

5 Boroughs Partnership NHS Foundation Trust

Forensic inpatient/secure wards

Quality Report

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Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/unit/team)	Postcode of service (ward/unit/team)
RTV06	Warrington	Chesterton unit	WA2 8WA
RTV06	Warrington	Tennyson unit	WA2 8WA
RTV06	Warrington	Auden Unit	WA2 8WA
RTV06	Warrington	Marlowe Unit	WA2 8WA

This report describes our judgement of the quality of care provided within this core service by 5 Boroughs 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 5 Boroughs Partnership NHS Foundation Trust and these are brought together to inform our overall judgement of 5 Boroughs Partnership NHS Foundation Trust.

Summary of findings

Ratings

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

Overall rating for the service

Good



Are services safe?

Good



Are services effective?

Good



Are services caring?

Good



Are services responsive?

Good



Are services well-led?

Good



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

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

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

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

Summary of findings

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Summary of findings

Overall summary

We rated forensic inpatient/secure wards as good because:

- The forensic wards were clean, tidy and well maintained. Environmental risk assessments were in place that included ligature risk assessments. Ligature points were mitigated against adequately and staff knew where they were. There was a plan in place to remove all of the identified risk points, however the timescale for this work to be completed had not been identified.
 - Staffing across the wards was sufficient to meet the needs of the patients. Most staff were up to date with mandatory training, supervision and appraisals, any additional training needs identified were provided. This in turn led to effective multidisciplinary team working and challenge. The trust had set a target of 90% for compliance with training and at this inspection, immediate life support was below this target at 61% and 75% for basic life support.
 - Clinical rooms were well stocked with equipment for physical health care and emergency lifesaving equipment and medicines were available to staff. Patients received a physical health care examination on admission and routine physical health care checks throughout their admission.
 - Patients had care plans and risk assessments in place that reflected their needs. Patients were involved in their care planning and risk assessments and staff had considered their views when writing them. Staff understood what constituted a safeguarding incident, and how to report safeguarding incidents. Staff received feedback from incidents in a variety of ways, including supervision, ward meetings and debriefs to ensure that any lessons learned were shared.
 - Medicines were prescribed within best practice guidelines that ensured that they were administered safely. There was a significant increase in the access to psychological interventions, both one to one and group session for patients that met the National Institute for Health and Care Excellence guidelines.
 - Outcome measuring tools were used to assess clinical outcomes for patients on all units. Chesterton unit had developed a patient own data base, that recorded individual patient's rating scales. These were used to have meaningful discussions both in one to one sessions and in the multidisciplinary team meetings.
 - Staff were seen to be kind, caring and respectful in their interactions with patients. Staff were knowledgeable about their patient's needs. Patients gave positive feedback about the staff on the units, and they told us that they felt safe on the units.
 - Referral and discharge pathways were in place that gave clear criteria for admission and the pathway to discharge. The average length of stay for patients on the secure units did not exceed the average for low secure services.
 - The units all provided environments that supported patients' recovery. Activity workers provided activities on and off the ward seven days a week. The units supported the needs of patients from a diverse background and provided a range of information for patients to support them in understanding their rights.
 - Complaints were managed both locally on the units and formally. Patients and staff all knew how to raise complaints. There was improvement in the units overall leadership, and staff reported an increase in team morale and felt more supported to perform their role. Improvement plans that had been put in place were monitored through regular meetings that sought assurances for on-going improvements. Support systems for staff were in place and effective.
 - Clinical audits were conducted regularly in areas that were seen as hot spots to ensure that action was taken quickly to rectify any problems. Key performance indicators were used to review and improve the services performance. The trust also had a corporate risk register that identified on-going risks to the secure services.
- However:
- Marlowe unit's ligature risk assessment identified ligatures within the patient bedroom areas. There was not an identified time scale for when these would be removed.

Summary of findings

- Tennyson unit's clinical room often rose above the required temperature for the area. This compromised the integrity of medications. There was a system in place to manage this and ensure medicines were safe to use.
- Care plans were not always written in a way that fully showed the level of a patient's involvement in their care plan as they were not written from their perspective
- There were complaints about the food quality and the portion sizes of the food, that this was being served cold or not receiving what they ordered.
- In a small number of files, the most up to date T2 and T3 forms were not correctly filed in the medication charts.

Summary of findings

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

Are services safe?

We rated safe as good because:

- The environments were clean, tidy and well maintained. Each unit had environmental risk assessments in place that included ligature risk assessments. All ligature points were mitigated against adequately and staff were aware of where they were.
- Seclusions rooms met the Mental Health Act code of practice standards.
- Clinical rooms were well stocked with equipment for physical health care. All the equipment was checked and cleaned regularly to ensure that it was in good working order. Emergency lifesaving equipment and medicines were available to staff.
- Staffing across the units met the required level agreed by the trust for each area and staff in most areas was up to date with and met the trust standards for mandatory training.
- Patients had risk assessments in place that reflected their risks, detail of how patients' risks were managed were found within their care plans.
- All restrictions placed on patients were based on an individual risk. We found no blanket restrictions during our inspection.
- Staff understood what constituted a safeguarding incident, and how to report safeguarding incidents.
- Staff were given feedback from incidents in a variety of ways, including supervision, wards meeting and debriefs to ensure that any lessons learned were shared.

However:

- Marlowe unit's ligature risk assessment identified potential ligature anchor points within the patient bedroom areas. There was not an identified time scale for when these would be removed.
- Tennyson units' clinical room often rose above the required a temperature for the areas. This compromised the integrity of medications.

Good



Are services effective?

