CareQuality Commission

Leeds and York Partnership NHS Foundation Trust

Evidence appendix

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This evidence appendix provides the supporting evidence that enabled us to come to our judgements of the quality of service provided by this trust. It is based on a combination of information provided to us by the trust, nationally available data, what we found when we inspected, and information given to us from patients, the public and other organisations. For a summary of our inspection findings, see the inspection report for this trust.

Facts and data about this trust

Leeds and York Partnership NHS Foundation Trust provides specialist mental health and learning disability services. They support people of all ages within the Leeds and York areas. It was awarded NHS foundation trust status on 1 August 2007. The trust merged with the mental health and learning disability services from NHS North Yorkshire and York on 1 February 2012, becoming Leeds and York Partnership NHS Foundation Trust.

The trust serves a population of 780,000 in Leeds, and 198,000 in York. It employs 2489 substantive staff, including 721 qualified nurses, 68 consultant psychiatrists, 156 allied health professionals and 651 health care support workers.

Its annual turnover for 2016/17 was £153 million.

The trust headquarters is located in Thorpe Park, Leeds. All community mental health services are registered to the trust headquarters.

The trust had 10 locations registered with the CQC (on 30 November 2017), across 48 sites.

Registered location	Code	Local authority
Asket Centre	RGD10	Leeds
Clifton House	RGDT5	York

Trust Headquarters	RGD01	Leeds
Mill Lodge	RGDVE	York
Parkside Lodge	RGDPL	Leeds
St Mary's Hospital	RGD17	Leeds
The Becklin Centre	RGDBL	Leeds
The Mount	RGD05	Leeds
The National Inpatient Centre for Psychological Medicine	RGD08	Leeds
The Newsam Centre	RGDAB	Leeds

The trust had 423 inpatient beds across 28 wards. Sixteen children's mental health beds were provided. The trust did not provide the number of outpatient clinics a week but did tell us they had 317 community clinics a week.

Total number of inpatient beds Total number of inpatient wards	423 28
Total number of day case beds	-
Total number of children's beds (MH setting)	16
Total number of children's beds (CHS setting)	-
Total number of outpatient clinics a week	-
Total number of community clinics a week	317

The trust provides the following mental health core services,

- Acute wards for adults of working age and psychiatric intensive care units
- Long stay/rehabilitation mental health wards for working age adults
- Forensic inpatient/secure wards
- Child and adolescent mental health wards
- Wards for older people with mental health problems
- Wards for people with learning disability or autism
- Community-based mental health services for adults of working age
- Mental health crisis services and health-based places of safety
- Specialist community mental health services for older people
- Specialist Deaf Community-based mental health services for children and young people
- Community mental health services for people with learning disability or autism
- Specialist Core Service - National Inpatient Centre for Psychological Medicine

The trust also provides one adult social care service which is the supported living service.

Leeds and York Partnership Foundation Trust had its last comprehensive inspection in July 2016. At the last inspection three of the core services were rated as requires improvement; nine of the 12 core services were rated as 'good' or 'outstanding,' and the supported living service was rated as 'requires improvement.' The trust was rated as 'requires improvement' overall; the Care Quality Commission deviated from its aggregation methodology due to governance and well led breaches of regulation at trust level.

Is this organisation well-led?

Leadership

NHS Improvement confirmed that in their experience, the trust board had the appropriate range of skills, knowledge and experience to perform its role. The board had six executive directors, including the chief executive officer, who all had career experience in a healthcare setting and relevant qualifications as appropriate for their leadership roles. There were seven non-executive directors including the chair of the trust who brought experience and knowledge of working within clinical, finance and business, and strategic roles.

The executive board had 0% black and minority ethnic (BME) members and 83% women.
The non-executive board had 14% BME members and 71% women.

	BME %	Women %
Executive	0%	83%
Non-executive	14%	71%
Total	8%	76%

Fit and proper person checks were in place. The trust had a robust system to ensure board members were fit to perform their role. Checks were completed as required on appointment and during employment. The trust was able to provide evidence of these checks upon request.

The trust had a senior leadership team in place with the appropriate range of skills, knowledge and experience relevant to their role, profession and directorate. Senior leaders from the different directorates, including the finance, medical, workforce development, care services, and nursing professions and quality, directorates demonstrated a good understanding of their areas of expertise, their responsibility in the organisation, and their accountability to the board. The care services directorate included the Specialist and Learning Disability Services Care Group and the Leeds mental health care group. Within the specialist and learning disability services care group, the trust had a lead for child and adolescent mental health, and learning disability and autism. The learning disability services manager and the child and adolescent mental health service/national deaf child and adolescent mental health service manager, plus the specialist professional leads, reported directly to the associate director and the clinical director of the specialist and learning disability services care group. The assistant director and the clinical director reported to the chief operating officer. All provided examples of areas of good practice and where improvements were required in these specialist services.

The trust board and senior leadership team demonstrated their integrity throughout the inspection. The chief executive and the chair had expectations that all the board and the senior leaders demonstrated the trust values and that they led by example in displaying behaviours that underpinned these, which included ‘having integrity.’ We saw constructive challenge and positive feedback in the board meetings we attended, for example in relation to the trust’s approach to the waiting list for the gender identity service and the new combined quality and performance report. Examples were provided by members of the board and the senior leadership team demonstrating their commitment to improving services and functions across the trust, and where they had considered people’s views in relation to the changes. They were also open and transparent in discussions where they felt they could improve or a situation could have been approached in a better way, for example, the recent administration team review.

The trust had commissioned an external review of ‘well led’, which included a review of the trust’s capacity and capability. This, in addition to the initial assessment of the chief executive and the

chair when they came into post, informed the trust's current leadership ability and where they could improve. As a result there had been changes in the executive team to increase the board's capability. Capacity and capability were reviewed by the trust on an ongoing basis, including when senior leadership and board vacancies arose, where there was service transformation, or where services had additional leadership priorities. This was informed by annual appraisals, one to one objective setting and development plans, and feedback between the board and the sub-board in relation to service changes, leadership team requirements, and management structure. The trust's board development programme and the senior leadership forum provided the board and the senior leaders the opportunity to improve their capability and effectiveness through agendas informed by the direction and priorities of the trust.

The leadership team had a comprehensive knowledge of current priorities and challenges and took action to address them across its mental health and learning disability services, including its social care provision for people with a learning disability. This included the trust-wide priorities and challenges; addressing out of area placements and delayed discharges, mandatory training compliance, and record keeping. The leadership team demonstrated an awareness of the care group and local service challenges like the forensic service ward closure and the impact on staff, as well as priorities like the installation of the electronic incident reporting system in the supported living service to improve the timeliness of reporting and the oversight of incidents.

There was a programme of board visits to services by the executive and non-executive directors. Members of the council of governors were also encouraged to attend these visits. Along with the planned service visits, visits could be prioritised according to concerns, for example where board data had identified waits for patients to access the gender service, or conversely where good practice had been identified. Reports from the visits and outcomes were reviewed at the board. Senior leaders in the care groups maintained their visibility through local forums, away days, back to the floor visits where they worked in the service for a day, and peer reviews. Almost all staff fed back that leaders were visible and approachable.

Leadership development opportunities were available, including opportunities for staff below team manager level. Staff at all levels we spoke with told us that the trust provided opportunities for them to develop through access to training and mentoring, to coach others and be coached, to shadow the board, as well as opportunities to complete specific pieces of targeted work and to act up to enhance their skills and experience. The trust was moving forward with a collective leadership approach. The trust acknowledged that this change in culture was more established at board level and in some areas compared to others, for example the specialist and learning disability care group compared to the Leeds mental health care group. This collective leadership approach was underpinned by the workforce and organisational development strategic plan 2018-2021. Central to this was engaging aspiring leaders in a number of ways; continuing with the senior leadership forum, bolstering the existing coaching offer, and continued in house delivery of the Mary Seacole NHS leadership programme. The trust was also further developing the leadership behavioural competency and talent management frameworks, with the initial talent management pilot focus on developing band 5 and 6 future nursing and allied health professional clinical leaders.

Succession planning was in place throughout the trust. The nominations committee had the responsibility for identifying the skills and experience required prior to recruitment in relation to the board. All the executive directors had deputies identified that could step up as required. Senior leaders provided examples of where succession planning had worked well across the trust including for non-executive directors. However, they were also aware of the roles where identifying successors had been more of a challenge and had prioritised actions to address this.

Vision and strategy

The trust had a clear vision and values. Since the last inspection in July 2016, the trust had developed three new values in partnership with the trust's staff, members and partners. Each

value was underpinned by a definition statement and the expected behaviours that supported these values, and together with the vision they demonstrated the trust's priorities in relation to quality and sustainability and a culture which was patient centred.

The trust vision is as follows:

- Our vision is to provide outstanding mental health and learning disability services as an employer of choice.

The three values and definition statements were:

- We have integrity - We treat everyone with respect and dignity, honour our commitments and do our best for our service users and colleagues
- We are committed to continuously improving
- We consider the feelings, needs and rights of others
- We give positive feedback and constructively challenge unacceptable behaviour
- We're open about the actions we take and the decisions we make, working as one team with service users, colleagues and relevant partner organisations

- We keep it simple - We make it easy for the communities we serve and the people who work here to achieve their goals
- We make processes as simple as possible
- We avoid jargon and make sure we are understood
- We are clear what our goals are and help others to achieve their goals

- We are caring - We always show empathy and support those in need
- We make sure people feel we have time for them when they need it
- We listen and act upon what people have to say
- We communicate with compassion and kindness

The trust had recently refreshed its strategy to reflect the change in the organisation and in national policy, as well as best practice and what stakeholders were telling them. Staff, patients, carers, members and external partners including local providers had the opportunity to contribute to discussions and co-create the strategy. This was completed through a number of listening events which started in 2016, and also through a series of online conversations using a platform similar to social media called 'crowdsourcing' to pose questions and discuss priorities, as well as through the local service user and carer networks. It was also discussed and scrutinised through a number of board development sessions. The trust simplified the strategy further in response to the challenge from the council of governors at a board to board meeting. The final strategy, 'living our values to improve health and lives, 2018 – 2023', was agreed at the November 2017 trust board meeting.

The trust strategy was robust and realistic to achieve their three strategic objectives and deliver the trust's vision:

- We deliver great care that is high quality and improves lives
- We provide a rewarding and supportive place to work
- We use our resources to deliver effective and sustainable services

The objectives that underpinned them included developing good quality, person centred, and sustainable care across all its mental health and learning disability services, including its adult social care provision. Priorities also included supporting people in their recovery and in achieving their goals and outcomes, with a key priority in relation to embedding the values through the behaviours framework which had been rolled out in the previous six months, and supporting, recruiting, retaining and developing the workforce.

The strategy prioritised maximising the use of resources including technology, estates, and working in collaboration with partners in the wider health economy. This included active involvement in two sustainability and transformation partnerships, to deliver better care in the most economical way possible to meet the needs of the local population as appropriate.

The trust embedded its vision with a heavy focus on the trust values in all corporate information received by teams, which we observed during the inspection. The 2018 – 2023 strategy had been recently agreed, and the trust was currently in the process of completing a brand refresh through their communications team in line with NHS brand regulations, with a planned launch in February 2018. However, staff and managers knew and understood the trust's vision and values and how the values were used to guide team and individual practice. The trust values were also heavily featured in recruitment and at recent assessment centres, as well as in the staff appraisals with the development of a toolkit to support the behavioural framework. Senior leaders confirmed that staff had a better understanding of the strategy despite its recent ratification and how achievement of the objectives applied to the work of their team due to the staff engagement in co-creating it and the 'ward-up' approach. The trust brief completed by the chief executive following the trust board meetings and trust-wide emails provided updates to staff on the strategy to maintain their engagement.

The leadership team regularly monitored and reviewed progress on delivering their previous strategy and local plans, with a minimum of quarterly updates at the board on progress against the trust's operational plan to deliver these strategic aims. However, in relation to the current strategy 2018 -2023, the trust board was responsible for delivering the strategy and had developed a set of five draft strategic plans with an identified executive lead to achieve their current strategic aims. These were still in draft form at the time of the inspection and a piece of work was being completed to align these strategic plans. As before, all actions and progress will be reported to the board but also at the council of governors.

The trust demonstrated a commitment to addressing the physical health needs of patients in their services. The trust ratified a physical health improvement procedure in April 2017 to improve its physical health offer for people with severe mental health problems and/or learning disabilities, in partnership with service users and carers and in line with best practice, using evidence based resources. In January 2018, the trust's draft clinical services strategic plan was presented at the trust board and detailed an integrated approach to physical and mental health care, to attempt to maximise the trust's offer in relation to physical health across the trust's service provision and to meet local need.

Culture

The trust provided the information in the table below on staffing as part of the pre-inspection request.

Definition

Substantive – All filled allocated and funded posts.

Establishment – All posts allocated and funded (e.g. substantive + vacancies).

Substantive staff figures			Trust target
Total number of substantive staff	30 September 2017	2318.66	N/A
Total number of substantive staff leavers	1 October 2016 – 30 September 2017	287.27	N/A

Average WTE* leavers over 12 months (%)	1 October 2016 – 30 September 2017	12.5%	10% – 15%
Vacancies and sickness			
Total vacancies overall (excluding seconded staff)	30 September 2017	-336.54	N/A
Total vacancies overall (%)	30 September 2017	-15%	N/A
Total permanent staff sickness overall (%)	30 September 2017	4.72%	3.70%
	1 October 2016 – 30 September 2017	4.79%	3.70%
Establishment and vacancy (nurses and care assistants)			
Establishment levels Qualified Nurses (WTE*)	30 September 2017	765.64	N/A
Establishment levels Nursing Assistants (WTE*)	30 September 2017	614.56	N/A
Number of vacancies, Qualified Nurses (WTE*)	30 September 2017	120.06	N/A
Number of vacancies Nursing Assistants (WTE*)	30 September 2017	89.65	N/A
Qualified Nurse vacancy rate	30 September 2017	16%	N/A
Nursing Assistant vacancy rate	30 September 2017	15%	N/A
Bank and agency Use			
Shifts bank staff filled to cover sickness, absence or vacancies (Qualified Nurses)	1 October 2016 – 30 September 2017	9405 (4%)	N/A
Shifts filled by agency staff to cover sickness, absence or vacancies (Qualified Nurses)	1 October 2016 – 30 September 2017	3013 (4%)	N/A
Shifts NOT filled by bank or agency staff where there is sickness, absence or vacancies (Qualified Nurses)	1 October 2016 – 30 September 2017	721 (<1%)	N/A
Shifts filled by bank staff to cover sickness, absence or vacancies (Nursing Assistants)	1 October 2016 – 30 September 2017	49172 (20%)	N/A
Shifts filled by agency staff to cover sickness, absence or vacancies (Nursing Assistants)	1 October 2016 – 30 September 2017	10899 (14%)	N/A
Shifts NOT filled by bank or agency staff where there is sickness, absence or vacancies (Nursing Assistants)	1 October 2016 – 30 September 2017	4138 (2%)	N/A

*Whole-time Equivalent

Workforce was one of the key risks identified by all the executive and non-executive directors. Being an employer of choice was the vision for the trust, and providing a rewarding and supportive place to work was one of the trust's strategic objectives. The trust aimed to deliver this strategic objective through its workforce and organisation development strategic plan 2018 - 2023 and had highlighted workforce as a key strategic risk on its board assurance framework. The trust recognised the challenges across the organisation in relation to recruitment and retention, as well as specific areas where there were current issues relating to vacancies, turnover and sickness, for example the forensic service. Recruitment, retention, talent management, embedding values, and staff support, health and wellbeing, disclosure and barring service checks completed every three years, in line with the recommendations of the Lampard Enquiry (2015), was included in this strategic plan.

The trust had a structured and systematic approach to staff engagement; this focus on staff engagement was a culture change being embedded across the trust. This was underpinned by the

workforce and organisational development strategic plan 2018 - 2023 to meet the trust's strategic objectives and priorities.

Communication systems such as the intranet, newsletters, the twice weekly trust email, and the trust brief with board meeting updates ensured staff had access to up to date information about their place of work.

Staff had opportunities to feedback on the trust as a place to work and as a place where people receive services. This included through the staff friends and family test, the staff survey, 'joining the conversation with' platforms with the chief executive and other senior leaders and managers, back to the floor visits with executive and non-executive directors, and through the 'your voice counts' online social media crowd-sourcing platform. Staff could also provide feedback to the council of governors through its staff representatives and through back to the floor visits. Staff were involved in decision-making about changes to the trust services, for example specific staff focus groups were held around service change to enable staff to feedback around the community restructure and the proposal for the new electronic patient record system. The trust also identified and implemented new learning where staff engagement had not been sufficient, for example in the administration team changes.

In the 2016 NHS Staff Survey the trust had better results than other similar trusts in five key areas:

Key finding	Trust score	Similar trusts average
KEY FINDING 11 - Percentage of staff appraised in last 12 months	91%	89%
KEY FINDING 29 - Percentage of staff reporting errors, near misses or incidents witnessed in the last month	93%	92%
KEY FINDING 17 - Percentage of staff feeling unwell due to work related stress in the last 12 months	35%	41%
KEY FINDING 16 - Percentage of staff working extra hours	70%	72%
KEY FINDING 27 - Percentage of staff / colleagues reporting most recent experience of harassment, bullying or abuse	64%	60%

In the 2016 NHS Staff Survey: the trust had worse results than other similar trusts in 12 key areas

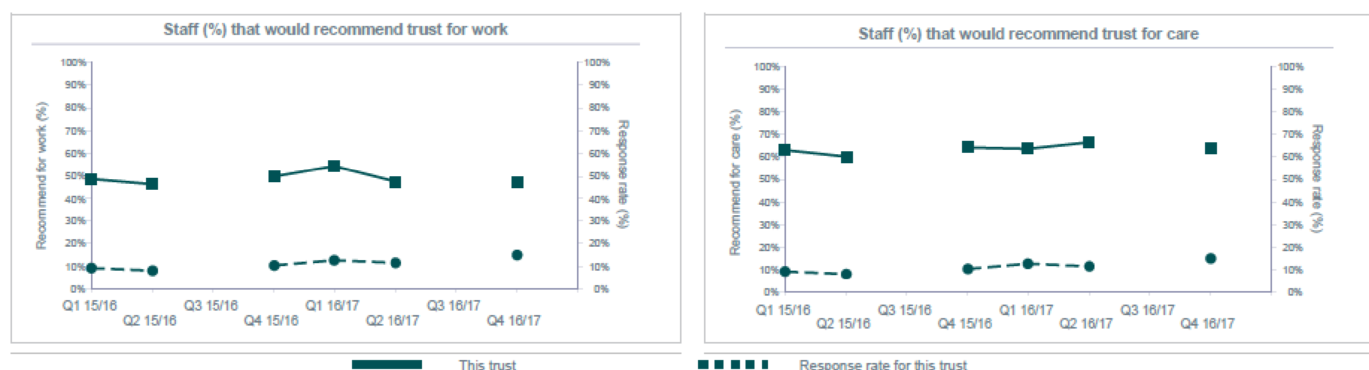
Key finding	Trust score	Similar trusts average
KEY FINDING 28 - Percentage of staff witnessing potentially harmful errors, near misses or incidents in last month	29%	27%
KEY FINDING 7 - Percentage of staff able to contribute towards improvements at work	72%	73%
KEY FINDING 6 - Percentage of staff reporting good communication between senior management and staff	30%	35%
KEY FINDING 22 - Percentage of staff experiencing physical violence from patients, relatives or the public in last 12 months	26%	21%
KEY FINDING 23 - Percentage of staff experiencing physical violence from staff in last 12 months	3%	3%
KEY FINDING 12 - Quality of appraisals	3.07	3.15
KEY FINDING 30 - Fairness and effectiveness of procedures for reporting errors, near misses and incidents	3.62	3.71
KEY FINDING 4 - Staff motivation at work	3.82	3.91

KEY FINDING 8 - Staff satisfaction with level of responsibility and involvement	3.83	3.87
KEY FINDING 9 - Effective team working	3.73	3.85
KEY FINDING 5 - Recognition and value of staff by managers and the organisation	3.46	3.56
KEY FINDING 32 - Effective use of patient / service user feedback	3.57	3.70

The staff friends and family test asks staff members whether they would recommend the trust as a place to receive care and also as a place to work.

The percentage of staff that would recommend this trust as a place to work in Q4 16/17 stayed about the same when compared to the same time last year. The percentage of staff that would recommend this trust as a place to receive care in Q4 16/17 stayed about the same when compared to the same time last year.

There is no reliable data to enable comparison with other individual trusts or all trusts in England.



Please note: Data is not collected during Q3 each year because the Staff Survey is conducted during this time

Despite some of the outcomes of the staff survey in 2016 (where the trust scored worse than other trusts for staff feeling motivated at work, recognition and value of staff by managers, and effective team working) during the inspection almost all staff across the learning disability and mental health services told us they felt respected, supported and valued, particularly by their local managers. Staff generally described feeling positive and proud about working for the trust and their team. There were good examples of cohesive teams with positive relationships between the multi-disciplinary professionals, who worked well together and addressed any conflict appropriately. Where there was conflict in teams, managers worked with the team using the ‘Aston Team Journey;’ an evidence based tool to assess and develop team effectiveness and performance.

The trust recognised staff success through its monthly staff recognition scheme, the ‘star award’ as well as through its annual award ceremony. The monthly and annual awards recognised both individual and team contributions to delivering the best possible service to service users and carers, as well as staff. Staff in most of the core services felt they received positive feedback from managers for their work.

The trust worked appropriately with trade unions. They discussed how they ensured staff were aware of their rights and responsibilities, and described how they supported staff to work with the trust to resolves issues before they escalated, and through grievance and disciplinary processes. They also gave examples of how they had been involved in changes across the trust, through meetings and other forums. They described a good relationship with the human resource department, the Freedom to Speak Up Guardian, as well as the executive team.

Managers addressed poor staff performance where needed. Managers and supervisors across the trust gave examples of where they had addressed poor performance with staff at different levels and in different roles. The disciplinary policy and procedure was available to all staff, and provided a clear flowchart of the procedure for staff to follow to address misconduct. Of the five disciplinary records we reviewed, one case remained open due to a police investigation. Two of the four remaining cases exceeded the procedures timeframe of a six week process from the incident occurring to a case conference to conclude matters. However all of the investigations reviewed were thorough and the outcomes were in line with the recommendations. Union representatives confirmed that where procedure timescales were exceeded, the reason was justified in order to ensure a robust and fair investigation that involved all necessary parties.

Staff were able to raise concerns through the grievance procedure, where issues could not be raised with their line manager or mediation. The trust had a clear policy for staff to refer to. They published the numbers of grievances by diverse groups annually and there had been no themes or trends identified. Grievance records we reviewed, including two allegations of racial discrimination, were comprehensive and outcome letters were sent where there was a delay in the process, confirming the reason, and the proposed new dates for completion. However in one of the five outcome letters, the outcome was not formally documented although the mediation was arranged quickly post the outcome.

Following Sir Robert Francis' Freedom to Speak Up review, published in February 2015, all NHS trust were required by the terms of their NHS contract to appoint a Freedom to Speak Up Guardian within the financial year 2016/17. In line with this requirement, the trust appointed a Freedom to Speak Up Guardian in mid-October 2017 and launched the role through its communication strategy in 2017. Following the retirement of the previous Guardian, the trust recruited to the post and the new Freedom to Speak Up Guardian started their employment at the beginning of October 2017, and continued to raise the profile of the role through a variety of methods, from attending trust-wide and local meetings and presenting on the trust induction, to posters, leaflets and blogs. They were also working closely with the Head of Diversity and Inclusion to ensure an inclusive approach to staff for raising concerns.

The Freedom to Speak Up Guardian confirmed that the trust provided them with sufficient resources and support to help staff to raise concerns. This two-day per week role was agile as opposed office-based, allowing the Guardian to be responsive and flexible in their approach. The Freedom to Speak Up Guardian had access to the Chair, Chief Executive and the Senior Independent Director, and reported bi-annually to the Board, with exceptional matters being escalated more quickly as required.

The handling of concerns raised by staff always met with best practice. The Freedom to Speak Up Guardian benchmarked the role against the key findings and recommendations from the Freedom to Speak Up Survey 2017, published by the National Guardians Office, as well as ongoing benchmarking against the 20 principles within the Francis review. Examples provided by the Freedom to Speak Up Guardian demonstrated how they had supported staff, and that themes and trends were collated identified, with appropriate action taken.

The trust had a ‘Freedom to Speak Up: raising concerns’ (whistleblowing) procedure which outlined the process for staff and key contacts, and complied with the NHS England minimum standards for whistle blowing / raising concerns to meet the expectations of the National Guardian. All staff knew how to use the whistle-blowing process and most staff knew about the role of the Freedom to Speak Up Guardian, except some staff in the inpatient learning disabilities service.

Almost all staff felt able to raise concerns without fear of retribution, though a small number of staff in the learning disability services and forensic services had some reservations about raising a concern. The trust reported no incidences of whistleblowing in the 12 months between 29 September 2016 and 1 October 2017. The Freedom to Speak Up Guardian confirmed that numbers of contacts from staff was increasing and the trust was performing well in terms of

numbers of concerns raised. Over the 12 month period between 1 November 2016 and 31 October 2017, the trust has had an average of 1.83 concerns raised per month in comparison to the national average (as advised by the National Guardian's Office in relation to 'small' trusts i.e. those with staff less than 5000) of 1.9 concerns raised per month. The trust took appropriate learning and action as a result of concerns raised through any forum including the staff survey, the Freedom to Speak Up Guardian, and incidences of whistleblowing.

There was good oversight from the trust in relation to mandatory training, clinical supervision and appraisal, and staff development was a priority for the trust. Staff told us that they felt supported to develop their skills, knowledge and experience. Preceptorship and apprenticeship schemes were in place at the trust.

All staff had the opportunity to discuss their learning and career development needs at appraisal, The trust's target rate for appraisal compliance is 85%. As at 8 November 2017, the overall appraisal rates for non-medical staff was 79%. Ten of the 15 core services did not achieve the trust's target appraisal rate and three of these did not achieve 75%. These three were 'Community mental health services for people with learning disabilities or autism´ (73%), ' Community-based mental health services for adults of working age.' (70%) and 'Community-based mental health services for older people' (67%).

The rate of appraisal compliance for non-medical staff reported during this inspection is slightly higher than the 77% reported at the last inspection.

