

Calderstones Partnership NHS Foundation Trust

Quality Report

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Date of inspection visit: 6-8 October 2015

Date of publication: 09/02/2016

Core services inspected	CQC registered location	CQC location ID
Forensic inpatient/secure wards	Gisburn Lodge Calderstones	RJX51 RJX04
Wards for people with learning disabilities or autism	Calderstones In-patient enhanced support - 15-16 Daisy Bank In-patient enhanced support- 4 Daisy Bank In-patient enhanced support- North Lodge Scott House	RJX04 RJXX5 RJXX4 RJXX3 RJX05

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 Mental Health Services safe?

Good 

Are Mental Health Services effective?

Good 

Are Mental Health Services caring?

Good 

Are Mental Health Services responsive?

Good 

Are Mental Health Services well-led?

Good 

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

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

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

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

Summary of findings

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Summary of findings

Overall summary

We found that the trust was performing at a level that led to a rating of **'Good'** because:

- Since our last inspection of the trust in July 2014, the trust had made significant improvements in the care and treatment that staff provided to patients and the environments in which this was delivered. The trust had developed an action plan following our last inspection and worked with external stakeholders to address the issues we had raised.
- The executive team had reviewed and strengthened the trust's governance structure. The trust had implemented reports which provided 'real time' information about a number of clinical key performance indicators which could impact on the quality of care provided. These included staffing issues, incidents, complaints and episodes of restraint and seclusion. This allowed the service managers and the board to monitor trends and possible gaps in service provision to enable them to take timely action.
- The trust's vision and values were fully embedded throughout the organisation and all of the staff we met with were aware of these and explained how the values underpinned their work. Staff were satisfied with the support they had from their managers and were proud of the work that they were doing.
- The trust had implemented a new model of working called 'safe wards' which focussed on reducing restrictive practices and improving patient outcomes. All staff had been trained in the new way of working and were committed to improving the care they provided to patients. All patients had a comprehensive risk assessment, positive behavioural support plan (PBS) and 'moving on' plan in place. The quality of the PBS plans was exceptional and there was evidence of patient involvement in the formulation of these.
- The implementation of the new model had significantly changed the culture within the trust and enabled staff to reflect on their practices to identify areas of improvement. The board was the driving force behind the changes and they had supported staff whilst maintaining good oversight regarding the monitoring and implementation of the changes.
- The most significant improvements noted was the reduction in the number of episodes of restraint, seclusion, the use of rapid tranquillisation and the eradication of the use of emergency response belts within the trust.
- This had been achieved despite the uncertainty regarding the future of the service. NHS England had recently announced that Calderstones Hospital would close as part of the Government's transforming care agenda. This uncertainty had led to the trust experiencing some challenging staffing issues over the previous year. The trust had managed the staffing issues proactively and we were satisfied that there were sufficient numbers of staff to deliver the care and treatment that patients needed safely and effectively with the appropriate use of bank and agency staff.
- Within the learning disability service, we saw some outstanding examples of staff adapting their interactions with patients based on their individual needs. The staff accepted and embraced the unique communication methods of patients who did not use speech to communicate, including individual sounds and gestures. All of the care plans we reviewed were person centred, and patients all had their own copy and reported their involvement in the care planning process where their capacity allowed. These plans clearly demonstrated that staff had a good understanding of patients' needs, their hobbies and interests, likes and dislikes. The patients who were able could describe their discharge plans and were animated about their future opportunities. We also found numerous examples of how the trust and staff engaged with patients and their carers and provided opportunities for them to be involved in service development initiatives.

However:

- We identified some inconsistencies across services in relation to staff training, supervision, de-briefs and staff understanding around the Mental Capacity Act.
- The number of staff trained in basic life skills was low within the learning disability services which could expose patients to a preventable risk within these services.

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?

We rated safe as **'good'** because:

Good



- All wards were clean, tidy and in a good state of repair. There were systems in place for maintaining hygiene and managing infection prevention.
- The trust had effective systems in place to ensure that there were enough staff on duty. Where there were vacancies, the trust employed temporary staff to ensure shifts were covered.
- Since the implementation of the 'safe wards' model of care throughout the trust, the number of incidents of restraint, seclusion and the use of rapid tranquillisation used during restraint had significantly reduced. The use of emergency response belts had also been eradicated.
- The trust was a high reporter of incidents, practices were reviewed and changed as a result of lessons' learnt. This demonstrated an open and transparent approach to incidents.
- There was an effective system in place to provide assurance from ward to board that risks were being managed safely. The trust ensured that each clinical area had assessed the risks presented by both the environment and individuals and ensured that active management was in place to reduce the potential of harm.
- The trust had effective safeguarding procedures in place which staff followed.
- The majority of staff we spoke with understood the underlying principles of the Duty of Candour requirements and the relevance of this in their work.
- The overall trust performance figure for mandatory training was 95%.

However;

- In some of the learning disability services we found that staff were not always being debriefed after being involved in an incident.
- In the learning disability service, areas for concern and risks were not a standard agenda item for handovers meaning these could be overlooked or missed.
- On Maplewood 1 and 2 there was no system to allocate staff to respond to activated alarms in an emergency.

Summary of findings

- Compliance with basic life skills training was below the trusts' target of 80%.

Are services effective?

We rated effective as '**good**' because:

- Patients were involved in the planning of their own care and attended meetings to discuss this. Patients had an assessment by a doctor and nurse on admission which covered all their physical and mental health needs. Each patient had a comprehensive, detailed risk assessment in place.
- Each patient had a Positive Behavioural Support (PBS) plan in place. The quality of the PBS plans was exceptional. These had been co produced with patients and or their family members where possible.
- Patients had been involved in making a DVD about the PBS model for staff as a practical training tool and numerous health promotion DVDs through the trusts patient led media group which were available for patients.
- The trust had implemented a range of evidenced based practices and initiatives to improve patient outcomes.
- All staff had participated in a training programme called creative intervention training in response to untoward situations (CITRUS).
- Staff worked collaboratively with others to formulate 'moving on' plans for each patient.
- The trust had been leading a national piece of work on behalf of the National Offender Management Service to improve outcomes for offenders with learning disability.
- Compliance with the requirements of the Mental Health Act and Mental Capacity Act was good.

However;

- There were inconsistencies regarding the recording of the responsible clinician's (RC) assessment of a patient's capacity to consent to treatment.
- Within the learning disability service, supervision of staff was not in line with the trust's policy.
- Some staff were uncertain around the principles of the Mental Capacity Act.

Good



Are services caring?

We rated caring as '**good**' because:

Good



Summary of findings

- On the learning disability wards, the staff clearly understood the needs of the patients including those with no speech. We saw some excellent examples of staff adapting their interactions with patients based on their individual needs. The staff accepted and embraced the unique communication methods of patients who did not use speech to communicate, including individual sounds and gestures. Members of the staff team ensured that the specific communication needs of the individual were taken into account and ensured that information was provided to them in a format they could understand
- All of the care plans we reviewed were person centred, and patients all had their own copy and reported their involvement in the care planning process where their capacity allowed. These plans clearly demonstrated that staff had a good understanding of patients' needs, their hobbies and interests, likes and dislikes. The patients who were able could describe their discharge plans and were animated about their future opportunities.
- On all of the wards we visited staff ensured that patients received care that was supportive and treated them with dignity and respect at all times.
- Staff actively worked with individuals to plan care and there was shared decision-making about care and treatment. Patients were involved as partners in their care.
- During the inspection, we saw several patients experiencing times of challenge and without exception the staff present at the time were compassionate and supportive.
- Staff had invested time in developing positive behavioural support plans with all patients within the trust which were formulated around their specific needs'.
- The trust had signed up to the 'triangle of care' initiative in 2010.
- Patient meetings were patient led with the support of staff.
- All patients had access to advocacy services and there were posters displayed to promote this services.
- Patients were fully trained and involved with the recruitment of staff.

Are services responsive to people's needs?

We rated responsive as '**good**' because:

- The trust had planned and delivered services in a way to meet the needs of the patients. The specific needs of patients had been taken into account when planning and delivering services.

Good



Summary of findings

- All patients had a moving on plan which the individual and other stakeholders had developed collaboratively. However; some patients were not able to move on as there was a shortage of accommodation and support to meet their needs available within community settings
- Care and treatment was coordinated with other services and providers to ensure that where possible patients were admitted and discharged in a timely manner.
- The trust had 'Our Shared College' on site and in 2014, patients took 322 courses on subjects including money management, maths, upholstery, curriculum vitae skills and horticulture. 126 accredited certificates, including nationally recognised qualifications were awarded to patients through the college.
- Facilities and premises were appropriate for the services delivered in them. The trust had designed services around the specific needs of the individual patients using then at the time.
- Staff had provided information in a variety of formats to ensure that it was easy for patients to complain or raise a concern.
- The trust had a Lesbian, Gay, Bisexual, Transgender (LGBT) forum called The Avenue. This had been developed after a request from a patient and was patient led.

However;

- Some staff within the learning disability service were not aware of the chaplaincy and spiritual support available to patients.

Are services well-led?

We rated well led as '**good**' because:

- There was good leadership at board level with a visible executive team. The leadership team recognised the importance of strong engagement with patients, relatives, staff and external stakeholders. The trust had a number of established initiatives in place to promote engagement and had systems in place to develop this further. The trust were working with other health providers to improve care outcomes for the patient group.
- The trust leadership has implemented and overseen significant changes across all of its services these have had a direct impact on improving the care and treatment of the patients in the service. This had had a direct impact on the number of incidents, episodes of restraint, use of rapid tranquillisation, use of emergency response belts and seclusion.

Good



Summary of findings

- The ward managers, senior managers and the trust board used the data set information and heat maps to monitor performance and identify any trends which could impact on the quality of service provision.
- Staff and patients told us that the hands on, supportive approach of the executive team had empowered them to take a person centred approach to the care being delivered.
- The governance structure from senior manager level to ward level monitored performance outcomes for patients. There were risk registers in place in all services and there were plans in place to mitigate these risks. There was board oversight and monitoring of these risks.
- The trust vision and values were fully embedded across the trust all of the staff we met with were aware of these and explained how the values underpinned their work. Staff were satisfied with the support they had from their managers and were proud of the work that they were doing.
- The organisation was working with other stakeholders to identify the current and future risks and to put systems in place to monitor and address these.
- The forensic units had successfully completed the self and peer review parts of the quality network for forensic mental health services annual review cycle.

However;

- Within the learning disability wards staff could not describe the key performance indicators that were monitored to drive improvements.
- Formal team meetings were not taking place regularly on all wards within the learning disability service.

Summary of findings

Our inspection team

Our inspection team was led by:

Chair: Dr Paul Gilluley, East London NHS Foundation Trust

Head of hospital inspection: Nicholas Smith, Care Quality Commission

Team Leader: Sharon Marston, Care Quality Commission.

The team included CQC inspectors and a variety of specialists including:

- Patient “experts by experience”
- Family carer “experts by experience”
- Forensic consultant psychiatrists
- Learning disability consultant psychiatrists
- Learning disability nurses
- Mental Health Act reviewers
- Occupational therapist
- Senior NHS managers
- Social workers
- Speech and language therapist

Why we carried out this inspection

We inspected this core service as part of our ongoing comprehensive mental health inspection programme.

This inspection was planned to assess if the trust had addressed the areas where breaches of regulation were identified at the inspection completed 8 to 11 July 2014. At this inspection the trust was found to be non-compliant with regulation 9 (safe care and treatment), 10 (assess and monitor the quality of service), 12 (cleanliness), 13 (medication).

Since our last comprehensive inspection of the trust in July 2014, the trust had developed a comprehensive 36 point action plan to improve and address the breaches in regulation we found during that inspection. The trust had also actively engaged in monthly quality improvement board meetings which were attended by a range of stakeholders including;

- Clinical commissioning groups
- Care Quality Commission (CQC)
- Monitor
- Local authority safeguarding leads
- NHS England

In addition, members of the senior management team engaged on a monthly basis with the CQC inspection manager and CQC inspectors for the trust to continuously review their progress against the action plan.

During this inspection, we found that the trust was meeting all regulation requirements in line with the Health and Social Care Act.

How we carried out this inspection

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

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

Before visiting, we reviewed a range of information we held about the trust and asked other organisations to share what they knew about the trust. We carried out an announced visit from 6 to 8 October 2015.