We rated effective as good because:

Good



Summary of findings

- All patients received a physical health care examination on admission, with routine physical health care checks throughout their admission.
- All patients had a care plan in place that was reflective of their needs, holistic, recovery focused, and patient centred. The trust was rolling out a 'living life well' programme that enhanced the care planning process.
- Medicines were prescribed within best practice guidelines that ensured that they were administered safely.
- There was a significant increase in the access to psychological interventions, both one to one and group sessions for patients.
- Outcome measuring tools were used to assess clinical outcomes for patients on all units. Chesterton unit had developed a patient own data based, that recorded individual patient's rating scales. These were used to have meaningful discussions both in one to one sessions and in the multidisciplinary team meetings.
- Staff received management and clinical supervision in line with trust policy and annual work performance appraisals were completed. Additional training was available and had been completed by staff to support them in their role.
- Effective multidisciplinary team meetings took place fortnightly, these were multi professional and patient centred.
- Effective systems were in place for the monitoring and management of the Mental Health Act. Staff were knowledgeable on the Mental Health Act and the Mental Capacity Act.

However:

- Care plans were not always written in a way in that showed fully the level of a patient's involvement in their care plan, as they were not written from their perspective.
- Two T2 and T3s that had been renewed were not stored with the medicine chart.

Are services caring?

We rated caring as good because:

- Staff were seen to be kind, caring and respectful in their interactions with patients. Staff were knowledgeable about their patients' needs.
- Patients gave positive feedback about the staff on the units, and they told us that they felt safe on the units.

Good



Summary of findings

- Patients were involved in their care planning and risk assessments and their views had been taken into consideration when they were written.
- Independent mental health advocacy was available on all the units for patients should they wish to access the service.
- Patients were able to provide feedback on the functioning of the service through weekly community meeting which took place.

Are services responsive to people's needs?

We rated responsive as good because:

- Referral and discharge pathways were in place that gave clear criteria for admission and the pathway to discharge.
- The average length of stay for patients on the secure units did not exceed the average for low secure services.
- Discharge planning was evident in all care plans. This showed at what point in the discharge pathways each patient was at and their future plans.
- The units all provided environments that supported patient's recovery. Patients had access to a pay phone and their own mobile phones to enable them to maintain contact with their family and friends. Patients were also able to personalise their own bedroom areas to give a more homely feel to their rooms.
- Activity workers provided activities on and off the ward seven days a week.
- The wards were able to support the needs of patients from a diverse background and provided a range of information for patients to support them in understanding their rights.
- Complaints were managed both locally on the units and formally. Patients and staff all knew how to raise complaints.

However:

- There were complaints about the food quality and the portion sizes of the food, that this was being served cold or patients not receiving what they ordered.

Good



Are services well-led?

We rated well led as good because:

- Staff we spoke to understood the vision and values of the trust. They also knew who the senior members of staff were and told us that some of these visited the units occasionally.

Good



Summary of findings

- Improvement plans that had been put in place were monitored through regular meetings that sought assurances for on-going improvements. Support systems for staff were in place and effective.
- Clinical audits were conducted regularly in areas that were seen as hot spots to ensure that action was taken quickly to rectify any problems.
- Key performance indicators were used to review and improve the services performance. The trust also had a corporate risk register that identified on-going risks to the secure services.
- There was improvement in the units overall leadership, and staff reported an increase in team morale and felt more supported to perform their role.

Summary of findings

Information about the service

The forensic inpatient/secure units are part of the secure mental health services delivered by 5 Boroughs Partnership NHS Foundation Trust. Secure services are based at the Hollins Park Hospital site, and contain four units designated as low secure and step-down/rehabilitation.

The service comprises a low-secure unit for women, a low-secure unit for men, a low-secure unit for women with learning disabilities, and a low-secure step-down rehabilitation unit for women.

We inspected all four units:-

Chesterton Unit

20 beds, female, low secure

The unit provides services for women aged 18 years and over with complex mental health needs who require specialist inpatient care. All patients were detained under the Mental Health Act.

Marlowe Unit

15 beds, male, low secure

The unit provide services for men aged 18 years and over with very complex mental health needs who require specialist inpatient care. All patients were detained under the Mental Health Act.

Auden Unit

10 beds, female, low secure

The unit provides services for people aged 18 to 65 who have mild to moderate learning disabilities and mental health difficulties. All patients were detained under the Mental Health Act.

Tennyson Unit

Eight beds, female, low secure

The unit provides step-down rehabilitation services for women aged 18 and over. Patients were detained under the Mental Health Act.

All the beds within the secure services are commissioned by NHS England specialist commissioning services.

The CQC previously inspected the trust in July 2015. The forensic inpatient/ secure units during this inspection had four requirement notices issued following their inspection. These were in relation to:

- Regulation 9, person centred care
- Regulation 12, safe care and treatment
- Regulation 17, governance
- Regulation 18, staffing

Our inspection team

Our team was led by:

Team leader: Sarah Dunnett, Inspection Manager, Mental Health, Care Quality Commission

The team that inspected this core service comprised two CQC inspectors, one senior nurse and a clinical psychologist.

Why we carried out this inspection

We undertook this focussed unannounced inspection to find out whether 5 Boroughs Partnership NHS Foundation Trust had made improvements to their forensic inpatient/secure units since our last comprehensive inspection of the trust between 20-24 July 2015. We also reviewed the ratings for all five key questions: safe, effective, caring, responsive and well-led.

When we last inspected the trust in July 2015, we rated forensic inpatient/secure units as requires improvement overall. We rated the core service as requires improvement for all five domains, safe, effective, caring, responsive and well-led. Following this inspection we told the trust that it must take the following actions to improve forensic inpatient/secure units:

Summary of findings

- The trust must ensure that staff complete seclusion and MHA records accurately.
- The trust must ensure that patient records, are complete and accurate and supporting management plans are in place where required. This includes risk assessments, care plans and discharge plans.
- The trust must ensure staff report serious incidents in accordance with trust policy and that learning from incidents is shared with staff.
- The trust must ensure that staff receive appropriate training to perform their role and are up to date with mandatory training.
- The trust must ensure that patients are involved in the planning of their care. Patients must be able to discuss care and treatment choices continually and have support to make any changes to those choices if they wish.
- The trust must ensure that patients are prescribed medicines in accordance with the forms of authorisation.

We also told the trust that it should take the following actions to improve:

- The trust should adopt a model of care in line with good practice for distinct service areas and relevant to the patient cohort.
- The trust should ensure that complaints are recorded and themes identified so that lessons can be learnt.
- The trust should ensure multidisciplinary teams are effective.