Core Service	Total number of permanent non-medical staff requiring an appraisal	Total number of permanent non-medical staff who have had an appraisal	% Non-medical staff who have had an appraisal
MH - Child and adolescent mental health wards.	30	28	93%
MH - Mental health crisis services and health-based places of safety.	58	53	91%
MH - Acute wards for adults of working age and psychiatric intensive care units.	169	151	89%
MH - Specialist community mental health services for children and young people	40	35	88%
Other Specialist Services (NICPM)	22	19	86%
MH - Long stay/rehabilitation mental health wards for working age adults.	62	52	84%
Other Specialist Services (Eating Disorder)	43	36	84%
MH - Forensic inpatient/secure wards.	129	105	81%
Adult Social Care	190	152	80%
MH - Wards for older people with mental health problems.	114	91	80%
MH - Wards for people with learning disabilities or autism.	39	31	79%
Other services	681	528	78%
MH - Community mental health services for people with learning disabilities or autism	78	57	73%
MH - Community-based mental health services for	334	233	70%

adults of working age.			
MH - Community-based mental health services for older people.	42	28	67%
Total	2028	1596	79%

The trust had recently implemented a new electronic system to record appraisal information. The appraisal rates for non-medical staff were on an improving trajectory to meet the trust's compliance rate, with no concerns identified in the six mental health core services we inspected during this well led review, or the supported living service.

The trust's target rate for appraisal compliance is 85%. As at 8 November 2017, the overall appraisal rates for medical staff was 100%.

The quality and performance report presented at board in January 2018 confirmed that appraisal rates were at 79.9%, confirming that performance rates continued to increase as work was ongoing to support staff through training and one-to-one to utilise the new trust systems.

The trust had a robust approach to medical appraisal and revalidation. The associate medical director for medical appraisals and continuing professional development delivered an efficient programme and ensured that all medical staff had completed their first five-year revalidation, connecting it with quality, job planning, and appraisal.

All staff had access to mandatory training and as at 30 September 2017, the overall training compliance for trust-wide services was 90% against the trust target of 85%. Of the 26 mandatory training courses listed, 10 failed to achieve the trust target. All of the training courses scored above 75%. The mandatory training compliance reported for the trust during this inspection was higher than the 81% reported at the last inspection and compliance had much improved across all the core services we inspected.

Since the last inspection the trust had transitioned from a paper based system for recording clinical supervision to an electronic system. The system was introduced in April 2017. Staff now recorded supervision themselves on their individual learning account. This system was not yet fully embedded at the time of the inspection across the trust.

The trust's target rate for clinical supervision is 85%. The pre-inspection information showed that as at 30 September 2017, overall clinical supervision compliance was 58%, with none of the core services achieving the trust's clinical supervision target.

Caveat: there is no standard measure for clinical supervision and trusts collect the data in different ways, it's important to understand the data they provide.

Core Service	Number of clinical supervision sessions required	Number of clinical supervision sessions undertaken	Clinical supervision rate (%)
MH - Community-based mental health services for older people.	1721	1449	84%
Other Specialist Services	282	237	84%
MH - Community-based mental health services for adults of working age.	3227	2512	78%
MH - Mental health crisis services and health-based places of safety.	144	103	72%

Other	1532	850	55%
MH - Community mental health services for people with learning disabilities or autism	478	255	53%
MH - Specialist community mental health services for children and young people	357	171	48%
MH - Acute wards for adults of working age and psychiatric intensive care units.	847	396	47%
MH - Long stay/rehabilitation mental health wards for working age adults.	395	156	39%
MH - Forensic inpatient/secure wards.	692	258	37%
MH - Child and adolescent mental health wards.	164	57	35%
MH - Wards for older people with mental health problems.	631	205	32%
MH - Wards for people with learning disabilities or autism.	169	25	15%
Adult Social Care	959	0	0%
NA	0	0	N/A
TOTAL	**11598**	**6674**	**58%**

The trust compliance rates for clinical supervision had risen to 67.4% at the time of the inspection in January 2018. The change in system for recording supervision had impacted upon the recorded data as at the time of our inspection, all but two core services inspected had figures in excess of the compliance rates provided by the trust in the pre-inspection information. Most staff reported receiving clinical supervision.

Senior leaders and managers were fully aware of the concerns we identified in relation to the completion and recording of supervision and were taking action to address this, including changing the templates to make this easier for staff to record, supporting staff locally, and introducing a care group audit of compliance against the trust clinical supervision policy. Managers were encouraging staff to ensure they recorded supervision in the correct system when it took place. Data provided by the trust in the combined quality performance report presented to the board in January 2018 confirmed that whilst clinical supervision was still below the trust target, it was on an upward trajectory.

As of the 30 September 2017, staff sickness was at 4.5%, and above the trust target of 3.70%. There were some services where sickness was high which managers and leaders were aware of. Staff support, health and wellbeing was one of the trust's strategic priorities. Staff had access to independent support for their physical and emotional health needs through occupational health. The trust had a specific fast-track referral pathway for responding to staff experiencing work-related stress, and offered physical health checks, physiotherapy to support with musculoskeletal conditions, and access to an external employee assistance programme which included counselling and short-term programmes to improve physical and mental wellbeing.

Leeds and York Partnership Foundation NHS Trust was nationally recognised as being within the top 100 NHS employers, placed at number 35 for equality and diversity. The executive director for workforce and development was the executive lead for equality and diversity. The trust had an equality, diversity and human rights procedure which sets out the trust's commitments and guidance for staff. Priorities for the trust in relation to equality and diversity included responding to the workforce race equality standards. This was overseen by the equality and inclusion committee and the workforce and organisational development group. The trust had developed a number of initiatives in response to the workforce race equality standards, using the 'your voice counts' as a

platform to gather feedback to inform this work, and were in the process of refreshing its diversity and inclusion strategy and quality improvement plan around diversity. Initiatives included quarterly equality and inclusion training days which were well attended, e-learning, and training on unconscious bias. The trust undertook a project to provide eight graduates from Black and Asian Minority Ethnic backgrounds with training in project management. Of the eight, six have found employment within the NHS. The trust was aware there was a disproportionate number of bank staff from Black and Asian Ethnic minority group; as a result they were doing work around supporting those staff into permanent roles. Staff told us although there were isolated incidents within the trust, they felt the trust supported them and put mechanisms in place to ensure they were being listened to. Staff felt as though there had been an improvement around equality, diversity and inclusion within the last few years but there were areas in which the trust could still develop.

Staff networks were in place promoting the diversity of staff. This included the well-established Rainbow Alliance, staff, service user and carer network, and its partnership group that oversaw the implementation of a development plan of attendance at community events and establishing community links. The Black and Asian minority ethnic network was still in its infancy and developing their membership.

Compliance with the duty of candour training was 98% and staff had access to the duty of candour policy. The policy outlined the trust's responsibilities in being open and transparent with the individual involved in providing a true and accurate knowledge of the facts and offering a "meaningful apology" where required. The trust policy required staff to follow the duty of candour for all incidents graded at severity level three and above; staff could use discretion to use the duty of candour on lower level incidents. We reviewed five incidents where duty of candour was appropriate; all complied with the regulation and contained sincere written apologies to the appropriate person. Some of the letters offered additional support to the families and the trust ensured information was appropriately communicated for patients and carers whose first language was not English, for example, one letter of apology had been translated into Urdu.

Governance

The trust had effective structures, systems and processes in place to support the delivery of its strategy including sub-board committees, committees and team meetings. These were reviewed annually to ensure they remained fit for purpose. However following an independent external review of governance against NHS Improvement's well-led framework in 2017 and board development sessions focussing on the governance and the purpose of the sub-board committees, the trust had changed the remit, terms of reference, meeting timescales and attendance at some of these sub committees. For example the finance and business committee now reviewed performance and was renamed the finance and performance committee, with its duties in relation to analytical strategic investment being transferred to the strategic development committee. Some of this work was still in the early stages of change with terms of reference for the trust's finance and performance committee and the quality committee at the board in January 2018 to agree the routes of assurance through the sub-board committees to the board.

The trust board of executive directors and non-executive directors met on a monthly basis in both public and private sessions. Papers of these meetings were of a good standard and contained appropriate information. The review of the trust sub-board committees had also clarified the assurance purposes of these committees to ensure that they were receiving the appropriate information for this assurance. Some sub-board committees were further on in this process than others.

The non-executive and executive directors were clear about their areas of responsibility. Regular executive director attendance at specific committees was in line with their allocated portfolios. They were clear about their individual responsibilities and were moving towards having a shared

responsibility for delivering the strategy and outcomes in a collective leadership approach. The non-executive directors chaired the committees in line with their areas of expertise and knowledge.

A clear framework set out the structure of ward, team, care group, and senior leadership trust meetings to ensure connectivity between the board and team level. Clinical governance forums and management meetings were replicated throughout the structures with identified lines of reporting. Therefore staff at all levels of the organisation understood their roles and responsibilities and what to escalate to a more senior person. Leaders and managers used meetings to share essential information such as learning from incidents, complaints and audits.

Appropriate governance arrangements were in place in relation to Mental Health Act administration and compliance. The trust had an executive and non-executive Mental Health Act lead to ensure the Mental Health Act was given appropriate oversight at board level. A Mental Health Act legislation committee reported directly to the board on Mental Health Act work streams, issues and risks. The trust reported on the use of the Mental Health Act quarterly and used this data to identify Mental Health Act issues and risks, which it actioned in partnership with other organisations where appropriate. The trust was aware of issues raised and were taking appropriate action, for example in relation to the availability of section 12 approved doctors and the low number of stays in the section 136 suites exceeding 24 hours. There was a robust process for developing and ratifying Mental Health Act-related policies and all Mental Health Act-related polices were up-to-date and in line with the Code of Practice 2015.

The Mental Health Act administration team was sufficiently resourced and members of the team felt supported in their roles. There were robust Mental Health Act systems and processes to ensure compliance with legislation and the Code of Practice. Checks and internal and external audits were in place to ensure staff followed processes. The trust audited 10% of each team member's caseload every month to maintain assurance and identify any concerns and there was a scrutiny checklist available to support ward staff. Training on the Mental Health Act was available to all clinical staff and compliance was 85% at the time of inspection. When there was a change to Mental Health Act legislation or updates to case law, staff were informed by the use of the staff intranet and a legislation bulletin.

There was a restrictive interventions reduction programme in place and the trust were committed to this approach. Staff completed a bi-monthly report with data from ward areas. Concerns from the data had led to a detailed look into the use of restraint. This information was fed back through trust-wide quality governance. There was bespoke work in forensic services, which included service users. The trust felt its programme of reducing restrictive practices was operating throughout the organisation but identified that there had been some local issues which they were acting to address. We saw blanket restrictions in the learning disability service.

Effective governance systems were in place for infection prevention demonstrated by improvements in training compliance, increased staff awareness and staff immunisations, low levels of infections on the wards and the trust's swift response in responding to, and containing, a recent out-break of flu on one ward in the older people's mental health service. The trust had appointed a new physical health lead in October 2017 with oversight from the director of nursing, professions and quality. Governance structures were in place to address to meet people's physical health care needs. This role was still in its infancy but the lead had identified priority areas to improve physical health outcomes for service users. During the inspection we saw good practice in relation to physical health monitoring on most wards.

The trust was working with third party providers to deliver some specialist services, and also to promote and deliver good patient care that met the patients' needs. Third parties included the acute trusts, the Local Authority, primary care, and third sector and voluntary organisations. We saw a number of examples across the trust. A partnership arrangement was in place for the provision of liaison psychiatry services with appropriate governance arrangements. At the time of

the inspection the trust was working with the acute trust to resolve issues around accommodation for the liaison team.

Management of risk, issues and performance

Providers must report all serious incidents to the Strategic Executive Information System (STEIS) within two working days of identifying an incident.

Between 1 October 2016 and 30 September 2017 the trust reported 37 STEIS incidents. The most common type was 'Apparent/actual/suspected self-inflicted harm' with 23 incidents. Sixteen of these occurred in the 'Community-based mental health services for adults of working age' core service.

Never events are serious incidents that are entirely preventable as guidance, or safety recommendations providing strong systematic protective barriers, are available at a national level, and should have been implemented by all healthcare providers. This trust reported zero never events during this reporting period.

We asked the trust to provide us with the number of serious incidents from the same period on their incident reporting system. The number of the most severe incidents was broadly comparable with the number the trust reported to STEIS.

Type of incident reported on STEIS	Acute ./ PICU	Community Adults	Forensic	Crisis and HBPoS	Other Specialist	Wards for Older People	Other	Total
Apparent/actual/suspected self-inflicted harm	3	16	0	2	2	0	0	23
Confidential information leak/information governance breach	0	2	1	0	2	0	2	7
Slips/trips/falls	0	0	0	0	0	2	0	2
Unauthorised absence	0	0	2	0	0	0	0	2
Disruptive/ aggressive/ violent behaviour	0	0	1	0	0	0	0	1
Pending review	0	0	0	0	0	1	0	1
Accident	0	0	0	0	0	1	0	1
Total	3	18	4	2	4	4	2	37

Providers are encouraged to report patient safety incidents to the National Reporting and Learning System (NRLS) at least once a month. They do not report staff incidents, health and safety incidents or security incidents to NRLS.

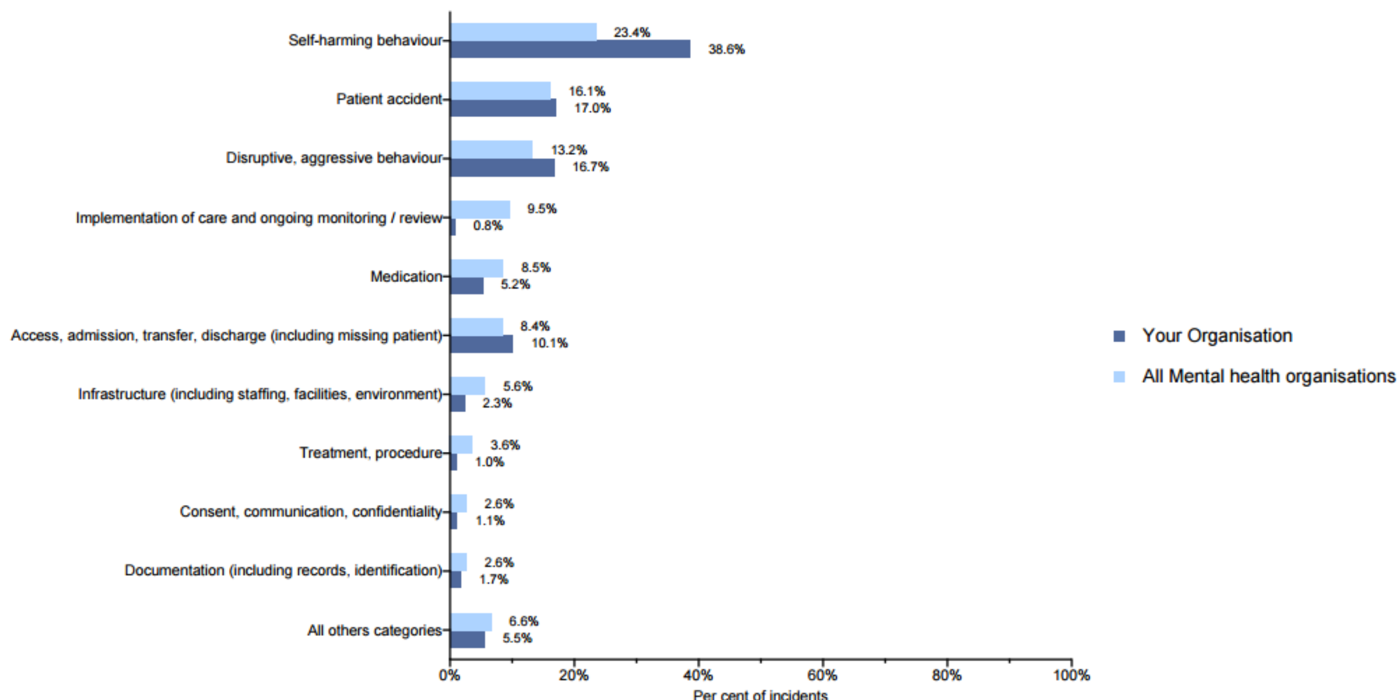
The highest reporting categories of incidents reported to the NRLS for this trust for the period 1 October 2016 to 30 September 2017 were 'Self-harming behaviour', 'Patient accident' and 'Disruptive, aggressive behaviour'. These three categories accounted for 70% of the incidents reported. 'Self-harming behaviour' accounted for 14 of the 19 deaths reported.

Ninety-seven percent of the total incidents reported were categorised as no harm (66%) or low harm (31%).

Incident type	No harm	Low harm	Moderate	Severe	Death	Total
Self-harming behaviour	1024	784	75	1	14	1898
Patient accident	703	301	17	1	1	1023
Disruptive, aggressive behaviour (includes patient-to-patient)	665	279	14	0	0	958
Access, admission, transfer, discharge (including missing patient)	401	131	13	0	0	545
Medication	328	20	3	0	0	351
Other	87	105	9	1	4	206
Infrastructure (including staffing, facilities, environment)	131	20	0	0	0	151
Documentation (including electronic & paper records, identification and drug charts)	93	4	1	0	0	98
Consent, communication, confidentiality	57	9	9	0	0	75
Patient abuse (by staff / third party)	36	22	12	0	0	70
Treatment, procedure	40	15	2	0	0	57
Implementation of care and ongoing monitoring / review	27	18	2	0	0	47
Medical device / equipment	8	1	0	0	0	9
Clinical assessment (including diagnosis, scans, tests, assessments)	9	0	0	0	0	9
Infection Control Incident	7	2	0	0	0	9
Total	3616	1711	157	3	19	5506

According to the latest six-monthly National Patient Safety Agency Organisational Report (October 2016 to March 2017), the trust was in the middle 50% of reporters nationally for similar trusts.

Self-harming behaviour, Patient accident, Disruptive, aggressive behaviour and Access, admission, transfer and discharge accounted for a higher proportion of the total number of incidents reported compared to similar trusts.



Organisations that report more incidents usually have a better and more effective safety culture than trusts that report fewer incidents. A trust performing well would report a greater number of incidents over time but fewer of them would be higher severity incidents (those involving moderate or severe harm or death).

This trust reported more incidents from 1 October 2016 to 30 September 2017 compared with the previous 12 months. The trust reported more incidents in the most recent 12 months but there were more low and no harm incidents and less severe harm and death incidents.

Level of harm	October 2015 – September 2016	October 2016 – September 2017
No harm	3158	3616
Low	1239	1711
Moderate	102	157
Severe	4	3
Death	23	19
Total incidents	4526	5506

Leeds and York Partnership NHS Foundation Trust has submitted details of the following external reviews commenced or published in the last 12 months.

- July 2016 - Serious incident report (2016.19236) crisis assessment unit was informed by police that a service user was in police custody following the attempted murder of her two neighbours. The trial took place in early 2017 and sentencing took place in February 2017 for Section 18, Wounding. External investigator commissioned to complete a comprehensive investigation into this incident.

- November 2016 – Serious incident report (2016.28818). Patient was to be discharged from in-patient care, on 4/11/16. She left the ward on the 3/11/16 after discharge was agreed to her father's house. She was reported as a missing person by her father and was found deceased by the police in woodlands on the morning of the 5/11/16. External investigator commissioned to complete a comprehensive investigation into this incident.

The trust was asked to comment on their targets for responding to complaints and current performance against these targets for the last 12 months.

	In Days	Current Performance
What is your internal target for responding to* complaints?	3	92%
What is your target for completing a complaint?	30	70%
If you have a slightly longer target for complex complaints please indicate what that is here	N/A	N/A

* Responding to defined as initial contact made, not necessarily resolving issue but more than a confirmation of receipt

**Completing defined as closing the complaint, having been resolved or decided no further action can be taken

	Total	Date range
Number of complaints resolved without formal process* in the last 12 months**	*"We do not currently record this information. We are reviewing our data collection process and will be amending the DATIX system to enable us to capture this data"*	
Number of complaints referred to the ombudsmen (PHSO) in the last 12 months	13	01/04/2016 – 30/03/2017

**Without formal process defined as a complaint that has been resolved without a formal complaint being made. For example PALS resolved or via mediation/meetings/other actions

We reviewed nine complaints referred to the Parliamentary and Health Service Ombudsman between 06 October 2015 and 08 November 2016. Of the nine referrals, five were closed with no further action, three concluded with partial fault claims which the trust actioned appropriately, and one remains open.

This trust received 310 compliments during the last 12 months from 1 October 2016 to 30 September 2017. This was higher than the 169 reported at the last inspection.

The trust had policies in place for both complaints and incidents, detailing staff responsibilities, procedures, timescales for responding and for investigations, and escalation processes. We reviewed a random sample of serious incidents and complaints; we found the trust had a systematic approach to reviewing both the incidents and the complaints that complied with their own policies and procedures for the most-part, with thorough investigations and identified recommendations and actions where necessary. The reviews and investigations were robust with a high level of involvement with service users, families and carers where appropriate, including in setting the terms of reference for investigations, but incidents and complaints were not always completed within the timescales set in the policy. However, we saw lots of evidence of ongoing contact with those involved, including agreeing revised timescales. Following a review, the trust had recently recruited additional staff into the team that reviewed complaints, incidents and deaths.

The trust had systems in place to identify learning from incidents and complaints to make improvements. Senior leaders met at a monthly care group meeting where complaints, litigation, Incidents and Patient Advice and Liaison Service reports presented key highlights of the month in relation to complaints and incidents. The report outlined the data so staff could see where the incidents were happening at a local level and how each team presented against each other. It also showed a trend analysis over the last 12 months. Staff received information about learning from complaints on different platforms, including the intranet, via email, newsletters, supervisions and team meetings. We saw examples of how staff had learnt from complaints and incidents and implemented new practice.

The trust had a safeguarding adults and children's policy in place which outlined staff responsibilities in protecting vulnerable adults and children. These were underpinned by best practice, national guidance and local frameworks. All staff had good knowledge of safeguarding and this was demonstrated through the records we reviewed. Staff discussed safeguarding cases during their weekly team meetings and multi-disciplinary team meetings. Specific cases of concern could be escalated into the 'front door safeguarding hub' meeting. This multi-agency meeting included the police, local authority and enabled the trust to discuss high level cases in which agencies could work together to provide appropriate support. Managers attended the safeguarding boards and multi-agency protection meetings.

The trust had a system in place to log safeguarding incidents and identify themes, trends and learning, which was an area of improvement since our last inspection. An audit programme was also in place. These were discussed at the safeguarding committee, which was attended by staff within the relevant care groups, clinical commissioning group, a non-executive director and the director of nursing, professions and quality. Learning was disseminated through the care groups to the teams. Assurance was provided to the board from the safeguarding committee through the trust-wide clinical governance forum, and the quality committee.

The leadership team were satisfied that their internal audits provided sufficient assurance. The Audit Committee had oversight of the strategic audit plan, 2017 to 2020, as well as the annual audit plan for 2017 to 2018. These internal audit plans focussed on the trust's strategic priorities across the three years and were mapped to the board assurance framework and the strategic risks on the corporate risk register. We reviewed three internal audits by independent auditors and the levels of assurance provided; where recommendations were made, these were prioritised by the trust, and actions were taken by specific responsible officers in identified timescales.

Similarly there were robust systems in relation to clinical audit. The agreement of annual clinical audit priorities, and ongoing monitoring, was the responsibility of the quality committee.
The clinical audit and effectiveness team provided ongoing support around completing clinical audit, delivered training and information sessions, monitored completion and outcomes, and maintained a database to ensure that clinical audit project findings associated action plans were shared throughout the trust. The team also sat within the care group structures so offered support and cascaded learning through these structures. The trust provided details of recently completed and ongoing audits; for the completed audits we saw evidence of learning implemented.

Local audits completed at service level were successful in identifying issues and care groups directors were held to account by senior leaders for the performance of the services. Therefore local audit were a priority in services to identify areas of concern and provide assurance in relation to quality and safety. Managers responded to these local audits, with outcomes and actions were monitored through the team and care group governance structures.

Staff had access to the risk register at service and care group level, and directorate level. They were able to effectively escalate concerns as needed onto the risk register. Robust arrangements were in place for identifying, recording and managing risks, issues and mitigating actions and were being further embedded following work completed with an independent external organisation to review the trusts approach to risk, audit and the board assurance framework. The risk registers and actions were reviewed and escalated through the clinical governance structures. The executive risk meeting was set up in 2017; the executive team and senior leaders from the care groups attended and the agenda included deep dives on individual risk registers to ensure they reflected current risk, and to review the corporate risk register. The different risk registers matched the concerns of staff, and the executive team articulated their own directorate risks and corporate risks. The trust board had sight of the most significant risks and mitigating actions were clear.

- The trust has provided a document detailing their highest profile risks. Each of these had a current risk score of 15 or higher (categorised by the trust as 'Extreme Risk').

