Lincolnshire Partnership NHS Foundation Trust

Forensic inpatient/secure wards

Quality Report

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Locations inspected

Name of CQC registered location	Location ID	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
Mental Health Unit Lincoln County Hospital Site	RP7EV	Francis Willis unit	LN2 5QY

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

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

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

Summary of findings

Ratings

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

Overall rating for Forensic inpatient/ secure wards

Are Forensic inpatient/secure wards safe?	
Are Forensic inpatient/secure wards effective?	
Are Forensic inpatient/secure wards caring?	
Are Forensic inpatient/secure wards responsive?	
Are Forensic inpatient/secure wards well-led?	

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

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

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

Summary of findings

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Summary of findings

Overall summary

Our findings at The Francis Willis unit were:

Risk assessments and management plans were available for patients and a current ligature audit risk assessment was seen. A local risk register was in place and this was used to identify any wider trust learning from incidents. These had been investigated appropriately and any lessons learnt had been shared through the trust's reporting systems. This meant that the trust had taken steps to ensure the safety of patients and others.

Staff received additional role specific training. For example, forensic services, substance misuse and reinforce the appropriate and implode the disruptive (RAID) training had been provided for front line staff. Different professions worked effectively to assess and plan care and treatment programmes for patients.

Patients were positive about the support which they received on the unit. We saw good examples of effective staff and patient interaction and individual support being provided.

Clear assessments were in place to ensure that the unit's admission criteria were being met. The trust reported responsive joint working with the commissioners of this service. Each patient had a weekly occupational therapy programme. Evidence was seen of monitoring arrangements to ensure that patients were offered at least 25 hours of activity per week.

Staff reported positive morale and good peer support. The unit was a member of the Royal College of Psychiatrist's quality network for forensic mental health services. The last review had taken place in March 2013.

But we also found:

- There was an inconsistent approach to the updating and review of some risk assessments and care plans.
- There was no dedicated family and child visiting room on the unit.

Summary of findings

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

Are services safe?
Our findings at The Francis Willis unit were:

Patients told us that they usually felt safe on the unit. Staff were responsive if individual concerns were identified.

Staff knew how to safeguard people who used the service from harm. Staff received training in the management of violence and aggression. We found that restraint was used safely and seclusion only used as a last resort.

Staff reported any incidents/accidents and there was a system in place for reviewing and learning from them to prevent a reoccurrence.

Risk assessments and management plans were available for patients and a current ligature audit risk assessment was seen. This meant that the trust had taken steps to ensure the safety of patients and others.

Systems were in place to ensure adequate staffing levels and appropriate skill mix on the unit to meet the needs of individual patients.

Are services effective?
Our findings at The Francis Willis unit were:

Patients had comprehensive multi-disciplinary assessments and updated care plans in place. Staff had identified any physical healthcare needs and care plans were in place to support these.

Staff received additional role specific training. For example, forensic services, substance misuse and reinforce the appropriate and implode the disruptive (RAID) training had been provided for front line staff.

Different professions worked effectively to assess and plan care and treatment programmes for patients.

Mental Health Act records were well kept and any identified concerns were promptly addressed by the provider.

But we also found:

- There was an inconsistent approach to the updating and review of some risk assessments and care plans.

Are services caring?
Our findings at The Francis Willis unit were:

Summary of findings

Patients were positive about the support which they received on the unit. We saw good examples of effective staff and patient interaction and individual support being provided.

Staff explained to us how they delivered care to individual patients. This demonstrated that they had a good understanding of the needs of patients on the unit.

Advocates were available on the unit and there was information available in the ward about access to advocacy services.

Are services responsive to people's needs?

Our findings at The Francis Willis unit were:

Clear assessments were in place to ensure that the unit's admission criteria were being met. The trust reported responsive joint working with the commissioners of this service.

Patients had access to a secure enclosed garden and this included a smoking shelter. The unit had their own occupational therapy department. Each patient had a weekly occupational therapy programme. Patients had access to a fully equipped gym. This facility was supported by a qualified gym instructor.

