Calderstones Partnership NHS Foundation Trust

Quality Report

Mitton Road
Whalley
Clitheroe
Lancasshire
BB7 9PE
Tel: 01254 822121
Website: www.cstone-tr.nwest.nhs.uk

Date of inspection visit: 8 - 11 July 2014
Date of publication: 17/12/2014

Core services inspected	CQC registered location	CQC location ID
Long stay/forensic/secure services Inpatient services for people with learning disabilities or autism	Calderstones	RJX04
Inpatient services for people with learning disabilities or autism	In-Patient Community Secure - 14-16 Daisy Bank	RJXX5
Long stay/forensic/secure services	Gisburn Lodge	RJX51
Inpatient services for people with learning disabilities or autism	In-Patient Community Secure - Daisy Bank	RJXX4
Inpatient services for people with learning disabilities or autism	In-Patient Community Secure - North Lodge	RJXX3
Inpatient services for people with learning disabilities or autism	Scott House	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.

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.

Summary of findings

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

Contents

Summary of findings

Overall summary

Calderstones Partnership NHS Foundation Trust is a unique organisation. It is the only NHS trust that provides care exclusively for people with learning disabilities. It is also unusual in that all of its patients are cared for in a hospital ward and almost all detained under the Mental Health Act. At the time of our visit 42% of the 216 patients were subject to a restriction order; which meant that they could not be discharged from hospital without authorisation from the Ministry of Justice. The great majority of people admitted to Calderstones stayed in the hospital for a long time. At the time of our inspection, 92 of the patients (43%) had been at Calderstones for more than five years.

We found that some of the wards and seclusion rooms at Calderstones were dirty and that effective infection control procedures were not in place. This is never acceptable in a hospital setting but it is of particular concern for wards that are, in effect, a person's home. We also found that some of the rooms used to seclude people at times when they were disturbed or distressed were neither clean nor safe.

The people who are admitted to Calderstones have severe mental health problems and complex needs. Many have behaviours that put themselves at risk and that sometimes put others at risk. As a result, some patients are cared for in single bed wards for long periods of time. Also, staff at Calderstones frequently seclude people for short periods of time and/or use physical restraint to protect people from harming themselves or from harming others. In light of this, we were concerned that not all staff were familiar with the trust policy on seclusion and segregation.

The trust frequently restrained people in the prone (face-down) position as a planned intervention. Recently published national guidance states that people should not be restrained in the face-down position because it is less safe than other methods of restraint. At Scott House, one patient had been repeatedly restrained in a face-down position. The care records of this patient showed that staff had not followed trust policy, which states that a doctor should be summoned to attend a prolonged episodes of restraint. Furthermore, the arrangements for medical cover to Scott House did not permit the prompt attendance of a doctor when required.

The trust has had difficulty recruiting nursing staff and many posts were vacant. As a result, it relied heavily on the use of agency and bank nurses. We had a specific concern about the safety of night-time cover to wards at 5 Chestnut Drive, North Lodge and 14/16 Daisy Bank.

Although the trust was good at providing and monitoring mandatory training for its staff, we concluded that it was less good at providing the training required to meet the care needs that are particular to the specific problems of the patient group admitted to Calderstones. In particular, too few staff had completed training in how to manage epilepsy, in eating and drinking difficulties in adults with a learning disability and in Makaton communication training.

Our findings about the quality of care were consistent with our conclusion about the relative lack of specialised training. The clinical staff made good assessments of people's general mental and physical health needs and had arrangements in place to provide medical care for people's physical health problems. However, few care records contained health action plans or communication passports and not all wards were following modern and best practice in managing challenging behaviour or in recovery-focused care.

We found many instances of failure to meet the requirements of the Mental Health Act. This is of particular concern given that nearly all of the patients in the learning disability services at Calderstones are detained.

We heard about, and observed numerous care interactions that showed that staff were caring and compassionate, and we found that most of the people who use services were active participants in their care planning. Staff told us that they felt able to raise concerns when they needed to and most patients told us that they would feel confident about making a complaint.

In response to the discovery of the abuse of people with learning disabilities at Winterbourne View hospital in 2011, the Department of Health had decided that people with learning disability should not be cared for in hospital wards for any longer than is absolutely necessary. Although the clinical teams at Calderstones held regular care programme approach meetings at which discharge

Summary of findings

was discussed, the trust had not yet implemented its formal approach to managing the discharge care pathway. Furthermore, some of the wards had 'blanket restrictions' in place, which limited patient autonomy, and were not consistent with a care approach geared towards rehabilitation and recovery. Although our overall conclusion was that Calderstones could have done more to facilitate discharge, we recognised that there were other factors that mitigated against this. These included the fact that many patients required authorisation from the Ministry of Justice for discharge, and that discharge was dependent on the availability of suitable accommodation and community services in the patient's home area.

Although we concluded that some of the governance arrangements were deficient, the trust senior leaders were visible to front-line staff who reported being engaged in work to develop and implement the trust's longer term strategy.

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?

Safe and clean ward environments

- Some of the wards and seclusion rooms that we visited were dirty, including at Woodview and West Drive, and staff were not able to provide us with cleaning schedules.
- We found deficiencies in infection control procedures on some wards with a lack of infection control audits at ward level, no handwashing facilities in areas where medicines were dispensed and incorrect labelling and use of sharps containers.
- There were potential ligature points in rooms that people who used services had unsupervised access to at Scott House, 4 Daisy Bank, Gisburn Lodge, Woodview and West Drive.
- The design and layout of some seclusion rooms at Gisburn Lodge, 4 West Drive and 1 Maplewood were not fit for purpose.

Staffing levels

- The trust had problems with recruitment and high staff turnover. The trust provided CQC with information that showed that in March 2014, 9.7% of nursing posts were unfilled and 15% of staff had left the trust in the previous year.
- The trust relied heavily on agency and bank nurses to staff the wards. On some shifts none of the nursing staff were permanent employees.
- The trust tried to ensure that it used agency and bank nurses who were familiar with the ward and knew the people who used services.
- A single nurse provided night-time cover to wards at 5 Chestnut Drive, North Lodge and 14/16 Daisy Bank. The arrangements to provide back-up in the event of an emergency on these wards did not sufficiently mitigate the risk to these staff members.

Assessing and managing risk

- All care records that we reviewed contained a risk assessment and those for patients on the forensic wards were particularly comprehensive. Risk assessments were reflected in care plans and we saw evidence both of patient involvement in advanced planning around risk and of creative use of less restrictive interventions.
- Despite this, there had been frequent episodes of both restraint (1661 episodes of which 479 were restrained on the floor) and seclusion (333 episodes) in the six months prior to the inspection visit.

Summary of findings

- 479 of the restraints were recorded as having been in the prone (face-down) position.
- Contrary to current Department of Health guidance, nurses sometimes restrain people in the prone (face-down) position as a planned intervention to manage disturbed behaviour. In some cases, clinical staff had asked the trust ethics committee to consider and review plans to use prone restraint as a planned intervention.
- At Scott House, staff had restrained one person in the prone position ten times during June 2014. At least one of these episodes of restraint had been prolonged. The records showed that on no occasion had a doctor been asked to attend at the time of the restraint. Furthermore, the medical cover to Scott House, which was located away from the main Calderstones Hospital site, would not permit a doctor to attend promptly when prolonged prone restraint was used; as was required by the trust policy.
- One patient at 1 Maplewood had been restrained in the prone position using leg straps despite their care record stating that this form of restraint had proven ineffective for that person.
- Some nursing staff that we interviewed were not fully familiar with the trust policies on seclusion and segregation. We found breaches and we found inadequate recording of episodes of seclusion at 5 Chestnut Drive and in the low secure wards.
- At Scott House, one person had been put into segregation for six weeks without having been assessed by an independent senior clinician.
- We found out of date medicines at 1 and 3 Woodview and out of date syringes and saline solution for injections at 4 West Drive.
- The trust had conducted several audits of medicines management but not made improvements as a result.

Reporting incidents and learning when things go wrong

- Staff throughout the organisation were aware of and used the trust system for reporting incidents and we saw good examples of staff learning from the investigation of adverse events.
- Staff were aware of the safeguarding procedures and told us that they would have no hesitation in escalating concerns to their managers.

Are services effective?

Assessment of needs and planning of care

Summary of findings

- Most care plans that we reviewed showed that a good assessment had been made of people's general physical and mental health needs. The care plans of patients on the forensic wards contained detailed pre-admission assessments.
- On the learning disability wards, just two of 33 records contained a health action plan; which is widely recognised as being the appropriate format to summarise the health needs of a person with learning disability. Also we identified several patients whose communication needs had not been adequately assessed and found little evidence of the use of communication passports.
- Positive behavioural support plans had recently been introduced. We saw some examples of these that included advanced decisions about how people wanted their care to be managed when they became distressed; including the use of restraint or seclusion. However these plans were not developed through assessments of the function of the behaviour that went on to develop behavioural approaches.
- Each person had a relapse prevention plan which provided specific details of interventions, which should be put in place if the person's mental health deteriorated, to prevent a relapse of their illness.
- The trust had met its own target of completing 90% of psychological assessments within 12 weeks of people being admitted to the service.

Best practice in treatment and care

- Although not the case for all wards or all patients, we saw evidence across the trust of the recent introduction of modern approaches to the assessment and care of people with learning disabilities and complex needs. For example:
  - the trust was implementing a challenging behaviour care pathway,
  - staff at Chestnut Drive, Pendle Drive, Ravenswood and Moor Cottage used the recovery star model,
  - forensic wards were at various stages of introducing, 'my shared pathway', 'my support plan' and the 'recovery star' documentation'
  - in some wards staff monitored status and outcomes through use of Health of the Nation Outcome Scale (HoNOS), Model of Occupational Screening Outcome Tool (MOHOST), the Recovery Star and a number of specific psychological assessments.
- The arrangements, involving trust doctors, physical health nurse practitioners and general practitioners, were sufficient to meet people's routine physical healthcare needs.

Summary of findings

- People who use services had access to a range of therapeutic and social activities during week days. There was more limited access to activities at weekends.

Skilled staff to deliver care

- The trust delivered and monitored a programme of 'mandatory' training for their permanant staff. For example, 83% of permanant staff had completed infection control training and 84% had completed safeguarding adults training.
- At the time of the inspection, staff on the learning disability wards had not received adequate training to meet some of the specific needs of the patient group at Calderstones. Too few staff had completed training in how to manage epilepsy, in eating and drinking difficulties in adults with a learning disability and in Makaton communication training.
- At Moor Cottage, staff had not completed their training on the Mental Capacity Act or the Mental Health Act 1983.

Multi-disciplinary and inter-agency team work

- Care and treatment was delivered through a multi-disciplinary team that included social workers, occupational therapists, psychologists, speech and language therapists and medical and nursing staff.
- Workers from these disciplines attended ward rounds and CPA meetings regularly and were actively involved in people's treatment and care.

Adherence to the Mental Health Act (MHA) and the MHA Code of Practice

- We found many instances where staff had not adhered to the requirements of the MHA. These included:
  - wards where information leaflets were out of date and did not incorporate amendments to the MHA made in 2007,
  - patients had not signed a form to confirm that they understood their rights,
  - care records that did not contain MHA documentation,
  - failures to provide patients with their section 17 leave forms,
  - T2 (certificate of consent to treatment) and T3 (certificate of second opinion) forms that were out of date, incorrectly stored or not followed.
- People who were detained had good access to an independent mental health advocacy services.
- All records we reviewed showed that the trust made appropriate use of second opinion appointed doctors.

Good practice in applying the Mental Capacity Act (MCA)

Summary of findings

- Most care records that we reviewed showed that staff had considered consent to treatment and had assessed mental capacity and that the multi-disciplinary team had been fully involved in discussion of best interest decisions. However:
  - not all care records contained a recent mental capacity assessment.
  - we found two cases where the best interests decision had been made before the mental capacity assessment had been recorded.

Are services caring?

Kindness, dignity, respect and support

- The great majority of people who used services that we talked to, or who completed comment cards, told us that they were treated kindly and respectfully by staff. The care interactions that we observed supported this.
- We observed staff knocking on the doors of bedrooms before entering.
- We observed staff responding compassionately to people experiencing emotional distress in a timely and appropriate way.

The involvement of people in the care they receive

- Overall, people were offered the opportunity to be fully involved in all aspects of their care and treatment. People who used services routinely attended the multi-disciplinary meetings. This was facilitated by the 'my ward round- things to talk about' document that supported people to express their needs and wishes during the meeting.
- However, most of the care plans we saw were not in an easy read format and most people did not have a copy of their care plan.
- All wards had community meetings.
- People who used services told us that staff supported them to make choices about their day to day lives.
- Patients were involved in the wider management of the ward or trust. This included as members of a media club, as contributors to a user led newsletter, in the recruitment of new staff and as representatives on project groups.
- The service had an on-site advocacy service. The majority of people we spoke with were aware of the service and how they could access it.

Are services responsive to people's needs?

Access, discharge and bed management

- Care programme approach meetings, at which discharge planning was discussed with staff from local services, took place at the interval required by the trust policy.
- In January to March 2014, the trust had identified eight people whose discharge had been delayed.
- Although the trust was developing formal care pathways leading to discharge, we did not find evidence that these were in place at the time of the inspection.
- In the forensic service, patients followed a care pathway that usually involved them moving from medium secure unit to a low secure unit to a step-down ward before being discharged.
- Staff told us that delays in discharging people sometimes resulted in the pathway being blocked due to beds in lower dependency settings being full.