Key:

High (15-20)	Moderate (8-15)	Low 3-6	Very Low (0-2)

ID	Description	Risk level (initial)	Risk score (current)	Risk level (target)	Last review date
23	High numbers of service users on CMHT caseloads impacting on the quality or intensity of interventions provided. Recruitment challenges impacting on significant vacancies across the community services Reduced availability of time for clinicians to process discharges off caseloads and adequate administrative support. Lack of robust availability of longer term support/intervention options at a primary care level is impacting on ability to discharge service users with stable or lower level mental health needs(clusters 1-4).	12	20	9	07/11/2017
24	Following community service redesign in June 2012 and the move to ageless services, patients are frequently undergoing assessment and treatment by clinicians who do not necessarily have the appropriate specialist knowledge and skills for this role. This leads to delays and omissions in patient care. Older people's clinical care is fragmented across community and inpatient services.	12	16	1	22/02/2017
41	LTHT have stated their intent to vacate the site currently used by NICPM, and there is currently no identified alternative location for the service to be housed (YCPM).	15	15	1	06/11/2017
56	The Care Group currently has approximately 80+WTE vacancies, mainly in clinical nursing and medical positions.	20	16	9	08/11/2017
58	High number of vacancies in Care Services (Clinical staff)	20	20	12	20/03/2017
92	The current level of demand for the gender service is greater than planned level of activity, resulting in a lengthy waiting list for assessment and treatment (and increasing risk of the service not attaining the proposed Referral to Treatment (RTT)times.) Reviewed 31 5 16: Waiting list time exceeding 4 years Reviewed 14 3 17: Waiting list time approx. 18 months Reviewed 18 5 17: Waiting list time approx. 18 months Review 09 10 17: Waiting list approx. 16 Months	15	15	3	09/10/2017
97	The Mount is currently experiencing very low levels of Registered nurses and low levels of support staff; this is due to: Vacancies and general recruitment issues	16	16	9	12/06/2017

	All wards hold 2.0 plus WTE staff vacancies. RN vacancies are particularly felt on wards 2 3 and 4 Recent recruitment event failed to ensure service was fully staffed from and RN perspective all but one RN recruited will not be able to take up post until Oct 2017 at the earliest All 4 wards requested to leave 1.0 wte HSW vacant due to pending staff review (Calderdale)				
103	Recent events have identified problems with how the Trust responds to incidents and issues out of normal work hours. These affected the ability to contact key stakeholders, summon assistance and enable staff to contact on call directors promptly to seek advice.	15	15	5	02/11/2017
105	The danger of a cyber-attack to the Trust's ICT infrastructure through malicious hacking or system virus infection. Major Cyber Attack to the NHS on 12/05/17 with Ransom Ware. 40 NHS sites affected. LYPFT not affected as all patches up-to-date and firewalls upgraded under existing controls. Threat remains high.	12	16	4	18/05/2017
456	Referral demand to community mental health teams has increased over last year by 12%. This is providing a challenge to consistently meet the contractual 14 day access performance standard of 80% within current clinical capacity, resulting in a remedial action plan being submitted to the CCG. Recent performance at 79.1% has been primarily achieved through providing additional weekend assessment clinics using overtime to meet demand. The out of hours clinics whilst maintaining access within our contractual obligation, incorporate clinical risk in not ensuring access to a wider multidisciplinary team perspective and formulation for assessment of more complex need for all assessments. With ongoing CMHT staffing shortages and turnover in the context of national recruitment issues, combined with significant increases in referral rates to secondary care, the current position against access within 14 days is almost certain to deteriorate further.	15	15	3	07/11/2017
488	There have been problems with recruiting and retaining staff at the unit. Staff working within Clifton House may suffer from further stress/ pressure due to lack of staff available to assist. Activities/ therapies within the unit maybe limited	15	15	1	01/11/2017

	due to reduced staffing.				
543	Inability to achieve full recruitment to the Psychiatry Leeds & Wakefield Core Training Scheme. (ST1-3)	20	16	9	24/10/2017
544	Inability to fill rota shifts to maintain planned out of hours cover. This has been separated from the recruitment risk.	12	16	6	24/10/2017
597	Continued inability to meet the demand for inpatient admission across the age range with Leeds Care group.	20	20	6	05/11/2017
603	During periods of planned and unplanned leave there are no consistent or agreed arrangements to provide cover for Allied Health Professionals including Dietetics, Physiotherapy, Speech and Language Therapy and Occupational Therapy. Current arrangements to contact the AHP professional lead to organise cover where none has been identified is in adequate, as there is insufficient resource to cover core hours. This can lead to a delayed response to urgent issues such as dehydration, re-feeding syndrome, malnutrition and complications related to choking/aspiration, reduced mobility, poor posture and pressure care.	15	15	5	23/08/2017
614	5 inpatient units do not have back-up generators in the event of a power outage. These are: Asket House Asket Croft Woodlands Square 2 Woodlands square 3 Parkside Lodge	16	16	2	02/11/2017

As the trust had refreshed its strategy, the trust revisited its board assurance framework to provide assurance that risks to the delivery of these strategic objectives were being managed and mitigated. The board agreed on a new reporting framework and determined its risk appetite for each of the strategic objectives in line with the good governance institute matrix for risk. The board assurance framework was discussed on a monthly basis at the executive risk management meeting, bi-monthly at the audit committee and quarterly at the other board sub committees and the board. Executive and non-executive directors cited better in depth discussions in the trust about the board assurance framework and strategic risks following the review.

The board assurance framework brings together all of the relevant information on the risks to the board's strategic objectives in one central place.

The trust provided its board assurance framework. This detailed 10 strategic risks which can be found below:

- Due to an inability to align our workforce capacity to planned models of care, there is a risk that we are unable to deliver high quality, evidence based, and person centred care.

- We are unable to maintain compliance with regulatory requirements relating to the quality and safety of our services due to a failure to provide care in line with national standards and best practice.
- Due to inadequate systems to support continuous learning, improvement and innovation, there is a risk that our services deliver poor outcomes for service users.
- We are unable to maintain effective, productive relationships with key external stakeholders, with the result that we are unable to work successfully with partners to support innovative care and exceptional outcomes for service users.
- If we cannot produce and effectively use information about our services to support the operation of our governance structures, there is a risk that there will be a lack of confidence in our management information and that we will be unable to ensure the safety of our services.
- We are unable to deliver an effective and attractive programme of training and development opportunities for our staff due to inadequate capability and capacity, corporately and within care services.
- As a result of a culture of blame which does not foster a psychologically safe environment for our staff, we are unable to reduce patient harms or provide a positive experience for our service users.
- A lack of financial sustainability results in us having insufficient funds to sustain and develop our services and invest in high quality outcomes for our service users.
- Due to inadequate, inflexible or poorly maintained estates and facilities, we are unable to provide a safe and positive environment for service users and staff.
- As a result of insecure, inadequate or unstable information technology systems and infrastructure, the quality and continuity of our services is compromised.

There were plans in place for emergencies underpinned by the trust's emergency (incident response) plan 2017, which linked with the trust business continuity management framework and policy. The emergency plan met NHS England's Core Standards for Emergency Preparedness, Resilience and Response and the requirements of the NHS Standard Contract service condition 30 – Emergency Preparedness and Resilience including Major Incidents. It was produced in collaboration and consultation with other local stakeholders and provided guidance for staff for dealing with business continuity, critical and major incidents using recognised tools. It identified potential risks and threats, for example fire, flood and disease outbreaks, where the incident response plan activation must be considered, including potential responses, and individual plans for each were also in place. The trust completed planned events to evaluate these plans, with learning identified escalated to the emergency preparedness, resilience and response group. The group reported to the finance and business committee and to the board via the chief financial officer who was the accountable officer for emergencies. The chief executive, as the resilience lead and corporate business manager, had overall responsibility for updating the emergency (incident response) plan as required.

Information provided by the trust prior to the inspection on their historic, current and projected financial situation is shown in the table below:

	Historical data		Projections	
Financial Metrics	Previous financial year (2 years ago)	Last financial year (2016-2017)	This financial year	Next financial year (2018/2019)
Income	£166.736m	£153.332m	£150.540m	£147.848m
Surplus	£3.072m	£5.190m	£3.679m	£0m
Full costs	£163.664m	£148.142m	£146.861m	£147.848m
Budget	£2.500m	£3.051m	£3.679m	£0m

NHS Improvement confirmed that the trust robustly plans efficiencies and has a good track record of ensuring efficiency targets deliver recurrently in year to ensure financial plans for future years remain sustainable. Their assessment of the 2017/18 plans was that they were realistic and deliverable.

Information provided by NHS improvement confirmed that the trust achieved the financial plan and exceeded the control total in 2016/17. The use of resources financial metric of 1 was reported. The trusts financial position at £0.1m ahead of the planned £1.7m surplus, with the trust is forecasting the delivery of the £2.7m surplus control total in 2017/18 (excluding the sustainability and transformation fund) and NHS Improvement had good assurance this will be delivered. The trust achieved its cost improvement plans on a recurrent basis in 2016/17 and was forecasting to deliver them again in 2017/18. The trust had not accepted the 2018/19 control total surplus and so was in segment 2. However NHS Improvement confirmed the trust remained committed to delivering financial balance in 2018/19. The trust had provided an update to NHS Improvement demonstrating it was appropriately planning efficiencies for 2018/19 to allow the board to consider the 2018/19 control total.

The trust had a large proportion of its estate owned by private finance initiative companies, which was identified as the top risk by all the executive and non-executive directors and was identified as a strategic risk on the board assurance framework. The trust had commissioned an independent organisation to evaluate the future private finance initiative estate options in October 2017 in order to take steps to address this largescale challenge. The planned private finance initiatives refinance cost improvement plan was delayed in 2017/18 which was a challenge for the trust to ensure its efficiency targets were delivered. However, the trust identified alternative mitigating schemes to ensure overall control total delivery.

Where cost improvements were taking place there were arrangements in place to consider the impact on patient care. The trust had a robust quality impact assessment staged process underpinned by procedural documentation to ensure all major service developments and reductions, and cost improvement savings plans, were assessed, scrutinised, and monitored in terms of their potential impact on quality through ‘star chamber’ sessions chaired by the chief executive. The director of nursing, professions and quality and the medical director were responsible for the final sign off of each cost improvement plan and supported in this work collaboratively with their executive colleagues. We reviewed examples of cost improvement proposals that were accepted and rejected and noted that senior managers considered patient care and quality in these decisions, and monitored these changes for potential impact on quality and sustainability. Some staff were aware of their contribution to cost improvement objectives in some of the core services.

However, whilst the trust identified targets, milestones and parameters in relation to large scale transformation to consider the impact on patient care, safety and quality, the trust did not complete quality impact assessments beforehand in line with this process, nor did it utilise its continuous improvement or service evaluation methodology.

Information Management

Complementing the board members’ visits to the services, the board received holistic information on quality and sustainability, which provided an understanding of performance across all sectors, including the social care provision. Along with the updates from the directorates from the executive team, the patient, carer or service story, and the updates from the non-executive director chairs of the sub-committees, the board also received the monthly board report. This meant that the trust was aware of its performance, including finance, through the use of key performance indicators and other safety and quality metrics.

Whilst the board and senior staff expressed a good level of confidence in the quality of the data and welcomed challenge, the board had recently reviewed the effectiveness and purpose of the monthly performance report. The effective use of information about the services to support the operation of the trust governance structures was identified as a risk to delivering the trust's strategic objective on its board assurance framework. The new combined quality and performance report was presented to the board in January 2018 for discussion. This report is set out in respect of four key areas; service performance, quality performance, workforce and finance, with each area overseen by an executive director. The plan was for this report to be considered by the quality committee and the finance and performance committee as part of their routine monthly agenda for additional assurance, with highlights going to the board. The trust had appointed an experienced director of quality and performance to support further development of the reporting arrangements. The board had also requested kite marks to be used as a measure in which each key performance indicator could be assessed to provide assurance that the data quality meets dedicated standards. This request had been reviewed through the performance, information and data quality group and they had set the standards by which the metrics could be measured to provide an assurance to the board. Kite marks were due to be provided in the March combined quality and performance report.

Leaders used the management and clinical governance meeting agendas to address quality and sustainability across the trust and through the governance structures to ward and team level. Care group and team managers had access to a range of information to support them with their management role. Information was in an accessible format, timely, accurate and identified areas for improvement. This included a monthly report detailing complaints, litigation, incidents, compliments, investigations, patient opinion and patient advice and liaison service updates for the care groups. They also had access to clinical, risk, human resources and staffing information through the trust's performance framework. Whilst this dashboard was available to all staff with access rights, the chief information officer confirmed that staff had not always accessed this information. In response the trust had recently started to email relevant staff with a link to their dashboard. Care group senior managers and clinicians gave examples of where they had used this data to drive improvement, for example the data provided by the informatics team, which included activities, ward stays and skill mix, in the redesign of the older people's service.

The performance data quality group and head of data quality worked closely with the information team to identify issues with the data and/or reporting and then worked with teams to improve, for example, staff understanding of the seven-day follow-up. Senior managers we spoke with felt they were able to challenge the reliability of the data and a robust process was in place to do this through the performance information data quality group attended by senior clinicians and the performance information teams. Systems were in place to collect data from wards; these were not over burdensome for front line staff.

To meet the strategic objectives the trust was committed to making the best use of technology. This included rolling out mobile technologies that supported agile working. The clinical operations group was the interface between the information technology teams and the clinicians and this forum was used to engage front line teams in using the new technology, for example in the roll out of smart phones.

However, not all staff had access to the information technology equipment and systems to complete their role. Some agency and bank staff did not have access to the patient care records despite being regular staff. In some services this was mitigated by the use of paper records. The chief information officer confirmed that in order to maintain the security of the systems, everyone who used the system must have certain training and permissions, including information governance training. They also confirmed that a temporary log in for agency nurses provided them with access to the prescribing tool and information. Leaders confirmed that a training plan had been put in place for bank staff.

Whilst the Information contained in the electronic patient care record, including care plans and risk assessments, were of a good standard, accessing this information in a timely way was a challenge for staff. It was not always recorded and stored consistently and contemporaneously. Managers and staff at ward and team level said that this was because the system was inefficient and difficult to navigate. Many wards and teams adapted their systems to accommodate this, for example using paper records to record things. Senior leaders recognised this issue and were in the process of procuring a new electronic care record system. This was in line with their strategy (making the best use of technology) and the risk of not achieving this was recorded on the board assurance framework in relation to the quality and continuity of the trust's services.

Where leaders were aware of incidents, safeguarding and deaths, and data breaches they submitted notifications to external bodies where required in appropriate timescales. This included notifying local and specialist commissioners, the Local Authority, Safeguarding Boards, the Department of Health, the Information Commissioner's Office, as well as national reporting systems including National Reporting and Learning System (a central database for safety incidents) and the Strategic Executive Information System (a central recording system for serious incidents). The trust regularly contacted CQC following serious incidents and provided investigation reports when required. The quality and timeliness of information provided at this inspection had improved since the last inspection, and stakeholders confirmed that there had been improvements in the trust providing them with accurate and timely information.

The trust completed the information governance toolkit assessment in March 2017 in line with their internal audit plan. An independent team had audited this assessment and identified that there was significant assurance of the trust achieving a level two score against all requirements of the toolkit which is necessary for a foundation trust. The trust had all the appropriate controls in place but some of the policies were past their review date, which the trust took action to rectify.

Information governance systems were in place; this included governance to ensure the confidentiality of patient records. Incidents relating to information governance were reported through the trust's electronic incident recording system, and reported in to the trust-wide clinical governance meeting quarterly. Themes and hot spots were identified; however the breaches were generally in relation to human error. There was oversight from the medical director who was the Caldicott guardian and chaired the trust-wide clinical governance meeting. Whilst there were incidents that had occurred in 2017 that were reportable to the Information Commissioner's Office, the trust had not received any financial penalties. The trust gave examples of where they had taken action to learn from data security breaches, for example sending information by alternative routes to fax. The trust had also implemented learning and enhanced their cyber security in response to the recent national cyber-attack, even though it had not been affected.

Engagement

There were lots of good examples of the how the trust engaged with people who use the services, those close to them and their representatives, including those from a range of equality groups. Mechanisms included the trust's recovery and social inclusion team and its support of the monthly service user network, 'your voice counts' programmes and 'your views' meetings. The learning disability and specialist services had also developed individual approaches tailored to the needs of the specific service populations. In line with one of the trust's equality objectives, the Rainbow Alliance staff, service user and carer network, established in January 2017, had increased engagement with the lesbian, gay, bisexual and transgender community through a range of events and groups to improve access and experience within the trust's services. The trust had also completed a recent review and restructure of its patient experience team and was in the process of recruiting this team. At the time of the inspection the trust did not have a structured systematic approach to this engagement, including prioritising actions and engagement for people from different equality groups. However, the trust had a gap analysis workshop planned for February

2018 to build on existing good practice and to formalise the service user experience and involvement committee's role in collating the service user, carer and their representative's feedback and to structure the future approach to this engagement.

Patients and carers had opportunities to give feedback on the service they received in a manner that reflected their needs. This included through the patient friends and family test, the patient advice and liaison service, care opinion, NHS choices, the annual inpatient and community survey, and the service user network. They could raise a complaint or provide more informal feedback to staff and managers at service level, or feedback to the trust's leadership team and council of governors. The service user network summary evaluation annual review was in easy read format. The trust's 'easy on the i' information design service within the learning disability services specialised in producing easy to understand information for the people who use these services, including a leaflet and activity planner. However, in relation to patients' care and treatment, there was limited evidence that staff on the wards for people with a learning disability and autism at Parkside Lodge, and the respite service at 3 Woodlands Square, assessed patients' communication needs, and used adaptive communication strategies.

During December 2017 there were seven stories placed on care opinion. One of those stories was withdrawn, four of the stories presented positive feedback and two stories described negative experiences. One very positive response related to the perinatal services, with one negative one relating to the gender identity service.

The patient friends and family test asks patients whether they would recommend the services they have used based on their experiences of care and treatment.

The trust scored better than the England average for patients recommending it as a place to receive care for four of the six months in the period (April 2017 – September 2017).

The trust was worse than the England average in terms of the percentage of patients who would not recommend the trust as a place to receive care in two of the six months. In April 2017, 61% would not recommend the trust as a place to receive care. This score was 17% in September 2017. The score was 0% for the months between May and August 2017.

Please note, the response rate was very low (less than 1% of the total eligible) so it is unlikely to represent the overall patient view of the trust.

	Trust wide responses				England averages	
	Total eligible	Total responses	% that would recommend	% that would not recommend	England average recommend	England average not recommend
Sep 2017	7246	6	67%	17%	89%	4%
Aug 2017	7079	10	100%	0%	88%	5%
Jul 2017	7281	18	94%	0%	89%	4%
Jun 2017	7372	19	95%	0%	88%	4%
May 2017	7303	10	90%	0%	89%	4%
Apr 2017	6822	18	28%	61%	89%	4%

The trust recognised that the uptake on this type of feedback was low and so consideration was being given to a survey at the point of discharge as the ward manager's responsibility. This was raised as an agenda item at the Ward and Community Managers' forum in December 2017 and will be progressed by the patient experience team.

The ward, team and care groups had access to feedback from patients, carers and staff which was reported through the governance structures, with oversight from the quality committee. The patient experience report produced quarterly and presented annually to the board contained details of the patient and carer feedback from a range of sources, including actions and recommendations. We saw examples of where the trust had used this feedback to make improvements.

Patients and carers were kept updated through the service user network, partner groups and organisations, as well as the lead for involvement in each of the clinical teams who regular local meetings to keep them up to date. The trust had also launched its new website which was developed in collaboration with services users and carers to ensure information was accessible and communication was more effective including via a mobile phone or tablet.

The council of governors included appointed and elected governors. On appointment the governors received an induction and training was available, However, the newly recruited learning and organisation facilitator was developing a new governor training programme to commence in quarter one 2018/19. The governors told us that they felt more engaged and actively involved in the operation of the trust in the last year. They felt able to challenge the executives and the non-executive directors and felt enabled to do this through attendance by the directors at the public governors meetings, and the information they received, enabled them to do so. Governors were invited to the public board, sub-committees and on the back to the floor visits.

Division leaders, on behalf of front line staff, engaged with external stakeholders such as commissioners and Healthwatch; the trust had good relationships with its stakeholders including NHS Improvement, specialist and local commissioners, the Local Authority and the voluntary sector. Feedback from all stakeholders confirmed there was open dialogue with the senior leaders and managers in the trust from all service areas, including around performance requirements, and this had been an improvement since the last inspection. External stakeholders said they received open and transparent feedback on performance from the trust; the trust worked with them to resolve areas of concern or new approaches to service delivery.

The trust was actively engaged in collaborative work with external partners including NHS partners, primary care, Local Authorities and the voluntary sector. Tenders had been successfully won to deliver new services. The trust was working with partners as part of the ‘Leeds plan’ to deliver changes to improve effectiveness and outcomes across health and social care. It was also actively involved in the West Yorkshire and Harrogate Health and Care Partnership (sustainability and transformation plans) to manage the out of area placements, and worked within the Humber Coast and Vale sustainability and transformation partnership in relation to its York services.

Learning, continuous improvement and innovation

The trust participated in appropriate NHS Improvement collaborative programmes to improve services.

The trust actively participated in the following quality improvement programmes (QIP):

- QIP 16a: Rapid tranquilisation
- QIP 7e: Monitoring of patients prescribed lithium
- QIP 11c: Prescribing antipsychotics for people with dementia.

They also participated in national innovation projects, for example working with the Quality Network team to look at appropriate adaptations to the generic standards for deaf services; to develop quality network standards for inpatient children and adolescent mental health services as currently there are no quality standards for children and adolescent mental health services for deaf children. Two of the trust’s services, the Leeds liaison psychiatry service and the National Inpatient Centre for Psychological Medicine, have been featured in national guidance for commissioners as

a benchmark for what good services look like. The trust also reviewed their own practice against service provision in other organisations in order to improve, for example to reduce their out of area placements. The trust had an internal audit completed in relation to its implementation of National Institute for Health and Care Excellence guidance. The audit report provided limited assurance. The trust responded with appropriate actions so that robust procedures were in place to ensure it complied with any external regulatory requirements in relation to National Institute for Health and Care Excellence guidance implementation and best practice.

NHS trusts can take part in accreditation schemes that recognise services' compliance with standards of best practice. Accreditation usually lasts for a fixed time, after which the service must be reviewed. The table below shows services across the trust awarded an accreditation and the relevant dates.

Accreditation scheme	Core service	Comments and Date of accreditation / review
Quality Network for Inpatient CAMHS (QNIC)	Child and adolescent mental health wards	The Trust's CAMHS inpatient services have been inspected and are awaiting accreditation with QNIC.
Memory Services National Accreditation Programme (MSNAP)	MH - Community-based mental health services for older people.	The Trust's memory service is accredited with MSNAP. The service was accredited on the 26 April 2016 for 3 years.
Quality Network for Eating Disorders (QED)	MH - Other Specialist Services	The Trust's Eating Disorders service is accredited with QED. The service was accredited on the 14 October 2017. A review took place in April 2017 and accreditation maintained.
Quality Network for Perinatal Mental Health Services (QNPMH)	-	The Trust's perinatal service based at the Mount is accredited with QNPMH. The service was accredited on 23 June 2017
ECT Accreditation Scheme (ECTAS)	-	The Trusts ECT service based at the Becklin Centre is accredited with ECTAS. The service was accredited on 13 June 2017 for 1 year.
Psychiatric Liaison Accreditation Network (PLAN)	-	The Trust's liaison service is accredited with PLAN. The service was accredited on the 23 March 2016 for 3 years.

During 2016/17 five national clinical audits and three national confidential enquiries covered relevant health services that the trust provides. During that period the trust participated in all the national clinical audits and two-thirds of the national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in. Following the national clinical audits, the trust completed actions to improve.

The national clinical audits and national confidential enquiries that the trust participated in during 2016/17 were as follows:

- NICSH (National Confidential Inquiry into Suicide and Homicide)
- NCEPOD (The National Confidential Enquiry into Patient Outcome and Death)
- POMH-UK (National Prescribing observatory for Mental Health, UK) – Topic 11c Prescribing antipsychotic medication for people with dementia
- POMH-UK (National Prescribing observatory for Mental Health, UK) – Topic 7e Monitoring of patients prescribed Lithium
- POMH-UK (National Prescribing observatory for Mental Health, UK) – Topic 16a Rapid Tranquillisation

- POMH-UK (National Prescribing observatory for Mental Health, UK) – Topic 1g Prescribing high dose and combined antipsychotics
- National MH Commissioning for Quality and Innovation (CQUIN) Indicator 3a - Cardio-metabolic screening.

The trust had a planned approach to take part in national audits and accreditation schemes and shared learning. However, the process for subscribing to the peer review quality networks and accreditation was held within local services and managed through the local clinical governance frameworks. The trust acknowledged in its draft clinical services strategic plan that key accreditation and kite mark awards were to become a core part of its clinical work.

The trust board were committed to investing in research and development and the trust was actively participating in clinical research studies. In 2016 -17 the trust recruited a total of 1196 participants into research. Examples of local studies included 'making sense of community treatment order', 'perceptions of anorexia' and 'experience of living with young onset dementia.' The trust exceeded its recruitment target of 600 participants into nationally funded projects (National Institute of Health Research), recruiting 884 participants into 42 different projects, including 'Molecular Genetic Investigation', the 'RADAR' (reducing pathology in Alzheimer's disease through angiotensin targeting) trial, and the 'Offender Personality Disorder Pathway (National Evaluation)'. The research and development team reported to the board through the research committee, the trust-wide clinical governance meeting, and the quality committee, using a research activity summary report. The research and development team also published a quarterly research and development newsletter and hosted an annual research forum to showcase the outcomes of projects.

There were organisational systems to support improvement and innovation work. The trust had a continuous improvement team working within the medical directorate, which supported staff, teams and services to address blocks and barriers and to streamline processes to deliver greater consistency in specific processes or services. The continuous improvement team had training in the trust's continuous improvement cycles, framework and resources but this was not rolled out to the wider teams at the time of inspection. Staff were encouraged to make suggestions for improvement and were supported in working through the continuous improvement process by one of the continuous improvement team. Staff could provide examples of improvements that had been implemented, for example a locked rehabilitation process-mapping consultation and a review of agile working in the community mental health teams.

In addition, services staff, teams and services could request a service evaluation. The audit and research team supported the evaluation including identifying what data needs to be collected, ongoing reviews, and a final analysis of the data, and had an evaluation tool to support staff with the process. The trust had 31 active service evaluations at the time of the inspection, for example the evaluation of an application for patients with eating disorders and evaluating access to psychology and psychotherapy services in Leeds for people from a black Asian minority ethnic background compared to those who are not.

Learning from both the continuous improvement projects and the service evaluations were cascaded through relevant identified networks and newsletters.

However, at the time of the well-led review, the trust did not use systematic approach to quality improvement across the trust using a quality improvement methodology that all staff were trained in. A culture of continuous quality improvement was therefore not fully embedded across the trust.

External organisations had recognised the trust's improvement work. Individual staff and teams received awards for improvements made and since the last inspection in July 2016 had been shortlisted, highly commended or won 14 awards. These included the personality disorder service being highly commended for the National Positive Practice in Mental Health Award from the Positive Practice Mental Health Collaborative, a psychiatrist being shortlisted for the Psychiatric

Communicator of the Year award from the Royal College of Psychiatrists, and the Head of clinical audit and service evaluation won the Mary Seacole Leadership and Development Award from the Royal College of Nursing. The senior leaders we spoke with confirmed that staff and teams in the trust were being encouraged to enter for awards to showcase their good practice as this was seen as an important part of the culture for the trust.

Following the publication of the report by Mazars (an independent organisation asked by NHS England to investigate all deaths of all service users who received Mental Health or Learning Disability services at Southern Health NHS Foundation Trust), an alliance of mental health trusts from Yorkshire, Cumbria and the North-East was formed, known as the Northern Alliance. This was supported by Mazars. The trust actively participated in the Northern Alliance, developing a common approach to mortality across the region in line with best practice. The trust also participated in the Learning Disabilities Mortality Review programme, commissioned by NHS England, to ensure that deaths are reviewed and the learning is used to improve health and social care services for people with learning disabilities. The trust had robust and effective systems in place to identify and learn from death, supported by their 'Learning from Deaths policy: the right things to do.' Deaths were reviewed and investigated where required, in line with the trust's policy and best practice, with actions reviewed through the learning from incidents and mortality meeting which was chaired by the medical director. Learning was cascaded to staff through learning reviews, lessons learned bulletins, and clinical governance forums. Information was also presented at the board as required. The trust was in the process of developing a dashboard and action log in relation to the mortality process and this was under review by the mortality review group. The trust assessed their progress through a mortality maturity matrix. The records for the five deaths that we reviewed showed accurate recording of the details of the death, staff being offered support, liaison with other agencies where necessary, thorough investigations as required, and appropriate recommendations, actions and timescales. Good practice and learning was identified. Also there was excellent level of contact with the families or carers throughout, with offers of support and opportunities to be involved in investigations and feedback.

