Quality Account
1 April to 30 June 2016

PART 1

Statement on Quality from Chief Executive

Calderstones Partnership NHS Foundation Trust (the Trust) is a specialist learning disability service, authorised on the 1st April 2009 by Monitor the Independent Regulator for Foundation Trusts. The Trust provides forensic and high support services to people with learning disabilities.

Calderstones Partnership NHS Foundation Trust continues to focus on improving the quality of care and the service we provide. I am therefore pleased to introduce on behalf of our Trust Board, our seventh Quality Account. This document summarises the quality improvements we have made to the safety and effectiveness of our services and the experiences of the people who use them.

The purpose of our Quality Account is twofold. Firstly, to demonstrate accountability to our service users, carers, commissioners, staff and the public for the quality of services we deliver. Secondly, to ensure the Trust Board assesses and reports on quality across all of the healthcare services we provide. It demonstrates that the leaders, Clinicians, Governors and staff are committed to continuous, evidence-based quality improvement.

The principle aims of this publication are to demonstrate:

- That we continuously review the quality of our services
- That we are transparent in our reporting of this information, reporting both where we are doing well, and where improvement is needed.
- The improvements plans we have for the forthcoming year.
- How we provide information on the quality of services to service users and other stakeholders, inclusive of our governors.

- Our organisational accountability to the Service Users, Commissioners, Staff, Governors and other relevant stakeholders.

- How we enable Service Users, Commissioners, Staff, Governors and other relevant stakeholders to review your services, comment on performance and identify priorities for improvement.

The central purpose of our Trust is to provide the highest quality specialist healthcare for people with learning disabilities that is person centred, and promotes independence and empowerment. This Quality Account describes the progress we have made over the last three months and outlines our quality priorities as we become part of Mersey Care Foundation Trust (MCFT).

Quality improvement work at the trust is guided by our clinical quality strategy which is based on our five commitments of:

1. Maintaining the very highest standards of care.

2. A promise to continuously strive to improve the quality of services.

3. Responding to the changing needs of people who use our services and those who commission them.

4. Safeguarding the welfare of the people we care for.

5. Listening and responding to the people we care for, their families and carers, staff and partners.

We are also guided by feedback from our service users and carers, which includes complaints, learning from incidents, regular audits of our services and feedback from our commissioners and regulators.

In the preceding couple of years there have been huge challenges for the Trust, however, we have responded to these challenges from board to ward, with the support of carers and families and our service users. As we become part of Mersey Care NHS Foundation Trust, we are recognised by commissioners and regulators as delivering the highest quality of care and wellbeing to our service users. It has been a considerable achievement in such a short time to gain a CQC "Good" across all domains (attained by a handful of trusts only), a ranking of 27 of 230 in the “Learning from Mistakes” league, a Monitor

"Green" for Governance rating and recognition by Mersey Care that the culture and quality of services of Calderstones will add real value to their organisation.

The acquisition of Calderstones Partnership NHS FT by Mersey Care NHS Ft will signal the start of a bright future full of innovation, new developments and setting new standards for mental health care. During this process , we have already learnt so much from each other, sharing good practice and new protocols. I am sure that will continue now we are all working together as part of the same Mersey Care family. As part of the new organisation, there will be opportunities, new ideas and a chance to shape the way care is delivered for some of the most vulnerable people in society.

We welcome the opportunity to present this final Quality Account for the period April to June 2016. To demonstrate our continued commitment to delivering high quality care and ensuring quality is at the heart of the organisation.

The directors are required under the Health Act 2009 and the National Health Service Quality Accounts Regulations to prepare quality accounts for each financial year.

Monitor has issued guidance to NHS foundation trust boards on the form and content of annual Quality Reports (which incorporate the above legal requirements) and on the arrangements that NHS foundation trust boards should put in place to support data quality for the preparation of the Quality Report.

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Report.

By order of the Board

Executive Director of Operations, Mersey Care NHS Foundation Trust (formerly Chief Executive, Calderstones Partnership NHS Foundation Trust)

PART 2

2.1 Priorities for Improvement 2016-2017

The quality standards for the Trust are clearly set out in the NHS Constitution and in the fundamental standards of quality and safety published by Care Quality Commission (CQC).

To meet these quality standards, we set out our quality priorities in the Trust's Clinical Quality Strategy 2013-2018; and our delivery plan for the year as part of our annual Quality Account. Our Clinical Quality Strategy 2013-2018, reviewed in 2014, underpins our quality commitments and the governance arrangements for the Trust's Annual Quality Account. Our Clinical Quality Strategy also takes account of the quality framework as outlined within High Quality Care for All (DH, 2008):

- Patient Experience
- Patient Safety
- Clinical Effectiveness

As we become part of the larger Mersey Care organisation, our quality priorities are underpinned by their vision, values and quality strategy. However, Transforming Care remains fundamental in ensuring that the service delivery is mindful of the 'five golden:

- Quality of life
- Keeping people safe
- Choice and control
- Support and interventions
- Equitable outcomes

Given the preparation for acquisition the quality priorities for the Trust post acquisition have a high degree of synergy with Mersey Care's quality priorities and remain pertinent as Calderstones becomes the Specialist Learning Disability division.

Quality Priority 1: Violence Reduction Project

Why are we doing this?

National data from a variety of sources indicates that staff at Calderstones are more likely to be assaulted than those at comparator Trusts. Whilst these arguments can be countered to some extent insofar as Calderstones is the only Trust of its kind in the UK (i.e. a specialist learning disability Trust), the recent risk identification report provided by The Risk Authority Stanford (TRA Stanford) also highlighted violence to staff as the single most prevalent risk within the organisation.

Exposure to risk of this nature on a daily basis is highly likely to impact negatively on staff experience and thereby lower staff morale (even if individual staff members themselves are not assaulted). It may potentially undermine therapeutic relationships with service users, which could arguably stifle progression along the care pathway and result in increased lengths of stay. Staff victim to assault are likely to incur injuries, leading to personal discomfort and possible psychological trauma, which may in turn lead to days lost to sickness absence.

This requires backfill with bank and agency staff which not only carries a financial cost, but may also serve to detract from consistent team working and thereby perpetuate the risk.

Through the application of design thinking methodology[1], the violence reduction project will seek to develop a range of interventions to mitigate the on-going risk of assaults to staff.

This project is aligned to:

- Patient Safety and Patient Experience
- Commitment 4: 'Safeguarding the welfare of the people we care for'
- Golden Thread: 'Quality of life' and 'Keeping people safe'
- 'No Force First' quality priority for MCFT

How will we measure success?

In order to monitor effectiveness of the selected interventions a range of metrics will be used:

[1] "Design thinking…used to solve problems and inspire innovative, and human centred solutions." Innovators Handbook The Risk Authority Stanford 2016

- The number of incidents of assault on staff;
- The severity of resultant harm/injury;
- Staff experience measures (possibly staff survey);
- Staff turnover;
- Days lost to sickness absence as a result of injuries sustained during assault;
- The cost of backfilling with bank and agency;
- The number of employer liability claims received;
- The cost of such claims.

Quality Priority 2: Reduction in Self harm

Why are we doing this?

Self-harm is an important issue that affects our service users regardless of age, ethnicity or gender. It also affects the people around them, staff, other service users and their families and friends. On an individual level the Trust is highly responsive to people who self-harm. There is a procedure aligned to NICE guidance, which informs Integrated Care Plans and Positive Behaviour Support Plans that aim to support people who self-harm. We aim to ensure that service users co-produce their support plans and have guidance in place for service users and multidisciplinary teams also consider 'harm minimisation' as a support option.

However, we want to be a safe, non-judgemental and a responsive organisation.
Therefore, the overall aim of this initiative is to reduce the incidence and severity of self-harm across the Trust, we plan to review and improve how we support our service users who self-harm to ensure:

- Service users feel good about themselves.
- We identify and respond early to service users in crisis.
- We increase our understanding of self-harm by our service users.
- We address the effects of self-harm.
- We manage the risk within the least restrictive principles.

This project is aligned to:

- Clinical Effectiveness and Patient Experience
- Commitment 3: 'Responding to the changing needs of people who use our services and those who commission them'
- Golden Thread: 'Choice and control' and 'Support and interventions'
- 'Towards Zero Suicide' quality priority for MCFT

How will we measure success?

- Agree a definition of self-harm and develop a non-stigmatising language and description of self-harm through review of procedure
- Increase awareness of self-harm and its determinants through audit of functional analysis
- Increase our understanding of effective methods of prevention evidenced through clinical audit of primary strategies of Positive Behaviour support Plans
- A reduction in the incidence of self-harm

Quality Priority 3: Ward Accreditation

Building on the systems developed in the 2015-2016 period Ward Accreditation is at the fore of discussions with the planned acquisition by Mersey Care and how both organisations can learn from each other's processes. This aligns to the key objectives for the Nurse Executive Team

- **Self-Assessment** - against clearly defined standards of best practice aligned to both compliance frameworks and clinical quality strategy. The teams should be able to demonstrate improvement by building a portfolio of evidence.

- **Key Performance Indicators** – demonstrating change and impact for service users with comparative external benchmarking wherever possible and internally monitored through the use of 'heat maps'.

- **Clinical Audit** – a programme of clinical audit topics that review the quality of care against standards and the cycle of improvement.

- **Quality Review Visit** – reviewing the integration of the processes into everyday practice.

How will we measure success?

Embedding of the Ward Accreditation Scheme is viewed as the way forward in establishing:

- Evidence of demonstrable improvements in services evidenced through the monitoring and reporting of the processes contributing to the ward Accreditation Scheme.
- Improvement quality, experience and patient safety.
- Assurance about the quality of care and standards on wards.
- Trust and confidence for service users, families and key stakeholders in the quality of care evidenced from stakeholder feedback.
- Support for leaders and clinicians to understand how they deliver care; identify what works well and where further improvements are needed evidenced through analysis of Quality Review Visits.