Ward environments that optimise recovery, comfort and dignity

- Although many of the wards were located in old buildings, the wards had a range of rooms and facilities to support people's individual treatment and care needs.
- Most wards gave people access to outside space that was sheltered from view. However the garden at Maplewood 1 was poorly maintained.
- At Woodview, internal doors and external windows in communal areas, quiet rooms, bedrooms and corridors could be overlooked by people using the external garden or recreational areas. There was no privacy screening on any of these windows. Although one of the panels looking into the female accommodation on Woodview 1 had been fitted with a frosted screen, men on an adjacent ward could still look into the ward.
- None of the forensic wards had a phone to which patients had easy access. Staff told us that people could use a portable telephone unit, which could be taken into the ward area, or use a cordless telephone to make and receive calls dependent upon personal restrictions.

Ward policies and procedures minimise restrictions

- The wards applied different rules to use of mobile phones by people who used services. The decision about a person's access to a mobile phone was not always taken on the basis of an individual assessment of risk.
- At Pendle Drive there were blanket restrictions relating to the use of phones, the locking of bedroom doors during the day and the locking of kitchen doors and cupboards.

Summary of findings

- In the low secure units, staff subjected all patients to a pat-down search upon return from unescorted leave. This practice was not based on an individual assessment of the risk posed by each person. Staff told us that consenting to this search was a condition of patients being allowed leave. We considered that this practice constituted a 'blanket policy' and was not in line with the MHA Code of Practice.

Meeting the needs of all people who use the service

- People's religious beliefs were supported through access to the multi faith rooms available on the different sites or through visits from spiritual leaders at their request.Religious calendars recording all the important dates and festivals of the various religions were displayed in the wards.
- People had access to interpreting and on site advocacy services if necessary.
- Written information that enabled people to understand their care was available across the service. This included information in different accessible formats.

Listening to and learning from concerns and complaints

- Staff on most wards provided people with information about how they could raise complaints or concerns and most people told us they felt able to raise any concerns and were confident that they would be listened to.
- Pendle Drive was an exception. Here, there was no information available on the ward on how to complain and the patients that we spoke with told us they did not know how to complain.
- The wards actively sought feedback from people through the use of a suggestion box and regular community meetings. Ward meetings had a set agenda which included complaints and feedback. Minutes of the meetings were available for people to look at on the ward.
- We examined a sample of complaints and found that all investigations had been completed within the prescribed timeframe outlined in the complaints policy..
- Staff described changes that the wards had made in response to feedback from people who used the service.
- The provider had a complaints system which could monitor trends across wards.
- One person told us that, when they had not been satisfied with the response to a complaint they had made, the chief executive had visited them to discuss the complaint and it was then resolved to their satisfaction.

Summary of findings

Are services well-led?

Vision and values

- Many of the trust board members, including the chief executive and chair, were relatively new in post.
- In early 2014, the trust had adopted a vision of 'Improving lives through excellence'
- The board had agreed a set of values and we found these displayed on wards throughout the trust.

Good governance

- The board assurance framework and risk register showed that the trust had identified many of the risks that were revealed by our inspection.
- However, our findings showed that some of the trust's governance systems were not effective. This is demonstrated by:
  - a failure to maintain clean ward environments and to fully implement infection control procedures,
  - non enforcement of the medicines management procedures,
  - a failure to recognise and address unsafe night-time cover on some wards located away from the main hospital,
  - a lack of awareness of and failure to follow trust policies relating to seclusion, segregation and restraint,
  - a failure to provide adequate training for staff in the skills required to meet the specific needs of the patient group cared for at Calderstones.
- We found that there was no board level monitoring of the Mental Health Act. This, together with the many failures of governance of the application of the MHA, is of particular concern because every patient but one was detained under the Act.
- Some aspects of governance were working better; including:
  - procedures for receiving, investigating and acting on complaints from people who use services,
  - procedures for reporting and analysing incidents,
  - systems for monitoring the provision of mandatory training, supervision and appraisal.

Leadership, morale and staff engagement

- Despite the challenge cause by high vacancy rates, staff at Calderstones told us that they were proud to work for the trust and felt supported by their managers
- The work by board members to engage with staff, for example through the 'big conversation' and 'big birthday breakfast', had

succeeded. Front-line staff reported that the executive team were visible and approachable and that they felt there were effective two-way channels of information between the ward and the board.
- Ward managers attended a weekly service development meeting,
- Staff were aware of internal and external whistleblowing policies and felt comfortable raising concerns with their managers.

Commitment to quality improvement and innovation

- The trust had recently introduced a performance dashboard and a quality and safety assurance form. However, information derived from this was not always fed back effectively to front-line staff.
- Ward staff participated in few clinical audits that were directly relevant to their clinical work.
- Observation of practice, review of records and what people told us demonstrated the wards were proactive in their approach to gaining feedback from people who used the service through ward meetings, speak up groups organised by the occupational therapy department, patient advice and liaison service and advocacy.
- The low and medium secure units all participated in the Royal College of Psychiatrists' quality network for forensic mental health services. This facilitates standards-based self and peer-review assessments. The trust had, as a participating service produced an action plan to address standards that were not met.

Summary of findings

Our inspection team

Our inspection team was led by:

Chair: Professor The Baroness Sheila Hollins.

Team Leader: Nicholas Smith Care Quality Commission.

The team included CQC inspectors and a variety of specialists including learning disability and forensic consultant psychiatrists, junior doctor, learning disability nurses, social workers, Mental Health Act Commissioners, consultant psychologists, patient “experts by experience”, family carer "experts" and senior NHS managers, an advocate, learning disability nurse consultant, pharmacist and AMHP's.

Why we carried out this inspection

We inspected this provider in the second wave of our new in depth mental health inspection programme. We selected this trust to review as they are the only specialist learning disability trust in England.

This inspection also allowed CQC to test tools and methodologies that had been developed for inspecting and reviewing services for people with a learning disability and autistic spectrum disorders.

How we carried out this inspection

To get to the heart of people who use services’ experiences of care, 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?

The inspection team always inspects the following core services at each inspection:

- Mental Health Act Monitoring
- Long stay/forensic/secure services
- Services for people with learning disabilities or autism

Before visiting, we reviewed a range of information we held about the provider and asked other organisations to share what they knew about the provider. We carried out an announced visit from 8 to 11 July 2014.

In completing this inspection we visited twenty four wards and spoke with 88 patients. On the wards we talked with approximately 115 staff, consisting of ward managers, deputy ward managers, occupational therapists, behavioural nurse therapists, staff nurses, health care support workers In addition, we spoke with physical health nurse practitioners and a general practitioner.

We looked at 63 patient records in detail and parts of 54 other patient records to check what had been recorded about their care and treatment. We attended seven multi disciplinary team (MDT) meetings where people’s care was discussed.

Prior to the inspection week we ran focus groups with people who used the service and detained on sections of the Mental Health Act. We met with 16 people at these groups.

During the inspection week we ran focus groups and held meetings with 141 people from the following groups:

- Learning and development team
- Registered nurses
- Service director, senior operation managers, clinical nurse managers
- Senior managers and deputy directors
- Independent hospital managers
- Allied health professionals
- Doctors in training
- Consultants and doctors
- Student nurses
- CCG’s, safeguarding reps and NHS England
- Support workers
- Council of governors

We also met with and interviewed key staff including:

Summary of findings

- Chief executive
- Chairman
- Medical director
- Director of finance
- Director of nursing
- director of strategy
- Mental Health Act lead

As part of the inspection process we spoke with 12 families of people who use the services. The feedback indicated that an area for development is to improve the involvement of family members in the care and treatment of their family member who was using the services.

There were elements of good practice across a range of units and teams within each core services. This good practice was overshadowed by a lack of a consistent approach between services at a local, service and board level.

The hospital inpatient model of care for people with a learning disability is no longer regarded as best practice. Health services for people with learning disabilities used to be based in long-stay learning disability hospitals. A learning disability was, at one time, regarded as a condition requiring medical treatment. However, a social model of care has now replaced this, and there is an expectation that people with learning disabilities will be supported in local services in their local communities.

Like everyone else in the population, people who require more specialist input need to be referred to specialist services. Calderstones is a specialist health service and provides care for people with learning disabilities and additional problems including severe behavioural problems. The people using the services at Calderstones often have a complex mix of learning disability, other developmental disorders, challenging behaviour ,poor mental health, personality disorders, substance misuse and physical conditions and have often not had their needs met in other specialist services.

In 2013 the Royal College of Psychiatry, Faculty of Psychiatry of Intellectual Disabilities identified that there were around 3954 in-patient hospital beds across England for people with a learning disability. A majority of these (2393) were in secure accommodation, similar to that provided by Calderstones. The report also identified that in-patient beds were required for five main reasons.

1. Behaviours previously hidden or tolerated within institutions became more visible in the community and lead to adverse consequences (Moss et al, 2002).
2. An increased social aversion to risk (Carroll et al, 204) makes this dynamic more potent. Behaviour whether it is aggression or self-injury, can pose a level of risk that is deemed unacceptable in a community setting. In this situation, in-patient settings of varying degrees of security are needed for varying periods of time.
3. Any patient who is seen as "liable to be detained" under the Mental Health Act will by law be required a hospital bed (R v Halllstrom ex p W [1986]).
4. Just as in the general population people with a learning disability also develop mental ill health. They also have in fact higher rates of psychiatric and developmental morbidity. For those who come into contact with specialist or generic mental health services, this is not just because they have a learning disability. Their clinical presentations are usually a complex mix of learning disability, mental illnesses and developmental disorders. The natural course of these mental disorders suggest that there may be both crisis situations and situations where symptoms or behavioural disturbances persist in spite of adequate treatment. During those times, they need a safe setting with professionally qualified staff who can treat them.
5. People with a learning disability and mental health problems also have an extraordinary range of physical disorders including epilepsy (Emmerson & Baines, 2012) that makes their presentation even more complex. For some people who present with challenging behaviour, physical and mental health issues are intricately linked with each other and often it can be difficult to tease out whether the presentation is because of an underlying organic (physical) condition. In many of these complex presentations, continuous nursing observation, physical investigations, medical and psychiatric expertise may be needed within an in-patient setting for an accurate diagnosis and effective treatment.

The majority of the patients at Calderstones Partnerships NHS Foundation Trust fit into one or more of the groups above. At the time of the inspection all but one of the patients were detained under sections of the Mental Health Act 1983, as discussed under (3) above.

A significant proportion of the population of people receiving care at Calderstones (64%) have been detained

Summary of findings

on Part 3 sections of the Mental Health Act. Part 3 of Mental Health Act deals with patients who have been involved in criminal proceedings. This means that these care pathways have been identified due to an increased level of risk. This means that these people will often pass through the levels of security within the hospital before being considered for discharge.

A number of people (29%) are detained on restriction orders.

A small group 13% of the patients were sentenced prisoners who were moved from prison to hospital because, on the advice of two doctors, the Secretary of State decided that they needed to spend time in hospital to have treatment for a serious mental health problem.

For 6% of the patients a court had convicted them but not yet decided a sentence. The reason for this was that two doctors advised the court that they may have a mental health problem which requires treatment in hospital.

For those patients with a restriction order the Ministry of Justice have to approve their discharge from hospital.

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:

- Long stay/forensic/secure services
- Inpatient services 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 Community Secure - 14-16 Daisy Bank
- In-Patient Community Secure - 4 Daisy Bank
- In-Patient Community Secure - 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 throughout 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 challenging behaviour.

The trust has had Foundation Trust status since 2009. The trust employed an average of 1,152full time equivalent staff and has 233 in-patient beds across its registered locations, with a budget of £60 million.

At the time of our inspection all but one of the patients were detained under sections of the Mental Health Act 1983. The trust provided 148 beds in conditions of Medium and Low security. The people cared for in these services are commissioned by, and access to these beds is gate kept through NHS England specialist commissioners.

Calderstones Partnership NHS Foundation Trust has been inspected 13 times since registration.

These inspections have looked at each of the registered locations.

What people who use the provider's services say

Overall, people we spoke with told us that they received good care from staff. People told us they received support from staff and some said they understood they would be moving on from the service.

People told us they received regular healthcare check for their individual conditions as well as annual health checks.

Summary of findings

People gave varied accounts of their experience of physical intervention in describing physical restraint as 'necessary at the time' to 'it's a way of keeping me safe'.

People said they had recently been involved in their positive behaviour support plans and advanced planning about the use of restraint and seclusion.

Most of the people who were able to communicate with us verbally told us they felt safe. They told us they were aware of how to complain and would feel comfortable to do so.

They were supported to access the community but only if there were enough staff available.

They were aware of the advocate and some told us they had used the advocacy service.

Good practice

- The patient led complaints summary being trialled on Gisburn Lodge.

Areas for improvement

Action the provider MUST or SHOULD take to improve

Action the trust MUST take to improve:

- The trust must ensure that there are systems in place to improve practice and adherence to cleanliness and infection control.
- The trust must ensure that there is improvement in practices and adherence to food labelling, fridge temperature monitoring and the maintenance of equipment.
- The trust must ensure that there is improvement in practice around storage of refrigerated medicines and disposals of sharps.
- The trust must ensure that there is effective quality monitoring of the systems designed to manage risks to the health, welfare and safety of people using the service and any others who may be at risk from those risks.
- The trust must ensure that staff adhere to their responsibilities under the Mental Health Act 1983 and follow the Code of Practice.
- The trust must ensure that the policy for restraint including mechanical restraint is reviewed to ensure compliance with recent guidance in relation to prone restraint to ensure people are safe.
- The trust must ensure emergency equipment on the wards is checked to ensure it is current, working and correctly labelled so all staff can access it quickly in an emergency.
- The trust must ensure there are sufficient numbers of suitably qualified, skilled and experienced staff employed at 1 North Lodge, particularly at night.
- The trust must ensure that staff are trained with an appropriate level of skill to communicate with people who they care for.