Evidence was seen of monitoring arrangements to ensure that patients were offered at least 25 hours of activity per week. We saw that patients were being supported to access Section 17 leave supported by staff following clear risk assessments.

But we also found:

- There was no dedicated family and child visiting room on the unit.

Are services well-led?

Our findings at The Francis Willis unit were:

Staff were aware of the trust's vision and values. These were displayed on the entrance to the unit. The unit manager and other senior clinicians were visible to front line staff and patients.

Staff reported positive morale and good peer support and told us that their line manager was supportive and provided clear guidance.

Senior clinicians had access to governance systems that enabled them to monitor the quality of care provided. This included the trust's electronic incident reporting system, trust and unit based audits and electronic staff training record.

Summary of findings

Staff received annual appraisals and the current rate was 91%. Systems were in place to gain patients' views and patients' experience feedback was collated every three months and reviewed by the trust's quality committee.

The chief executive officer held monthly roadshows to engage with frontline staff. The unit was a member of the Royal College of Psychiatrist's quality network for forensic mental health services. The last review had taken place in March 2013.

Summary of findings

Background to the service

The Francis Willis unit is a purpose built unit providing care and treatment in a low secure setting for men with severe and enduring mental health needs. It is located within the grounds of a large NHS acute trust in Lincoln.

The unit has 15 beds and these were all occupied. Each patient was detained under the Mental Health Act 1983. They were subject to additional restrictions by the Ministry of Justice.

The location was last inspected by the Care Quality Commission on 03 June 2013 and there were no regulatory breaches identified.

Our inspection team

Our inspection team was led by:

Inspection manager**: Peter Johnson, interim hospital inspection manager CQC**

The team that inspected this location were a CQC hospital inspection manager, two CQC inspectors, a Mental Health Act reviewer, a specialist senior registered mental nurse advisor and an expert by experience that had experience of using mental health services.

Why we carried out this inspection

We carried out an unannounced focused inspection of this core service following concerns identified to the Care Quality Commission.

How we carried out this inspection

To get to the heart of people who use services' experience 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?

Before visiting this location, we reviewed information which was sent to us by two whistle-blowers and reviewed a number of incidents that were notified by the trust via the national reporting and learning system (NRLS) and those reported directly to the Care Quality Commission.

During the inspection visit the inspection team:

- Visited the unit and looked at the quality of the ward environment and observed how staff were caring for patients.
- Spoke with five patients.
- Spoke with the ward manager and charge nurse for the unit.
- Spoke with five senior trust managers with accountability and responsibility for this location. This included two trust directors, the interim deputy director of nursing and quality, the modern matron for these services and the team leader.
- Spoke with five frontline staff members including the responsible clinician (RC) and lead social worker.

We also:

- Reviewed in detail four individual assessment and treatment records and the relevant prescription charts.
- Examined the legal records in relation to people's detention under the Mental Health Act 1983.

Summary of findings

- Looked at a range of policies, procedures and other records relating to the running of this service.

The team would like to thank all those who met and spoke to the inspection team during the inspection and were open and balanced with the sharing of their experiences and their perceptions of the quality of care and treatment at this location.

What people who use the provider's services say

During the inspection the inspection team

- Spoke with five patients
- Reviewed the trust's quality monitoring systems such as patient surveys.

Patients told us that they usually felt safe on the unit and received good treatment. They told us that they felt involved in their individual care and that staff listened to them.

Patients told us that activities that they enjoyed were offered. They confirmed that the food provided was good. Patients said that they were seen regularly by their responsible clinician and were aware of their care plans

Good practice

- A local risk register was in place and this was used to identify any wider trust learning from incidents. These had been investigated appropriately and any lessons learnt had been shared through the trust's reporting systems.
- Staff received additional role specific training. For example, forensic services, substance misuse and reinforce the appropriate and implode the disruptive (RAID) training had been provided for front line staff.
- Periodic 'mock' Care Quality Commission inspection visits had started in the trust to monitor the quality of the service with actions identified as relevant.

