Lincolnshire Partnership NHS Foundation Trust

Acute wards for adults of working age and psychiatric intensive care units

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	Peter Hodgkinson Centre	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 Acute wards for adults of working age and psychiatric intensive care units

Are Acute wards for adults of working age and psychiatric intensive care units safe?	
Are Acute wards for adults of working age and psychiatric intensive care units effective?	
Are Acute wards for adults of working age and psychiatric intensive care units caring?	
Are Acute wards for adults of working age and psychiatric intensive care units responsive?	
Are Acute wards for adults of working age and psychiatric intensive care units 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 Peter Hodgkinson Centre were:

Patients told us that they usually felt safe on the unit. Staff reported incidents/accidents and there was a system in place for reviewing and learning from them to prevent a reoccurrence. Systems were in place to ensure adequate staffing levels and appropriate skill mix on both wards to meet the needs of individual patients.

Staff provided a range of therapeutic interventions in line with National Institute of Clinical Excellence (NICE). Regular team meetings took place and staff told us that they felt supported by colleagues. Health care assistants were receiving training in order to obtain the care certificate. Staff reported receiving effective training opportunities.

Patients knew who their primary nurse was and felt able to talk to them. They told us that they felt involved in their individual care and that they met with their doctor regularly.

Clear admission assessments were in place. Patients were being supported to access Section 17 leave supported by staff. We found that patients had discharge plans where appropriate. The average length of stay on this unit was three months.

Staff reported good morale and positive peer support and told us that their line manager was supportive and provided clear guidance. Both wards had the accreditation for in-patients mental health service (AIMS). This is a standards-based accreditation programme designed to improve the quality of care in inpatient mental health wards and is managed by the Royal College of Psychiatrists Centre for Quality improvement.

But we also found:

- The trust did not have a psychiatric intensive care unit (PICU) and this meant that patients who needed this service received this out of area.
- Two male patients were being nursed out of area whilst awaiting a bed on Connolly ward.

Summary of findings

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

Are services safe?
Our findings at the Peter Hodgkinson Centre were:

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

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

The unit used the nationally recognised Morgan risk assessment tool to measure risk to self and others. These assessments had been updated to reflect assessed changes in clinical need.

We found that staff hand overs were comprehensive and included updates on potential risk factors. 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 both wards to meet the needs of individual patients.

Are services effective?
Our findings at the Peter Hodgkinson Centre were:

The unit used the Manchester care assessment schedule (MANCAS) as a generic mental health screening tool. Patents had care plans and personal support plans that were comprehensive and up to date. These care plans were personalised and sufficiently detailed to ensure staff understanding and consistency of approach.

A physical health care nurse was employed by the trust and acted as resource to the unit.

Staff provided a range of therapeutic interventions in line with National Institute of Clinical Excellence (NICE). Regular team meetings took place and staff told us that they felt supported by colleagues.

Health care assistants were receiving training in order to obtain the care certificate. Staff reported receiving effective training opportunities.

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

Are services caring?
Our findings at the Peter Hodgkinson Centre were:

Summary of findings

Patients knew who their primary nurse was and felt able to talk to them. They told us that they felt involved in their individual care and that they met with their doctor regularly.

Patients felt well supported by front line staff. One patient told us that the staff believed in them and had been a great help.

Are services responsive to people's needs?

Our findings at the Peter Hodgkinson Centre were:

Clear admission assessments were in place. The trust reported responsive joint working with the commissioners of this service.

We saw that patients were being supported to access Section 17 MHA leave supported by staff. We found that patients had discharge plans where appropriate.

The average length of stay on this unit was three months. Delayed discharges were noted and these were mostly due to accommodation difficulties and finding suitable alternative arrangements to admission.

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.

But we also found that:

- The trust did not have a PICU and this meant that patients who needed this service received this out of area.
- Two male patients were being nursed out of area whilst awaiting a bed on Connolly ward.