We issued the trust with four requirement notices that affected forensic inpatient/secure units. These related to:

- Regulation 9, person centred care
- Regulation 12, safe care and treatment
- Regulation 17, governance
- Regulation 18, staffing

How we carried out this inspection

To fully understand the experience of people who use services, we 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 the inspection visit, we reviewed information that we held about these services and asked a range of other organisations for information.

During the inspection visit, the inspection team:

- visited all four of the wards on the hospital site and looked at the quality of the ward environment and observed how staff were caring for patients
- spoke with 20 patients who were using the service

- spoke with the managers for each of the wards
- spoke with 14 other staff members; including doctors, nurses and psychologists
- interviewed the assistant director, head of specialist inpatient and community service, and the modern matron with responsibility for the service
- attended and observed two hand-over meetings, two multi-disciplinary meetings, two group clinical supervisions, and two living life well meetings
- completed a Short Observational Framework for Inspection and observed one mealtime
- looked at 18 care and treatment records of patients
- carried out a specific check of the medication management on four wards and looked at 40 prescription charts
- looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the provider's services say

- Patients told us that they felt safe on the wards and that they were treated with kindness and respect.

Summary of findings

- Patients told us that there were plenty of on the ward activities available. On Tennyson ward patients told us they all had lots of leave for off the ward activities but ward activities were more limited.
- Patients told us that their physical health care was monitored and they saw the GP and doctors when they needed it.
- Patients told us that they were involved in their care planning and could have a copy if they wished.
- Patients told us that the nurses were there for them to talk to and that community meetings happened regularly.

Areas for improvement

Action the provider **SHOULD** take to improve

Action the provider **SHOULD** take to improve

- The trust should provide a time limited plan for removal of the ligature points in Marlowe unit.
- The trust should continue with their plans to roll out the 'living life well' programme and review how care plans can be written from a patient perspective.
- The trust should ensure that the most up to date T2 and T3 forms are correctly filed in the medication charts.
- The trust should review the concerns raised by patients about the quality and portion size of the food provided.

5 Boroughs 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
Chesterton unit	Warrington
Tennyson unit	Warrington
Auden Unit	Warrington
Marlowe Unit	Warrington

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 received training on the Mental Health Act. The training figures across the secure service varied from 87% compliance on Chesterton unit and 100% compliance on Tennyson unit.

Mental Health Act documentation was in place and staff were regularly explaining patients their rights under the Mental Health Act. This happened on a three monthly basis or when there were changes.

T2 and T3 forms were in place for all medication charts. Form T2 is a certificate of consent to treatment. It is a form completed by a doctor to record that a patient understands

the treatment being given and has consented to it. Form T3 is a Certificate of second opinion. It is a form completed by a second opinion appointed doctor to record that a patient is not capable of understanding the treatment he or she needs or has not consented to treatment but that the treatment is necessary and can be provided without the patient's consent. We found one where medication was prescribed that was not included on the T3 form. This was rectified on the day.

Independent mental health advocates were available on the units.

Each patient had a file for all Mental Health Act documentation. Section 17 leave forms for individuals were in place.

Detailed findings

Mental Capacity Act and Deprivation of Liberty Safeguards

Staff received training in the Mental Capacity Act. The training figures for the secure units varied from 91% on Marlowe unit and 100% on Tennyson unit.

Staff were able to describe the principles of the Mental Capacity Act. Staff were able to give some good examples of how they would look to support patients to make decisions.

The trust had a specific form in place to record capacity assessments. We found a good example of a form that had been completed regarding a patient's capacity to understand the consequence of a specific behaviour whilst using her mobile phone. This showed that staff had a clear understanding of the Mental Capacity Act and knew how to apply the principles.

Are services safe?

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

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

Our findings

Safe and clean environment

All four units appeared to be well maintained, clean and tidy. The furniture provided, although functional, was comfortable and in a good state of repair. The lay out of the wards in some areas did not allow easy observation of all areas of the unit. Parabolic mirrors were in place to increase observation in areas where this was hindered. Hourly checks of the environment and the patient's whereabouts took place, those patients that were an increased risk to themselves or others would be placed in the higher observation rooms, or have an increased level of observations. This reduced the possibility of unwitnessed incidents occurring.

Environmental risk assessments were in place on each of the units that included ligature risk assessments for each unit. These were available on the units during our inspection. Staff were aware of all the ligature points and mitigation that was in place for those areas. On Chesterton unit, we observed a handover where staff received a full handover of all ligature risks. This was standard practice across the service. Some areas that had higher risk ligature points such as the disabled bathrooms and activity or occupational therapy rooms were locked off unless patients were risk assessed to have unsupervised access or staff would be in attendance whilst they were used.

We saw that efforts had been made since the previous inspection to remove ligature points from areas where this was possible on Chesterton unit.

Marlowe unit had identified that in 10 of the 15 bedroom areas there were taps that were a high-risk ligature point. Staff were aware of these; it had been put on the ligature risk assessment. Five other bedrooms on the unit were used for those patients that were a high risk of harm to themselves. However, on reviewing the ligature risk assessment there did not appear to be any timescale for these to be removed and replaced with anti-ligature taps.

The secure units were all single sex therefore this complied with the Department of Health standards for same sex accommodation.

The seclusions rooms on Chesterton, Auden and Marlowe unit did not have any blind spots as parabolic mirrors were in place. We found that all the rooms had clocks, were well ventilated with a heating control panels. All provided access to a toilet and washing facilities. Intercoms allowed two-way communication and windows had internal blinds. This met the Mental Health Act Code of Practice standards for the seclusion facilities.

The clinical rooms on each of the units were clean, organised, and of a reasonable size for their purpose. Each area was well stocked with equipment for physical health care, including a blood pressure machine, thermometer, blood glucose monitoring machine and various stock dressing and syringes. All the medical devices had an annual maintenance check and it was clear when these were next due to be undertaken. All routine stock dressings and syringes were in date. Sharps bins were labelled correctly.