Part 2.2 Review of Services

2.2.1 Statement of Assurance from the Board

During the reporting period 1 April to 30 June 2016 Calderstones Partnership NHS Foundation Trust provided for people with a learning disability:

- Specialist on-site in-patient services inclusive of:
  - Secure service provision
  - Enhanced services
  - Rehabilitation services

- Specialist forensic outreach support service

Calderstones has reviewed all the data that is available to them on the quality of care in the above NHS services (inclusive of social care provision). The income generated by the NHS services reviewed in the reporting period 1 April to 30 June 2016 represents 94.1% of the total income generated from the provision of NHS services by the Trust for the reporting period 1 April to 30 June 2016.

2.2.2 Participation in Clinical Audits

During 1 April to 30 June 2016 the Trust was eligible to participate in 0 national clinical audit 0 cases were submitted which is 100% of eligible cases.

There was a nil return for the Trust response to the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (CISH) covered NHS services that the Trust provides.

The reports of 5 local clinical audits were reviewed by the provider in 1 April to 30 June 2016 and as a division of MCFT intends to take action to improve the quality of healthcare provided.

All of the Trust's clinical audits were presented to and reviewed by the multidisciplinary Clinical Audit Committee. Selective reports were presented to the Quality and Risk Committee (as a subcommittee of the Trust Board) to provide the assurance that quality issues are being addressed at Board level. The Trust encourages all services to be quality focused and as such encourages all clinical areas and disciplines to participate in the review of services through clinical audit.

2.3.3 Participation in Clinical Research

The number of patients receiving NHS services provided or sub contracted by Calderstones Partnership NHS Foundation Trust in the first Quarter of 2016-2017 that were recruited during that period to participate in research approved by a research ethics committee was 0. However, one new study on the NIHR portfolio has recruited 2 staff participants in that time period.

The level of participation in clinical research demonstrates Calderstones Partnership NHS Foundation Trust's commitment to improving the quality of care offered and to making a contribution to wider health improvement.

Calderstones Partnership NHS Foundation Trust was involved in conducting 2 clinical research studies in Quarter 1 of 2016/17. These studies are ongoing into Quarter 2 of 2016/17 as part of the Mersey Care portfolio of studies. The Trust used national systems to manage the studies in proportion to risk. Of the 1 new study given permission to start, 1 was given permission by an authorised person less than 30 days from receipt of a valid complete application. 1 of the studies were established and managed under national model agreements and this 1 new study used a Research Passport.

In the first Quarter of 2016-2017 the National Institute for Health Research (NIHR) supported 1 of these studies through its research networks, with it being given permission from Calderstones through the NIHR portfolio. The new study recruiting in the first Quarter of 2016/17 was registered on the NIHR portfolio and recruited a total of 2 staff to date, with more expected through the rest of 2016/17. In total 5 studies on the NIHR portfolio remain open and eligible to recruit from the Trust; 0 have closed during the first Quarter of 2016/17; 1 is in study set up.

In the last three years 23 publications have resulted from our involvement in clinical research or innovative practice in Calderstones, helping to improve patient outcomes and experience in this specialist field. During the first quarter of 2016/17 there have been a

further 5 publications of studies conducted at Calderstones; however, none of these five new publications were studies on the NIHR portfolio.

The Trust has established working partnership links with Lancaster University and continues to be a member organisation of the Lancaster Health Hub, working collaboratively in developing research proposals.

2.3.4 Goals Agreed with Commissioners – The Use of CQUIN Payment Framework

A proportion of the Trust's income in 1 April to 30 June 2016 was conditional on achieving quality improvement and innovation goals agreed between the Trust, NHS England – North of England Specialised Commissioning and East Lancashire CCG (on behalf of 17 Associate CCGs within the North West). Further details of the agreed goals for 2015-2016 and for the following 12 month period are available electronically at https://www.england.nhs.uk/wp-content/uploads/2016/03/cquin-guidance-16-17-v3.pdf

The amount of income for 1 April to 30 June 2016 is £8.5 and is conditional upon achieving quality improvement and innovation. The Trust achieved the indicators in 1 April to 30 June 2016 and successfully received the payment of £194k.

Table 1 Payment Schedule for CQUIN Goals

Contract Income			
		East Lancashire CCG (*on behalf of 17 North West Associate CCGs*)	**North of England Specialised Commissioning**
		£000	**£000**
2016-2017	Contract	1,980.9	6,397.0
	CQUIN	34.7	159.0
	Total	**2,015.6**	**6,556.0**

The Trust continues to work with the North of England Specialised Commissioning Team and the Clinical Commissioning Groups (CCGs), to agree goals that reflect measured improvements in the performance of quality

The Trust is required to undertake a CQUIN Programme for the period 2016-2017 which is 2.5% of contracted income which amounts to £683,000.

2.3.5 Statements from the Care Quality Commission

The Trust is required to register with the Care Quality Commission and its current registration status is registered to carry out the following regulated activities:

- Treatment of disease, disorder or injury

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

The Trust is registered without conditions and has been rated 'Good" across all domains.

Overall rating for services at this Provider source: Care Quality Commission, 2016	Good
Are Mental Health Services safe?	Good
Are Mental Health Services effective?	Good
Are Mental Health Services caring?	Good
Are Mental Health Services responsive?	Good
Are Mental Health Services well-led?	Good

The 'Good' rating was awarded following a visit in October 2015 under the Care Quality Commission's new approach to inspection and regulation. Calderstones was previously inspected in 2014. At that time the CQC said that "the great majority of people" at Calderstones are treated "kindly and respectfully" but also raised a number of concerns.

The regulators focused on determining whether services are safe, effective, caring, responsive and well-led in their exhaustive week-long inspection of the Trust.

In the latest report, the CQC noted:

- Caring, respectful staff
- Person-centred care
- In depth knowledge
- Clean, tidy and well maintained wards
- The service meeting 100% of (national good practice) criteria in four standard areas including relational security, safeguarding, physical healthcare, and governance.

The Trust has worked closely with the CQC and focussed on quality, safety, and compassionate care. There were areas identified that required improvement and there is an action plan in place to address these issues. The key areas for action include:

- Improved compliance with life support training
- All staff to receive an annual appraisal
- Review night time staffing arrangements
- Staff receive regular documented supervision and that this is documented
- Staff and patients are debriefed following a difficult incident
- Ensure regular staff meetings

The Trust has not participated in any special reviews or investigations by the CQC during the reporting period.

In respect of reporting for April to June 2016 the inspection report from October 2015 remains the current ratings for Calderstones Partnership NHS FT.

2.3.6 Data Quality

NHS Number and General Medical Practice Code Validity

Calderstones Partnership did not submit records during 1 April to 30 June 2016 to the Secondary Uses service for inclusion in the Hospital Episode Statistics, which are included in the latest published data.

2.3.7 Information Governance Toolkit attainment levels

The Trust score for 2015-2016 for Information Quality and Records Management assessed using the Information Governance Toolkit was 77% and was graded satisfactory based upon scores of:

- level 2 for 26 applicable items
- level 3 for 16 applicable items
- exemptions granted for 2 items and
- 1 item marked “Not Relevant”

In light of the planned acquisition of the Trust by Mersey Care NHS Trust in July, the Information Governance action plan for 2016-2017 will be coordinated in conjunction with Mersey Care’s Information Governance Lead. Activities prior to the acquisition will focus on alignment of policies, procedures and reporting standards in preparation for the Trust’s Information Governance framework to be assimilated into the Mersey Care framework at which point Calderstones information Governance Toolkit will be closed down.

2.3.8 Clinical coding error rate

The Trust was not subject to the Payment by Results clinical coding audit during 1 April to 30 June 2016.

PART 3:

3.1 Review of Quality Performance: Priorities for Improvement as at 30 June 2016

In June 2016 the Trust produced its seventh Quality Account, aligned to the Trust's quality commitments as outlined in the Clinical Quality Strategy 2013-2018 and the quality framework of patient safety, patient experience and clinical effectiveness. The following section outlines what we have achieved over the three months (1 April to 30 June 2016) against both our quality improvement priorities and our quality dashboard.

Quality Priority 1: Violence Reduction Project

Why are we doing this?

National data from a variety of sources indicates that staff at Calderstones are more likely to be assaulted than those at comparator Trusts. Whilst these arguments can be countered to some extent insofar as Calderstones is the only Trust of its kind in the UK (i.e. a specialist learning disability Trust), the recent risk identification report provided by The Risk Authority Stanford (TRA Stanford) also highlighted violence to staff as the single most prevalent risk within the organisation.

Exposure to risk of this nature on a daily basis is highly likely to impact negatively on staff experience and thereby lower staff morale (even if individual staff members themselves are not assaulted). It may potentially undermine therapeutic relationships with service users, which could arguably stifle progression along the care pathway and result in increased lengths of stay. Staff victim to assault are likely to incur injuries, leading to personal discomfort and possible psychological trauma, which may in turn lead to days lost to sickness absence.

This requires backfill with bank and agency staff which not only carries a financial cost, but may also serve to detract from consistent team working and thereby perpetuate the risk.

Through the application of design thinking methodology[2], the violence reduction project we are developing a range of interventions to mitigate the ongoing risk of assaults to staff.

What have we achieved?

In order to monitor effectiveness of the selected interventions a range of metrics are used:

- The number of incidents of assault on staff monitoring for reduction in numbers and severity of resultant harm/injury;
- Monitoring days lost to sickness absence as a result of injuries sustained during assault

Two key work streams have been agreed

Quality Priority 2: Reduction in Self harm

Why are we doing this?

Self-harm is an important issue that affects our service users regardless of age, ethnicity or gender. It also affects the people around them, staff, other service users and their families and friends. On an individual level the Trust is highly responsive to people who self-harm. There is a procedure aligned to NICE guidance, which informs Integrated Care Plans and Positive Behaviour Support Plans that aim to support people who self-harm. We aim to ensure that service users co-produce their support plans and have guidance in place for service users and multidisciplinary teams also consider 'harm minimisation' as a support option.

However, we want to be a safe, non-judgemental and a responsive organisation. Therefore, the overall aim of this initiative is to reduce the incidence and severity of self-harm across the Trust, we plan to review and improve how we support our service users who self-harm to ensure:

- Service users feel good about themselves.