In completing this inspection, we visited all 24 wards and spoke with 69 patients and six carers.

Summary of findings

We collected 38 comment cards across the trust. On the wards we talked with approximately 120 staff, consisting of ward managers, deputy ward managers, doctors and consultant psychiatrists, psychologists, occupational health therapists and support workers, behavioural nurse therapists, staff nurses, health care support workers and housekeeping staff. In addition, we spoke with physical health nurse practitioners and a general practitioner.

We looked at 83 patients records in detail to check what had been recorded about their care and treatment. We attended two multidisciplinary team (MDT) meetings where patients care was discussed and five shift handovers.

We completed a short observational framework for inspection (SOFI) at Moor Cottage.

During the inspection week we ran 14 focus groups and held 20 meetings with key members of staff and executives. These included people from the following groups:

- advocacy
- patients council
- carers and relatives
- registered nurses
- trade unions
- ward managers
- unqualified ward staff
- independent hospital managers
- allied health professionals
- doctors in training
- consultant psychiatrists
- student nurses
- CCG and NHS England commissioners
- council of governors
- clinical nurse managers
- trust board members.

We also completed four Mental Health Act monitoring review visits.

Information about the provider

Calderstones Partnership NHS Foundation Trust provides specialist learning disability services across the North West of England including areas of Lancashire, Greater Manchester and South Cumbria to a population of approximately 6.6 million people. The trust provides the following core services:

- Forensic inpatient/secure wards
- Wards for people with learning disabilities or autism

Calderstones Partnership NHS Foundation Trust was first registered with CQC on 1 April 2010 and has the following six active locations:

- Calderstones
- Gisburn Lodge
- In-patient enhanced support - 15-16 Daisy Bank
- In-patient enhanced support – 4 Daisy Bank
- In-patient enhanced support - North Lodge
- Scott House

The trust was the first single speciality trust to be approved as a foundation trust. Originally formed in 1993, the trust is based in the village of Whalley in East Lancashire and, with

services in Lancashire and Greater Manchester. The trust supports individuals with a learning disability who require treatment in specialist and secure services, including those with forensic needs and those who present with severe, enduring challenging behaviour.

The trust has had foundation trust status since 2009. The trust employed an average of 1,073 full time equivalent staff and has 214 in-patient beds across its registered locations, with a budget of £64 million.

At the time of our inspection all of the patients were detained under sections of the Mental Health Act 1983. The trust provided 111 beds in conditions of medium and low security. The patients cared for in these services are commissioned through NHS England specialist commissioners.

Calderstones Partnership NHS Foundation Trust has been inspected 14 times since registration.

These inspections have looked at each of the registered locations.

Summary of findings

What people who use the provider's services say

We spoke to 69 patients and six family members and received 25 comment cards from patients.

Patients told us that staff were respectful, caring and understanding. They told us that they felt safe on the wards.

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

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

Parents and other family members were positive about the service; they described positive progress made in the behaviour and presentation of individuals. Family members felt fully involved in their relative's care and were invited to meetings and visited regularly.

Some of the patients told us that some activities were cancelled due to staffing difficulties. Others raised concerns about the quality of the food; these concerns included the temperature of the food, variety and availability of healthy options.

Good practice

Good practice trust wide

- The trust leadership has implemented and overseen significant changes across all of its services which have had a direct impact on improving the care and treatment of the patients in the service by significantly reducing the number of episodes of restraint, use of rapid tranquillisation, seclusion and eradicating the use of emergency response belts.
- Each patient had a positive behaviour support plan (PBS) in place. The quality of the PBS plans was exceptional.
- All staff had participated in a training programme called creative intervention training in response to untoward situations.
- Patients had been involved in making a DVD about the PBS model for staff as a practical training tool and numerous health promotion DVDs through the trust's patient led media group which were available for patients.
- The trust had been leading a national piece of work on behalf of the National Offender Management Service to improve outcomes for offenders with learning disability.
- The trust had a Lesbian, Gay, Bisexual, Transgender forum called The Avenue. This had been developed after a request from a patient and was patient led.
- All patients had a moving on plan which the individual and other stakeholders had developed collaboratively.

- The trust had 'Our Shared College' on site and, in 2014 patients took 322 courses on subjects including money management, maths, upholstery, curriculum vitae skills and horticulture. 126 accredited certificates, including nationally recognised qualifications were awarded to patients through the college.

Good practice in the forensic service

- We witnessed staff responding to a patient in a potentially emergency situation on Woodview 2 with professionalism, compassion and expertise.
- The seclusion rooms all had a pictorial sign showing the rights of an individual who had been secluded. Staff were able to play relaxing music through the intercom to patients if they had identified this in their care plan as something that may help them to de-escalate.
- The standard of PBS plans across all wards was exceptional with a clear, staged approach to managing challenging behaviours. Staff at all levels had a sound understanding of the plans and how they worked to manage and reduce incidents.
- The dialectical behavioural therapy groups that we observed were structured and supported patients to

Summary of findings

manage their emotions in positive ways. All the patients we spoke to who attended these groups said they found that they helped them to manage their emotions.

- At 5 West Drive, there was a good example of person-centred care around the resuscitation status of a patient. Staff told us how they worked with the patient to look at how that patient wanted to be treated at the time of their death.

Good practice in the learning disability wards

- Easy read and accessible information was available to patients, including information on medication and treatment. Staff printed the easy read information from the electronic clinical records system to share with patients as appropriate.
- One-page profiles were in place in some of the wards, a person-centred document showing what was important to the individual, what was important for the individual and how best to support them.
- The use of a leave ladder at Scott House to show the progress for patients towards unescorted leave.
- A patient chaired the monthly speak up meeting with the support of an occupational therapist at Scott House.

Areas for improvement

Action the provider **MUST** take to improve

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

Action the provider **SHOULD** take to improve

- The provider should ensure that regular documented supervision takes place with staff.
- The provider should ensure that staff and patients are debriefed following a difficult incident and evidence is available to confirm they have taken place.
- The provider should ensure that regular staff meetings take place to enable staff to share information, ideas and experiences.
- The provider should ensure that staff receive all required information during handovers.

- The provider should ensure that the training in prevention and management of violence and aggression reaches the trust target of 80% attendance.
- The provider should date the actions on the environmental risk assessments within the learning disability services to enable monitoring and progress of the actions.
- The provider should ensure that staff understand the MCA and their role in relation to the Act.
- The provider should review the spiritual support available to patients and ensure that staff are aware of the provision to increase access.
- The trust should ensure that staff on Maplewood 1 and 2 allocate dedicated staff members to respond to activated alarms.

Calderstones Partnership NHS Foundation Trust

Detailed findings

Mental Health Act responsibilities

All patients within the trust were detained under the MHA at the time of our inspection. We found that whilst some patients were detained under section 3, a significant number of patients were detained under a forensic section of the Act. There was clear evidence that effective systems were in place for the administration of the MHA and in each case that we checked, scanned copies of detention documents, renewals and tribunal information were contained within the electronic patient records. This meant there was a clear audit trail of patients detention even for those patients who had remained at Calderstones for a number of years.

Mental Capacity Act and Deprivation of Liberty Safeguards

There were no deprivation of liberty safeguarding applications in the twelve months leading up to inspection.

There were policies in place for both Mental Capacity Act (MCA) and DOLs.

There was evidence in patients' records of mental capacity being considered and this was a separate part of the patients' care plans that was reviewed by the key worker on a weekly basis. We saw staff supporting people in making specific decisions rather than assume lack of capacity on all the secure wards

MCA training was coupled with Mental Health Act training in the trust and consisted of five briefings in total. All staff had completed the first four briefing. The fifth briefing had not been released at the time of inspection.

Good 

Are services safe?

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

Detailed findings

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

Summary of findings

Our findings

Track record on safety

The Strategic Executive Information System (STEIS) records serious incidents and 'never events'.

(Note: 'Never events' are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented, so any 'never event' reported could indicate unsafe care.)

Trusts have been required to report any 'never events' through STEIS since April 2011. Between 1 June 2014 and 11 August 2015 the trust reported no never events.

The trust reported 23 incidents through STEIS during this time period which were;

- 14 safeguarding vulnerable adults including abuse/alleged abuse of adult patient by third party.
- 6 absconds/unauthorised absence
- 1 allegation of assault by inpatient (in receipt)
- 1 allegation of assault from staff
- 1 diagnostic incident

The trust also reported seven incidents between 3 June 2014 to 22 May 2015 that met the criteria for requiring further investigation as defined by the NHS Commission Board Serious Incident Framework 2013. All these incidents related to safeguarding issues and each one had been fully investigated by the trust. We reviewed the investigation reports which the trust had completed for two of these incidents. The reports were comprehensive, thorough and included action plans for improvement and lessons learnt.

Since 2004 trusts have been encouraged to report all patient safety incidents to the National Reporting and Learning System (NRLS) and since 2010 it has been mandatory for them to report all death or severe harm incidents to the Care Quality Commission (CQC) via the NRLS.

A total of 2,058 incidents were reported to NRLS between 01 June 2014 and 31 July 2015. There were no incidents

categorised as deaths during this period. The majority of incidents resulted in low harm (58%) or no harm (41%). Moderate harm incidents accounted for 0.5% of incidents and severe harm incidents accounted for 0.1%.

The incident category which was most frequently reported was self-harming behaviour (47%), followed by disruptive, aggressive behaviour (22%) and patient accident (15%).

The most common speciality was forensic (98%) followed by occupational therapy (1.4%) The speciality was unknown for five of the reported incidents.

Between June 2014 and June 2015, the number of incidents the trust reported to NRLS resulting in moderate and severe harm has remained low month on month with up to one incident being reported each month, with the exception of three incidents reported in September 2014. The number of low harm incidents reported has significantly reduced over this time period. The incident of low harm incidents reported between June 2014 to May 2015 was between 69 and 128. The figure for June 2015 was 65 which had reduced to 22 in July 2015. The figure for no harm incidents from June 2014 to October 2014 was between 21 to 28. Over the following eight months, it remained between 54 and 89 with the exception of a peak of 146 in February 2015. In July 2015, the figure had dropped to eight incidents. The trust took an average of 39 days to report incidents to NRLS.

The national staff survey results showed that staff were within the top 20% of all mental health and learning disability trusts for 'reporting errors, near misses or incidents witnessed in the previous month'.

The NHS Safety Thermometer is a national audit tool which trusts are encouraged to use to measure, monitor and analyses incidents of patient harms such as pressure ulcers, falls and catheters. The tool is used on a month by month basis to establish a baseline and tracks improvement. The prevalence rate for the trust was at zero for 11 of the 13 months from June 2014 to June 2015. There were two pressure ulcers reported in November 2014, one in May and June 2015. These were both grade 2 pressure ulcers and were non hospital acquired.

The Department of Health issues patient safety alerts to trusts through the central alerting system. This is a web-

Detailed findings

based cascading system which trusts are required to submit assurance that they have responded to alerts before they are closed on the system. The trust had a system in place to effectively manage and respond to NHS patient safety alerts. This was monitored by senior managers to ensure appropriate action had been taken before alerts were closed.

We held a focus group with NHS commissioners who reported that over the past 12 months, they had noted an improvement regarding the trust notifying them about serious incidents which took place.

Learning from incidents

The trust used an electronic system for reporting incidents called Ulysses. All permanent staff had access to the incident reporting system. Agency staff did not have access and were required to input information alongside a substantive staff member. The system had been in place for approximately a year. All staff had received training in the use of the system when it was implemented. New staff received training through the induction process. Staff informed us they were encouraged to use the system to report incidents. There was an incident administrator to support staff in the use of the system.

The trust 'incident and accident reporting (incorporating serious/untoward incident)' policy, which was issued on 25 February 2015, had clear timescales for reporting incidents. All incidents were required to be reported as soon after the incident as possible but no later than 24 hours. The incident and risk manager received reports of all incidents which occurred on a daily basis and twice weekly any incidents graded as moderate are discussed with the wards to ascertain the details.

