Good

Calderstones Partnership NHS Foundation Trust

Forensic inpatient/secure wards

Quality Report

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Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RJX04	Calderstones	Maplewood 1 Maplewood 2 Maplewood 3 Woodview 1 Woodview 2 Woodview 3 1 West Drive 4 West Drive 5 West Drive	BB7 9PE
RJX51	Gisburn Lodge	Gisburn Lodge	BB7 4 HX

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

Summary of findings

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

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

Summary of findings

Ratings

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

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

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

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

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

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

Summary of findings

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Overall summary

We rated Forensic inpatient/secure wards as good because:

All of the wards were clean, tidy and well maintained. Staff completed regular checks on the ward resuscitation equipment. These checks were recorded.

Staff managed physical, relational and procedural security well. The outdoor areas met the secure service standards set out by the Department of Health in its Environmental Design Guide (2011). The wards had airlock systems at their entrances and a central office managed keys and alarms so that staff collected these on their way in and left them on their way out. Staff used the 'see think act relational security explorer' during handovers. Staff knew how to access the security policies that were available on the trust intranet. These were all in date.

Care plans focused on recovery. Ward staff understood the principles of positive behavioural support and applied these when developing care plans.

All of the care records we reviewed showed that staff checked the physical health of patients regularly. The trust ensured that patients had good access to a range of physical healthcare services including GP services, opticians, dentists, dieticians and podiatrists.

The staff worked well together as multi-disciplinary teams.

Staff at all levels were kind and respectful when speaking to patients. They respected patient privacy and dignity and maintained confidentiality. Staff involved patients in all aspects of care planning, including in the development of positive behavioural support plans.

The trust ensured that advocacy services were available and present on the wards. Patients told us that they had good relationships with advocates.

The trust made a wide range of therapeutic and social activities available to patients on all of the wards. Patients could use the outdoor areas at any time. There were good facilities for children to visit away from the ward areas.

The care was discharge-oriented. Staff actively planned for discharge to appropriate alternative placements, taking account of patient needs and risks. The ward teams worked collaboratively with community teams mental health and learning disability teams that would support patients post-discharge, and with commissioners.

Staff at all levels understood and supported the trust's vision for the service. Ward staff knew who the members of the trust board were and told us that they saw them regularly. The trust ensured that there were systems in place to monitor quality and to give feedback on performance to staff throughout the organisation.

However:

Managers had not undertaken an appraisal of all ward staff in the previous 12 months.

On Maplewood 1 and 2, the managers had not put in place a system that allocated staff to respond when an alarm was activated.

Summary of findings

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

Are services safe?

Good

We rated safe as good because:

- All wards were clean, tidy and in a good state of repair.
- Staff completed regular environmental and ligature risk assessments and took action to mitigate risks. Staff carried out comprehensive risk assessments with all patients.
- There was good evidence of physical security, relational security and procedural security. This included outdoor areas being in line with secure service standards set out by Department Of Health in Environmental Design Guide (2011) Royal College of Psychiatrists. Policies around security were available and up to date on the trust intranet. Staff knew how to access these policies. Relational security was evident on all the wards and staff used the 'see think act relational security explorer' during handovers.
- Resuscitation equipment, including automated external defibrillators, was available and checked regularly. All equipment was in date and had clearly identified expiry dates. There were good medicine management practices and all clinic rooms were clean and tidy. There was good storage, dispensing, reconciliation and destruction of medication.
- Staff recruitment was ongoing. There was some use of bank and agency staff and this was managed appropriately to ensure the skill mix of the nursing team was maintained.
- There was a good balance between security and least-restrictive practice to ensure care met the needs of the patient group.
- Section 17 leave was rarely cancelled. However, there were occasions on which it was rearranged. Rearrangements were mitigated by use of an online tool through which staff could record the reasons for the rearrangements and the rescheduled dates.

However,

On Maplewood 1 and 2 there was no system to allocate staff to respond to activated alarms.

Are services effective?

Good

We rated effective as good because:

- Each patient had a positive behavioural support plan and told us that they had been involved in all aspects of planning their care. There was a good understanding of the support plans at

Summary of findings

all levels in the service, including among bank and agency staff. Staff had been trained in dialectical behavioural therapy (DBT). DBT sessions took place weekly and patients told us they helped them to manage their emotions.

- All the secure services were engaged in the Safewards initiative. This is part of national initiative aimed at reducing physical interventions and encouraging positive interactions between patients and staff to keep people safe
- There was good access to a range of physical healthcare including GP, dental and dietician services. Patients all had monthly physical health checks that were seen as important parts of their care.
- There were good multidisciplinary teams on each ward and patients had weekly meetings with them in order to discuss their care and treatment. There were good links with community services and commissioners and the focus of care was planning for discharge with the patient.
- All staff had received training on the Mental Health Act 1983 and patients had access to a range of information leaflets in formats they could understand.

However,

Not all staff had received an appraisal in the last twelve months

Are services caring?

Good

We rated caring as good because:

- Staff at all levels were kind and respectful when speaking with patients and their carers. Staff spoke about patients in a respectful manner and demonstrated a good understanding of their individual needs. Staff respected the privacy and dignity of patients at all times and maintained confidentiality.
- The patients we spoke with understood the availability of the voiceability advocacy service and were aware of how to access the service. The advocates were present on some of the wards. Patients addressed the advocates by name and we saw that interactions between them were positive.
- The service had invested in ensuring the environment, although secure, was the least restrictive it could be for patients. There were some good examples of patients being involved in their care planning and able to make their own choices regarding care and treatment.

Are services responsive to people's needs?