[2] "Design thinking…used to solve problems and inspire innovative, and human centered solutions." Innovators Handbook The Risk Authority Stanford 2016

- We identify and respond early to service users in crisis.
- We increase our understanding of self-harm by our service users.
- We address the effects of self-harm.
- We manage the risk within the least restrictive principles.

What have we achieved?

- Clinical audit completed reviewing compliance with standards for the prevention of suicide; findings recommend improved risk assessment and understanding of supportive observations.

Quality Priority 3: Ward Accreditation

Building on the systems developed in the 2015-2016 period Ward Accreditation is at the fore of discussions with the planned acquisition by Mersey Care and how both organisations can learn from each other's processes.

- **Self-Assessment** - against clearly defined standards of best practice aligned to both compliance frameworks and clinical quality strategy. The teams should be able to demonstrate improvement by building a portfolio of evidence.

- **Key Performance Indicators** – demonstrating change and impact for service users with comparative external benchmarking wherever possible and internally monitored through the use of 'heat maps'.

- **Clinical Audit** – a programme of clinical audit topics that review the quality of care against standards and the cycle of improvement.

- **Quality Review Visit** – reviewing the integration of the processes into everyday practice.

What have we achieved?

Early stages of development building on the quality review process.

3.2 Review of Quality Performance: Quality Indicators as at 30 June 2016

3.2.1 Department of Health Quality Indicators

The Trust will report on the following indicators as required by Monitor's *Compliance Framework/Risk Assessment Framework*:

Indicator	Score	National Average	Highest Scoring Trust	Lowest Scoring Trust
Rate of patient safety incidents reported within the trust during the reporting period, and the number and percentage of such patient safety incidents that resulted in severe harm or death.	0% (n0/448)	Not Applicable	Not Applicable	Not Applicable
The data made available to the trust by the Information Centre with regard to the percentage of patients aged— (i) 0 to 15; and (ii) 16 or over, readmitted to a hospital which forms part of the trust within 28 days of being discharged from a hospital which forms part of the trust during the reporting period.	0%	Not Applicable	Not Applicable	Not Applicable

The Trust does not routinely report this information to the Health and Social Care Information Centre as it is not routinely captured as part of the learning disability dataset.

Staff Survey 2015 results and subsequent actions are reported in the 'Staff Report' section of the full Annual report 1 April to 30 June 2016.

Complaints data for 1 April 2016 to 30 June 2016 is reported via the 'Complaints' section of the full Annual report 1 April to 30 June 2016.

Duty of Candour

The Trust is required under statue to comply with the duty of candour (the duty); this requires us to act in an honest, open and transparent way in relation to care and treatment provided to service users. The application of duty of candour is not limited to the service user themselves, but takes account of persons acting on their behalf. This is particularly important when service users have limited or fluctuating capacity, and also in recognition of family and carers as partners in care delivery.

The duty means that, as soon as reasonably practicable after becoming aware that a notifiable safety incident has occurred, the provider must notify the relevant person that the incident has occurred, and provide reasonable support to them in relation to the incident. To satisfy the statutory requirements the Trust has implemented the following:

- Clinicians taking the lead in the notifying the service user and/or their representative of any notifiable safety incident. This includes an account of all the facts they know about the incident at that time; any subsequent investigation; and an apology;
- The requirement for written records both as part of the clinical records and the Trust's Risk Management System (Ulysses).
- Investigation findings followed up in writing (with service user's and/or their representative agreement), verbally and an apology given.

The Trust has implemented processes through the Ulysses system to ensure that all notifiable safety incidents are identified and acted upon. All incidents of harm are reviewed to ensure the incident reporters have correctly assessed them. Once a notifiable incident has been identified, the Duty of Candour module within Ulysses is activated to ensure prompts and follow up for those healthcare professionals with responsibility.

The Trust also has systems to ensure compliance with other reporting requirements to the Care Quality Commission, the local safeguarding board, the Health and Safety Executive and Commissioners.

Other key actions to date:

- Being Open Policy amended to incorporate Duty of Candour.
- Incident Management Policy and Procedure requires amended to incorporate Duty of Candour
- 'Speak Up Guardian' appointed to support reporting of notifiable incidents.
- Awareness raising via Team Brief.
- All incidents graded as 'moderate' harm and above reviewed by the Risk Department to establish whether Duty of Candour applies (on individual case-by-case basis).
- Staff supported to contact individual affected/responsible individual where Duty of Candour is deemed to apply and ensure notes made of discussion(s).
- Duty of Candour recording mechanism on Ulysses Safeguard system developed and implemented.

Sign Up to Safety

The Trust has "Signed up To Safety" which is planned to run for the next three years. Sign up to Safety is linked indirectly to the NHS Litigation Authority (NHSLA) assessment process. This Trust's commitment to 'Sign Up to Safety' is to improve services as we are not eligible NHSLA discounts.

The Trust has committed to four Safety Pledges all based on reducing harm. These pledges have been developed into full Safety Improvement Plans. The Trust's safety pledges are:

- Medication Safety Strategy - aim is to eliminate high risk medication errors *(see section 3.2.2 Patient Safety: Medicines Management)*

- Restrictive Intervention Reduction Plan – Reducing the need for all restrictive interventions across secure services – aim is to achieve a 74% reduction in the frequency of restrictive interventions and to eliminate altogether the use of prone restraint

- Reducing the Risk of Choking at Mealtimes – reducing the number of patient safety incidents from choking – aim is to have 0% harm resulting from choking incidents and 100% compliance with risk of choking screen assessments

- Vitalguard Seclusion Room Monitoring (contact monitoring)

The first three pledges are discussed elsewhere in this report the following is an overview of the fourth project Vitalguard Seclusion Monitoring.

The Safety Improvement Plans were submitted in May 2015 to the Programme Team and we received very positive feedback.

The Trust attended events run by the Advancing Quality Alliance (AQUA) linked to the Sign up To Safety Programme and sent representatives on the “Patient Safety Champion” training which ran in 2016.

Vitalguard

In settings of medium and low secure units, a seclusion room provides a place of safety where someone can be separated from their peers during a period of acute distress. Seclusion is considered an intervention of last resort and should only be used where failure to do so is likely to result in significant harm to service-user or carer (UK Mental Health Act, 1983; Nelstrop et al. 2006; NICE 2005). At this time the person in seclusion may be considered to be vulnerable and at risk of physical health complications such as respiratory depression, hypotension or cardiovascular collapse depending on the level of distress and possible use of medication leading up to the clinical decision to use seclusion.

Having a technology based contactless monitoring system allows staff to assess the presence of life in a seclusion room without requiring the service-user to wear physical attachments or personnel to enter the seclusion room and disturb the person. The system is based upon radar technology identifies frequencies produced by human respiration and motion and determines the presence of life in the scan area. The system will alarm at a seclusion room location and/or a remote control room if the vital signs (respiration movement) fall below a threshold predefined by an administrator.

With this project the Trust had the following objectives:

- To introduce the use of technology to support seclusion monitoring.

- To evaluate whether such technology is able to accurately detect the presence of life in a seclusion room in a ward setting, without interference from background living noise and electronic ‘noise’ from other systems.

We introduced one example of Vitalguard and with its installation in the evolution of paperless seclusion records. We conducted a brief quantitative study to assess the reliability and validity of the technology. We tested its ability to respond to several situations that could occur during use of a seclusion room. We conducted a series of tests conditions, focussing on false positive i.e. indications of human presence when no human was present in the room and on false negatives i.e. not detecting a human presence when a human was in the room.

In our experimental conditions, the contactless monitoring system displayed 100% validity and reliability in terms of determining false positives and false negatives.

The Trust has purchased further monitoring units for the remaining seclusion areas in the Trust. Six months after all units are installed and working, we propose undertaking a qualitative study to gain nurses views on how the use of Vitalguard technology has altered practice, added to or detracted from confidence in seclusion room observations. We will also undertake a review to compare the new electronic seclusion records to the established paper seclusion records.

3.2.2 Development of a Quality Dashboard

The Quality Dashboard has been designed with clinical teams to help improve performance by providing regular, timely feedback against locally predetermined measures to assist successful intervention and improvement. They are an active performance-monitoring tool for safety, effectiveness, clinical outcomes and service user experience. They also provide opportunities to detect emerging quality and safety issues and permit timely mitigating actions to be taken - improving the overall level of high quality, person-centred care.

The Trust recognises that good quality information is a driver of performance amongst clinical teams, and helps to ensure the right services and best possible care is provided to service users. A key element of providing good quality information is ensuring that clinicians delivering the service receive regular and timely feedback on their performance

There are three different versions of the dashboard, one for the ward teams, one for directorate leads and one for the board. The individual dashboard functionality means clinicians as well as managers can view their compliance and performance against the measures for service users' cares planning, risk assessments, outcomes, and experience. With the clinical dashboard, you have a visual display, which enables clinicians and managers to look at differences between wards. Having the same information, which goes from 'ward to board' is key to monitoring quality.

The Quality Dashboard largely reflects effectiveness, safety and experience of service users on their care pathway. Our metrics are aimed at improving the efficiency and effectiveness of the care pathway for people using services.

The following information is an overview of the performance of the metrics that inform the Trust's Quality Dashboard. The information is structured around national priorities and the three domains of High Quality Care for All (DH, 2008):

- Patient Safety
- Clinical Effectiveness
- Patient Experience

The following key is used to explain Trust performance and trend in relation to the metrics:

NB All the data is sourced via the Trust's Business Intelligence System or Risk Management System

The direction of the arrow means:	Improving ↑	No change ➔	Worsening ↓
The colour of the arrow means:	Achieving target ●	Just below target ●	Not achieving target ●

National Priorities

Whilst there is a national definition of ‘delayed discharges’ this does not adequately describe or define ‘delay’ in the context of discharge from secure services (see Table 1). The Trust has pressed our commissioners to agree a common definition, which has now been agreed:

‘Patient will be a delayed discharge once it’s agreed at CPA (that has been attended internally and externally) that the patient is clinically and legally ready for discharge and the patient then remains in the service for a further 12 weeks’.