Action the trust SHOULD take to improve:

- The trust should review the systems currently in place for administering medication from kitchen areas.
- The trust should review the systems in place for the safe and prompt administration of medication at services on the Calderstones hospital site.
- The trust should review the physical environment of the seclusion rooms to ensure that the privacy and dignity of people is maintained and protected.
- The trust should ensure that the searching of people and their bedrooms within low secure services is compliant with the MHA Code of Practice and based on individual risk assessment.
- The trust should ensure that all ligature risk assessments are reviewed to make sure there are no ligature points where people are unobserved.
- The trust should ensure that people's access to the internet and to personal telephones is consistent and is in line with their assessment and care plan, as opposed to meeting service needs

Summary of findings

- The trust should ensure that people who are cared for in single person services (long term segregation) are reviewed to ensure segregation is appropriate.
- The trust should ensure staff understand their responsibility to accurately complete and manage care and treatment records which demonstrates people are receiving the service they need.
- The trust should ensure that overly restrictive environments and blanket restrictions are reviewed so that any restriction on an individual is based on risk specific to the individual.
- The trust should ensure that the fire evacuation plan for Chestnut Drive is robust and tested to include actions to be taken at 1 Chestnut Drive if internal and external doors are locked.
- The trust should ensure that all patients have an up to date moving on plan in place. These should be produced with the individual to ensure understanding of the content and what goals are being worked towards.

Calderstones Partnership NHS Foundation Trust

Detailed findings

Are services safe?

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

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

Summary of findings

Safe and clean ward environments

- Some of the wards and seclusion rooms that we visited were dirty, including at Woodview and West Drive, and staff were not able to provide us with cleaning schedules.
- We found deficiencies in infection control procedures on some wards with a lack of infection control audits at ward level, no handwashing facilities in areas where medicines were dispensed and incorrect labelling and use of sharps containers.
- There were potential ligature points in rooms that people who used services had unsupervised access to at Scott House, 4 Daisy Bank, Gisburn Lodge, Woodview and West Drive.
- The design and layout of some seclusion rooms at Gisburn Lodge, 4 West Drive and 1 Maplewood were not fit for purpose

Staffing levels

- The trust had problems with recruitment and high staff turnover. The trust provided CQC with information that showed in March 2014 9.7% of nursing posts were unfilled and 15% of staff had left the trust in the previous year.
- The trust relied heavily on agency and bank nurses to staff the wards. On some shifts none of the nursing staff were permanent employees.
- The trust tried to ensure that it used agency and bank nurses who were familiar with the ward and knew the people who use services.
- A single nurse provided night-time cover to wards at 5 Chestnut Drive, North Lodge and 14/16 Daisy Bank. The arrangements to provide back-up in the event of an emergency on these wards did not sufficiently mitigate the risk to these staff members.

Assessing and managing risk

- All care records that we reviewed contained a risk assessment and those for patients on the forensic wards were particularly comprehensive. Risk assessments were reflected in care plans and we saw evidence both of patient involvement in advanced planning around risk and of creative use of less restrictive interventions.
- Despite this, there had been frequent episodes of both restraint (2433 episodes of which 2627 were restrained on the floor) and seclusion (333 episodes) in the six months prior to the inspection visit.
- 479 of the restraints were recorded as having been in the prone (face-down) position.
- Contrary to current Department of Health guidance, nurses sometimes restrain people in the prone (face-down) position as a planned intervention to manage disturbed behaviour. In some cases, clinical staff had asked the trust ethics committee to consider and review plans to use prone restraint as a planned intervention.
- At Scott House, staff had restrained one person in the prone position ten times during June 2014. At least one of these episodes of restraint had been prolonged. The records showed that on no occasion had a doctor been asked to attend at the time of restraint. Furthermore, the medical cover to Scott House, which is located away from the main Calderstones Hospital site, would not permit a doctor to attend promptly when prolonged prone restraint is used; as is required by the trust policy.
- One patient at 1 Maplewood had been restrained in the prone position using leg straps despite their care record stating that this form of restraint had proven ineffective for that person.
- Some nursing staff that we interviewed were not fully familiar with the trust policies on seclusion and segregation and we found breaches and we found inadequate recording of episodes of seclusion at 5 Chestnut Drive and in the low secure wards.
- At Scott House, one person had been put into segregation for six weeks without having been assessed by an independent senior clinician.
- The quality of local medicines management was not enforced, despite the trust having conducted several medication audits. We found out of date medicines at 1 and 3 Woodview and out of date syringes and saline solution for injections at 4 West Drive.

Are services safe?

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

Reporting incidents and learning when things go wrong

- Staff throughout the organisation were aware of and used the trust system for reporting incidents and we saw good examples of staff learning from the investigation of adverse events.
- Staff were aware of the safeguarding procedures and told us that they would have no hesitation in escalating concerns to their managers.

Our findings

Safe and clean ward environments

We found a number of significant concerns relating to the prevention and control of infection during our visit. The trust had gained a score of 89% against the National Specifications for Cleanliness of the NHS. The expected value for this indicator against all other trusts is 95%. This was a recognised trust risk and appeared on the Risk Register presented to the trust board April 2014, where the following areas of risk we identified:

- Risk of outbreaks of infection due to a lack of decontamination and infection control standards
- Knowledge, skills and training of key staff requiring urgent review
- No access to professional cleaning at weekends and bank holidays
- There was a lack of audits undertaken at ward level to demonstrate effective management of infection control.

During the inspection we found that some of the wards and seclusion rooms that we visited were dirty. On several of the wards staff were not able to provide us with cleaning schedules, nor were all of the ward mangers able to provide us with their local infection control audits.

We found deficiencies in infection control on some wards including; a lack of infection control audits at ward level, no handwashing facilities in areas where medicines were dispensed and incorrect labelling and use of sharps containers.

On some wards we found that no audits of fridge temperatures had been undertaken; on wards where audits had been completed there were 'gaps' in the recording of these and a lack of action taken in response to identified issues

We saw that single use medicine administration containers were being washed, left to dry and re-used and we found sharps bins that had not been labelled when assembled, temporary closure mechanisms not in place.

We found that there were potential ligature points in rooms that people who used services had unsupervised access to at Scott House, 4 Daisy Bank, Gisburn Lodge, Woodview and West Drive. Ligature audits were periodically undertaken on the wards however there were inconsistencies across the service in relation to the identification and management of risks.

We were particularly concerned about the physical condition of some of the seclusion rooms and raised these issues with the trust during our visit and were informed that plans were in place to refurbish the seclusion rooms this year including the removal of ligature risks. The design and layout of some seclusion rooms at Gisburn Lodge, 4 West Drive and 1 Maplewood were not fit for purpose

We were concerned about some staff practices. At 3 Woodview a staff member described how a person was given their insulin injection over the bottom half of the stable door; this was not a safe or dignified procedure and had been put in place due to the risk of staff injury. The Trust acted upon our concerns by amending the care plan, however the plan did not describe what would happen if the risk to staff re-emerged and we conclude that the person's dignity and safety could not be ensured.

Several of the clinic rooms within the low secure services were in an untidy and unkempt state. All of the wards had emergency first aid and resuscitation equipment which staff were trained to use. On 2 West Drive the first aid kit was kept in a bookcase on a corridor, there was no signage to inform staff of this. The items in the first aid kit were not stored correctly or were out of date, including a penlight that did not work, an out of date airway and a mask in the emergency bag uncovered. Some syringes and saline solution for injections on West Drive 4 were out of date and the medication fridge was kept in the laundry room.

Are services safe?

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

In several of the ward areas in the low secure service we found several pieces of equipment had not been portable appliance tested (PAT) and managers were not able to provide evidence of equipment audits.

Although many of the wards are located in old buildings, most of the rooms in the wards were reasonably well maintained. Some of the single person wards had been specially adapted to meet people's needs.

There was a system in place for reporting maintenance requests and we were told requests were dealt with promptly; it was not clear why requests had not been made to address the equipment issues we identified.

Safe Staffing

The trust had benchmarked staffing levels across the service and identified staffing at two levels.

1. Safe level, this is the level where people feel and are kept safe and
2. Quality level, this is the level where full care and activities can be delivered.

The report to the board identified that actual staffing is generally over the minimum Quality levels but when it does drop below this it does not fall below the safe staffing level which the trust have set at 95% of the quality level.

Staff told us that most staffing shortages were filled by the trust's own bank staff which meant that staff would have knowledge of the ward or unit and the people's care needs. Staff managed foreseeable risks to care, through their assessments and knowledge of people, and felt able to respond to local staffing and emergency situations. They told us recruitment was taking place, and either staff worked overtime or they used staff from the hospital bank to cover the vacancies.

The trust provided information that showed the permanent nursing and support staff, headcount, was 652 WTE. In the 12 months prior to the inspection 102 people left the trust, which is a turnover rate of 15%. The staff sickness rate was 6.9%. In quarter 4 2013/14, bank and agency staff usage had reduced to 11% and 2% respectively.

We found that the use of agency or bank staff in the service was high and there were shifts which had no regular staff. The trust presented data that showed there were 20,141 occasions when bank or agency staff were required to meet the required ward staffing compliment in the three month prior to the inspection covered. It was only possible to cover 14,316 of these.

Where staffing fluctuation does happen (for example when enhanced support is required) this is managed locally by the ward managers who are able to deploy staff from other areas to meet local needs.

When we talked with managers they told us there were enough staff to meet people's needs during the day, staffing numbers were reviewed daily and increased if needed. They told us recruitment was taking place, and staff worked overtime or bank staff were used to cover the vacancies. Many of the people using the service told us that there were not enough staff. We were told that this was worse at the weekend and for leisure activities. When we explored this they explained that there were not enough staff able to escort people on section 17 leave and during the evening and at weekends there was not enough staff to support them to attend the onsite social club. Some of the people in the remote services told us that community access was not possible as people were not comfortable going out into the community with unfamiliar staff.

We found that staffing levels were sufficient on the day of our visit on all the wards. There was a system in place to enable ward managers to see the staffing levels on all wards. This allowed managers to identify and cover any shortfalls. We were concerned that services located in the community did not have sufficient staff numbers at night. Staff in these units had been advised to phone the emergency services if their personal safety was at risk whilst working. We were concerned that wards not on the main Calderstones Hospital site did not have sufficient staff numbers at night.

There was concerns that in the Lancaster services bank and agency staff were required on 572 occasions in the three months prior to 30 April 2014. On 125 occasions these individual staff shifts were not filled by bank or agency staff. In Scott House there were 769 occasions when staff from the bank or agency were used.

We were concerned there were operational systems in place which placed people using services and staff at risk, in particular the qualified nursing cover at night at Calderstones Hospital. The fire and evacuation plan did not take account of locked doors at 1 Chestnut Drive, the plan

stated 'all occupiers immediately leave the building and report to assembly points' but staff failed to provide assurance of how this could be achieved when all internal doors were locked.

In the staff focus group we were told that some vacancies across the service had not been filled and recruitment of staff was ongoing. Bank and agency staff were being used as interim cover for shifts and to supplement existing staff levels when relational security and risk increased. Where possible bank staff familiar with the ward environment were used, to promote continuity of care.

An information board informed staff of the arrangements in place for people accessing social and recreational facilities off site; this meant staff were aware of the deployment of staff within the unit and could plan staffing levels around risks on each ward. Ward staff were supported by occupational therapy staff in planned individual and group social and therapeutic activities on and off the ward. People on 1, 2 and 3 Woodview, Maplewood 1 and West Drive 2 told us their leave had been cancelled due to staff shortages or lack of appropriate staff able to escort people with section 17 leave conditions. This was very frustrating for people who did not feel it was fair; staff would re-arrange leave however this was frequently cancelled.

There was a ward doctor and consultant psychiatrist available between office hours. There was an 'on-call' system in place for out-of-hours medical cover. We were not made aware of problems in accessing a doctor on the main hospital site when needed.

Assessing and managing risk to patients and staff

We looked at the incidents that had occurred recently at the trust. All trusts are required to submit notifications of incidents to the National Reporting and Learning System. Serious (NRLS) incidents known as 'never events' are events that are classified as so serious they should never happen. In mental health services, the particular relevant never events are suicide of an in-patient from a fixed ligature point and absconding from within medium and high secure services. The trust had not reported any 'never events'.

There were 453 incidents reported by the trust to the NRLS between June 2013 and May 2014; of which the Trust had reported 18 serious incidents between May 2013 and May 2014. Serious incidents are those that require an investigation. Of those serious incidents eleven were people absconding from hospital.

The trust had a range of risk registers held at different levels of the organisation. Where we identified issues, we saw that the trust had already recorded the risk on the risk register and actions had been taken to mitigate the risk were in place.

The Corporate Risk Register provided an overview of the individual hazards / risks and the actions in place to mitigate them and progress being made with these actions.

The trust supplied their Significant Risk Register which went to the trust board on 24 April 2014. It contained 26 risks categorised by the trust into workforce (4 risks), finance 12 risks), clinical safety (5 risks), or reputation (5 risks). It is noted that a high proportion of the risks were categorised as relating to finance.

A number of the financial risks also refer to 'ELFS' (East Lancashire Financial Services) which according to the trust website is a business division of the Trust and provides transactional financial and business systems services to 21 NHS client organisations throughout England.

The trust supplied an action plan to accompany the April 2014 Significant Risk Register. This outlined the actions required in relation to each of the 26 risks, along with the name of the action plan owner. Trust board minutes from January to March 2014 showed that the Significant Risk Register (SRR) was a regular agenda item, and the downgrading of risks was approved along with inclusion on new risks.