Are services well-led?

Our findings at the Peter Hodgkinson Centre were:

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

Staff reported good morale and positive 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.

Senior staff carried out separate unannounced visits to the service in order to monitor the quality of services provided.

Summary of findings

Both wards had the accreditation for in-patients mental health service (AIMS). This is a standards-based accreditation programme designed to improve the quality of care in inpatient mental health wards and is managed by the Royal College of Psychiatrists Centre for Quality improvement.

Summary of findings

Background to the service

The Peter Hodgkinson Centre is a purpose built unit providing care and treatment in two separate gender specific wards. It is located within the grounds of a large NHS acute trust in Lincoln.

Charlesworth ward provided 20 beds for female patients. Connolly ward provided 22 beds for male patients. During the inspection both wards were full. There were nine detained patients on each ward.

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 inspected this core service unannounced following concerns received by 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 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 both wards and looked at the quality of the ward environment and observed how staff was caring for patients.
- Spoke with twelve patients across both wards.
- Spoke with the ward managers for each ward.
- Spoke with five senior trust managers with accountability and responsibility for this core service 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 senior clinicians including two consultant psychiatrists.
- Spoke with nine frontline staff members including allied healthcare professionals, trained nurses and health care assistants.

We also:

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

Summary of findings

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 twelve patients across both wards.
- 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 there were enough staff on duty and that staff were responsive when concerns were raised. Patients knew who their primary nurse was and felt able to talk to them. They told us that they felt involved in their individual care and that they met with their doctor regularly.

One patient told us that the staff believed in them and had been a great help. Most patients told us that the food provided was good. Some patients told us that they would like more Section 17 leave and others that they would like more activities at the weekend.

Good practice

- Both wards had the accreditation for in-patients mental health service (AIMS). This is a standards-based accreditation programme designed to improve the quality of care on in-patient mental health wards and is managed by the Royal College of Psychiatrists Centre for Quality improvement.
- Periodic 'mock' Care Quality Commission inspection visits had started by 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

- The trust should explore the provision of a psychiatric intensive care unit (PICU) within its wider trust service improvement plan.

Lincolnshire Partnership NHS Foundation Trust

Acute wards for adults of working age and psychiatric intensive care units

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Peter Hodgkinson Centre – Charlesworth and Connolly wards	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. 91% of staff had received their refresher training for this year. Detained patients told us that they were aware of the rights under the Act. Staff outlined how they ensured that the rights of informal patients were protected.

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

We saw that people's mental capacity to consent to their care and treatment had been assessed where relevant.

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. Staff demonstrated an awareness of the Act and 91% 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 Peter Hodgkinson Centre were:

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

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

The unit used the nationally recognised Morgan risk assessment tool to measure risk to self and others. These assessments had been updated to reflect assessed changes in clinical need.

We found that staff hand overs were comprehensive and included updates on potential risk factors. 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 both wards to meet the needs of individual patients.

Our findings

Safe and clean ward environment

- The ward layout enabled staff to observe patients effectively.
- Enhanced observation records were completed well.
- Relational security arrangements were in place when patients accessed the unit's smoking areas.
- We saw a ligature audit risk assessment of the unit dated July 2014. Identified risks were being managed appropriately.
- Both ward areas were well maintained.
- Patients told us that the wards were usually kept clean.
- Staff told us that maintenance requests were promptly addressed where ever possible.
- Arrangements were in place to support visits by external contractors.
- Resuscitation equipment was in place and checked regularly to ensure that it was fit for purpose and could be used in an emergency situation.