A process was put in place with the support of the Governance and Information Services. All new delayed discharges are discussed weekly at Referrals Capacity and Flow for monitoring. The Trust has embarked upon an exercise to retrospectively review all service users against the new definition and has reported against this definition from April 2016. As can be seen this new definition has resulted in a much clearer identification of service users experiencing delays to planned discharges. This aligns to the Trust’s overall contraction plans in line with the Transforming Care agenda. Care and Treatment Reviews are now six-monthly to ensure all stakeholders are fully engaged in the discharge plan.

All Annual Health Checks (see Table 1) are undertaken in the Trust’s Primary Care Service based within the Calderstones site, and physical healthcare of service users is seen as an integral part of the care pathway. Every service user is provided with an appointment and the recall system’ historically this was via a Primary Care System just operated with the Health Centre and the ward staff had local procedures for diarising appointments. This has resulted in a number of missed appointments, which creates a backlog of appointments and wasted time.

The Trust has developed a fully integrated record for physical healthcare which is now embedded within the Trust electronic patient record known as Carenotes. This now runs an appointment system and sends automatic reminders to teams when appointments are due.

To ensure that the annual schedule for Annual Health Checks could be delivered, the schedule was re-planned and the additional resources provided to ensure all service users were seen. The programme also makes allowances for those service users with complex behaviours that impedes on their ability to engage in health surveillance. For these service users Annual Health Checks were completed in sections at the pace that the can accommodate. There was also Work by the MDT supporting service users refusing to engage in an Annual Health Check.

Table 1 National Priorities

Metric	13-14	14-15	15-16	April to June 2016	Target	Trend
Delayed transfers of care	0.76%	2.69%	1.3%	15.79%	<= 7%	↓
Annual health check	96%	98.23%	93%	93%	100%	→

Patient Safety

One of the key aims of the Trust is to ensure everyone plays a part in helping to reduce harm and improve the safety of services. The vulnerable nature of many service users means staff play a particularly active and important role in safeguarding and improving safety. The Trust is dedicated to building a service where every member of staff has the commitment, confidence and skills to eliminate harm to service users, and by doing so builds the capacity and capability for improving the quality and safety of services.

The Trust's profile of metrics outlines the Trust's priority concern for safety and the provision of a safer environment for service users. The Trust is committed to ensuring that there is a strong safety culture. The metrics focus on the systems for assessing and managing the highest risks to service users, at specific junctures in the care pathway and across clinical teams.

Safe and Effective Physical Intervention

Whist restraint was once perceived as therapeutic practice now the Trust views it as traumatising practice and is only to be used as a last resort when less-restrictive measures have failed and safety is at severe risk.

The Trust continues to try to deal with the challenges of service users and staff becoming injured during physical intervention. There have been a number of initiatives attempting to address the significant differential between service user and staff injuries. There is standardised training for all staff using both the non-aversive British Institute of Learning Disabilities approved training, and the more commonly used care and responsibility methods with much more secure holds for people.

There has been deterioration from the previous year's results for both service users and staff (see Table 2). Analysis of the injuries for service users has revealed that they are minor harm incidents usually soft tissue or abrasions. It is anticipated that this will improve as compliance with Prevention and Management of Aggression training increases.

The majority of injuries to staff are still caused by a very few service users; cared for in personalised packages of care. These service users have enduring and complex needs that continue to present challenges to services. During 2015-2016 aligned to the Positive and Safe Programme, the Trust eliminated the routine use of prone (facedown) restraint, and all use of Emergency Response Belts. There is a hypothesis that this may have resulted in the additional staff injuries, but will continue to be monitored closely.

The Trust maintains an active Positive and Safe programme with clear targets and objectives for restraint reduction, which is the most effective approach to reducing injuries.

Table 2 Injuries during physical intervention

Metric	13-14	14-15	15-16	April to June 2016	Target	Trend
Reduction of injuries sustained by service users as a result of physical intervention	1.5%	0.8%	2.7%	4% (n20/492)	<= 2%	↓
Reduction of injuries sustained by staff as a result of physical intervention	11%	7.94%	9.7%	9.8% (N48/492)	<= 5%	→

Care Planning

Concerning the 'Suicide Risk Screening Assessment', the results of 87.5% (n7/8) are still not meeting the 100% target; however this is an improvement on previous years. The failure to meet the target is again associated with the 24-hour timeframe from admission. All service users are assessed within 48 hours. However, the target remains unchanged, as it is important that we seek assurance that the wards recognise the increased risk of attempted suicide in the crucial first 24 hours of admission to hospital and ensure the safety of service users.

Table 3 Care Planning Measures

Metric	13-14	14-15	15-16	April to June 2016	Target	Trend
All new admissions to the Trust will have a 'Suicide Risk Screening Assessment' completed within 24 hours of admission	67%	85%	89%	100%	>= 95%	↑

Medicine Management

The purpose of the Trust's Medicines Management Strategy is to proactively support staff and service users in achieving safe and effective medicines management. Medicine management for the Trust means service users getting the maximum benefit from their medicines whilst at the same time minimising potential harm. All healthcare practitioners have a duty to competently perform safe medicines management.

Table 4 outlines the measures for missed medications and high-risk errors based upon the number of people affected. The Trust introduced a target of 0% for medicine omissions without clinical reason and medication errors with highest potential for harm.

There has been increased monitoring of safe and effective medicines management, with an emphasis on missed dose incidents. There was no harm incurred by any service user as a result of any omissions or errors. However, the Trust recognises that there is potential for harm and reviews all incidents as an opportunity to learn and prevent errors in the future.

Progress has been made by the Trust detecting, reporting, and learning from medication errors, but we want to make improvements to maximise the learning from medication errors to minimise harm from medication errors. This also forms part of the Trust's 'Sign Up to Safety Plan'.

Medication errors are any incident where there has been an error in the process or processes of prescribing, preparing, dispensing, administering, monitoring, or providing advice on medicines. The incidents related to this metric are errors of commission for example, wrong medicine or wrong dose.

The data in Table 4 gives an outline of the number of incidents classified as presenting the highest risk of harm to service users although there have not been any medication errors that have caused harm to service users. The errors reported are in three classifications:

- Error without harm
- Intercepted error
- Potential error

Analysis of these errors is in recognition of the near-miss potential. As with omitted medicines, there has been an increase in reporting of errors through increased audit from both independent auditors and the pharmacy team. Improved recognition and reporting is fundamental to error prevention. Audit is viewed as by the Trust as educational activity to promote high-quality care. As part of the audit cycle, we put in place corrective actions to improve the performances of individuals and systems.

There have been some significant interventions by the Trust in response to learning from medication errors:

- Review of the medicine administration record
- Redesign of clinical areas to ensure no dual use
- Private consultation with service users when administering medicines to all time for therapeutic engagement and education
- Improving the handover process between MDTs

Table 4 Medication Errors

Metric	13-14	14-15	15-16	April to June 2016	Target	Trend
Medicine Omissions	NA	NA	N=44	N=9	> 0	NA
Medication errors presenting highest risk of harm	NA	N=31	N=39	N=11	> 0	NA

Clinical Effectiveness

Clinical effectiveness is about whether a service user's treatment, care and support was successful and whether it has the impact that it is supposed to have is it achieving the best possible result or outcome for the service user.

Providing effective treatment, care, and support is at the heart of our vision to make a meaningful impact and change to our service users' lives. We aim to make sure that the care we provide to our service users and their families achieves the best possible impact on their health, wellbeing, and quality of life.

We continue to work with our clinical team to develop a set of clinical effectiveness metrics because we believe they act as an incentive to improve quality. Clinical effectiveness metrics also inform our service users and others to see how we are doing in relation to the effectiveness of the care pathway, and enable the Trust board, through its Quality and Risk committee, to monitor performance.

Safe and Effective Identification of Risk of Choking

The metrics in relation to risk of choking are indications of the Trust focusing on an evidenced based approach to mitigating against one of the highest risk of injury to our service users. The Trust has been at the forefront of developing a risk-screening tool for dysphagia. There have been focussed efforts on ensuring that all service users are risk assessed routinely and in response to a change in clinical presentation. This also forms part of the Trust's 'Sign Up to Safety Plan'. The screening upon admission, whilst it has not met the target has significantly improved. However, we are assured that all service users had a risk screen on admission but not within the first 2 weeks.

The annual review of risk of choking has achieved full compliance and is another indication of the effectiveness of the Integrated Treatment and Care Plan.

Table 5 Risk of Choking Assessments

Metric	13-14	14-15	15-16	April to June 2016	Target	Trend
All new admissions to the Trust have received a risk of choking screening assessment by week 2 of the care pathway	79%	78%	90%	100%	100%	↑

Metric	13-14	14-15	15-16	April to June 2016	Target	Trend
All service users receive an annual risk of choking screening assessment	97%	99%	100%	!00%	100%	➔

The Care Pathway

NHS England has introduced an ambitious programme of change called 'Transforming Care (DH, 2015) to improve the care provision for people with learning disabilities. Fundamental to delivering the Transforming Care agenda is the Trust's care pathways. Our care pathways show a clear journey of care for service users, which set out what they can expect from their treatment, how long it may take and who will provide their care. Table 6 gives an overview of the metrics that identify key processes in the care pathway, and give an indication of their effectiveness.

The multi-disciplinary teams have been outstanding in the implementation of the new Integrated Treatment and Care Plan with 100% completion by week 12.

There is almost full compliance with six-monthly review of the risk assessment. This measures the routine review of the Trust's risk screening tool to ensure no service user goes longer than 6-months without a full review of all their risks. The areas of non-compliance are again related to the risk assessment being confirmed by the consultant psychiatrist, although the multi-disciplinary team had fully reviewed the risk assessments was part of the ward round process.