Staff received training in the management of violence and aggression, the trust data recorded this at 89%. We were told that restraint was used safely and only as a last resort and all staff across services employed strategies to reduce aggressive incidents that may lead to people being restrained. However we found that staff in the secure service were using a different method of restraint to that used by agency staff and this meant the agency staff were not able to become involved in restraint incidents.

The trust had recorded 1661 incidents of restraint in the six months until May 2014. Of these people have been restrained in the prone position(face down) 479 times. New guidance published by the Department of Health in April

Are services safe?

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

2014 called "Positive and Safe" included new guidance on the use of face down restraint which aims to ensure it is only used as a last resort. Seclusion was used on 333 occasions.

We found that incidents of restraint and seclusion were not always being used and recorded appropriately.

- On Maplewood we found that mechanical restraint and a blanket wrap had been used against clinical advice. We found across the site that doctors were not attending seclusion incidents within the time period required by the Code of Practice Mental Health Act 1983.
- At Scott House staff did not adhere to the trusts' policies for restraint and seclusion. The trust policy on restraint stated that 'prone' floor holds should not be used for more than three minutes. Department of Health guidance 'Positive and Proactive care': reducing the need for restrictive intervention published 3 April 2014 is clear that 'there should be no planned or intentional restraint of a person in a prone /face down position'. We found evidence of planned prone restraint interventions at Scott House. The plans in place for the use of prone restraint had been reviewed and agreed by the trust ethics committee. We found that the identified intervention as set out in the trust policy with regards to a doctor attending to review the patient was not happening. There was significant risk in the continued use of prone restraint particularly without availability of clinical intervention as per trust policy; this had not been put in place with either a GP practice or Calderstones Hospital. There is a clear risk to a people's safety.

Some nursing staff that we interviewed were not fully familiar with the trust policies on seclusion and segregation and we found breaches and we found inadequate recording of episodes of seclusion at 5 Chestnut Drive and in the low secure wards. At Scott House, one person had been put into segregation for six weeks without having been assessed by an independent senior clinician.

On 1 Woodview there had been 374 occasions when patients had been restrained and 203 seclusion episodes in the six months prior to the inspection.

We found that there was a number of people receiving care in a single person services. These people are not free to leave and associate with others, so they are being nursed in what might amount to longer term segregation.

In the engagement events that we completed prior to the inspection people told us restraint was used as punishment and people were unhappy with restraint as an appropriate response when they were distressed or self-harming. There were incidents of patients reporting that they had been shouted at during a restraint.

The trust was asked to submit their last restraint/physical intervention audit. In response they supplied a 'Use of Physical Intervention and As Required Medication' audit carried out during May 2011 and reported in October 2011. Although this audit is now three years old it concludes from a sample of 117 incidents that the use of as required medication was low in comparison to the use of physical intervention. The 'As Required Medication' usage on medication cards was higher than reported on PRISM (Prescribing Information System) which highlighted that staff were not always fully completing the incident form.

The trust had an identified safeguarding lead and well developed systems for ensuring that abuse was recognised, reported upon and investigated appropriately. Staff showed good awareness of safeguarding arrangements.

We found the trust had a system in place to safeguard people from abuse. Most staff we spoke with understood the importance of safeguarding vulnerable adults. The trust policy was up to date and clearly advised staff how to raise an alert and who to contact.

The trust clinical audit that included safeguarding practices identified recommendations to strengthen compliance in areas of staff training and policies and practices to maintain a safe environment. This is to be re-audited in 2014/15. Staff training records for safeguarding mandatory training have moved from red in April 2013 with 38% of staff up to date to amber in March 2014 with 85% of staff up to date.

Whilst visiting wards people using the service told us of safeguarding concerns. These were reported to the local safeguarding teams. With the exception of one, these reports were all historical and had been reviewed and investigated previously. This indicates that for the individuals there are still some matters that need to be resolved with regard to these incidents. Feedback we received from the local authority and the police was that safeguarding arrangements were working well and information was being shared appropriately.

Are services safe?

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

Medicines management and storage was found to be an area of concern. We found a number of concerns around the prescribing, storage and administration of medication across all areas of the trust. These included:

- No hand washing facilities in the medication dispensing areas across the sites.
- Single use medicine administration containers were being washed, left to dry and re-used.
- Out of date syringes and saline solution for injections.
- Medication fridge being stored in a laundry room.
- The medication cupboard on the wall in a kitchen.
- Out of date section 58 authorisation stored with the current authorisation.
- Treatment authorised by a form T2 (certificate of consent to treatment) not authorised by their current responsible clinician (RC).
- No capacity assessments in relation to treatment for mental disorder from the current RC.
- T3 forms were not stored with the medication chart.
- Medication prescribed and administered not included on the form T3 (certificate of second opinion) authorisation.
- A patient with both form T2 (certificate of consent to treatment) and T3 (certificate of second opinion). It was unclear to the staff which form was authorising treatment.
- Ward staff unclear who authorised treatment where the RC was not a doctor.
- Support staff who worked without a qualified nurse in some units were not authorised to administer 'as required' medicines for anxiety or distress, the policy stated these could only be administered by a nurse. People using the service had to wait until a nurse visited to administer this medication.

Systems were in place for reporting and acting upon NHS England patient safety alerts and for medicines incident reporting such as the recent changes to the maximum dose of Haloperidol that had been communicated to prescribers.

Arrangements were in place to ensure that medicine incidents were recorded and investigated. We found that there was an open culture of reporting medicine errors in order to change practices and to share lessons learned.

We saw that all care records that we reviewed contained a 'historical clinical risk management-20 (HCR 20)' risk assessment which assessed the risk of violence to self and others. These were updated on a regular basis and in response to incidents. Risk assessments were reflected in care plans and we saw evidence both of patient involvement in advanced planning around risk and of creative use of less restrictive interventions, We found several examples of positive risk taking to enable people moving towards independent living.

Reporting incidents and learning from when things go wrong

Changes had been made to policies and procedures following a safeguarding alert in 2013. Managers now ensured that staff were moved around in services that had high dependency one person accommodation.

The trust provided training figures that identified 84% of staff had completed safeguarding adults training.

All of the staff we spoke with were aware of the Winterborne View recommendations and talked positively about how it had affected their work.

There were systems in place to capture and review any incidents which enabled staff to identify potential risk. Staff demonstrated how each incident was graded according to severity (A - E); the severity dictated the managerial level for reporting and investigation. The trust board would be informed of the most severe (A & B). In addition the clinical service manager told us they attended the incident, risk and data quality assurance group that ensured data quality regarding incident and risk management reporting was monitored and assured.

We met with the risk and patient safety lead, he told us the trust was in the process of procuring a risk information management system. That can provide in-depth information about individual patients and patient groups and would provide a more functional analysis for staff of ward incidents.

We looked at the incidents that had occurred recently at this trust. All trusts are required to submit notifications of incidents to the National Reporting and Learning System. Serious incidents known as 'never events' are events that are classified as so serious they should never happen. In mental health services, the particular relevant never events are suicide of an in-patient from a fixed ligature point and absconding from within medium and high secure services

Are services safe?

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

the trust provides medium secure care. The trust had not reported any 'never events'. We did not see or hear about any incidents that should have been classified as never events.

There were 453 incidents reported by the trust to the NRLS between June 2013 and May 2014.

During the inspection we held several focus groups with staff from the trust and they described their role in reporting concerns through the safeguarding processes and that they would have no hesitation in escalating concerns to their manager. There was a safeguarding lead and staff knew how to contact them for advice or support and showed us the safeguarding policy.

Patients in the low secure services told us that they felt safe on the wards; although sometimes the behaviour of other people using services made them feel unsafe. People told us they felt confident about raising any concerns with staff. Patients in the medium secure services felt safe, although some felt intimidated or bullied, but any concerns were responded to by staff.

The 2013 Survey of NHS Staff identified the trust in the worst 20% of mental health/learning disability trusts in England for staff witnessing potentially harmful errors, near misses or incidents. However, the trust scored better than the England average for the percentage of staff reporting errors, near misses or incidents.

The trust reported 19 serious untoward incidents during 2013-2014.

During the inspection several patients raised safeguarding concerns. CQC forwarded these to the local authority and passed details on to the trust. Of these concerns all but one were identified to have been historical and had previously been investigated and close with the local authority safeguarding team.

We met with the risk and patient safety lead, he told us the trust was in the process of procuring a risk information management system. That can provide in-depth information about individual patients and patient groups and would provide a more functional analysis for staff of ward incidents.

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

Assessment of needs and planning of care

- Most care plans that we reviewed showed that a good assessment had been made of people's general physical and mental health needs. The care plans of patients on the forensic wards contained detailed pre-admission assessments.
- On the learning disability wards, just two of 33 records contained a health action plan; which is widely recognised as being the appropriate format to summarise the health needs of a person with learning disability. Also we identified several patients whose communication needs had not been adequately assessed and found little evidence of the use of communication passports.
- Positive behavioural support plans had recently been introduced. We saw some examples of these that included advanced decisions about how people wanted their care to be managed when they became distressed; including the use of restraint or seclusion. However these plans were not developed through assessments of the function of the behaviour that went on to develop behavioural approaches.
- Each person had a relapse prevention plan providing specific details of interventions, which should be put in place if the person's mental health deteriorated, to prevent a relapse of their illness.
- The trust had met its own target of completing 90% of psychological assessments within 12 weeks of people being admitted to the service.

Best practice in treatment and care

- Although not the case for all wards or all patients, we saw evidence across the trust of the recent introduction of modern approaches to the assessment and care of people with learning disabilities and complex needs. For example:
  - the trust was implementing a challenging behaviour care pathway,
  - staff at Chestnut Drive, Pendle Drive, Ravenswood and Moor Cottage used the recovery star mode,
  - forensic wards were at various stages of introducing, 'my shared pathway', 'my support plan' and the 'recovery star' documentation'
  - in some wards staff monitored status and outcomes through use of Health of the Nation Outcome Scale (HoNOS), Model of Occupational Screening Outcome Tool (MOHOST), the Recovery Star and a number of specific psychological assessments.
- The arrangements, involving trust doctors, physical health nurse practitioners and general practitioners, were sufficient to meet the people's routine physical healthcare needs.
- People who use services had access to a range of therapeutic and social activities during week days. There was more limited access to activities at weekends.

Skilled staff to deliver care

- The trust delivered and monitored a programme of 'mandatory' training. For example, 83% of staff had completed infection control training and 84% had completed safeguarding adults training.
- At the time of the inspection, staff on the learning disability wards had not received adequate training to meet some of the specific needs of the patient group at Calderstones. Too few staff had completed training in how to manage epilepsy, in eating and drinking difficulties in adults with a learning disability and in Makaton communication training.
- At Moor Cottage, staff had not completed their training on the Mental Capacity Act or the Mental Health Act 1983.
- The speech and language therapy (SALT) service was provided by Lancashire Care NHS Trust under a service level agreement which provided only 1.2 whole time equivalent staff. Four different speech and language therapists provided this service.

Are services effective?

Multi-disciplinary and inter-agency team work

- Care and treatment were delivered through a multi-disciplinary team that included social workers, occupational therapists, psychologists, speech and language therapists and medical and nursing staff.
- Workers from these disciplines attended ward rounds and CPA meetings regularly and were actively involved in people's treatment and care.

Adherence to the Mental Health Act (MHA) and the MHA Code of Practice

- We found many instances where staff had not adhered to the requirements of the MHA. These included:
  - wards where information leaflets were out of date and did not incorporate amendments to the MHA made in 1997,
  - patients had not signed a form to confirm that they understood their rights,
  - care records that did not contain MHA documentation,
  - failures to provide patients with their section 117 leave forms,
  - T2 (certificate of consent to treatment) and T3 (certificate of second opinion) forms that were out of date, incorrectly stored or not followed.
- People who were detained had good access to an independent mental health advocacy service.
- All records we reviewed showed that the trust made appropriate use of second opinion appointed doctors.

Good practice in applying the Mental Capacity Act (MCA)

- Most care records that we reviewed showed that staff had considered consent to treatment and had assessed mental capacity and that the multi-disciplinary team had been fully involved in discussion of best interest decisions. However:
  - not all care records contained a recent mental capacity assessment.
  - we found two cases where the best interest decision had been made before the mental capacity assessment had been recorded.

Our findings

Assessment of needs and planning of care

The inspection looked at whether people were being involved in decisions about their own care. Most people we spoke with told us they felt involved in their care and were involved in decisions. However, in some of the services we visited we did not see the person's involvement being recorded in the records we reviewed. In most services individuals did not have a copy of their care plan.

The trust worked closely with commissioners, local authorities, NHS England, people who use services, primary care services and family carers to understand the needs of the people using the service. The trust provide a specialist service not available in other areas and some of the people using the service are a significant distance from their home.

The trust was in the process of implementing a recovery-based model of care across its services to promote people's recovery. We found examples of how people had been offered the opportunity to be fully involved in all aspects of their care and treatment.

People in the service received care and treatment from a range of professionals within the multi-disciplinary team who used a range of assessment tools to monitor and assess people's progress, outcomes and promote their recovery.

Care plans were mostly in place and staff carried out risk assessments and developed management plans to protect people from the identified risks. There was examples of positive risk taking to enable people moving towards independent living. Staff talked about people moving on from secure to less secure services and then into the community. People told us that staff discussed their care and treatment with them but they did not have a copy of their care plan and seemed unsure of what a care plan was, often referring to their activity planners. When we talked with staff we found them to be knowledgeable about the care and treatment needs of the patients..