Mental health services

Forensic inpatient/secure wards

Facts and data about this service

Location site name	Ward name	Number of beds	Patient group (male, female, mixed)
Clifton House	Bluebell Ward	12	Female
Clifton House	Riverfields Ward	13	Male
Clifton House	Rose Ward	10	Female
Newsam Centre	Ward 2 (Women's Service)	11	Female
Newsam Centre	Ward 2 (Assessment/Treatment)	12	Male
Newsam Centre	Ward 3	14	Male

The methodology of CQC provider information requests has changed, so some data from different time periods is not always comparable. We only compare data where information has been recorded consistently.

Leeds and York Partnership NHS Foundation Trust provides inpatient services for men and women aged 18 years and over with mental health conditions, who require management under conditions of low security accommodation. The trust provided services at two locations: Clifton House in York and The Newsam Centre in Leeds.

Clifton House in York provides three low secure wards:

- Riverfields Ward was a 13 bed male low secure ward for continuing care and rehabilitation. At the time of the inspection, the ward had 13 patients detained under the Mental Health Act.
- Rose Ward was a 10 bed female low secure ward for women with a diagnosis of personality disorder to receive assessment, treatment, and rehabilitation. It was due to close in October 2017 as part of the sustainability transformation partnership plans with specialist commissioners. The closure of the ward was delayed because NHS England was unable to find alternative beds for two patients. At the time of the inspection, there were two patients detained under the Mental Health Act. Both patients had identified suitable placements at different locations and were awaiting discharge as soon as a bed became available.
- Bluebell Ward was a 12 bed female low secure ward for patients with functional mental disorders to receive assessment, treatment, and rehabilitation. At the time of the inspection, there were 11 patients detained under the Mental Health Act.

The Newsam Centre in Leeds provides three low secure wards:

- Ward 2 (assessment and treatment) was a 12 bed male low secure ward for assessment and short-term treatment. At the time of the inspection, the ward had 11 patients detained under the Mental Health Act.
- Ward 2 (women) was an 11-bed female low secure mental health ward. At the time of the inspection, the ward was full with all patients detained under the Mental Health Act.
- Ward 3 was a 14 bed male low secure treatment and recovery unit. At the time of the inspection, the ward was full with all patients detained under the Mental Health Act.

The Care Quality Commission inspected the forensic and secure inpatient services in July 2016. Forensic and secure wards were rated requires improvement with breaches of the following regulations:

- Regulation 13 (4) (b) of the Health and Social Care Act (Regulated Activities) Regulations 2014. Safeguarding service users from abuse and improper treatment.
- Regulation 18 (2) (a) of the Health and Social Care Act (Regulated Activities) Regulations 2014: Staffing.

Is the service safe?

Safe and clean care environments

Safety of the ward layout

The ward complied with NHS guidance on eliminating mixed-sex accommodation. All wards were gender specific. Over the 12 month period from 1 October 2016 to 30 September 2017 there were no mixed sex accommodation breaches within this core service

The trust carried out an annual environmental audit of ligature risks for this core service. Each ward had an in-date audit. The ligature risk audits identified potential places where patients intent on self-harm might tie something to strangle themselves. Each audit contained actions and a management plan to minimise the ligature risk. During the inspection, the ward manager for Ward 2 (women) had taken delivery of a profile bed. These beds are electric care beds that can be adjusted to reposition and support the user. The bed presents a potential barricade risk. Consequently, they had updated their wards environmental risk audit to reflect this.

The trust was undertaking comprehensive work on their estate to address the risk of potential ligature points. For example, the trust had ordered new anti-ligature furniture for wards at The Newsam Centre.

Most of the ward layouts allowed staff to observe all parts of the ward. Staff mitigated any blind spots where they could not observe patients by regular staff presence on the communal areas of the ward. Staff were aware of the ligature risks and reviewed patients' risk assessments, risk management plans and observation levels regularly to manage ligature risks.

We found maintenance arrangements and records were in order. Contingency plans, building control certificates and liability insurance were in place.

All staff carried personal alarms, which they could activate if they required assistance. This meant that they could activate the alarm wherever they were on the ward. Staff followed trust procedures in the safe management of keys and security on the wards. All substantive staff, bank staff, and agency staff had to undergo a role specific induction before they worked on the ward. Each ward had its own security profile. Each ward assigned a member of staff to the security role. They undertook and recorded checks of the environment to ensure the safety of staff and patients during each shift. Nurse call systems were in place at The Newsam Centre however, on Bluebell Ward there was no nurse call system in patients' bedrooms. Risk management plans were in place for those patients' allocated rooms without a nurse call system. Staff offered patients the option of having a personal alarm.

Maintenance, cleanliness and infection control

The wards were clean and tidy with well-maintained furniture, fixtures and fittings. Domestic support staff were present and cleaning the wards during our inspection. Cleaning schedules at both locations were up-to-date and demonstrated staff cleaned the ward areas regularly.

There were effective systems in place to reduce the risk and spread of infection. The wards displayed hand hygiene signs and dispensers for patients, visitors and staff to use. During the inspection, we saw staff adhered to infection control principles, including handwashing.

Patient-led assessments of the care environment are self-assessments undertaken by teams of NHS and independent healthcare providers. The teams include at least 50% members of the public (known as patient assessors). For the most recent patient-led assessments of the care environment assessment (2017), The Newsam Centre scored better than similar trusts for three of the four of aspects overall. Clifton House scored better than similar trusts for two of the four aspects overall and received a score worse than other similar trusts for disability scoring 83.20% compared to 86.94% nationally. Clifton House and The Newsam Centre did not score for 'Dementia friendly'.

Site name	Core service(s) provided	Cleanliness	Condition appearance and maintenance	Dementia friendly	Disability
Clifton House	Forensic inpatient/secure wards	99.81%	96.78%	-	83.20%
The Newsam Centre	Acute wards for adults of working age and psychiatric intensive care units / forensic inpatient/secure wards / long stay/rehabilitation mental health wards for working age adults.	98.70%	98.43%	-	96.49%
Trust overall		99.37%	98.30%%	99.72%	93.96%
England average (Mental health and learning disabilities)		98.40%	95.13%	85.53%	86.94%

Seclusion room (if present)

At Clifton House, Rose Ward and Bluebell Ward shared a seclusion room. A CQC Mental Health Act review visit in November 2017 identified there was no two-way communication allowing the patient to speak with nursing staff. During the tour of the ward, nursing staff told us the trust had scheduled the installation of an intercom to address this issue.

The layout of the seclusion room at The Newsam Centre was poorly designed. A CQC Mental Health Act review visit in October 2017 identified the narrowness of the entrance to this room as an issue. The trust estates team were assessing ways to improve it as part of their follow up action.

With the exception of these issues, which the trust were taking action to address, the seclusion rooms at Clifton House and The Newsam Centre met the requirements detailed within the Mental Health Act Code of Practice.

Clinic room and equipment

Clinic rooms were organised and clean. At Clifton House, the clinic rooms had a schedule that showed staff had carried out weekly clean checks. For example, on Rose Ward, we saw "I'm clean" stickers on equipment, identifying when it was cleaned and by whom. We could not find such a checklist on ward 2 (assessment and treatment) at The Newsam Centre.

Not all clinical rooms had examination couches, and so on some wards, staff used patients' bedrooms for examinations. Physical health equipment and resuscitation equipment were available in all clinic rooms. We saw staff had undertaken the required checks of resuscitation equipment.

Across all wards, staff checked the medicine fridge temperature on a daily basis. There were a couple of instances where staff had not recorded the daily check. This could mean drugs were stored at the wrong temperature and may be less effective. There were appropriate arrangements for the management of controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse).Controlled drugs and medications were stored appropriately. Emergency drugs were available, in date and checked regularly.

Safe staffing

Nursing staff

The service could not always guarantee that staffing levels matched their minimum staffing complement during the day shifts. The service manager and matrons for the forensic service reviewed and set their identified safer staffing levels in April 2017. The minimum, daily staffing levels for each ward were set against the safer staffing levels. The nursing teams comprised of a band seven ward manager, band six clinical team leaders, band five staff nurses and bands two to four nursing assistants.

During the daytime, nurses worked a combination of early/late or long day shifts. When staff worked a long shift, it minimised the number of nurses available on the ward to facilitate leave and access to outdoor space. The staffing complement for each ward for a daytime shift was two qualified nurses and two nursing assistants. During this inspection, we found that filled shifts sometimes comprised a minimum complement of four staff but not always two qualified nurses. For example, on Bluebell Ward there was one qualified nurse on duty and three healthcare assistants at the time of the inspection.

Two ward managers across the service confirmed they sometimes dropped into the staffing numbers to make their wards safe. Unfilled shifts comprised less than four minimum staffing complement. On Bluebell Ward, the three band six nurses covered the band five-nurse duties where there were shortfalls. The safer staffing report for November 2017, discussed at the board meeting in January 2018, showed that there were lower than planned numbers of registered nurses on Bluebell Ward, and higher than planned for healthcare assistants. The establishment level for the night shift was one qualified nurse and two healthcare assistants.

Please refer to the tables below for details about staffing on the ward.

Definition

Substantive – All filled allocated and funded posts.
Establishment – All posts allocated and funded (e.g. substantive + vacancies).

Substantive staff figures			**Trust target**
Total number of substantive staff	30 September 2017	135.29	N/A

Total number of substantive staff leavers	1 October 2016 – 30 September 2017	24.60	N/A
Average WTE* leavers over 12 months (%)	1 October 2016 – 30 September 2017	18%	10-15%
Vacancies and sickness			
Total vacancies overall (excluding seconded staff)	30 September 2017	23.91	N/A
Total vacancies overall (%)	30 September 2017	15%	N/A
Total permanent staff sickness overall (%)	30 September 2017	5.6%	3.7%
	1 September 2016 – 30 September 2017	6.0%	3.7%
Establishment and vacancy (nurses and care assistants)			
Establishment levels qualified nurses (WTE*)	30 September 2017	67.20	N/A
Establishment levels nursing assistants (WTE*)	30 September 2017	72.60	N/A
Number of vacancies, qualified nurses (WTE*)	30 September 2017	13.96	N/A
Number of vacancies nursing assistants (WTE*)	30 September 2017	5.36	N/A
Qualified nurse vacancy rate	30 September 2017	21%	N/A
Nursing assistant vacancy rate	30 September 2017	7%	N/A
Bank and agency Use			
Shifts bank staff filled to cover sickness, absence or vacancies (qualified nurses)	1 October 2016 – 30 September 2017	798	N/A
Shifts filled by agency staff to cover sickness, absence or vacancies (Qualified Nurses)	1 October 2016 – 30 September 2017	981	N/A
Shifts NOT filled by bank or agency staff where there is sickness, absence or vacancies (Qualified Nurses)	1 October 2016 – 30 September 2017	272	N/A
Shifts filled by bank staff to cover sickness, absence or vacancies (Nursing Assistants)	1 October 2016 – 30 September 2017	4321	N/A
Shifts filled by agency staff to cover sickness, absence or vacancies (Nursing Assistants)	1 October 2016 – 30 September 2017	1564	N/A
Shifts NOT filled by bank or agency staff where there is sickness, absence or vacancies (Nursing Assistants)	1 October 2016 – 30 September 2017	742	N/A

*Whole-time Equivalent

The trust struggled to recruit staff to Clifton House. This affected both locations, as substantive staff at The Newsam Centre covered shortfalls in staffing at Clifton House. This core service reported an overall vacancy rate of 20% for registered nurses at 30 September 2017 and an overall vacancy rate of 8% for registered nursing assistants. This core service has reported a vacancy rate for all staff of 15% as of 30 September 2017.

At the time of the inspection, Bluebell Ward had five qualified band five nurse vacancies against an establishment level of eight qualified nurses. Ward and senior managers said they struggled to recruit to Clifton House due to its location. The trust had advertised extensively through traditional routes and using social media but this had not resolved staffing at this hospital site.

Rose Ward, which was due to close at the end of January 2018, had a staff turnover rate of 45%. There were currently two patients on the ward, who were awaiting discharge to their new placements before the ward could close. This ward required a minimum complement of two

qualified nurses and two healthcare assistants plus a full time occupational therapist. Substantive staff from across the service filled shifts at Rose Ward on a regular basis. However, the safer staffing report for November 2017 (discussed at the board meeting in January 2018) showed there were lower than planned numbers of registered nurses on Rose Ward; the trust had confirmed they maintained the normal staffing ratios on Rose Ward due to the increasing acuity of the remaining patients. Clifton House staff held a morning meeting, which they did not minute, to assess the staff fill rates and identify any required staff movement. Due to the high turnover and vacancies, the service could not always ensure that skilled staff with specialist knowledge in personality disorder worked on the ward.

	Registered nurses			Health care assistants		
Ward/ Team	Vacancies	Establishment	Vacancy rate (%)	Vacancies	Establishment	Vacancy rate (%)
Ward 2 (assessment/ treatment)	0.26	10.26	3%	0.9	12.5%	7%
Ward 2 (womens)	0.85	10.85	8%	1.5	12.50	28%
Ward 3	1.89	9.89	19%	4.86	12.50	39%
Riverfields Ward	3.60	12.40	29%	-4.30	12.50	-34%
Rose Ward	4.66	13.10	36%	-0.10	10.10	-1%
Bluebell Ward	2.70	10.70	25%	0.50	12.50	4%
Core service total	13.96	67.2	20%	5.36	72.6	8%
Trust total	120.06	765.64	16%	89.65	614.56	15%

NB: All figures displayed are whole-time equivalents

	Overall staff figures		
Ward/ Team	Vacancies	Establishment	Vacancy rate (%)
Ward 2 (assessment/ treatment)	1.16	22.76	5%
Ward 2 (womens)	4.35	23.35	19%
Ward 3	5.75	22.39	26%
Riverfields Ward	-0.70	24.90	-3%
Rose Ward	4.56	23.20	20%
Bluebell Ward	3.20	23.2	14%
Core service total	21.01	164.10	15%
Trust total	257.28	2028.82	13%

NB: All figures displayed are whole-time equivalents

Between 1 October 2016 and 1 September 2017, bank staff filled 798 shifts to cover sickness, absence or vacancy for qualified nurses. In the same period, agency staff covered 981 shifts for qualified nurses and 272 shifts were unable to be filled by either bank or agency staff.

Ward/Team	Shifts filled by bank staff	Shifts filled by agency staff	Shifts NOT filled by bank or agency staff
Ward 2 (assessment/ treatment)	297	75	13
Ward 2 (womens)	166	88	16
Ward 3	238	150	33
Bluebell Ward	59	181	79
Riverfields Ward	1	98	19
Rose Ward	37	389	112
Core service total	798	981	272
Trust Total	52673	184336	5150

Between 1 October 2016 – 30 September 2017, 4321 shifts were filled by bank staff to cover sickness, absence, or vacancy for nursing assistants. In the same period, agency staff covered 1564 shifts and 742 shifts were unable to be filled by either bank or agency staff. Wherever possible the wards sought to use a regular pool of bank and agency workers.

Ward/Team	Shifts filled by bank staff	Shifts filled by agency staff	Shifts NOT filled by bank or agency staff
A&C Forensic Reception	188	158	97
Ward 2 (assessment/ treatment)	1310	269	73
Ward 2 (womens)	931	293	99
Ward 3	1261	340	104
Bluebell Ward	303	133	166
Riverfields Ward	90	58	30
Rose Ward	238	313	173
Core service total	4321	1564	742
Trust Total	52673	184336	5150

During this inspection, we looked at rotas and safer staffing figures for the three months preceding this inspection across all the wards. We found the wards continued to have shifts they were not able to fill using bank or agency staff. A safer staffing report dated 15 January 2018 produced at Clifton House showed on Bluebell Ward there were 8 shifts were filled with the wrong grade of staff and 5.7% shifts remained unfilled. Rose Ward had 12.3% unfilled shifts. We looked at rotas on ward three with the ward manager and saw there were five unfilled shifts in October, three unfilled shifts in November, and six unfilled shifts in December. An unfilled shift was when staffing fell below the minimum staffing complement of four staff on duty for a day shift.

In addition, the rotas did not always accurately reflect the staffing position because staff did not always update the rota. Staff we spoke with confirmed that the receiving ward did not always update their rotas to show changes to staffing levels. For example, on Bluebell Ward, the rota

showed there was no qualified nurse on duty on one early shift in December 2017 while on another occasion there were four qualified nurses on duty, as they had not accounted for staff being placed on shift on other wards.

The trust reported 21 incidents of staffing shortages between 18 October 2017 and 15 January 2018. However, there appeared to be a disparity between the number of incidents reported and the unfilled shifts identified on staffing rotas. For example, Riverfields Ward showed there were 43 unfilled shifts between October and December 2017 and Ward three had 14 unfilled shifts. Team meeting minutes reminded staff to report staff shortages as incidents.

Staff shortages for the night shifts at Clifton House resulted in movement of staff across the service. Ward managers reported this happened frequently. This could affect the safety of the ward supplying staff. For example, In January 2018, the forensic nurse coordinator at The Newsam Centre moved to cover Clifton House. Consequently, another core service had to cover qualified nurse shortages on the forensic wards at The Newsam Centre. This potentially affected the skills and gender mix, and left staff unable to facilitate breaks, respond to incidents, or operate the air lock to allow other wards to respond to incidents.

Patients had access to section 17 leave (permission for patients to leave hospital). However, It was not clear if staff reported all incidents of cancelled leave. Several staff we spoke with said section 17 leave was often cancelled, shortened, or postponed. There was a notice displayed on Riverfields Ward requesting patients ‘share section 17 leave fairly’ as low staffing levels meant they could not accommodate all leave. Patients we spoke with were either not entitled to leave or had unescorted leave.

The service reported cancelled section 17 leave (a planned activity) and other cancelled activities daily via a computerised audit sheet, resulting in a monthly activities report. The latest activities report for November 2017 stated that staff facilitated 99.7% of planned section 17 leave. Reasons for cancellations included lack of patient attendance, patient cancellation, staff cancellations, lack of a vehicle and financial restrictions. Planned activities showed a cancellation rate of 18% with most cancellation attributed to patients not attending.

The report did not show how many times staff reduced section 17 leave due to low staffing levels. Furthermore, team meeting minutes for three wards across the service reminded staff to complete the activities sheet and report accurately on patient activity levels.

This core service had 24.6 (18%) staff leavers between1 October 2016 and 30 September 2017.

Ward/Team	Substantive staff	Substantive staff Leavers	Average % staff leavers
Newsam Centre	6.80	1.0	14%
Ward 2 (assessment/ treatment)	22.11	3.6	19%
Ward 2 (womens)	20.00	0.0	0%
Ward 3	17.14	3.0	15%
Bluebell Ward	23.00	5.0	22%
Riverfields Ward	24.60	2.0	8%
Rose Ward	21.64	10.0	46%

Core service total	135.29	24.6	18%
Trust Total	1801.83	166.73	9%

At Clifton House, staff we spoke with said uncertainty about the future of the wards was the main reason staff left. At The Newsam Centre, the main reason for staff leaving was through job progression.

The sickness rate for this core service was 6% between 1 October 2016 and 30 September 2017. The most recent month's data (September 2017) showed a sickness rate of 5.61%.

Ward/Team	Total % staff sickness (at latest month)	Ave % permanent staff sickness (over the past year)
Newsam Centre	8.29%	8.54%
Ward 2 (assessment/ treatment)	8.84%	7.31%
Ward 2 (womens)	13.86%	4.36%
Ward 3	1.98%	16.31%
Clifton House	0.00%	0.27%
Bluebell Ward	3.52%	4.03%
Riverfields Ward	1.17%	1.56%
Rose Ward	4.22%	2.10%
Core service total	5.61%	6.02%
Trust Total	4.48%	5.3%

Staff sickness levels for this service were higher than the trust average. The forensic service performance report for December 2017 showed staff sickness levels due to stress. Please see the table below.

Riverfields Ward	Bluebell Ward	Rose Ward	Ward two (women)	Ward two (A&T)	Ward three
16.37%	0.0%	47.9%	29.83%	15.68%	36.01%

The below table covers staff fill rates for qualified nurses and care staff during July, August and September. All wards had below 90% of the planned registered nurses for all day shifts in the months of August and September. Most of the wards had above 125% of the planned care staff for both day and night shifts across the three months. Nurse fill rates for night shift fluctuated across the 3 months.

Key:

> 125%	< 90%

	Day		Night		Day		Night		Day		Night	
	Nurses	Care staff	Nurses	Care staff	Nurses	Care staff	Nurses	Care staff	Nurses	Care staff	Nurses	Care staff
	September 2017				**August 2017**				**July 2017**			
Bluebell Ward	77.5%	145.9 %	96.9%	100.0 %	98.6%	145.8%	103.9%	141.8 %	117.5%	188.5 %	96.7%	101.7 %
Riverfields Ward	86.5%	232.5 %	100.0%	98.3%	95.2%	217.6%	103.5%	111.3 %	86.8%	192.8 %	93.5%	100.0 %
Rose Ward	73.8%	90.6%	93.3%	111.9 %	89.9%	112.5%	82.7%	135.5 %	109.7%	127.5 %	96.5%	183.1 %
Ward 2 (Women's)	70.5%	136.5 %	100.0%	100.00%	88.4%	129.8%	90.30%	103.2 %	89.2%	128.2 %	99.9%	119.4 %
Ward 2 (Assessment/Treatment)	83.1%	121.6 %	100.0%	101.7 %	92.6%	135.4%	88.7%	127.9 %	92.9%	163.9 %	103.4 %	196.7 %
Ward 3	83.9%	132.0 %	100.0%	105.2 %	85.9%	135.4%	96.8%	103.3 %	96.6%	116.3 %	100.0 %	105.1 %

Medical staff

Between 1 September 2016 and 30 September 2017, 5% of shifts were filled by agency staff to cover sickness, absence or vacancy for medical locums.

Ward/Team	Staffing Type	Available shifts	Shifts filled by agency staff	Shifts NOT filled by bank or agency staff
Ward 2 (Women's)	Consultant	744	26	7
Ward 2 (Women's)	Middle Grade Doctor	240	-	-
Ward 2 (Women's Service)	Doctor in Training	240	43	-
Bluebell Ward	Consultant	504	-	-
Ward 3	Consultant	-	9	-
Core service total		1728	78 (5%)	7 (<1%)
Trust Total		45168	1037 (2%)	84 (<1%)

* Percentage of total shifts

Medical staff

There was adequate medical cover during the day, with doctors at The Newsam Centre working across more than one forensic ward. A doctor could attend the ward quickly in an emergency.

Mandatory training

The trust provided mandatory training in a range of key skills which staff were required to complete. Bank staff and agency staff were required to meet the same standards for these key skills. The agency supplying monitored their staff training compliance. The compliance for

mandatory and statutory training courses at 30 September 2017 was 88%. Of the training courses listed 10 failed to achieve the trust target and of those, five failed to achieve above 75% compliance. Those five included Clinical Risk (64%), Personal Safety with Breakaway (50%), Safeguarding children Level 2 (71%), Safeguarding children Level 3 (74%), and Moving and Handling Principles (50%).

During the inspection, we reviewed compliance with mandatory training. Where staff were not compliant with required key training there was a risk they may not have the necessary skills to provide safe care and treatment. For example, personal safety with breakaway skills had a compliance rate of 60%. Consultants and doctors on the ward undertook this training. On ward three, compliance with immediate life support was 50% and essential life support 67%. This meant there might not be enough adequately trained staff on duty at all times. Apart from Riverfields Ward, the forensic service compliance with clinical risk remained below 64%. Ward managers felt the impact of this on safe care and treatment was low because staff completed patient risk assessments on a regular basis. However, this training had been identified by the trust as mandatory to complete their role safely.

The trust had a rolling month on month basis for training. Where training was lowest, ward managers said staff had been booked onto upcoming courses where these were available. Although compliance with mandatory training had improved since the last inspection, there were still elements of mandatory training that were non-compliant. This meant there was a continued breach of Regulation 18 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Key:

Below CQC 75%	Between 75% & trust target	Trust target and above

Training course	**This core service %**	**Trust target %**	**Trustwide mandatory/ statutory training total %**
Personal Safety with Breakaway Skills	50%	85%	85%
Moving and Handling Principles	50%	85%	90%
Clinical Risk	64%	85%	82%
Safeguarding children Level 2	71%	85%	82%
Safeguarding children Level 3	74%	85%	81%
Moving and Handling Essentials	75%	85%	80%
Immediate Life Support	77%	85%	78%
Mental Health Act - Inpatient - Level 2	78%	85%	78%
Food Regeneration	78%	85%	82%
Mental Capacity Act and DoLs - Level 2	82%	85%	85%
Infection Control – Clinical	85%	85%	81%
Essential Life Support	86%	85%	87%
Fire - Level 3	86%	85%	81%
Food Safety Level 2	87%	85%	88%
High Level Physical Interventions with PSTS and Breakaway skills	88%	85%	89%
Mental Health Legislation Awareness - Level 1	89%	85%	90%
Information Governance	93%	85%	92%
Health and Safety	95%	85%	96%
Fire - Level 2	95%	85%	91%

Equality and Diversity	97%	85%	96%
Safeguarding Adults	98%	85%	95%
Duty of Candour	98%	85%	98%
Trust Induction	99%	85%	99%
Fire - Level 1	100%	85%	95%
Infection Control - Non-Clinical	100%	85%	97%
Personal Safety Theory	100%	85%	99%
Safeguarding children Level 1	100%	85%	93%
Core Service Total %	88%	85%	90%

Assessing and managing risk to patients and staff

Assessment of patient risk

The service ensured staff used an established risk assessment tool and management plan. This meant staff could assess the risks patients posed to themselves and the staff caring for them and manage these risks safely. We reviewed 21 patient records. Overall, 18 of the patient risk assessments we reviewed were completed and up to date. On Bluebell Ward, records showed that risk assessments were not always up to date. However, staff were made aware of changes to risk during handover. Staff attributed this to low staffing numbers although there was no indication they reported this impact as an incident. Staff completed risk assessments on all patients admitted to the forensic service. The Newsam Centre used electronic functional analysis of care environments risk assessment tool. Clifton House used safety and management plans. Both these risk assessments were updated on a monthly basis or sooner if the need arose.