The relocation of all clinical staff not direct care roles on to the wards in response to introducing the metric 'service users have had a review in between their ward round review' has had a significant impact on the metric. We continue to have an ambitious target of 100% but for the 2015-2016 reporting period we have seen a 39% improvement on last year's metric and a further 2 % improvement for quarter 1 of 2016. We continue to monitor within the Medical team meetings to ensure we are maintaining our commitment to ensure that a psychiatrist regularly reviews our service users.

NICE guideline 'Challenging behaviour and learning disabilities: prevention and interventions for people with learning disabilities whose behaviour challenges' (NG11)

makes clear recommendations for the monitoring of side effects of anti-psychotics for people with learning disabilities. The Department of Health issued advice regarding the use of antipsychotic medicines and potential for side effects for people with learning disabilities. The LUNSERS metric is an indication that the Trust already viewed this issue as concerning and had introduced steps to ensure monitoring and change. As previously reported we have not had any reported cases of service users experiencing side effects resulting in a 'high' score. We continue to monitor that service users are reviewed routinely every 12 weeks and we are extremely pleased that we have achieved compliance with the metric with 96%. Compliance with LUNSERS will continue to be driven through regular monitoring and education of clinical staff and service users.

Table 6 Care Pathway Measures

Metric	13-14	14-15	15-16	April to June 2016	Target	Trend
All service users will have an Integrated Care Plan by week 12 of the care pathway	83%	88%	100%	100%	>= 95%	→
All service users will have a review of their current risk profile by the MDT at least every six months	99%	99.%	99%	99%	>= 95%	→
Service users have had a review in between their ward round review (new September 2014)	NA	51%	91%	93%	100%	↑
3 monthly monitoring of side effects of antipsychotics using Liverpool University Neuroleptic Side Effect rating Scale (LUNSERS)	NA	35%	72%	96%	>= 95%	↑

Patient Experience

NB There has been no change to these measures during 1 April 2016 to 30 June 2016. A new set of experience measures are in development aligned to MCFT. Whilst no data sets collected between April to June 2016 the service continues to learn from the 2015/16 findings

Feedback from our service users on their experiences is increasingly valued by the Trust. We have improved our data collection processes, our reporting of the data, and using it to improve services.

Staff engagement in service user experience work is fundamental to improving services. The Trust ensures that:

- Data is available at team and ward level
- Experience data is recognised as valuable and contributes to good outcomes and safety
- Staff are engaged in carrying out experience work (gathering and using data)
- Good clinical leadership
- Service users and families/carers are involved in dialogue about what the data means and what can be done about it

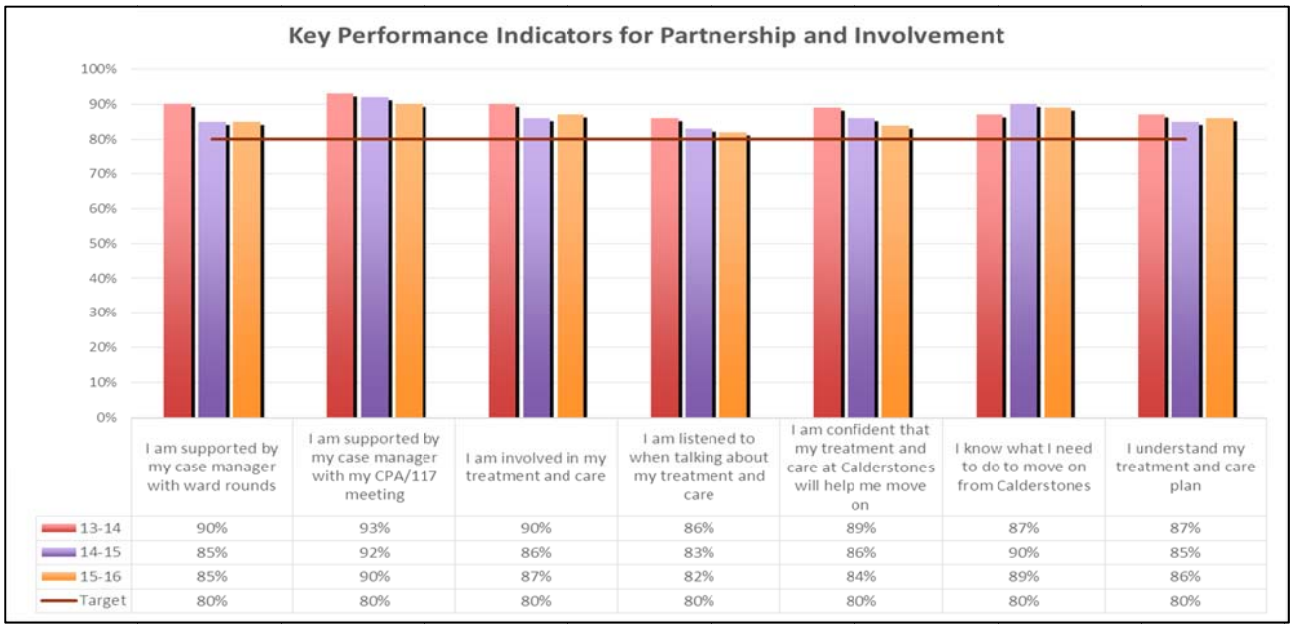
Listening to service users' views is essential to provide person-centred services. The experience metrics systematically gather the views of service users about the care they have recently received.

The metrics outlined in figures 5 to 10 focus upon the experience of service users, and endeavour to address the importance of the service user experience within the Trust, and ensure that service users are treated with compassion, dignity and respect within a clean, safe and well-managed environment (High Quality Care for All, 2008). The Trust has experience metrics aligned to the NICE Clinical Guidelines 136 (2011) “Service User Experience in Adult Mental Health”, and the Department of Health’s Final review of Winterbourne View (DH, 2012), the CNO’s 6Cs, and the values and principles underpinning the preferred ‘model of care’.

Partnership and Involvement

Good partnership and involvement makes a significant difference to our services users experience of care, it also helps to improve our services. Involvement in individual treatment and care increases self-esteem and improves outcomes. Involvement in care planning has beneficial effects on decision-making by service users. It is welcoming to see the performance of our partnership and involvement metrics all comfortably above their targets for the second year. With the investment in developing the new Integrated Treatment and Care Plan it is good news to see that involvement and understanding of treatment and care planning has improved

Table 5 Partnership and Involvement Metrics



	I am supported by my case manager with ward rounds	I am supported by my case manager with my CPA/117 meeting	I am involved in my treatment and care	I am listened to when talking about my treatment and care	I am confident that my treatment and care at Calderstones will help me move on	I know what I need to do to move on from Calderstones	I understand my treatment and care plan
13-14	90%	93%	90%	86%	89%	87%	87%
14-15	85%	92%	86%	83%	86%	90%	85%
15-16	85%	90%	87%	82%	84%	89%	86%
Target	80%	80%	80%	80%	80%	80%	80%

The Trust is committed to shared decision-making to ensure relationships more open and transparent. We want service users to be engaged and involved, more able to take responsibility for their actions, and more committed to following the care plans they have been involved in developing.

Trust and Support

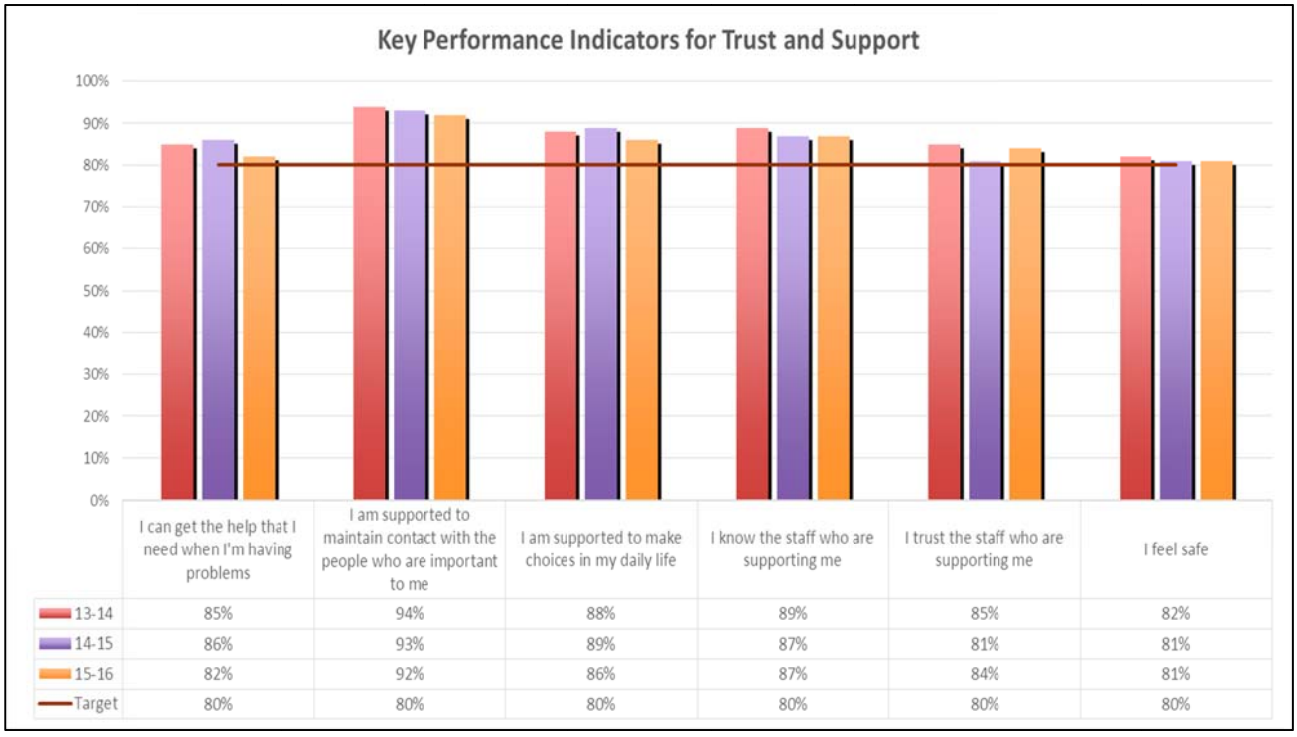
A service users' 'trust' in their care teams is recognised as vital as it underpins a positive therapeutic relationship. We understand the concept of 'trust' to mean 'we keep our promises' to our service users.

