ensure patient safety.

All of the core services we visited had access to adequate medical cover. Doctors could attend the wards quickly in an emergency. Staff told us that it was easy to contact responsible clinicians and junior doctors during the day and out of hours.

Information provided by the trust before the inspection showed that the overall mandatory training compliance for the core services we inspected was 89%. The mandatory training topics for all core services except learning disability and autism secure services were: conflict resolution; equality, diversity and human rights; fire safety; health and safety; infection control; Mental Health Act and Deprivation of Liberty Safeguards level two; moving and handling; safeguarding adults levels one, two and three; and safeguarding children levels one, two and three. Compliance rates for each of these five core services were above 75% with the following exceptions:

- Mental Health Act and Deprivation of Liberty Safeguards level two: high secure wards 3%; medium and low secure wards 30% and substance misuse services 61%.
- Safeguarding adults level two: substance misuse services 62% and wards for people with learning disabilities or autism 57%.
- Safeguarding adults level three: high secure wards 38%, substance misuse services 62% and wards for people with learning disabilities or autism 70%.
- Safeguarding children level two: substance misuse services 61% and wards for people with learning disabilities or autism 57%.
- Safeguarding children level three: high secure wards 38%, substance misuse services 62% and wards for people with learning disabilities or autism 70%.

Moving and handling of people was mandatory training for staff working on wards for older people with mental health problems. Compliance with this training was low at 42%.

Requires improvement

Are services safe?

Basic life support and immediate life support were not listed as mandatory training topics. However we looked at compliance as part of our expectation that staff have the skills, knowledge and experience to deliver effective care and treatment. Compliance rates for each of the same five core services were above 75% with the following exceptions:

- Basic life support: wards for older people 68%
- Immediate life support: wards for older people 45%

We had concerns that some individual wards showed very low levels of compliance with basic life support, which could put patients at risk of not receiving timely and effective interventions in an emergency. These wards were: STAR unit (60%), Boothroyd ward (43%) and Heys Court (55%).

Autism and learning disability secure services had a different set of mandatory training topics. These were: information governance, fire, positive management of vulnerable adults, infection control, food hygiene, moving and handling, equality and diversity, safeguarding, life support, Mental Capacity Act and Mental Health Act. Staff compliance with this training was between 84% and 97%. At our last inspection of Calderstones NHS Foundation Trust (October 2015) we issued a requirement notice to wards for people with learning disabilities or autism for a breach of regulation 18 (staffing). This was because only 58% of staff were up to date with training in basic life support. At this inspection, compliance rates for all wards for basic life support were above 95%, which meant that the requirement notice had been met.

Team level reports were available to managers from 6 February 2017. This meant that managers could monitor their staff's training compliance more easily.

Assessing and managing risk to patients and staff

The trust had a restrictive practice reduction programme called 'No Force First'. Training sessions had been delivered to all wards in the local and secure divisions by qualified trust facilitators and an expert by experience with experience of being restrained. The No Force First training manual (Positive and Safe Violence Reduction and Management Programme) was developed by the trust's high secure steering group and endorsed by the National Institute for Health and Care Excellence. There was a clear focus on prevention of aggression rather than reactive strategies. At the time of inspection, training was being rolled out to learning disability and autism secure wards. These wards were already implementing 'Safewards', which is an evidence-based model for reducing restrictive practice that has similar principles to No Force First.

Between 1 January and 31 December 2016 the trust reported 3109 incidents of restraint, 776 incidents of seclusion and 350 incidents that resulted in the use of rapid tranquilisation. Rapid tranquilisation is the use of medication, usually administered by injection, to sedate a patient who is posing a risk to themselves or others. Learning disability and autism secure services had the most incidents of restraint with 1504, which accounted for almost half of the trust's restraint incidents. The trust told us that they had reduced their overall use of physical restraint by 22% between 2015 and 2016, and reduced the use of rapid tranquilisation on learning disability secure wards by 80%. There had also been a 40% reduction in work-related sickness over the same period, which suggests that fewer staff were being hurt during incidents.

The use of rapid tranquilisation was now considered in the trust's policy for reducing restrictive practices and there were plans to include the monitoring the use of rapid tranquilisation at the trust's secure and local divisions' reducing restrictive practice groups, as part of the trust's commitment to reducing restrictive practice.

There were 185 incidents of prone restraint, which accounted for 6% of restraints. The trust's No Force First training manual defined prone restraint as 'physical restraint that involves a service user being placed chest-down for any period (even if briefly prior to being turned over)'. Prone restraint can increase risk of physical and psychological harm to patients. It should therefore never be used as a planned intervention and used for only the shortest possible time as an unplanned intervention (Mental Health Act Code of Practice, 2015; National Institute for Health and Care Excellence guideline NG10 Violence and aggression). At our previous inspection we found that 18% of restraints between September 2014 and February 2015 were prone. This meant that the trust had reduced the proportion of their restraints that were prone by 67% over a two-year period. When we inspected the wards and reviewed a sample of incidents, we found that prone restraint was used only in circumstances there were no less

restrictive alternatives appropriate and proportionate to the risks posed. All incidents of prone restraint were reviewed by the No Force First divisional lead to address trends and try to prevent future episodes.

Across the trust, 69% of eligible ward staff were trained in restrictive interventions. In local and specialist learning disability divisions, this training did not include the deliberate use of prone restraint, but did include safe management of prone restraint that might occur in the context of the incident. In the secure division training included the safe use of prone restraint for incidents that were judged to be unmanageable or life-threatening. This training included a modification to lift the patient's chest from the floor so that their breathing would not be restricted.

The trust had a safeguarding strategy and its safeguarding policies and procedures were up to date. Policies and procedures referred to current legislation and national and local guidance. This included human trafficking and modern slavery legislation, and guidance on female genital mutilation. The 'safeguarding adults from abuse' policy had been updated to reflect the requirements of the Care Act 2014, which was a recommendation that we made following our last inspection.

There was a commitment to safeguarding at all levels of the trust. The trust's quality assurance committee was responsible for ensuring that arrangements to safeguard adults and children were managed appropriately across the organisation. It was supported by the safeguarding strategy committee, which met quarterly, and the safeguarding operational group, which met monthly. The safeguarding strategy committee and safeguarding operational group worked together to assist board scrutiny of safeguarding arrangements, implement policy and recommendations from statutory agencies, and identify and report significant risks related to safeguarding.

The trust had commissioned a peer review of their safeguarding arrangements from a local university in November 2015, and had taken action based on recommendations. For example, the trust had recruited an additional safeguarding specialist practitioner in June 2016.

Senior trust staff attended local safeguarding children boards and safeguarding adults boards, and held regular monitoring meetings with commissioners. There was also a named doctor and named nurse for safeguarding children. Trust safeguarding leads received external supervision from safeguarding leads within Liverpool clinical commissioning group safeguarding children/adults teams.

The trust had 37 safeguarding ambassadors embedded in clinical teams. The trust's own evaluation of the ambassador role, and comments from the ambassadors we spoke with, indicated that they saw their safeguarding role as an 'add on'. They said it was difficult to find the time to do the role properly. Only four of the 37 safeguarding ambassadors had attended regular group safeguarding supervision.

The trust made 712 adult safeguarding and 149 child safeguarding referrals to the local authority between 1 January and 31 December 2016. When we visited the core services we found that all of the staff we spoke with understood the procedure to report and escalate safeguarding concerns. There was clear guidance on the staff intranet and on display in office areas to help staff know what to do if they were worried that patients or their families might be at risk of abuse.

However, commissioners told us that the trust did not always meet their key performance indicators in relation to safeguarding. When we reviewed the information we could see that the trust's systems did not allow them to report on some indicators accurately, for example the percentage of strategy meetings attended or whether safeguarding issues were covered during clinical supervision. This meant that some targets were not being met. The trust had considered how to improve their reporting.

Sixty-three per cent of staff were compliant with Prevent strategy training at the end of December 2016, which is on target for the rolling strategy specified by clinical commissioning groups. Prevent is a government initiative aimed at reducing the risk of vulnerable people being drawn into extremism.

We reviewed 250 individual patient risk assessments across the six core services. Two hundred and forty-two of these were thorough and up to date. All of the secure services (high, medium, low and those for people with a learning disability) used nationally-recognised risk assessment tools to provide a comprehensive formulation of patients' risks, including the risk of violence. This showed that staff were recording and acting on information needed to keep themselves and their patients safe. Four risk assessments

at Ambition Sefton (Bootle) (a community substance misuse service) did not include risk management plans. Four risk assessments across wards for older people with mental health problems were not up to date.

There was evidence of good medicines management across all of the core services and most of the wards. Medicines were stored safely and securely, with the exception of Boothroyd ward where the refrigerator temperature was noted to be out of range on six occasions in March 2017. We reviewed 226 patients' medication charts across the six core services. All but four were completed thoroughly, with mandatory information such as date of birth and allergies and medicines signed for as given. On Irwell ward, a ward for older people with mental health problems, the administration of medicines and patients' allergy status was not always recorded on individual medication charts. On the STAR unit, a ward for people with a learning disability or autism, a medication reconciliation error meant that medication for one patient was not continued for two days. Also on the STAR unit a different patient had not received medication for three days as it was not available from the pharmacy. This was a breach of regulation.

The trust had a medicine optimisation strategy and performance metrics but the pharmacy services business plan was not linked to the trust's business plan. Since our previous inspection, the trust had completed a roll out of electronic prescribing and medicines administration within the secure services division. Benefits realisation had not yet been completed but nurses and doctors we spoke with were positive about the new system. Further roll out had paused to ensure that NHS England standards (dictionary of medicines and devices specification) for communicating medicines information were met.

Additionally, pharmacy staffing had been reviewed at Broadoak (a hospital that was not inspected on this occasion) and within learning disability and autism secure services. However, the trust was not meeting its own target for medicines reconciliation within only 78% of patients having their medicines reconciled within 72 hours of admission to hospital. A re-audit was being completed in March 2017.

Track record on safety

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

Providers of care for NHS patients are required to report serious incidents to the Strategic Executive Information System. These include 'never events' (serious patient safety incidents that are wholly preventable). The trust reported 232 serious incidents between 1 November 2015 and 31 October 2016. None of these were never events.

For the same period, 1 November 2015 to 31 October 2016 the trust reported 236 serious incidents through its internal reporting system. We checked these incidents against the incidents listed in the Strategic Executive Information System extract and were satisfied that incidents had been reported appropriately and in a timely manner. Twenty-four per cent of all incidents were categorised as apparent, actual or suspected self-inflicted harm. The high secure service reported more incidents than any other core service – 36% of the total.

Providers are also encouraged to report all patient safety incidents of any severity to the National Reporting and Learning System at least once a month. The trust reported 7336 incidents to the System between 1 November 2015 and 31 October 2016. Of the incidents reported, 73.5% resulted in no harm, 23.8% resulted in low harm, 1.3% resulted in moderate harm, 0.7% resulted in severe harm and 0.6% (47 incidents) resulted in death. 34.3% of incidents related to self-harm. Between April and September 2016 the trust took a median of 23 days to report incidents to the National Reporting and Learning System. This was slightly faster than the 27 day average for NHS mental health trusts. During the same period the trust had a reporting rate of 35 incidents per 1000 bed days, which puts them in the middle 50% of NHS mental health trusts.