In addition, both locations used the historical clinical risk management - 20 tool. Staff completed this within three months of admission and updated it every six months during the care programme approach meeting. During the multi-disciplinary team review, we saw patients were included in discussions around risk and treatment plans. Risk assessments included routine and ongoing monitoring of existing physical health problems and potential physical health risks that might develop.

Management of patient risk

The assessment process, observation levels, handover, and reviews meant staff were up to date with their knowledge of individual patient risks. Staff followed trust policies and procedures and were confident in the use of different levels of observation. We observed a handover meeting at Clifton House where staff discussed individual patient risks and required observation levels.

The trust had a policy for searching patients. Staff gave patients and carers information about restricted items and searches in patients' welcome packs on admission. Staff checked patients' belongings on admission to the ward. At the last inspection, we found blanket restrictions were in place for routine searching following periods of leave and access to outside space. During this inspection, we found searches of patients were risk specific and reviewed as necessary. As part of the quality network for mental health services, staff followed the low and medium secure standards 2016 in relation to patient access to outside space.

The service was in the early stages of implementing reduced restrictive interventions. There was evidence of ongoing reviews and wards introducing changes. Riverfields Ward had introduced a mutual expectation guide, which they displayed on their notice board. All patients had keys to their bedrooms and access to mobile phones where appropriate.

The trust was a smoke free site. However, the trust had relaxed its position temporarily for the acute wards due to a recent fire inspection; they were working to re-instate the acute wards being smoke free. However, patients in the forensic services were still expected to observe a smoke free

environment and at The Newsam Centre could see patients from the acute service smoking whilst they were outside. At The Newsam Centre, 12 of the 13 patient comments cards about the service focused negatively on the smoke free environment for forensic patients.

Since the last inspection, the service had reviewed arrangements at both sites and installed lockers for patients to leave their smoking materials when returning from leave. Both sites confirmed there were still incidents of suspected smoking on the wards. Staff recorded these incidents using the trust electronic reporting system.

Use of restrictive interventions

This core service had 59 incidents of restraint (on 31 different service users) and 21 incidents of seclusion between 1 October 2016 and 30 September 2017. Over the 12 months, the incidence of restraint peaked in the month of June 2017 (20) and seclusion in June 2017 (five).

The below table focuses on the last 12 months' worth of data: October 2016 to September 2017.

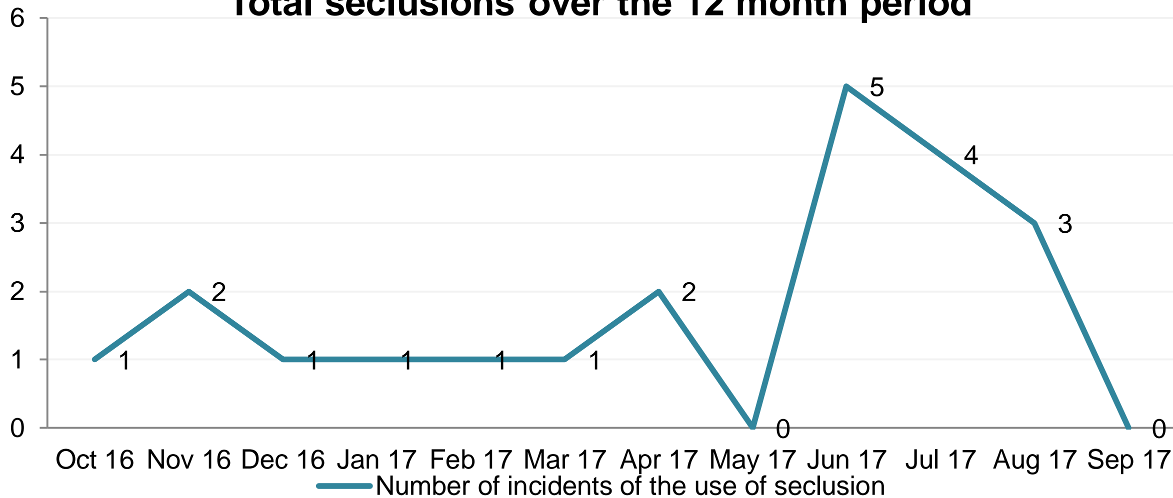
Ward name	Seclusions	Restraints	Patients restrained	Of restraints, incidents of prone restraint	Rapid tranquilisations
Rose Ward	13	35	17	3 (9%)	2 (6%)
Ward 2 (assessment / treatment)	3	16	7	7 (44%)	4 (25%)
Ward 2 (womens)	0	2	1	0 (0%)	0 (0%)
Ward 3	3	3	3	1 (33%)	0 (0%)
Riverfields Ward	2	2	2	0 (0%)	0 (0%)
Bluebell Ward	0	1	1	0 (0%)	0 (0%)
Core service total	21	59	31	11 (19%)	6 (10%)

There were 11 incidents of prone restraint, which accounted for 19% of the restraint incidents. There have been zero instances of mechanical restraint over the reporting period. A restraint happens when staff place hands on patients to prevent them from harming themselves or others, or when staff hold a patient for a sustained period to provide basic care in their best interests.

Incidents resulting in rapid tranquilisation for this core services fluctuated, with the highest numbers in May 2017 and July 2017. Rapid tranquilisation is when staff administer an injection to patients who are very agitated and disturbed. The aim is to quickly calm them and reduce any risk to themselves or others.

There had been no episodes of restraint or rapid tranquilisation since September 2017 and the wards appeared settled. Staff used restraint only after de-escalation techniques, such as positive engagement and diversion had failed. We reviewed two episodes of restraint and found staff had followed protocol. There were no records of rapid tranquilisation available on the wards to review.

Between the months of October 2016 and April 2017 the instance of seclusion ranged between one and two seclusions. This peaked in the month of June 2017 with five instances of seclusion reported. This decreased over the next few months and the trust reported 0 instances in September 2017.



There were low incidents of seclusion reported since October 2017. When we inspected this service previously, we identified that staff were not always recording seclusion episodes in line with the Mental Health Act Code of Practice. We checked the most recent seclusion records and found staff used seclusion appropriately and adhered to best practice when they did so.

There have been no instances of long-term segregation over the 12 month reporting period, similar to the number reported at the time of the last inspection.

Safeguarding

A safeguarding referral is a request from a member of the public or a professional to the local authority or the police to intervene to support or protect a child or vulnerable adult from abuse. Commonly recognised forms of abuse include: physical, emotional, financial, sexual, neglect and institutional.

Each authority has their own guidelines as to how to investigate and progress a safeguarding referral. Generally, if a concern is raised regarding a child or vulnerable adult, the organisation will work to ensure the safety of the person and an assessment of the concerns will also be conducted to determine whether an external referral to Children's Services, Adult Services or the police should take place.

This core service made eight safeguarding referrals between 29 September 2016 and 1 October 2017, all of which concerned adults. There was a peak identified in adult referrals across the period in April 2017 with 4 referrals.

Staff were compliant with safeguarding adults training and had achieved 71% and 74% compliance with safeguarding children levels two and three respectively. We reviewed six safeguarding records, which showed staff were aware of how to identify adults at risk of, or suffering, significant harm and the procedure to alert and refer. Staff we spoke with gave current examples of safeguarding concerns affecting their ward. They had a good relationship with trust safeguarding team and discussed/ sought advice with the team to see if concerns met the safeguarding threshold.

There were rooms off the wards that patients could use when children visited. This meant that patients could see their young family members in a suitable environment.

Leeds and York Partnership NHS Foundation Trust has not submitted details of any serious case reviews commenced or published in the last 12 months (29 September 2016 and 1 October 20170] that relate to this core service.

Staff access to essential information

Not all staff had access to essential information. The provider used an electronic system for substantive staff to record essential information on patient care and treatment. Agency staff did not have access to this system. Staff made paper records available to agency staff and provided patient updates during handover. The forensic nurse coordinator on the night shift could access essential information from the system for agency staff if the need arose. Agency staff provided hand written notes from their shift, which ward clerks or substantive staff then input on to the system to update the records.

We found staff did not always maintain patient records in a consistent manner, with some information stored in different locations within the electronic system. Whilst staff could find the documentation we requested, it required them to check multiple locations within the system. Not having easy access to the information could be a challenge and time consuming for staff not used to working on the ward and showed a lack of consistency across the wards. This created a risk that staff might not be aware of a patient's full care and treatment as there was the potential for staff to miss information. For example:

- staff documented physical health assessments, updates and monthly reviews in different locations, which meant physical health referrals/follow-ups could be missed
- seclusion records were not easy to follow making it difficult to ensure reviews were done at appropriate times
- documentation of patients' rights under the Mental Health Act was in different locations, which meant timely updates did not always take place
- section 17 care plans were not always in place.

Staffing rotas and incidents regarding low staffing levels were not always clear and transparent.

Medicines management

We found systems and processes in place for the safe management of the medicines on the wards. During our inspection, we reviewed all the medication charts. We found medicines were prescribed in accordance with the provisions of the Mental Health Act. Qualified nurses completed a yearly competency for the administration of medication on line. Pharmacy technicians attended the wards regularly to review and audit medication charts and all medication on the wards. The pharmacist attended the weekly multi-disciplinary team reviews.

Medicines were stored securely in the clinic rooms with access restricted to authorised staff. The wards had appropriate arrangements for the management of controlled drugs. These medicines require extra checks and special storage arrangements because of their potential for misuse.

Staff ensured they monitored patients prescribed antipsychotic medication. They carried out relevant tests and investigations in line with National Institute for Health and Care Excellence guidance CG178 (psychosis and schizophrenia in adults: prevention and management).

Staff encouraged some patients to self-administer their medicines and carried out appropriate risk assessments to support this. Staff reviewed patients weekly to ensure self-administration remained safe and appropriate for each individual. We found gaps in one patient's record and brought this to the attention of the ward manager, who reviewed the record with staff. Patients understood about their medications and had opportunity to discuss their choices with staff.

Track record on safety

Providers must report all serious incidents to the Strategic Executive Information System (STEIS) within two working days of an incident being identified. Between 1 October 2016 and 30 September 2017 there were four serious incidents reported by this core service. The most common type of incident was unauthorised absence meeting SI criteria with two reports. This core service reported no unexpected deaths.

A 'never event' is classified as a wholly preventable serious incident that should not happen if the available preventative measures are in place. This core service reported zero never events during this reporting period.

We asked the trust to provide us with the number of serious incidents from the past 12 months. The number of the most severe incidents recorded by the trust incident reporting system was comparable with STEIS.

The number of serious incidents reported during this inspection was higher than the zero reported at the last inspection.

	Number of incidents reported			
Type of incident reported on STEIS	Bluebell Ward	Rose Ward	Ward 3	Total
Unauthorised absence meeting SI criteria	0	2	0	2
Disruptive/ aggressive/ violent behaviour meeting SI criteria	0	0	1	1
Confidential information leak/information governance breach meeting SI criteria	1	0	0	1
Total	**1**	**2**	**1**	**4**

At Clifton House there where two occasions were patients failed to return from unescorted leave in the timeframe granted for the leave period. The wards responded to these incidents in an appropriate manner, making the necessary notifications.

Reporting incidents and learning from when things go wrong

The Chief Coroner's Office publishes the local coroner's Reports to Prevent Future Deaths. These reports all contain a summary of Schedule 5 recommendations, which had been made, by the local coroners with the intention of learning lessons from the cause of death and preventing deaths.

In the last two years, there has been one 'prevention of future death' report sent to the trust. The report was not related to this core service.

Staff reported incidents using the trust's electronic incident reporting system. Staff knew the types of incidents they needed to report, although there appeared to be under reporting in respect of staffing shortages in comparison to ward rotas.

Staff confirmed they received debriefing after serious incidents. For example, at Clifton House, staff and patients received debrief and support following a racially charged incident. The trust sent their staff emails containing information about trust-wide incidents and lessons learned. This meant that staff learnt from incidents in order to improve their practice.

The trust had a policy and procedure for the duty of candour and staff knew about the requirements placed on them to meet the duty of candour in relation to being open and honest and

providing a written apology in certain circumstances. All staff received mandatory training in duty of candour. Duty of candour was included in the incident reporting system as a prompt and actioned where necessary.

Is the service effective?

Assessment of needs and planning of care

Staff completed a comprehensive mental health assessment of the patient's needs upon their admission, which followed Maudsley guidelines. Staff then developed care plans, including an inpatient treatment plan, in partnership with the patient. The care plans reflected the patient's needs identified in the comprehensive assessment. We looked at 21 patient records across the service. All patient records had a personalised, holistic, and recovery-oriented care plan. We found 18 of the care plans were up to date. The remaining care plans were of a variable standard, and not always updated when necessary. Observations of multidisciplinary meetings and handovers showed staff were knowledgeable and familiar with patient's needs and what care they currently received.

Staff carried out a physical health examination and assessment on all patients upon admission. They used the 'modified early warning score' tool to monitor blood pressure, heart rate, temperature, respirations and oxygen saturations. There was evidence of ongoing physical healthcare monitoring and assessment in every patient record we looked at. For example, care plans for diabetes, asthma, dual diagnosis, and nutritional screening.

Best practice in treatment and care

We looked at 21 patient care records and 44 prescription records. The multidisciplinary team provided a range of care and treatment interventions that were suitable for the patient group. We saw staff discuss and adhere to the relevant National Institute for Health and Care Excellence guidance during multidisciplinary reviews. Staff received information about updates on policies and National Institute for Health and Care Excellence guidance through a generic email. The local clinical governance meetings discussed National Institute for Health and Care Excellence guidance. In addition, the advanced practitioner at Clifton House audited guidance and ensured the service was up to date with any changes relevant to the service.

The service offered medication and psychological therapies. We found medical staff followed National Institute for Health and Care Excellence guidance and prescribed medication within British National Formulary limits in the prescription charts we reviewed. The pharmacist and pharmacy technicians attended the ward on a regular basis and checked that prescribing and relevant physical checks were in keeping with best practice. However, four prescription charts did not show evidence of a review of medications prescribed 'as required' after 14 days. This is medication given when necessary. The service has assured us they review all medication at patients' multi-disciplinary review meetings. One prescription chart showed a patient was on leave when their clozapine medication was due. There was no arrangement for the patient to take out this medication although regular monitoring was in place to minimise the risk of loss of therapeutic effect.

All wards had psychological provision. The psychologists facilitated reflective practice and formulation sessions with staff, which supported them with the work they did with patients, as well as providing in-house training for staff. Psychologists used a range of evidence-based assessment tools and therapies such as cognitive behavioural therapy, cognitive analytical therapy, dual diagnosis, and eye movement desensitisation and reprogramming and family therapy.

Patients had good access to activities intended to help them acquire living skills. Occupational therapists used appropriate forensic occupational therapy guidelines, such as the Model of Human Occupation Screening Tool. This enabled them to gain a base line assessment of patients' needs and highlight specific interventions that patients may require. For example, training and work opportunities intended to help patients acquire living skills. Activities were occurring across the

wards during our inspection. We reviewed the activities timetable for each ward that included sessions on budgeting, shopping, cooking, craft, walking groups, and health and fitness

We looked at 22 patients' physical healthcare records. These showed patients had access to physical healthcare. Staff ensured patients received medical treatment when required, such as dentists, opticians, and supported patients to attend specialist hospital appointments when required. All patients registered with a local GP service but not all patients registered with dental services and opticians, if they did not feel the need for it. Staff assessed patients' needs for food and drink and supported patients to live healthier lives. For example, through referral to the healthy living advisor and dealing with issues relating to substance misuse.

We saw evidence of staff using recognised rating scales to assess and record severity and outcomes in patient records. For example, Health of the Nation Outcome Scales and the short version of the Warwick–Edinburgh Mental Well-being Scale.

Staff used technology to support patient care in relation to the safe administration of medication. The trust used an electronic prescribing and medicines administration system. One of the benefits of the system was a reduced risk of drug errors such as errors in recording administration of a medication and ordering medication.

Staff participated in clinical audits specific to the service. These included audits such as compliance with the Mental Health Act and Mental Capacity Act, and defensible documentation. Staff also carried out regular checks of equipment and medicines to make sure they were safe to use.

This core service participated in one clinical audit as part of their clinical audit programme 2016 – 2017. Please refer to the table below.

Audit name	Audit scope	Audit type	Date completed	Key actions following the audit
Consent to medical treatment in Forensic psychiatry inpatient service in York	Forensic Services	Clinical	25/09/2017	There may be scope to implement a more systemic approach to ensuring good practice around consent to treatment by involving senior nursing staff and the MHA Administration Team as well.

Skilled staff to deliver care

A range of suitably skilled healthcare professionals provided input to the service and supported the needs of patients on the ward. We spoke with a number of staff including, consultants, ward managers, registered nursing and non-registered nursing staff, the clinical psychologist, occupational therapists, and the pharmacist.

Substantive staff were experienced and qualified, and had the right skills and knowledge to meet the needs of the patient group. Staff movements and the use of bank and agency staff had the potential to dilute the skills mix on the wards. For example, when a night shift nurse from The Newsam Centre moved to cover a shift at Clifton House recently, their post had to be backfilled by staff from the acute service who were not familiar with the forensic setting.

The trust's target rate for appraisal compliance is 85%. As at 8 November 2017, the overall appraisal rates for non-medical staff within this core service was 81%. The wards failing to achieve the trust's appraisal target were Bluebell Ward (65%), Newsam Ward 2 Male (80%) and Newsam Ward 3 (63%). This meant that managers on wards with low appraisal rates were not always able to support staff with their professional development.

Please refer to the table below for information about appraisal rates for permanent non-medical staff as at 8 November 2017.

Ward name	Total number of permanent non-medical staff requiring an appraisal	Total number of permanent non-medical staff who have had an appraisal	% appraisals
Ward 3	19	12	63%
Bluebell Ward	22	15	68%
Ward 2 (assessment/ treatment)	20	16	80%
Ward 2 (women's)	20	17	85%
Rose Ward	23	21	91%
Riverfields Ward	25	24	96%
Core service total	129	105	81%
Trust wide	2028	1596	79%

The trust's target rate for appraisal compliance is 85%. There was no medical appraisal information provided for this core service.

At the last inspection, we identified supervision as an area requiring improvement. Clinical supervision allows a member of staff to meet with a senior staff member to discuss case management, to reflect on and learn from practice, and for personal support and professional development. Between 1 April 2017 and 1 October 2017, the average clinical supervision rate across this core service was 37% of the trust's target. The rate of clinical supervision reported in the pre-inspection information for this inspection was lower than the 57% reported at the last inspection.

Caveat: there is no standard measure for clinical supervision and trusts collect the data in different ways, it is important to understand the data they provide.

Ward name	Clinical supervision sessions required	Clinical supervision sessions delivered	Clinical supervision rate (%)
Rose Ward	118	22	19%
Ward 2 (assessment/treatment)	99	28	28%
Ward 3	96	31	32%
Bluebell Ward	124	44	35%
Ward 2 (women's)	113	42	37%
Riverfields Ward	142	91	64%
Core Services Total	692	258	37%
Trust Total	11598	6674	57.5%

During this inspection, we found that although supervision rates had improved in January 2018, not all staff received clinical supervision in compliance with the trust target. Riverfields Ward and Ward two (women) had a supervision rate of 95% and ward two (women) 82.35% respectively in the month preceding the inspection. However, Bluebell Ward compliance was 55%, Rose Ward

48%, Ward two (assessment and treatment) 67% and Ward three 47 % This was a continued breach of Regulation 18 of the Health and Social Care Act (Regulated Activities) Regulations 2014. Staff placed the needs of the patients on the ward over individual supervision, particularly when staffing levels were below the required fill rate or substantive staff moved wards for the shift. Staff at The Newsam Centre had access to weekly team/group reflective practice forums and formulation meetings facilitated by the psychologist although they did not document this.

Since the last inspection, the trust changed how it recorded clinical supervision from a paper-based system to an electronic system. The service had not fully embedded the new system and continued to use a combination both systems for recording supervision.

Each ward had regular team meetings. We reviewed the minutes of these meetings and found Ward 2 (women) had standing agenda items that covered staffing, infection control and relational security amongst others. This meant they tracked progress of items for discussion and followed up at the next team meeting.

Managers provided all new staff with an appropriate induction to forensic services before they commenced work on the ward. Healthcare assistants had access to training in the care certificate. This qualification is a set of standards that act as a benchmark for providing quality care and treatment. Staff on both wards had access to specialist training for their roles and continuous professional development. For example, staff had undertaken training in leadership skills, dual diagnosis, venepuncture, and electrocardiography amongst others.

There was one staff member engaged in performance management at the time of inspection. Managers were able to give specific examples outlining the process for dealing with poor performance.

Multi-disciplinary and interagency team work

Patients received multi-disciplinary input from medical staff, registered nursing and non-registered nursing staff and other professionals including psychologists, and occupational therapists. Staff held weekly multidisciplinary meetings seeing patients on each ward on a fortnightly basis. We observed two multi-disciplinary team meeting to review patients' progress. The multi-disciplinary team had in-depth knowledge of each patient leading to comprehensive discussion. This ensured that all members of the multidisciplinary team were up-to-date on current issues with patients and decisions about future care and treatment. The team updated care plans and discussed any safeguarding concerns, incidents, section 17 leave, or discharge plans for their patients. Care co-ordinators from community mental health teams attended these meetings when appropriate.

It was evident from discussion with staff on ward three that relationships between ward staff and the multi-disciplinary team were not as effective as they could be. The ward had a period without a permanent ward manager, during this time relationships deteriorated. The current ward manager was aware of this issue and seeking to improve relationships. We saw from recent team meeting minutes, that staff discussed ward function at length.

Ward staff had a range of opportunities to share information about patients including up to three handovers every day. We observed a handover meeting and saw staff shared information about patients' current presentation, risks and observation levels, medication and physical health care needs. This ensured that staff coming on duty were up to date with all aspects of patient care and treatment. Staff documented each handover discussion using a standardised format. This gave the ward manager assurance of the quality and consistency of information that staff handed over.

The ward teams had effective working relationships with other relevant teams within the trust, such as care co-ordinators, community mental health teams and the safeguarding team. Staff worked with external services and agencies to support patients' care and treatment. They liaised with local GPs, social workers with the patient's local authority, step down services and other providers when planning for a patient's discharge.

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

As of 30 September 2017, 78% of the workforce in this core service had received training in the 'Mental Health Act – Inpatient – Level 2' and 89% of the workforce in this core service has received training in the 'Mental Health Legislation Awareness – Level 1'. The trust stated that this training is mandatory for all core services for inpatient and all community staff and renewed every two years.

On this inspection, we reviewed care and treatment of 17 detained patients for adherence to the Mental Health Act and the Code of Practice. There were systems in place to support the operation of the Mental Health Act. Staff had easy access to the trust's Mental Health Act policies, procedures and to the Code of Practice, both on the internet and in hard copy format on the wards. They knew whom their Mental Health Act administrators were and how to access support and legal advice on the implementation of the Mental Health Act and the Code of Practice.

Patients had easy access to information about independent mental health advocacy. Independent mental health advocates help people who use services have their opinions heard and make sure they know their rights under the law. There were posters displayed, advertising the service, on notice boards across the wards. Staff ensured patients could access the independent mental health advocacy service. We met the advocate for the forensic ward at The Newsam Centre, who said they regularly attended the ward and engaged with the patients.

We found all patients' records showed staff explained to patients their rights under the Mental Health Act. On Ward two (assessment and treatment) and Ward three, five out of seven records showed staff did not always repeat reading patients' rights within the frequency stated. We also found staff had not always documented the discussion of treatment options in line with consent and capacity. The ward manager followed up on this issue and assured us that these discussions had taken place. During the multi-disciplinary reviews, we saw a full discussion with a patient about detention being in the least restrictive placement. There were also discussions around care and treatment where the patients consent was sought.

We saw evidence in patients' records that staff had requested an opinion from a second opinion appointed doctor when necessary. Copies of the patients' detention papers and associated records (for example,section 17 leave forms) were available on the wards to all staff that need access to them. Detention papers showed staff had undertaken the appropriate medical and administrative scrutiny for patients detained under the Mental Health Act. Detention paperwork was completed, and up to date. The pharmacist regularly checked treatment cards to make sure that all treatment was authorised correctly.

The Mental Health Act office carried out audits to ensure the detention paperwork was correctly completed. Administrators sent prompts to the responsible clinician for section renewals, rights, and consent forms. Band six nurses on the wards audited patients' records against the Mental Health Act. We saw evidence of audits of staff undertaking discussion with patients about their rights in accordance with Section 132 of the Act on the electronic recording system.

Good practice in applying the Mental Capacity Act

As of 30 September 2017, 82% of the workforce in this core service had received training in the 'Mental Capacity Act and Deprivation of Liberty Safeguards – Level 2'. The trust stated that this training is mandatory for all core services for inpatients and all community staff and renewed every two years.

Staff were able to demonstrate their knowledge of the Mental Capacity Act and gave examples of assessing patient capacity in relation to finances, gambling and the right to make unwise decisions. The multi-disciplinary team provided information to patients to support them to make their own decisions and understood the reasons why a capacity assessment may be required. They liaised with advocacy to assist.

The trust had a policy on the Mental Capacity Act. Staff had access to the policy on the trust intranet and a hard copy on the wards. Staff were able to get help and support in relation to the Mental Capacity Act from the Mental Health Act office and from Mental Capacity Act champions on each ward.

Staff assessed patients' capacity where it was relevant. In one safeguarding record, we saw a good example of a capacity assessment carried out alongside the safeguarding referral. During multi-disciplinary team reviews, we observed capacity issues discussed throughout the meetings. Responsible clinicians carried out and recorded mental capacity assessments in patients' notes. We saw documented discussion between the responsible clinician and patient for patients who might have impaired capacity. Responsible clinicians were able to explain the principles supporting the Mental Capacity Act definition of restraint.

There were no Deprivation of Liberty Safeguard applications made to the Local Authority for this core service between 1 October 2016 and 30 September 2017. Deprivation of liberty safeguards applications protect people without capacity to make decisions about their own care.

Is the service caring?

Kindness, privacy, dignity, respect, compassion and support

Staff attitudes and behaviours towards their patients were discreet, respectful, and responsive. We observed positive, patient-centred interactions between staff and patients. Staff were kind, supportive and had clearly developed a therapeutic relationship with their patients. We saw staff treating their patients with compassion and respecting their dignity. Patients we spoke with said staff always knocked on the door before entering their room.

During the inspection, we spoke with 14 patients across the service. Overall, patients were positive about the care they received. Patients said they felt safe and settled in their environment. Some patients felt involved in their care plan and reported they regularly attended their review meetings. Patients confirmed staff explained their care and treatment to them, including their medication, detention under the Mental Health Act and if section 17 leave was applicable. One patient told us they had friends in the wider community and received staff support to develop and maintain these relationships.

The 2017 patient-led assessments of the care environment score for privacy, dignity and wellbeing at both core service locations scored better than similar organisations.