The fridge and room temperatures in the clinical rooms were checked daily. There were clear processes in place of how to escalate any concerns about the temperature of the rooms or fridges. Tennyson unit's clinical room was often above the recommended temperature, this affected the shelf life of certain medications. The pharmacy had put a system in place to ensure that the medicines had been reviewed and a shorter shelf life had been put on all the medicines affected. Staff regularly checked the stock and removed all medication that had gone over their shelf life. A business plan had been submitted for the installation of air conditioning as a longer-term solution.

Each unit had a 'red bag' that contained resuscitation equipment, automated external defibrillator, oxygen and a suction machine. Staff checked the contents of the 'red bag' and the expiry dates of the equipment daily. Emergency drugs such as an anaphylaxis kit and flumazenil were available on the units and were in date.

Medication was kept in lockable medicine cabinets, and the controlled drugs were kept in a separate internal lockable cabinet. A key to both the cupboards was kept on a qualified member of staff's person at all times. The key for the controlled drugs cupboards and the medication

Are services safe?

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

cupboards were held separately when there were two qualified nurses on duty, this was seen to be a good practice. The controlled drugs were managed appropriately and regular stock checks took place three times per day.

Annual infection prevention and control audits took place. The recent audit in May 2016, showed all the secure units had achieved the target of 90% or above in all areas, with the exception of Marlowe unit in the nursing domain reaching just below this at 88%.

Hand hygiene, and bare below the elbow formed part of the audit. Marlowe and Tennyson unit were 100% compliant in both areas with Auden unit being 100% compliant in hand hygiene, but were just below the 90% standard for staff that was bare below the elbow. Chesterton ward scored 74% and 50% for hand hygiene and bare below the elbow retrospectively. However, we did not observe any clinical intervention being carried out by staff that were not bare below the elbow during the inspection.

Staff had access to personal alarms and they confirmed that there was always one present at the start of each shift, and all staff had received a key induction for the secure services. Keys and personal alarms were provided through the reception area to the unit or by the security nurse. Security nurses were assigned at the start of each shift and were responsible for signing people in and out of the units, and the physical and relational security of the ward. Champions were in the process of being developed for physical, relational and personal security. All staff had received, or were in the process of receiving, training in these areas including the 'See, Think, Act' guidance and boundary training. There was a strong sense that there was a move to balancing therapeutic care and security.

Safe staffing

The trust continued to use the professional judgement model for estimating its staffing establishment for each ward. Auden and Marlowe unit worked on a daily establishment of five staff in the morning and afternoon and four staff at night. Chesterton unit worked on seven staff in the morning and afternoon and four staff at night. Tennyson ward worked on two staff per shift. Additional staffing was available above these numbers on the units during core hours Monday to Friday nine to five such as the ward manager, occupational therapist and psychologists. Activity workers also worked on the ward and were

additional to the core establishment across seven days a week. On the day of inspection, we found that the compliment of staff on duty met their expected establishments.

The budget for staffing whole time equivalents for each unit at the time of inspection was:

- Chesterton unit – 45
- Tennyson – 16
- Auden -41
- Marlowe – 41

This shows an increase in the budgeted staffing establishments since the previous inspection in July 2015. Across the secure units there were a total of 12 whole time equivalent vacancies with the highest number on Auden unit with four vacancies. A recruitment strategy was in place to fill the vacancies; a recent recruitment day took place in which a number of these posts were filled.

From March 2016 to June 2016, there was a reduction in the number of shifts requested by the secure units for bank and agency staff. In March 2016 there were 589 shifts request across all four units, 446 of the shifts were covered by bank staff, and 88 by agency staff. This left 55 unfilled shifts. In June 2016, there were 369 shift requested across the four units 313 of these were filled by bank staff, and 38 by agency staff leaving 18 unfilled shifts. Bank and agency staff was used to fill vacancies, long-term sickness and absences.

For the period June 2015 to May 2016, the sickness and absence rates for each unit was:

- Chesterton unit – 5%
- Tennyson unit -18%
- Auden unit – 7%
- Marlowe unit – 8%

For the same period the turnover of staff for each unit was:

- Chesterton unit – 18% with seven staff leaving
- Tennyson Unit – 23% with three staff leaving
- Auden unit – 13% with five staff leaving
- Marlowe unit – 11% with four staff leaving

Are services safe?

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

On speaking with the manager and staff on Chesterton unit, they felt that the number of staff leaving previously was due to the difficulties the unit was experiencing at the time with the number of incidents, staffing levels and patient mix. However, they were able to tell us that they had employed more staff and retention of staff was now improved as the overall functioning of the unit had improved.

Ward managers felt that they were able to increase and decrease staffing based on the needs of the patient group.

The majority of patients on all units with the exception of Tennyson unit described difficulties with accessing leave when the ward was short staffed or there were patients that needed escorting to other appointments. All the patients on Tennyson ward said that they had plenty of access to community leave and activities that were off the ward. Staff we spoke with confirmed that in emergencies where there was an incident, last minute sickness or hospital appointments leave could be cancelled.

Patients and staff told us that activities and one to one time with staff was very rarely cancelled due to being short staffed. Activity workers were employed on the units and were additional staff to the core establishment.

There was medical cover on site 24 hours a day, in core working hours there was access to the consultant psychiatrist and their associated doctors. Out of hours, there was access to medics through an on-call system.

Overall training figures for mandatory training on was:

Chesterton unit

- Statutory – 93%
- Core- 89%
- Clinical Statutory – 89%
- Specialist (mandatory) – 88%

Tennyson unit:

- Statutory – 83%
- Core – 95%
- Clinical statutory -65%
- Specialist (mandatory) – 97%

Auden unit:

- Statutory – 94%
- Core – 93%
- Clinical statutory – 77%
- Specialist (mandatory) – 92%

Marlowe unit:

- Statutory – 86%
- Core – 87%
- Clinical Statutory – 75%
- Specialist (mandatory) – 84%

Some areas of training fell below the trust target of 90%. Common themes were evident across all units in some training such as medication management with an overall compliance rate of 62%. However, we saw that medication was being managed effectively and in line with their own policies. Immediate life support also fell below 90% overall compliance of 61%, however, this did not take into consideration the shortfall due to long-term sickness and absences across the trust. From our previous inspection there was noted to be a significant improvement in the overall training compliance on all the units.