Good

We rated responsive as good because:

Summary of findings

- Discharge planning took place at monthly review meetings. The planning considered patients' existing needs, including current and potential risks, in order for patients to move safely to appropriate placements. The wards worked closely with community teams to ensure that patients received the right support on discharge.
- A large variety of therapeutic and social activities was available both on and off the wards seven days a week. Occupational therapy teams were allocated to each unit. There was a secure outdoor space for patients to use at any time. Patient diversity and human rights were respected and staff understood patients' individual needs.
- There were good facilities available for children visiting; these were in a separate area away from the main ward.

Are services well-led?

Good

We rated well led as good because:

- The trust's vision for the service was evident. Staff at all levels could tell us what the vision was, how it related to their work, and the direction in which the trust was moving. Staff were aware of who the members of the board were and reported they were regularly visible on site. There were local meetings for managers to discuss quality and safety issues.
- The staff spoke positively about their roles and reported that morale was good. They felt supported by their teams and senior management. There was a clear sense of pride from the staff in the jobs they did and they strove to improve the service.
- The wards had good governance systems that enabled staff to monitor and manage the wards and provide information to senior trust staff.

Summary of findings

Information about the service

Calderstones Partnership NHS Foundation Trust provides care and treatment for people aged between 18 and 65 with learning disabilities or autism.

The trust provides low and medium secure forensic services over nine sites:

- Maplewood 1 is a 24-bed female-only low secure ward. It is split into four flats
- Maplewood 2 is a 16-bed male-only low secure ward
- Maplewood 3 is a 16-bed male-only low secure ward. It is split into two flats
- Gisburn Lodge is a 16-bed male-only medium secure unit.
- 1 Woodview is a 12 bed medium secure unit split into two flats; 6 bed female only and 6 bed male (unoccupied)
- 2 Woodview is a 12-bed male-only medium secure unit. It is split into two flats
- 3 Woodview is a 12-bed unit that is split into two flats. The unit provides services to male patients
- 1 West Drive is a pre-discharge ward that provides enhanced support for up to 12 male patients
- 4 West Drive is a 15 bed facility is split into three flats and is a service for male patients being transferred from the low secure service
- 5 West Drive is a 16 bed facility made up of two services split over five flats. The first service is a relapse prevention and sex offenders treatment programme. The second service is for patients with autism

The trust has had one comprehensive inspection under the new approach. The inspection took place on the 8th July 2014 to 11th July 2014. There were compliance actions for the trust following the inspection:

Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010

The registered person had not taken proper steps to ensure that people were protected against the risk of receiving inappropriate or unsafe care.

Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010

The registered person had not protected service users and others who may be at risk, against the risks inappropriate or unsafe care and treatment, by means of effective operation of systems designed to enable the registered person to regularly assess and monitor the quality of service.

Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010

The registered person had not maintained appropriate standards of cleanliness and hygiene in relation to the premises and equipment in the forensic services.

Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010

The registered person had not protected people against the risks associated with medicines because there was not a sufficient system in place to manage medicines in the forensic services.

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 that inspected this core service comprised four CQC inspectors, three learning disability nurses, two Mental Health Act reviewers, one occupational therapist , two consultant psychiatrists, one psychiatric nurse, one forensic psychologist and a pharmacist. The team also included an expert by experience in forensic services for people with learning disabilities.

Summary of findings

Why we carried out this inspection

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

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?

Prior to the inspection visit, we reviewed information that we held about the services, and contacted a range of other organisations for information.

As part of the inspection we carried out announced visits to the forensic low and medium secure services.

During the inspection visit, the inspection team:

- visited all ten units at the hospital sites and looked at the quality of the ward environments
- observed how staff cared for patients
- spoke with 35 patients and one family member and collected feedback from one patient using comment cards
- spoke with the managers or acting managers for each of the units
- spoke with 49 other staff members including doctors, nurses and social workers
- interviewed the clinical services manager with responsibility for the services
- attended and observed one hand-over meeting and four multi-disciplinary meetings
- looked at 42 patient treatment records
- carried out a specific check of medication management on three wards
- completed a review of seclusion records
- completed two Mental Health Act Reviewer visits
- looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the provider's services say

All patients across the service told us that they felt safe. Patients told us they liked it on the wards and they were well looked after by staff. When asked, patients told us that there were enough staff on the wards and they were able to go out with staff into the local area.

Patients told us that they we are able to voice any concerns they had to the staff and at weekly community meetings. Staff listened to their concerns and changes had been made following the meetings. For example, the format of the community meetings on Maplewood 1 had been changed to a more informal chat. Patients reported that this change made them feel more comfortable in speaking up about any concerns.

Patients were positive about the activities on the wards, and in particular commented about the dialectical behavioural therapy provided on Maplewood 1, 2 and 3.

Staff were able to provide patients with information about their medicines and show us leaflets in formats that were easy to understand. Staff could also tell us about the medicines patients were taking.

We only received one response from the comment cards we left on the wards prior to and during the inspection. This asked for there to be more choice of television channels.

Summary of findings

Good practice

A patient appeared to be unresponsive in his bedroom during our inspection of Woodview 2. Staff immediately took control of the situation both inside the patient's room and outside in the general ward area. Patients were led away from the ward area while staff brought the defibrillator and oxygen and other staff dealt with the patient's immediate needs. The patient suddenly sat up and stated that he had only been asleep. Staff continued to take observations and ensure that the patient was not in distress. The incident was then recorded on the incident reporting system. The incident was handled in a most efficient, caring and professional manner.

The seclusion rooms all had a visible 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 positive behavioural support plans across all wards was high 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 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.