Between October 2015 and October 2016, the trust recorded 1587 cases of 'harm free' care. They reported a median of 97.5% per month for the rate of harm free care since July 2012. The trust reported 31 falls with harm between December 2015 and December 2016. In October

2016, the trust completed a fall audit across wards for older people with mental health problems and found that 32% of patients were not promptly examined by a doctor following a fall.

In the NHS Staff Survey 2016, 29% of staff said that they had experienced physical violence from patients, relatives or the public in the last 12 months, which is eight percentage points more than the national average. Three per cent of staff said that they had experienced physical violence from staff in the last 12 months, which is the same as the national average for mental health trusts.

At our June 2015 inspection we reported the following findings from the NHS Staff Survey 2014: the trust scored worse than average with regards to 'staff witnessing potentially harmful errors, near misses or incidents in the last month', 'fairness and effectiveness of incident reporting procedures' and 'percentage of staff agreeing they would feel secure raising concerns about unsafe clinical practice'. The trust's scores had improved in the NHS Staff Survey 2016. 'Fairness and effectiveness of incident reporting' was still slightly worse than average but scores for 'staff witnessing potentially harmful errors, near misses or incidents in the last month' and 'percentage of staff agreeing they would feel secure raising concerns about unsafe clinical practice' were within the average range. This suggests that the trust has acted to reduce incidents and promote reporting.

Reporting incidents and learning from when things go wrong

The trust did not receive any prevention of future death reports from local coroners in the 12 months leading up to the inspection. The most recent prevention of future death report issued to the trust was in October 2013. Coroners have legal powers and duties to write reports when the findings of an inquest indicate that there is a risk of other deaths occurring in similar circumstances. The reports are sent to people or organisations who are in a position to reduce this risk. They must respond within 56 days to say what action they plan to take.

The head of patient safety told us that the trust worked closely with families and coroners following patient deaths. They explained that if their own internal investigation suggested that there were risks to other patients then they would act quickly to ensure that measures to reduce these risks were put in place. Staff felt that this could often mean that a prevention of future deaths report was not necessary. When we viewed the trust's internal investigations into patient deaths we could see that the trust did complete a thorough action plan and did work closely with families. This process was underpinned by the trust's 'Being Open' policy.

Staff reported incidents through an electronic reporting system. Staff we spoke with were able to describe the types of incident that they would report. They understood the systems by which the incidents would be reviewed. Learning was fed back through team meetings, supervision and quality practice alerts. The trust also held Oxford Model events, where staff discussed lessons learned from incidents or complaints.

Duty of Candour

The trust had a 'Being Open' policy, which included duty of candour. Duty of candour is a legal requirement for providers of health and social care services to be honest and to apologise to people when things go wrong. The trust policy emphasised the importance of honest, open communication with patients, carers, partner organisations and commissioners.

The trust provided training on duty of candour for staff who were likely to have direct contact with patients and carers who had been involved in a serious incident. The training included information on working with people who are bereaved, the statutory requirements of duty of candour and the role of family liaison manager. The Patient Advice and Liaison Service and director of patient safety provided direct support and guidance for staff working with people affected by a serious incident.

The trust recorded all duty of candour appropriate incidents on their risk management database. Information on timeliness of initial contact made with patients and carers, progress of investigations and completion and sharing of reports was reviewed once every two months by the trust's quality assurance committee. This enabled the trust to monitor adherence to duty of candour legislation.

We reviewed a sample of ten duty of candour notifiable incidents and were satisfied that the trust had met the requirements.

Anticipation and planning of risk

Requires improvement

Are services safe?

The trust had taken potential risks into account when planning services. The trust risk register included twelve items relating to anticipation and planning of risk.

The trust had an up to date business continuity policy, which met NHS Emergency Preparedness, Resilience and Response Framework requirements. The policy described how the trust would maintain critical services during a disruptive event. Disruptive events include fires, breakdown of utilities, significant equipment failure, hospital acquired infections and violent crime. The policy clearly outlined responsibilities for relevant departments (for example communications and estates) and for all staff.

The trust also had a set of lockdown procedures and action cards for use in an emergency (for example, a bomb threat).

Good

Are services effective?

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

Summary of findings

We rated effective as good because four of the core services we inspected on this occasion, and all of the core services we inspected previously, were rated at least good for this key question.

- Care planning and record keeping were mostly good throughout the trust. All patients with a learning disability or autism who presented with challenging behaviour had high-quality positive behaviour support plans. Staff could easily access the information they needed to be able to deliver safe and effective care.
- We saw many examples of best practice being implemented across the core services. NHS England's recommendation to 'stop the overmedication of people with a learning disability' was reflected in trust policy and practice. There was a clear aspiration across high secure services to reduce the use of seclusion and long-term segregation.
- The trust had recruited an additional 19 psychology staff since our last inspection, which increased the availability of psychological therapies. The quality and range of psychological and occupational therapies in learning disability and secure services was excellent.
- Overall, staff were experienced and skilled. All had received additional training to support them in their role. The majority of staff in high secure, medium secure, low secure, learning disability and autism secure and substance misuse services were compliant with trust policy requirements for supervision and annual appraisal. The trust had a leadership development pathway that was open to all staff.
- There were policies and support in place to address staff poor performance. The trust was in the process of implementing a 'fair and just culture' based on feedback from staff.
- Multidisciplinary meetings and handovers were patient-focused and effective. All of the teams worked collaboratively with external organisations.
- Most staff had completed Mental Health Act and Mental Capacity Act training. There were effective systems in place to ensure that the requirements of the Mental Health Act and Code of Practice were met. Most staff understood the application and principles of the Mental Health Act and Mental Capacity Act.

However:

- Five trust policies referred to the out of date 2008 Mental Health Act Code of Practice, which meant staff were not following current guidance.
- The trust had not notified CQC of authorised Deprivation of Liberty Safeguards applications. This is a requirement of their registration.
- At Wavertree Bungalow, care plans for patients who were not independently mobile did not include a detailed moving and handling risk assessment. Also at Wavertree Bungalow, there was insufficient information in care records to enable staff to safely support two patients with epilepsy.
- Psychological therapies and dementia-appropriate environments were not consistently available across all wards for older people with mental health problems.
- Compliance rates for supervision and/or appraisal were low on three wards for older people with mental health problems and one ward for people with learning disabilities or autism.
- Staff on the STAR unit (a ward for people with learning disabilities and autism) had not received training in autism, learning disability, epilepsy and communication skills.
- Only 56% of staff on wards for older people with mental health problems had completed Mental Health Act training.

Good

Are services effective?

- Only 30% of staff in medium and low secure services and 57% of staff in wards for older people with mental health problems had completed Mental Capacity Act training.

Our findings

Assessment of needs and planning of care

Care planning and record keeping was mostly effective throughout the trust. We reviewed 252 care records across the six core services. All of the records in high secure services, medium and low secure services, learning disability and autism secure services and wards for older people with mental health problems contained a comprehensive multidisciplinary assessment of patients' needs completed shortly after admission. Patients in these core services also had personalised, recovery-oriented care plans. However, five care plans for patients in wards for older people with mental health problems were not up to date and 21 records we viewed in substance misuse services did not contain a complete needs assessment or complete care plan.

All patients with a learning disability or autism who presented with behaviours others find challenging had high-quality positive behaviour support plans. This meant that the staff working with them could easily understand the reasons behind the challenging behaviour, and could therefore act to support the patient in a safe and person-centred way. Patients using the health respite service at Wavertree Bungalow all had acute care plans based around the activities of daily living model. Some patients in learning disability and autism secure services had sensory assessments and sensory diets, which helped staff ensure that their environments did not contain any stimuli (such as noises and lights) that might distress them. Most of the patients across the core services also had care plans for physical health where a specific need had been identified. This included nutrition and hydration needs.

However, at Wavertree Bungalow care plans for patients who were not independently mobile did not include a detailed moving and handling risk assessment. This is a requirement of the trust moving and handling policy and the Manual Handling Regulations 1992. Also at Wavertree Bungalow, there was insufficient information in the care record to enable staff to safely support two patients with epilepsy. This is a breach of regulation.

The trust used three different electronic patient record systems: one for high secure services, one for learning disability and autism secure services, and one for all other services. We did not identify any problems in communication when patients moved between different divisions (for example, high to medium secure). All staff except for healthcare assistants on wards for people with learning disabilities and autism, and agency staff across the trust who had not completed the relevant induction, could access the electronic system. We saw that key details about patients were held on confidential paper files on wards that were affected, which meant that all staff could easily access the information they needed to deliver safe care. This information included 'one page profiles' and positive behaviour support summaries for people with a learning disability, and a 'know your patient' file created by patients on medium secure services explaining how they would like to be treated when distressed.

All electronic and paper records were stored securely. However, on four wards in medium secure services, patients could see into the staff office through the window in the seclusion room. We were concerned that patients might be able to see computer screens, which could breach confidentiality when staff were inputting to patients' electronic records. The trust took immediate action by ordering privacy screens for all computers across the site.

Best practice in treatment and care

Trust operational policies referred to best practice guidance in treatment and care. We saw many examples of best practice being implemented when we visited core services. This included National Institute for Health and Care Excellence guidance on violence and aggression, medicines management, personality disorder, schizophrenia, dementia and substance misuse. The trust also had overall strategies in place for patients with specific mental health problems including eating disorders and personality disorders.

Pharmacists attended the wards and multi-disciplinary meetings to support prescribers. Patients who were prescribed high levels of anti-psychotic medication received all of the recommended physical health checks.

However on Irwell ward (a ward for older people with mental health problems) one patient was prescribed covert medication, but there was no guidance in the patient's care plan about how to administer it appropriately.

NHS England's recommendation to 'stop the over medication of people with a learning disability' was reflected in trust policy and in practice in learning disability and autism secure services. The recommendation is about reducing the use of psychotropic medication to control challenging behaviour. All of the doctors we spoke with on these wards were able to give a clear rationale around antipsychotic prescribing. In community substance misuse services, a doctor or non-medical prescriber reviewed patients who were prescribed an opioid replacement at least once every six months. Staff at Brook Place had liaised with a local acute trust to arrange for a nurse to offer blood-borne virus testing at Brook Place. They had also applied for funding to provide treatment for Hepatitis C, which is in line with recommendations made by the Public Health England Hepatitis Report (2014).

At our last inspection in June 2015 we issued a trust-wide requirement notice for a breach of regulation 18 (staffing). At that time there was evidence that individuals were not receiving timely access to psychological therapies. The trust has since recruited an additional 19 psychology staff, mainly across the local division. The head of psychology appointed shortly before our previous inspection had worked closely with clinical and forensic psychologists across the trust to standardise provision and keep track of demand. There were plans in place to train the whole workforce in the delivery of different levels of psychological formulation and interventions for all service users. We therefore considered that this requirement notice had been met.

A range of psychological therapies was available in all of the secure services, in substance misuse services and at the STAR unit (a ward for people with learning disabilities and autism). Clinical and forensic psychologists also facilitated reflective practice groups for staff, and contributed towards multi-disciplinary assessment. There were examples of outstanding practice in learning disability and autism secure services. The psychological treatment services team at this core service was able to provide evidence-based therapies specifically for this patient group. These included cognitive behaviour therapy, dialectical behaviour therapy, cognitive analytic therapy, art psychotherapy, systemic therapy and an adapted sex offender treatment programme. The wider multidisciplinary team had also developed bespoke packages. We observed an 'autism risk group' which helped patients with autism understand and recognise situations that might lead them to offend. We were impressed by the level of engagement staff had achieved.