Incidents were categorised A to E with A being the most serious. For category A and B incidents the person in charge was required to notify their senior manager immediately. Incidents were graded for severity of impact from one (insignificant) to five (catastrophic) and for probability of recurring from one (remote - less than 1%) to five (almost certain 100%). The trust used a matrix to rate incidents from two to 25. Incidents graded below eight were overseen by the matrons and managed by the ward managers. Any incidents graded 15 (red-high) or above were required to be escalated to the chief executive within one working day. Incidents graded between eight and 12 (yellow-moderate) were escalated to the operational

manager. The risk management team held weekly meetings to review all moderate incidents to determine if further investigation was warranted. Moderate incidents could be up-graded or downgraded during these meetings.

The incident and risk manager reported on a monthly basis to the incident risk & data quality subcommittee which was chaired by the director of nursing and quality. The report for this meeting included unclosed, reviewed upgraded and downgraded incidents. The subcommittee fed directly into the trust board quality and risk committee which was chaired by a non-executive director and attended by the director of nursing and quality. This process ensured that the trust board had strategic oversight of all incidents which occurred within the trust.

Managers were required to complete an initial investigation report within 72 hours for all incidents requiring further investigation. For incidents graded 15 or above, the policy stated that reports of the investigation and remedial action plan should be completed within 45 working days.

We looked at a sample of investigations that the trust had completed following a serious incident. The investigations followed a root cause analysis methodology. Overall, they were comprehensive and identified recommendations, which were used to formulate action plans. Of the serious incidents reported over the time period June 1st to August 11th 2015 38% were on going investigations and were all over due.

We held a focus group with senior managers including ward managers. They confirmed that they shared action plans and disseminated learning from incidents to their teams through locality team meetings, supervision, newsletters and e-mails. They informed us that learning was also shared within services. However, they identified there were further opportunities for sharing learning across all directorates in terms of peer support and reflective practice which they wanted to develop.

There was an established process for supporting staff following a serious incident. This included group or individual debriefing sessions and support from a psychologist or the occupational health service if required.

The policy also provided clear guidance for staff about the process for supporting patients post incident which included;

Detailed findings

- evaluate the physical and emotional impact on all individuals involved (including any witnesses)
- identify if there is a need and if so, provide counselling or support for any trauma that might have resulted
- help patients who use services and staff to identify what led to the incident and what could have been done differently
- determine whether alternatives, including less restrictive interventions, were considered
- determine whether service barriers or constraints make it difficult to avoid the same course of actions in future
- where appropriate recommend changes to the service's philosophy, policies, care environment, treatment approaches, staff education and training.

Within the forensic services, staff reported that they always received de-briefs following incidents. However, this was not the case within the learning disability services where staff reported they did not always receive de-briefs following incidents.

Safeguarding

The trust had a safeguarding adult's policy, a safeguarding children policy and a child visiting policy which were up to date. The trust's safeguarding policy provided staff with comprehensive details of the safeguarding escalation and investigation process. Staff we spoke with were knowledgeable about their responsibilities in relation to reporting safeguarding concerns. Staff received safeguarding training at induction and completed a work book as well as e-learning training. The trust wide compliance rate for safeguarding training was 96%.

The Care Quality Commission had received one safeguarding alert and 56 safeguarding concerns since June 2014 to March 2015 for Calderstones main hospital site with another two concerns raised at Gisburn Lodge and 1 concern raised at Scott house. The number of safeguarding alerts received from March 2015 to August 2015 was 47. Maplewood 2 had the most with seven alerts followed by 1 Woodview and Maplewood 3 with six each.

Between 1 June 2015 and 11 August 2015, the trust had reported 14 safeguarding incidents through to STEIS. Nine of these were closed.

The deputy director of nursing was identified as the trust safeguarding lead with the support of the director of

nursing. The deputy director of nursing directly managed the trust safeguarding lead nurse for adults and children. Any serious safeguarding concerns were escalated from the wards to the board through the trust governance structure.

We spoke with the trust safeguarding lead. They explained that when there was a possible safeguarding incident on a ward, ward staff logged onto the Ulysses system and could flag the issue as a safeguarding concern. This meant the incident report would then automatically be sent to the lead to review. The governance manager and two governance workers also reviewed all incidents and passed any that may be potential safeguarding concerns onto the lead. In addition, the service managers received copies of all incidents to review. This system reduced the risk of a possible safeguarding incident not being reported as such.

The safeguarding lead worked closely with the police. There were able to provide an example of how the trust had proactively contacted the police recently regarding an allegation of staff abuse from a patient (which was investigated and concluded to be unfounded).

The safeguarding lead was a member of the local multi-agency safeguarding hub (MASH) sub-board. The lead confirmed that safeguarding cases were only closed when the local safeguarding authority had agreed with this decision.

Whistleblowing

CQC had received four whistle-blowing enquiries since March 2014. Issues raised included, staffing levels, safety and inappropriate restraints and alarms not being answered. The trust responded positively to the CQC's requests to investigate these concerns. The trust had a whistle-blowing policy and procedure in place which staff we spoke with were aware of. The 2014 NHS staff survey results scored the trust higher than the national average for 'staff agreeing they would feel secure raising concerns about unsafe clinical practice.' Staff we spoke with individually and within the staff focus groups we held confirmed they would feel confident raising any concerns they had and that these would be listened to and acted upon by their managers.

Assessing and monitoring safety and risk

All clinical areas including the occupational therapy departments had a completed environmental ligature risk audit including an action plan where required. However,

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we found within the learning disability wards that some of the risk assessments did not have clear dates for the completion of actions which would make it difficult to track progress.

On each ward there was an assessor and support assessor identified who completed the risk assessments. The risk manager had produced an overarching ligature review plan which incorporated each action within the local audits. They worked with the estates department to prioritise the work streams within the plan. Areas that required action had been red amber green rated with completion dates attached. The risk manager had oversight of the plan and was responsible for signing off each action when it had been completed. The action plan was monitored and reviewed through the risk assurance subcommittee which fed directly into the quality and risk committee. This meant the board had oversight of the plan through this committee.

Staff had received training to assist them in identifying possible ligature points within the clinical environments. In addition to this, a video was accessible on the trust internet advising staff on how to conduct ligature audits.

Within the forensic services, there was good evidence that staff balanced relational security with the needs of the patients. Relational security is about staff having a good working knowledge of the patients they look after and of the environment they are working in. This allows staff to keep an appropriate and proportionate balance between restrictive practices and a caring environment. The layout of some of the wards did not allow staff to observe all parts. However, this was mitigated by the use of risk assessment, mirrors, regular checks and good relational security. Staff used the 'see, think, act' relational security tool to monitor and manage security on the wards.

We found inconsistencies across the wards in relation to how staff were allocated to respond to emergencies within the forensic wards. On most wards, staff were allocated at the beginning of their shift however; on Maplewood 1 and 2, they were not allocated. This meant it was not clear which staff needed to respond to a possible emergency on these wards which could lead to confusion. Despite this however; we witnessed staff responding to a possible emergency situation on Woodview 2 efficiently and professionally.

The trust had emergency planning procedures in place which were overseen by the risk manager. The trust had worked with ten other organisations (medium and low secure providers) from the National Health Service and independent sector to develop the emergency contingency plan. The group had developed a bed usage plan in the event of a major emergency occurring for example; if there was a fire and a ward had to be evacuated and the patient group needed to be relocated to another provider if there were no hospital beds within available within Calderstones.

Fire evacuation plans and drills were in place. Staff compliance with fire safety training was 95%.

We reviewed 83 sets of patient care records across all of the wards. Every record we looked at had an up to date and detailed individual risk assessment and positive behavioural support plan in place for each patient.

Safe and clean environments

During our previous inspection in July 2014, we had identified a number of concerns regarding the cleanliness of some of the wards and the storage and labelling of food. Since that inspection, the trust had purchased an electronic assurance package tool called 'Credits for cleaning'. The tool is used to assess the cleaning requirements of each room and communal areas within a service and provides a breakdown of the time needed to effectively clean each area. This information is then submitted into the tool which calculates the amount of cleaning hours needed for each area. The tool showed that the trust required an additional six whole time equivalent cleaning staff to ensure that the required cleaning standards could be achieved. In response to this, the trust employed six additional cleaning staff within the hospital.

All the wards had regular infection control and cleaning audits in place. Food was stored and labelled appropriately. Staff compliance with infection control and food hygiene training was over 95%.

Throughout the trust, the standard of cleanliness and maintenance was very good. The trust engaged in monthly patient led assessment of the care environment (PLACE) on all wards. The outcome of PLACE visits were reported to, and monitored by the trust quality and risk committee. The PLACE visits between June and September 2015 were scored between 90% to 97% on average. However; one score for cleanliness and maintenance for the Lancaster

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service was only 35%. The trust had developed an action plan in August 2015 which identified that refurbishment was required for this service. At the time of our visit, this work had been completed.

All wards we visited were compliant with the Department of Health same sex accommodation guidance.

The forensic wards met the forensic secure service specifications as set out within the Department of Health guidance 'Environmental Design Guide' (2011).

All the forensic wards had fully equipped clinical rooms with appropriate storage of medication. Within the learning disability services, the trust had moved medication storage cupboards from all kitchen areas and into staff offices since our last inspection. The trust had also installed appropriate hand washing facilities for staff on these wards. All wards had access to emergency equipment and defibrillators.

All the seclusion rooms within the trust met the requirements of the Mental Health Act code of practice guidance. They had a pictorial sign showing the rights of a patient who had been secluded. Staff were able to play relaxing music through the intercom to patients if they had identified this in their care plan as something that may help them to de-escalate. For patients who needed a low stimulus environment, there were also de-escalation rooms available for them to use.

Seclusion and segregation

Seclusion refers to the supervised confinement and isolation of a patient, away from other patients, in an area from which the patient is prevented from leaving, where it is of immediate necessity for the purpose of the containment of severe behavioural disturbance which is likely to cause harm to others (Code of Practice 26.103).

- Long term segregation refers to a situation where, in order to reduce a sustained and significant risk of harm posed by the patient to others, which is a constant feature of their presentation, a multi-disciplinary review and a representative from the responsible commissioning authority determines that a patient should not be allowed to mix freely with other patients on the ward on a long-term basis.

The trust had a policy and procedure in place dated 15 May 2015 for staff to follow for the use of seclusion and long term segregation.

There were 276 incidents of the use of seclusion across 10 locations in the six months ending 31 May 2015. The highest number of seclusion incidents were in Woodview ward 1 (160) followed by Coniston and Grasmere (41) and Woodview Ward 2 (30).

The use of seclusion has reduced significantly since October 2014 when 63 incidents were reported that month to August 2015 when 26 incidents were reported.

The team at Woodview 1 had identified there was a high number of use of seclusion on the ward. They had reflected on this and asked the team psychologist to do some work to see why this was the case. The psychologist had been working on cognitive analytic therapy, to identify relationship patterns identified by the female patients. This identified that some female patients felt abandoned at times, and the seclusion time allowed a low-threat-high-contact time for the patient. The ward manager had introduced individual seclusion plans for each patient. The team psychologist believed this work would impact on the number of seclusion episodes on the ward.

At the time of our inspection, three patients required long term segregation. All three patients who required long term segregation had been referred to the local multi-agency safeguarding team with oversight from the trust safeguarding lead. The use of segregation had also been placed on the trust significant risk register. During the last six months, six incidents of long term segregation had taken place, two on Woodview ward 1, two Woodview ward 2, one on Woodview ward 3, and one on Maplewood. Two of these patients' were awaiting high secure assessment outcomes and transfer due to the high level of risk they posed to others.

Restraint

The trust had introduced a project of work following the Department of Health publication guidance 'positive and safe: reducing the need for restrictive interventions' (April 2014) as part of the compassionate care and mental health service reforms.

The trust appointed a positive & safe programme lead at the beginning of 2015 to support the implementation of the positive and safe guidance. The lead had reviewed and replaced the training for physical interventions with the 'safe wards-no force first' model of care. The trust wide compliance rate with positive management of violence and aggression training was 79% Governors we spoke with told

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us that a new funding bid to extend this training was in the process of being approved and patients had been involved in developing this bid. They said training on 'safe wards' had also improved staff understanding of managing patients' distressed behaviour. Governors described work on safe wards and had a DVD presented to them which demonstrated staff were supporting patients with positive language.

The new model involved staff working with patients to identify possible triggers and situations which may cause them to become agitated and putting plans in place to manage these times. Patients described how they were involved in this process. This included how they would like staff to respond to and support them during these times. This information was used by staff to develop positive behavioural support plans for each patient, which included the functional analysis of behaviours. All the care records we looked at included an individual positive behavioural support plan for that patient. The trust identified in their September 2015 update to the quality and risk committee that 75% of patients had a plan in place. At the time of our inspection, this figure had increased to 100%.