From our previous inspection, there was a concern that there was not a requirement to train bank staff who worked within the secure services breakaway techniques. The training teaches staff to avoid or escape from an assault. Since the previous inspection, there is now a requirement that all staff must undertake the breakaway training before they can work within the secure services. Ninety-eight bank staff had been trained at the time of inspection. This meant that bank staff would be able to protect themselves should the need arise. In addition to this, the trust had also started to roll out the restrictive physical intervention training to bank staff with a total of 29 staff trained.

Assessing and managing risk to patients and staff

There were 171 incidents of restraint across the secure units for the period January 2016 to June 2016. The highest number of restraints took place on Auden unit with 87, and Chesterton unit with 80. Five of these resulted in a prone restraint and 15 uses of rapid tranquillisation.

There were 45 episodes of seclusion across the same period, with 25 on Auden unit and 18 on Chesterton unit.

Are services safe?

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

On reviewing the data from our previous inspection this showed a significant reduction in the number of episodes of seclusion, prone restraint and rapid tranquillisation across the secure units. On speaking with staff, it was clear that there had been a shift in their approach to patients and that understanding their triggers and what helps patients de-escalate was their focus. Staff were able to provide good examples, such as during a clinical group supervision an approach to a patient was discussed which reduced the number of incidents occurring.

We reviewed three seclusion records. Two of the records reviewed followed the trust policy and the Mental Health Act Code of Practice. However, one seclusion record showed that some of the required reviews did not take place. The doctor did not attend within 30 minutes of seclusion being instigated, and a four-hour review by a doctor was not completed on two occasions. An audit of the seclusion record had taken place and an action was identified for the ward manager to complete a clinical workshop with staff to improve compliance.

The secure units all used the care programme approach risk assessment screen and summary alongside the Historical, Clinical, Risk management 20. The Historical Clinical, Risk management 20 tool is a comprehensive set of professional guidelines for the assessment and management of violence risk.

All care records we reviewed had a completed risk screen, risk assessment and Historical, Clinical Risk management 20 tool completed. These were all up to date, comprehensive and were seen to include the patients' views. We found a number of Historical, Clinical Risk management 20 patient interviews that had taken place prior to the completion of the tool. The risk assessments adequately reflected all the risks of the patients and although the management plans were not always detailed or thorough, we found all of the detail around this within the care plans. This was a significant improvement from our previous inspection where risk assessments were not present or incomplete in most areas with the exception of Marlowe unit.

There were very few restrictions in place for patients on the units. Restrictions that were in place were individualised for each patient based on risk assessments such as patients

holding their own mobile phones. There were work streams within the secure services that reviewed all blanket restrictions and work was ongoing to review the necessity of any restrictions in place.

There was a clear search policy in place and patients were search on a risk-based basis or if there was a breach in security.

Staff we spoke with was clear on what constituted a safeguarding concern and knew how to report these. A safeguarding policy was in place and there was a lead person within the trust who staff were able to contact for advice. Staff described many of the safeguarding concerns being patient on patient incidents that were not reportable to the local authority but were managed locally.

For the period January 2016 to June 2016, there were a total of 47 safeguarding adult concerns raised across the secure units internally with two requiring a referral to the local authority. Chesterton unit raised 33 of these safeguarding concerns. For the same period, there were three safeguarding children concerns raised across three of the wards with one being referred to the local authority.

There was an on-site pharmacy, and pharmacists were employed by the trust. There were effective systems and processes in place for dispensing and the transport of medicines. Pharmacists attended the ward frequently and would complete medication reconciliation for all new patients admitted to the service.

The secure units all had areas that were designated for family visiting.

Track record on safety

From January 2016 – June 2016, there was one serious incident requiring investigation reported within the secure services on Chesterton unit regarding an allegation of abuse.

Staff we spoke with were able to describe significant improvements in safety that had been made since the last inspection in July 2015. This included improvement in the quality of the risk assessments, handovers included information about ligature points on the unit, clinical psychology input to look at the risk formulations and clinical approach to patients. Staff also told us about increased support and debriefs following incidents.

Are services safe?

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

Reporting incidents and learning from when things go wrong

The staff we spoke with knew how to report incidents using the electronic incident reporting system. They were able to describe the type of incidents that should be reported.

For the period April 2016 to June 2016, there were a total of 367 incidents across all the secure units. Chesterton having the highest number of incidents with 208 and Tennyson had the lowest number with 7 incidents. The highest category of incident was violence and aggression with 57 incidents, then self-harm with 49 incidents on Chesterton unit.

There had been a debrief pathway introduced. Staff we spoke with told us of the increase in debriefs that they received following an incident. Staff also told us that there was regular clinical peer supervision sessions that looked at incidents and more complex patients to review care plans and the approach that staff take to patients to help reduce incidents. Staff were able to give us good examples of where this had worked well.

Feedback and lessons learned was received on more serious incidents from not only within the secure services but also from around the trust. Staff told us that this feedback came through the ward meetings, reflective practice sessions, within supervision and lessons learned briefings from the trust. We observed two of these sessions and saw that all staff were listened to, and their views and the patients were considered and respected. The ward managers also attended a lessons learned meeting where feedback and discussion takes place about all complaints and incidents within the specialist services.

Staff told us that they would apologise to patients when thing went wrong. We saw an example of this during the inspection. As part of a debrief, staff had an agreed action to apologise to the patient and support the patient to make a formal complaint if they wanted to. There was a duty of candour policy in place.

Are services effective?

Good 

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

Our findings

Assessment of needs and planning of care

We reviewed 18 care records. All the records showed that patients had a full pre admission assessment completed. All patients received a physical health examination on admission. There was on going monitoring of patients' physical health care through the GP and other professionals within the secure service. Staff referred patients to other outside services such as cardiology, neurology, diabetic clinics, and dietitians.