Service users' experience of trust is a reflection of the commitment from our clinical teams in developing the relationships with our service users. It is important to build trust with our

service users not only to ensure we provide the right level of support but also to promote optimism and aspiration as part of their recovery.

These metrics are a means of assessing service user satisfaction with the trust our service users have in the level of support they receive. All of the measures are meeting the 80% threshold, and in the case of supporting contact with significant others the feedback for a second year is excellent. This is important when considering future planning for service users and supporting the relationship between service users, family/friends and the care team. There has been improved performance with knowing and trusting the staff supporting our service users, which is a superb commendation for our staff commitment to building meaningful relationships.#

Figure 6 Trust and Support Metrics



	I can get the help that I need when I'm having problems	I am supported to maintain contact with the people who are important to me	I am supported to make choices in my daily life	I know the staff who are supporting me	I trust the staff who are supporting me	I feel safe
13-14	85%	94%	88%	89%	85%	82%
14-15	86%	93%	89%	87%	81%	81%
15-16	82%	92%	86%	87%	84%	81%
Target	80%	80%	80%	80%	80%	80%

Communication and Support

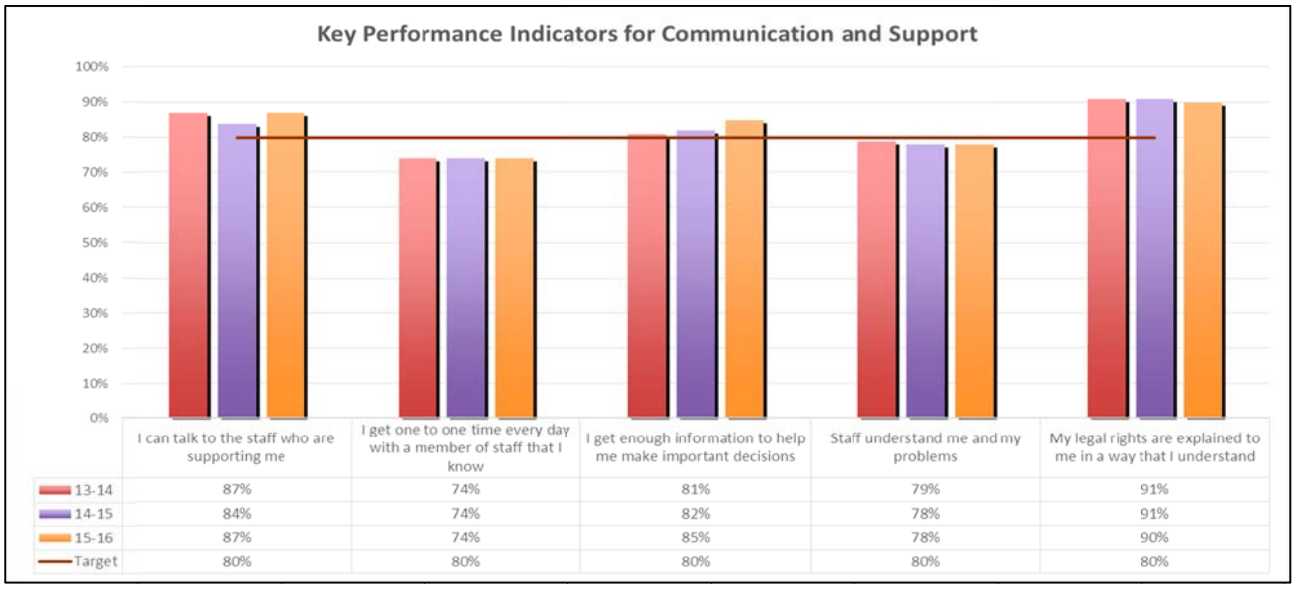
Communication is vital in ensuring that people with learning disabilities can express themselves and make sense of what is happening within their treatment and care pathway. With the right support, people with a learning disability can achieve their full potential, as long as support is communicated in an understanding way.

Communication as a Trust value means 'we are open and honest in our communication'. The metrics in figure 7 outlined in our experience metrics are a way of enabling us to evaluate how well we communicate with service users.

There is little variation in feedback between this year and last year, although this is evidence of considered responses from our service users. Again the service users appear to have confidence in talking to the staff, as well as trust and support, but it would appear that they may not be getting that one to one time with familiar staff. Yet there is incongruence between the feedback for being able to talk to staff, which is at 87% and feeling that they are understood. As part of the ICP development, the Trust has ensured that all service users have a communication and sensory needs screening assessment. Based upon this assessment were needed service users all have an augmentative and alternative communication plan.

In addition, the Trust has been leading a national piece of work on behalf of the National Offender Management Service (NOMS) to improve outcomes for offenders with leaning disability. This has been the development of a communication tool, which has been piloted in criminal justice services and is to be implemented across the Trust. It would be anticipated that this should improve service user's perceptions of being understood.

Figure 7 Communication and Support Metrics



	I can talk to the staff who are supporting me	I get one to one time every day with a member of staff that I know	I get enough information to help me make important decisions	Staff understand me and my problems	My legal rights are explained to me in a way that I understand
13-14	87%	74%	81%	79%	91%
14-15	84%	74%	82%	78%	91%
15-16	87%	74%	85%	78%	90%
Target	80%	80%	80%	80%	80%

Ownership and Empowerment

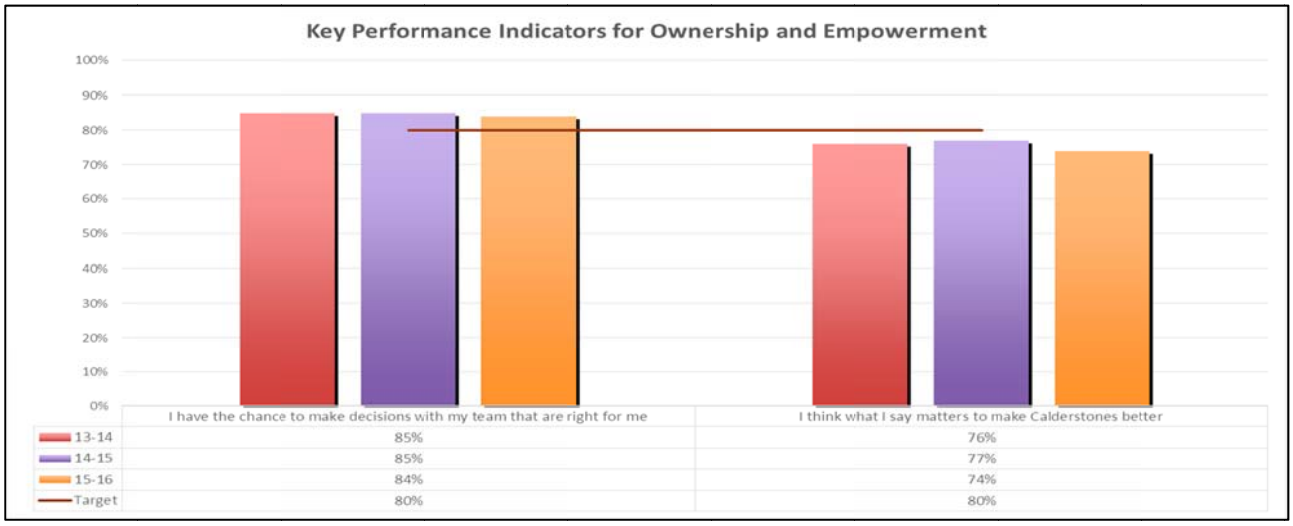
Service user participation in decision making is considered an essential to recovery. There is great potential in shared decision to make an impact on service users' knowledge and positively influence their experience of care. To facilitate shared decision making, there is a need for increased knowledge regarding the users' own perspective. The principle aims are that service users are perceived as competent and equal decision makers.

People with learning disabilities when viewed as service users are not seen as equal partners in designing and implanting solutions to a wide range of issues and problems. These metrics are designed to get feedback from our service users on how empowered they feel about taking control and making decisions about personal care and service delivery at Calderstones. The service users' direct experiences of using services, means they have a unique insight into what works, which can be used to improve services. For service users with offending backgrounds involvement can support desistance, by giving them an opportunity to become active citizens, to gain skills and a sense of self-worth.

The feedback relation to decision making in treatment and care is very positive for the third consecutive year, and correlates with previous measures about involvement with treatment and care.

However, in relation to wider Calderstones issues the feedback is not as positive as we would have hoped. The Transforming Care agenda means Calderstones is experiencing a significant amount of change and there is a level of uncertainty but raised expectations form our service users. The results indicate the need for improved consultation with our service users and ensuring they are active in shaping the changes to services.

Figure 8 Ownership and Empowerment Metrics

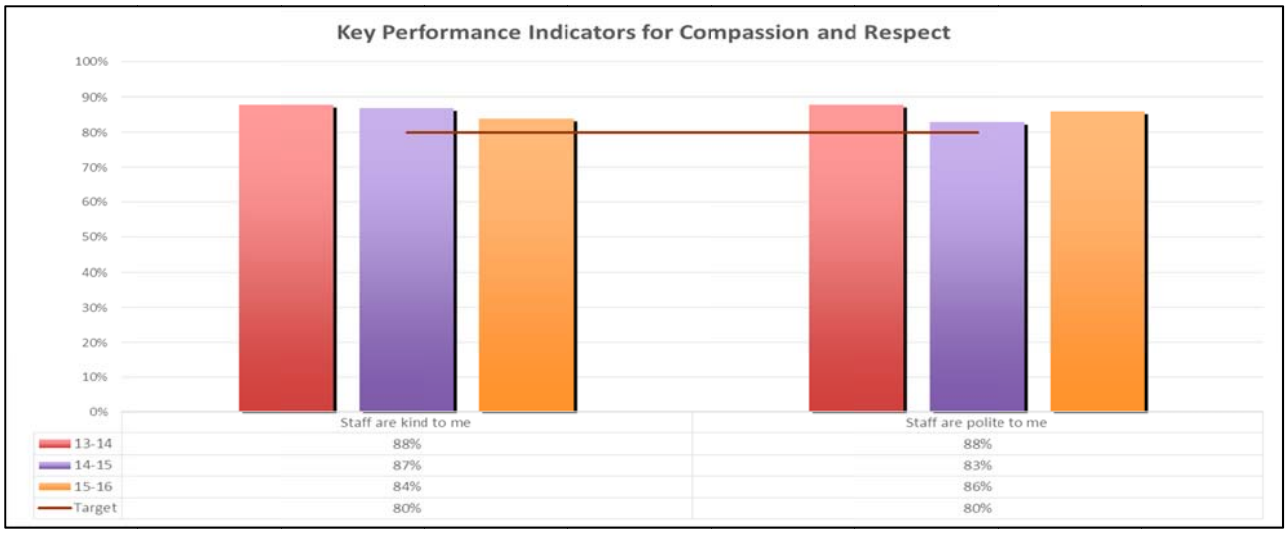


Compassion and Respect

For the Trust values 'compassion' and 'respect' we endeavour to show empathy and sympathy to the needs of others, as well as engage, listen to and value the contribution of others. As a Trust, we believe that 'kindness' is central core value to ensure service users recovery. Kindness conveys openness and generosity without judgment and respects the dignity of the other person.