The plans included staged de-escalation techniques starting from the least restrictive intervention such as the use of distraction techniques to more restrictive interventions including the use of medication (including intramuscular) and restraint if it was required.

Patients' care records we looked at showed evidence that restraint was used only as a last resort and that other alternatives had been explored first, for example, the use of distraction techniques identified by the patient which included use of animals, art work and one to one time with staff.

Staff were able to describe how they also used positive supportive language with patients to de-escalate a situation.

The positive and safe project lead told us they provided monthly updates to the quality and risk committee which reviewed progress made to monitor performance and identified any trends. Minutes we looked at confirmed that the use of all types of restraint were discussed at these meetings. The use of prone restraint and emergency response belts were required to be presented, reviewed

and approved by the trusts ethics committee prior to being used on the wards. Minutes we looked at confirmed that alternative less restrictive interventions were considered prior to approval being granted.

As a whole, the trust recorded 4,323 incidents of the use of all restraint between November 2014 to September 2015. These occurred on 31 patient accessible areas within the trust. The highest incidents were reported on Woodview ward 1 with 1104 incidents recorded, Coniston & Grasmere, Maplewood had 552 incidents recorded and 399 incidents were reported at 1b West Drive.

The trust provided data that showed in October 2014, the number of restraints recorded was over 300. By August 2015, this had reduced by half to 150 incidents.

The trust had a policy and procedure dated April 2015 for the use of emergency response belts and handcuffs. Between November 2014 to September 2015, three patients had Ministry of Justice authorisation for the use of handcuffs. Handcuffs were used 19 times on patients in this time period for the purpose of transferring them safely outside the security of the hospital.

Between November 2014 to August 2015 a emergency response belt (ERB) was used on 163 occasions with the highest being recorded on 1b West Drive being used 96 times and 50 times on 4d West Drive. All these restraints had involved the use of staff either placing or removing the ERB whilst the patient was in the 'prone' (face down) down position. The use of the prone down position of restraint presents increased risks to patients. Trusts have therefore been required to reduce the use the prone down position with the goal of eliminating the practice completely.

From September 2015, the use of the ERB had been totally eliminated within the trust. Staff had achieved this by working with the three patients who had been restrained by the use of an ERB, to identify less restrictive interventions which could be used when they were agitated or presented with behaviours which could harm others. Staff had enabled the patients to take control by allowing them to 'hand over' their ERB to staff when they felt safe with the implementation of the less restrictive intervention. In September, the last patient had handed their ERB to staff.

Of the 4,323 incidents of restraint reported between November 2014 to September 2015, 405 incidents of patients were restrained in the face down or 'prone'

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position. The use of prone restraint (excluding those which included the use of ERB'S) had decreased from 289 incidents between November 2014 to April 2015 to 39 incidents between May 2015 to October 2015.

Between February 2015 to July 2015, 355 incidents of restraint had resulted in rapid tranquillisation being used. In February 2015, there had been 95 uses reported. This figure had decreased month on month with 21 uses in July 2015.

The number of intramuscular medications used during incident management was 37 for the same period with most incidents on Woodview ward 2 with 17 incidents over this period. Staff reflected on the use of restraint and intramuscular injections during handovers and team meetings, discussing what had and had not worked, and the effect on patients' behaviour.

In the care records we looked at, there was good evidence that staff were complying with the seclusion policy and procedures.

Blanket restrictions

The trust did not have any blanket restrictions in place. Restrictions which were in place, for example access to the internet, leave or mobile phones were based purely on patient's risks or restrictions which were imposed by the Ministry of Justice to protect others. Since our last inspection in July 2014, the trust had supported ward staff in identifying practices on the wards which may have been unnecessarily restrictive. The trust supported staff to remove all restrictions on the wards and only re-introduce any restrictions based on risk with justification and the involvement of patients. This had led to changes in practice for example; staff at Scott House had successfully introduced the unlocking of one of the ward flats and were in the process of rolling out a phased plan to unlock the second. This was to enable patients to have greater freedom and responsibility. It meant that patients were able to leave the ward freely and to leave the main building, going into the gardens if they wish to do so. This was a change as previously patients could only leave the wards if they had a member of staff with them.

The wards did not undertake room or personal searches for all patients routinely but did these based on identified risk.

Medicines Management

All the wards had appropriate storage for the safe management of medicines and disposal of medicines facilities in place. The trust had dedicated pharmacy staff who undertook a cycle of medicine audits and provided support and advice to ward staff.

The trust's medicine policies had been reviewed to consider the local medicines arrangements in the Lancaster services. Audits of medicines and safe storage of controlled drugs completed by the pharmacists had demonstrated improved compliance. However, the trusts audits of 'Rapid Tranquillisation' in May and July 2015 demonstrated a, "lack of evidence during the required timeframe that some of the physical observations have been carried out." We looked at the records for one patient where rapid tranquillisation had been administered on two occasions and found that their physical observations had not been completed in line with trust policy. The trust had an action plan in place to improve compliance with the policy.

A medicines safety committee (medicines surveillance group) was established in June 2015 and the role of the medicines safety officer was still being established. We found that in July and August 2015 the infection control nurse and the clinical nurse manager took lead roles around medication, rather than the named medicines safety officer.

The trust had a medicines management committee to "advise on implementation of national guidelines" including National institute for Health and Care Excellence (NICE). However, we found that the trust policy for Rapid Tranquillisation issued in June 2015 made reference to the superseded 2005 NICE guidance, as did the July 2015 Audit. Contrary to current guidance we also found a lack of detail about "the rationale and circumstances in which p.r.n (when required) medication may be used" within the care plans we viewed.

Safe staffing

Following our last inspection, the trust had an action plan in place to manage staffing issues which they had escalated onto their board assurance framework and corporate risk register. These identified the specific staffing issues the trust were facing which included;

- recruitment of specialist learning disability nurses due to a national shortage

Detailed findings

- retention of staff due to uncertainties about the future due to the impact of the transforming care agenda
- high staff sickness rates

The action plan identified controls the trust had in place and actions to address the staffing issues which included;

- implementation of the trust workforce strategy to effectively manage human resource issues
- daily meetings between ward managers and operational managers
- weekly staffing meetings between operational and clinical managers
- weekly up-dates to the board
- weekly recruitment reports
- recruitment open days at job fairs and local colleges and universities
- a planned reduction of beds by commissioners
- monthly safe staffing reports to the board through the quality and risk committee
- quarterly human resource reports to the strategy and performance committee

The trust completed a full review of their staffing and skill mix requirements to ensure that they identified the appropriate resources needed to meet their patients' assessed needs.

To address some of the staffing issues the trust had also:

- introduced a 'red flag' system for staff to escalate staffing issues to the director of nursing
- introduced a dashboard 'swipe in' system for staff so live data was available on staffing in all clinical areas
- temporarily closed parts of the organisation to ease staffing pressures
- jointly agreed an extended bank pool staff with a local NHS Foundation Trust
- focused on high quality and appropriate discharges
- agreed to recruit into band 6 qualified nursing vacancies from non nursing professional groups such as occupational therapists
- worked with agencies to block book staff for consistency
- agreed a risk escalation protocol with NHS England
- secured funding from NHS England until September 2016 for staffing

Trust wide, the staff turnover was 25% from the year from September 2014-15. Staff sickness rates were highest for unqualified staff in August 2015 at Woodview 3 at 31% and for qualified staff at 5 West Drive at 24%. Lowest sickness

levels were at 4 West Drive for both qualified and unqualified at less than 1%. Trust wide staff vacancies for August 2015 were 20% for qualified staff and just over 6% for unqualified staff. Data from April 2014 to October 2015 showed a decrease in vacancies month on month from May 2015 for both qualified and unqualified staff.

Each ward displayed their actual staffing and fill rate for the week in line with safer staffing requirements.

The trust used bank staff in the first instance to cover any shortfalls in shifts. Trust staff made up 75% of the bank and were therefore familiar with the services provided. The trust recruited agency staff from an NHS endorsed agency. Agency staff had undertaken training in core areas before working on the wards. This training included management of violence and aggression, working within mental health and learning disabilities services, basic life support and safeguarding. However, compliance with basic life skills was below the trusts' target of 80%. Within the learning disability service it was 58% and within the forensic services it was 67%. Agency workers told us they were encouraged and supported to continue attending training to ensure their skills and knowledge improved. We reviewed six agency staff induction checklists and could see the ward lead ensured staff not familiar with the environments had important information before starting their shifts. Agency staff that we spoke to had worked on the wards for up to four years.

At Mitton Road, North Lodge and Daisy Bank, there was not always a qualified nurse on the premises. The qualified band 5 or band 6 nurse based in one of the wards also provided support across a number of the houses. These houses were walking distances from each other. The qualified nurses attended each of the houses to undertake specific interventions or to dispense medicines and provide support to the non-qualified staff. At Daisy Bank and North Lodge the qualified nurse provided on call cover at night from their own home.

The trust monitored the impact staffing levels had on patients' meaningful activities and any sessions that were rearranged due to staffing issues were recorded. Within the forensic service, staff told us that the wards were rarely short staffed. When we spoke with patients they did not raise staffing levels as a concern. There were instances where activities or leave had been rearranged. These instances were recorded using the ULYSSES red flag system and analysed in the weekly staffing analysis group. Where

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activities or leave had been cancelled, the ward manager was required to provide an explanation. We saw evidence in ward diaries that activities and leave were rearranged when they had to been cancelled.

Staff and patients within the forensic service told us that activities were rarely cancelled due to staffing issues. Figures provided by the trust showed a general downward trend for missed activities across all wards. The majority of patients we spoke with within the learning disability service told us there were usually enough staff and that it was not a problem finding a staff member to spend time with on a one-to-one basis

The wards had a dedicated consultant psychiatrist and medical cover in addition to occupational therapy workers and psychologists.

Ward managers were managing sickness and absence in line with the trust policy.

Compliance with annual appraisals trust wide was between 92% for band 6 staff and below to 99% for band 7 staff and above. 94% of doctors had a completed annual appraisal.

Duty of Candour

The new statutory Duty of Candour was introduced for NHS bodies in England from 27 November 2014. The obligations associated with the Duty of Candour are contained in regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The key principles

are that NHS trusts have a general duty to act in an open and transparent way in relation to care provided to patients. This means that an open and honest culture must exist throughout the organisation. Appropriate support and information must be provided to patients who have suffered (or could suffer) unintended harm while receiving care or treatment.

Duty of Candour was built into the induction programme for new starters. All board members had received training on the Duty of Candour.

The trust had a strategy in place to ensure that it was meeting the regulation. The trust also had a procedure described in the core brief which was available to staff in July 2015. This noted that all staff had a responsibility for making sure incidents or complaints were acknowledged and reported as soon as they were identified and they should be managed with compassion and understanding. It also provided a link for staff to access the guidance provided by the General Medical council and the Nursing Midwifery council.

The trust incident reporting system had an applicable tick box for staff to select and consider any incidents that may relate to the Duty of Candour. The trust was also monitoring each ward via their quality dashboard which identified any incidents where the Duty of Candour principles may be applicable. The trust had identified six incidents which met the criteria for Duty of Candour.

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

Our findings

Assessment and delivery of care and treatment

All admissions to the trust were planned admissions. The NHS England specialist commissioning team were gate keepers for patients admitted to the secure service. These patients had complex needs and presented with risky behaviours that necessitated a secure environment to protect themselves and others from harm. Within the forensic services, there was a multidisciplinary approach to admission assessments. A team of staff from the service would go out to meet with the patient and complete an assessment. This would usually include a doctor, a senior nurse and members of the occupational therapy and psychology teams.

On admission, all patients were assessed by a doctor and nurse. This assessment covered the patients' physical, psychological, social, occupational, spiritual and cultural needs. Each patient also had a detailed, comprehensive risk assessment completed.

The trust had implemented a new model of care and treatment following the publication of, 'Positive and proactive care: reducing the need for restrictive interventions' Department of Health (2014). The model was based on understanding patients' behaviour and providing person centred interventions to meet their individual needs within a recovery focussed approach. We looked at the care records of 83 patients. We found that the principles of the model had been used to develop a 'positive behavioural support' (PBS) plan for each patient formulated around their specific needs'. These plans included detailed relapse prevention plans, early warning signs and protective factors etc. The staff had all participated in a training programme called creative intervention training in response to

untoward situations (CITRUS). Staff described how they used positive language and the least restrictive practices in response to aggression and interventions that were in the best interest of the individual patient.