Areas for improvement

Action the provider MUST or SHOULD take to improve

Action the trust SHOULD take to improve

- The trust should ensure a consistent approach to the updating and review of every risk assessment and care plan.
- The trust should explore the provision of a dedicated family and child visiting room on the unit.

Lincolnshire Partnership NHS Foundation Trust

Forensic inpatient/secure wards

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Francis Willis Unit	Mental Health Unit Lincoln County Hospital Site

Mental Health Act responsibilities

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

Staff at this location were aware of their duties under the Mental Health Act (1983). They had received the relevant mandatory training. Eighty-one percent of staff had received their refresher training for this year.

Records relating to the Act were well kept and any concerns identified were shared with and addressed by front line staff during our inspection.

Mental Capacity Act and Deprivation of Liberty Safeguards

Whilst all of the people who used the services at this location were currently detained under the 1983 Mental Health Act. We saw that people's mental capacity to consent to their care and treatment had been assessed.

The assessment and treatment records showed us that where people had been assessed as not having the mental capacity to consent to their care and treatment, decisions were made in their best interests. Most staff spoken with demonstrated an awareness of the Act. Eighty-one percent of staff had received their refresher training for this year.

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

Our findings at The Francis Willis unit were:

Patients told us that they usually felt safe on the unit. Staff were responsive if individual concerns were identified.

Staff knew how to safeguard people who used the service from harm. Staff received training in the management of violence and aggression. We found that restraint was used safely and seclusion only used as a last resort.

Staff reported any incidents/accidents and there was a system in place for reviewing and learning from them to prevent a reoccurrence.

Risk assessments and management plans were available for patients and a current ligature audit risk assessment was seen. This meant that the trust had taken steps to ensure the safety of patients and others.

Systems were in place to ensure adequate staffing levels and appropriate skill mix on the unit to meet the needs of individual patients.

Our findings

Safe and clean ward environment

- The ward layout enabled staff to observe patients effectively.
- Relational security arrangements were in place when patients used the secure garden or the smoking shelter.
- We saw a ligature audit risk assessment of the unit dated July 2014. The four action points were being addressed by the trust.
- The records showed that there had been no self-harm or self-ligature incidents since November 2013.
- There was a secure airlock to enhance security.
- The unit was clean and well maintained.
- We noted isolated examples of minor damage around the unit but staff told us that this had been reported and was awaiting repair.
- Staff told us that maintenance requests were promptly addressed where ever possible.
- Arrangements were in place to support visits by external contractors.
- Patients told us that the wards were kept clean.
- Emergency equipment was in place and checked regularly to ensure that it was fit for purpose and could be used in an emergency.
- Alarms were available throughout the service and staff also had access to mobile phones when escorting patients off the unit.

Safe staffing

- We reviewed the current and previous staff rotas and these showed us that there were enough staff on duty to meet the needs of the patients on this unit.
- Additional staff had been rostered to meet the need for enhanced staffing numbers during the evening.
- Evidence was seen that additional staff were used when the needs of patients required this.
- Each patient was on 30 minute enhanced observation levels based on assessed clinical risk.
- There were no vacancies on this ward and short term staffing gaps were covered within the team.
- Managers informed us that they provided additional support through an 'on call' system and worked ward based shifts if needed. This was supported by those duty rotas reviewed.
- The unit had received accreditation as a placement for student nurses.
- New staff received an induction to the unit.
- A monthly safer staffing report was submitted to the trust board.

Assessing and managing risks to patients and staff

- Patients felt safe on the unit and told us that staff reacted promptly to any identified concerns.
- Each patient had an individualised risk assessment and these had been reviewed by the multi-disciplinary team.
- Risk assessments took into account historic risks and identified where additional support was required.
- The provider used the historical current risk (HCR 20) and the Health of the Nation outcome Scales (HoNOS) as part of their initial and ongoing assessment of risk.

Are services safe?