Safe staffing

- We reviewed the current and previous staff rotas and these showed us that there was 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.
- Some staff raised concerns about one trained nurse being on duty at night on each ward.
- The trust confirmed that this was under review and recruitment was taking place to enable two trained nurses to be on duty at night for each ward commencing in January 2015.
- Evidence was seen that additional staff were used when the needs of patients required this. Access to these staff was through the bed management team.
- Some patients were on enhanced observation levels following clear risk assessments.
- Charlesworth ward had a newly appointed ward manager.
- Connolly ward had an acting ward manager.
- Both managers confirmed that they were well supported by their line manager and the wider trust.
- Senior 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.
- New permanent, bank and agency staff received an induction to the ward.
- A monthly safer staffing report was submitted to the trust board and the commissioners of the service.

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 unit used the nationally recognised Morgan risk assessment tool to measure risk to self and others.

Are services safe?

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

- These assessments had been updated to reflect assessed changes in clinical need.
- We found that hand overs were comprehensive and included updates on potential risk factors.
- Staff had received 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.
- Safeguarding incidents had been reported through the trust's safeguarding protocols and where required had been investigated appropriately.
- Seclusion records were well maintained.
- The seclusion room met the requirements of the 1983 Mental Health Act code of practice.
- Use of restraint was closely monitored and audited by the trust.
- Staff knew how to report incidents and the trust provided clear guidance to staff on incident reporting.
- All current serious untoward incidents were reviewed weekly by trust management.
- Post incident debriefing was available for patients and staff and we saw examples of these.
- Medication administration records (MAR) charts were well completed with reasons for any non-administration clearly recorded.

Track record on safety

- Patients told us that they generally felt safe on the wards.
- Ward based community meeting minutes showed us that safety concerns were being addressed by front line staff.
- 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 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.
- 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.
- 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 Peter Hodgkinson Centre were:

The unit used the Manchester care assessment schedule (MANCAS) as a generic mental health screening tool. Patents had care plans and personal support plans that were comprehensive and up to date. These care plans were personalised and sufficiently detailed to ensure staff understanding and consistency of approach.

A physical health care nurse was employed by the trust and acted as resource to the unit.

Staff provided a range of therapeutic interventions in line with National Institute of Clinical Excellence (NICE). Regular team meetings took place and staff told us that they felt supported by colleagues.

Health care assistants were receiving training in order to obtain the care certificate. Staff reported receiving effective training opportunities.

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

Our findings

Assessment of needs and planning of care

- The unit used the Manchester care assessment schedule (MANCAS) as a generic mental health screening tool.
- Patients had comprehensive multi-disciplinary assessments in place.
- Patents had care plans and personal support plans that were comprehensive and up to date.
- These care plans were personalised and sufficiently detailed to ensure staff understanding and consistency of approach.
- Physical healthcare monitoring was taking place for example, monitoring of blood pressure for potential side effects caused by prescribed medication.
- A physical health care nurse was employed by the trust and acted as resource to the unit.

Best practice in treatment and 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.
- Staff provided a range of therapeutic interventions in line with National Institute of Clinical Excellence (NICE).
- 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.

Skilled staff to deliver care

- Overall staff compliance at mandatory training was between 90% and 95%.
- 76% of staff had received their positive management of violence and aggression (PVMA) training on Charlesworth ward. Other training sessions had been scheduled for staff to attend.
- 80% of staff had received their positive management of violence and aggression (PVMA) training on Connolly ward. Other training sessions had been scheduled for staff to attend.
- Staff received additional role specific training. For example, leadership, new staff development and substance misuse courses were available to front line staff.
- Health care assistants were receiving training in order to obtain the care certificate.
- Staff reported receiving effective training opportunities.
- Monthly training updates were provided to senior management.
- 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, activities co-ordinator, occupational therapist and physiotherapist.

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.

- 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

- 91% 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
- The provider had clear procedures in place regarding their use and implementation of the Mental Health Act and the code of practice
- Information regarding patient rights under the Act were on display.
- The records showed that patients had been informed of their rights of appeal against their detention.
- Detained patients had access to an independent mental health advocacy service (IMHA).
- Independent generic advocacy services were available and informal patients told us they were aware of their rights.
- Several people were supported in applying to the Mental Health Act first tier tribunal to seek a discharge from their section.