Areas for improvement

Action the provider SHOULD take to improve

- The trust should ensure that all staff receive an appraisal each year.
- 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

Forensic inpatient/secure wards

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Maplewood 1 Maplewood 2 Maplewood 3 1 West Drive 4 West Drive 5 West Drive Woodview 1 Woodview 2 Woodview 3	Calderstones
Gisburn Lodge	Gisburn Lodge

Mental Health Act responsibilities

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

A Mental Health Act reviewer visited each of the secure wards as part of our inspection. All patients across the 10 wards were detained under the Mental Health Act.

Detention documents were available in the electronic patient records. These included original authorisations, transfer orders and renewal documents. There was a clear audit trail of patients' detention even for those patients who had remained at Calderstones for a number of years.

There was a comprehensive system for planning and authorising section 17 leave.

Leave was granted for a set period and the parameters of leave were clearly recorded on the block leave forms. However, we noted that this form was also populated with

confidential information in the "alert" section and we were concerned about the inclusion of this type of information on the section 17 leave forms. The Ministry of Justice authorisation of leave was available in the files for restricted patients.

The recording of capacity to consent was variable across the secure service and seemed to be dependent on individual responsible clinicians. Maplewood 1 clearly recorded assessments of capacity to consent to treatment prior to any medication change, for example, but this was not the case elsewhere in the service.

We found that all patients had a T2 (certificate of consent to treatment) or T3 (certificate of second opinion) in place to authorise their medical treatment and these were attached to the medication charts.

There was a clear system to ensure that patients were informed of their rights under section 132. Patients confirmed that they had regular discussion about their rights. Easy read versions of this information were available to support understanding.

Independent Mental Health Advocates (IMHA) were available, including a gender specific advocacy service for the female patients. All patients we spoke with confirmed that they had met the IMHA and knew how to contact them should they require advocacy support.

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. There was one example of a capacity decision around the finances of one patient on Maplewood 2 being taken to the ethics committee. On Woodview a patient wanted to buy a games console and music equipment. The patient's notes clearly documented a full and frank discussion with the patient, including a capacity assessment as to making a final decision; this was deemed by the trust to be better than simply applying a blanket restriction. Independent mental health advocates were involved with any patients who lacked capacity and were present at wards rounds to support the patient. 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

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

Our findings

Safe and clean environment

All of the wards were clean and tidy and the furniture was in good condition. Domestic staff kept their equipment in locked cupboards and we saw cleaning schedules that were completed and up to date. Infection control procedures were in place and adhered to. Staff used alcohol gel and washed their hands when necessary. Patients told us the wards were always clean. We saw evidence of fire safety checks including fire drills

There were lounges and activity rooms and access to good size outdoor areas that was enclosed and met the forensic secure service specifications laid out by department of health Environmental Design Guide (2011). All patients had access to a telephone that they could use to make private phone calls should they wish to. Bedrooms were spacious with en suite facilities and all the rooms we saw were personalised by the patients. In the low secure wards, each patient had a key to their own room to secure it when they weren't in it. In the medium secure wards, only one ward allowed patients to have their own keys but access to rooms was only refused if a risk assessment and care plans indicated this was appropriate. The rooms all had a lockable space where valuable items could be stored safely and patients all had their own keys or a code to open these. All wards complied with same-sex accommodation guidance as detailed by Department of Health and the Mental Health Act Code of Practice.

Annual environmental and ligature risk assessments were carried out and ligature points that were highlighted as high risk were on a local action plan to be removed. Although these were not all completed at the time of our inspection, the work was ongoing and the trust estates department were carrying this out. All staff were aware of the ligature points and were able to tell us how the risks were mitigated on their shift. All ward managers were able to tell us about their involvement in environmental risk assessments. This risk assessment was done by a peer from another unit to provide an objective view.

There was good evidence of physical security in all the wards. In the reception area of all wards the staff signed in using a fob system. An electronic board showed how many staff were in the building at any time and their role. Staff collected keys and personal alarms from the reception on entering the building and gave them back in as they left. Entrance to all wards for visitors, staff and patients was via an airlock. There were procedures and checks to ensure that the alarms and keys were safely managed. There was evidence on all the wards that the physical security of the building was checked by a dedicated member of staff on each shift and this was documented in the observation folder. All staff were able to tell us what needed to be checked to maintain the physical security of the building

The layout of the wards did not allow staff to observe all parts. However, this was mitigated by use of risk assessment, mirrors, regular checks and good relational security. Relational security is about the staff having a good working knowledge of the patients they look after and of the environment they are working in. This allows the staff to keep a good balance between restrictive practice and a caring environment. The trust induction included training on relational security and the importance of it and staff were able to make reference to the "see think act relational security explorer" This is a tool which looks at four key areas of relational security in order for staff to be able to maintain good relational security on their ward. This was on the wall in each of the wards we visited and was discussed in each handover.

Staff from each ward, with the exception of Maplewood 1 and 2, were allocated to respond to alarm calls. This was done at the start of their shift so that staff were clear who would respond to their own and other units. On Maplewood 1 and 2 there was no clear system for allocating staff to respond to an alarm should it be activated.

The trust has an up to date index of procedural security policies and staff were able to locate these on the intranet and show us how to find different policies competently. There were separate policies for the low and medium secure wards as stipulated by NHS England in the standards for secure services.

The seclusion rooms in all wards were clean and had access to natural light. A clock was visible from each room. There was a two-way intercom in each seclusion room so that patients and staff could communicate with each other.

Good

Are services safe?

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

The seclusion rooms all had a visible 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. For patients who needed a low stimulus environment there were also de-escalation rooms available for them to use.