Psychological therapies and dementia-appropriate environments were not consistently available within wards for older people with mental health problems. Irwell and Boothroyd wards each had a clinical psychologist providing dedicated time. Oak ward, Acorn ward and Heys Court did not, however patients did have access to occupational therapy and may have been able to access psychological therapies through their community teams. Environments on Acorn,Oak and Irwell wards fully met the needs of patients with dementia, but Boothroyd ward and Heys Court did not.

The trust had also fully implemented their 'no force first' restrictive practice reduction programme since our last inspection. Physical restraint across the trust had reduced by 22% since 2015. In high secure services, we saw that significant improvements had been made in patient welfare and treatment. There was a clear aspiration across the service to reduce the use of seclusion and long-term segregation through positive risk-taking and patient empowerment. Some staff told us proudly of how past patients had been transferred to medium and low secure services, and then discharged.

The trust ran a recovery college, available to all patients in the trust including those in high secure services. The 31 available courses were designed to assist recovery and improve wellbeing. This kind of 'supporting self-management' is recommended for adult mental health services by the National Institute for Health and Care Excellence, and has a growing evidence base according to Implementing Recovery through Organisational Change.

Trust staff across the core services evaluated the effectiveness of their interventions by using standardised outcome measures and clinical audit. The outcome measures included the Health of the Nation Outcome Scales, Beck's Depression Inventory, the Modified Early Warning Scale, Waterlow Scale (for pressure ulcers), Mental Health Recovery Star, Alcohol Use Disorders Test, Treatment Outcomes Profile and Liverpool University Neuroleptic Side Effect Rating Scale. Staff from learning

disability and autism secure services routinely evaluated their adapted sex offender treatment programme for effectiveness and patient satisfaction. They had published articles about this in peer-reviewed journals. Clinical audits that staff had participated in included termination of seclusion and long-term segregation, triangle of care (compliance with guidelines on carer engagement), falls and malnutrition screening tools. Services acted on the audits' findings.

One of the trust's priority areas for improvement was access to physical healthcare. High secure learning disability and autism secure services both had health centres on site. They had also implemented 'Dr Feelwell', a patient-led initiative to improve physical health through healthy eating and exercise. All of the patients in these services and in substance misuse services whose care records we reviewed had had an annual health check. Wards for people with learning disabilities and autism also offered good access to physical healthcare. Patients on wards for older people with mental health problems and medium and low secure services all had a physical health check on admission and regular monitoring throughout their stay. However, across the wider trust only 51% of patients on care programme approach had had an annual health check.

Skilled staff to deliver care

The trust employed a range of clinicians and assistants to deliver care. Overall, staff were experienced and qualified, and had received additional training to support them in their role. All staff had access to regular team meetings. Staff, including bank and agency staff, received a corporate and local induction. Most staff told us that local induction included the opportunity to shadow more experienced members of staff, however some expressed concern that this was not always possible due to low staffing levels on the wards.

The majority of staff in high secure, medium secure, low secure, learning disability and autism secure and substance misuse services were compliant with trust policy requirements for supervision and annual appraisal. We were assured that staff in these services had the opportunity to reflect on their practice, discuss safeguarding issues and set learning objectives. We had concerns about low compliance rates in some of the wards for older people with mental health problems and one of the wards for people with learning disabilities and autism. Supervision compliance rates were 40% on Acorn ward, 45% on Heys Court and 45% at Wavertree Bungalow. Appraisal rates were 30% on Oak ward, 38% on Heys Court and 53% at Wavertree Bungalow. This is a breach of regulation. In the NHS Staff Survey 2016, the trust scored 3.06 for quality of appraisals, which is slightly less than the national average for mental health trusts (3.15).

Across five of the core services, staff had access to a range of relevant specialist training. For example, in substance misuse services staff had completed training in physical health assessment, motivational interviewing and advanced supervision. The team manager at Brook Place had recognised the impact of organisational change on the staff, and had arranged an away day facilitated by the trust's organisational effectiveness team. However, on the STAR unit (a ward for people with learning disabilities and autism), staff had not been trained in topics essential to the provision of safe and quality care for this client group. These topics included autism awareness, learning disability awareness, epilepsy and communication skills. This is a breach of regulation.

Staff from all wards could access the moving and handling coordinator for support and advice. This was particularly important on wards for older people with mental health problems and wards for people with learning disabilities and autism, which routinely accepted patients who were not independently mobile.

Staff told us that they felt supported to develop their leadership skills. The trust had a leadership development pathway that was open to all staff. Eighty teams across the trust had started team development using an evidence-based model for health and social care services.

There were policies and support in place to address staff poor performance, and we saw that performance was a standard agenda item in supervision. Managers told us that they felt supported by the trust's human resources department.

Multidisciplinary and inter-agency team work

All of the teams we visited worked effectively between themselves and with agencies external to the trust.

Core services held regular multi-disciplinary meetings to review patients' care and treatment. We observed eight of these meetings during our inspection. All included detailed discussions of physical healthcare, progress, leave

entitlement, Mental Health Act status and (where appropriate) capacity. The multidisciplinary meetings were patient-focused. All staff showed respect for patient and carer views. Trust and other staff involved in supporting the patient in the community were also invited to ensure continuity of care.

Handovers between staff changing shifts on the wards were effective. We attended a sample of handovers on wards for people with learning disabilities and autism and substance misuse services, and reviewed records of handovers at other core services. Handovers contained a summary of patients' presentations, current risks, level of observation, physical care issues, additional medication and relational security. We also saw that staff mobilised from other wards after a shift had started received a comprehensive individual handover.

All of the teams worked collaboratively with external organisations. We saw some very good examples in learning disability and autism secure services. Over the last twelve months, staff in this core service had provided training to 12 external agencies to ensure safe transition for patients moving into the community. In substance misuse services, staff worked with primary care and voluntary sector agencies to provide a seamless shared care pathway for patients. Services caring for people with a learning disability attended regular meetings with commissioners and local authority colleagues, with a focus on admission and discharge pathways and planning.

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

Mental Health Act training was mandatory for all trust staff. Local records indicated that the majority of staff in the following core services had completed Mental Health Act training at the time of inspection: wards for people with learning disabilities and autism; learning disability and autism secure services; high secure services; medium and low secure services. However, only 56% of staff in wards for older people with mental health problems were compliant.

We did not review adherence to the Mental Health Act and the Mental Health Act Code of Practice at substance misuse services because these services did not accept patients who were detained.

We were satisfied that the specific powers and duties of the hospital managers were being discharged according to the provisions of the Mental Health Act. Their role was embedded within the trust. They were able to contact the Mental Health Act lead, director of patient safety or responsible non-executive director at any time. Several training sessions were provided by the trust solicitors each year, with additional training for high secure services. Hospital managers were assessed, appraised and reviewed annually before re-appointment. They fully understood the responsibilities and requirements of their role.

Staff we spoke with, including staff from areas where compliance with training was low, were able to tell us how they applied the Mental Health Act within their role. This included facilitating section 17 leave and ensuring that legal paperwork was present and up to date. Staff received regular legal and practice updates through the Mental Health Act lead bulletin. They felt supported by Mental Health Act administrators, and knew who to contact for legal advice when needed. Mental Health Act administrators were based on site at all of the secure services.

Mental Health Act documentation was received by a qualified nurse and scrutinised by a Mental Health Act administrator prior to patients' admission. Patients had their rights under the Mental Health Act explained to them initially and routinely thereafter. Easy read versions of Mental Health Act leaflets were available for patients with a learning disability.

Consent to treatment and capacity requirements were adhered to, and copies of consent to treatment forms were attached to medication charts where applicable. Detention paperwork was up to date and filled in correctly. There were efficient systems in place to prompt staff to complete section renewals, section 132 checklists and tribunal reports. Mental Health Administrators audited documentation and escalated any concerns through the Mental Health Act law governance groups.

All patients in high secure services who were cared for in long-term segregation were reviewed on a daily basis, consistent with the requirements of the current Code of Practice. Segregation care plans were up to date and comprehensive.

There was an inter-agency working group including hospitals, approved mental health professional services, police and ambulance which considered the implications of sections 135 and 136. These services had a joint policy.

Good

Are services effective?

Their work was monitored and reported in to the trust Mental Health Act law governance group. There was also a street car triage system provided jointly with police, which had reduced the use of section 136 by 40%.

At the time of inspection, a number of trust policies referred to the 2008, rather than 2015, Mental Health Act Code of Practice. These policies included:

- Mental Health Act 1983 overarching policy
- Consent to treatment policy
- Leave for an informal patient and equality and human rights analysis
- Section 117 – aftercare under the Mental Health Act 1983
- < >

This meant that staff were not following current guidance, and is a breach of regulation. The trust updated all of these policies in April 2017 to refer to the 2015 Mental Health Act Code of Practice.

There were 35 Mental Health Act Reviewer visits to trust hospital sites between 1 January 2015 and 23 January 2017. All of these were unannounced. Over the 35 visits there were 134 issues found at locations across the trust. The category which received the highest number of issues was 'protecting patient rights and autonomy' with 43 issues, equating to 32% of the trust total. 'Care, support and treatment in hospital' followed with 34 issues, which accounted for 26% of the total.

Good practice in applying the Mental Capacity Act

Staff compliance with training in the Mental Capacity Act was below 75% on medium and low secure wards (30%) and wards for older people with mental health problems (57%). However, most staff we spoke with in all core services showed a good understanding of the principles and application of the Act. Some staff in high secure services carried the five principles on a small folding card. We saw some very good examples of Mental Capacity Act assessments and best-interest decision making in high secure services, learning disability and autism secure wards, wards for older people with mental health problems and wards for people with learning disabilities and autism.

Staff at Heys Court, a ward for older people with mental health problems, did not always understand the principles and application of the Mental Capacity Act. There was one patient on the ward waiting for a Deprivation of Liberty Safeguards assessment from the local authority. We could not find any evidence that his capacity had been assessed or reviewed since November 2016. We also observed that staff did not have a system in place to prompt them well in advance of when an existing Deprivation of Liberty Safeguards authorisation was nearing time for renewal.

Two core services had applied to the local authority for Deprivation of Liberty Safeguards in the past 12 months. Wards for older people with mental health problems and wards for people with learning disabilities and autism. The trust is required to notify CQC of any Deprivation of Liberty Safeguards authorisations granted. Wards for older people had failed to notify us of eight of 26 approved applications. Wards for people with learning disabilities had failed to notify us of their one single approved application. This is a breach of regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

The trust had a Mental Capacity Act overarching policy, which included the new case law (Birmingham City Council) ruling about the application of the Act to young people aged 16 and 17. It also had a 'Management of the Deprivation of Liberty Safeguards (DoLS) within the meaning of the Mental Capacity Act 2005' policy. This stated that copies of standardised authorisation should be forwarded to CQC.

Good

Are services caring?

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

Summary of findings

We rated caring as good because five of the core services we inspected on this occasion, and all of the core services we inspected previously, were rated at least good for this key question.