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

- Risk assessments had been updated to reflect assessed changes in clinical need
- Staff confirmed that hand overs were comprehensive and included updates on potential risk factors.
- Staff had received level three safeguarding training. We found that 100% of staff had attended their annual refresher training.
- Staff were aware of their individual responsibility in identifying any individual safeguarding concerns and reporting these promptly. They knew who the trust's safeguarding lead was.
- Eight safeguarding incidents had been reported since November 2013. These had been investigated appropriately.
- 91% of staff had received their annual refresher training on the use of restraint and seclusion records were well maintained
- Use of restraint was closely monitored and audited by the trust.
- Post incident debriefing was available for patients and staff and we saw examples of these
- Patients were secluded on the unit. Two seclusion episodes had taken place since April 2014.
- The seclusion room met the requirements of the Mental Health Act (MHA) 1983 code of practice.
- Medication administration records (MAR) charts were well completed with reasons for any non-administration clearly recorded

Track record on safety

- We saw that there was a low level of incidents on this unit. For example, two seclusions since April 2014 and 33 restraints since November 2013.
- A local risk register was in place and this was used to identify any wider trust learning from incidents. These had been investigated appropriately and any lessons learnt had been shared through the trust's reporting systems.

Reporting incidents and learning from when things go wrong

- Staff knew how to report any incidents on the trust's electronic reporting system.
- Senior staff were aware of incidents and these had been discussed at the trust's local clinical governance group.
- Actions identified from incident reviews had been effectively followed up.
- Senior trust staff were aware of their new roles and responsibilities around 'duty of candour' and plans were in hand to embed this into the trust's clinical governance arrangements.
- Staff told us that they received feedback about the outcome of incidents that had happened.

Are services effective?

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

Summary of findings

Our findings at The Francis Willis unit were:

Patients had comprehensive multi-disciplinary assessments and updated care plans in place. Staff had identified any physical healthcare needs and care plans were in place to support these.

Staff received additional role specific training. For example, forensic services, substance misuse and reinforce the appropriate and implode the disruptive (RAID) training had been provided for front line staff.

Different professions worked effectively to assess and plan care and treatment programmes for patients.

Mental Health Act records were well kept and any identified concerns were promptly addressed by the provider.

But we also found:

- There was an inconsistent approach to the updating and review of some risk assessments and care plans.

Our findings

Assessment of needs and planning of care

- Patients had comprehensive multi-disciplinary assessments in place.
- Patents had care plans and personal support plans that were comprehensive and up to date.
- Staff had identified any concerns with physical healthcare and care plans were in place to support these.
- There was an inconsistent approach to the updating and review of some risk assessments and care plans.

Best practice in treatment and care

- Assessments took place using the Health of the Nation Outcome Scales (HoNOS) and HCR 20. These identified historical and current risks.
- A rapid tranquilisation algorithm and policy was in place.
- One prone restraint out of 33 restraints had been recorded. Staff confirmed that prone restraints were avoided as much as possible.
- Patients were seen regularly by a psychologist as part of their treatment programme.
- Regular physical healthcare check-ups had been carried out and patients were registered with a local GP where required.
- The unit was supported by the trust's pharmacy service.
- Regular medicine audits were being carried out and the trust had taken action to address any identified concerns.
- Medicines were well managed and medicine administration records (MAR) were completed appropriately.
- Arrangements were in place for the granting of emergency Ministry of Justice section 17 MHA leave when urgent medical treatment was required.
- Ward based audits took place. Action plans were in place to address any identified concerns.

Skilled staff to deliver care

- Overall staff compliance at mandatory training was 91%.
- Staff received additional role specific training. For example, forensic services, substance misuse and reinforce the appropriate and implode the disruptive (RAID) training had been provided for front line staff.
- New staff had an induction programme prior to working on the unit.
- Regular team meetings took place and staff told us that they felt supported by colleagues and managers.