Patients had been involved in assisting staff understanding by making a DVD for staff regarding the practical application of the model. This included an overview of the model, the use of positive statements and role play scenarios.

Patients were involved in planning their own care and developing positive behavioural plans with staff. Plans were reviewed regularly within multidisciplinary team meetings under the under framework of the care programme approach (CPA) process.

Speech and language therapists helped develop communication aids for those with difficulties in this area. They developed communication passports and included these in the care record to document non-verbal cues to communication for those with extreme communication difficulties. The trust had a range of information available in different formats such as pictorial, easy read and languages for patients who required these.

The quality of the PBS plans we reviewed was exceptionally high across the trust.

Patients physical care needs were being met. Each patient had an annual health check completed. Patients were encouraged to attend primary care community based general practitioners, dentists and opticians. However, on site health centre facilitates were available for patients who were unable to attend community based services. The health care centre also provided specific services to meet patient's longer term conditions and needs such as smoking cessation, weight management and blood monitoring etc. The health centre and good established links with primary care to provide physical health care to patients.

The centre also provided education about a range of conditions. Patients had made numerous health promotion DVDs through the trusts patient led media group which were available for patients.

Are services effective?

NHS England had completed community treatment reviews for all patients requiring one with support from the staff. These involved each patient's care and treatments being independently reviewed to ensure their care needs were being met appropriately. Commissioners we spoke with told us they had worked collaboratively with the trust to plan for the transition of patients into community services and listened to what the trust needed from commissioners, especially about the security and risks associated with some patients.

Every patient had a 'moving on plan' in place. These were developed with patients and their carers where appropriate and identified what needed to be in place to support each patient's discharge.

All patients had a moving on plan which staff had developed with the patient, carers and other stakeholders where appropriate. Moving on plans included reason for admission, discharge area of choice, capacity, risk management plan, activities of daily living, health, finance, equality and diversity, model of care, my transition plan and impact on wellbeing. We saw information within the sections on what was important for the patient, the patient's family and the team. Patients had monthly multidisciplinary meetings to review their care and treatment including their moving on plans. Patients were given the opportunity to discuss what was important to them in these meetings.

The wards worked closely with local community services to ensure smooth discharges or transfers between services. Patients from the services based in Lancaster said they had good engagement with the local community and were supported to attend recreational and social events as well as prepare for discharge. However; patients on the Calderstones site told us that recreational time at evenings and weekends were more limited.

Outcomes for people using services

The trust had an audit committee which fed directly into the trust board. The audit committee linked across all the trusts seven sub committees. Workstreams related to audit were disseminated down to the subcommittees and to the board through the audit committee. The trust had an identified National Institute for Health and Care Excellence (NICE) lead for the trust.

The trust's quality account highlighted the following top seven quality priorities for 2015/16 as:

- positive and safe at Calderstones
- credits 4 cleaning
- ward accreditation scheme
- eliminating omitted medicines without clinical reason
- integrated treatment and care planning
- national offender management project
- commissioning for quality and innovation (CQUIN) 2015-2016

These had been:

- agreed with commissioners and other external stakeholders such as NHS England, Monitor and specialist commissioning services
- developed by the trust in response to national guidance
- developed to ensure compliance with the Care Quality Commission regulatory requirements
- developed to meet 'gaps' identified by the trusts internal audit programme.

The trust had a dedicated clinical audit department within the trust and clinical staff actively participated in the delivery of these audits. Pharmacy staff completed monthly medication audits on the wards.

Between 19/12/2014 –19/05/2015, the trust had completed the following audits:

- continuation monitoring of patients on atypical antipsychotics
- compliance with the handcuffing policy
- bipolar disorders; managing bipolar disorder in adults and secondary care
- the physical health element of national audit of schizophrenia.
- medicine management
- non oral rapid tranquillisation
- first aid at ward
- dysphagia
- antibiotic prescribing
- food labelling
- patient led assessment of the care environment (PLACE) visits
- hand hygiene.

The trust had been leading a national piece of work on behalf of the National Offender Management Service (NOMS) to improve outcomes for offenders with learning

Are services effective?

disability. This had been in the form a jointly funded project to work with prisons and probation services to improve delivery. The project had been led by the forensic support service which has successfully:

- developed a range of tools to enhance practice
- led the development of a clear practice framework
- helped NOMS to revise its national strategy.

The teams had implemented a range of evidenced based practices and initiatives to improve patient outcomes which included:

- implementation of the 'safe wards' model of care
- implementation of 'quality data sets' and 'heat maps'
- the implementation of the creative intervention training in response to untoward situations programme
- the development of positive behavioural support plans for all patients
- access to psychological therapies including cognitive behavioural therapy, dialectical behavioural therapy, aggression management therapy, and sex offender treatment programmes as per NICE guidance
- comprehensive risk assessments for each patient
- the implementation of the 'Good Lives' model of care at Scott House. This model aims to reduce the risk of re-offending amongst patients with a forensic background
- the Liverpool University neuroleptic side effect rating scale which was used by patients as a self-assessment tool for measuring the side-effects of antipsychotic medications
- the use of the health of the nation outcome scale. This covered 12 health and social domains and enabled the clinicians to build up a picture over time of patients responses to interventions
- the use of the recovery star.

Since the implementation of the trusts positive and safe strategy, the number of incidents of restraint and seclusion had significantly reduced and the use of emergency response belts had been eradicated.

Staff skill

We looked at the employment records of the five most recently employed registered nurses, five most recently employed support workers, the most recently employed doctor and five most recently employed non clinical staff.

We checked the registered nurses were registered with the nurses regulatory organisation the Nursing and Midwifery Council(NMC) and the General Medical Council (GMC) for

the doctor. The registration of the five registered nurses and doctor were checked against the data base for the NMC and GMC and staff found to have current registration with their regulatory organisations.

All 16 records contained the information required in Regulation 19, Schedule 3 of the HSCA 2008 (Regulated Activities) 2014, which requires proof of identity, employment history, disclosure and barring check, full employment history, qualification check and health checks.

In addition there were application forms, curriculum vitae and additional references were the human resources department had required additional proof of character or employment. There was evidence of how the interview process had been adhered to in all sixteen files which meant that it was possible to determine that the interview process had been followed for these appointments in line with trust policy.

The trust had applied for enhanced DBS checks for support workers and were waiting for the result of the checks to be received. The trust had allowed staff to commence employment before the checks had been received by putting supervisory arrangements into place to ensure staff were supervised at all times. This remained until the staff could demonstrate required and acceptable levels of competence to carry out their role. This required the director of nursing and quality to sign a declaration of accountability to accept the responsibility on behalf of the trust for staff to commence employment pending the outcome of the enhanced DBS check.

In the NHS Staff Survey 2014, the trust were in the top 20% of mental health /learning disability trusts for questions relating to receiving job relevant training, learning or development, receiving health and safety training and having equality and diversity training.

The trust target for compliance with mandatory training was 80%. The overall trust performance figures for mandatory training was 95%.This is broken down to:

- Fire training 95%
- Positive management of violence and aggression 79%
- Infection Control 96%
- Food Hygiene 96%
- Moving / Handling 95%
- Equality & Diversity 88%
- Safeguarding 96%

Are services effective?

- Information governance 95%.

Basic life skills was not included in the mandatory training. The figure for this was lower than the trust target at 58% within the learning disability service and 67% within the forensic services.

Ravenswood scored the highest with 100% training achieved across the board and 1 West Drive had the lowest overall scores.

On the LD wards there was a two week induction period for staff covering the conditions of the patients in their care, communications, first aid and physical interventions. There was a similar induction for the forensic wards as well and all staff also completed a trust induction.

We looked at the five most recent disciplinary and grievance procedures completed by the trust human resources department where staff had requested the grievance procedure or the trust had implemented the disciplinary procedure. The files contained all the relevant documents relating to the process and followed trust policy.

Multi-disciplinary working

The NHS Staff Survey 2014 showed that the trust was in the top 20% of all mental health/learning disability trusts for questions relating to 'good communication between senior management and staff and effective team working'.

The LD and forensic wards we visited had a multidisciplinary framework in evidence with ward rounds either weekly or fortnightly dependent on the needs of the patient. The patients were involved with the process and carers had the opportunity to express their opinions.

The full multidisciplinary team was invited to attend patient meetings, although, there were some issues with social workers not attending, and this was often due to availability of the social worker. However, support workers were not always invited to the learning disability ward rounds, they felt that they had a lot of important information to give and told us they would like the opportunity to attend.

We attended five staff handovers on the LD wards, all unannounced, and observed the handovers taking place. We heard information being presented, staff noting concerns from the previous shift and talking positively about the safe wards initiative. On the forensic wards, calendar invites were sent each day reminding staff to

attend handover. These were observed on one of the 10 wards visited and involved all the staff groups. We observed relational security being discussed at the meeting and on the wards we visited.

Staff told us that they had good links with local services. Patients used local primary care services, GP, dentists and opticians. The forensic wards had good links with the public protection multiagency arrangements (MAPPA) and the local mental health teams. The care programme approach meetings were attended by the multidisciplinary team. Doctors were present on the wards and both the doctors and staff reported that this had a positive effect in terms of feeling involved with the ward.

The LD wards had good links with the forensic support team and the local safeguarding team. The care coordinator from the patient's home region attended the MDT to ensure smooth transfer on discharge.

Information and Records Systems

The trust had an electronic patient record system which all authorised staff could access. Patients' records were stored securely and were easily accessible to staff when needed.

More than 95% of staff had undertaken the training for information governance.

Consent to care and treatment

There was a system in place to ensure that patients were advised of their rights in accordance with section 132. We saw that there was an easy read version of this information to support patients with a learning disability to understand information about their legal detention. The trust policy stipulated that rights should be repeated at monthly intervals and we saw evidence that this was being adhered to on the wards that we visited. Patients told us that they were aware of their rights and had been supported to appeal against their detention where required.

We found that patients who lacked capacity were automatically referred to an independent mental health advocate (IMHA). Information regarding IMHA was available on all wards and included a photograph of the named advocate for the ward. There was a specialist gender specific advocacy service provided an IMHA for the female patients. We found that advocacy was an integral part of the service that was offered at Calderstones and both patients and staff valued the IMHA role. We found that staff on the learning disability wards had a limited understanding of mental capacity act (MCA) and were

Are services effective?

uncertain of the principles and how this affected their role. There was, however, evidence of mental capacity assessments in the patients records, which were then reviewed weekly by their key worker.

Assessment and treatment in line with Mental Health Act

The trust had presented the board with a briefing paper in June 2014 which set out a proposal to re-structure the Mental Health Act 1983 (MHA) Administration structure function within the trust to address the issues raised by CQC during our previous inspection. All the issues we raised were incorporated within the trust CQC action plan.

The board ratified the proposed changes to the structure which included the appointment of a new MHA trust lead.

All patients within the trust were detained under the MHA at the time of our inspection. We found that whilst some patients were detained under section 3, a significant number of patients were detained under a forensic section of the Act. There was clear evidence that effective systems were in place for the administration of the MHA and in each case that we checked, scanned copies of detention documents, renewals and tribunal information were contained within the electronic patient records. This meant there was a clear audit trail of patients detention even for those patients who had remained at Calderstones for a number of years.

We saw that there was a clear system in place for the authorisation of section 17 leave and that risk assessment

was integral to this. An overarching leave principles document outlined the rationale for therapeutic leave and the block leave forms clearly stated the parameters of each incident of leave from the ward.

In relation to section 58, we found that with few exceptions, prescribed medication was authorised by a form T2 or T3. However, there were inconsistencies regarding the recording of the responsible clinician's (RC) assessment of a patient's capacity to consent to treatment. Patients capacity to consent (or refuse) treatment was not regularly reviewed as part of the section 61 review of treatment within the medium secure service.

Good practice in applying the Mental Capacity Act

There were no deprivation of liberty safeguarding applications in the twelve months leading up to inspection.

There were policies in place for both Mental Capacity Act (MCA) and DOLs.