- Almost all of the patients and carers we spoke with were positive about the staff and the service. Patients said that staff were supportive, caring, respectful, helpful and kind.
- All of the interactions we observed in five of the six core services were caring and respectful. Staff were good at recognising and responding to patients' needs.
- The trust involved patients and carers in the care they received. Ninety-five per cent of patients who completed the trust's patient experience survey reported that they had been involved in the development of their care plan. Trust policies and strategies were in place to ensure carers were meaningfully involved in care planning. Patients had been involved in many different projects across the trust.
- Advocates and the patient advice and liaison service visited wards regularly to support patients and help facilitate community meetings. All mental health wards held community meetings at least monthly. High secure services and learning disability and autism secure services also held monthly forums attended by patient representatives. The patient representatives felt valued in their role and able to make changes on behalf of their peers.
- Staff oriented patients to the wards on patients' arrival. Some wards gave patients an information pack that was specific to the ward. Patients from learning disability and autism secure services had been involved in making videos to help new patients know what to expect from admission.
- The trust had employed seven peer support workers, who were people with direct experience of using trust services.

However:

- We observed negative interactions on wards for people with learning disabilities or autism. On Wavertree Bungalow, we saw staff ignoring patients, talking about patients in front of other patients, and failing to provide verbal reassurance during moving and handling.

Our findings

Kindness, dignity, respect and support

We spoke with 175 patients and 24 carers during our inspection and received 55 completed comment cards. We also received feedback though the trust from a group of ten carers of patients at the STAR unit (a ward for people with learning disabilities or autism).

Almost all of the patients and carers we spoke with were positive about the staff and the service. Patients said that staff were supportive, caring, respectful, helpful and kind. Patients with specific individual needs (for example dietary requirements, personal care needs or communication needs) told us that that staff assisted them appropriately. Some patients said that staff were genuinely interested in their wellbeing. Others told us that they felt safe on the wards. Many of the carers told us that they felt involved in their family member's care and that communication was good. Two carers said that the care provided to their family member on learning disability and autism secure wards was excellent.

Only a small number of the patients and carers we spoke with had negative things to say about the service. Some of the patients at high secure services were unhappy about aspects of the care and/or future plans for their care. When

we reviewed these patients' care records we were satisfied with the actions that high secure services had taken. Several patients learning disability and autism secure wards said that staff were not always respectful and polite.

We also spent time observing staff interactions with patients and carers on all of the wards within the six core services we visited. This included a number of short observational framework for inspection assessments. A short observational framework for inspection is a tool used by inspectors to capture the experiences of patients who may not be able to express those experiences for themselves. We completed two of these on learning disability and autism secure wards, three on wards for people with learning disabilities or autism, and four on wards for older people with mental health problems. We also viewed six group activity sessions, four assessment sessions and five keyworker sessions in community substance misuse services.

In five of the core services (high secure services, medium and low secure services, learning disability and autism secure services, wards for older people with mental health problems and substance misuse services) all of the interactions we observed between staff and patients were caring and respectful. Staff were good at recognising and responding to patients' needs. On wards for older people and in learning disability and autism secure services staff understood the meaning behind patients' behaviours, and skilfully engaged patients in activities. Throughout these five core services staff spoke about patients in a respectful way. Patient confidentiality and dignity was maintained.

On wards for people with a learning disability or autism we observed some positive but also some negative staff attitudes and behaviours. At Wavertree Bungalow, staff sometimes ignored patients. We saw a patient expressing physical affection to staff, and staff managing this poorly. We saw staff discussing patients in front of other patients, breaching confidentiality, and failing to provide appropriate reassurance to a different patient during moving and handling. At STAR unit patients' communication aids were not used when they should have been.

Before our inspection we left 16 comment cards and confidential boxes around the trust so that we could collect feedback from patients. We received 55 responses. Thirty-one comments were positive, 11 were negative, a further 11 were mixed and two were unclear. The majority of comment cards described staff as helpful, friendly, pleasant or caring. The main theme of the negative comments was staffing – many respondents said that more staff were needed.

The trust received 27 compliments during the last 12 months (1 January 2016 to 31 December 2016). Nine of these were for the core services being inspected.

The involvement of people in the care they receive

The trust involved patients and carers in the care they received. All 179 patient records that we reviewed in high secure services, medium and low secure services, and learning disability and autism secure services included evidence that patients and/or carers had been invited to be involved in care planning and risk assessment. Patients in these services had access to their care plans. We saw very high quality care plans in learning disability and autism secure services; there was a clear model for seeing patients as experts in their own care.

In substance misuse services, only care plans in Ambition Sefton (Southport) included clear evidence of patient involvement. Care plans in the other four services (Liverpool Community Alcohol Service, Windsor Clinic, Brook Place and Ambitions Bootle) did not. However, patients that we spoke to told us that they had been involved in planning their own care. We also observed collaborative discussion of goals and treatment options during keyworker sessions.

On wards for older people with mental health problems, there was evidence in 16 of the 23 records we reviewed that patients or carers were involved in care planning. On wards for people with learning disabilities and autism, we saw evidence of patient involvement in only one of 17 care plans. However, patients at STAR unit did contribute towards other documents, for example 'likes and dislikes', that informed the care plans. Wavertree Bungalow was a respite service for people with severe learning disability. Patients therefore did not require mental health care plans. We did see that carers had been involved in discussions about the purpose of admission.

Patients were provided with extra assistance, when required, to allow them to be involved in their care. Patients were informed of the role and contact details for

Good

Are services caring?

local advocacy services through posters and leaflets. Advocates and the patient advice and liaison service visited wards regularly to support patients and help facilitate community meetings.

Staff oriented patients to the wards on patients' arrival. There was a standard trust 'welcome to Mersey Care: useful information for service users' booklet which explained patients' rights, how to complain and gave contact details for advocacy and other relevant organisations. The same information was provided in an accessible format for patients with a learning disability. Some wards also gave patients and carers additional information, for example about visiting times. High secure services and Irwell ward gave patients a welcome pack that was specific to the ward. In high secure services, this pack had been developed by 'recovery champions' a group of patients and staff. Patients from learning disability and autism secure services had been involved in filming a number of short videos about the wards. These videos were available online to help new patients know what to expect from admission.

All mental health wards held community meetings for patients at least monthly. Wavertree Bungalow held monthly carers' meetings. This meant that patients were able to express their views about the day-to-day running of the wards. High secure services and learning disability and autism secure services also held monthly patient forums (known as 'speak out' meetings at learning disability and autism secure services), attended by patient representatives and intended to improve the patient experience. The patient representatives we spoke with felt valued in this role. We saw that they had been able to contribute towards decisions at service level, for example choosing new group activities and food suppliers.

The trust had a carer's policy designed to ensure that carers were meaningfully involved in care planning and offered the health and social care support they needed to be able to care safely and effectively. The policy included the legal requirements set out in the Care Act 2014. The trust used the 'triangle of care', a recognised good practice guide, to support their engagement with carers. Triangle of care progress was monitored through the quality dashboard report made to the trust's quality assurance committee. Most of the carers we spoke with were happy about the level of involvement they had in patients' care, and we saw that carers contributed to decisions about treatment where appropriate. Each ward in learning disability and autism secure services had a 'carer's champion' link person. The trust had a separate policy and procedure for young carers, which emphasised the importance of 'whole family' approaches to assessment and support.

Patient experience results were one of the key quality indicators scrutinised through divisional surveillance meetings. They were also was discussed at the trust's board and council of governors meetings. We saw from meeting minutes that the board requested action plans to address areas for improvement where necessary.

The trust carried out a monthly trust-wide patient experience survey, which included questions relating to involvement in care. The survey was based on the National Institute for Health and Care Excellence guidance CG136: Service user experience in adult mental health: improving the experience of care for people using adult NHS mental health services. Between April 2016 and April 2017 95% of the trust patients that completed the survey reported that they had been involved in the development of their care plan.

Good

Are services responsive to people's needs?

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

Summary of findings

We rated responsive as good because five of the core services we inspected on this occasion, and all of the core services we inspected previously, were rated at least good for this key question.

- The trust's services were planned and delivered to meet the diverse needs of the population. The trust's three priorities for improvement were identified in consultation with stakeholders.
- The trust had a five-year plan to integrate the community physical health services they were due to take over from 1 June 2017.
- Patients in learning disability and autism secure services had 'moving on' care plans to prepare them for discharge. Trust staff had done exemplary work with local placement providers to ensure that transition to the community was as successful as possible.
- The trust took active steps to engage people who found it difficult to engage with mental health services.
- There were good escalation procedures in place for delayed discharges.
- Staff took a proactive approach to understanding the needs of different groups of patients. All of the wards provided access to separate rooms where patients could practise their faith. Wards were also able to cater for specific dietary needs. We saw good examples of compliance with NHS England's accessible information standard.
- All of the core services had a full range of rooms and equipment to support treatment and care. Trust premises were accessible to people who used wheelchairs or who had mobility difficulties. The trust's patient-led assessment of the care environment scores for food had improved since our last inspection. Patients on all but two of the wards we inspected had access to at least 25 hours of activity each week. All patients were able to make private telephone calls (with limitations for some patients in high secure services).
- All of the core services provided information on treatments, local services, patient rights and how to complain. The trust listened to and learned from complaints.

However:

- There was a lack of meaningful activity on wards for people with learning disabilities or autism.
- On STAR unit, a ward for people with learning disabilities and autism) we found that staff did not always use patients' communication aids and could not control the level of noise in the environment to make it suitable for patients with sensory needs.
- The trust was not meeting its own targets for timeliness of response to complaints.

Our findings

Service planning

The trust's services were planned and delivered to meet the mental health needs of people living in Liverpool, Sefton and Kirkby and the specialist mental health needs of secure patients across North West England, central England and Wales. The trust served a total population of around 11 million people.

Most of the trust's service users lived in Liverpool or Sefton unitary authorities. According to the 2016 health profile reports published by Public Health England, the overall health of people living in Liverpool and Sefton is generally worse than the England average. Life expectancy for men and women is lower than the England average. About 32% of children in Liverpool and 20% of children in Sefton live in low income families. Rates of hospital stays for self-harm and hospital stays for alcohol-related harm in both areas are significantly worse than England average.

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The trust had identified three priorities for improvement in 2016 to 2017 following a period of consultation with stakeholders. The stakeholders included Healthwatch, NHS England, local clinical commissioning groups, local overview and scrutiny committees and local service user and carer groups. The three priorities were:

- No force first (continuing work to reduce restrictive practice)
- Towards zero suicide (safety planning intervention to be embedded at high risk points in local services)
- Improvements in physical health pathways.

The trust's estates strategy clearly outlined the plans for future development of trust estate over a five-year period based on the current and predicted needs of the local population. The director of estates and the executive director of finance managed the implementation of the plan. They submitted annual reports to the trust board's performance, investment and finance committee. This committee also reviewed and approved capital expenditure proposals in line with the trust's stated aims to involve patients and carers, design new buildings to be flexible and accessible, improve the condition of existing estate and enable efficient and effective use of estate in line with the Carter Review. (The Carter Review is a 2015 Department of Health report on efficiency in NHS hospitals.) The trust had three major estates schemes approved and planned to start building works in 2017. These were: a new hospital in Southport to replace the Hesketh Centre and Boothroyd Ward, a new hospital in Liverpool to replace the Mossley Hill site and a new medium secure unit at Maghull to replace the Scott Clinic. The medium secure unit would also include 46 forensic beds for people with a learning disability, to ensure some continuation of service following the anticipated closure of the specialist learning disability division. The plans for the new medium secure build were in line with commissioners' targets for 50% bed reduction over five years. Staff, patients and carers had been involved in the development of plans for the new buildings.