All wards had a fully equipped clinic room with access to medical emergency equipment including automated external defibrillator. Resuscitation bags were regularly checked by staff and records showed they were up to date. Staff were able to explain how to order a replacement if the equipment had been used. There was evidence of fridge temperatures being checked on a regular basis and being in an acceptable range in each of the clinic rooms.

CCTV was installed in communal areas but the screens were in the ward office which was separate from the ward area. Signage was in place to inform patients and visitors that CCTV was in use. It was not used for routine observations but could be used for post-incident debrief and analysis.

Each ward had a dining room. There were menus displayed in the wards so that patients could choose the meals they wanted and also see what they could order four weeks in advance. Patients had access to the kitchen 24 hours a day every day and this meant they could make themselves a hot or cold drink or get a snack whenever they required.

Safe staffing

1 West Drive

Establishment levels: qualified nurses whole time equivalent (WTE) 8 with 5 posts vacant

Establishment levels: nursing assistants (WTE) 13 with 3 posts vacant

Staff sickness rate in 12 month period 8%

Staff turnover rate in 12 month period 4

4 West Drive

Establishment levels: qualified nurses (WTE) 10 with 2 posts vacant

Establishment levels: nursing assistants (WTE) 21.5 with 3 posts vacant

Staff sickness rate in 12 month period 1.%

Staff turnover rate in 12 month period 6

5 West Drive

Establishment levels: qualified nurses (WTE) 11 with 1.5 posts vacant

Establishment levels: nursing assistants (WTE) 18.6 with no posts vacant

Staff sickness rate in 12 month period 9.8%

Staff turnover rate in 12 month period 4

Maplewood 1

Establishment levels: qualified nurses (WTE) 25 with 6 posts vacant

Establishment levels: nursing assistants (WTE) 46.4 with 2.8 posts vacant

Staff sickness rate in 12 month period 9.2%

Staff turnover rate in 12 month period 10

Maplewood 2

Establishment levels: qualified nurses (WTE) 12 with 2 posts vacant

Establishment levels: nursing assistants (WTE) 25 with 3 posts vacant

Staff sickness rate in 12 month period 12.8%

Staff turnover rate in 12 month period 9

Maplewood 3

Establishment levels: qualified nurses (WTE) 12 with 2 posts vacant

Establishment levels: nursing assistants (WTE) 23 with 4 posts vacant

Staff sickness rate in 12 month period 8.6%

Staff turnover rate in 12 month period 10

Individualised Package of Care Maplewood 1

Establishment levels: qualified nurses (WTE) 2 with 1 post vacant

Establishment levels: nursing assistants (WTE) 15 with 3 posts vacant

Staff sickness rate in 12 month period 6.1%

Good

Are services safe?

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

Staff turnover rate in 12 month period 0

Woodview Ward 1

Establishment levels: qualified nurses (WTE) 13 with 2 posts vacant

Establishment levels: nursing assistants (WTE) 30 with 7 posts vacant

Staff sickness rate in 12 month period 24.2%

Staff turnover rate in 12 month period 10

Woodview Ward 2

Establishment levels: qualified nurses (WTE) 13 with 1 post vacant

Establishment levels: nursing assistants (WTE) 23

Staff sickness rate in 12 month period 8.7%

Staff turnover rate in 12 month period 5

Woodview Ward 3

Establishment levels: qualified nurses (WTE) 13 with 1 post vacant

Establishment levels: nursing assistants (WTE) 21

Staff sickness rate in 12 month period 8.9%

Staff turnover rate in 12 month period 4

Gisburn Lodge

Establishment levels: qualified nurses (WTE) 14 with 4 posts vacant

Establishment levels: nursing assistants (WTE) 27.3 with 4 posts vacant

Staff sickness rate in 12 month period 4.4%

Staff turnover rate in 12 month period 9

According to the establishment figures there were 133 posts for qualified nurses and 262.5 posts for nursing assistants. At the time of the inspection there were 27.5 posts vacant for qualified nurses and 30 posts vacant for nursing assistants. Vacancy levels were highest on Gisburn Lodge, Woodview Ward 1 and 1 West Drive. The overall staff sickness rate was 12%. It was highest on Woodview Ward 1 and Maplewood 2.

A weekly staffing analysis group monitored staffing, sickness rates and use of bank and agency staff by the forensic service. It also planned for the week ahead taking into account leave and activities. Staff were moved around to other wards if required based on the need of the ward. There was a daily morning meeting where they would check that staffing levels matched the identified need. Any issues around staffing were escalated immediately to the operations manager.

There was ongoing recruitment to vacancies. The recruitment schedule showed that the trust was due to have recruited to all health care assistant vacancies by the end of December 2015. The trust acknowledged that it would take longer to recruit qualified staff, however; this is a recognised issue across the country. In the meantime the trust utilised a regular cohort of bank staff and agency staff. The minutes from the staffing analysis meeting held on the 22 September 2015 showed that since August 2015, 23 support staff and six registered nurses had been employed by the trust. The trust had also been attending jobs fairs at local universities and colleges to try and boost recruitment.

There was an electronic board in the reception area of each ward that showed how many staff were on shift and what their role was. This detailed the staff on duty for days and nights. As staff signed in they were added to the board so it was clear who was in the building at any time. This enabled patients, visitors and staff to see who was on duty over the week.

Staff told us that the wards were rarely short staffed and this was confirmed by looking at staff rotas. When we spoke with patients they did not raise staffing levels as a concern. There were instances were 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 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.

The trust provided us with data on episodes of missed escorted leave from 6 July 2015 to 30 September 2015. Out of a total of 425 sessions offered per month the most that were rearranged in one month was 50 sessions. This was higher than average with every other month rearranging between 10 and 20 sessions.