There was evidence in patients' records of mental capacity being considered and this was a separate part of the patients' care plans that was reviewed by the key worker on a weekly basis. We saw staff supporting people in making specific decisions rather than assume lack of capacity on all the secure wards

MCA training was coupled with Mental Health Act training in the trust and consisted of five briefings in total. All staff had completed the first four briefing. The fifth briefing had not been released at the time of inspection.

Are services caring?

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

Summary of findings

Our findings

Dignity, respect and compassion

All of the patients across the whole of the service that we inspected were positive about the way staff team treated them. We observed staff treating patients with compassion and respect throughout the inspection.

During the inspection, we saw several patients experiencing times of challenge. Without exception, the staff present at the time were compassionate and supportive. They allowed patients to express themselves and provided support and reassurance as required. We also saw staff actively intervene and provide patients with the support to cope themselves when they recognised changes in patients' behaviour. This prevented behaviour escalating and avoided the use of restrictive interventions (restraint, seclusion or extra medication). On each of these occasions, the staff interventions maintained the respect and dignity of the patient.

During the inspection, we visited every ward area and we completed one short observational framework for inspection (SOFI) at Moor Cottage. SOFI is an observational tool used to help us collect evidence about the experience of people who use services, especially where they may not be able to fully describe these themselves because of cognitive or other problems. This scored highly for staff interactions and understanding the communication needs of the patients.

At Scott House, staff displayed an in-depth knowledge of the patients' likes and dislikes and methods of communication.

Within other settings, we observed staff being respectful, knocking on doors and waiting for patients to tell them to come in before entering a room. Staff were encouraging and enabling towards patients whilst respecting their privacy and dignity at all times.

Patients reported staff were friendly, caring, respectful and understanding. Staff were approachable and patients felt able to talk to staff.

We saw some excellent examples of staff adapting their interactions with patients based on their individual needs. For example; staff were quiet and calm with patients who required a quieter environment and were chatty and livelier with patients who embraced this form of communication.

Within the forensic services, staff maintained a good balance between the security requirements of the environment with the needs of the patients.

The atmosphere on the wards was calm and relaxed.

We spoke and met with carers, relatives and other stakeholders who confirmed that the care provided was person centred and focussed on the needs of the patients. Many of the carers explained that the care provided exceeded their expectation and gave us examples when visits and family occasions had been made possible with additional and individual support.

We left comment cards in all of the clinical areas and we received 38 completed cards. 28 of the cards had been completed by patients. Feedback from these comments cards was generally good and patients reported being happy. However, some patients stated they would like an increase in activities and an update on their future placement options. Three patients would like to move near to their families and four said they would like more staff. Of the feedback from the comment cards we received; the majority (21 of 28 patient respondents) were positive comments from patients about their care, staff caring for them and providing good support.

The Friends and Families Test shows that 36% of respondents were either likely or extremely likely to recommend the trust as a place to work. 39% of respondents rated the trust as a place to receive care. The national averages are 61% and 76% respectively.

There have not been any comments for the trust via the Patient Opinion framework.

Are services caring?

The patient led assessment of the care environment (PLACE) 2015 gave the trust an overall score of 95% for privacy, dignity and wellbeing; this put it at 6% above the England average of 89.5%.

We held a focus group with 10 patients, the patient public involvement manager, and a representative from Health Watch and the advocacy service. Patients were supported by support workers. Feedback from the focus group with the patient involvement group was that staff were caring and kind and that patients and carers were always respected.

Our family carer professional advisor visited Slaidburn and Woodview 1 wards and spoke with five patients and three staff. They observed positive and respectful interactions between patients and staff. One patient said staff did not treat them respectfully or listen to them. The other four patients said staff treated them respectfully and listened to their concerns.

The carers' focus group we held gave examples of staff referring to patients as 'they' and overhearing staff telling their relatives not to tell them about their care and treatment during telephone calls.

Involvement of people using services

Since the last inspection completed at the trust there have been improvements in the involvement of patients in their care. Patients across services told the inspection team that they had been encouraged by staff to become more involved in their own care and the development of the service. The introduction of the use of positive supporting language had allowed the patients to make their own DVD as a staff training tool to demonstrate this process for meetings that discussed patients.

In response to 'Positive and safe: reducing the need for restrictive interventions' the trust had completed a review to ensure that there were no overly restrictive practices in place. Following this review, the trust had reduced many of the restriction in place, including the restrictions on mobile phones and internet access. This had allowed patients to use communication programs to communicate with family members who were not able to visit as frequently.

For those patients able to, as part of the positive behaviour support planning, they had contributed to plans to support them in time when they were upset, agitated or angry. These plans identified proactive interventions that they knew worked for them in the past.

We spoke with patients who had been offered a copy of their care plan. For those that accepted, they had been given copies in a format they could understand. If patients had been offered and refused a copy this was clearly documented in the patients' care records.

Patients told us that they were involved in decisions about their care. The staff demonstrated in their interactions with patients true partnership working by encouraging them to release their potential and supporting them to address those areas they found challenging.

The patients from the patients' involvement group attending the focus group commented that staff were very busy but over the last four weeks, staff had more time to sit and talk with them. The involvement group met regularly and was a service user subgroup feeding in to the governor meetings. However, we reviewed the minutes of the last two meetings of the patient involvement group and could not see any evidence of the group consulting with or bringing the views of other patients to the meeting.

The patient involvement group told us about their involvement with the recruitment of staff. This involved attending interview panels and appointing staff. Six of the ten patients said they had attended staff interviews and they asked questions and provided an assessment score of the candidate's performance. Patients said their views, feedback and assessment scores were used in the overall decisions to appoint staff. The group told us about a set of qualities they had developed to assist them in making decisions to appoint staff. This was called 'What the service users say they want from support staff'. This had been developed by asking patients about the positive values and support they wanted from staff and the negative values they did not want. From this was developed a set of values for prospective staff. For example, positive values were staff being respectful, supporting patients to deal with their emotions and feelings and keeping patients safe. Negative values they did not want from prospective staff were not being respected, being bullied and being made fun of. This had resulted in a core set of values being developed called 'What we think are good staff qualities'. Examples of good qualities patients wanted included staff that were not judgemental, reliable and thoughtful.

The governors told us in their focus group they had engaged with the patient experience subgroup as this fed into the council of governors. Governors told us they were

Are services caring?

aware through their meetings with the patients experience group that patients were involved in the recruitment of staff. They said patients were involved in research projects and had fed back at conferences.

Services held a range of patient community and patient council meetings to gather feedback and encourage involvement from patients. Patients took part in 'speak up' groups and 'mutual respect' meetings. A patient chaired the meetings with the support of an occupational therapist. The minutes were accessible to other with photographs and symbols. Staff supported individuals to understand the minutes and agenda if they were having difficulties.

We held a carers focus group and completed telephone interviews with carers. Carers described very different experiences within the work of the trust. Some were extremely satisfied, where individual packages of care were provided and some carers were extremely dissatisfied. Whilst most carers were happy with the care provided and felt listened to by staff, other carers expressed concerns about the quality of care, activities and communication between staff and carers, lack of staff and cancellation of activities.

We held a focus group with six NHS commissioners. Commissioners gave examples of patient involvement in service design. For example at a meeting attended by a commissioner there was a patient presentation on restrictive practice and on positive and safe. Another commissioner gave an example of doing an unannounced visit for a mock CQC inspection and said patients were very knowledgeable about the inspection process.

Emotional support for people

Staff had invested time in developing positive behavioural support plans with all patients within the trust which were

formulated around their specific needs'. These plans included detailed relapse prevention plans, early warning signs and protective factors etc. which were individual to that patient. The plans had been developed with the involvement of the patient, members of the team and the patient's carers where appropriate. The plans were graded with the least restrictive intervention identified as the first course of action staff should take if the patient was becoming distressed or aggressive. The plans recorded that the next more restrictive intervention was only to be used if the less restrictive one had been ineffective in de-escalating the situation.

The staff had all participated in a training programme called creative intervention training in response to untoward situations to support this new approach. Staff described how they used positive language and the least restrictive practices in response to aggression and interventions that were in the best interest of the individual patient.

Staff had explained how they had used this approach to support three patients who did not feel emotionally ready for staff to stop the use of emergency response belts when they were distressed or behaving in an aggressive manner. Over several months, staff had worked with the patients exploring new less restrictive ways they could cope and supporting the patients to 'test these out'. This enabled them to take control by allowing them to 'hand over' their ERB's to staff when they felt safe with the implementation of the less restrictive intervention. In September, the last patient had handed their ERB to staff.

All patients had access to advocacy services and there were posters displayed to promote this service.

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

Our findings

Planning and delivery of services

There was an open visiting policy in place for most areas. In the non-secure areas, people were able to visit the patient's own room. In the secure wards, there were identified visiting rooms to facilitate family visits.

Patients within the learning disability service were very keen to show us their rooms and were proud of their personalised space.

The trust had signed up to the 'triangle of care' initiative in 2010. The 'triangle of care' approach was developed nationally to improve carer engagement in mental health acute inpatient and home treatment services. The trust held monthly meetings which were advertised on the trusts' website.

Calderstones Partnership NHS Foundation Trust provided care for patients with a learning disability and or autism. The trust took patients mainly from the Greater Manchester and Lancashire area but also accepts patients from other parts of the United Kingdom.

The trust had actively engaged staff in consultations regarding the future of the service in response to the transforming care agenda and was proactively working with people through this. The trust had identified that this had a negative effect on staff morale, sickness, staff turnover and recruitment which they were proactively managing. The trust had secured staff funding from NHS England until September 2016 to provide staff with some stability.

Diversity of needs

The 2013 learning disability census indicated that the trust was one of the largest providers of inpatient care.

On the census day in 2013 there were 218 patients.

This was broken down as follows:

- males 180 (83%); females 38 (17%)
- ethnic category white British: 193 (89%)
- one hundred and thirty three (61%) patients were receiving treatment authorised without their consent by a Second Opinion Approved Doctor under section 58 of the Mental Health Act
- thirty six (17%) patients were deaf and 16 (7%) had a hearing impairment
- sixty seven (31%) patients had an autistic spectrum disorder including Asperger's syndrome
- thirty five percent of the patients were detained on section 3 of the Mental Health Act, 26% were on section 37/41 and 19% were detained on section 37. The remainder were detained on other sections of the Act
- thirty three percent of the referrals had been received from the NHS, 31% from social services, 18% from prisons or the courts and the remainder were from other agencies.

We found mixed access to faith and spiritual leaders. There were rooms identified that could be used for prayer or religious services. Staff had supported one patient with changing their faith. In some of the clinical areas, there was access to religious texts of all faiths. The trust had previously arranged for a chaplain to visit, but we were told that this was no longer available. Patients on the autism wards did not have access to spiritual support.

The trust had an equality strategy and action plan to ensure that staff and patients using the service had access to personal, fair and diverse services. There was an identified executive lead for equality that was responsible for implementing the strategy. 88% of staff had undertaken training in equality and diversity.

The trust had in place a communication plan for each patient and were ensuring this was being delivered by training staff accordingly. Staff had access to a range of material and resources to support them to communicate effectively with patients, including easy read material, speech and language therapists and interpreters.

The trust has a Lesbian, Gay, Bisexual, Transgender forum called The Avenue. This had been developed after a request from a patient and was patient led. The forum provides support to patients in a safe environment.

Are services responsive to people's needs?

The Avenue was nominated and shortlisted for a national award in the Tackling Stigma category in the National Service User Award 2015.

The trust had Our Shared College on site. In 2014, patients took 322 courses on subjects including money management, maths, upholstery, curriculum vitae skills and horticulture. 126 accredited certificates, including nationally recognised qualifications were awarded to patients through the college.

Right care at the right time

Ravenswood, Maplewood, South Lodge, 15-16 Daisy Bank, Moor Cottage, 2 North Lodge and 1-2 Pendle Drive all had 100% bed occupancy. Ravenswood (Step Down) experienced the lowest average bed occupancy rates with 49% during the time period.

The average mean percentage bed occupancy rate over the past six months for each location were;

- Enhanced support unit (offsite) 87%
- Enhanced support unit (on site) 96%
- Low secure unit 88%
- Medium secure unit 91%
- Step down services 70%.

The trust was achieving its national targets for number of days from referral to initial assessment.