Site name	Core service(s) provided	Privacy, dignity and wellbeing
Clifton House	Forensic inpatient/secure wards	93.47%
The Newsam Centre	Acute wards for adults of working age and psychiatric intensive care units / forensic inpatient/secure wards / long stay/rehabilitation mental health wards for working age adults.	95.27%
Trust overall		93.96
England average (mental health and learning disabilities)		89.64

Involvement in care

Involvement of patients

Staff had a clear admission process to inform and orient patients to the wards and to the service. Patients met staff at pre-admission stage. When appropriate, patients visited the service before formal admission to familiarise themselves with the environment. On admission, staff gave patients a welcome pack containing information that helped orient them to the ward. At Clifton House, a ‘buddy system’ was in place to help patients adjust to their new environment. Patients confirmed they knew who their named nurse was.

We saw patients worked in partnership with staff during the care planning and risk assessment process, with care plans reflecting the patient voice. Staff ensured patients were involved in reviews of their care and treatment, with patients participating in their multidisciplinary team reviews. Staff communicated with patients so that they understood their care and treatment. They found effective ways to communicate with patients with communication difficulties. For example, one patient had a pictorial discharge care plan.

Staff involved patients when appropriate in decisions about the service. For example, each ward had a patient representative sitting on the Patients’ Council, who also attended the service-wide clinical governance meetings. Discharged patients or patient representatives were also involved in

the staff recruitment process. Staff enabled patients to give feedback on the service they received via suggestion boxes, 'your views' meetings, and community meetings. Patients were involved in developing patient experience questionnaires. The service held a focus group at each location with patient representatives to consider the questions asked and the format it should take.

Staff ensured that patients could access the independent mental health advocacy service. We met the advocate for the forensic wards at The Newsam Centre, who said he regularly attended the ward and engaged with the patients.

Involvement of families and carers

Staff informed and involved families and carers appropriately and provided them with support when needed. Carers who attended the focus groups spoke positively about the behaviour of staff, finding them to be kind and polite.

Carers told us that they felt appropriately involved in decisions made about the care provided by the ward and could attend ward rounds and meetings. Carers knew who their relative's keyworkers were and said staff informed them if there were any significant changes or incidents on the ward affecting their relative. The service held specialist care group meetings, which enabled patients and carers in to be involved in driving the forensic service forward. The patients council was a well-established feedback platform. The service invited carers to coffee mornings and open day event presented by patients.

Staff at both locations enabled families and carers to give feedback on the service they received, for example, via 'friends and families' surveys and carers questionnaires. In the most recent feedback for Clifton House, nine carers rated the service as follows:

- Approachability - 100% rated as very good or good
- Dignity and respect - 100% rated as very good or good
- Involved in decisions - 80% rated as very good or good

Staff provided carers with an information pack, which contained details about how to access a carer's assessment.

Is the service responsive?

Access and discharge

Bed management

There were no ward moves reported for this core service between 1 October 2015 and 30 September 2017 for non-clinical reasons. Ward managers at Clifton House confirmed there had been no ward moves in the twelve months preceding the inspection. At The Newsam Centre, patients moved wards as part of their pathway based on clinical need and presentation.

There were no moves at night reported for this core service between 1 October 2016 and 30 September 2017. Staff only moved patients at night in the event of a medical emergency.

Before admission, patients met staff during their initial pre-assessment and received information about the service. Patients also had the opportunity to visit the ward pre-admission, where this was appropriate. Carers also received a letter from the carers lead on the ward to provide essential information.

The trust provided information regarding average bed occupancies for six wards in this core service between 1 October 2016 and 30 September 2017. Four of the wards within this core service reported average bed occupancies ranging above the provider benchmark of 85% over this period. Rose Ward reported the lowest average bed occupancy (53.50%) with a decrease

from 60.00% in May 2017 to 31.33% in September 2017. This was due to the imminent closure of Rose Ward. The average bed occupancy continued to be above the provider benchmark of 85% for the remaining wards at the time of the inspection. When appropriate, patients went on short periods of leave as part of their recovery. After these leave periods, patients always returned to the same bed.

Ward name	Average bed occupancy range (October 2016 – September 2017) (current inspection)
Bluebell Ward	86.56% - 100.00%
Ward 2 (assessment/ treatment)	91.67% - 99.46%
Ward 2 (Womens)	86.51% - 100.00%
Ward 3	93.11% - 100.00%
Riverfields Ward	71.43% - 92.86%
Rose Ward	31.33% - 60.00%

The trust provided information for average length of stay for the period 1 October 2016 to 30 September 2017.

Ward name	Average length of stay range (1 October 2016 – 30 September 2017) (current inspection)
Bluebell Ward	22 days – 1114 days
Ward 2 (assessment/ treatment)	34 days – 1338 days
Ward 2 (Womens)	7 days – 892 days
Ward 3	176 days – 1064 days
Riverfields Ward	179 days – 1248 days
Rose Ward	134 days – 728 days

This core service reported no out area placements between 17 October 2016 and 1 October 2017 or in the three months preceding the inspection. This core service reported no readmissions within 28 days between 1 October 2016 and 30 September 2017 or in the three months preceding the inspection.

Discharge and transfers of care

Between 1 October 2016 and 30 September 2017 the trust reported one ward had had a delayed discharge within this core service. Bluebell Ward had seven discharges of which one was delayed. This amounts to 3% of the total number of delayed discharges (30). At the time of the inspection, an informal patient on Riverfields Ward was expecting to be discharged at the end of January 2018. They were currently waiting for funding for a move out of area and had made several visits to their new placement. There were two patients on Rose Ward awaiting either transfer or discharge. Themes for delayed discharges were delays in funding, the lack of availability of beds in suitable accommodation and meeting service criteria of step down services.

Staff planned for patients' discharge in conjunction with community teams. We saw evidence in care records of discharge planning and attendance of care coordinators at care pathway approach meetings. At Clifton House, the service was funding a patient to visit suitable accommodation on the outskirts of the trust area on a daily basis. At Riverfields Ward, staff resisted a push to

discharge a patient to unsuitable accommodation and sourced charitable funds to enable a custom-made bed to facilitate the discharge.

Facilities that promote comfort, dignity and privacy

The facilities at both locations ensured patients had access to a range of rooms and equipment to support their care and treatment. Patients had their own bedrooms and were able to personalise them with their possessions. Some rooms were en suite and all rooms had access to secure storage in which patients could keep their possessions. All patients had keys to their own bedroom.

The quality and availability of rooms was variable across the service. Each ward had a patient kitchen, communal areas, and outside space. Clifton House had a number of shared facilities, such as an IT suite, gym, music room, social space, library, and contemplation room, which were located off the ward. The Newsam Centre had an IT suite. Patients could access, where appropriate, a multi-faith room and gym, which were outside the secure perimeter. They shared these facilities with other wards on the hospital site. Ward 2 (Assessment & Treatment) had limited rooms available on the ward. An agreed business plan to repurpose rooms on the ward to increase therapy space available was awaiting an action date. All wards had an outside space that patients could access. Some wards had set times for patients to access outside space although patients could request access at other times. This was dependent on staff availability.

All wards had access to quiet areas and were able to facilitate visits for patients. Visits with children always took place off the ward.

On most of the wards, the telephone was in a shared patient area although staff advised they would support patients to have calls with ward mobiles in private. Patients could use basic mobile with no camera and no internet access on the wards based on individual risk assessment. Patients were not able to have personal access to the internet but could access it in IT suites at each location.

Patients and staff reported the quality of food varied. The food menu rotated on a four weekly basis. There was a variety of options and this included any special dietary needs and cultural requirements, for example brittle diabetes and halal food. The trust was implementing changes from cook chill to cook freeze in response to patient feedback. Cooking was an important part of patients' treatment plans and with supervision, patients were able to cook for themselves. Patients spoke positively about this experience.

Patients had access to drinks and snacks 24 hours a day based on individual risk assessment. Snacks consisted of biscuits, yoghurt and fresh fruit. Hot and cold drinks were available.

The 2017 patient-led assessments of the care environment score for ward food at Clifton House and The Newsam Centre scored better than similar trusts.

Site name	Core service(s) provided	Ward food
Clifton House	Forensic inpatient/secure wards	94.66%
The Newsam Centre	Acute wards for adults of working age and psychiatric intensive care units / forensic inpatient/secure wards / long stay/rehabilitation mental health wards for working age adults.	95.55%
Trust overall		95.66%
England average (mental health and learning disabilities)		92.92%

Patients' engagement with the wider community

Patients had access to meaningful activities onsite and within the wider community. Occupational therapists and activity organisers worked core hours between Monday to Friday. However, they would be flexible to facilitate a specific activity patients wanted to do. For example, a theatre trip at the weekend or cooking an evening meal after 5pm. Diversional activities at the weekend were facilitated by ward based staff for example a Brunch Club.

Staff ensured that patients had access to education and work opportunities. They encouraged patients to develop and maintain relationships with people that mattered to them, both within the services and the wider community. Staff supported patients to maintain contact with their families and carers. Patients used technology to maximise contact with friends and families.

Activity co-ordinators and occupational therapy staff planned a range of regular weekly activities including cooking, art and additional trips for example to the cinema and art galleries. On Ward three the occupational therapy team had developed multiple person-centred pathways fostering independence and relationships within the wider community. For example, patients attending local gyms, engaging in part-time work or work placements, and undertaking forklift truck-driving qualifications. During the inspection, patients and staff from both sites attended a celebration of the Recovery College at The Newsam Centre. Across the service, a number of patients held voluntary positions within the local community and a recent Creativity Exhibition at Clifton House involved external organisations including MIND, Arts in Mind and NHS England.

Meeting the needs of all people who use the service

Staff were committed to ensuring the wards met the individual needs of each patient wherever possible and appropriate. Patients with physical disabilities had access to appropriate facilities. These included assisted bathrooms and kitchens with adjustable units. Personal fire evacuation plans were in place for patients requiring additional support, for example wheelchair users. All patient accommodation was on the ground floor. There was a lift available for staff and visitors to use at Clifton House.

Each ward had a number of notice boards that displayed a range of information about treatments, local services, the Mental Health Act, and how to complain. Patients received an information pack on admission to their ward. At Riverfields Ward, the occupational therapist had redesigned the information pack and produced a clear and concise booklet that was colourful, in a larger font and easy to understand. There were plans to produce a similar style booklet for Bluebell Ward. Staff could access signers, interpreters, and information in other languages via the trust to support patients with specific communication needs.

Staff ensured that patients had access to appropriate spiritual support and a choice of food to meet their needs. All wards had access to a multi-faith room for patients to use. At Clifton House, patients had changed the name of the multi-faith room to the contemplation room, to reflect a broader understanding of spirituality. The service had links with the local community to support patients' spiritual needs, for example a visiting chaplain and attendance at local places of worship.

Listening to and learning from concerns and complaints

Patients we spoke with said they knew how to complain or raise concerns. All wards had community meetings in which patients could raise concerns, informally in the first instance. Riverfields Ward was reviewing mutual expectations within community meetings to identify areas for further development and to generate an action plan. Clifton House has an active Patient

Council, which was monitoring the trust's response following concerns they raised about the quality of food.

Leaflets were available and posters displayed throughout ward areas informing patients and carers about the different ways to complain. This included through the trust, Patient Advice and Liaison Services and the Care Quality Commission. There was also information in patients' information packs.

All staff were aware of the trust's complaints policy and knew how to handle complaints appropriately. They aimed to resolve any concerns informally in the first instance. Staff were able to give an example of how they managed a complaint while ensuring the patient who raised the complaint was free from discrimination and harassment. The manager followed up any concerns raised by patients; staff then fed this back to patients in the patient communication groups.

Staff received feedback on the outcome of investigation of complaints during staff meetings and by email. However, several staff told us they did not always receive feedback. This meant there may have been missed opportunities for staff to improve patient experience.

This core service received 18 complaints between 1 October 2016 and 30 September 2017 which accounted for 9% of complaints received by the trust overall.

This core service received 23 compliments during the last 12 months from 1 October 2016 to 30 September 2017, which accounted for seven per cent of all compliments received by the trust as a whole.

Is the service well led?

Leadership

Ward managers had a good understanding of the services they managed and used their skills, knowledge, and experience to ensure the wards remained safe for staff and patients. The service was undergoing a period of change, with the imminent closure of Rose Ward and the reconfiguration of forensic services as part of the sustainability transformation partnership for the region. The service manager and matron based at Clifton House focused on the way forward for that location and future service changes. However, the service manager did acknowledge staff morale was low across both sites due to uncertainty about the future and the impact of staff moves.

The trust commissioned an external trust to review its forensic services, and published the findings in March 2017 along with 24 recommendations. We saw the service had produced an action plan to implement changes at various recommended times. The action plan did not reflect progress with the actions or if any actions were completed. The trust provided minutes from quality initiative meetings, which showed discussion on the progress made.

Ward managers were visible on the wards and sometimes made up staffing number when there was a low fill rate. Across the service, all ward staff we spoke with felt well supported by their ward manager, but no higher. Staff at Clifton House told us the matron was visible to patients. Staff knew who their service manager was but were less familiar with leaders at senior board level. They reported the Chief Executive had visited their service recently and met with staff.

Vision and strategy

Since the previous inspection, the trust had revised its trust values. The trust had launched three new values with accompanying statements explaining the expected behaviours from staff, which would demonstrate the values in practice.

The three values were:

- We have integrity
  We treat everyone with respect and dignity, honour our commitments, and do our best for our service users and colleagues.
- We keep it simple
  We make it easy for the communities we serve and the people who work here to achieve their goals.
- We are caring
  We always show empathy and support those in need.

Most ward staff could describe one or more of the trust values. They were all aware the values had changed and knew the trust intranet site displayed information about the values. The staff appraisal process incorporated the trust values and behaviours to ensure staff worked in accordance with them.

The service had developed an initial proposal to reconfigure the forensic services to a low security, step-down rehabilitation and community forensic services. They acknowledged within the proposal itself, the limited opportunity for discussion with clinical staff regarding the detail of this proposal.

The service invited staff working at Clifton House to two drop-ins to discuss the future of the services at this location. The drop-ins took place on two separate afternoons in November 2017.

We saw evidence in team meeting minutes and a letter sent by the ward manager for ward two (women) that leaders shared information with the service regarding the sustainability and transformation partnership for the region.

Culture

Staff morale was low across the service. Staff we spoke with said they felt respected, supported and valued within their teams but made the clear distinction this did not extend further than ward manager level.

Staff had a clear understanding of whistleblowing process for raising concerns. Some staff said they felt able to raise concerns without fear of retribution but other staff members qualified this by saying it depended on the concern. All staff knew how to use the whistle-blowing process and about the role of the Speak Up Guardian.

All staff interviews on ward three identified problems with the culture on the ward. There was conflict between the multidisciplinary team and ward staff. The manager had undertaken a cultural survey with her team and was working with them to find a way forward. The team had scored below the recognised benchmark for cohesive team working. The remaining forensic wards at The Newsam Centre had undertaken the same survey but with better results.

Ward managers were clear on the process for dealing with poor performance. They gave specific examples of how they used the process within the forensic services in the last 12 months. There was one member of staff being performance managed at the time of the inspection.

The service was developing training around equality and diversity for staff to support cultural awareness in line with the trust wide policy. The service’s staff sickness and absence were higher than the average for the trust. Sickness levels due to stress were particularly high for five of the six wards in December 2017. Rose Ward had the highest stress related sickness levels. Staff had access to support for their own physical and emotional health needs through an occupational health service.

The trust recognised staff success through the yearly staff awards. Trust wide, individual staff members and teams received nominations to recognise their practice. In 2017, at Clifton House, Bluebell Ward, the occupational therapist for Riverfields Ward and domestic staff all won recognition awards in their category.

Governance

The governance systems in place were not always used to their full potential. During this inspection, we noted from team meeting minutes that managers reminded staff to report incidents relating to low staffing levels and record section 17 leave and activities appropriately. There were discrepancies in rotas, making it difficult to work out when staff had moved wards to cover other wards. Although patient record keeping was of an acceptable standard overall, there was a lack of consistency in recording notes in the same location within the electronic system used. However, senior staff were aware of the issues and the trust was tendering for a new electronic record keeping system.

The service had a system to monitor the quality and performance of each ward. The ward managers received a weekly performance report detailing sickness levels, occupancy rates, compliance with mandatory training and clinical supervision among others. Ward managers were aware of the need for improvements in the service's approach to providing and recording clinical supervision.

The service held monthly business meetings at team and directorate level. We reviewed the minutes of some of these meetings as part of our inspection. Ward consultants, senior managers, ward managers, senior staff nurse, and occupational therapy and dietician attended the monthly clinical governance meetings among others. These meetings reviewed information about the service and discussed items such as performance, incidents, risk register, and clinical audits.

At ward level, team meetings took place either weekly or monthly. It was obvious from minutes from these meetings that not all teams had a standing agenda for items. The minutes for ward two (women) clearly showed a discussion about an incident that occurred on the ward and evidence of learning from the incident.

Senior nurses carried out local clinical audits such as daily clinic room and equipment checks.

At our last inspection, there was a breach of Regulation 18 of the Health and Social Care Act (Regulated Activities) Regulations 2014. While the service had made improvements in compliance with mandatory training and had introduced a new system for recording supervision, the service was still in breach of this regulation.

The trust has provided a document detailing their 128 highest profile risks. The following relate to this core service and each of these has a current risk score of at least high (score of 8).

Key:

Extreme Risk (15-20)	High Risk (8-15)	Moderate Risk 3-6	Low Risk (0-2)

ID	Description	Risk level (initial)	Risk score (current)	Risk level (target)	Link to BAF strategic objective no.	Last review date
128	The use of estate is constrained by lack of clear clinical strategy for some services, potential tender changes/risks and lack of commissioner strategy/intent. (main services affected are Leaning Disability, Forensic CAMHS, Perinatal, Personality Disorder, Yorkshire Centre for Psychological Medicine).This is impacting the development of long term estate strategy and business cases for key changes required.	High	12	Moderate Risk	9	09/03/2017

579	Due to a high number of vacancies we are not always able to cover the out of hours supernumerary Band 6 Forensic Nurse Coordinator rota across both sites, and often have one band 6 nurse overseeing both sites, and sometimes none at all. This leaves band 5 nurses covering the units, and results in a reduced capacity to respond and the absence of any senior support / coordination. The FNC role was introduced following the outcome of an SUI as recommendation to prevent further incidents	High	9	Low Risk	1	25/10/2017
488	There have been problems with recruiting and retaining staff at the unit. Staff working within Clifton House may suffer from further stress/ pressure due to lack of staff available to assist. Activities/ therapies within the unit maybe limited due to reduced staffing.	Extreme Risk	15	Low Risk	1	01/11/2017

Management of risk, issues and performance

Staff maintained, and had access to, the risk register at ward or directorate level. Staff at ward level could escalate concerns when required. Team leaders attended governance meetings to explain and discuss these risks first hand prior to escalating to the board for further consideration. Staff concerns in relation to high vacancies and their impact on staff matched the risks identified on the risk register.

The service risk register was up to date. It highlighted ligature risks and actions, and an emerging staffing risk identified limited clinical leadership on ward two (women) due to vacancies, absence, and sickness levels.

The service had business continuity plans in place in the event of an emergency that threatened service delivery.

Information management

The trust used a number of tools and audits to collect data from the forensic service, which informed ward specific performance reports as well as service wide reports. They produced information reports regarding key areas of performance, such as mandatory training, appraisal rates, occupied bed rates, length of stay and discharges. This gave ward managers a breakdown of their current position and an overview of budget expenditure in areas such as staffing.

Staff had access to the electronic equipment and paper documents they needed to do their work. The electronic system supported staff to report incidents and manage their own performance,

although not all staff used the system to the same extent. The managers had oversight of the information they needed to support their roles. There was sufficient equipment and information technology available for staff to do their work.

The service made notifications to external bodies as required.

Engagement

The trust worked closely with external stakeholders such as commissioners and NHS Improvement. Commissioners had recently visited both services to see the standard of care and treatment provided.

Staff had access to the trust's intranet through which they received emails and updates about the trust. They also received updates at team meetings and through supervision.

Patients and carers could access information about the service through the trust website. The information available on the website gave a brief description of each ward and the contact details for each location.

Everyone had opportunities to give feedback about the service. This could be formal through surveys, and comment cards or informal by attending various meetings. Patients told us that they were able to feedback at their morning meetings and directly to staff.

Learning, continuous improvement and innovation

Team leaders for the service were participating in 'The Aston Team Journey' programme. This was a course designed to help managers improve team performance. Staff had opportunities to participate in research. The ward manager for ward three was undertaking a course on research. A qualified nurse at Clifton House was undertaking research on poly pharmacy. The service was part of the quality network for forensic services.

Child and adolescent mental health wards

Facts and data about this service

Location site name	Ward name	Number of beds	Patient group (male, female, mixed)
Mill Lodge Community Unit	CAMHS Inpatient	16	Mixed

Leeds and York Partnership NHS Foundation Trust has one child and adolescent mental health ward.

Mill Lodge is a sixteen bed unit which provides care and treatment for children and young people up to the age eighteen.

The methodology of CQC provider information requests has changed, so some data from different time periods is not always comparable. We only compare data where information has been recorded consistently.

Is the service safe?

Safe and clean care environments

Safety of the ward layout

There were no mixed sex breaches reported by the trust for this ward between 1 October 2016 and 30 September 2017.

The trust had undertaken a ligature risk assessment on the CAMHS inpatient ward on 22 May 2017. No high level risks were identified.

The layout of the ward did not allow staff to observe all parts of the ward. This was however, mitigated by staff presence in those areas. At night staff were positioned around the ward so that they were able to observe these areas. Although there were some ligature risks on the ward, staff managed these through different levels of observations, good risk assessments and care plans. Some rooms were only accessible with staff present due to risks such as the occupational therapy kitchen. Staff carried personal alarms.

Maintenance, cleanliness and infection control

For the most recent patient-led assessments of the care environment (PLACE) assessment (2017) the location scored better than similar trusts for three of the four aspects overall.

Site name	Cleanliness	Condition appearance and maintenance	Dementia friendly	Disability
Mill Lodge Community Unit	99.48%	98.28%	-	93.84%
Trust overall	**99.37%**	**98.30%**	**99.72%**	**93.96%**
England average (Mental health and learning disabilities)	**98.40%**	**95.13%**	**85.53%**	**86.94**

The ward was bright, clean and well maintained. On the day of our visit the ward was very hot. Staff informed us that this was due to the fact there were no controls for the heating; there was only the option to have it on or off with no temperature thermostat. Staff reported they had complained about this before, but nothing had been done about it.

Seclusion room (if present)

The ward had a high dependency room used for seclusion. At our last inspection, we found that staff were unclear about what constituted seclusion and therefore were not following the Mental Health Act Code of Practice when it occurred. At this inspection, we found that this had been fully resolved. Staff completed seclusion paperwork correctly and for patients who used the high dependency room as part of their care plan when they became agitated or upset this was clearly documented and the patient was able to leave whenever they chose to. The seclusion room had clear observation and a separate shower and toilet area. There was no two way communication system but staff explained that they would always be in the room with the patient when it was being used.

Clinic room and equipment

The clinic room was clean and tidy. Clinic room checks were completed on the night shift by the qualified nurse on duty; this included equipment such as oxygen and the resuscitation bag. Pharmacy visited the ward regularly and monitored stock levels and ordering of medications.

Fridge temperatures were monitored on a daily basis and we found the records to be complete and up to date.

Safe staffing

Nursing staff

Definition

Substantive – All filled allocated and funded posts.
Establishment – All posts allocated and funded (e.g. substantive + vacancies).

Substantive staff figures			**Trust target**
Total number of substantive staff	30 September 2017	29.19	N/A
Total number of substantive staff leavers	1 October 2016 – 30 September 2017	11.80	N/A
Average WTE* leavers over 12 months (%)	1 October 2016 – 30 September 2017	37%	10% - 15%
Vacancies and sickness			
Total vacancies overall (excluding seconded staff)	30 September 2017	11.20	N/A
Total vacancies overall (%)	30 September 2017	28%	N/A
Total permanent staff sickness overall (%)	30 September 2017	5.34%	3.7%
	1 October 2016 – 30 September 2017	3.9%	3.7%
Establishment and vacancy (nurses and care assistants)			
Establishment levels qualified nurses (WTE*)	30 September 2017	18.30	N/A
Establishment levels nursing assistants (WTE*)	30 September 2017	13.27	N/A
Number of vacancies, qualified nurses (WTE*)	30 September 2017	6.90	N/A
Number of vacancies nursing assistants (WTE*)	30 September 2017	2.08	N/A
Qualified nurse vacancy rate	30 September 2017	38%	N/A
Nursing assistant vacancy rate	30 September 2017	16%	N/A
Bank and agency Use			
Shifts bank staff filled to cover sickness, absence or vacancies (qualified nurses)	1 October 2016 – 30 September 2017	72	N/A
Shifts filled by agency staff to cover sickness, absence or vacancies (Qualified Nurses)	1 October 2016 – 30 September 2017	311	N/A
Shifts NOT filled by bank or agency staff where there is sickness, absence or vacancies (Qualified Nurses)	1 October 2016 – 30 September 2017	47	N/A
Shifts filled by bank staff to cover sickness, absence or vacancies (Nursing Assistants)	1 October 2016 – 30 September 2017	803	N/A
Shifts filled by agency staff to cover sickness, absence or vacancies (Nursing Assistants)	1 October 2016 – 30 September 2017	399	N/A
Shifts NOT filled by bank or agency staff where there is sickness,	1 October 2016 – 30 September 2017	364	N/A

absence or vacancies (Nursing Assistants)			

*Whole-time Equivalent

The core service reported a vacancy rate for all staff of 28% as of 30 September 2017. The overall vacancy rate fluctuated over the 12-month period ranging from 12% to 30%.

The core service reported an overall vacancy rate of 38% for registered nurses at 30 September 2017. The core service has had a least 5.90 WTE (32%) vacancies for qualified nurses for the last six months.

The core service reported an overall vacancy rate of 16% for registered nursing assistants. The vacancy rate for nursing assistants fluctuated over the 12-month period ranging from 2% to 32%.