Each ward had a ward manager on duty Monday to Friday. The manager was responsible for managing any sickness

and ensuring that wards were staffed appropriately. There were two qualified staff on each shift. In addition during the week this included a ward manager and a deputy ward manager who also worked nights and weekends on a rota system. During the night shift, there was one qualified member and a number of support staff. The number of support workers depended upon the ward and activity levels. In addition to these figures the wards all had an occupational therapy team and access to a psychologist.

Mandatory training compliance varied across the wards. The compliance rates across the forensic wards combined from April 2015 onwards were as follows. Information Governance, appraisal band 7 and above and safeguarding 91%, Fire 85%, PMVA 85%, infection control 83%, food hygiene 82%, moving and handling 80% equality and diversity 83%, These all met the trusts' target for the reporting period.

Assessing and managing risk to patients and staff

We reviewed 42 sets of care records across all of the wards. All had an up to date and detailed risk assessment and positive behavioural support plans place. All patients told us they were involved in planning their care and had regular meetings with their key worker to discuss and update the plan.

Since our last inspection in 2014 there had been a large reduction in the use of restraint and in particular prone restraint. There were no prone restraints at all across the service in the period from March to July 2015. Data provided to us by the trust showed the extent of the reduction in restraint. This showed that in October 2014 there were over 300 incidents of restraint across the secure service. In the month of July 2015 nine months later, this had reduced by more than half to 125 episodes of restraint across the secure service. Similarly, the use of seclusion has been reduced significantly with figures provided showing 65 episodes of seclusion in the month of October 2014. This had reduced to only 25 episodes of seclusion in August 2015. During the months from April to the time of our inspection the trust had done a lot of work around reducing the number of emergency restraint belts across the secure services. This had gone from 27 in April to zero at the time of our inspection. The use of medication during restraint was also decreasing and this included intramuscular medication used during restraint.

The trust was engaged in the "safewards" model of care. This is about reducing restrictive practices in mental health and learning disability settings by using positive language to reduce conflict in mental health settings, in particular the use of restrictive practices such as restraint. This was undertaken following the Department of Health (2014) guidance "Positive and Proactive care" which aims to reduce restrictive practice in particular prone restraint. The staff described to us how they use positive words to describe patients. We saw examples of this being used in handovers and multidisciplinary meetings. The staff and patients described a cultural change where patients were able to choose their own preferred management techniques for when they became distressed. This was done at a time when the patient was calm so they could explain how they might feel and what may help them to relax.

The staff had all participated in a training programme called creative intervention training in response to untoward situations (CITRUS).Staff described this as using promoting positive communication between staff and patients. Using least restrictive practices in response to aggression and promoting interventions that are in the best interest of the individual patient.

Seclusion records and adherence was monitored by MHA reviewers on this inspection. Through discussions the team at Woodview one had identified there was a high number of seclusions. 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 female patient. The team psychologist believed this work would impact on the number of seclusions for Woodview 1.

Staff were aware of the trust seclusion policy and were able to explain to the inspection team when seclusion could be used. From reviewing the care records it was clear that seclusion was used as a last resort and that patients were monitored correctly when placed in seclusion. This included monitoring physical observations after the use of rapid tranquilisation.

Each patient had an individual risk profile on the computerised case note system. Patients were aware of

Good

Are services safe?

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

their risk profiles and had been involved in helping to develop them. Risk profiles were audited every six months as a key performance indicator or if an incident had occurred involving the patient.

Track record on safety

The trust data provided showed that three serious incidents had been reported relating to the medium secure units (MSU) in the period 3 June 2014 to 22 May 2015. Two of these were at Woodview 1 and one at Woodview 2. Two of the incidents involved assaults by patients against other patients; the third incident was an allegation of excessive force by staff during restraint. Documentary evidence showed that the trust was actively and effectively responding to serious incidents in MSUs. The decrease in use of restraint and seclusion confirmed the effective nature of procedures on the MSU wards

There were no reported serious untoward incidents in the low secure service six months prior to inspection.

Reporting incidents and learning from when things go wrong

Staff reported incidents onto the online reporting system Ulysses. All staff had access to this system including bank and agency staff. All staff told us that they would be supported to complete this if they felt they needed it.

Adverse incident reporting levels and information about incidents was fed into the trust governance framework to be analysed. Ward managers and their deputies were able to manage the incidents on the system; for example, reviewing them and closing them following any actions required. Managers identified how they learnt through incidents on other wards via regular management meetings with ward managers from across the trust. Staff also discussed incidents in supervision to identify learning opportunities and how things could be done better. There was a debrief process in place where more serious incidents could be discussed. The trust also offered counselling should it be felt necessary.

Staff showed good knowledge of safeguarding procedures and policy in discussion. Data provided by the trust showed that safeguarding alerts were made by the secure unit staff. In the period 1 March 2015 to 31 August 2015 there was a total of 30 safeguarding alerts raised across the secure services.

Are services effective?

Good

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

Our findings

Assessment of needs and planning of care

We reviewed 42 care records over the ten wards. Care planning was evidently patient centred and was focused on recovery and discharge planning. The positive behavioural support (PBS) plans were developed in collaboration with the patient and some were completed with carer involvement with the permission of the patient. These were available for all staff to read and gave an excellent overview of the patient's history and risk factors and how to manage these in stages. Staff had received training in PBS and there was excellent understanding at all levels. Staff described training as an online course with access to a two-day face to face course.

Information was stored securely on the computer system. This was easily accessed by staff with a password. Staff, commented on the speed of the system stating that on occasions the time taken to access information could be lengthy.