We looked at 33 care records in the learning disability services. We found that there was effective physical health care recording and annual health checks in the clinical record however, we only saw one Health Action Plan. The Department of Health recommends that Health Action Plans/Hospital Passports, should include a full medical and

family history, a comprehensive mental and physical assessment, information about medication, weight and reviews, to enable it to travel with the person should they attend hospital.

We found that some people's physical health needs were monitored by staff and some people told us they had access to physical health care.

Physical health monitoring was completed by a local GP practice. There was also an advanced nurse practitioner who visited to complete diagnostic tests and take blood for health and medicine monitoring. Due to the remoteness of the site the unit had a telemetric system for Electrocardiograms (ECG) linking direct to the diagnostic centre. This meant a test could be instantly read by cardiologists if required.

Where people were unable to communicate verbally we asked to see communication passports which would inform all staff how best to communicate with people within their service and which should be based on a speech and language therapy assessment. These were not available. In one service where people had no verbal language we found that of the 47 staff only two staff had had Makaton training. Whilst we were in this unit we observed staff signing to patients and when we talked to the staff it was clear that they had been using the wrong signs.

We were told that while activities were available during weekdays this was not always the case in the evenings and at weekends due to staff not being able to escort people to attend.

In the care records we looked at, we found completed pre-admission assessments for each person. These identified people's social, psychological, physical, cultural, spiritual and emotional needs. Overall, we found that where a need had been identified; an assessment of that need had been undertaken.

The service was in the process of implementing a recovery-based model of care across the service to promote people's recovery. We found some good examples of how people had been offered the opportunity to be fully involved in all aspects of their care and treatment. The wards were at different stages of implementing, 'My Shared Pathway', 'My Support Plan' and the, 'Recovery Star' documentation.

These user led recovery tools provided details of the person's care needs, strengths, future wishes, advanced statements and decisions. They provided information about how the person's needs should be met.

Each person had 'Historical Clinical Risk Management-20' (HCR-20) risk assessment completed which identified the person's risk to self and others. Where a risk had been identified, there was a clear psychological risk formulation which had been completed. We saw the trust was piloting a new integrated version with opportunity to enter historical data that was relevant to the continued assessment of individual risk. We noted that the wards did not use any form of structured assessment designed to be used in combination with other risk assessment instruments like the HCR-20. The addition of such tools would create a more balanced risk assessment and include risk of vulnerability which is not included in the HCR-20 for future violence risk.

Across the forensic service we saw that positive behavioural support plans had also recently been introduced and we saw some examples of these however, these were not developed following assessments of the functions of behaviour to develop a treatment plan using behavioural approaches. They were based on person centred planning tools and used user friendly language, using people's words describing how they wanted to be cared for when distressed. These plans were not recognised Positive Behaviour Support Plans.

Some staff were qualified gym instructors so could be available to supervise people on a one to one basis and monitor people's physical health prior to and during their use of the gym. We saw evidence that people using the gym had to be physically examined and declared medically fit by a doctor before they could use the equipment.

The trust provided information which showed they had achieved their target of completing 90% of psychological assessments within 12 weeks of people being admitted to the service.

Each person had a relapse prevention plan providing specific details of interventions, which should be put in place if the person's mental health deteriorated, to prevent a relapse of their illness. We found evidence to show that some people were involved in developing their plan with staff.

Are services effective?

Best practice in treatment and care

The trust had arrangements to ensure that physical health issues were properly assessed and treated. The trust had a range of policies to ensure that physical health issues were considered.

We saw that people's physical health needs were being met. The service had a health centre within the hospital grounds. People could access the centre to see a health practitioner nurse or General Practitioner (GP) if they had any physical health issues. People who lived in wards in the community accessed a local GP and other local services for physical healthcare.

Specific care plans for people's physical health needs had been developed where appropriate.

During the inspection we found there was variation in the therapeutic activities available to people. Some people told us they felt there should be more activities in particular in the evening and at the weekend.

The trust had recently introduced, and was developing further, a new performance dashboard to monitor performance across divisions. This had a number of indicators to monitor outcome performance. At the time of the inspection it was in the process of developing its information system to provide more robust data on individual team performance.

Outcomes for people were also assessed through use of a range of multi-disciplinary assessment tools to monitor people's progress and promote their recovery. These included: Health of the Nation Outcome Scale (HoNOS), Model of Occupational Screening Outcome Tool (MoHOST), the Recovery Star and a range of specific psychological assessments. The tools were used to assess people's social, psychological, occupational and physical needs and progress. However; we found the wards were at different stages of fully embedding some of these in practice. The trust had recently developed a challenging behaviour care pathway which they were rolling out to all staff.

The trust provided information which showed they had achieved their target of completing 90% of psychological assessments within 12 weeks of people being admitted to the service.

The trust draft Quality Account 2013-14 said that during 2013-2014 the trust was not eligible to participate in any national clinical audits. There was a nil return for the trust response to the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness covered by NHS services that the trust provides.

There were 28 local clinical audits reviewed by the provider in 2013-2014. All of the trust's clinical audits were said to be presented to, and reviewed by the multidisciplinary Clinical Audit Committee. Selective reports are presented to the Quality Committee (as a subcommittee of the trust board) and provide the assurance that quality issues are being addressed at board level.

We found there was a lack of locally driven audits or bench-marking taking place on all the wards we visited. There were no qualitative audits of care records, cleaning schedules or medical equipment which took place on the wards. It was therefore difficult to measure performance improvement locally or across services.

We saw that data about the use of physical interventions was compiled centrally but not routinely available to frontline staff for individuals or for the whole ward group

The trust took part in the Quality Network for Forensic Mental Health Services review cycle in January 2014. The peer-review process by the Quality Network for Forensic Mental Health Services included an action plan for the Trust to complete its recommendations by 2015 and 2016.

We saw that each person had a care plan. These were written and reviewed, where possible, with the involvement of the person. The care plans we looked at were centred on the needs of the individual person and demonstrated a knowledge of current, evidence based practice.

Most of the care plans we saw were not in a format accessible to the individual and most people we spoke with did not have a copy of their care plan, however most people had an activity programme. Some of the wards were in the process of implementing pictorial care plans for people who had difficulties understanding written text, however this had not been fully embedded in practice.

Each person had a relapse prevention plan providing specific details of interventions, which should be put in place if the person's mental health deteriorated, to prevent a relapse of their illness. We found evidence to show that some people were involved in developing their plan with staff.

Are services effective?

The service had good facilities on-site which people from all the wards could access dependent upon their risk assessment and care plan. These included a gym, all-weather pitch and football field, art room, gardening, private meeting rooms, a child visiting room, a multi faith room and assessment kitchens.

The trust provided us with evidence that the low and medium secure services had completed the self and peer-review parts of the Quality Network for Forensic Mental Health Services eighth annual review cycle in January 2014. The Quality Network reviewed services against criteria which had been developed from the Best Practice Guidance: Specification for adult medium-secure services, Department of Health 2007.

The peer-review process by the Quality Network for Forensic Mental Health Services included an action plan for the Trust to complete its recommendations by 2015 and 2016. As a result of this information we concluded the Trust was open to external scrutiny as a means of improving practice and the treatment and care of people that used the service.

Skilled staff to deliver care

The trust employs a range of mental health disciplines who provided input to the ward including occupational therapists, psychologists, social workers, pharmacists.

The speech and language therapy (SALT) service was provided by Lancashire Care NHS Trust under a service level agreement which provided a 1.2 whole time equivalent staff. Provided by four part-time members of staff.

We were concerned that the speech and language therapy team told us that they are not aware of how many people need augmented communication tools in the hospital and are not aware of how many staff have been trained in the use of such communication tools as Makaton or British Sign Language. A dysphagia (swallowing problems) audit, completed in February 2014 had not been followed up and there was no record of any of the recommendations has being implemented.

The trust clinical supervision audit identified that staff were being supervised and supervision sessions are recorded. The trust had recently introduced a new supervision process with support from University of Central Lancashire this was being rolled out to staff at the time of the inspection.

Staff told us they had regular supervision and this included clinical and managerial supervision. The trust provided information that identified clinical supervision had recently reached 89% of staff but for the preceding six months had been at just below 70%. This also identified that only 73.5% of staff in band 6 and below had received an annual appraisal.

The learning and development team monitor the uptake of appraisal and supervision within the services; this is included in the trust's dashboard. Each service manager can see performance on this issue at each ward or unit level. This dashboard is also presented at trust board meetings with supporting action plans where required.

Since December 2012, seven doctors have been revalidated with no deferrals or non-engagement.

The trust delivered and monitored a programme of mandatory training. For example 83% of staff had completed infection control training and 84% had completed safeguarding adult training. We found that there were gaps in specific training regarding people's individual needs which had not been completed. In one service where people had a risk of choking and had no verbal language we found that of the 47 staff only two staff had had Makaton training, Also only 58 members of staff had completed training in how to manage epilepsy. At Moor Cottage, staff had not completed their training on the Mental Capacity Act or the Mental Health Act 1983.

The trust had recently completed a training needs analysis, which included a number of training requests from staff for development and job specific training. This was to be finalised and presented to the Director of Strategy for consideration and would then be implemented.

Managers were able to track whether staff had completed their mandatory training; those staff we met confirmed they had received mandatory training. It was also acknowledged there had been a lack of MCA training, but this was being addressed by the trust.

The trust used specialised computer software (Carenotes) for people's health and care records. However during our inspection we found some staff were unable to demonstrate how to use the system. This left staff uninformed about people's care needs.

The staff we spoke with individually and in our small focus groups told us that they had access to a range of training

relevant to their roles and they felt well supported by their local managers. We also saw evidence on wards and by staff electronically that staff were recording their e-learning, competency based training books and recording their attendance at training so their individual electronic staff record was kept up to date.

Multi-disciplinary and inter-agency team work

People who used the service told us they attended part of their MDT meetings, some told us how they were able to contribute to these meetings. We attended six MDT meetings, staff confirmed meetings were held every week and generally people were reviewed every month. We found participants in the meetings were the responsible clinician, ward managers, nursing staff, occupational therapists, speech and language therapists, psychologists and advocates and people were invited to attend the meetings to discuss their care and the decisions made involved the team.

Adherence to the MHA and the MHA Code of Practice

At the time of the inspection 216 patients at were detained under the Mental health Act 1983.

Records showed the principles of the Mental Health Act 1983 Code of Practice had not been applied consistently across locations and within units.

We found the following areas of concern:

- Copies of section papers could not be found for some patients within the electronic record.
- Out of date section 58 authorisation stored with the current authorisation.
- Patients who had their treatment authorised by a form T2 (certificate of consent to treatment) did not have a form T2 completed by their current responsible clinician (RC) but from a previous RC.
- No capacity assessments in relation to treatment for mental disorder from the current RC.
- We found T3 (certificate of second opinion) forms not stored with the medication chart.
- Delays in doctors attending the ward when seclusion had been implemented.
- Medication prescribed and administered not included on the form T3 (certificate of second opinion) authorisation.
- A patient with both form T2 (certificate of consent to treatment) and T3 (certificate of second opinion). It was unclear to the staff which form was authorising treatment.
- Ward staff unclear who authorised treatment where the RC was not a doctor.
- Out of date section 58 authorisation stored with the current authorisation.
- A patient without any authorisation in place for their treatment.
- Missing details in the records explaining the reason why restraint or seclusion had been used.
- Incomplete records of observations made whilst the patient was being restrained or secluded
- No recording of de-briefing for both patients and staff after restraint or seclusion had ended.
- Ineffective systems to scrutinise detention papers.
- Lack of board oversight of its duties in relation to the Mental Health Act
- Out of date information being given to patients regarding their right whilst detained.

The Trust had a Mental Health Act 1983 legal documents grading system to monitor when Mental Health Act 1983 legal documents were due to be renewed.

We found evidence across the services that people had access to mental health tribunals and their legal representation was recorded.

On the wards inspected we saw that a second opinion appointed doctor (SOAD) had seen people where appropriate authorised to treatment to be administered.

We spoke with staff about private telephone facilities at Gisburn Lodge. A staff member told us that patients could make telephone calls in one of the offices in private but then said staff had to stay in the room with them. The staff member said this included telephone calls to legal representatives. We brought this to the attention of the ward manager to action.

We noted at Woodview that following a recent Mental Health Act monitoring visit that some recommendations were made about the completion of documentation. We saw the recommendations had been implemented and a copy of the action plan was available in the audit of Mental Health Act documentation.

We reviewed records and held discussions with members of the executive team and non-executive directors. From

these it was identified that there was no Trust wide oversight and scrutiny of the Mental Health Act 1983. Overall, staff spoken with did not demonstrate a good understanding of their roles and responsibilities under the Mental Health Act. The training programme for the Trust was reviewed and it identified that limited training was provided to staff with regard to the Mental Health Act 1983 and the Mental Capacity Act 2005.

One patient record looked at showed that the person using the service had been moved between units. There was no evidence on the patient's record that their rights been explained and discussed with them. We asked a member of staff to view the renewal notice for the patient's continued detention under the Act. The member of staff was unable to find it and had no understanding of the need for this document. Patient rights and information leaflets, that were shown to us on the ward related to the Mental Health Act before the Act was amended in 2007.

Mental Health Act administrators did not have an effective system in place to effectively scrutinise the renewal of a patients section. We saw a patient who had their section reviewed by a nurse consultant who is a responsible clinician. A second nurse counter signed the detention documentation. This means the same discipline had signed the renewal documentation; this makes the detention invalid. This was not picked up by any of the trusts' internal monitoring systems. The trust took immediate action once this had been highlighted to them.