However Gisburn Lodge and Maplewood 3 were not achieving the 90 day target in days from initial assessment to onset and treatment. Gisburn Lodge (162 days & 98 days) & Maplewood 3 (112 days).

Delayed transfer of care

Between May 2014 and May 2015 the number of delayed discharges were accounted for as, 58% housing these were, patient not covered by NHS and Community Care Acts, waiting further NHS non-acute care and awaiting care package in own home. Fifty eight percent of delayed transfers of care in the 13 months reported were the responsibility of the NHS. Many of the delays were due to the complex needs of the individual who was ready to move on. The trust had recognised these issues and was being proactive in addressing these with the commissioners of the service.

Staff monitored the patients who were delayed. Some had been subject to long periods of delay, between May 2014 and May 2015. The following number of days delay was as follows:

- 732 days, housing patient not covered by NHS and community care acts
- 355 days, awaiting care package in own home
- 326 days, awaiting further NHS non acute care
- 180 days, awaiting residential care home placement or availability
- 95 days, disputes
- 92 days, patient or family choice
- 92 days, awaiting nursing home placement or availability

Many of the extended delays were due to the complex needs of the individuals and there not being packages of care available to meet these needs. NHS England staff had completed treatment and care reviews on all patients. Trust staff had developed moving on (discharge) plans for every patient in the service.

Some patients also were delayed due to past risk history and Ministry of Justice restrictions.

The trust had provided all patients with a moving on plan based on a multidisciplinary assessment of their needs.

Learning from concerns and complaints

In 2013/14 there were 116 complaints of these 28 were up-held. In 2014/15 69 complaints were received with 32 being up-held. The highest number received was about nursing, with 64 received and 15 being up-held. There were 22 complaints related to attitude of staff with 4 being up-held. Complaints about staff attitudes require the staff to apologise to the complainant. Where the complaint was about restraint, the ward manager is required to review the notes and care plans.

Patients' complaints were responded to using appropriate language and used a personal narrative. The case manager and ward manager did get copies of the response letters, to go through with the patient. With patient complaints these were triangulated with other information for example staffing levels.

There is a governance structure in place that supports learning and improved outcomes. There are clear timeframes in place for responses to complaints. There is a clear definition between concerns and complaints. There is a process in place to move through concerns, complaints, serious untoward incidents, the Strategic Executive Information System and on to police reporting.

Are services responsive to people's needs?

Complaints are not investigated in their own area; they are investigated by another area. This has increased the time

scale for responses with the majority now missing the 25 days' timeframe compared to before. There is no official training for staff; there are templates and sample investigations as a guide for staff to use.

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

Our findings

Vision, values and strategy

The trust had a clear vision 'Changing lives through excellence' which they had developed with the involvement of staff, patients and their carers.

The vision was underpinned by the trust's seven strategic objectives and a set of values which were;

- trust; we keep our promises
- excellence; we continuously strive to deliver the highest standards of care
- compassion; we show empathy and are sympathetic to the needs of others
- respect; we engage, listen to and value the contribution of others

ownership; we are responsible and accountable for our individual and collective actions

- communication; we are open and honest in our communication
- partnership; we work together with clients, carers, colleagues, commissioners and communities

The trust had identified three clear strategic aspirations it aimed to achieve through the delivery of its strategic objectives and implantation of its key values which were:

- to deliver life-changing outcomes for our service users
- to be the provider of choice for learning disability services
- to be recognised nationally as the industry lead for learning disability services

The trust had integrated the Department of Health's 6C's within clinical areas to support the implementation of their strategic objectives and values:

- Care
- Compassion

- Courage
- Commitment
- Communication
- Competency

The strategy was further supported by a quality and risk focussed approach set out in the trusts five year 'Clinical Quality Strategy' 2013-18 and the 'Quality Account' 2014-2015. These identified the key themes and priorities the trust had identified for improvement which included:

- promoting leadership at all levels to deliver the quality priorities
- creating an understanding of the role and contribution every staff member can make to improving quality
- promoting individual responsibility for taking action to improve safety, experience and outcomes for the people who use our services, their families and staff
- ensuring the trust achieves and maintains high standards of cleanliness
- improving the governance systems with regards to Mental Health Act administration
- reviewing the workforce in terms of capacity and capability to deliver safe and effective care
- ensuring the trust delivered its objective to reduce restrictive practices and eliminate prone restraint
- improving the clinical environments to make medicine administration safer
- embedding and improving organisational learning
- developing safer seclusion environments.

The trusts visions and values were displayed within clinical areas we visited. They were well known by staff who were able to explain how they related and impacted on their clinical practice. For example, staff were able to explain how they had reduced the use of restraint and seclusion through the implementation of positive behavioural plans in line with the Department of Health guidance around reducing restrictive practices, "Positive & Proactive Care: reducing the need for restrictive practices" (April 2014).

There was a strong monitoring and reporting culture from ward to board and board to ward to support the

Are services well-led?

achievement of the trusts' vision, values and objectives. This was evident in the minutes of governance and board meetings that we looked at and confirmed by staff we spoke with.

Good governance

The trust had a strong embedded governance structure in place which was underpinned by four committees that fed directly into the board which was accountable for the running of the trust and provided the overall strategic leadership to the trust.

There were:

- remuneration and nominations
- audit committee
- quality and risk committee
- strategy and performance committee

There was a council of governors who provided a link between the communities and board of directors. They understood they held the non-executive directors (NEDs) to account and provided assurance to members, stakeholder organisations and the public on compliance with the provider licence, the delivery of strategic direction and the quality of services. There was representation from the trust governors at board meetings. During a focus group we held with governors, they told us they were confident to raise any issues they had with the NEDs and other senior board members and managers. The trust had also appointed a lead NED to act as a link between the trust board and governors. The governors stated the reports they received from the trust board were well presented, informative and well received. Governors commented positively about the channels of communication they had with the trust describing it as 'first class'. They also said that the board prepared well for governor meetings and sent a weekly bulletin to them every Friday to inform them of progress the trust was making and any issues they needed to be aware of.

We reviewed a sample of trust board minutes from the past 12 months and saw evidence that the meetings were well attended and covered standing agenda items including; safe staffing, the board assurance framework, strategic risk register, financial plan and position, corporate key performance indicators (KPIs) reports and the trusts Care Quality Commission (CQC) action plan.

We found evidence in the board meeting minutes we looked at which showed that board members provided

challenge and scrutiny of the information which was presented to the board. For example; during the meeting which took place in March 2015, some board members had requested further information from senior managers regarding some of green rated risks on the (CQC) action plan. Board members had requested additional information regarding some of the green rated risks on the plan as further assurance before they were prepared to agree that these risks could be closed. This demonstrated that the board did not close actions unless they had the evidence to confirm it was appropriate to do so. This also supported what the governors we met said, that the trust board was open to challenge and democratic in the way it functioned. At the time of our inspection, all the actions on the CQC action plan had been rated as green by the board.

The trust had commissioned an external independent review of its governance arrangements in October 2013 by a nationally recognised organisation. The organisation was commissioned again by the trust in June 2014 to review the progress it had made against the recommendations the organisation had made following the October 2013 review. The report from the most recent review dated September 2015 identified that the trust had made, 'significant and sustained improvements in transforming its approach to governance' since the last review in October 2013.

Improvements identified included;

- the trust had developed its management information system to enable the board and senior staff to drill down through KPIs to clinical areas
- a stronger more cohesive board
- improved staff engagement by the chief executive and chair through a range of initiatives such as the 'Big conversations' programme
- trust engagement with service users and carers
- an on-going programme to develop the executive team and board
- a rigorous approach to the identification, escalation and management of risk which has been strengthened through the investment of a new electronic risk management system
- a continued focus on the quality agenda and the use of heat maps to routinely monitor trust wide compliance with quality standards.

Are services well-led?

The review identified five areas where the trust could further improve and develop. These had been added to the trusts corporate risk register and were reflected in the board assurance framework. This ensured that the board maintained a strategic oversight of progress made against the areas for improvement. The commissioning of the report demonstrated that the trust was open to external scrutiny and was committed to improving the quality of services provided.

The quality and risk committee was the principal provider of quality and safety assurance to the board with the exception of clinical audit which was escalated to the board through the audit committee.

The trust had oversight and assurance of clinical effectiveness, safety and patient experience through seven sub committees that reported into the quality and risk committee and audit committee. These included;

- Medicines management
- Clinical audit
- Infection control
- Health and safety
- Research and development
- Incident, risk and data quality
- Operational governance

There was representation from senior operational and clinical managers at each of these sub committees. The trust had established service wide governance meetings which were attended by ward managers and other senior clinical staff from a range of disciplines. These meetings covered operational, clinical and quality issues as standing agenda items. They provided the key link between the wards and the board.

Risk registers were held at service level and reviewed through the local governance meetings. Risks were assessed and reviewed regularly by senior managers with escalation as appropriate to the corporate risk register. Staff within clinical areas understood how to raise and escalate incidents and risks and reported they were confident in doing so.

The trust had recently introduced quality dashboard data sets within the forensic service and was in the process of rolling these out within other services within the trust. The quality dashboard information was used by the trust to develop quality data sets. The quality data sets could be broken down by each KPI or to track progress against KPIs

over a specific time period. Data could be extracted relating to individual staff (for staff training, supervision and appraisals), ward level, service level or trust wide. The data set information was used to develop 'heat maps' which were RAG rated to show progress against each KPI. The ward managers communicated on a daily basis with senior managers to review the heat maps relating to their ward.

The ward managers, senior managers and the trust board used the data set information and heat maps to monitor performance and identify any trends which could impact on the quality of service provision. The data sets provided 'real time' data on a range of key performance indicators such as safe staffing, compliance with training and number of incidents of restraint and seclusion. This meant that staff had information relating to their specific clinical area and were able to monitor progress and identify any trends. The board were provided with this information through the trusts governance structure and were able to 'drill down' to ward level if required.

The trust had introduced quality dashboards on all the forensic wards. These contained information about specific KPIs such as staffing, risks, incidents, staff training and complaints. Ward managers were able to feed information about their service into their quality dashboard so that information was up to date and current. The quality dashboard information was displayed on each of these wards and staff were able to provide examples of how they used this information to monitor performance and drive improvement. The trust had plans to roll out the dashboards within the learning disability service although at the time of our inspection, this had not been established. Staff within this service were unable to describe the wards key performance indicators for driving improvement. However, they did use heat maps to support the implementation of action plans to make improvements.

The quality dashboard information was used by the trust to develop quality data sets. The quality data sets could be broken down by each KPI or to track progress against KPIs over a specific time period. Data could be extracted relating to individual staff (for staff training, supervisor and appraisals), ward level, service level or trust wide. The data set information was used to develop 'heat maps' which were RAG rated to show progress against each KPI. The ward managers communicated on a daily basis with senior managers to review the heat maps relating to their ward.

Are services well-led?

The ward managers, senior managers and the trust board used the data set information and heat maps to monitor performance and identify any trends which could impact on the quality of service provision.

Feedback from the focus group we held with senior clinical managers, including ward managers, confirmed that staff found the data sets and heat maps to be extremely useful tools. They reported that they enabled them to focus their attention and resources on areas which could compromise patient care or impact on the quality of service delivery. Staff also understood the data sets and heat maps and were provided with information relating to these.

Each ward held ward team meetings locally. These meetings linked into the service governance meetings. Staff reported they were kept up to date with any changes which may impact on their clinical practice through trust wide e-mails, staff meetings or newsletters for example. This ensured there was a robust integrated governance structure from ward to board. However, we found within the learning disabilities service that the frequency of ward meetings was inconsistent.

Qualified staff and those at senior manager level and above could describe the trust governance structures although staff below this level were not as clear about the overarching trust governance structures from board to senior management level. However; all staff we spoke with understood and had access to the risk and incident management reporting systems. Staff reported they were confident and encouraged to report any concerns or incidents which occurred and many staff could describe changes that had been made as a result of them reporting incidents. Most staff felt they had had relevant and timely feedback on issues they had raised.

The trust target for compliance with mandatory training was 80%. Overall, the trust was significantly exceeding this target with the exception of positive management of violence and aggression which was at 79%. However; we found that basic life skills training was not included in the trusts mandatory training and compliance rates for this training was also below the trusts target. Within the learning disability service it was 58% and within the forensic services it was 67%.

The trust had a system which alerted ward managers in advance when staff members were due to renew their training. This enabled them to forward plan to avoid staff training becoming out of date.