The trust was in the process of rolling out the 'living life well' care-planning document. At the time of this inspection the 'living life well' care plan had been piloted and embedded on Chesterton unit and had commenced on Marlowe unit. In all 18 care plans we reviewed we found that they were comprehensive, met all the needs of the patients and contained the patients' views.

On Chesterton unit, we found all the care plans were written from the patients' perspective. However, we did find that the other units that had not yet had the living life well care planning fully embedded or it was yet to be rolled out and that care plans were not written from the patients' perspective.

All care plans that we reviewed were signed and dated by both staff and patients. It was evident where patients had been asked if they wished to have a copy of their care plan. Each care plan was clear about what stage the patient was at in their care pathway, and their on-going plan for working towards discharge. Overall, we found there was a significant improvement in the care planning for patients across the secure units.

Paper record files were kept for each patient that had a clear chronology and were easy to follow. Electronic records were kept where information was updated and printed out and placed in the paper files. This ensured that there was easy access to records and staff could have access to the most up to date version of the records.

Best practice in treatment and care

We reviewed 40 prescription cards and found that all were thoroughly completed. We found prescription cards had all mandatory information such as name, date of birth, and

allergy status documented. Where antipsychotic medication was above British National Formulary limits, we saw the recommended physical health care checks were taking place for those patients.

There had been a significant increase in the psychology provision across the secure units. This included:

- 0.6 whole time equivalent clinical psychologist, and a whole time equivalent assistant psychologist on Chesterton Unit
- 0.6 whole time equivalent clinical psychologist on Auden unit
- 1 whole time equivalent clinical psychologist on Marlowe unit

Chesterton unit also had an additional consultant clinical psychologist who had been seconded on to the unit for six months to establish the model of care, which was based on a mentalization theory, and to provide additional leadership.

The psychology provision across the secure units included individual one to one work with patients, group sessions, staff support and clinical supervision. The clinical psychologists also led on the 'living life well' programme. This was in line with the National Institute for Health and Care Excellence guidelines.

A GP held weekly clinics on each unit. The GP referred to outside specialist services where this was required such as diabetic clinics, and cardiology. On reviewing patient care records there was clear evidence that patients received good access to physical health care from both within the trust and from other specialist services.

The secure services used a number of recognised rating scales to assess and record clinical outcomes, such as Health of the Nation Outcome scales, malnutrition screening tool, Liverpool university neuroleptic side effect scale, and model of human occupation screening tool.

Chesterton unit had introduced an electronic system for measuring outcomes called 'patient owned database' or POD. This was held on an electronic tablet all patients had their own individual log in details and dependant on their clinical pathway either psychosis or non-psychosis they would access various rating scales. Some of the rating scales available were:

- Barrett impulsiveness scale

Are services effective?

Good 

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

- Incident recording – aggression and self-harm
- Living life well engagement questionnaire
- Patient health questionnaire
- Standardised assessment of personality
- Psychotic symptom rating scale.

The information from the rating scales were then used to promote discussions in named nurse one to one sessions and multidisciplinary team meetings.

Skilled staff to deliver care

There were a full range of professionals employed to work within the secure services including, doctors, nurses, psychologists, occupational therapists and pharmacists. Staff were experienced and qualified and had received additional training to support them in their role such as:

- professional boundaries training
- advanced statement clinical workshop
- clinical supervision
- clinical structure model
- recovery star
- multi-agency public protection arrangements
- structured assessment of protective factors.

All substantive and bank staff received a corporate mandatory induction on commencing their role, also a local induction to the unit.

All the staff we spoke with confirmed that they had regular line management and clinical supervision sessions. Supervision took place every four to eight weeks, in line with their trust policy. Additional to this staff also received clinical group supervisions or workshops weekly.

For the period June 2015 to June 2016 the percentage of annual work performance appraisals that were completed was:

- Chesterton unit - 83%
- Tennyson unit – 68%
- Auden Unit – 87%
- Marlowe unit – 89%

The uptake of supervision, appraisals, and additional training within the secure services had increased from 2015. This meant that the overall reports from staff were they felt skilled to perform their role, and felt much more supported by the team and managers.

Multi-disciplinary and inter-agency team work

Multidisciplinary team meetings took place weekly and reviewed each patient on a fortnightly basis. We observed two multi-disciplinary team meetings during our inspection that were well attended by a number of different professionals. We found the meetings to be collaborative with the patients, the multidisciplinary team were thoughtful and listened to the patient, and made clear explanations for any decisions made.

We also attended two living life well meetings. The meetings were held every morning on both Chesterton and Marlowe unit. All staff on the ward attended the meetings that included doctors, nurses, allied professionals, housekeeper, and health care assistants. The meeting looked at the progress and needs of specific patients. This included their care plan and what interventions would be taken forward that day. This included referrals to safeguarding teams, an introduction to mindfulness, current patient psychological formulation and suggested approaches. This meant that there was a more consistent team approach to patients and that all staff were aware of the needs, risks and progress of each individual.

We observed two handovers that were comprehensive and holistic; this also covered areas such as the patients' diagnosis, risks, incidents and observation level. We observed that staff also handed over the wards ligature points and how these should be managed during the shift.

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

Staff received training on the Mental Health Act. The training figures for across the secure service varied from 87% compliance on Chesterton unit and 100% compliance on Tennyson unit. The training figures were within the trust target for this training.

We reviewed the Mental Health Act documentation for 18 patients and found that all the statutory documentation was in place. We found that staff were regularly explaining rights to patients under the Mental Health Act and this happened on a three monthly basis and was increased if this was necessary.

Are services effective?

Good 

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

We reviewed 40 medicine charts. We found on one medicine chart that medication had been prescribed and administered that was not identified on their T3 form. A second opinion doctor completes a T3 form when a patient does not agree with their mental health treatment. Patients should not be given any medication outside the parameters that the second opinion doctor and the patients' consultant have agreed. The ward staff rectified this and a section 62 was put in place on the day of inspection. A section 62 allows staff to administer this medication until a further second opinion is received.

Two T3 forms had been renewed and updated; staff had not replaced the old version T3 form with the updated version. This was rectified on the day of inspection.