There was good access to healthcare and we saw evidence of this during the inspection with patients visiting the GP and the dentist in the community. There was an onsite health centre that patients could visit for their physical health needs, such as blood samples, weight management and smoking cessation. This was in keeping with the recovery-based approach to care and patients visiting the doctor at the health centre as they would in the community.

Best practice in treatment and care

The wards followed national guidance relating to the care and treatment of patients in a forensic setting. This was evident in the care notes we reviewed with reference to guidance such as National Institute for Health and Care Excellence (NICE) in multidisciplinary team meeting notes. This included dialectical behavioural therapy for patients with a diagnosis of a personality disorder as is recommended by NICE. The trust had a National Institute for Health and Care excellence lead in place. Pharmacy records showed consideration of NICE guidance in relation to polypharmacy, and that pharmacists were involved in decisions relating to changes in medication and interaction of various drugs.

Psychological therapies were available to all patients on forensic wards, including cognitive behavioural therapy, dialectical behavioural therapy, aggression management therapy, and sex offender treatment programmes. Psychologists were part of unit teams. Patients on all wards had access to physical healthcare and we were aware that some appointments were taking place whilst we were on our inspection. Care records showed that patients had been escorted to appointments at the general hospital when required and had attended other appointments such as eye tests, dental appointments and podiatry as out patients.

The wards all used a range of recognised rating scales to assess and record outcomes. These included Health of the Nation Outcome Scales (HoNOS). HoNOS is recommended by the English National Service Framework for Mental Health and by the working group to the Department of Health as an outcome indicator for severe mental illnesses. The recovery star tool was completed with the patients on all wards; the tool has been developed for use in adult services as a key working tool. It enables staff to support individuals they work with to understand their recovery and plot their progress. As an outcomes tool it enables organisations to measure and assess the effectiveness of the services they deliver. The STAR tool was developed specifically for people with a learning disability or autism.

In order to look at the prevention of incidents, the wards completed functional behaviour analysis post-incident reviews. These included an antecedent behaviour consequence chart to see ways they can prevent further similar incidents in the future. There was evidence of this being used in patients' PBS plans to explain what triggered different types of behaviour for patients and how the patient would like this to be managed. This was found to have been especially useful for patients with limited communication skills; for example, previously unnoticed behaviours such as prolonged eye contact were noted in the care plan as indicators for possible aggressive behaviour. Ways to prevent escalation were clearly documented. When we interviewed staff at all levels they were all aware of patients' triggers and how to manage these.

Skilled staff to deliver care

Patients had access to support from a wide range of professionals through multi-disciplinary working, including medical, nursing, occupational therapy, social work, and psychology and speech and language therapy. Nursing staff included registered mental health nurses and registered

Are services effective?

Good

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learning disability nurses. All staff were skilled in working with the patient group and had received specific training for the types of patients they were working with for example, anger management and PBS training.

The trust had a full induction course for staff joining the trust, and each forensic ward had a local induction.

The trust had taken action to address poor staff performance. This had led to the dismissal of two staff members earlier in 2015 for inappropriate behaviour.

Appraisal data supplied by the trust for all wards showed varying levels of compliance across the wards. The percentage of non medical staff who had an appraisal as of September 2015 was 100% at band 7 or above. For the staff at band 6 or below compliance was variable with Gisburn Lodge being the highest at 100% compliance and Maplewood one being the lowest at 66%.

Multi-disciplinary and inter-agency team work

The Multidisciplinary teams (MDT) met weekly and patients attended the meetings. Patients said they felt involved in their care. Examples they gave of this were attending their MDT meetings, spending one to one time with their key worker and developing care plans together with the staff. Thy also told us that staff were interested in how they were doing. The staff on the wards reported that they had good links with the community mental health teams; this included teams for people who were placed away from their local area. The ward staff ensured that the community teams were kept involved and updated on progress of all patients under their care. Care programme approach meetings were multi-disciplinary led. Doctors were present on all wards and reported a feeling of involvement in the team. This was reciprocated by the ward staff as they reported feeling that the doctors were easily contacted should they need them. Handovers on the wards happened at any staff changeover as well as an additional handover when staff working from nine to five started work. This included all members of the MDT including doctors, occupational therapists and psychologists. Invitations to handover were sent each day as a calendar invite to encourage all members to attend. During our inspection we observed a handover meeting and saw that various members of the MDT attended. Relational security was strongly considered, and this was reflected in the information on each ward about relational security, and its positive benefits. Evidence of this approach was apparent on each ward.

The secure services had good links with the multi-agency public protection arrangements (MAPPA) which are in place to ensure the successful management of violent and sexual offenders. Leading up to discharge and during discharge planning MAPPA meetings were held to ensure that local agencies such as the police were aware of the risk profile of those patients and where they were going to be moving to in order for them to be managed safely in the community.

The secure services had links to the local primary care services that patients accessed. This included opticians, dentist and GPs We saw evidence of these being accessed during our inspection including patients going to the local dentist to have their teeth checked.

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

Detention documents were available in the electronic patient records. This included original authorisations, transfer orders and renewal documents. There was a clear audit trail of patients' detention even for those patients who had remained at Calderstones for a number of years.

There was a comprehensive system for planning and authorising section 17 leave.

Leave was granted for a set period and the parameters of leave were clearly recorded on the block leave forms. However, we also noted that this form was populated with confidential information in the "alert" section and we were concerned about the inclusion of this type of information on the section 17 leave forms. The Ministry of Justice authorisation of leave was available in the files for restricted patients. However, we were concerned that two section 17 forms in the West Drive service stated that handcuffs were not required for escorted community leave. It was not clear why there should be any reference to mechanical restraint for these patients.