There was no board level monitoring or scrutiny of the functions of the Mental Health Act. There were no systems in place such as a Mental Health Act steering group to determine if the application of the functions of the Act were applied using the guiding principles as detailed in the Code of Practice. This was recognised by the board and there was a plan in place to address this shortfall.

The Trust had eight associate hospital managers. It is the hospital managers who have the authority to detain patients under the Act. They have the primary responsibility for seeing that the requirements of the Act are followed. In particular, they must ensure that patients are detained only as the Act allows, that their treatment and care accord fully with its provisions, and that they are fully safeguarded through this process.

Good practice in applying the Mental Capacity Act (MCA)

We found that in most care records we reviewed, showed that staff had considered consent to treatment and had assessed mental capacity and that the multi-disciplinary team had been fully involved in discussion of best interest decisions. However not all care records contained a recent assessmment of mental capacity and we found two cases where the best interest decision had been made before the mental capacity assessment had been recorded.

Are services caring?

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

Summary of findings

Kindness, dignity, respect and support

- The great majority of people who use services that we talked to, or who completed comment cards, told us that they were treated kindly and respectfully by staff. The care interactions that we observed supported this.
- We observed staff knocking on the doors of bedrooms before entering.
- We observed staff responding compassionately to people experiencing emotional distress in a timely and appropriate way.

The involvement of people in the care they receive

- Overall, people were offered the opportunity to be fully involved in all aspects of their care and treatment. People who use services routinely attended the multi-disciplinary meetings. This was facilitated by the 'my ward round- things to talk about' document that supported people to express their needs and wishes.
- However, most of the care plans we saw were not in an easy read format and most people did not have a copy of their care plan.
- All wards had community meetings.
- People who use services told us that staff supported them to make choices about their day to day lives.
- Patients were involved in the wider management of the ward or trust. This included as members of a media club, as contributors to a user led newsletter, in the recruitment of new staff and as representatives on project groups.
- The service had an on-site advocacy service. The majority of people we spoke with were aware of the service and how they could access it.
- As part of the inspection process we made telephone calls to family members. During these calls we were told by Family carers that an area for improvement is the involvement of family members in the care and treatment of their family member.

Our findings

Kindness, dignity, respect and support

The majority of people we spoke with told us that staff treated them with respect and dignity. We also received many positive comments from people regarding staff's attitude towards them in the comments boxes which we left on all the wards during our visit. People said that they could approach staff with any issues they had and that staff treated them with respect and care. One person told us, "Staff are brilliant, can't complain about the regular staff, but I won't talk to the agency ones if I need to talk as they don't know me and I won't trust them like the regular staff". Another said "It's better now, as I wanted to go back to prison, but I have changed my mind as it might work for me". One person told us, "Everything is excellent." Another person said, "I like Calderstones because they have treated me with respect and dignity in every way. The staff always listen to me and respond nicely."

People told us that they felt involved in their care and treatment and had good access to advocacy services. We also received many positive comments from people regarding staff's attitude towards them in the comments boxes which we left on all the wards during our visit.

Throughout our visit to the wards, we observed staff speaking with people who used the service in a respectful manner. People appeared comfortable and relaxed in the presence of staff. We saw that staff respected the confidentiality of people at all times.

Patients told us that staff respected their privacy and dignity. One person told us that staff always knocked on their door before entering their bedroom. We observed staff knocking on people's bedroom doors throughout our visit to the wards.

We observed that confidentiality was respected at all times when delivering care, in staff discussions with people and those close to them and in any written records or communication.

Are services caring?

We observed staff responding compassionately to people experiencing emotional distress in a timely and appropriate way. We observed the person later that day and saw they appeared to be relaxed and were visibly laughing and interacting well in activities with staff outside.

People in the forensic service could have access to their own room keys subject to risk assessment. People had access to their bedrooms and during the day if needed.

The service had an, 'Observation and Engagement' policy which required staff to check the welfare of people within specific time limits dependent upon their clinical risk. We saw that bedroom doors had window vision panels that could be opened or locked by staff. This meant that staff did not have to disturb people during the night by opening their bedroom door when carrying out observations.

We found evidence to show that people had access to therapeutic interventions and groups which were focussed on assisting people to develop ways to cope with their emotions, mental health awareness and healthy lifestyles.

The involvement of people in the care they receive

Overall, we found some good examples of how people had been offered the opportunity to be fully involved in all aspects of their care and treatment. Care and treatment was delivered under the framework of the Care Programme Approach (CPA). This is a particular way of assessing, planning and reviewing someone's mental health care needs. People we spoke with told us they had the opportunity to attend reviews about their care. We found evidence to show that people had CPA review meetings. Most people told us staff involved them in their care and treatment. People met regularly with staff took part in the MDT meetings. We were told about ward meetings and the issues raised were responded to.

We found the service involved people in a number of initiatives within the ward and at trust level. These included a media club, a user led newsletter and the recruitment of new staff at all levels. Some people we spoke with told us they had been involved in interviewing new staff and had received support from staff to do so. People also took lead roles within the unit. For example; there were representative roles for a variety of subjects. People could be a representative for the gym, library or on project groups. This meant that people took responsibility for ensuring for example the library was refreshed and the inventory of books, cd's, DVD's, audio books and computer games was up to date and organised. People told us there was an application process to go through to be a representative and this was taken seriously and included an interview.

There was good access to advocacy services and often advocates would support people at MDT meetings.

Some wards had welcome packs for people who were admitted to the wards which helped to orientate them when they first arrived and information was provided to people before they were admitted to the wards. The pack gave details of the services anti-bullying code of conduct in addition to the contact numbers of a range of external organisations people could contact for support or advice. This included the Care Quality Commission and Advocacy services.

We found some examples which demonstrated that staff took account of people's views to influence how their care and services were planned and delivered. People told us they attended Community meetings on all wards. People we spoke with told us that in general, they felt staff listened to them and responded to them in a timely manner. One member of staff told us that they had changed one of the unisex toilets in the therapy centre into a female only toilet following feedback from people who used the service.

We were told how people had opportunities to be involved in developing their care plans and attending reviews of their care. We found evidence which showed that people's family, friends and advocates were involved in people's care as appropriate and according to the person's wishes.

As part of the inspection process we made telephone calls to family members. During these calls we were told by Family carers that an area for improvement is the involvement of family members in the care and treatment of their family member.

During the interviews we were also told the following

- One family told us that they are aware of the discharge plan and been involved in creating it but do not know of any timescales relating to the plan.
- Another family member told us that activity plans are completed in advance.
- One person told us that there is incorrect information recorded in the care plans for their family member.
- A family member has asked for a weekly call but in 9 weeks they have only had 3 calls.

Are services caring?

- One person told us that activities are used a reward.
- One family told us that they had a long poor relationship with the ward staff relating to communication and alleged staff focus on their workloads rather than on the needs of the patients.
- One family member told us how their family member's behaviour had deteriorated because it was taking too long to source alternative accommodation.
- Another family member told us of the difficulties obtaining funding, over three years.

Other family members expressed positive outcomes these included:

- Family members who explained how they had been involved in the planning of care and felt part of the team
- We were told how much one family members had progressed during their time at Calderstones
- One family member told us that their relative had been very unhappy when they to Calderstones but now they are happy and progressing.

We saw that people had been involved in the NHS England 6 C's (Compassion in Practice is the new three year vision and strategy for nursing, midwifery and care staff) for improving people's experience of care. People said these were useful prompts to explain their goals when attending their CPA or multi-disciplinary meetings

People told us they were supported and encouraged to maintain relationships with their relatives and friends in the community; we observed people leave the ward to visit relatives. However we did find examples where contact with relatives had not been pursued or where more could have been done by staff to support the relationship with family members. We were told people were actively supported to have relationships and friendships with other people.

The service was responsive in meeting the needs and supporting people of the lesbian, gay, bisexual, and transgender (LGBT) community. We were told there was a group called AVENUE

We saw that people had been involved in the NHS England 6 C's for improving people's experience of care. People had designed posters around the 6C's. People had also made visual model representation models of their personal therapeutic goals. People said these were useful prompts to explain their goals when attending multidisciplinary meetings.

People had access to advocacy, translation services and the Patient Liaison Advice Service (PALS). The majority of patients we spoke with were aware of the service and how they could access it.

Where appropriate people were supported to stay connected to their family, friends and community, so that they did not become isolated and disconnected. Visitors were encouraged and supported with visiting times that suited them, with staff available for discussions in a private space if necessary. We were told people were actively supported to have relationships and friendships with other people. We were given an example of one person who visited their girlfriend on a weekly basis and how they went for walks together and had lunch at the local canteen with supervision from staff. We were told by another person that they had an individual arrangement in place for visiting their companion once a month which was not affected by staff availability.

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

Access, discharge and bed management

- Care programme approach meetings, at which discharge planning is discussed with staff from local services, took place at the interval required by the trust policy.
- In January to March 2014, the trust had identified eight people whose discharge had been delayed.
- Although the trust was developing formal care pathways leading to discharge, we did not find evidence that these were in place at the time of the inspection.
- In the forensic service, patients followed a care pathway that usually involved them moving from medium secure unit to a low secure unit to a step-down ward before being discharged.
- Staff told us that delays in discharging people sometimes resulted in the pathway being blocked due to beds in lower dependency settings being full.

Ward environments that optimise recovery, comfort and dignity

- Although many of the wards are located in old buildings, the wards had a range of rooms and facilities to support people's individual treatment and care needs.
- Most wards gave people had access to outside space that was sheltered from view. However the garden at Maplewood 1 was poorly maintained.
- At Woodview, internal doors and external windows in communal areas, quiet rooms, bedrooms and corridors could be overlooked by people using the external garden or recreational areas. There was no privacy screening on any of these windows. Although one of the panels looking into the female accommodation on Woodview 1 had been fitted with a frosted screen, men on an adjacent ward could still look into the ward.
- None of the forensic wards had a phone to which patients had easy access. Staff told us that people could use a portable telephone unit, which could be taken into the ward area or use a cordless telephone to make/receive calls dependent upon personal restrictions.

Ward policies and procedures minimise restrictions

- The wards applied different rules to use of mobile phones by people who use services and the decision about a person's access to a mobile phone was not always taken on the basis of an individual assessment of risk.
- At Pendle Drive there were blanket restrictions relating to the use of phones, the locking of bedroom doors during the day and the locking of kitchen doors and cupboards.
- In the low secure units, staff subjected all patients to a pat-down search upon return from unescorted leave. This practice was not based on an individual assessment of the risk posed by each person. Staff told us that consenting to this search was a condition of patients being allowed leave. We considered that this practice constituted a 'blanket policy' and was not in line with the MHA Code of Practice.

Meeting the needs of all people who use the service

- People's religious beliefs were supported through access to the multi faith rooms available on the different sites or through visits from spiritual leaders at their request.Religious calendars recording all the important dates and festivals of the various religions were displayed in the wards.
- People had access to interpreting and on site advocacy services if necessary.
- Written information that enabled people to understand their care was available across the service. This included information in different accessible formats.

Are services responsive to people's needs?

- We made telephone calls to family members. During these calls we were told by Family carers that an area for improvement is the involvement of family members in the care and treatment of their family member.

Listening to and learning from concerns and complaints

- Staff on most wards provided people with information about how they could raise complaints or concerns and most people told us they felt able to raise any concerns and were confident that they would be listened to.
- Pendle Drive was an exception. Here, there was no information available on the ward on how to complain and the patients that we spoke with told us they did not know how to complain.
- The wards actively sought feedback from people through the use of a suggestion box and regular community meetings. Ward meetings had a set agenda which included complaints and feedback. Minutes of the meetings were available for people to look at on the ward.
- We examined a sample of complaints and found that all investigations had been completed within the prescribed timeframe.
- Staff described changes that the wards had made in response to feedback from people who used the service.
- The provider had a complaints system which could monitor trends across wards.
- One person told us that, when they had not been satisfied with the response to a complaint they had made, the chief executive had visited them to discuss the complaint and it was then resolved to their satisfaction.

Our findings

Access, discharge and bed management

Calderstones NHS Foundation Trust had an established pathway through the secure services and into step down and enhanced support.

The forensic care pathway included medium secure, low secure, 'Step down' services or in some cases, return to prison. In a focus group we were told due to the some people's risk history, legal restrictions and the availability of appropriate accommodation to move on to being available; it was difficult to move people through the pathway. This meant that people sometimes remained at a level of restriction not required to meet their needs.

The step down or high dependency services visited and were generally flats or houses. Staff described people using the service as moving towards discharge into the community but recognised progress had been slow and sometimes delayed.

The provider explained that people using the service may be moving from medium secure to low secure and then to step-down and enhanced services. When this was compared with other providers each move through the service may be counted as a new episode of care. At Calderstones this is not the case and the length of stay remains aggregated.

The provider also identified that discharge may be delayed due to factors beyond the control of the trust and these include a lack of suitable community placements and a lack of a community responsible clinician (RC) availability.

There was a weekly meeting which looked at capacity and flow across all services at Calderstones. Trust data relating to people delayed from discharge showed there were eight people who were classified as being delayed from leaving the service in January, February and March 2014.

We were told of plans to develop two care pathways. The first would be a slower stream for people whose behaviour challenged or people with autism, this would span 2 to 5 years. The second would be a forensic rehabilitation pathway lasting for 2 years. We saw no evidence of this work in action during the inspection.

The wards which were considered step-down wards, North Lodge, Trentville and Scott House, we found there were restrictive practices which may have prevented peoples' rehabilitation.

The provider had a procedure for new referrals to the services, which covered emergency and planned admissions.

We found that some patients had spent a significant time in hospital. The trust submitted data about the length of stay as of 21 May 2014 this shows that 43% of patients had a length of stay of over 5 years.