Independent mental health advocates were available on the units. We spoke with a mental health advocate who told us that the staff on the units were receptive to the service they provided. Patients told us that they knew how to access the independent mental health advocates service.

Each patient had a file for all Mental Health Act documentation. We found on reviewing the section 17 leave for individuals that there could be multiple forms for differing leave. For example, one form for grounds leave, one for the local area and one for specific activities. We also found that there could be duplicate forms within the files for leave that could lead to confusion and mistakes occurring when deciphering the leave that the patient is granted. We were told that the trust was working on streamlining this process to avoid duplication and confusion.

Overall there had been a significant improvement in the management of the Mental Health Act

Good practice in applying the Mental Capacity Act

Staff received training in the Mental Capacity Act. The training figures for the secure units varied from 91% on Marlowe unit and 100% on Tennyson unit. The training figures were within the trust target for this area.

All patients within the secure units were detained under the Mental Health Act therefore, there no Deprivation of liberty safeguards applications had been made.

The staff we spoke with all were able to describe the principles of the Mental Capacity Act, whether this by directly telling us what they were or describing instances where they would have concerns about a person's capacity to make informed decisions and the process they would follow. Staff gave some good examples of how they would look to support patients to make decisions.

The trust had a specific form in place to record capacity assessments. We found these present in a number of files where there were a concern regarding a patient's capacity to consent to treatment was questioned. We also found a good example of a form that had been completed regarding a patient's capacity to understand the consequence of a specific behaviour whilst using her mobile phone. This showed that staff had a clear understanding of the Mental Capacity Act and new how to appropriately apply the principles.

Are services caring?

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

Our findings

Kindness, dignity, respect and support

During our inspection, we observed staff engage in positive and caring interactions with patients. Staff during handovers, multi-disciplinary team meetings and through the clinical supervision sessions, we saw staff spoke positively about patients and their recovery.

On Auden unit, we conducted an observation of the care and treatment being delivered for a period of 30 minutes. We found that all interactions between staff and patients were positive. Staff understood the different communication needs of each individual patient and adjusted their communication accordingly. Staff involved patients in the day-to-day activity of the ward promoting their independence, and gave praise and encouragement throughout.

Patients from across the secure units told us that staff were 'friendly', 'treated them with respect', 'lovely'. We received no negative comments from patients regarding the attitude or behaviour of staff during this inspection and staff were knowledgeable about their patient's needs. All patients we spoke with told us that they felt safe on the units.

Where there were complex patients that brought about challenges for staff in their interactions with patients, we saw that support was in place to help staff to understand the patients' perspective and alternative approaches to support them. This had contributed to the overall

improvement in the culture on the secure units. This was most noted on Chesterton unit where on the previous inspection patients had felt they were unsupported and not cared for.

The involvement of people in the care that they receive

Patients told us that they were orientated to the ward on admission. Patients were overall involved in their care planning. We saw clear evidence that their views were written down and taken into consideration and they were offered copies of their care plans. This was particularly evident in the care records on Chesterton unit where in the previous inspection we found there to be some derogatory language used in care plans. Care plans using the 'living life well' booklets were written by the patient and showed their thoughts on their recovery and the associated care plans were written from the patient's perspective and were written in a professional manner.

There was access to independent mental health advocates across the service, and this service was well used by patients who felt that they required an advocate.

Weekly patient community meetings were available on each of the unit; this allowed patients to provide feedback on the service. We reviewed a sample of the community meetings and saw that this included feedback on the ward environment, the atmosphere, food, and activities. We saw that there were appropriate responses to some of the concerns raised and that where answers to concerns could not be given directly then actions were taken away and feedback was given at the next meeting.

Are services responsive to people's needs?

Good 

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

Our findings

Access and discharge

All referrals to the secure services were submitted to the forensic outreach team who were based within the secure inpatient service department. The forensic outreach team submitted the referrals to a weekly allocations meeting where the assessment team were assigned based on the patients' needs. A forensic outreach worker would then be allocated as a caseworker and co-ordinated the assessment. Once the assessment had taken place, the professionals who conducted the assessment made a clinical judgement as to whether the patient met the admission criteria or not.

The secure service had a clear referral, admission and discharge pathway in place. This was clearly stated in operational guidance. Staff we spoke with were aware of the process for assessment and admission.

The average bed occupancy for each unit for the end of quarter one 2016 was:

- Chesterton unit - 71%
- Tennyson Unit – 50%
- Auden unit – 87%
- Marlowe unit – 99%

There were no reported waiting lists or out of area placements for any of the secure units at the time of inspection.

Patients only moved between wards when it was clinically indicated and did so as part of the step-down service provided on Tennyson unit.

The average length of stay (in days) in March 2016 for each unit was:

- Chesterton unit – 695
- Tennyson unit – 835
- Auden unit – 462
- Marlowe unit – 692

The highest length of stay was on Tennyson unit at two years and three months.

Discharge planning was evident in all care plans for patients. A secure pathways and discharge steps procedure

was in place which gave patients an allocated number based on where they were in their recovery. We saw that patients had been allocated the correct number based on their recovery and pathway and it was written in their care plan identifying what steps were being taken. Care programme approach meetings took place with the patients' locality team care coordinator to review the patients' recovery and plans for discharge.

The facilities promote recovery, comfort, dignity and confidentiality

The secure units provided a full range of rooms to support patients' recovery that included activity rooms, rooms for family visiting, and quiet areas for patient's and one to one time. Additionally there were occupational therapy kitchens, and on Tennyson unit there were two flats, which supported more independent living for patients who were preparing for discharge.

During our previous inspection there were concerns raised by staff and patients about the complexity and mix of patients on Chesterton unit. There had been significant work completed around the patients group to support both patients and staff to manage those complex patients. Those patients who required a higher level of security had been transferred out to more appropriate placements for their needs, and the ward reported a significant change in the management and atmosphere on the ward.

There were quiet areas of the ward where there were pay phones for patients to use, and patients that had a full risk assessment had access to their mobile phones throughout their stay on the wards.