The trust had recently been successful in a bid to provide community physical health services in South Sefton. At the time of inspection, the trust planned for these services to be transferred on 1 June 2017. The trust had appointed a director of integration to lead on this project. We saw that the trust had a five-year plan to fully integrate the new services. The trust's aim was to improve patient care for people in South Sefton by providing joined-up services for mental and physical health problems. The trust referred to this as a 'bio-psycho-social clinical model'.

The trust had taken on the provision of learning disability and autism secure wards. At the time of inspection, NHS England were consulting about the future of the service. A bed retraction programme had already been implemented, in line with the transforming care agenda to get people with learning disabilities out of long-term hospital care and into the community. Calderstones NHS Foundation Trust had already responded to this by investing more in their forensic support service team. The forensic support service existed to ensure that the staff expertise held within the hospital was made available to patients, carers and providers in the community following discharge. The trust anticipated that many staff would move into this team as beds continued to close.

Access and discharge

During 2015 to 2016 Mersey Care provided care, treatment and support to 41,934 service users: 41,173 in local services and 761 in secure services.

The trust had an average bed occupancy rate of 92% between 1 January and 31 December 2016. Bed occupancy is the average number of mental health beds occupied as a proportion of all available beds. The trust's figures included patients on leave. High secure services had bed occupancy rates of 100% and medium and low secure services had bed occupancy rates of 97%, which in line with commissioning of secure services.

Average bed occupancy rates for the other four core services we inspected ranged between 92% (wards for people with learning disabilities and autism) and 80% (learning disability and autism secure services). Rates were lower in learning disability and autism secure services because the trust were working towards an overall bed reduction in line with the UK government's transforming care agenda. Rates on the low secure units within the service were much higher, which meant that patients on the medium secure units could not immediately 'step down' to a lower level of security when ready.

Length of stay across the core services being inspected ranged from eight days to 2,386 days between 1 January and 31 December 2016. High secure services had the longest average length of stay with 2,386 days followed by

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learning disability and autism secure services with 2,025 days. The average length of stay trust-wide was 53 days. There were 76 out of area placements over the same period, 46 of which were ongoing at the time of inspection. None of these related to the core services we inspected. The trust had achieved a reduction in unplanned out of area placements from 23 in December 2016 to 6 in February 2017.

The trust reported 770 delayed discharges between 1 January and 31 December 2016. Delayed discharges are a way of describing patients who no longer need to be in hospital, but cannot move on due to the lack of an appropriate community placement. CQC requested this data from the trust for each month, which means that patients whose discharges were delayed for longer than a month will have been counted more than once. Learning disability and autism secure services had the highest number of delayed discharges with 178, followed by wards for older people with mental health problems with 133. Delays in discharge can negatively impact individual patients' recovery and create a barrier to admissions. The board assurance framework included a risk relating to delays in access to beds which is currently rated as major and likely. However, the trust was achieving the trajectory for delayed discharges that it had agreed with NHS Improvement. There were good escalation procedures in place for delayed discharges, and the trust was working closely with commissioners to resolve any issues with blockages to funding or placements.

The trust reported 36 readmissions within 28 days between 1 January 2016 and 31 December 2016 across 12 wards. Six of the re-admissions were attributed to core services being inspected: five for substance misuse services and one for wards for older people with mental health problems. Patients were not inappropriately moved between wards, and never moved between wards after 10pm.

Community substance misuse services did not have a waiting list. New referrals were allocated to a member of staff straight away. Patients were easily able to access advice and support within office hours by ringing the duty practitioner at the service.

There is a national target for 95% of patients on care programme approach to be followed up in the community within seven days of being discharged from a mental health ward. The trust had consistently performed above this target between 1 January and 31 December 2016.

Learning disability and autism secure services had agreed a bed retraction programme with NHS Improvement, in line with the transforming care agenda. We observed that individual care and treatment reviews and 'moving on' care plans had been completed, with full patient involvement. We case-tracked two patients who had been discharged recently after long admissions. Trust staff had worked closely with external providers and community teams to help them understand patients' complex needs and ensure that placements would provide safe, quality care. Both discharges had been successful, which was a credit to the staff involved.

Patients could access Mersey Care's services when they needed to, including in an emergency. The trust's hospital mental health liaison teams offered a 24-hour service and were based at the three accident and emergency departments in Liverpool and Sefton. The trust also had urgent care and support teams, which gatekept mental health beds and provided an out of hours service for patients in acute distress. We did not inspect the mental health liaison or urgent care and support teams at this inspection. We observed that, at STAR unit, out of hours decisions about admissions were made by staff without expertise in learning disabilities. On at least one occasion this had resulted in an inappropriate admission.

The trust took active steps to engage people who found it difficult to engage with mental health services. Community substance misuse services tried to contact patients who did not attend appointments, either by telephone or through a third sector support agency. The service at Brook Place ran clinics in two local hostels. Patients were only discharged if they failed to attend three appointments.

The trust also provided the Liverpool Community Development Service alongside two partner agencies. The Liverpool Community Development Service was commissioned to help improve access to mental health services for people from a Black and minority ethnic background living in Liverpool.

The facilities promote recovery, comfort, dignity and confidentiality

The trust's average score for food on the 2016 patient-led assessments of the care environment for their hospital sites was 92%. Patient-led assessments of the care environment are self-assessments undertaken by teams of NHS and independent health care providers. The teams include at

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least 50% members of the public. The trust's score was the same as the 2016 England average, and an improvement on their 2015 score of 84%. Heys Court (a ward for older people with mental health problems) and Rathbone Hospital (low secure services) were the lowest-scoring sites for food, with 88% and 89% respectively. Learning disability and autism secure services achieved the highest score for food, with 96%. All patients had access to hot and cold drinks and snacks throughout the day. Most of the patients we spoke with were satisfied with the food, although some at low secure services felt that it was 'tasteless and repetitive'.

All of the core services we inspected had a full range of rooms and equipment to support treatment and care. Wards had quiet space, access to outside space and separate rooms where patients could practise their faith. Patients could personalise their bedrooms and store their possessions in lockers. In high secure services, we saw a gym, pool tables, television rooms and music rooms. Low secure services had a large communal area for both wards called 'Wavertree Street', which included a family visiting room, gym, multifaith room and dining area. STAR unit had a sensory room for patients with learning disabilities or autism, which included soft padding, adjustable lighting and fibre optic tubes. Acorn and Irwell wards (for older people with mental health problems) had interactive tactile walls in the corridors to engage patients. Community substance misuse services' buildings included interview rooms and rooms for urine testing. The rooms for urine testing included a separate toilet, with door, to protect patients' privacy. All rooms were sufficiently soundproofed to mean that private conversations could not be overheard. However, we observed on medium secure wards that clinic rooms were small, with no space for physical examination. The availability of rooms for seeing visitors on medium secure wards and Boothroyd ward (a ward for older people) was limited.

Patients on all but two of the wards we inspected had access to at least 25 hours of activity each week. Activities were available every day, including at weekends. For example, in medium and low secure wards patients had access to cooking, arts and crafts, woodwork, health and fitness sessions, music lessons and a reading group. Patients at the Windsor Clinic (substance misuse service) took part in walking groups. Activities on older people's wards included weekly visits from the Philharmonic orchestra and a dance and movement group. Many patients in learning disability and autism secure services accessed activities in the community, including horse riding and football clubs. We were impressed by the 'bike ability' initiative at learning disability and autism secure services. The trust had brought specialist cycling trainers in to help patients learn to ride and look after a bicycle. Most of the patients we spoke with across the core services said that there were enough activities. However, there was a lack of meaningful activity on wards for people with learning disabilities or autism. We observed a patient at Wavertree Bungalow colouring in a colouring book that had already been coloured in. On STAR unit an exercise group planned for the day of our inspection did not take place. On three of the wards for older people with mental health problems we observed a delay of between 60 and 90 minutes for activities to start on the day of our visit.

All patients were able to make private telephone calls. Some patients in high secure services were subject to restrictions on their telephone calls and/or restrictions on their correspondence in line with Section 134 of the Mental Health Act. These patients could only contact people on a list that had been agreed by their clinical team. The list would always include CQC and the patient's solicitor. Additionally, a random 10% of all telephone calls made by patients in high secure services was reviewed by the security team, except when these calls were to solicitors or CQC. We reviewed restrictions between March 2016 and March 2017, and were satisfied that they had been applied in the interests of the safety of the patient or protection of other people.

All of the core services provided accessible information on treatments, local services, patients' rights and how to complain. We saw posters on walls and leaflets given to patients. This information was also available on the trust's website.

Meeting the needs of all people who use the service

The trust understood and appreciated the diverse needs of their population, and planned services to meet those needs.

The trust provided the Liverpool Community Development Service jointly with two partner agencies. This service's remit was to help tackle health inequalities and improve the mental health and wellbeing of the Black and minority

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ethnic community, taking into account the nine protective characteristics in the Equality Act 2010. Their staff worked closely with Mersey Care's wider mental health services to promote access.

The trust had recognised a disproportionate use of the Mental Health Act to detain people from a Black or minority ethnic background. (NHS Digital figures show that this is a national issue, not specific to Mersey Care NHS Foundation Trust). The trust had recently commissioned a detailed analysis of the data from a local university, with the aim of developing a 5-year plan to support long-term change.

Staff took a proactive approach to understanding the needs of different groups of patients. Staff in substance misuse services had close links with voluntary organisations supporting sex workers, homeless people and asylum seekers. The trust also had a dedicated service for veterans and a veteran lead who championed veteran issues across the trust.

All of the wards provided access to separate rooms where patients could practise their faith. The trust also had a spiritual and pastoral care service representing all religious denominations.

We saw some good examples of compliance with NHS England's accessible information standard across the six core services. The aim of the standard is to make sure that people who have a disability, impairment or sensory loss get support with communication and information in a format they can understand. In learning disability and autism secure services, speech and language therapists worked alongside staff and patients to develop easily accessible information. We saw consistent use of patients' communication passports, pictorial prompts, comic strip symbols and talking mats. Leaflets in learning disability and autism secure services and wards for people with learning disabilities and autism were available in easy-read format. However, on STAR unit we found that patients' pictorial communication aids were not always available for use and that care plans were not presented in an accessible way.

On STAR unit (a ward for people with learning disabilities and autism) some patients had sensory needs. It was difficult for staff to maintain a low stimulus, low noise environment. For example, when nurses activated personal alarms a loud, piercing bell sounded throughout the unit.

The menu choices on the wards included halal, kosher and vegetarian options. The trust also catered for patients with food allergies or diabetes. At Wavertree Bungalow, staff made appropriate meals for patients who needed softened diets or thickened fluids.

Staff could request interpreters and written translations for patients or carers whose first language was not English. We spoke to one patient who routinely used an interpreter; he was happy with his care and said that the ward had obtained books in his own language.