It is reassuring that our service users have given such positive feedback regarding the level of kindness and politeness they receive from staff both comfortably above target. It is indicative of the attentiveness of our staff to service users' needs and their empathy and compassion.

Figure 9 Compassion and Respect Metrics


Key Performance Indicators for Compassion and Respect
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
Staff are kind to me
Staff are polite to me
13-14
88%
88%
14-15
87%
83%
15-16
84%
86%
Target
80%
80%

Excellence and the Meaningful Day

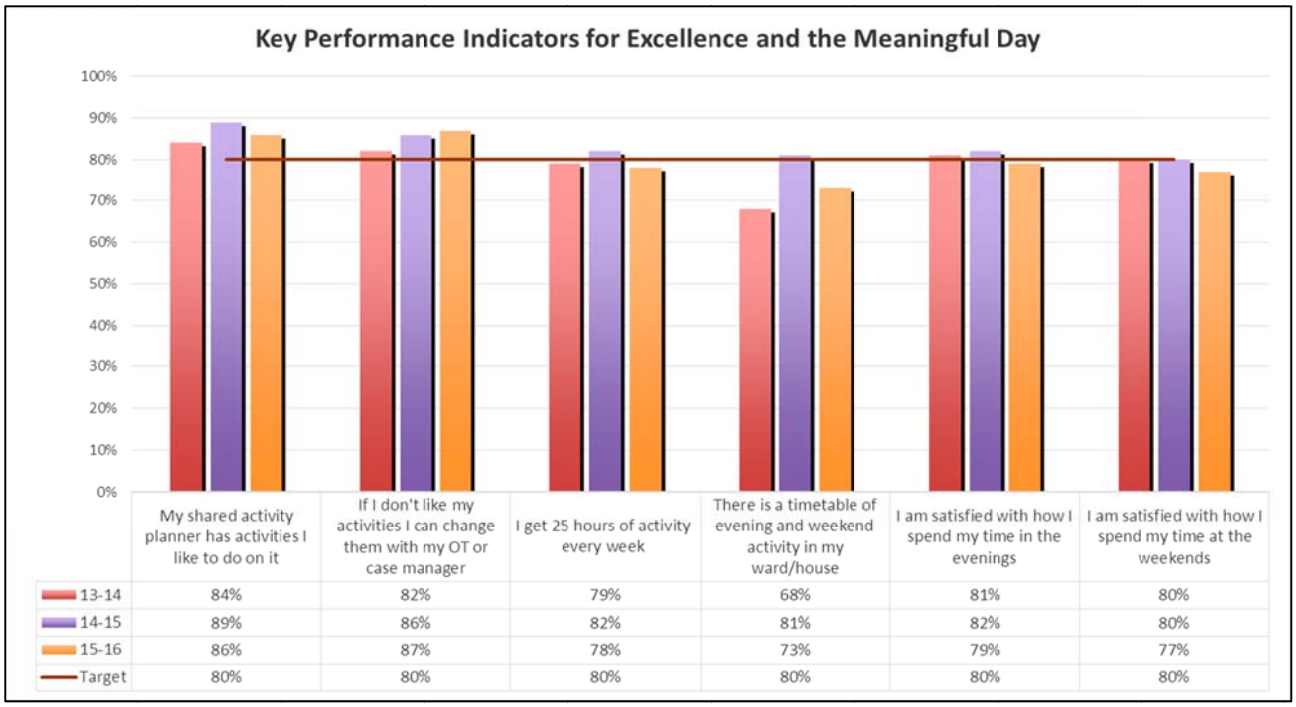
NICE Quality Standard 14 Service User Experience in Adult Mental Health states people in hospital for mental health care will access meaningful and culturally appropriate activities seven days a week and not restricted to 9am to 5pm. This should be tested through experience surveys and feedback that service users in hospital.

These metrics have been developed to test our compliance with the NICE standard, and how well we align to our Trust value of ‘excellence’. Meaningful activities give the service user a sense of purpose and control over their life. Social interaction, learning, and employment (both paid and unpaid) are important factors in generating a sense of hope and meaningfulness.

A sense of meaningfulness is the belief that the activity the service user is undertaking is worth effort, commitment and emotional investment. The Shared Activity Planner is developed by actively engaging with service users about their goals and developing a programme of activities that will help meet their aspirations. Having a meaningful Shared Activity Planner ensures motivation and central to recovery.

All of the metrics are reporting above the target, with the exception of weekend activities. This feedback emerged early into the 2015 reporting period. The Trust took action to rethink and redesign the staffing resource to address this issue. A dedicated support role was created and appointed to each ward are to ensure the development of ward-based activities particularly at weekends. Teams deployed the role in varying ways; some introducing it as a rotational role for all staff to undertake, with the message that meaningful activities were all staffs' responsibility; and others creating a standalone role. There would appear to be greater success where the role is a standalone as that person develops their skills and expertise. There has been an agreement that the role will be implemented as dedicated role across the whole service.

Figure 10 Excellence and Meaningful Day Metrics



	My shared activity planner has activities I like to do on it	If I don't like my activities I can change them with my OT or case manager	I get 25 hours of activity every week	There is a timetable of evening and weekend activity in my ward/house	I am satisfied with how I spend my time in the evenings	I am satisfied with how I spend my time at the weekends
13-14	84%	82%	79%	68%	81%	80%
14-15	89%	86%	82%	81%	82%	80%
15-16	86%	87%	78%	73%	79%	77%
Target	80%	80%	80%	80%	80%	80%

Statement of directors' responsibilities for the quality report

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare Quality Accounts for each financial year.

Monitor has issued guidance to NHS foundation trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS foundation trust boards should put in place to support the data quality for the preparation of the quality report.

In preparing the Quality Report, directors are required to take steps to satisfy themselves that:

- The content of the Quality Report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2015/16 and supporting guidance;
- The content of the Quality Report is not inconsistent with internal and external sources of information including:
    - Board minutes for the 1 April 2016 to 30th June 2016;
    - Papers relating to quality reported to the Board over the period 1 April 2016 to 30th June 2016;
    - Feedback from Commissioners dated 23/05/2017:
    - Feedback from local Healthwatch organisations dated 17/05/2017;
    - The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 19/07/2016
    - The national staff survey dated 23/02/2016;
    - Subsequent to the acquisition of the Trust by Mersey Care NHSFT in July 2016 there were no identified weaknesses in the process and control environment highlighted through the organisation via Mersey Internal Audit Agency(the Trusts Internal Auditors)
- The Quality Report presents a balanced picture of the NHS foundation Trust's performance over the period covered;
- The performance information reported in the Quality Report is reliable and accurate;
- There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice;

- The data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and

- The Quality Report has been prepared in accordance with Monitor's annual reporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the Quality Report.

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Report.

By order of the board

Date: 24/5/17 Joe Rafferty, Chief Executive

Date: 24/5/17 Mark Hindle, Executive Director of Operations, Mersey Care NHS Foundation Trust (formerly Chief Executive, Calderstones Partnership NHS Foundation Trust)

Annex 1:

Statements received from Local Involvement Networks, Service Users Forum, Overview and Scrutiny Committee, Primary Care Trust and Specialist Commissioning

- **Healthwatch Lancashire's Response to Calderstones Partnership NHS Foundation Trust's Quality Account 1 April to 30 June 2016**

Thank you for enabling Healthwatch Lancashire to comment on your Quality Account.

First we must congratulate you on being rated 'Good' at your most recent CQC inspection. For a diverse Mental Health Trust undergoing many changes, this is indeed a highly creditable outcome.

We trust that those areas which still 'require improvement', especially any connected with the well-being of staff and the care of patients will be given urgent attention. We are somewhat concerned to note that staff appraisals are not yet fully comprehensive. Whilst recognising that other Trusts have problems in this area, it does seem to be an especially significant concern for a mental health organisation.

We note that you emphasise that one of the purposes of the Quality Account is to communicate your work with stakeholders, carers and patients. To us, this is a vital though by no means straightforward matter. We appreciate that the form of such Accounts is already prescribed for you. But that means that they are no 'easy read', and we would urge that such a version be produced if feedback from such groups is to be seen as genuinely sought.

As a Lancashire based body, we are still registering concerns about how former patients of Calderstones who were able to live 'in community' can continue to do so, especially given the shortage of locally available support staff and accommodation.

Finally, we hope that it may be possible for you to respond to our submission. Our experience in attempting to respond constructively to other Trusts and CCG's in the area in which we operate sometimes gives the impression that we are being consulted merely for form's sake rather than as genuinely concerned stakeholders.

We wish the Trust all success as it moves forward in a very uncertain environment.