The recording of capacity to consent was variable across the low secure service and seemed to be dependent on individual responsible clinicians. Maplewood 1 clearly recorded assessments of capacity to consent to treatment prior to any medication change for example, but this was not the case elsewhere in the service.

All patients had a T2 certificate of consent to treatment or T3 certificate of second opinion in place and these were attached to the medication charts. These were being adhered to.

Are services effective?

Good

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

There was a clear system in place to ensure that patients were informed of their rights under section 132. Patients confirmed that they had regular discussion about their rights. Easy read versions of this information were available to support understanding.

Independent Mental Health Advocates (IMHA) were available including a gender specific advocacy service for the female patients. All patients we spoke with confirmed that they had met the IMHA and knew how to contact them should they require advocacy support.

Good practice in applying the Mental Capacity Act

There were no Deprivation of liberty safeguards (DoLS) applications in the twelve months leading up to inspection.

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

There was good evidence in patients' records of mental capacity being considered and this was a separate part of the patients' care plan that was reviewed by the key worker on a regular basis. There was one particular example of a capacity decision being taken to the ethics committee around the finances of one patient. Similarly, one patient had requested to buy a games console and music equipment. Patient notes clearly documented a frank discussion with the patient including capacity assessment as to making a final decision; this was deemed by the trust to be better than simply applying a blanket restriction. Independent Mental Health Advocates were involved with any patients who lacked capacity and were present at wards rounds to support the patient. Support was seen to be given in making specific decisions rather than assume lack of capacity on all the secure wards.

MCA training was coupled with MHA training in the trust, and consisted of briefings, five briefings in total. For the medium secure units the figures for completed training ranged between 91-100% and all low secure units were at 80%.

Good

Are services caring?

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

Our findings

Kindness, dignity, respect and support

On all of the wards we observed staff treating patients with dignity and respect. The staff knew the patients well and had a close working relationship with them. For example, patients were evidently pleased to see the staff coming over and talked to them in a relaxed way. Staff were very knowledgeable about the patients and were able to use this knowledge to anticipate patients' behaviours. Staff spoke about the patients in a respectful manner and this was observed in handovers and group work as well as when we saw staff walking in the hospital grounds with patients.

The involvement of people in the care that they receive

Patients told us that on arrival to the ward they had received a welcome pack with lots of relevant information included such as visiting times, activities available on the ward and information about the hospital. Patients told us they met weekly with their key worker to develop and update care plans. They had been encouraged to make their own decisions about the care they received and future plans. We saw evidence of patients being involved in planning their care. For example, care plans were written in the first person in the patients' own words. 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.

We saw evidence of patients personalising their bedrooms with positive words from their Dialectical Behavioural Therapy groups. They also contained photographs of family and friends and personal belongings. These were also displayed on the ward for other patients to use.

Ward reviews and meetings were planned so that families and key workers could attend if they wished to with the patients' consent. The patients had access to an independent mental health advocacy service. Posters and leaflets explaining how to access the service were displayed around the wards and notice boards.

Patients were encouraged to not only attend but chair the community meetings on the wards and to discuss anything they were unhappy with or wanted to change. The meeting minutes were displayed for everyone to read and any changes arising from them were noted for the next meeting. We saw evidence of patients making decisions in these meetings and their decisions being acted on; for example, new equipment being ordered and paint colour choices being made.

Patient records we reviewed had advance statements in place in relation to medication and rapid tranquilisation. The most recent monthly newsletter (July) for Calderstones featured a full story of a patient's involvement in the recruitment of new staff.

Are services responsive to people's needs?

Good

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

Our findings

Access and discharge

Across all wards, 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. They would then make a decision about which service would best meet the patient's needs. Moving-on (discharge) plans were developed for each of the patients, which detailed the steps a patient would take to be discharged.

Discharge planning took place at monthly review meetings and this took into account the existing needs of the patient. This included current and potential risk in order for people to move to an appropriate placement safely. The wards worked closely with the community teams in order to ensure that patients received the right support on discharge.

The facilities promote recovery, comfort, dignity and confidentiality

The wards were clean and tidy and there were colourful pictures on display and a range of information was displayed on the walls, including groups available, local information and nearby support networks.

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

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

All wards had a range of rooms to support the care and treatment of the patients. This included dining rooms, lounges, quiet areas and activity rooms. The bedrooms on the wards had personalised touches such as photographs of family, artwork that they had completed in groups and motivational words relating to their positive behavioural support plans. All patients had access to their bedrooms. In the low secure wards they had their own key so they could secure their belongings when they were not in the room. In the medium secure wards, only one ward allowed patients to have their own keys but access was only refused if a risk assessment and care plans indicated this was appropriate. All bedrooms had a lockable space within them for patients to store their valuables which they held the key to.

All the wards had access to a secure outdoor space and there were rooms located off the ward area for children to visit.

The patients on all of the wards had access to a kitchen where they could make a hot or cold drink throughout the day and night. There was also access to snacks throughout the day and patients could buy their own food if they wished to and store it in the fridge.

The wards had phones which the patients could use to make a phone call in a private area.

There was a robust activity programme across all wards which included activities on and off the ward. On Maplewood 1, 2 and 3 the patients could go to another part of the building where there were larger activity rooms in order to join specific groups such as dialectical behavioural therapy which were ongoing for several months. Nursing staff and occupational therapists facilitated the activities on the wards. Activities off the ward were facilitated by staff with specialised training in that area. For example, one manager had completed dialectical behavioural therapy training so she led these groups on a six month rolling programme. Activities available included board games, knitting, animal therapy, pampering, baking and art. More structured psychological therapies available included anger management, DBT, compassion therapy (emotional regulation) and the sex offender treatment programme. There was a gym that the patients could attend and some patients were able to tell us how they enjoyed this and used it as a way to relax if they became upset of angry. Occupational therapy teams were allocated to each unit. There was a secure outdoor space for the patients to use at any time they wished. Patients' human rights and diversity were respected and staff understood the individual needs of the patients.