All of the core services, and the trust headquarters, were accessible for people who used wheelchairs or who had mobility difficulties. Staff on wards for people with learning disabilities and autism and on wards for older people with mental health problems were able to use hoists to lift people where needed.

On learning disability and autism secure wards, staff had developed a 'keeping me safe and well' risk assessment. This explicitly considered human rights and risks relating to the person's disability, ethnicity, culture, sexuality and gender as well as risks to self and risks to and from others. Mersey Care NHS Foundation Trust staff had also designed a board game called 'FREDA challenge' in collaboration with patients. 'FREDA' stood for fairness, respect, equality, dignity and autonomy and is a recognised human rights approach to healthcare. FREDA challenge was used on learning disability and autism secure wards to empower patients to stand up for their own and others' human rights. Patients on these wards were also able to access on-site and off-site support and groups for people who identified as lesbian, gay, bisexual, transgender and/or questioning their sexual identity.

Learning from concerns and complaints

The trust listened to and learned from complaints. There was a dedicated complaints team, who logged and oversaw the process of responding. Investigators were clinical staff allocated by the director of operations in each division. We reviewed a sample of ten complaints, with at least one from each core service inspected. Investigations were comprehensive and recommendations clear. Action plans were completed when it was identified that services could improve. All complainants received an acknowledgement letter or telephone call within two weeks restating the subject of the complaint, explaining the process and giving a date by which they could expect a

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response. The two complaints from patients or carers at learning disability and autism secure services were of particularly high quality, with a detailed chronology of events and outcomes. In both of these cases the investigator met with the patient and family to discuss the findings as well as writing to them in easy read format. All complaints were signed off by the trust chief executive, director of patient safety, complaints lead or divisional chief operating officer.

The trust received 709 complaints with 16% fully upheld and 9% partially upheld between 1 January and 31 December 2016. Eight complaints were referred to the ombudsman and none of these were upheld. The core services being inspected accounted for 397 (56%) of all complaints received by the trust. High secure services accounted for almost half of all complaints received by the trust with 329. Sixteen percent of these complaints were fully upheld and 12% partially upheld. One complaint was referred to the ombudsman but was not upheld.

The trust aimed to fully respond to complainants within 25 days or sooner where possible. During the three months from December 2016 to February 2017 25 complaints were closed within 10 days, 44 between 10 and 25 days and 121 (64% of the total made) took longer than 25 days. The response times to the 10 complaints we reviewed ranged between 12 and 112 days, with an average response time of 48 days. The trust told us that delays were caused by difficulties allocating an appropriate reviewer, the complainant being too unwell to meet with the investigator, complexity of complaints, need to interview several members of staff and/or the checking and scrutiny process for investigation reports. We saw that the complaints team had sent letters to complainants who were waiting longer than 25 days to ensure they were kept updated of progress. This letter and the final response letter included an apology for the delay.

Delays in response to complaints had been escalated at weekly quality surveillance meetings. There had been a recent drive to respond to straightforward complaints in under 10 days, with support from the patient advice and liaison officer. The trust had managed to reduce the proportion of complaints that were not resolved within 25 days from 49% in June 2016 to 32% in December 2017.

Patients and carers using five of the six core services we inspected told us that they knew how to complain. On wards for older people with mental health problems, nine of 20 patients and 7 of 11 carers told us that they knew how to complain. We saw information about complaints and contact details for the patient advice and liaison service, CQC and mental health advocates in all of the wards and community services.

All staff understood the complaints procedure and could explain how they would support a patient or carer who wanted to complain.

Learning from complaints was fed back to teams through learning bulletins, quality practice alerts, staff meetings and 'you said, we did' noticeboards. We saw examples of action being taken following investigations into complaints.

Good

Are services well-led?

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

Summary of findings

We rated well-led as good. Four of the core services we inspected on this occasion, and five of the core services we inspected previously, were rated good for this key question. However, two of the core services we inspected on this occasion and two of the core services we rated previously were rated requires improvement for well led. We made a decision to deviate from our aggregation tool in this case because one of the core services rated as requires improvement for well-led (wards for people with learning disabilities and autism) represented only 14 of the trust's 672 beds. We also found evidence that the trust overall was well led. It would therefore have been disproportionate for us to rate this key question as requires improvement.

- The trust had a clear vision underpinned by four values. Staff knew and understood the vision and values. It was clear from the trust's strategy that safety and quality were paramount. The trust had developed their overarching strategic goal following consultation with staff. Staff and patients were engaged in all aspects of strategy delivery.
- The trust was financially stable and secure. The trust non-executive directors and council of governors were effective in holding the trust to account. The trust minimised the impact of pressures and efficiency changes on the quality of care.
- Each division had a clear governance structure from ward or team level up to the board. There were thorough surveillance systems in place. There was evidence from the assessment of core services that the trust governance framework was effective, with some exceptions. The trust had an up to date risk register and there were clear risk identification and review processes in place for risks at corporate and divisional level.
- At core service level, managers had access to 'dashboards' to monitor their team's performance. The trust completed internal quality review visits to assess safety and quality at individual wards and locations.
- Leadership at all levels of the trust was visible and effective. Leaders encouraged collaborative and supportive relationships among staff. Senior staff visited the core services. Staff were aware of the whistleblowing policy and felt able to raise concerns. Staff described the new 'freedom to speak up guardian' as visible and approachable. The trust was committed to its goal of developing a fair and just culture
- Overall, staff morale was good despite service pressures. Many staff said that they enjoyed their work and felt valued by their teams. Staff in core services facing organisational change felt supported, and most said that communication was good. Staff were able to give feedback and suggest ideas for service improvement. The trust leadership development pathway was open to all staff.
- Poor staff performance was addressed promptly and effectively. The trust had analysed the causes of staff sickness, and put plans in place to address it. The trust was compliant with the workforce race equality standard, and working to address shortfalls.
- The trust had refurbished a popular local building to provide a well-used community hub. The trust offered volunteering opportunities to patients, staff, trust members and the public through its 'people participation programme'. The trust had employed eight service users to help train staff and support patients through their recovery. The trust was also running a public campaign to encourage people to talk about mental health problems.

However,

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- Some ward staff told us that low staffing levels were impacting on their morale and making it difficult for them to perform their roles safely. The proportion of staff who would recommend the trust as a place to work was worse than the national average for mental health trusts. Staff sickness across the trust was high. Some staff expressed frustration about the lack of clarity for band 2 healthcare assistant roles, particularly in the local division.
- Governance at local level was not always effective. Learning from the specialist learning disability division (about care plans for patients with epilepsy) was not transferred for people with learning disabilities accessing inpatient beds in the local division.
- Some patients felt that it was unfair that the trust did not pay volunteers for their work.

Our findings

Vision, values and strategy

The trust had a clear vision, which was:

- "To be recognised as the leading organisation in the provision of mental health care, addiction services and learning disability care."

This vision was underpinned by four values:

- Continuous improvement
- Accountability
- Respect
- Enthusiasm

It was clear that safety and quality were the trust's top priorities. The trust's goal in 2017 was 'striving for perfect care and a just culture'. 'Perfect care' was defined as getting the basics right, making improvements, learning from mistakes and helping staff to innovate. 'A just culture' was defined as an environment putting equal emphasis on accountability and learning. A 'strategic wheel' illustrated how the trust aimed to achieve its goal through empowered teams and empowered service users, with ten key aims under four headings ('our services', 'our people', 'our resources' and 'our future'). The trust had three specific 'perfect care' goals, which were zero suicide, no force first, and improved physical health.

The trust's goal and wheel had evolved since our last inspection. 'A just culture' was a new addition for 2017. The trust had consulted with their own senior clinical staff over the previous 12 months to gain a better understanding of factors that might be affecting openness and transparency. The trust had found that staff did not always feel confident in raising concerns, as they worried about a 'blame culture'. The chief executive of the trust had publicised the concept of the just culture through his blog and 'mega-conversations' (visits to various trust localities to engage with staff).

There was a robust, realistic strategy for achieving the goal and developing good quality care. For example, since our last inspection 3000 staff had been trained in suicide awareness, which was one of the objectives under 'zero suicide'. The current operational plan listed a number of quality priorities, with clear, measurable targets and outcomes. Progress was monitored by the board through the trust's governance structure.

The strategy was embedded within the trust. All of the staff we spoke with during our inspection knew about the trust's vision and values. Many told us what 'perfect care' meant to them. Staff in secure services were proud of the achievements of No Force First. A focus group of trade union representatives were pleased about the priority given to 'just culture' and hopeful that it would increase staff morale and reduce the number of disciplinary investigations. Team objectives and individual annual work performance objectives were based on trust values. Bank staff and student nurses told us that they saw the trust values replicated across the different services.

The trust was financially stable and secure. All cost improvement plans were subject to a quality impact assessment by the medical director and executive director of nursing before being submitted to the performance, investment and finance committee and trust board for approval.

Good governance

The trust had a board of directors. The board comprised the chief executive, the chairman, five voting executive

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members, seven voting non-executive directors and three non-voting executive directors. The board provided strategic leadership and was accountable for the running of the trust.

The trust had established a council of governors shortly before attaining Foundation Trust status in May 2016. The council of governors included elected 31 public, staff, service user and carer representatives, and five appointed representatives from local stakeholder groups. When we spoke with the governors, we were assured that they were undertaking their role to hold the non-executive directors to account on compliance with the provider licence, delivery of strategy and service quality. The council of governors were developing systems for better communication with trust members, stakeholder organisations and the public. There was representation from governors at trust board meetings, and representation from the board at governors' meetings.

We reviewed a sample of trust board meeting minutes. Trust board meetings were well-attended and included comprehensive review of the board assurance framework and board governance. The quarterly reports discussed provided assurance against strategically significant risks. Key performance indicators were presented under the four areas ('our services', 'our people', 'our resources' and 'our future') identified in the trust's strategy.

The trust had four committees that reported to the board. These were: the audit committee, the executive committee, the quality assurance committee and the performance, investment and finance committee. All were chaired by a non-executive director, who gave appropriate challenge. The trust had a constitution which clearly outlined the duties of the trust board and council of governors.

We also reviewed a sample of four meeting minutes from the quality assurance committee. Meetings were chaired by a non-executive board member and attended by members of the board, senior corporate and operational staff, and a patient or carer representative. Issues discussed included quality and risk, staffing reviews, patient-led assessment of the care environment results, audit, safeguarding, research and development, the annual report, infection control, Mental Health Act managers' committee report, and policies ratified. We noted a good example demonstrated within the minutes of the trust making improvements following a national report relating to clinical outcomes for patients with epilepsy.

The trust had three clinical divisions: secure division, specialist learning disability division and local division. Each division had a clear governance structure from ward or team level up to the board. Since our last inspection trust had implemented new surveillance mechanisms on a divisional, corporate and executive level. We reviewed a sample of four minutes from each of the divisional quality surveillance meetings. The weekly meetings were attended by a range of senior staff including clinical managers, safeguarding lead, equality and diversity lead, information analyst, deputy chief operating officer, head of risk and safety, estates manager, union representative and deputy director of nursing. The meetings covered a range of issues, including incidents, medicines errors, restraint and restrictive practice, sickness absence, training, duty of candour and complaints. We could see that actions raised had been revisited at the following meetings to ensure that work was completed within timescales. The data provided to the committee enabled them to understand and monitor fluctuations at ward level. For example, any ward that had reported more than ten incidents was identified and then information about the incidents was triangulated with other intelligence to establish whether there was cause for concern. Areas reporting low levels of incidents were contacted by the relevant service line lead to check that things were not being missed.