Compliance with annual appraisals trust wide was between 92% for band 6 staff and below to 99% for band 7 staff and above on some wards and areas with facilities and estates administration at 16.67%.

The trust had experienced significant staffing challenges due to a number of factors beyond their control. These were escalated onto the strategic risk register. Despite these challenges, we found that staffing levels were sufficient to meet the needs of the patients. The risk register action plan identified controls the trust had in place and actions to address the staffing issues. The trust had completed a full review of their staffing and skill mix requirements to ensure that they identified the appropriate resources needed to meet their patients assessed needs. In response to the concerns the trust had also introduced a 'red flag' system for staff to escalate staffing issues to the director of nursing. There was also a "live" dashboard that reflected staffing on the unit as they swiped in and out. The trust had also temporarily closed parts of the organisation to ease staffing pressures and jointly agreed an extended bank pool staff with a local NHS Foundation Trust.

Leadership and culture

The trust board executive team were located on the main Calderstones site. There was clear clinical and operational leadership from the board members and executive team within the trust. Staff and patients within the trust were able to identify key members of the board including the chief executive officer (CEO) and director of nursing. The trust had good clinical leadership with clear direction around nursing quality and safety which was led by the director of nursing.

Members of the trust board were visible and accessible to staff. This was evidenced by the regular visits members of the team made to the wards to undertake planned quality 'walk around' visits in addition to more informal unplanned visits to clinical areas.

During the focus groups we held with external stakeholders such as commissioners and advocacy and internal meetings we held with key staff and staff groups, there was a consistent theme which reoccurred in relation to the change in culture within the trust. In all the interviews and

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focus groups we held, staff reported there had been a significant cultural shift within the trust which had led to a more open, transparent culture developing in addition to a proactive willingness to engage more with partner organisations. This is evident in the work the trust had engaged in with regulatory bodies, stakeholders and commissioners over the previous 12 months within the remit of the monthly quality improvement board meetings which were established following the previous CQC inspection of the trust.

The NHSE announced the closure of Calderstones on 30/10/2015 and that Mersey Care NHS Trust will take over the services. The trust has also developed a good working relationship with a neighbouring NHS trust and was sharing some resources to assist with staff development and organisational growth. The ward managers told us they had been to visit some wards within this trust to observe their practices and exchange good practice initiatives. They told us they had developed strong links with their colleagues within the trust and they hoped the support they currently received would continue. They reported to feeling empowered and encouraged to share their ideas and learning across both trusts.

One member of the executive team told us, "It is not a defensive organisation anymore; we are more open to partnership working."

This was reflected by the trust governors who described the trust as having an open and transparent culture in which learning and development was promoted. They told us the whole ethos of the trust was patient centred and the board was visible in patient areas.

This was also supported by feedback we received from the ward managers in the focus group we held with them. They reported there was a high level of support from the CEO, director of nursing and the senior management team. They described the CEO as being very approachable and supportive and that they were responsible for leading a number of initiatives. They stated that the change process had, 'enabled us to be leaders'. The ward managers described how they had become more outcome focused in their approach with a back to basics emphasis. There was a high emphasis on decreasing restrictive practices and the safer wards implementation which had helped staff to focus on using different approaches with patients.

The governors said they felt connected to the patients and the trust board members and proud of staff when they observed seeing patients' self-esteem and confidence rise during their visits to clinical areas.

The trust had a Board Assurance Framework (BAF) for 2015-2016 which identified the trust's seven overarching strategic objectives and 15 associated risks. The BAF was reviewed in April 2015. The seven objectives were;

- to work collectively with service users and carers to agree desired outcomes, enable progression through the care pathway and to influence and develop best practice in service delivery
- to work with commissioners to influence and develop future care pathways that are the best for service users
- to develop and engage our workforce to design and deliver high quality care
- to implement innovative new ways of using physical resources to deliver care in more economical, effective and efficient ways
- to secure long term financial viability
- to build a specialist forensic learning disability service to achieve national recognition
- to meet our statutory/compliance obligations.

Each of the strategic objectives included a detailed plan of the associated risk(s) to the trust if the objectives were not met. The plan detailed the existing controls, assurance and mitigating actions the trust had in place to manage the risks in addition to identifying any gaps in assurance.

The BAF was reviewed by the quality and risk committee quarterly who reported directly to the trust board. Minutes of the trust board meetings showed that the board reviewed and discussed the board assurance framework as a standing agenda item. The board were responsible and accountable for agreeing any changes to the BAF and associated actions. This meant the board had full oversight of the trusts strategic risks and progress made against these.

The trust also had a corporate risk register which identified 12 operational or clinical risks to service delivery. The register identified controls in place to manage the risks in addition to further actions required with target dates.

Each service had a risk register which were reviewed at the local governance meetings. Risks were assessed and reviewed regularly by senior managers with escalation as

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appropriate to the corporate risk register. Staff within clinical areas understood how to raise and escalate incidents and risks and reported they were confident in doing so.

The director of nursing had developed a CQC action plan following our previous inspection of the trust in July 2014. It had been developed and implemented by the trust to address the issues we had raised during the inspection in addition to issues the trust had identified as areas to improve. The plan was comprehensive and included 38 overarching actions. Underneath each of these, there were a number of additional actions included. The plan was RAG rated to track progress. Where progress had not been made against an action, the action was rated red. If some progress had been made but the issue had not been fully resolved, the action was rated as amber. Where the action was fully resolved the action was rated as green. The plan was reviewed monthly by the board that monitored progress against the actions and were responsible for 'signing off' any changes to the ratings for each action. At the time of our inspection, all the actions on the plan were rated green.

Staff at ward level told us they were supported by their ward managers and felt able to raise any concerns or ideas they had with them. This mirrors the 2014 NHS staff survey results for the trust which scored higher than the national average for 'staff support from immediate managers' and 'staff agreeing they would feel secure raising concerns about unsafe clinical practice.'

The trust had not received any reports or allegations of staff bullying, harassment or grievances.

Despite the uncertainty regarding the future of Calderstones due to Government policy such as the Transforming Care agenda (which aims to achieve a 40% reduction in the number of in-patient learning disability beds nationally), we found that staff job satisfaction was high and there was a commitment among staff to deliver a high quality service to patients. This is also reflected in the 2014 NHS staff survey results for the trust which scored higher than the national average for 'staff motivation at work' and 'staff recommendation of the trust as a place to work or receive treatment'. Staff reported they were proud of the organisation and the work they did. Staff morale had been low within the forensic services which staff reported was due to the changes which had taken place. However, they reported this had improved and they felt they were

moving forward with the changes and working well as a team. Within the learning disability service, staff continued to express some anxiety about job security which was negatively impacting on their morale.

Fit and Proper Person Requirement

The fit and proper person requirement (FPPR) is one of the new regulations that applied to all NHS trusts, NHS foundation trusts and special health authorities from 27 November 2014. Regulation 5 says 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, have the necessary qualifications, skills and experience for the role, and be able to supply certain information (including a Disclosure and Barring Service check (DBS) and a full employment history).

The director of human resources told us that the recruitment policy had been amended to reflect the FPPR in November 2014. The trust board also commissioned bespoke training from an external legal company regarding FPPRs.

We reviewed the personnel records of the 12 senior directors in the trust in line with the FPPR. Some of the directors had been in post for several years. Only one director had been appointed since the new regulation was introduced.

All twelve records showed that DBS checks had been carried out on initial appointment. However the trust had recognised the initial checks had only been standard DBS checks completed on appointments made several years ago. As a result enhanced DBS checks had been completed on all appointments. The trust policy states DBS checks should be repeated every three years and these had been completed in 2015 where required.

The trust had completed the necessary DBS, health screening and solvency checks for each person to meet the requirements of the new regulation. All 12 out of the files had photographic identification and supporting

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documents, for example proof of address. As part of the fit and proper person process the trust completed a fit and proper person test, which consisted of a bankruptcy, insolvency and disqualified directors' checks. In addition fit and proper person declarations were completed. This covered the Rehabilitation of Offenders Act exemptions amended 2013, Safeguarding Vulnerable Groups Act 2006 and Protection of Freedoms Act 2012. Senior directors had to answer nine questions and make declarations relating to these three Acts. All twelve senior directors had completed this declaration. In addition senior directors were provided with a copy of the Board of Directors Code of Conduct, which each director had completed a signed declaration of, to confirm they had read and agreed to abide by.

There were application forms, curriculum vitae's and evidence of recruitment via a consultancy agency. There was evidence of how the interview process had been adhered to in all the files we saw. There were references in all twelve files which meant that it was possible to determine that the interview process had been followed for these appointments in line with trust policy.

Engaging with people and staff

The trust had implemented a number of initiatives to promote engagement with staff, patients, carers and external stakeholders. These included:

- the CEO staff briefing sessions and team brief up-dates regarding the transaction & transforming care agendas and the impact of this on the inpatient services
- members of the trust board undertook planned quality 'walk around' visits in addition to more informal unplanned visits to the clinical areas where they engaged with staff and patients
- the 'Big Conversation' which was led by the CEO and attended by other members of the senior management team. These meetings provided staff and patients with the opportunity to meet the CEO and members of the senior management team directly to discuss the trusts vision and values. Attendees were encouraged to ask questions and raise challenges or issues they may have during these forums.
- the 'Big Picture' which provided staff with information about the trusts strategy
- the 'Birthday Breakfasts' where staff met with the CEO informally during the month of their birthday

- the 'celebrating success' nights where staff nominated by their peers received recognition from the trust
- the trust was members of the 'Triangle of care' which is a joint initiative between the Carers Trust and the National Mental Health Development Unit. The trust held monthly informal meetings for carers and had carried out a survey for carers to identify how they could promote better engagement with them
- all the wards held regular meetings with patients some of which were chaired by patients. These included patient council meetings, 'speak up' groups and 'mutual respect' meetings for example where patients' could feedback any concerns or ideas they had with staff
- the trust published a 'Connect' magazine quarterly for members and a monthly 'News and Views' magazine for staff and patients which contained trust wide information in addition to 'local' news
- the trust had a 'media club' which was run by patients. The club produced DVDs, newsletters and hosted events which provided information for both staff and patients on a range of topics from health promotion to patients sharing their own experience
- the trust had actively engaged in monthly quality improvement board meetings which were attended by a range of stakeholder
- members of the senior management team engaged on a monthly basis with the CQC inspection manager and CQC inspectors for the trust to continuously review their progress against their action plan.

Staff we spoke with told us that the trust and their service were proactive in gaining the views of patients and carers and involving them in service development initiatives. They were able to provide examples of how they had achieved this which included involving patients at Scott House to choose in choosing decor to improve the environment to involving patients' in the recruitment of staff.

This is reflected in the 2014 NHS staff survey results for the trust which scored within the top 20% of all mental health and learning disability trusts nationally for 'staff agreeing feedback from patients is used to make informed decisions in their directorate.'

Feedback we received from the range of focus groups we held with external stakeholders was consistently positive regarding the trusts level of engagement with staff,

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patients, carers and external organisations. For example; feedback from the group we held with commissioners included, "I am very impressed with them (the trust), I am impressed with their level of engagement. The senior management team have been very industrious."

The local advocacy service also commented that the trust had always been very responsive and welcoming of their service.

Feedback from carers and families during the focus group, however, gave examples of patients being referred to as 'they' and patients being told not to tell carers about their care and treatment during phone calls.

Quality improvement, innovation and sustainability

The forensic units had successfully completed the self and peer review parts of the quality network for forensic mental health services annual review cycle. The quality network reviews services against criteria set out by the 'Standards

for Medium Secure Services, 2014 and Low Secure Services: Good practice commissioning guide (consultation draft) 2012'. Overall, within the low secure units, West Drive met 82% of low secure standards and Maplewood had met 90% of low secure standards. The wards were commended by the peer review team for more than one aspect of the service they provided. In particular, both scored highly on areas such as admission, physical health care, physical security and procedural security meeting 100% of the criteria in these areas. Areas such as service environment and discharge were identified as areas in need of improvement over the coming year. The medium secure unit met 89% of overall medium secure standards. The service met 100% of criteria in four standard areas including relational security, safeguarding, physical healthcare and governance. Areas highlighted in need of improvement over the next year included procedural security, family and friends, environment and facilities and patient pathways and outcomes.