Multi-disciplinary and intra-agency team work

- Different professions worked effectively to assess and plan care and treatment programmes for patients.
- The unit had a dedicated social worker, occupational therapist and psychologist.
- The responsible clinician was a section 12 MHA approved authorised consultant forensic psychiatrist.
- The trust was part of the multi-agency public protection arrangements (MAPPA) network.
- Enhanced care programme approach (CPA) meetings were held and attendance was encouraged by all involved in the patient's care and treatment.

Adherence to the MHA and MHA code of practice

- 81% of staff had received their refresher training for 2014/2015.
- Mental Health Act records were well kept and any identified concerns were promptly addressed by the provider

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.

- The provider had clear procedures in place regarding their use and implementation of the Mental Health Act and the code of practice
- Information regarding detention under the Act was available on the unit.
- The records showed that patients had been informed of their rights of appeal against their detention.
- Independent advocacy services were available and patients told us they were aware of their rights.
- Several people were waiting for a first tier tribunal appeal hearing. Evidence was seen that they had obtained the required legal representation.

Good practice in applying the MCA

- The trust had systems in place to assess and record people's mental capacity to make decisions and had developed care plans for this where applicable.
- 81% of staff had received their refresher training for 2014/2015.

Are services caring?

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

Summary of findings

Our findings at The Francis Willis unit were:

Patients were positive about the support which they received on the unit. We saw good examples of effective staff and patient interaction and individual support being provided.

Staff explained to us how they delivered care to individual patients. This demonstrated that they had a good understanding of the needs of patients on the unit.

Advocates were available on the unit and there was information available in the ward about access to advocacy services.

Our findings

Kindness dignity respect and support

- Patients were positive about the support which they received on the unit.
- We saw good examples of effective staff and patient interaction and individual support being provided.
- Staff treated patients with kindness and respect and patients confirmed this.
- Staff explained to us how they delivered care to individual patients. This demonstrated that they had a good understanding of the needs of patients on this unit.

The involvement of people in the care they receive

- Patients told us that staff supported them well.
- Patients received copies of their care plans and weekly activity programme if they wished and this was recorded in their care notes.
- Patients said that they were seen regularly by their responsible clinician.
- Patients told us that if they had questions about their medication staff would answer these where ever possible.
- Advocates were available on the unit and there was information available about access to advocacy services.
- The trust was planning to introduce a weekly advocacy 'drop in' clinic to help promote access to this service
- The trust had produced a 'welcome pack' for patients who were admitted to help orientate them to the unit.

Are services responsive to people's needs?

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

Summary of findings

Our findings at The Francis Willis unit were:

Clear assessments were in place to ensure that the unit's admission criteria were being met. The trust reported responsive joint working with the commissioners of this service.

Patients had access to a secure enclosed garden and this included a smoking shelter. The unit had their own occupational therapy department. Each patient had a weekly occupational therapy programme. Patients had access to a fully equipped gym. This facility was supported by a qualified gym instructor.

Evidence was seen of monitoring arrangements to ensure that patients were offered at least 25 hours of activity per week. We saw that patients were being supported to access Section 17 leave supported by staff following clear risk assessments.

But we also found:

- There was no dedicated family and child visiting room on the unit.

Our findings

Access discharge and bed management

- Clear assessments were in place to ensure that the unit's admission criteria were being met.
- The trust reported responsive joint working with the commissioners of this service.
- Patients had access to the trust's community forensic team.
- We found that patients had transitional plans to move to less restrictive care settings and discharge plans where appropriate.
- Staff had received MAPPA awareness training.
- The average length of stay in this unit was 18 months.

The ward optimises recovery, comfort and dignity

- Access to Mental Health Act section 17 leave was audited.
- Clear arrangements were in place to facilitate visits to the unit.
- There was no dedicated family and child visiting room on the unit.
- Patients had access to a secure enclosed garden and this included a smoking shelter
- The unit had their own occupational therapy department.
- Each patient had a weekly occupational therapy programme.
- Patients had access to a fully equipped gym. This facility was supported by a qualified gym instructor
- Evidence was seen of monitoring arrangements to ensure that patients were offered at least 25 hours of activity per week.
- We saw that some patients were being supported to access Section 17 MHA leave supported by staff following a cleasr risk assessment.
- Patients attended doctors, dentists and other health appointments when needed.