	Registered nurses			Health care assistants		
Ward/Team	**Vacancies**	**Establishment**	**Vacancy rate (%)**	**Vacancies**	**Establishment**	**Vacancy rate (%)**
CAMHS Inpatient	6.90	18.30	38%	2.08	13.27	16%
Core service total	6.90	18.30	38%	2.08	13.27	16%
Trust total	**120.06**	**765.64**	**16%**	**89.65**	**614.56**	**15%**

NB: All figures displayed are whole-time equivalents

	Overall staff figures		
Ward/Team	**Vacancies**	**Establishment**	**Vacancy rate (%)**
CAMHS Inpatient	11.20	40.50	28%
Core service total	11.20	40.50	28%
Trust total	**257.28**	**2028.82**	**13%**

NB: All figures displayed are whole-time equivalents

Between 1 October 2017 and 1 September 2017, bank staff filled 76 shifts to cover sickness, absence or vacancy for qualified nurses. In the same period, agency staff covered 311 shifts for qualified nurses and 47 shifts were unable to be filled by either bank or agency staff.

Ward/Team	Shifts filled by bank staff	Shifts filled by agency staff	Shifts NOT filled by bank or agency staff
CAMHS Inpatient	76	311	47
Trust Total	**52673**	**184336**	**5150**

Between 1 October 2017 and 1 September 2017, 803 shifts were filled by bank staff to cover sickness, absence or vacancy for nursing assistants. In the same time period, agency staff covered 339 shifts and 364 shifts were unable to be filled by either bank or agency staff.

Ward/Team	Shifts filled by bank staff	Shifts filled by agency staff	Shifts NOT filled by bank or agency staff
CAMHS Inpatient	803	339	364
Trust Total	52673	184336	5150

This core service had 11.8 (37%) staff leavers between 1 October 2016 and 30 September 2017.

Ward/Team	Ave. Substantive staff	Substantive staff Leavers	Average % staff leavers
CAMHS Inpatient	31.57	11.80	37%
Core service total	**31.57**	**11.80**	**37%**
Trust Total	**1801.83**	**166.73**	**9%**

The sickness rate for this core service was 3.9% between 1 October 2016 and 30 September 2017. The most recent month's data (September 2017) showed a sickness rate of 5.4%. This was better than the 5.8% sickness rate reported at the last inspection in March 2016.

The sickness rate for qualified nurses was less than 1% for six of the last seven months.

Ward/Team	Total % staff sickness (at latest month)	Ave % permanent staff sickness (over the past year)
CAMHS Inpatient	5.4%	3.9%
Core service total	**5.4%**	**3.9%**
Trust Total	**4.5%**	**5.3%**

The below table covers staff fill rates for registered nurses and care staff during July 2017, August 2017 and September 2017. Mill Lodge had below 90% of planned daytime nurses and care staff in August 2017. Between July and September 2017, Mill Lodge did not have 100% fill rate for nurses at any point.

Key:

> 125%	**< 90%**

	Day		**Night**		**Day**		**Night**		**Day**		**Night**	
	Care Staff	Nurses	Care Staff	Nurses	Care Staff	Nurses	Care Staff	Nurses	Care Staff	Nurses	Care Staff	Nurses
	September 2017				**August 2017**				**July 2017**			
Mill Lodge	100.4	68.09	105	94.9	76.1	67.7	121.4	87.3	99.1	70.9	104.8	95.2

The ward ran on a three shift system, early, late and night shift. On an early shift there were six staff which included a minimum of two qualified staff and four healthcare support workers. This was the same on the late shift with one member of staff working a twilight shift that ended at 23:00. On a night shift there were four staff; one qualified nurse and three healthcare support workers. The ward had reported a vacancy rate of 38% in September 2017 which equated to six qualified staff. However, during our inspection we found that these vacancies had all been filled except one. The one that had not been filled was being advertised and there were plans for interviews to be held later in the month.

The ward had also employed a new catering assistant (who was due to start the week after the inspection) who would be responsible for the ordering, storing and serving of food on the ward. This was previously done by the healthcare support workers on the ward and the ward manager was pleased that this new role would allow the support staff to spend more time on direct patient care.

The ward had also employed a family therapist in order to assist the psychologists already in place with family therapy. The ward staff felt this was an important part of the treatment they offered to the patients and having a dedicated member of staff to do this would ensure that all families were offered this therapy.

The ward manager was able to request extra staff when needed for example, when patients had appointments outside of the unit or when patients required higher levels of observations.

The ward had a small pool of local bank and agency staff that were experienced in working with young people with mental health problems. This meant that where possible staff who knew the ward were on duty when non-permanent staff were used.

During our inspection we discussed the high turnover rate of staff for the previous twelve months (37%). The majority of these staff had left for a promotion either in the community or at a private child and adolescent service.

Over the period where vacancy rates had been high there had also been high numbers of shifts that were unable to be filled by bank and agency (364). In addition to this, over July, August and September shifts fill rates for qualified staff were below 90%. We discussed this during and inspection and explored how this was managed. If there were less staff than required at the start of shift the shift coordinator would see if any of the permanent staff were willing to stay on for the next shift. They would also review planned activities and amend them to match the staffing levels.

Any event where staffing was below the required amount was also recorded as an incident and this then fed up to the senior management team to review and take any wider actions required. The clinical services manager on call would also be notified if the ward could not manage with the number of staff they had in order to source staff from other areas.

Bank and agency staff were given a local induction when they worked on the ward. This included fire safety procedures, resuscitation equipment location, observation policy and where to locate alarms and keys. Bank staff also attended the trust induction prior to commencing any shifts in the trust. Staff would always show them around and introduce them to patients on the ward.

There were enough staff on duty should an incident occur. Staff wore alarms so that they could summon assistance if needed. One hundred percent of staff had completed the trust personal safety training and eighty three percent of staff had completed the High Level Physical Interventions with Breakaway skills

During our inspection, there were staff visible on the ward at all times. Patients told us that staff were available to speak to when they needed them and that leave and activities were rarely cancelled.

Activities were available seven days a week. There were activity coordinators who were employed for this sole purpose; they worked into the evenings and at weekends. Patients also attended education during school term time and this was facilitated by teaching staff.

Medical staff

There were two consultant psychiatrists allocated to the ward, along with their juniors who provided adequate medical cover day and night to the unit.

Between 1 October 2016 and 30 September 2017, medical agency staff to cover sickness, absence or vacancy for medical locums, filled 1% of shifts.

Six of the “total shifts” were for consultants but were filled by “middle grade” staff. The trust told us that “whilst the trust is discussing the transition of medical staff on to the e-Rostering system, the exact data in relation to medical staffing deployment has to be derived from other sources. Until we transition across to e-Rostering the rationale for appointing an agency locum on either less shifts or on a lower grade than the substantive post is held only with the service and is not available centrally.

The top box on the medical agency locum tab has been derived from the contractual hours of each employee held in ESR plus the additional PAs and hours that Consultant and Jnr Doctors do respectively. For example, 1 WTE Consultant is classed as 40hrs. 40hrs is equivalent to 5 shifts p/w. Any additional PAs are classed as shifts and any additional hours for a Jnr Dr are classed as 1 shift. Therefore a 1 WTE Consultant with 3 PA’s would be considered to work 8 shifts p/w or 32 shifts per month.”

Ward/Team	Available shifts	Shifts filled by bank staff	Shifts filled by agency staff	Shifts NOT filled by bank or agency staff
CAMHS Inpatient	456 (Consultant)	-	6 (Middle Grade)	0
Core service total	456	-	6 (1%*)	0 (0%)
Trust Total	45168	-	1037 (2%)	84 (<1%%)

* Percentage of total shifts

Mandatory training

The compliance for mandatory and statutory training courses at 30 September 2017 was 86%. Of the training courses listed, 10 were below the trust target of 85% and of those, four failed to score above 75%.

These four were ‘Safeguarding children level 2’ (50%), ‘Moving and Handling Essentials’ (57%), ‘Safeguarding children Level 3’ (64%) and ‘Food Safety Level 2’ (74%).

Training figures for ‘Safeguarding children level 1’ were not provided for this core service. This was because level 2 was a minimum for this service.
The training compliance reported for this core service during this inspection was better than the 76% reported at the last inspection.

Key:

Below CQC 75%	Between 75% & trust target	Trust target and above

Training course	This core service %	Trust wide %
Information Governance	100%	92%
Personal Safety with Breakaway Skills	100%	85%
Equality and Diversity	96%	96%
Duty of Candour	96%	98%
Trust Induction	96%	99%

Food Regeneration	94%	82%
Fire - Level 3	93%	81%
Fire - Level 2	92%	91%
Mental Health Legislation Awareness - Level 1	92%	90%
Safeguarding Adults	89%	95%
Infection Control - Clinical	89%	81%
Health and Safety	88%	96%
Clinical Risk	88%	82%
High Level Physical Interventions with PSTS and Breakaway skills	83%	89%
Mental Health Act - Inpatient - Level 2	83%	78%
Immediate Life Support	79%	78%
Essential Life Support	79%	87%
Mental Capacity Act and DoLs - Level 2	79%	85%
Moving and Handling Principles	75%	90%
Food Safety Level 2	*74%*	88%
Safeguarding children Level 3	*64%*	81%
Moving and Handling Essentials	*57%*	80%
Safeguarding children Level 2	*50%*	82%
Core Service Total %	86%	90%

The mandatory training compliance rate for the ward was 86%. There were four courses below 75%. These were; food safety level 2, Safeguarding children level 2 (50%) and 3 (64%) and moving and handling essentials (57%). There had been some problems with staff accessing the face to face element of the safeguarding children training as this was offered in Leeds only. For some staff this was a very long journey and it was not possible for them to get there. The ward manager and the service manager had arranged for the training to be completed on site so that all staff requiring the training could attend. This was happening the week of our inspection and we were able to see that once this was completed the compliance rate for these courses would be above 80%. By the time of our inspection, moving and handling essentials was up to 83% for this core service. The ward also had access to the moving and handling team for specialist advice if they needed specific help around a particular patient.

Assessing and managing risk to patients and staff

Assessment of patient risk

The ward used a risk assessment tool known as “SAMP” (the safety assessment and management plan tool). Prior to a patient’s admission the ward would receive a referral for the patient which included the risk history. Then on admission, the admitting nurse would complete the ward risk assessment tool. We reviewed eight sets of care records and found them all to have an up to date comprehensive risk assessment that was updated promptly when an incident occurred or a risk had changed. Risks and observation levels were discussed during the handover and the weekly ward round for patients.

Management of patient risk

There was a trust observation policy which guided staff on how to safely manage patients whilst on the ward. These ranged from hourly observation for someone with lower levels of risk to thirty minutes then ten minutes and then one-to-one either within arms’ length or eyesight. Staff were

aware of the policy and carried out observations in accordance with this. During handover and ward rounds, observation levels were discussed in order to ensure that patients were nursed in the least restricted way possible. This included trial periods on lower levels of observations and lower levels of observations at night time if risks were mainly focused around daytime.

Use of restrictive interventions

We did not find any evidence of blanket restrictions on the ward.
This core service had 306 incidents of restraint (on 48 different service users) and 151 incidents of seclusion between 1 October 2016 and 30 September 2017.

Ward name	Seclusions	Restraints	Patients restrained	Of restraints, incidents of prone restraint	Rapid tranquilisations
Mill Lodge (CAMHS Inpatient)	151	306	48	3 (1%)	0 (0%)
Core service total	151	306	48	3 (1%)	0 (0%)

The number of restraint incidents reported during this inspection (306) was higher than the 166 reported in the previous 12 months. The number of service users' that restraint was used on during this inspection (48) was more than double the 21 service users restrained in the previous 12 months.

There were three incidents of prone restraint, which accounted for 1% of the restraint incidents. The number of prone restraint incidents reported during this inspection was lower than the nine reported in the previous 12 months.

Over the 12 months, there was a lot of fluctuation in the use of restraint. In January and February 2017 there were 42 restraint incidents in each month and in March this number dropped to seven and in May it increased to 30.

Between 1 October 2016 and 30 September 2017 there were no incidents resulting in the use of rapid tranquilisation for this core services. There have been no instances of mechanical restraint over the reporting period.

We discussed with the ward staff and the ward manager the reason for the increase in the number of restraints over the last twelve months. Staff felt that in general the patient population were more challenging now than in previous years. This may be due to the fact community services are now larger and the focus is more on keeping patients at home unless it is absolutely necessary to admit them. There were longer waits for psychiatric intensive care units with the ward needing to use private beds for this as the trust did not have a child and adolescent psychiatric intensive care unit. The lack of a trust psychiatric intensive care unit was highlighted on the trust risk register. This was well known to the commissioners for the service and was also being considered on a national level. They were in talks with NHS England regarding the possibility of transforming part of Mill Lodge into twelve high dependency beds. The trust had been joint talks with NHS England and an architect to discuss how this could be progressed. The trust were awaiting the publication of the new NHS England Tier 4 child and adolescent mental health service specifications (to ensure plans are consistent with these) and will be progressing this work once these are available. During our inspection one patient had been waiting over three weeks for a private intensive care bed, this had meant that the ward staff had been using more restraint for this unwell patient on a daily basis. By speaking to staff and reviewing records we were able to see that restraint was only ever used as a last resort and that staff were skilled in using verbal de-escalation and distraction skills. In order to manage the impact on other patients during these times the ward ensured that there were lots of therapeutic activities available. The occupational therapy team and activity staff were outside of the staffing numbers so were able to ensure this continued for the other patients

whilst staff were caring for the more unwell patients. Activities were available at all times and outside of normal working hours (evenings and weekends). There were also lots of areas around the ward where patients could go for some quiet relaxing time.

Over the 12 months, there was an increase in the use of seclusion in January and February 2017, where there were a total of 31 and 26 instances respectively.

The number of seclusion incidents reported during this inspection (151) was more than three times higher than the 43 reported in the previous 12 months.

At our last inspection we found that staff were unclear about what constituted seclusion and we asked them to improve on this. For example, when patients went to the high dependency area of their own will but were stopped from leaving, this was not documented as an episode of seclusion. During this inspection we found that this was not the case and that staff were all very clear about what constituted seclusions and the associated paperwork was filled in correctly and in a timely manner. This may account for the increase in the number of seclusion episodes recorded as well as the lack of psychiatric intensive care beds for the child and adolescent service in general and the fact that community services were trying to manage more unwell patients in the community with the introduction of crisis teams.

There have been no instances of long term segregation in the last 24 months.

Safeguarding

Safeguarding training was part of the mandatory training at the trust. Safeguarding adults training was at 83% compliance at the time of our inspection. Safeguarding children level 2 and 3 had a compliance rate of 50% and 64% respectively. There had been some problems with staff accessing the face to face element of the safeguarding children training as this was offered in Leeds only. For some staff this was a very long journey and it was not possible for them to get there. The ward manager and the service manager had arranged for the training to be completed on site so that all staff requiring the training could attend. This was happening the week of our inspection and we were able to see that once this was completed the compliance rate for these courses would be above 80%.

Staff knew what constituted a safeguarding concern and how to report it. The trust had a central safeguarding team staff used for guidance and to liaise with local safeguarding authorities. Managers discussed safeguarding in team meetings and they discussed any concerns in handover meetings.

A safeguarding referral is a request from a member of the public or a professional to the local authority or the police to intervene to support or protect a child or vulnerable adult from abuse. Commonly recognised forms of abuse include: physical, emotional, financial, sexual, neglect and institutional.

Each authority has their own guidelines as to how to investigate and progress a safeguarding referral. Generally, if a concern is raised regarding a child or vulnerable adult, the organisation will work to ensure the safety of the person and an assessment of the concerns will also be conducted to determine whether an external referral to Children's Services, Adult Services or the police should take place.

This core service made three safeguarding referrals between 29 September 2016 and 1 October 2017, all of which concerned children.

Referrals

Adults	Children	Total referrals
0	**3**	**3**

The trust said they had been named in or involved in a serious case review in the last 12 months. This related specifically to this core service but the serious case review is still at 'panel stage' so final recommendations are not yet identified.

Staff access to essential information

The ward used an electronic records system and medication system. This was accessed using a password which meant that staff were able to access information when required. Some records were kept as a paper record which was later scanned onto the electronic system. This included some physical health checks which were kept in a paper file so they were quickly accessible in an emergency situation. Computers to access records were kept in a locked office where staff only had access to.

Medicines management

We reviewed eight medication charts. Medications were dispensed using an electronic prescription management system. This is a system used to reduce medication errors and prescribing error. Charts on the electronic system were easy to access for staff with a password and as all information was typed, charts were clear and legible. We found no issues with medication storage, dispensing or ordering.

Medication was stored in a locked cabinet in the clinic room. At the time of our inspection there were no controlled drugs being stored on the ward. However, should someone be admitted on a controlled drug there was a cabinet which complied with guidelines for the storage of controlled drugs.

Records showed that where rapid tranquilisation was used, staff followed the trust policy for post dose monitoring. This was recorded on the patient physical health monitoring forms that were then uploaded later to the electronic system.

Track record on safety

Providers must report all serious incidents to the Strategic Information Executive System (STEIS) within two working days of an incident being identified. Between 1 October 2016 and 30 September 2017 there were no serious incidents reported by this core service.
We asked the trust to provide us with the number of serious incidents from the past 12 months. The number of the most severe incidents recorded by the trust incident reporting system was comparable with STEIS.

The number of serious incidents reported during this inspection was the same as the last inspection (zero).

Reporting incidents and learning from when things go wrong

The Chief Coroner's Office publishes the local coroners Reports to Prevent Future Deaths which all contain a summary of Schedule 5 recommendations, which had been made, by the local coroners with the intention of learning lessons from the cause of death and preventing deaths.

In the last two years, there has been one prevention of future death' reports sent to the trust but it did not relate to this core service.

Staff used an electronic incident reporting system. They were able to tell us what kind of incidents were reported and how this was done. Dependent on the type of incident it was copied to various departments, for example, if it was an incident involving restraint the managing violence and aggression team were automatically copied in. This ensured the correct people were aware of incidents so they could be managed in the correct way. Managers and senior nurses had permission to view and manage incidents in order for them to check they had been correctly completed and that actions were followed up on.

Is the service effective?

Assessment of needs and planning of care

We reviewed eight care records during our inspection. All of those contained a care plan and risk assessment that was completed on admission. We were able to see evidence of baseline physical health checks being completed on admission and continuously throughout a patients stay. We found that patients were involved in the completion of their care plans and their own goals and coping strategies were included in the plan. Patients were given a copy of their care plan and where this had been refused it was documented clearly.

Although records were kept mostly on the trust's electronic recording system, some records remained in paper format. This included physical health monitoring. This was so they could be quickly sent with the patient in an emergency. These were uploaded onto the electronic system periodically.

Best practice in treatment and care

This core service participated in two clinical audits as part of their clinical audit programme 2016 - 2017.

Audit name	Audit scope	Audit type	Date completed	Key actions following the audit
Audit of MARSIPAN assessment guidelines in Inpatient CAMHS	CAMHS	Clinical	03/07/2017	1. Review PARIS entries/ MDT sheets in June and August 2017. 2. Creation of local standard. Marsipan preformat to be discussed while care planning on admission. Care plan to be done within 5 days of admission New standard shared with the team. 3. Ensure glucose tubes are provided to increase adherence to Blood glucose monitoring on admission. Check every 5-6 months or so.
The assessment of capacity or competence on young people in an inpatient child and adolescent psychiatry unit.	CAMHS	Clinical	26/05/2017	Discussion at MDT to inform staff, including medical and non-medical staff To be reviewed at each MDT meeting (weekly) Email to be sent to doctors on the unit with the template attached

Medications were prescribed in line with National Institute for Health and Care Excellence guidance. These guidelines included- 'Self-harm in over 8s: long-term management clinical guideline' [CG133] and 'depression in children and young people: identification and management' (CG28). The ward also admitted young people with an eating disorder and followed Junior Marsipan guidance in relation to anorexia nervosa. There was also an up to date British National Formulary for children in the clinic room.

Staff used Health of the Nation outcome scales to monitor severity of patient needs and outcomes.

There were plans to introduce the safe wards model on the ward later in the year.

There were a number of clinical audits that were carried out on the ward, including outcome measures, supervision, care plans, seclusion and risk assessments. Following the last inspection, where a breach in regulation was given around the documentation of seclusion and recognition of when seclusion began, there was a seclusion audit introduced to ensure that documentation was filled in correctly for anyone entering seclusion. At this inspection, we found no issues with seclusion paperwork. Following the audit of MARSIPAN assessment guidelines in Inpatient child and adolescent mental health services there had been in improvement of monitoring of risk factors for example, assessment of irregular heart rhythm (previously 57%, currently 100% adherence) and muscular strength: SUSS Test (previously 29%, currently 100% adherence) within 24 hours of admission.

Skilled staff to deliver care

The disciplines on the ward consisted of doctors, nurses, occupational therapist, dietitian, psychologist and trainee psychologist, healthcare support worker, domestic staff and administration staff.

Staff had access to supervision on a monthly basis and this included group and one-to-one supervision. There were also reflective practice sessions facilitated by an outside agency. Staff reported they found this meaningful and that as the person did not work for the trust they felt they got a lot out of the session, as they could be completely open and honest. The trust had introduced a new system for recording clinical supervision; this was now recorded by the individual staff member on their personal learning account. As this was a new system recently implemented it meant that not all staff were confident yet with using the new system. This had impacted upon the recording data as at the time of our inspection, managers held figures in excess of this and all staff reported receiving clinical supervision. Managers were encouraging staff to ensure they recorded this in the correct system when it took place.

New staff that joined the ward had a three week induction prior to commencing work on the ward. This included mandatory training as well as an introduction to the trust. Staff who were new to their role spoke positively about the trust induction.

The manager was confident to manage staff that were underperforming with support from human resources. At the time of our inspection there was nobody being performance managed.
The trust's target rate for appraisal compliance is 85%. As at 8 November 2017, the overall appraisal rates for non-medical staff within this core service was 93%. The rate of appraisal compliance for non-medical staff reported during this inspection was better than the 86% reported at the last inspection.

Ward name	Total number of permanent non-medical staff requiring an appraisal	Total number of permanent non-medical staff who have had an appraisal	% appraisals
CAMHS Inpatient	30	28	93%
Core service total	**30**	**28**	**93%**
Trust wide	**2028**	**1596**	**79%**

The trust's target rate for appraisal compliance was 85%. There was no medical appraisal information provided for this core service.
Between 1 April 2017 and 1 October 2017 the clinical supervision rate for the ward was 35% against the trust's target of 85%.

Caveat: there is no standard measure for clinical supervision and trusts collect the data in different ways, it's important to understand the data they provide.

The rate of clinical supervision reported during this inspection was worse than the 62.7% reported at the last inspection.

Ward name	Clinical supervision sessions required	Clinical supervision sessions delivered	Clinical supervision rate (%)
CAMHS Inpatient	164	57	35%
Core service total	**164**	**57**	**35%**
Trust Total	**11598**	**6674**	**58%**

Multi-disciplinary and interagency team work

Multi-disciplinary team meetings happened on a Tuesday and Wednesday. This was a chance for patients and families to meet with the doctor formally. Some patients preferred not go into the ward round so their named nurse filled in a document with them prior to the ward round that allowed their views to be shared with the team. There were daily handovers at the change of each shift (three times per day) where each patient was discussed and an overview of the last 24 hours was given. This included any risks, changes in observation levels, leave, incidents as well as the general mental state of the patient. All staff disciplines were involved in the handover in the morning including occupational therapists, psychologists and doctors.

Staff on the ward reported good working relationships with the community mental health teams and social services. The school on the ward had two teachers who kept in contact with the young person's home school to ensure the work they were doing whilst in hospital matched with the work they were doing at school.

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

Staff we spoke to had a good understanding of the Mental Health Act and the Code of Practice. Mental Health Act training was mandatory for qualified staff only. However, we found that all staff had a general understanding for example, checking people's leave status before taking them off the ward and ensuring that informal patients knew they had a right to leave.

We reviewed patient records and found that patients were given their rights under section 132 at appropriate intervals and when there were any changes to their detention status. Patients had signed to say that they understood them and if they hadn't there was clear documentation of why they had not signed and further attempts to explain rights were documented. For all patients the correct legal authority was in place for treatment and where necessary second opinion doctors had been requested in a timely way. There was support from the Mental Health Act administrator who sent reminder emails to staff when rights were due and when detentions were due to expire. Staff reported they found this helpful but also kept a note in the ward diary to ensure these were not missed. Informal patients were made aware of their right to leave and this was detailed in signs around the ward.

The ward had access to an independent mental health advocate who attended ward rounds and supported young people when decisions were being made about their care and treatment. The patient advice and liaison service representative had an open invite to the young person's council and had attended the council twice over the last eight months.

In addition to the current provision, the unit were looking at working with a local mental health charity which would deliver a two hour fortnightly drop in with an advocate and a staff member, over 48 weeks of the year (allowing for holidays). Their first visit was planned for February 2018.

The trust provided details of two Mental Health Act related courses for this core service and the training compliance for each as of 30 September 2017. These were ‘Mental Health Legislation Awareness - Level 1’ (92%) and ‘Mental Health Act - Inpatient - Level 2’ (83%).
The trust stated that these training courses were mandatory, but not statutory, and should be renewed every two years.
The training compliance reported during this inspection (for both training courses) was better than the 74% reported for ‘Mental Health Legislation Awareness - Level 1’ and the 60% reported for ‘Mental Health Act - Inpatient - Level 2 ‘at the last inspection.

Good practice in applying the Mental Capacity Act

The trust provided training in the Mental Capacity Act. Staff we spoke to during the inspection had a good understanding of its guiding principles. Staff told us if they had concerns about anything to do with a patient’s capacity they would contact the Mental Health Act team for support and advice. For young people under sixteen their decision-making ability is assessed under Gillick Competency, this recognises that some children under sixteen may be capable of making decisions for themselves. Staff received training in Gillick Competency and staff we spoke to were able to explain this concept to us. Capacity was discussed during ward rounds and we saw evidence in patient records of where staff had ensured where possible young people made decisions for themselves with support from staff.

As of 30 September 2017, 79% of the workforce in this core service had received training in the ‘Mental Capacity Act and DoLs - Level 2 ‘.The trust stated that this training course was mandatory but not statutory and should be renewed every two years.

The training compliance reported during this inspection was better than the 63% reported at the last inspection.

The trust told us that there were no Deprivation of Liberty Safeguard applications made to the Local Authority for this core service between 1 October 2016 and 30 September 2017. Deprivation of liberty safeguards only apply to patients that were over sixteen years of age and would be done via court.

Is the service caring?

Kindness, privacy, dignity, respect, compassion and support

During our inspection we observed staff showing patients respect and kindness when caring for them. We saw that staff had a good understanding of individual patient needs and ensured care was delivered in line with each individual's care plan. Patients told us that staff were kind and genuinely cared about their wellbeing. Patients told us they felt safe and that staff were always around if they wanted to talk to them.