Hot and cold drinks were available throughout the day. On Tennyson unit, patients had free access to the kitchen and were able to make their own drinks and snacks as they wished. On Chesterton unit a trolley was refreshed throughout the day for patients to access hot drinks. Marlowe and Auden Unit patients had access to hot drinks throughout the day on request.

Patients were able to personalise their bedroom area with poster and photographs. There was a safe available for patients in their bedrooms where they were able to securely store their valuables.

There was access to outside space on all units. However, some outside spaces designated for smoking were restricted. Patients with unescorted leave were able to leave the ward areas as they wished.

Are services responsive to people's needs?

Good 

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

Activity workers were employed on all the units, they provided activities across seven days a week. Patients we spoke with on Tennyson unit told us that there was not a lot on the ward activity that happened. However, as Tennyson unit was a step-down service the patients had significant amounts of leave for off the ward activities. We observed on the day of inspection that the patients on the ward had planned off the ward activities for the day. Patients as part of their on-going recovery bought their own foods with a budget they received weekly and had open access to a kitchen in which they cooked all their own meals.

The feedback from the patients on the quality and portions of the food particularly on Chesterton and Marlowe units was poor. Concerns raised were around food that was ordered was not always what was given, some of the food was cold when received, and the Sunday brunch items was limited.

The patient-led assessments of the care environment for 2016 had been completed but the trust was awaiting their assessment results. However, we did find the wards to be clean and tidy and in a good state of repair.

Meeting the needs of all people who use the service

All units with the exception of Tennyson unit were on the ground floor and allowed disabled access. Tennyson unit had a lift that could be used for anyone who had difficulties with using the stairs. All the units had an assisted bathroom area.

On touring the units, we found that there was a lot of information displayed for patients. This included information on the Mental Health Act, the CQC, how to make complaints, and advocacy service. On Auden unit, we

found this information to be in an easy read format also. Although this information was not found to be displayed in alternative languages this could be accessed if required and given to individuals.

Interpreters were available on request, and staff did not describe any concerns with accessing these. We saw a good example of how a patient was supported with their first language and maintaining contact with their community. The staff had attempted to learn some of the basic language in order to improve their communication with the patient.

Patients were able to order different foods to meet their dietary requirements, this included for those patients who were vegetarian, vegan and required halal foods. This was ordered through the kitchen on request. There was access to an on-site chaplain and access to other faiths if required.

Listening to and learning from concerns and complaints

There were a total of 30 complaints across the secure units from July 2015 to July 2016. These were:

- Auden unit - 17 complaints, 12 were locally resolved, one was withdrawn, two were partially upheld, and two were not upheld
- Tennyson – one complaint which was locally resolved
- Chesterton – eight complaints, five were locally resolved, one was withdrawn, and two were not upheld
- Marlowe – four complaints and all were not upheld.

Staff and patients were spoke with all were able to describe the complaint process. We found that a high number of complaints were recorded locally and local resolutions were now in place. Staff told us that they received feedback from complaints through supervision sessions, and staff meetings.

Are services well-led?

Good 

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

Our findings

Vision and values

The trust had five values which were:

- We value people as individuals ensuring we are all treated with dignity and respect.
- We value quality and strive for excellence in everything we do.
- We value, encourage and recognise everyone's contribution and feedback.
- We value open, two-way communication to promote a listening and learning culture.
- We value and deliver on the commitments we make.

The staff we spoke with were aware of the trust values. The ward managers told us that in recent away and development days, the trust vision and values were discussed. Most of the staff were able to identify who the senior managers were told us that they visited the ward periodically.

Good governance

Effective systems and processes had been put in place since our previous inspection to ensure that the governance on the wards had improved. We found that all staff had a good knowledge and understanding of the concerns raised through our previous inspection and were able to clearly identify how things had improved. Although in some areas sickness and absence, retention of staff along with vacancies were still high, there was evidence to show that there was a recruitment strategy in place. Staff were aware of where their vacancies were and what point of the recruitment process each was up to.

Overall there was a significant improvement in the support of staff through staff meetings, supervisions, appraisals, debriefs following incidents and clinical supervision. Staff received regular feedback on incidents and complaints that were seen to support improvements in the care and treatment of patients.

Clinical audits around hot spot areas such as care planning and risk assessments were routinely completed by the matron with responsibility for the service. This quickly picked up gaps to enable them to be rectified quickly and common themes to be shared across the units.

Governance meetings took place to review lessons learned and how these were disseminated. A specialist inpatient and community business meeting, and a specialist services quality and safety meeting was in place to review safety and performance of the service.

On discussion with the senior managers from the service, it was evident that they were aware of their on-going improvement plan and had a strategy for moving forward. They acknowledged that a lot of work had been done around Chesterton unit that was up, running, and embedded within the service particularly around the 'living life well' programme. This was to be continued to be rolled out fully across all the other units.

The trust produced quarterly reports of its key performance indicators that were used to gauge the performance of the team. The ward managers told us that they had access to their key performance indicator data.

The ward managers all felt that they had sufficient authority to perform their role with adequate administrative support.

The trust had a corporate risk register where any on-going risk identified was recorded. Ward managers told us should they have concerns that they were able to discuss risk with their line managers and a decision was reached as to whether they needed to be placed on the risk register.

Leadership, morale and staff engagement

All the units across the secure service had permanent ward managers in place during our inspection including a ward manager for Tennyson unit who had been in post since November 2015. All the staff we spoke with told us of the positive changes over the past 12 months. This has had a positive effect on the staff morale on all the units. Staff described the secure units as a good place to work with a supportive leadership team in place. The staff all felt that the teams worked together cohesively and that they supported each other well and morale was much improved.

There were no bullying or harassment cases open at the time of inspection, and staff were confident that if they had any issues or concerns that they would be able to raise these knowing that action or an explanation would be given.

Are services well-led?

Good 

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

Staff had access to regular team meetings, development days, clinical supervision sessions where the team were able to work together to look how they would drive forward improvements, and look at the clinical management of the more complex patients.

Commitment to quality improvement and innovation

The low secure services, Chesterton, Auden, and Marlowe unit all participated in the quality network for forensic mental health services. A peer review took place in April 2016.