Are services responsive to people's needs?

Length of Stay: 1-30 days; No. of patients: 3

Length of Stay: 31-60 days; No. of patients: 1

Length of Stay: 61-120 days; No. of patients: 6

Length of Stay: 18-26 weeks; No. of patients: 3

Length of Stay: 27-52 weeks; No. of patients: 13

Length of Stay: 53-104 weeks; No. of patients: 26

Length of Stay: 0-3 years; No. of patients: 27

Length of Stay: 3-4 years; No. of patients: 34

Length of Stay: 4-5 years; No. of patients: 11

Length of Stay: over 5 years; No. of patients: 92

The trust also submitted length of stay data relating to people discharged in the last 12 months. The data showed that of the 29 discharges, 45% had a length of stay of over five years. The data submitted did not break down as to the numbers of people discharged were from the low or mediums secure services.

Length of Stay: 1-30 days; No. of patients: 0

Length of Stay: 31-60 days; No. of patients: 0

Length of Stay: 61-120 days; No. of patients: 1

Length of Stay: 27-52 weeks; No. of patients: 0

Length of Stay: 31-60 days; No. of patients: 0

Length of Stay: 53-104 weeks; No. of patients: 3

Length of Stay: 0-3 years; No. of patients: 5

Length of Stay: 3-4 years; No. of patients: 3

Length of Stay: over 5 years; No. of patients: 13

The data supplied by the trust relating to delayed discharges covered the period January to March 2014. This showed that for each of the three months there were eight delayed discharges. From the information provided we could not conclude if the transfer of people to low secure, rehabilitation or discharge form the service was proactively responding to people's needs .

The service accepted patients referred from the prison service, other NHS and independent low and medium secure services, psychiatric intensive care units (PICU) and acute wards. Staff we spoke with told us that the ethos of the hospital had changed over the past two years with the forensic services moving to a recovery focussed model.

We were told that in the last six months two people had been discharged directly from the Woodview medium secure service without the need to progress through step down services..

At the time of the inspection all but one of the patients were detained under the Mental health Act 1983. A significant proportion of the population of people receiving care at Calderstones (64%) have been detained on Part 3 sections of the Mental Health Act. Part 3 of Mental Health Act deals with patients who have been involved in criminal proceedings. This means that their care pathways have been identified due to an increased level of risk. This means that these people will often pass through the levels of security within the hospital before being considered for discharge.

A number of people (29%) are detained on restriction orders. A further 14% are sentenced prisoners who have been transferred from prison because they need time in hospital for treatment of a serious mental health problem.

A small group 13% of the patients were sentenced prisoners who were moved from prison to hospital because, on the advice of two doctors, the Secretary of State decided that they needed to spend time in hospital to have treatment for a serious mental health problem.

For 6% of the patients a court had convicted them but not yet decided a sentence. The reason for this was that two doctors advised the court that they may have a mental health problem which requires treatment in hospital.

For those 48% of the patients at Calderstones the Ministry of Justice have to approve their discharge from hospital.

Staff we spoke with in our small focus groups and individually told us that due to the nature of some people's risk history, legal restrictions and appropriate accommodation being available; it was sometimes difficult to move people on from the wards into a less restrictive environment even if this had been identified as clinically appropriate to meet their needs'. This meant that people could sometimes remain on a low or medium secure ward for longer than needed.

Are services responsive to people's needs?

We found that staff could describe the process how people moved towards discharge into the community but found some discharges had been delayed. The trust identified that there were often difficulties moving people out of hospital due to their previous risk history, restrictions placed upon them or their specialist need requirements. Staff we spoke with explained how they took great care to ensure that people were discharged to appropriate accommodation which could meet their needs. The discharge process included staff supporting people during the transitional period from the ward to community based accommodation to reduce the risk of relapse.

The trust did not supply delayed discharge information as requested by CQC. However they did supply some data for January to March 2014. This showed that for each of the three months there were eight delayed discharges.

The Department of Health publishes monthly data relating to Delayed Transfers of Care across 243 acute and non-acute NHS trusts, including both the number of delayed days and the number of patients who experienced a delayed transfer of care each month. For Calderstones this identified that between April 2013 and February 2014, the number of delayed days was between 28 and 62 per month, with no more than one or two patients experiencing delays per month.

However, in March 2014 the number of delayed days sharply increased to 284 (10 patients with delays). This continued into April 2014, albeit slightly decreased to 216 delayed days (8 patients with delays).

One person who used the service told us they had a 'moving on' plan and were working towards discharge; others said they were involved in discussions about moving on but not sure when this would happen.

We found that one patient had experienced their discharge being postponed on four occasions. We were informed that this was due to the move on placement insisting that Calderstones retain responsibility to provide care in case the patient required to be recalled to hospital.

We saw that discharge planning was included as part of the Care Program Approach meeting however we were told by staff that they thought discharge planning and preparation was 'weak' and that ward round discussion outcomes did not always get to front line staff with the speed and clarity it should. There was evidence that staff were not aware of discharge plans and any of their interventions which may be preventing people from working towards discharge.

The trust had a procedure for new referrals to the services, which covered emergency and planned admissions.

The ward environment optimises recovery, comfort and dignity

We found that although several of the ward were located in old buildings, the wards had a range of rooms and equipment to support people's individual treatment and care. North Lodge, Daisy Bank, Pendle Drive, and Trentville where people were nearer to discharge, the wards were semi-detached houses with communal living.

We found on all wards that people were not able to access a telephone at all times and there were no direct telephone facilities available in the secure services. The trust policy also did not allow any mobile telephones within the clinical areas. Staff told us that people could use a portable telephone unit, which could be taken into the ward area or use a cordless telephone to make and receive calls dependent upon personal restrictions. At Gisburn Lodge patients could make telephone call in one of the offices but staff had to stay in the room with them.

We found that there was a blanket restriction on the use of phones and access to the kitchen at Pendle Drive, creating a higher level of restriction than should be required in a community based setting; these restrictive practices were not in line with the intention of moving people on.

We were told that all patients had access to Skype but we found differences across the wards in people's access to Skype. This was related to the ward environments and availability of facilities rather than people's clinical need.

The low secure services had an IT room fitted with computers however; these were not connected to the internet. We were told by managers that the trust was addressing this. We found there were differences across the wards in terms of people having access to Skype, access to phones and internet access. This was related to the ward environments and availability of facilities rather than people's clinical needs'. This inequity meant that some people had more limited opportunities to use technology to keep in touch with friends and relatives.

Are services responsive to people's needs?

There was outside space for recreation and people had opportunities for fresh air daily. Each ward had a garden area although the garden area on Maplewood 1 required attention. There were thistles and nettles in the raised beds which could cause discomfort to a person who came into contact with them. The service had extensive grounds which people could walk around.

A common theme throughout most wards visited was in relation to the food quality. The majority of people we spoke with told us the food was not good. Staff we spoke with said they used to cook people's food on the wards however; that food was now cooked centrally on site. Staff said this was to ensure that people could have a wider choice and to make sure that people's specific dietary needs' were being met. Managers we spoke with told us that the food provision within the hospital was currently being reviewed and they were aware of the issues people had raised in relation to this.

We found that on Woodview Internal doors and external windows in communal areas, quiet rooms, bedrooms and corridors could be overlooked by people walking around the perimeter or looking through internal doors between the flat areas within wards. There was no privacy screening on any of these windows. Although one of the panels looking into the female accommodation on Woodview 1 had been fitted with a frosted screen, men on an adjacent ward could still look into the ward.

Ward policies and procedures minimise restrictions

We were concerned about the use of routine pat down searches which were not based upon individuals' risk assessments in the low secure services. We were told by staff that the patient had to consent to having a pat down search each time they returned from any period of unescorted leave. There was a room designated for these searches at the entrance to the building. The trust had a policy; 'Searching of Service Users/Patients, their Belongings and the Environment' dated 1st July 2014 which provided guidance for staff on how to conduct such a search. It did not however; specify in the policy that routine pat down searches should be undertaken.

We asked several staff what would happen if a person refused to provide consent. One member of staff told us that people had been unhappy about the procedure and had refused to go on unescorted leave. However; they told us they had, "Got used to it now." Other staff told us that if a person did not consent to being searched, then they would not be allowed leave as this was a condition of their leave. This practice constituted a, 'Blanket policy' and was not in line with the Code of Practice guidance which states:

16.15 Consent obtained by means of a threat, intimidation or inducement is likely to render the search illegal. Any person who is to be searched personally or whose possessions are to be searched must be informed that they do not have to consent.

As consent is only applicable at the time that it is given, we asked staff what processes they would follow if a person refused to consent when they returned from leave. Staff were not clear about this nor were they clear about the rationale for conducting searches of people returning from unescorted leave.

The wards applied different rules to the use of mobile phones by people who use the service and the decision about the level of access was not always based on individual assessment of risk.

We found that there was a blanket restriction on the use of phones, the locking of bedroom doors during the day and access to the kitchen at Pendle Drive.

Meeting the needs of all people who use the service

We received positive feedback that staff meet people's spiritual needs. People told us they were supported to access the multi-faith rooms in the therapy department or arrangements would be made for a spiritual advisor to visit the ward.

There were religious calendars recording all the important dates and festivals of the various religions displayed in ward areas.

Some staff had attended an Equality and Diversity event on the 4 March 2014; the purpose of which was an opportunity to focus on the trust's performance on equality and diversity in the previous 12 months. Five people who used learning disability services attended this event.

We saw evidence that religious calendars recording all the important dates and festivals of the various religions were displayed in the wards. These had been developed by people that used the service.

Written information that enabled people who used the service to understand their care was available across the

service. This included ensuring people had access to information in different accessible formats. People had access to interpreting and on site advocacy services if necessary.

We received positive feedback from patients who told us there were a variety of activities they could participate in for developing their daily living skills. We found people were actively engaged in activity planning through ward meetings, patient council and individual activity planners. People told us there was a good balance between activities and psychological therapies but some people within the medium secure services said they would like more opportunity for "rehabilitation" for preparation to step down to low secure facilities. People said links between occupational therapy and nursing staff were effective. We saw and observed people had opportunities for therapy and recreation and relaxation. We saw a detailed activities board and were told these regularly took place. People and staff told us that encouragement was given to people to attend activities available.

We spoke with people and staff about access to treatment off site. We were concerned that a person on the Woodview site had their eye treatment delayed because the person did not wish to be taken off site in handcuffs, which was a policy used by the trust and approved through the Ministry of Justice. The person had refused on the grounds that this was not in keeping with their Human Rights. We were told that alternative arrangements were being looked into by the ward manager, but treatment was delayed.

The service was responsive in meeting the needs and supporting people of the lesbian, gay, bisexual, and transgender (LGBT) community. We were told there was a group called AVENUE where people were fully supported to attend. We were told the group celebrated LGBT history month and people were supported to participate in speaking at events. A member of staff told us about a person who had spoken at an event where they described what it was like for them to be gay and have a learning disability and the impact this had on them to form relationships.

Listening to and learning from concerns and complaints

We found information available to assist people to raise complaints or concerns about the ward.

We saw that people were provided with information about how they could raise complaints or concerns about the ward they were staying on. The wards actively sought feedback from people through the use of a suggestion box and the regular community meeting. There were minutes of the meetings available for people to look at on the ward complaints and feedback from people who used the service were standing items on the agenda.

Each ward held weekly 'Service development' meetings local complaints were discussed routinely at these meetings.

One person told us how the Chief Executive had visited them to discuss the complaint and it was then resolved to their satisfaction. The person told us, "It showed me how seriously they took my complaint when the Chief Executive came to see me".

Where people had complained or raised a concern they felt the trust had responded and they told us about changes made as a result of complaining. People had been supported to use the computer to complain.

Overall, people told us they felt able to raise any concerns they may have with staff and had confidence they would be listened to. The service had an established Patient Advice and Liaison Service (PALS) available. However, at Pendle Drive there was no information available on the ward on how to complain and all the people we spoke with told us they did not know how to complain

The complaints manager co-ordinates the investigation of complaints and independent managers are appointed to investigate. We examined a sample of complaints and found they had been completed within the appropriate time frames stated within the policy. There were quarterly meetings with people who used the service and staff to look at common themes and to learn lessons from complaints and concerns.

We saw that the provider had a complaints system which could monitor trends across wards.

From the data submitted by the trust in the excel spreadsheet, as requested by CQC, 100 formal complaints were made to the provider in the period April 2013 to April 2014. 32 were upheld. Complaints were received for 22 different wards or teams. There were 10 or more complaints for two service areas. Scott House there were 12 and none upheld, 5 West Drive 10 and four uphel.

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

Vision and values

- Many of the trust board members, including the chief executive and chair, were relatively new in post.
- In early 2014, the trust had adopted a vision of 'changing lives through excellence'
- The board had agreed a set of values and we found these displayed on wards throughout the trust.

Good governance

- The board assurance framework and risk register showed that the trust had identified many of the risks that were revealed by our inspection.
- However, our findings showed that some of the trust's governance systems were not effective. This is demonstrated by:
  - a failure to maintain clean ward environments and to fully implement infection control procedures,
  - patchy medicines management procedures,
  - a failure to recognise and address unsafe night-time cover on some wards located away from the main hospital,
  - a lack of awareness of and failure to follow trust policies relating to seclusion, segregation and restraint,
  - a failure to provide adequate training for staff in the skills required to meet the specific needs of the patient group cared for at Calderstones.
- We found that there was no board level monitoring of the Mental Health Act. This, together with the many failures of governance of the application of the MHA, is of particular concern because every patient but one is detained under the Act.
- Some aspects of governance were working better; including:
  - procedures for receiving, investigating and acting on complaints from people who use services,
  - procedures for reporting and analysing incidents,
  - systems for monitoring the provision of mandatory training, supervision and appraisal.