Quality surveillance groups were able to escalate significant issues to the board on 'stand up Thursdays'. This was a brief meeting with full senior team engagement, held every Thursday. It was called 'stand up' because all attendees stood instead of sitting. We observed a 'stand up Thursday' and saw that it was extremely effective; all risk issues were discussed and understood.

At core service level, we saw that managers had access to monthly 'dashboards' that illustrated their team's performance in a number of areas. These areas (or key performance indicators) included mandatory training, patient experience scores, staff sickness, staff injuries, patient harm and other incidents. Core services also had specific targets, for example completion of the malnutrition universal screening tool in wards for older people with mental health problems. Managers in the core services had sufficient authority to be able to fulfil their role.

Following our last inspection, the trust implemented an action plan to address all areas of concern. The trust provided CQC with written assurance and formally met with

us in May 2016 to present progress. The trust also ran a rolling programme of internal quality review visits. These visits took place weekly, with each ward and service being visited in turn. The team of quality reviewers comprised experts by experience, independent clinical staff and (more recently) trust governors. The teams assessed safety and quality against criteria similar to CQC's key lines of enquiry. We saw that action had been taken based on these visits, for example a tracker was in place at Ambition Sefton (community substance misuse service) to improve compliance with care plan targets.

The trust had commissioned the Mersey Internal Audit Agency to review 17 patients' care plans in the secure learning disability division against National Institute for Health and Care Excellence guidelines for epilepsy. There were a number of recommendations and actions to be taken. The care plans were re-audited in August 2016, but there were still some outstanding issues. They were therefore re-audited again in September 2016, when full compliance was reported. The issue was also on the risk register at board level. The audit was incorporated into the trust's annual clinical audit programme to ensure future monitoring and oversight. This was a clear example of the trust taking pre-emptive action to ensure patient safety. However, the trust only audited patient records in the specialist learning disability division, not patient records for people with learning disabilities accessing inpatient beds in the local division. We found that care plans for two patients with epilepsy in Wavertree Bungalow were not sufficiently detailed.

Mental Health Law governance groups gathered assurance on the robustness of arrangements within each division to meet the trust's duties in relation to the Mental Health Act, Mental Capacity Act and associated Codes of Practice. The governance in place around the Mental Health Act was effective. All of the detention paperwork that we reviewed at core service level was fully completed, and systems prompted staff when renewals were due. However, the governance around the Mental Capacity Act was not always effective. For example, systems were not in place on wards for older people to ensure that applications for Deprivation of Liberty Safeguards authorisations were sent to the local authority in good time. We also struggled to find evidence that capacity had been reviewed regularly while staff were waiting for the local authority to complete their assessments. Individual wards were expected to notify CQC of authorised Deprivation of Liberty Safeguards applications. There was no oversight of this at corporate level, which contributed to the trust's failure to notify us of nine authorisations between March 2016 and March 2017.

Overall, the trust had done a good job of integrating governance for the new specialist learning disability division. For example, senior trust staff had reviewed all of the risks on the former Calderstones NHS Foundation Trust board assurance framework, and updated them to fall in line with Mersey Care NHS Foundation Trust policy. Specialist learning disability division risks were monitored through the same committees as risks from local and secure divisions. However, difficulties in extracting information from incompatible systems could sometimes mean that data returns to commissioners were delayed.

The trust provided us with a full copy of its risk register. The risk register included 188 risks and reflected most of the risks we observed at local level. All entries included dates of when the risk had been added, when it was due for review, and any controls or action taken. There were clear risk identification and review processes in place for risks at corporate and divisional level. The process stated that any member of staff could identify and escalate a risk, which was confirmed by staff that we spoke with during our inspection. The trust had developed a leaflet for staff, 'healthcare risk assessment made easy', which provided accessible guidance on the assessment and scoring of risk and explained how to report for inclusion on the trust's risk management system. It included key points from the trust's risk management strategy and risk management policy. Risks assessed as being significant or unable to be mitigated by the team were referred to the divisional risk lead.

There was evidence from the assessment of core services that the provider governance framework was effective, with some exceptions. Overall, staff were clear about their roles and understood what they were accountable for. The majority of staff were compliant with mandatory training. Staff reported and learned from incidents and patient feedback. Staff used clinical audit and research to monitor the safety and effectiveness of their care. Restrictive practices (restraint, seclusion and segregation) were in line with the Mental Health Act Code of Practice and followed national guidance. We had some concerns about oversight of training compliance. Figures provided to us by the wards did not always match those provided by the trust.

Good

Are services well-led?

The trust had reporting structures and policies in place to ensure effective management of infection control, safeguarding, application of the Mental Health Act, medicines and staffing. We felt less assured about the application of the Mental Capacity Act.

Fit and Proper Person Requirement

The fit and proper person requirement is a regulation that has applied to all NHS trusts, NHS foundation trusts and special health authorities since 27 November 2014. Regulation 5 states that individuals who have authority in organisations that deliver care, including providers, board

directors or equivalents, are responsible for the overall quality and safety of that care. This regulation is about ensuring that those individuals are fit and proper to carry out this important role and providers must take proper steps to ensure that their directors (both executive and non-executive), or equivalent, are fit and proper for the role. Directors, or equivalent, must be of good character, physically and mentally fit and have the necessary qualifications, skills and experience for the role.

We were satisfied that appropriate systems and processes were in place to ensure that all new directors and existing directors were, and continued to be, fit. The trust provided us with a document informing the board of the process adopted; it covered the steps the trust took for new appointments and for the annual review of existing directors. All directors were required to join the disclosure and barring update service either on commencement with the trust or at the time of their 3-yearly renewal. We reviewed six directors' personnel files; all included a fit and proper person declaration, a disclosure and barring service check, two pre-employment references and all other relevant information.

Leadership and culture

Leadership at all levels of the trust was visible and effective. Leaders encouraged collaborative and supportive relationships among staff. There was evidence that the trust was committed to developing a fair and just culture, in line with its 2017 strategy.

All of the staff we spoke with said that they knew the whistleblowing policy and felt able to raise concerns. Some staff said that their immediate managers championed a culture of no blame. The trust had recently appointed a 'freedom speak up guardian' as part of their drive to become a more open and transparent organisation. Staff we spoke with told us that the guardian was very visible and approachable. She had visited many services, including wards during night shifts, to explain her role. We also saw posters around the trust giving the guardian's photograph and contact details.

Overall, staff morale was good. Many staff told us that they enjoyed their jobs and felt proud of the difference they made to their patients. All staff felt valued within their teams. Some staff told us that trust schemes such as team and employee of the month made them feel recognised for their work, although others felt differently. Some ward staff told us that low staffing levels were impacting on their morale and making it difficult for them to perform their roles safely. Staff on Irwell ward (a ward for older people with mental health problems) were unhappy that decisions about the use of their ward had been made without consultation.

Some staff expressed frustration about changes to terms and conditions for new healthcare assistants on the wards. There were two elements to this. New staff working in high secure services were no longer eligible for the 'special hospital lead'; an additional payment on top of the usual salary that was intended to attract staff to working in a higher-risk environment. The second issue concerned the job descriptions for band 2 and band 3 healthcare assistants. We reviewed the job descriptions, and there appeared to be only one significant difference. Band 3 healthcare assistants were required to do physical observations, where band 2 healthcare assistants were not. Staff told us that in practice there was confusion about what differentiated the two roles. The band 2 staff that we spoke with in the local division were frustrated; their managers had tried to reduce the range of tasks they were asked to complete but the consequence was that they felt less valued by their teams. The trades unions had raised this issue with the trust, with the consequence that all band 2s in the specialist learning disability division were being progressed to band 3.

Staff in learning disability and autism secure services and staff in substance misuse services were facing uncertainty and organisational change. There was an NHS consultation in progress regarding the future of the trust's learning disability and autism secure site, the outcome of which was expected the week following our inspection. Funding for substance misuse services had been reduced by a

significant amount. Despite this, most of the staff in these services told us that they felt positive about coming to work. Many said that they appreciated the trust's efforts to keep them informed of any changes, and that the trust and their managers were 'doing everything they can' to ensure that jobs were safe and that services continued to provide quality care. A minority of staff felt that communication within the trust could be improved, as they had found out about significant changes through colleagues or social media.

All staff were able to give feedback about the service through team meetings, supervision and 'Tell Joe'. We saw evidence of where staff had been able to change and develop services in wards for people with learning disabilities and autism, and in substance misuse services. 'Tell Joe' was an email address for staff to use to direct concerns and questions directly to the chief executive. We reviewed 12 'Tell Joe's from the period 30 November 2016 to 8 February 2017. Full responses were sent back to staff between 0 and 54 days later (an average of 25 days). Three included apologies and all included some degree of recognition of the staff's point of view.

Senior staff, including members of the board, visited the core services. For example, there was a daily 'morning meeting' for staff at high secure services, attended by the modern matron, duty manager and head of social care, which was rotated around the wards. Some staff told us that the chief executive had visited their ward, and others said that another executive had worked on a ward for a day to understand what daily life was like.

Poor staff performance was addressed promptly and effectively, including among senior staff members. The 'staff charter', which had been developed with staff, formed the basis for all people management and development practice. The trust also had a clear policy for disciplinary procedures, grievance procedures and a number of other human resource processes. Trades unions told us that they had been working with the trust to improve the performance management procedures in line with the new 'fair and just culture' strategy. Between 1 January and 31 December 2016 there were 56 cases where staff had either been suspended or moved. Forty-one staff were suspended (including 9 bank staff) and 15 were moved. Learning disability and autism secure services had the most staff suspended, with 17.

The 2016 staff Friends and Family Test showed that the percentage of staff who would recommend the trust as a place to work (68%) was worse than the England average of 80%. However, this was still an improvement on the 2015 score, which was 56%.

According to the 2016 NHS Staff Survey 82% of staff believe that the organisation provides equal opportunities for career progression or promotion, which is five percentage points less than the national average for mental health trusts (87%).

Staff engagement included 'mega conversations' with the chief executive, leader and manager forums, 'birthday breakfasts' (a chance for staff to have breakfast with the chief executive during their birthday month) and values based employee and team of the month. The team of the month reward and recognition scheme aimed to increase staff engagement by recognising staff and team who made a positive difference and demonstrated the organisational values. In February 2017 Scott House multidisciplinary team won team of the month for their work supporting patients to be successfully discharged into the community. Scott House is part of the learning disability and autism secure wards core service.

The trust had recognised that their sickness absence rates were significantly above target. They had analysed the causes of staff sickness within each clinical division, and identified themes within staff groups or teams. Trades unions had been involved in developing strategies to reduce sickness rates. Plans included provision of improved support for staff with a disability, health checks, discounts for exercise classes, better support for staff following a traumatic incident and a general review of sickness absence practices, processes and performance to ensure they aligned with emerging evidence of best practice.