We observed mealtimes on each unit. On Gisburn Lodge in particular, we saw consideration was given to the presentation of food as well as quantity and quality. Patients gave mixed feedback on the food across the service.

Patient Led Assessment of the Care Environment (PLACE) is a system for assessing the quality of the patient

Are services responsive to people's needs?

Good

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

environment. Local people go into hospitals as part of teams to assess how the environment supports patients' privacy and dignity, food, cleanliness and general building maintenance. It focuses entirely on the care environment and does not cover clinical care provision or how well staff are doing their job. For 2015 for Calderstones trust had an overall PLACE score of 95%, which was 6% above the England average of 89%.

Meeting the needs of all people who use the service

We saw good evidence of patients' diversity and human rights being respected. Examples of this were access to specific dietary requirements, attendance at the trust's lesbian, gay, bisexual and transgender group and attendance at church. Multi-faith rooms were available across the service. All this was documented on patients' weekly planners. This also included cultural and language requirements; for example, interpreters were available and were used when required. We saw information leaflets available in easy read format and in a range of languages.

All patients were offered ward information packs. Leaflets were available about the Mental Health Act 1983 and patients' rights under the Act. Patients who had experience of the service had made a DVD for people coming into the service to watch.

Staff and patients told us that activities were rarely cancelled due to staffing issues. The staffing and analysis group minutes from the trust showed that episodes of missed leave were closely monitored and actioned via the staffing and analysis group. Figures showed a general downward trend for missed activities.

Listening to and learning from concerns and complaints

There were a total of 53 complaints made across the secure service in the twelve months leading up to our inspection. 24 off these complaints were upheld and none were referred to the ombudsmen. The most complaints received were about Woodview Ward 2 and Woodview ward 3 was the least with only one complaint.

Across all the wards, both staff and patients were able to tell us about the complaints procedure. There were leaflets and posters around all wards explaining how to make a complaint and patients told us they felt they could ask staff to help them with this.

Staff received feedback on the outcome of investigations and complaints at staff meetings, in supervision and by email from their line managers. There was a weekly meeting in place where ward managers would receive information about incidents on other units so that learning could be spread across the trust.

One patient had raised a complaint of bullying against a member of bank staff and the investigation was ongoing at the time of the inspection.

Are services well-led?

Good

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

Our findings

Vision and values

Staff were able to tell us about the trust's vision and values and how these underpinned their work. We saw information up on walls on the wards about the trust's vision and values. The staff we spoke with were able to tell us the names of some of the most senior people in the trust; for example, the chief executive. The ward managers felt supported by their immediate line managers.

Good governance

The wards had access to good governance systems, these allowed managers to monitor issues such as incidents, missed leave and staffing problems. This was then fed up to senior management and monitored accordingly. For example, there was an electronic system that alerted staff when their mandatory training was due to expire so that managers could book staff onto training.

The ward managers told us that they felt they had enough authority to manage their own wards, with support when they asked for it from their immediate managers. They told us they felt confident in raising concerns and were aware of the trust risk register and how to add to this. They attended weekly meetings with senior managers to discuss the risk register and decide if anything needed to be added to it and escalate their concerns.

Key performance indicators were used to gauge and monitor performance across the trust. They were displayed on a dashboard that related to the key services. These included the corporate dashboard report, the quality risk committee dashboard report and the strategy performance committee dashboard report. Each of these reports allowed ward managers to gauge performance for the forensic units. Ward managers were also able to feed information about their service into the dashboards so that information was up to date and current.

Leadership, morale and staff engagement

The wards were well led. The ward managers were present during core hours and they also worked weekend and evenings on a rota system with the other senior staff. There was a culture of openness on the wards and all staff we spoke with felt they could raise concerns with their immediate line manager. They also told us they felt confident to approach more senior management if necessary. Staff were happy that they would be listened to.

There were no bullying or harassment cases reported before or during the inspection. Staff were aware of the whistleblowing process and how to access the policy. They did not fear victimisation if they raised concerns about their place of work. One staff member reported "I love it here; I really feel I make a difference".

Staff told us there had been a lot of changes over the past year and that at one point morale had been quite low. However, staff told us this had improved a lot and that they were now moving forward with the changes and felt they were working well. Examples of this staff gave us included teams working better together following the introduction of the safe wards model. This included better communication at handovers and understanding the needs of their patient group by discussing them regularly as a team. They told us this had led to a decrease in use of restraint which they felt made going to work more pleasurable.

Staff told us they were kept up to date with changes locally via staff meetings and emails. They also spoke about meeting with the board level staff at meetings such as "the big breakfast" where staff were invited to have an informal breakfast with the chief executive in the month of their birthday. Another initiative was the chief executive's "big conversation" events, which involved talking directly to staff at all levels to discuss the key issues in the organisation.

All ward managers we spoke to had completed at least one form of leadership and management training. They told us this had assisted them in developing skills to manage staff and had improved their confidence in doing so. They all felt supported by their immediate line managers.

Commitment to quality improvement and innovation

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, on low secure units, West Drive met 82% of low secure standards and Maplewood 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, procedural security and governance, meeting 100% of the

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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.

The ward manager at Gisburn Lodge was involved in observational policy research at Liverpool university. Staff were involved in the "safe wards" research; this model looks at conflict and containment and both staff and patient attitudes towards this.