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.
- 91% 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 Peter Hodgkinson Centre were:

Patients knew who their primary nurse was and felt able to talk to them. They told us that they felt involved in their individual care and that they met with their doctor regularly.

Patients felt well supported by front line staff. One patient told us that the staff believed in them and had been a great help.

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.
- One patient told us that the staff believed in them and had been a positive factor in their recovery.
- 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.
- Evidence was seen of an emphasis upon least restrictive practice wherever possible.

The involvement of people in the care they receive

- Patients received copies of their care plans and this was recorded in their care notes.
- They were seen regularly by their responsible clinician and that if they had questions about their medication staff would answer these.
- Advocates were available on the unit and there was information available about access to advocacy services.
- 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 Peter Hodgkinson Centre were:

Clear admission assessments were in place. The trust reported responsive joint working with the commissioners of this service.

We saw that patients were being supported to access Section 17 MHA leave supported by staff. We found that patients had discharge plans where appropriate.

The average length of stay on this unit was three months. Delayed discharges were noted and these were mostly due to accommodation difficulties and finding suitable alternative arrangements to admission.

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.

But we also found that:

- The trust did not have a PICU and this meant that patients who needed this service received this out of area.
- Two male patients were being nursed out of area whilst awaiting a bed on Connolly ward.

Our findings

Access discharge and bed management

- Clear admission assessments were seen.
- The trust reported responsive joint working with local commissioners.
- Patients had access to the trust's community teams upon discharge.
- The unit had a bed management team.
- The trust did not have a PICU and this meant that patients who needed this service received this out of area. This could lead to delays in accessing treatment.
- Some other patients were being nursed out of area
- The trust had an accredited electro-convulsive therapy (ECT) service.
- A health based place of safety unit had recently opened at this location.
- We found that patients had discharge plans where appropriate.
- The average length of stay in this unit was three months.
- Delayed discharges were noted and these were mostly due to accommodation difficulties and finding suitable alternative arrangements to remaining on an acute admission ward.

The ward optimises recovery comfort and dignity

- Access to Mental Health Act section 17 leave was documented.
- Clear arrangements were in place to facilitate family visits to the unit.
- Patients had access to a courtyard and a smoking shelter.
- The unit had their own occupational therapy department.
- Patients attended GP, dentists and other health appointments when required.

Meeting the needs of all the people who use the service

- The unit had a dedicated social worker 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 ward based kitchen was risk assessed.
- Patients' diverse needs such as religion and ethnicity was recorded and we saw these were being met for example through religious specific diets.
- 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.

- Ten complaints had been recorded since July 2013. One complaint was currently 'open' and being investigated.
- Staff told us that complaints were discussed at staff meetings and this was supported by those meeting minutes seen.

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 Peter Hodgkinson Centre were:

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

Staff reported good morale and positive 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.

Senior staff carried out separate unannounced visits to the service in order to monitor the quality of services provided.

Both wards had the accreditation for in-patients mental health service (AIMS). This is a standards-based accreditation programme designed to improve the quality of care in inpatient mental health wards and is managed by the Royal College of Psychiatrists Centre for Quality improvement.

Our findings

Vision and values

- Staff were aware of the trust's vision and values. These were displayed on the entrance to the unit.
- Senior managers were visible to front line staff and patients.
- Unit staff had access to the trust's intranet and received a weekly update via e-mail from senior trust leaders.

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 ward 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.
- Staff received regular supervision and there was a supervision matrix.

Leadership morale and staff engagement

- Staff reported good morale and positive peer support.
- Front line 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 by 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.
- Both wards had the accreditation for in-patients mental health service (AIMS).

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.

- AIMS is a standards-based accreditation programme designed to improve the quality of care in inpatient mental health wards and is managed by the Royal College of psychiatrists Centre for Quality improvement.