The trust leadership development pathway was open to all staff. It included four core leadership programmes:

- Essentials of management and supervision for 'first line leaders' and new starters
- 'STRiVE' foundation leadership development programme for medics and staff at bands 5 and 6
- 'THRiVE' intermediate leadership development programme for medics and staff at bands 7 and 8

- 'DRiVE' advanced leadership development programme for medics and staff and bands 8 and 9

Cohorts of 25 to 30 staff ran twice a year. So far 36 staff had completed STRiVE and 188 staff had completed THRiVE. DRiVE was planned to start later in 2017. In addition to these core leadership programmes the trust ran quarterly leadership masterclasses (214 attendees since 2016), quarterly leadership forums (419 attendees since 2015) and twice yearly management forums (175 attendees since 2016). Some staff at bands 5 and 6 told us that there were not enough opportunities for leadership development. This makes sense as the STRiVE programme had been rolled out more recently than THRiVE.

The workforce race equality standard requires NHS trusts to demonstrate progress against nine indicators. The trust was compliant with the standard. It collected data using the equality delivery system, analysed and published the data, and took action to close the gap between the treatment of white staff and Black and minority ethnic staff. In 2016, 2,212 trust staff completed the workforce race equality standard survey. The trust's scores on five of the nine indicators were good – experiences of Black and minority ethnic staff were similar to those of white staff in relation to access to training, experience of bullying and harassment. However, there were no voting board members and only a low proportion of the total workforce in senior roles from a Black and minority ethnic background. Eighty-two per cent of white staff believed that the trust provided equal opportunities for career progression or promotion, but only 65% of Black and minority ethnic staff did. The relative likelihood of white staff being appointed from shortlisting was 4.15 times greater than the likelihood for Black or minority ethnic staff. This score on this indicator was worse in 2016 than it was in 2015. The trust had implemented an action plan to address shortfalls. The action plan included training in unconscious bias, reciprocal mentoring for senior leaders and Black and minority ethnic staff, and a targeted recruitment programme.

Since September 2012, 71 Mersey Care healthcare assistants had been seconded to train as mental health or learning disability nurses, one occupational therapy assistant had been seconded to train as an occupational therapist, and 11 nurses had been funded to do advanced practitioner training. These figures do not include staff from the specialist learning disability division, which only joined the trust in 2016. There were an additional nine healthcare assistants in the specialist learning disability division seconded to do their nurse training at the time of the inspection. All of the staff that we spoke with who had completed or were in the process of completing these qualifications said how much they valued the opportunity. They felt that the trust recognised the commitment they had shown in their roles as healthcare assistants.

Engagement with the public and with people who use services

The trust had refurbished the old Walton library to create the Life Rooms, a hub retaining some of the library facilities alongside a service for advice on employment, money, housing, physical health and mental health; an information technology and media suite; and meeting spaces for community groups. The Life Rooms were free for the public to use. We observed a trust-facilitated International Women's Day event there just prior to the inspection. The event was well-attended and featured an introduction by the trust chair, poetry readings and stories, and workshops. The trust had plans to provide a second Life Rooms in Southport.

The trust had a 'people participation programme' (implemented in October 2014) and a dedicated director of social inclusion and participation. The people participation programme comprised volunteering opportunities for patients, staff, trust members and the public. There were 500 volunteers registered with the trust, 300 of whom were patients and carers. We saw that volunteers from the programme had been involved in service level and trust-wide development projects, including:

- Design of new buildings and refurbishment of old buildings
- Interviewing for new members of staff
- Presenting at the National Restraint Reduction Conference (October 2016)
- Delivering courses at the trust's recovery college
- Creating videos with the trust media team on a range of topics
- Sitting on the trust's veterans' advisory group
- Designing a new health promotion initiative called 'Dr Feelwell'

Good

Are services well-led?

Dr Feelwell was designed by patients and staff from high secure services. It won a National Service User Award for Health and Wellbeing in 2016.

Volunteers gained access to training and development opportunities, but were not paid for their time. The trust told us that they had taken this decision so that more people could get involved over shorter periods of time, and that they had used the funds to refurbish the Life Rooms (a community hub in Walton). We saw from the minutes of a 'speak out' meeting that some patients felt that the lack of payment for their work was unfair.

At the time of inspection, the trust had employed seven peer support workers on fixed-term contracts. The peer support workers were embedded in community teams. All had been recruited because they had direct experience of using Mersey Care's services. Their role was to help service users engage and inform recovery-based approaches. The trust had commissioned an external evaluation of the success of the peer support worker posts. This showed that their overall impact was positive.

The trust had also developed a new paid role, improvement lead for lived experience. A person who had used Mersey Care's services had taken up this post in March 2017.

The most recent Healthwatch listening event held at the trust was July 2016; the chief executive of the trust had responded to the report. The trust routinely collected patient feedback through the patient experience survey and friends and family test.

The trust had a 'big brew' campaign, aimed at members of the public as well as staff, patients and carers. The intention of the campaign was to encourage people to talk about their problems, access services early and therefore stand a better chance of recovery.

The council of governors were confident that the voices of patients and carers were actively engaged by the trust.

The trust ran 14 patient and carer support groups. It was a member of the triangle of care scheme, which sets standards for good practice in carer involvement and support in mental health services.

Quality improvement, innovation and sustainability

Of the six core services we visited, three had received national accreditations:

- Medium and low secure services (Quality Network for Forensic Mental Health Services)
- Learning disability and autism secure services (Quality Network for Forensic Mental Health Services)
- Two ward for older people with mental health problems (Accreditation for Inpatient Mental Health Services)

In addition, we found many examples of quality improvement and innovative practice. Secure services showed a clear commitment to improvement by continually seeking to build on the successes of No Force First. They had added the HOPE(S) clinical model and barriers to change checklist to reduce use of long-term segregation. HOPE(S) meant ' harness the system and engage the person, opportunity for positive structured activity, preventative and protective factors, and enhance coping skills'. The HOPE(S) model had already resulted in an 80% reduction in the use of rapid tranquilisation in learning disability and autism secure wards. High secure services were piloting the dynamic situational appraisal of aggression and care zoning on six wards. The success of these approaches were being evaluated through completion of outcome measures, so that the trust could decide whether to implement them across all secure services. Staff from high secure services were delivering training and supervision to reduce long term segregation to three high secure prisons. Ashworth Hospital also achieved a prison service audit score of 100%, which according to the trust is the first time 100% has been achieved by a high secure hospital.

Learning disability and autism secure services had adapted their provision to ensure that patients discharged in line with the transforming care agenda successfully transitioned to the community. Staff worked closely with patients, commissioners and partners. It was clear that patients were seen as experts in their own care.

Substance misuse services had conducted clinical studies, in conjunction with partners, resulting in successful bids for funding to provide community blood-borne virus clinics. They were also the chosen provider for the National Veteran Community Recovery Project, which was commissioned to provide seamless access to detoxification, rehabilitation and reintegration to veterans across the UK.

Good

Are services well-led?

We were satisfied that the trust did all it could to minimise the impact of pressures and efficiency changes on the quality of care. Staff and patients were engaged in all aspects of strategy delivery.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect How the regulation was not being met: At Wavertree Bungalow, during observations, inspectors witnessed poor interactions with patients, particularly of patients being ignored. There were poor interactions observed when managing the care of a patient who required verbal reassurances. Staff discussed other patients due to be admitted in front of patients. There were two inappropriate physical affection interactions noted during observations. We witnessed interactions using child-like language towards patients. In wards for people with learning disabilities and autism, positive behaviour support plans and care plans were not followed by staff. Communication strategies and aids were not used by staff with patients who required these. On STAR unit we observed negative descriptions of patients' behaviour used in a nursing handover. This was a breach of 10(1) and(2)(a)(b)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment How the regulation was not being met: On wards for older people with mental health problems, medicines were not being managed safely. Staff had not

This section is primarily information for the provider

Requirement notices

given or recorded accurately the administration of medicines on medicine cards at Irwell ward and there was no guidance in place for staff of how to give medicines covertly, including in a care plan.

Not all medicine cards included allergies of patients at Heys Court and Irwell ward.

Fridge temperatures were out of range for the medicine fridge at Boothroyd ward, meaning the integrity of medicines in the fridge could be compromised.

The physical observation monitoring equipment had not been recorded as being cleaned at Oak ward.

There were no written moving and handling plans in place for patients at Wavertree Bungalow

Not all patients with epilepsy at Wavertree Bungalow had a detailed epilepsy care plan.

There was out of date clinical stock at the STAR unit and medicines had not been prescribed as part of reconciliation at admission. There had been delays for two patients in starting treatments as medicines were not available and one patient's medicines were not signed for.

This meant the provider was not providing safe care and treatment.

This was a breach of 12(1)(2)(a)(b)(c) and 12(2)(g)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment How the regulation was not being met: At Scott Clinic we found that on four of the wards the patient laundry room was also used as a sluice room. On Hawthorne, Ivy, Myrtle and Olive ward the laundry room that patients accessed to use the laundry facilities to wash, dry and hang their clothing, also had a metal sink which was used for emptying dirty water from mop buckets, and to store mops and buckets. This increased

This section is primarily information for the provider

Requirement notices

the risk of cross infection where dirty contaminated water was in the same space as clean patient laundry, this risk increased further should there have been an outbreak of infection such as diarrhoea and vomiting.

This is a breach of regulation 15(2)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance How the regulation was not being met: Five trust policies referred to the out-of-date Mental Health Act Code of Practice. Staff were therefore not following current guidance. On the STAR unit, staff were undertaking up to seven hours of observations without a break. The trust policy is for no longer than two hours. There were also gaps in the observation records where no entries were made and this had not been identified. There was no system to record additional training undertaken by staff at the STAR unit. This was a breach of 17(1) and (2)(b)(c)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing How the regulation was not being met: Staff on wards for older people with mental health problems had not received training in dysphagia. There was a death of a patient and learning from that was for staff to have dysphagia training; a number of patients we observed had thickened drinks and liquidised food. This meant staff may not have had the knowledge and skills to support patients effectively. On wards for older people with mental health problems, training levels of basic life support was 68% and moving and handling of people was 42% and for immediate life support 45%. This meant there may not be sufficiently skilled staff able to respond in an emergency.

This section is primarily information for the provider

Requirement notices

On wards for older people with mental health problems the average clinical supervision rate across all wards was 64%. We reviewed managerial supervision records on site and found that staff were not receiving supervision as per trust policy. The overall appraisal rates for non-medical staff within wards for older people with mental health problems was low at 68%. This meant staff were not receiving the training and support required for their role.

On STAR unit there were not sufficient numbers of staff on duty to manage the level of observations.

On STAR unit only 60% of qualified nurses had completed immediate life support training. Staff had also not had sufficient training in a range of areas essential to this core service, including autism awareness, learning disability awareness, epilepsy and communication skills.

On wards for people with learning disabilities and autism staff were not receiving regular supervision or an annual appraisal as per the trust policy.

This was a breach of 18(1)(2)(a)

Regulated activity

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Diagnostic and screening procedures

Treatment of disease, disorder or injury

Regulation

Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents

How the regulation was not being met:

There were patients where Deprivation of Liberty Safeguards had been authorised in Acorn ward, Boothroyd unit, Irwell ward and Heys Court. The provider was not submitting the notifications to CQC as required. We reviewed our notifications systems and found that Acorn ward had been submitting the notifications, however, the other wards had not.

This meant the provider was not informing CQC of patients who were deprived of their liberty under the Deprivation of Liberty Safeguards.

This was a breach of 18(1)(2)(c)