Meeting the needs of all the people who use the service

- The unit had a dedicated social worker lead and they liaised closely with patients' families and with statutory agencies as applicable.
- Patients told us that the food provided was good.
- Access to the unit's facilities such as the laundry and gym was risk assessed due the risks patients could pose to themselves or others
- Patients' diverse needs such as religion and ethnicity was recorded and we saw these were being met for example through religious specific diets and access to spiritual visitors.
- There was information available throughout the service for patients and this included information about rights under the Mental Health Act 1983
- Examples were seen of advocacy support during clinical reviews and at care programme approach (CPA) meetings.

Listening and learning from concerns and complaints

- Information was displayed on the unit for patients to provide them with information about making a complaint.
- The trust had a clear complaints policy and procedure systems for them to be investigated and complainants to be given a response.
- There were additional systems for patients to raise issues at community meetings.

Are services responsive to people's needs?

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

- One formal and three informal complaints had been recorded since January 2014.
- These had been appropriately investigated and the learning from these had been disseminated to staff.

Are services well-led?

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

Summary of findings

Our findings at The Francis Willis unit were:

Staff were aware of the trust's vision and values. These were displayed on the entrance to the unit. The unit manager and other senior clinicians were visible to front line staff and patients.

Staff reported positive morale and good peer support and told us that their line manager was supportive and provided clear guidance.

Senior clinicians had access to governance systems that enabled them to monitor the quality of care provided. This included the trust's electronic incident reporting system, trust and unit based audits and electronic staff training record.

Staff received annual appraisals and the current rate was 91%. Systems were in place to gain patients' views and patients' experience feedback was collated every three months and reviewed by the trust's quality committee.

The chief executive officer held monthly roadshows to engage with frontline staff. The unit was a member of the Royal College of Psychiatrist's quality network for forensic mental health services. The last review had taken place in March 2013.

Our findings

Vision and values

- Staff were aware of the trust's vision and values. These were displayed on the entrance to the unit.
- The unit manager and other senior clinicians were visible to front line staff and patients.
- Monthly unannounced visits by a patient governor from the trust's board of governors took place.

Good governance

- Senior clinicians had access to governance systems that enabled them to monitor the quality of care provided. This included the trust's electronic incident reporting system, corporate and unit based audits and electronic staff training record.
- Monthly clinical governance meetings took place. The minutes showed us that these were comprehensive and any actions arising had been addressed.
- Staff told us that unit team meetings took place.
- Trust monthly team briefs were circulated for staff to read and signed when completed
- The trust monitored staff training on and off site and via 'e learning'.
- Staff received annual appraisals and the current rate was 91%.
- Staff received regular supervision and there was a supervision matrix.

Leadership morale and staff engagement

- Staff reported positive morale and good peer support.
- Staff told us that their line manager was supportive and provided clear guidance.
- The trust had a human resources department and referred staff to occupational health services where applicable.
- Systems were in place to gain patients' views and patients' experience feedback was collated every three months and reviewed by the trust's quality committee.
- Senior staff were visible in the service and examples were seen of staff approaching them to raise concerns.
- The trust had a system for raising staff concerns confidentially.
- The trust had introduced a new escalation policy for staff to raise issues.
- All incidents of whistle-blowing were reviewed by the executive team.
- Evidence was seen that regular unannounced visits took place by executive directors.
- The chief executive officer held monthly roadshows to engage with frontline staff.

Commitment to quality improvement and innovation

- Key performance indicators were discussed at the trust's monthly clinical governance meeting. For example, safeguarding, incidents and complaints.
- Periodic 'mock' Care Quality Commission inspection visits had started in the trust to monitor the quality of the service with actions identified as relevant.
- Senior staff carried out separate unannounced visits to the service in order to monitor the quality of services provided.

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.

- The unit was a member of the Royal College of Psychiatrist's quality network for forensic mental health services. The last peer review had taken place in March 2013.