- **East Lancashire Clinical Commissioning Group Response to Calderstones Partnership NHS Foundation Trust's Quality Account 1 April to 30 June 2016**

Priorities 2016/17

Prior to their acquisition by Mersey Care NHS Foundation Trust (MCFT), CPFT identified 3 priorities for improvement in 2016/17:

- *<u>Violence reduction project</u> – This project is aligned to the 'No Force First' quality priority for MCFT. The CCGs commend the Trust on progress made against 'No Force First' with achievement of all objectives identified, and a reduction in restraint across all wards throughout 2016/17. The number of restraints increased in May 2016 but started to decrease in June 2016 at CPFT. The CCGs were disappointed*
- *to note the increase in injury sustained by service users as a result of physical intervention from 2.7% in 2015/16 to 4% for quarter 1, 2016/17. Injuries to staff as a result of physical intervention remained at 9.8%, which is similar to the 2015/16 annual position.*

- *<u>Reduction in self-harm</u> – This project is aligned to the 'Towards Zero Suicide' quality priority for MCFT. The Trust has not achieved all objectives for 'Towards Zero Suicide'.*

- *<u>Ward accreditation</u> – This project has been incorporated into the Trust wide ward accreditation work stream.*

The CCGs are pleased that MCFT have continued these schemes following the acquisition and are encouraged with the work carried out in these areas. The CCGs note the actions to implement the priorities and objectives will continue into 2017/18.

The CCGs were delighted with CPFTs Care Quality Commission (CQC) rating of 'Good' following a visit in October 2015. The CCGs commend the Trust on all the hard work undertaken to achieve the fundamental standards of quality and safety.
In addition, the CCGs support the safety pledges developed as part of the 'Sign up to Safety' campaign. The CCGs commend the Trust on the progress made with achievement of 100% of new admissions receiving a risk of choking assessment with 100% of service users having this updated annually.

CPFT have implemented some interventions in response to learning from medication errors to attempt to reduce and eliminate high risk medication errors. The data reported in the Quality Account compares the period 1st April 2016 to 30th June 2016, with previous years data. It is difficult for the CCGs to note a reduction in these errors as there is no quarterly breakdown of the previous years to compare trends. High risk medication errors for the quarter 1 period are reported at 11. The previous year (2015/16) reported a total of 39 across all 4 quarters. The CCGs will work with the Trust to progress this agenda.

2016/17 Quality Indicators and CQUIN

CPFT performed well against the 2016/17 quality indicators. Compliance with NICE guidelines is currently under review and work is on-going with MCFT following the acquisition. The CCGs are supporting the development of a robust review and implementation process where the Trust have identified applicable guidance, with timescales to implementation. The CCGs continue to work with MCFT to ensure that data and information can be reconciled against the quality indicators, providing assurance of standards to stakeholders.

All three Commissioning for Quality and Innovation (CQUIN) schemes have been achieved for the period 1st April 2016 to 30th June 2016.

Between 1st April 2016 and 30th June 2016, CPFT were not eligible to participate in any of the National Clinical Audit programmes or National Confidential Enquiries.

A number of data quality targets and patient experience reporting is unavailable for the period 1st April 2016 to 30th June 2016 and is therefore not included in the CPFT 2016/17 Quality Account.

It is disappointing to note that the Friends and Family test scores for quarter 1, 2016/17, have not been included in the Quality Account. However the CCGs are aware that 53.7% of service users would be likely or highly likely to recommend the service, 19.5% were neither likely nor unlikely to recommend and 26.8% indicated they would be highly unlikely to recommend the service to friends and family.

Following the acquisition of CPFT to MCFT; the CCGs will continue to work with MCFT on the Quality agenda, meeting to review quality performance, liaising with other Commissioners and carrying out announced and unannounced quality walk rounds to ensure that services commissioned are of a high quality standard and provide safe, personal and effective care.

Lancashire Overview and Scrutiny Committee Response to Calderstones Partnership NHS Foundation Trust's Quality Account 1 April to 30 June 2016

No comment provided

Annex 2: Report on Clinical Audit Outcomes. Qtr. 1 (April – June 2016)

	Audit Topic	Date of Audit	Audit Objective	Re-Audit	Summary of Findings	Outcomes/Changes in Practice
1	Collaborative Risk Assessments	April 16	To ensure that all service users are involved in a process of collaborative risk assessment and management To ensure that adequate staff members have been trained enabling them to complete the collaborative risk assessments with service users	✕	This audit was undertaken as part of the CQUIN measures set out by NHS England with regards to secure service users active engagement programmed (collaborative risk). • 100% of service users had a normal risk profile. • 99% of service users had a user friendly risk profile in place. • 93% of service user's had a clinical note confirming that the risk profile had been completed collaboratively. • Overall 100% of service users had either of a	Following the audit a brief was sent out though the local team meeting (LTM) reminding staff to update the user friendly risk profile when changes are made to the normal risk profile. IT also sent out guidance to all staff on completing the user friendly version. Discussions are ongoing with IT regarding the possibility of adding the user friendly risk profile version onto Carenotes Assist to act as a prompt. As a result of the low number of the user friendly risk profiles matching that of the normal risk profiles IT will create and run a report which will clearly identify where there are differences. There are no plans for a re-audit in 16-17.

	Audit Topic	Date of Audit	Audit Objective	Re-Audit	Summary of Findings	Outcomes/Changes in Practice
					user friendly risk profile or a clinical note evidencing that their risk profile had been completed collaboratively. • Only 45% of the user friendly risk profile scores matched that of the normal risk profile. • 73% of the trusts qualified staff had received training on collaborative risk.	
2	Smoking Cessation	April 16	To ensure that all service users within the trust who smoke are offered the relevant information and support with regards to smoking cessation.	✕	This audit was undertaken as part of CQUIN measures set out by NHS England with regards to smoking cessation in mental health services. There is little evidence to suggest that when service users are admitted to the trust they are given any	As a result of the audit the following actions are currently in progress. This was slightly delayed due to the acquisition by Mersey Care but should now be back on track. • Band 4 and ward based "smoking cessation champions" to be trained up to provide information on benefits of smoking cessation as part

	Audit Topic	Date of Audit	Audit Objective	Re-Audit	Summary of Findings	Outcomes/Changes in Practice
					information regarding smoking cessation and the support that the trust can provide should they wish to give up smoking either following admission or at some point in the future. The service users did not appear to have received any information on the trusts policy re smoking or the benefits of stopping smoking. It would appear from the information available that if the service user said 'don't want to give up/ not ready to give up smoking' no further information was given to them. The trust's admission health physical form is completed and has to parts, A and B. Part A is completed within the 1st hour of admission and does not contain any	of the programme and once in post implement NICE guidelines around pre-admission smoking cessation checklist. • Part A admission physical Health document to include questions relating to smoking habit of new admissions • Person centred smoking cessation plan to be integrated into individualised smoking cessation plan of current smokers. • Service users will be supported to comply with recommended pharmacotherapies in their smoking cessation plan/abstinence. This is a continuing CQUIN however there are no plans for this specific aspect of smoking to be re-audited in 16-17.

	Audit Topic	Date of Audit	Audit Objective	Re-Audit	Summary of Findings	Outcomes/Changes in Practice
					smoking related questions. Part B which does have smoking related questions can be completed up to 7 days after admission.	
3	Type 2 Diabetes	May 16	To ensure that the trust is discharging their responsibility with regards to NICE guidance for type 2 diabetes	✕	This audit was undertaken to establish the trusts level of compliance with the NICE guidance for type 2 diabetes. Overall impressions for the management of type 2 diabetes at Calderstones NICE guidelines were followed. But there are areas, we could improve as follows: • Adherence to healthy life styles including weight management and smoking cessations. • Monitoring lipid profile annually.	As a result of the audit Dr responsible for physical health is giving consideration for a protocol to be completed with regards to the unlicensed use of metformin. This is still ongoing. There are no plans for a re-audit in 16-17.

	Audit Topic	Date of Audit	Audit Objective	Re-Audit	Summary of Findings	Outcomes/Changes in Practice
					• Lipid lowering medication should be prescribed for all type 2 diabetes. • Albumin Creatinine ratio measurement check-up annually.	
4	Standard of Completion of H5 Form	May 16	To set standard for completion of form H5.	✕	This audit was requested to be completed by a consultant. It had come to light that there was a big variation in the completion of the H5 form. The audit found the following: • No mention of patient's exact diagnosis of mental disorder-Learning disability of Mild, Moderate or severe in nature. • Variation in description of Nature and degree of illness. • It appears that there is no	Following the audit it was agreed that the following should be standard items when completing H5: • Patient's admission date and Diagnosis if available. • Reason for admission briefly. • Nature and degree of illness especially degree. • Current risk at the time of completion of H5 should indicate patients health, safety and protection of others. • Brief reason why informal admission is not appropriate. There are no plans for a re-audit in 16-17.

	Audit Topic	Date of Audit	Audit Objective	Re-Audit	Summary of Findings	Outcomes/Changes in Practice
					uniformity of information given on completion of H5 form and no standard was set by the trust.	
5	Medicines	April 16	To ascertain the compliance throughout Trust with storage and handling of medication procedures and to make any recommendations for improvement.	✕	This audit was completed by the trust's pharmacy team after reviewing the previous CQC report and identifying key areas where the trust did not meet the standards. Extensive improvements have been made in all areas throughout the year, most significantly in the reduced numbers of expired medicines and the reduction of untidy cupboards providing safer administration. Along with the action plans above and more proactive input from the pharmacy team further improvements	No recommendations were made from this audit. The storage and handling of medicines is continuously monitored by the trusts pharmacy team. There are no plans for a re-audit in 16-17.

	Audit Topic	Date of Audit	Audit Objective	Re-Audit	Summary of Findings	Outcomes/Changes in Practice
					should continue to be made. Savings have been made towards the end of the year with more control over supplies of monthly mediation supplied from BGH. Although not all wards were included in the March Savings, (11 wards only) the total saved reached £1009.50p. Other areas identified as needing improvement will be taken on board and will be addressed over the coming months, with the implementation of a robust system, specifically the medicine trail of supplied medicines to outside care providers (Leave medicines) and returned items back to the ward and BGH.	