Leadership, morale and staff engagement

- Despite the challenge cause by high vacancy rates, staff at Calderstones told us that they were proud to work for the trust and felt supported by their managers
- The work by board members to engage with staff, for example through the 'big conversation' and 'Big Birthday Breakfast', had succeeded. Front-line staff reported that the executive team were visible and approachable and that they felt there were effective two-way channels of information between the ward and the board.
- Ward managers attended a weekly service development meeting,
- Staff were aware of internal external whistleblowing policies and felt comfortable raising concerns with their managers.

Commitment to quality improvement and innovation

- The trust had recently introduced a performance dashboard and a quality and safety assurance form. However, information derived from this was not always fed back effectively to front-line staff.
- Ward staff participated in few clinical audits that were directly relevant to their clinical work.
- Observation of practice, review of records and what people told us demonstrated the wards were proactive in their approach to gaining feedback from people who used the service through ward meetings, speak up groups organised by the occupational therapy department, patient advice and liaison service and advocacy.
- The low and medium secure units all participate in the Royal College of Psychiatrists' quality network for

Are services well-led?

forensic mental health services; which facilitates standards-based self and peer-review assessments The trust had as a participating services produced an action plan to address standards that are not met.

Our findings

Vision and values

Many of the trust board members , including the chief executive and chair, were relatively new in post and since appointment the trust has made some significant changes to the leadership of the organisation.

In early 2014, the trust had adopted a vision of 'Improving lives through excellence'. To support this the board had agreed a set of values and we found these displayed on wards throughout the trust.

We found that the directors understood their roles and duties effectively. Whilst recognising that the trust had to make a series of significant changes to ensure that the care delivered was high quality and to develop systems that provided assurance of this.

We found that the provider's strategy was accessible on their website. On each of the wards visited we saw posters with information about the trust's values and outcomes. All staff we spoke with told us they had the opportunity to be involved in the 'Big conversation' organised by the trust which involved discussing future developments and the direction of the trust. However; not all staff we spoke with knew about the trust's strategy although they understood and were able to identify the trust's values.

The trust supplied their Board Assurance Framework (BAF) dated April 2014 – March 2015. This indicates that some important strategies (estates, engagement with commissioners, commercial, workforce) are not yet not in place. There were 24 board level risks identified. For each risk it details the executive owner, key controls, gaps in control, where assurance will come from and gaps in weakness in assurance.

All of the staff we spoke with told us that they felt proud working for the trust and in their individual wards. They recognised the challenges of working with people with complex needs, management and staff changes and the introduction of new care pathways.

Good governance

We saw that there was systems in place to identify risks. The board assurance framework and risk register showed that the trust had identified many of the risks that were revealed by our inspection. However, our findings showed that some of the trust's governance systems were not effective. This is demonstrated by:

- a failure to maintain clean ward environments and to fully implement infection control procedures,
- patchy medicines management procedures,
- a failure to recognise and address unsafe night-time cover on some wards located away from the main hospital,
- a lack of awareness of and failure to follow trust policies relating to seclusion, segregation and restraint,
- a failure to provide adequate training for staff in the skills required to meet the specific needs of the patient group cared for at Calderstones.

We found that there was no board level monitoring of the Mental Health Act. This, together with the many failures of governance of the application of the MHA, is of particular concern because every patient but one is detained under the Act. During the inspection we identified significant concerns with the application of the Mental Health Act across the service. The trust had identified this and a paper had been presented to the board to ensure that this was addressed.

During the inspection we identified that aspects of governance were working better these included, the procedures for receiving, investigating and acting on complaints from people who use services. The system and procedure that was in place for reporting and analysing incidents. The trust has a system for monitoring the provision of mandatory training, supervision and appraisal.

Within all services across the trust we saw that staff received a variety of clinical, managerial and group support and staff attended regular team meetings. Trust vision was cascaded through emails and shared in team meetings.

Staff told us there had been significant changes at the trust and improvements had been made to governance of the trust. They told us about the changes and how they were now involved in the development of the wards.

Are services well-led?

There was a system in place to monitor performance. All of the ward managers were able to demonstrate how they used it and adhered to it. We were told that it had been recognised that this system was not providing the trust with quality data about performance.

The trust has introduced a dashboard of monthly metrics including staff sickness, supervision, training and service user experience on each ward. However; it was not clear from speaking with staff how this information was used on the wards to improve performance.

We also found there was a lack of locally driven audits taking place on all the wards we visited or bench-marking. We found there were no qualitative audits of care records, cleaning schedules or medical equipment which took place on the wards. Staff found it difficult to measure performance improvement locally or across the wider service.

The use of physical interventions was also included in the dashboard monitoring. However; we saw that data about the use of physical interventions was compiled centrally and the wards did not have any local statistical analysis of the use of physical intervention.

Leadership, morale and staff engagement

Despite the challenge cause by high vacancy rates, staff at Calderstones told us that they were proud to work for the trust and felt supported by their managers and were able to approach them when they needed to discuss any concerns or idea's they may have.Staff we spoke with were aware of internal and external whistleblowing policies, and where to find them and would feel comfortable raising concerns with their managers.

The work by board members to engage with staff, for example through the 'big conversation' and 'big birthday breakfast', had succeeded. Front-line staff reported that the executive team were visible and approachable and that they felt there were effective two-way channels of information between the ward and the board. The staff we spoke with told us they felt 'listened' to by the management. Qualified nursing staff said they had been invited to leadership events and the deputy ward managers were involved in unit hub meetings which were intended to develop the services.

Ward managers told us they attended weekly Service development meetings with the service manager. They told us that senior managers, the director and Chief Executive provided a visible presence by regular visits to the wards.

Trust Board minutes reported that concerns had been expressed from ward managers regarding resilience levels of teams particularly in relation to reliance on bank and agency staff which were becoming increasingly difficult to access when required. The trust provided CQC with information that showed in March 2014, 9.7% of nursing posts were unfilled and 15% of staff had left the trust in the previous year.

The Trust provided us with information that staff sickness had been consistently above the England average for mental health and learning disability trusts over the two years between January 2012 and December 2013 but the sickness rated had improved with the current sickness rate for permanent staff at 6.91%.

Commitment to quality improvement and innovation

The trust had recently introduced a performance dashboard and a quality and safety assurance form. However, information derived from this was not always fed back effectively to front-line staff.

The quality and safety assurance form was completed daily by the member of staff in charge of the ward. This asked the staff to report daily about the numbers of the staff team, people's activities, and quality assurance regarding medication, environment and finances. We were told these were reviewed by the service manager at the end of each week, which would then raise a further quality assurance form to send to their managers. We were told this was to ensure information about performance and quality was elevated quickly to senior managers.

We asked how the ward managers ensured the records on the electronic patient notes system were of good quality, for instance that they were defensible and accurately reflected people's needs. They told us they reviewed them as part of the MDT and we were told by staff that care plans were audited through the carenotes system which automatically alerted through a RAG (risk) rating system when care plans, risk assessments and other associated

Are services well-led?

documents needed to be updated. However, we found that although some care plans appeared to be 'green' which meant they were up to date, the content of the care plan was not completed or lacked information.

Ward staff participated in few clinical audits that were directly relevant to their clinical work.

We saw examples of staff meeting records and staff told us there were regular ward meetings and meetings for each professional discipline.

Observation of practice, review of records and what people told us demonstrated the wards were proactive in their approach to gaining feedback from people who used the service through ward meetings, speak up groups organised by the occupational therapy department, patient advice and liaison service and advocacy.

The low and medium secure units all participate in the Royal College of Psychiatrists' quality network for forensic mental health services which facilitates standards-based self and peer-review assessments. The trust had as a participating services produced an action plan to address standards that are not met.

We saw following a safeguarding incident in 2013 that the trust had put in place a system to make sure they could identify when staff were under stress and becoming 'burnt out'. They informed us to date approximately 20 staff working in Individual Packages of Cares (IPC's) have been moved to different areas as a result of assessed or expressed stress or burnout.

We saw there was a monitoring system in place to make sure staff had both annual appraisal and monthly supervision. We found most wards had this up to date and where there were exceptions the staff could explain why these had occurred.

We found evidence that the service had pro-actively built relationships with external stakeholder to enhance the care provided to people. For example; the service had links with a local football club where people went to play football. The service had also built up a good partnership relationship with the, Supporting Women in Secure Services' network who provided support to females within the service.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	**The registered person had not taken proper steps to ensure that people were protected against the risk of receiving inappropriate or unsafe care.** **How the Regulation was not being met:** **We found instances of where staff were not adhering to the requirements of the Mental Health Act.** • Staff were unable to find current information leaflets relating to patients' rights, the leaflets they provided were dated 1994 and clearly did not reflect amendments to the Act from 2007 • People often could not take section 17 leave due to lack of staff to escort them • Copies of section papers could not be found in some electronic records • Out of date section 58 authorisation stored with the current authorisation • People were not usually provided with a copy of their section 17 leave form • The condition for section 17 leave was not always linked to the actual leave being authorised. • We found evidence that capacity assessments completed by previous Responsible Clinicians and four years old were recorded as the latest capacity test in some recent ward round notes • Mental capacity assessments were not documented in all records we reviewed. • Recording by statutory consultees was not found on all files • We found T2 forms that had been completed by a previous responsible clinician. • One patient had been given medication not authorised on a T3 form • In one record, we found both a T2 and T3 form, it was not possible to determine under what authority treatment was been given • We found one form T3 was not stored with the medication chart.

This section is primarily information for the provider

Compliance actions

- We found one patient was prescribed and administered medication outside of the form T3 authorisation

Staff in the low secure units did not always complete the seclusion room records fully.

We found that doctors were not attending seclusion episodes in line with the requirements of the Code of Practice.

There was significant concern over the use of prone restraint using leg straps and a blanket at 1 Maplewood. It had been recorded this type of restraint was ineffective for the individual, who was subsequently placed in seclusion where they used the floor as a toilet; this was left for 6 hours. On leaving seclusion the person cleaned the room themselves and this was considered to be their choice.

Regulation 9

Regulated activity

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

Treatment of disease, disorder or injury

Regulation

The registered person had not protected service users and others who may be at risk, against the risks of 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.

How the Regulation was not being met:

- There was a lack of audits undertaken at ward level to demonstrate effective management of infection control.
- On some wards no audits of fridge temperatures had been undertaken; on wards where audits had been completed there were 'gaps' in the recording of these and a lack of action taken in response to identified issues
- Several pieces of equipment had not been portable appliance tested (PAT) within the low secure services and managers were not able to provide evidence of equipment audits.
- A seclusion audit from March 2013 was carried out to monitor compliance with the trust's Seclusion Procedure dated 1st November 2012, including all

This section is primarily information for the provider

Compliance actions

secure services. The recommendations included some specifically for registered nurses regarding record keeping, note writing and the continued welfare of patients in seclusion. Wwe found these same concerns at the time of inspection.

- There was inconsistent local management of medicines. Several medication audits had been completed, however we found:
- out of date intramuscular injections dating from 2013 and June 2014, on 1 and 3 Woodview.
- syringes and saline solution for injections which were out of date by several years on 4 West Drive.
- the medication cupboard, which included the controlled drugs cupboard, was in the kitchen of 4 West Drive
- We looked at the prescribing of medicines under the Mental Health Act 1983. We knew that previously there had been administration errors on medicine administration records. The trust had introduced an auditing process to reduce the errors. We saw very clear action plans in place as the result of the audits however at Woodview staff were not aware of any weekly review of compliance with section 58 of the Mental Health Act 1983.
- We found there were no qualitative audits of care records, cleaning schedules or medical equipment which took place on the wards. It was therefore difficult to measure performance improvement locally or across services.

Regulation 10

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	**The registered person had not maintained appropriate standards of cleanliness and hygiene in relation to the premises and equipment in the forensic services.** How the Regulation was not being met: • The general ward environment at Woodview was dirty and a seclusion room had saliva on the windows and a soiled and dirty toilet,

This section is primarily information for the provider

Compliance actions

- The seclusion room at West Drive 4 was unclean and had a pool of dirty water in the toilet area (although we were told that this seclusion room had been decommissioned, people continued to use the shower),
- West Drive 2 ward was dirty
- At Gisburn Lodge, the kitchen was unclean.
- There were concerns about the prevention and control of infection including:
- There was a lack of infection control audits at ward level,
- There was a lack of cleaning schedules on some wards,
- In some areas where medicines were dispensed there were no hand washing facilities.
- We found incorrect labelling and use of sharps containers.

We found that the fridge in the therapy kitchen at Gisburn Lodge was running above the maximum operating temperature and the food stored in fridges had no use by date.

Regulation 12

Regulated activity

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

Treatment of disease, disorder or injury

Regulation

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

How the Regulation was not being met:

- We found out of date medicines for intramuscular injection, dating from 2013 and June 2014, on 1 and 3 Woodview,
- We found syringes and saline solution for injections which were out of date on 4 West Drive,
- We found the medication cupboard, which included the controlled drugs cupboard, was in the kitchen of 4 West Drive.
- Also a review of a person's medication charts at Daisy Road which had been agreed under the Mental Health Act 1989 showed that medicines had been given to one

This section is primarily information for the provider

Compliance actions

patient who was not authorised; when the responsible clinician was informed they indicated they would attend the next day. This information was shared with the staff.

- We found T2 forms that had been completed by a previous responsible clinician.
- One patient had been given medication not authorised on a T3 form
- We found one patient was prescribed and administered medication outside of the form T3 authorisation

Regulation 13