During the clinical governance meeting we observed a representative from the patient council attend to summarise any issues raised by the other patients that week. Staff listened to this person and ensured their questions were answered. Staff also took time to give answers to previous questions asked by the council at the last meeting. This included items such as showers draining slowly, the suggestion of more relaxation sessions and rules around patients changing the radio station too frequently. Where possible patients were encouraged to sort these issues amongst themselves for example with the radio it was suggested that patients meet together and set some timescales for changing the radio station and write them down so all patients were in agreement.

The 2017 patient-led assessments of the care environment (PLACE) score for privacy, dignity and wellbeing at Mill Lodge Community Unit scored worse than similar organisations. During our inspection we reviewed this area and found that privacy and dignity was respected at Mill Lodge. For example, we saw staff knocking and waiting prior to entering patient bedrooms. All rooms were single occupancy, not en-suite but there were plenty of bathrooms and all in appropriate areas for privacy when accessing. There were privacy screens on bathroom doors and curtains so if the door opened people could not see in. There were private rooms where patients could make calls and have visitors; the treatment room had a sign on when medication was being dispensed so that other people did not come in. There was lockable storage for each patient.

Patients had access to television and radio and were able to choose what to watch, part of the patient council meeting which was presented at the meeting we observed contained a discussion between the young people about how they could manage the choice of stations and staff encouraged them to come up with a solution between themselves.

Site name	Privacy, dignity and wellbeing
Mill Lodge Community Unit	88.38%
Trust overall	93.96%
England average (mental health and learning disabilities)	89.64%

Involvement in care

Involvement of patients

On admission, patients were orientated to the ward by a member of staff. If possible, the patient would also be invited to visit the ward prior to admission. There was a welcome pack that patients received on arrival, this detailed information such as mealtimes, visiting arrangements, therapeutic programme and complaints information.

Patients were involved in their care plans and we saw evidence of this when reviewing care records. Patients were offered a copy of their care plan.

The patient council gave patients a voice on the ward. This was a monthly meeting where patients could raise any issues that they wanted. This could include issues with food, facilities on the ward and activities/leave. There were also daily community meetings where patients could discuss their plans for the day and any leave requirements.

There was information in the welcome pack about access to advocacy. The advocacy service used was not specifically for children and adolescents. We raised this at our last inspection. The trust had done some work to try and seek out an advocacy service specifically for young people. The trust had procured a local advocacy service to provide them with advocacy services commencing February 2018. This was going to be based on a two hour fortnightly drop in with advocate and a staff member over 48 weeks of the year.

Involvement of families and carers

Carers were given information about the ward when their loved one was admitted. This included information around visiting, telephone numbers and ward round days. Parent/carer wishes were discussed in ward rounds and families and carers were involved in the planning of their relative's care. Staff always ensured they met with carers/relatives post leave (with patient consent where necessary) to assess how the leave had gone and parents received feedback on formulation sessions in order for them to understand the reasons why staff managed certain behaviours in a certain way. Due to the fact that a lot of relatives lived some distance away, there was not an active carers group on the ward. The ward manager had met with relatives before Christmas to discuss the possibility of starting one up again and if they would be interested. This work is ongoing and relatives of current patients appeared to be open to the idea when approached.

Is the service responsive?

There were no ward moves reported for this core service between 1 October 2015 and 30 September 2017.

Transfers to specialist child and adolescent mental health service (such as psychiatric intensive care unit or other specialist tier 4 provision) were not recorded locally by the trust as an out of area placement. They reported this was because these services were commissioned regionally or nationally, with no in area provision.

They were however, recorded by the case managers from specialised commissioning. The ward worked closely with them, and were able therefore to access both current and historic information relating to all placements in specialised services for any children/adolescents from their area. This information was looked at in local provider meetings and in discussions with commissioners.

There were no ward moves at night reported for this core service between 1 October 2016 and 30 September 2017.

Access and discharge

Bed management

The trust provided information regarding average bed occupancies for the ward between 1 October 2016 and 30 September 2017. The bed occupancy largely ranged below the CQC benchmark of 85% with the exception of June and July 2017 where the range was slightly higher than 85%.

Ward name	Average bed occupancy range (October 2016 – September 2017) (current inspection)
CAMHS Inpatients	45.56% - 87.30%

The trust provided information for average length of stay for the period 1 October 2016 to 30 September 2017. The ward had an average length of stay which ranged between 23.5 days and 86.9 days.

Ward name	Average length of stay range (1 October 2016 – 30 September 2017) (current inspection)
Ward 1	23.5 days – 86.9 days

This core service reported no out area placements between 17 October 2016 and 1 October 2017.

This core service reported seven readmissions within 28 days between 1 October 2016 and 30 September 2017. The average of days between discharge and readmission was 14 days. There were no instances where patients were re-admitted on the same day as being discharged and there were no instances where patients were readmitted the day after being discharged.

Ward name	Number of readmissions (to any ward) within 28 days	Number of readmissions (to the same ward) within 28 days	% readmissions to the same ward	Range of days between discharge and readmission	Average days between discharge and readmission
CAMHS Inpatient	7	7	100%	2 - 28	14

Discharge and transfers of care

Between 1 October 2016 and 30 September 2017 there were 69 discharges within this core service, of which three were delayed. This amounts to 4% of the discharges being delayed.

	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12
Discharges	6	8	2	7	7	7	4	4	6	7	5	6
Delayed	0	0	0	1	0	1	0	0	0	1	0	0
% Delayed	0%	0%	0%	14%	0%	14%	0%	0%	0%	14%	0%	0%

No data was provided for outpatients who have been lost to follow up.

No data for referral to assessment and treatment times was provided for this core service.

Patients were admitted at an appropriate time of day unless it was an emergency admission. Patients were not moved at night time but were sometimes moved if they required a psychiatric intensive care unit as the trust did not have one of these. These moves would take place during the day. The ward was funded by NHS England and therefore patients were admitted from all over the UK not just the local area. If the ward was very busy then the staff could refuse admissions.

From admission, staff began discharge planning. This was discussed during ward rounds and also care planning. Of the 69 discharges in the twelve months leading up to our inspection there were three delayed discharges. Staff reported this was usually due to lack of placements in the patient's local area or funding taking a long time to be approved.

Facilities that promote comfort, dignity and privacy

The 2017 patient-led assessments of the care environment (PLACE) score for ward food at Mill Lodge Community Unit scored better than similar trusts.

Site name	Ward food
Mill Lodge Community Unit	96.33%
Trust overall	95.66%
England average (mental health and learning disabilities)	92.92%

Patients' engagement with the wider community

Staff ensured that patients remained in contact with their home school (if appropriate). This included liaising with home school teachers to ensure that the work being set in the school on the ward was at a similar level to what the patient was doing at school previously. For patients who were past compulsory school age, the education department ensured that if the patients wanted to continue their education they had access to college level education. Patients who had sat their GCSEs earlier in the year achieved promising results with the support of the staff team.

Staff supported patients to maintain contact with family and friends whilst in hospital. They also supported patients to maintain relationships with each other whilst on the ward. This included facilitating group sessions where patients could get to know each other better and learn how to develop and maintain meaningful relationships. The ward offered family therapy to all patients and

this was well received. More thann 90% of patients families were involved in family therapy at the time of our inspection.

Meeting the needs of all people who use the service

The ward was all on one level so was easily accessible to people requiring disabled access. There was a range of rooms to promote recovery and these included education facilities, occupational therapy rooms, activity rooms and quiet areas. There was also a female specific lounge.

Staff told us that there was access to interpreters if required and this was easily accessed via a quick booking system. There was also access to leaflets and information about treatments in other languages and easy read formats. Food was delivered by an outside agency but this was due to change quite soon after the inspection. It would change to “cook freeze” which meant that the patients would have more choice and staff would be able to cook meals outside of the usual times. There was access to snacks and hot and cold drinks at all times if patients were hungry.

Listening to and learning from concerns and complaints

All patients we spoke to told us that they knew how to complain. There was information up around the ward and it was also contained in the welcome pack they received on arrival. Patients received feedback from the ward manager when they made a complaint and likewise this was discussed in team meetings, handovers and in one-to-one supervision to disseminate learning to all staff.

The staff we spoke to were aware of how to sensitively manage a complaint and the different ways in which a complaint could be dealt with dependent on how it was made.

The ward kept track of all compliments received and sent them to the senior leaders at the trust to be logged. There were lots of cards and thank you letters around the ward from past patients that staff displayed with pride.
This core service received no complaints between 1 October 2016 and 30 September 2017.

There were, however, a number of issues that were raised and resolved informally, or through the patient advice and liaison service.

This core service received one compliment during the last 12 months from 1 October 2016 to 30 September 2017 which accounted for less than 1% of all compliments received by the trust as a whole.

Is the service well led?

Leadership

The ward manager was permanent in post and had worked on the ward for a number of years. They had an office based on the ward and had a good level of knowledge and oversight of the learning and development needs of their staff. All staff we spoke to felt supported by the ward manager and senior staff on the ward. Staff felt that their views were listened to and concerns were acted upon with an explanation given if there was something that could not be done. Staff told us that they were fully supported to develop their skills with extra training if required. The ward manager was able to plan their staffing levels and bring in extra bank or agency staff if required to fill gap or increase staffing levels when required.

Staff felt supported by the senior leadership team for the service who regularly visited the ward. On the day of our visit there was a governance meeting which took place monthly and senior managers attended this as well as ward based staff and patients.

Vision and strategy

The trust values were:
We have integrity

- We treat everyone with respect and dignity, honour our commitments and do our best for our service users and colleagues.

We keep it simple

- We make it easy for the communities we serve and the people who work here to achieve their goals.

We are caring

- We always show empathy and support those in need.

All staff had a good understanding of the values and they were displayed on the ward. The trust spent time engaging staff in the development of the values and there was information about this on the trust intranet. There was a staff engagement session run by the Chief Executive of the trust on the ward where staff were asked to get involved in developing the trust values.

Locally the trust values were incorporated into supervision, appraisal and in interviewing new staff members. As part of staff appraisal there was a section where staff were asked to show how they demonstrate the trust values in their work. During interviews there were value-based questions that were asked of prospective staff. These were generally asked by service users who took part in interviews. Managers engaged with staff in relation to service changes and the constraints of working within a budget. There was opportunity for staff to be involved in changes and the ward held an away day three times a year so staff could have some time to think about the goals for the service going forward and how these could be achieved.

Culture

Staff morale was generally positive and staff felt supported to carry out their role. The Christmas period had been particularly busy for the staff due to a number of patients, who were very unwell and requiring a lot of staff support presenting with challenging behaviours. The staff had an away day planned for a few weeks later and during the clinical governance meeting that we attended as part of our inspection it was discussed how this would be a good time to give staff positive feedback on the way they had managed the difficult time.

Managers felt comfortable dealing with poor staff performance and policies were in place to support them with this. There were no staff being performance managed at the time of our

inspection but staff were able to tell us how this would be managed if it occurred and how human resources would support them with this process.

There were a number of support options in place for staff if they wanted to use them. This included occupational therapy services; a fast track service was available for people identified as having work related stress. There was also access to counselling for staff.

Governance

There were systems in place to monitor the service. The ward manager received a weekly performance report for mandatory training, appraisals and supervision. The senior managers for the service had regular meetings to review information about the service. Team meetings had a clear agenda and learning from incidents was discussed as part of these. There were monthly clinical governance meetings which discussed items such as risks, staffing, clinical audits and performance. As part of this meeting clinical risk was also discussed and this was where the team looked at clinical incidents and themes and trends were studied. Safeguarding and the risk register were also discussed at this meeting. This was well attended and took place on the day of our inspection. Attendees included a representative of the patient council, the ward consultant, senior managers, ward manager, senior staff nurse and occupational therapy and dietitian.

Management of risk, issues and performance

The trust has provided a copy of its most recent risk register. One of these risks relates directly to this core service – details can be found below.

Key:

High (15-20)	Moderate (8-15)	Low 3-6	Very Low (0-2)

ID	Description	Risk level (initial)	Risk score (current)	Risk level (target)	Last review date	Action
627	The current lack of / difficulty in accessing CAMHS PICU / secure provision results in a high level of disturbance at Mill Lodge, and requires the staff to manage a high level of incidents (including violence and aggression)	12	12	6	Not provided	Joint work with commissioners to redesign and develop flexible PICU at Mill Lodge - work underway

Information management

The trust used information management to gather information about the service. They were able to interpret data about mandatory training, incidents, risk issues, rapid tranquilisation and clinical supervision. The electronic incident reporting system was able to pick out key data for the trust to monitor such as restrictive practices. The ward manager and senior nurses on the ward had access to view all incidents and therefore look at trends and themes from incidents occurring on the ward. This was then used for deeper analysis when trends were identified to learn from those incidents and improve the service.

Staff on the ward had access to the information management systems they needed to be able to carry out their role. Staff were generally positive about the electronic care notes, medication system and incident reporting system. There were contingency plans in place for if the electronic systems went down and staff were able to explain these to us in detail. They reported this did happen on occasion but not on a regular basis.

The ward notified outside organisations to incidents as required and had good relationships with the local safeguarding team.

Engagement

The trust website contained information both about the trust and the ward. Potential patients and their families were able to download an information leaflet which detailed the purpose of the ward, information about treatments and the therapeutic programme. There were different leaflets dependent on diagnosis for example there was a specific one for people diagnosed with an eating disorder.

Learning, continuous improvement and innovation

NHS trusts are able to participate in a number of accreditation schemes whereby the services they provide are reviewed and a decision is made whether or not to award the service with an accreditation. A service will be accredited if they are able to demonstrate that they meet a certain standard of best practice in the given area. An accreditation usually carries an end date (or review date) whereby the service will need to be re-assessed in order to continue to be accredited.
The table below shows which services within this core service have been awarded an accreditation or have been reviewed for an accreditation together with the relevant dates of accreditation and any comments.

Accreditation scheme	Service accredited	Comments and date of accreditation / review
Quality Network for Inpatient CAMHS (QNIC)	N/A	The trust's CAMHS inpatient services have been inspected and are awaiting accreditation with QNIC.

Staff at Mill Lodge were also encouraged to take part in QNIC inspections for other child and adolescent mental health wards in order for them to learn what was being done in other areas and improve their own ward through this.

In addition to this more than half the staff on the ward had been trained in dialectical behavioural therapy. This was with a view to eventually having all staff members trained in this and increasing the current weekly group to twice weekly and introducing behavioural analysis as part of this. This was in order to try and reduce the amount of self-harm that occurs on the ward in particular the use of ligatures. This work was due to be evaluated for outcomes after six months.
The ward was involved in a research project to validate a recovery measure for use in tier four child and adolescent mental health services. This was being done in association with a doctoral psychology trainee from Manchester University. The project was in its final phase. The ward was validating the newly adapted and translated autism assessment instruments for deaf children, namely; the screening tool, parent semi-structured interview and the play/interaction based assessment. The study was due to report in October 2018.

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

Facts and data about this service

Location site name	Ward name	Number of beds	Patient group (male, female, mixed)
Becklin Centre	Becklin Ward 1	18	Female
Becklin Centre	Becklin Ward 3	22	Male
Becklin Centre	Becklin Ward 4	22	Male
Becklin Centre	Becklin Ward 5	22	Female
Newsam Centre	Newsam Ward 1 PICU	12	Mixed
Newsam Centre	Newsam Ward 4	21	Male

The methodology of CQC provider information requests has changed, so some data from different time periods is not always comparable. We only compare data where information has been recorded consistently.

Is the service safe?

Safe and clean care environments

Safety of the ward layout

Staff undertook assessments of risks within the care environment. This included an assessment of ligature risks with an action plan about how to manage potential ligature points. A ligature point is anything which could be used to attach a cord, rope or other material for the purpose of hanging or strangulation. Copies were available on each ward and managers reviewed these annually or sooner if necessary. All wards had areas of high risk ligatures which staff managed via clinical practice and individual patient observations. Ligature cutters were available on all wards. Since our last inspection the trust had undertaken refurbishment work to help reduce ligature risks. This work was continuing and the final work to replace fittings in the communal bathrooms, which were high risk areas, was due to be completed in March 2018.

The layouts of the wards offered a good line of vision for staff to observe all areas. Convex mirrors were located for extra visibility. This helped staff be aware of the location of patients on the ward.

All wards complied with guidance on eliminating mixed sex accommodation. The four wards located at The Becklin Centre and ward four at The Newsam Centre all provided single sex accommodation. The psychiatric intensive care unit at The Newsam Centre was mixed sex and had separate sleeping areas for males and females. Two rooms on a separate corridor could be used flexibly for either males or females dependent on the split of patients. The ward had a female only lounge and patients did not have to pass through sleeping areas of the opposite sex to access a bathroom. Over the 12 month period from 1 October 2016 to 30 September 2017 there were no mixed sex accommodation breaches within this core service.

Patients and staff had access and means to call for assistance. Nurse call systems were situated in patients' rooms. Staff wore personal alarms and we saw some attached their alarms and ward keys on lanyards around their neck. We were concerned this could pose a safety risk. For example, if a patient attempted to grab the items they may have had a greater chance of obtaining these as the lanyard was designed to break free for safety purposes.

Maintenance, cleanliness and infection control

Most wards were maintained to an adequate standard. Records showed each ward was subject to a regular program of cleaning. However, we observed some areas in need of attention. One bathroom on ward four at The Becklin Centre had loose side panels and dirt and mould present. A staff member told us it had been this way for some time. There was no record of this being reported for repair. The toilet was badly stained despite it having already been cleaned some time earlier that day. We highlighted this to a senior member of staff and later found the bathroom had been marked out of use and the repair reported. Some wards had rooms which were cluttered and had poor storage. There was litter in the patient courtyard at The Newsam Centre. Our observations suggested that cleanliness and maintenance issues were not always dealt with in a timely way.

The acute and psychiatric intensive care wards participated in the 2017 patient-led assessments of the care environment. These are self-assessments undertaken by teams of trust staff and specially trained members of the public. They focus on different aspects of the environment in which care was provided. For these assessments, the wards scored better than similar trusts for three of the four aspects overall. Newsam Centre and Becklin Centre did not score for 'Dementia friendly'.

Site name	Core service(s) provided	Cleanliness	Condition appearance and maintenance	Dementia friendly	Disability
Newsam Centre	Acute wards for adults of working age and psychiatric intensive care units / forensic inpatient/secure wards / long stay/rehabilitation mental health wards for working age adults.	98.70%	98.43%	-	96.49%
Becklin Centre	Acute wards for adults of working age and psychiatric intensive care units	99.83%	98.49%	-	96.49%
Trust overall		99.37%	98.30%%	99.72%	93.96%
England average (Mental health and learning disabilities)		98.40%	95.13%	85.53%	86.94%

Staff adhered to infection control principles to try to help prevent the spread of infection. There were hand gel dispensers on entry to the wards which staff and visitors were prompted to use. Infection control information was displayed around the wards. Staff had access to personal protective equipment. The trust undertook an annual infection and prevention control audit of each ward. All scored highly for overall compliance which equated to an outcome of minimal risk. There were specific areas on all wards which had scored less well. Where this was the case, actions plans had been implemented to address this.

Seclusion room (if present)

There was one seclusion room which was located at the psychiatric intensive care unit at The Newsam Centre. The room allowed for observation via a window in the bedroom door. This had air holes for staff and patients to talk through to communicate with each other. Staff told us they had no difficulties communicating with patients in this manner. Patients had access to toilet and washing facilities and a clock was visible from inside the room. Staff could externally control the room temperature and the lighting. There was a leak in the shower area at the time of our visit which had led to areas of discolouration.

Clinic room and equipment

Clinic rooms were suitably stocked and equipped with resuscitation equipment which included a defibrillator, grab bag, oxygen and drugs for use in an emergency. There was an examination couch, an electrocardiogram machine and blood pressure monitor present. Staff regularly checked these to ensure they were safe for use. The medicines fridge on ward five at The Becklin Centre was out of use at the time of our inspection and medicines for refrigeration were being stored on another ward. Staff told us a replacement fridge was on order.

Staff regularly cleaned and maintained items in the clinic room. Staff checked room and fridge temperatures on a daily basis and we saw these were all within recommended safe ranges.

Safe staffing

Senior managers used an electronic rostering system to enable them to establish the core staffing levels and skill mix for each of the wards. The actual staffing levels for each ward were published on the trust website on a monthly basis and reported to the monthly trust board meetings for further scrutiny. The staffing information for the core service as at September 2017 was as follows:

Nursing staff

Definition Substantive – All filled allocated and funded posts. Establishment – All posts allocated and funded (e.g. substantive + vacancies).

Substantive staff figures			Trust target
Total number of substantive staff	September 2017	189.24	N/A
Total number of substantive staff leavers	1 October 2016 – 30 September 2017	11.80	N/A
Average WTE* leavers over 12 months (%)	1 October 2016 – 30 September 2017	6.11%	10% - 15%
Vacancies and sickness			
Total vacancies overall (excluding seconded staff)	September 2017	20.05	N/A
Total vacancies overall (%)	September 2017	9.46%	N/A
Total permanent staff sickness overall (%)	30 September 2017	5.61%	3.70%
	1 October 2016 – 30 September 2017	7.56%	3.70%
Establishment and vacancy (nurses and care assistants)			
Establishment levels qualified nurses (WTE*)	30 September 2017	96.22	N/A
Establishment levels nursing assistants (WTE*)	30 September 2017	74.00	N/A
Number of vacancies, qualified nurses (WTE*)	30 September 2017	10.22	N/A
Number of WTE vacancies nursing assistants	30 September 2017	6.69	N/A
Qualified nurse vacancy rate	30 September 2017	11%	N/A
Nursing assistant vacancy rate	30 September 2017	9%	N/A
Bank and agency Use			
Shifts bank staff filled to cover sickness, absence or vacancies (qualified nurses)	1 October 2016 – 30 September 2017	1490	N/A
Shifts filled by agency staff to cover sickness, absence or vacancies (qualified nurses)	1 October 2016 – 30 September 2017	464	N/A
Shifts NOT filled by bank or agency staff where there is sickness, absence or vacancies (qualified nurses)	1 October 2016 – 30 September 2017	134	N/A
Shifts filled by bank staff to cover sickness, absence or vacancies (Nursing Assistants)	1 October 2016 – 30 September 2017	8680	N/A
Shifts filled by agency staff to cover sickness, absence or vacancies (Nursing Assistants)	1 October 2016 – 30 September 2017	3085	N/A
Shifts NOT filled by bank or agency staff where there is sickness, absence or vacancies (Nursing Assistants)	1 October 2016 – 30 September 2017	1188	N/A

*Whole-time Equivalent

This core service reported an overall vacancy rate of 11% for registered nurses at 30 September 2017. The vacancy rate for registered nurses was lower than the 17% reported at our last inspection. The service reported an overall vacancy rate of 9% for healthcare assistants. The vacancy rate fluctuated over the past 12 months ranging from 4% to 18%.

The service had reported a vacancy rate for all staff of 9% as of 30 September 2017. The overall vacancy rate remained between 10% and 12% for the first 11 months, dropping to nine in the final month.

	Registered nurses			Health care assistants			Overall staff figures		
Ward /Team	Vacancies	Establishment	Vacancy rate (%)	Vacancies	Establishment	Vacancy rate (%)	Vacancies	Establishment	Vacancy rate (%)
Becklin Ward 1	0.76	16.06	11%	1.89	10.08	19%	3.65	29.14	13%
Becklin Ward 3	1.43	16.03	9%	0.09	11.89	1%	2.02	31.42	6%
Becklin Ward 4	1.42	16.02	9%	1.29	11.89	11%	2.21	31.41	7%
Becklin Ward 5	-0.35	16.55	-2%	0.49	11.89	4%	1.14	31.44	4%
Newsam 1PICU	2.22	16.02	14%	0.23	16.35	1%	2.85	34.37	8%
Newsam Ward 4	4.74	15.54	31%	2.70	11.90	23%	7.44	29.44	25%
Core service total	10.22	96.22	11%	6.69	74.00	9%	19.31	187.22	9%
Trust total	120.06	765.64	16%	89.65	614.56	15%	257.28	2028.82	13%

NB: All figures displayed are whole-time equivalents

Between 1 October 2016 and 30 September 2017, bank staff filled 1,490 shifts to cover sickness, absence or vacancies for qualified nurses. In the same period, agency staff covered 3,013 shifts for qualified nurses. One hundred and thirty four shifts were unable to be filled by either bank or agency staff.

Ward/Team	Available shifts	Shifts filled by bank staff	Shifts filled by agency staff	Shifts NOT filled by bank or agency staff
Becklin Ward 1	277	235	34	8
Becklin Ward 3	259	171	69	19
Becklin Ward 4	353	195	133	25
Becklin Ward 5	345	225	92	28
Newsam 1PICU	237	221	5	11
Newsam Ward 4	617	443	131	43
Core service total	2088	1490	464	134

Trust Total	10125	6391	3013	721

Between 1 October 2016 and 30 September 2017, 8,680 shifts were filled by bank staff to cover sickness, absence or vacancy for healthcare assistants. In the same time period, agency staff covered 3,085 shifts. One thousand, one hundred and eighty eight shifts were unable to be filled by either bank or agency staff.

Ward/Team	Available shifts	Shifts filled by bank staff	Shifts filled by agency staff	Shifts NOT filled by bank or agency staff
Becklin Ward 1	1521	1032	362	127
Becklin Ward 3	1045	626	298	121
Becklin Ward 4	1960	1385	401	174
Becklin Ward 5	1990	1125	632	233
Newsam 1PICU	4467	3121	1003	343
Newsam Ward 4	1970	1391	389	190
Core service total	12953	8680	3085	1188
Trust Total	242159	52673	184336	5150

* Percentage of total shifts

The acute and psychiatric wards had 11.8 (6%) staff leavers between 1 October 2016 and 30 September 2017. This was lower than the average percentage of staff leavers across the trust which was 9%.

Ward/Team	Substantive staff	Substantive staff Leavers	Average % staff leavers
173 Becklin Ward 5	30.30	4	13%
173 Becklin Ward 1	24.33	2	8%
Newsam Ward 4	22.42	1.8	8%
173 Becklin Ward 4	28.95	2	7%
173 Becklin Ward 3	27.52	1	4%
Newsam Ward 1PICU	30.67	1	3%
Becklin Centre	28.85	0	0%
Core service total	193.03	11.8	6%
Trust Total	1801.83	166.73	9%

The average sickness rate for the core service was 7.6% between 1 October 2016 and 30 September 2017. This was greater than the trust average of 5.3% in the same time period. In

September 2017 the sickness rate was recorded as 5.6% which was slightly higher than the trust total of 4.8% in the same period. Generally, sickness levels decreased over the 12 months period, with a peak in January 2017 of 8.8%.

Ward/Team	Total % staff sickness (at latest month)	Ave % permanent staff sickness (over the past year)
Becklin Ward 4	5.1%	12.3%
Newsam 1PICU	5.6%	8.6%
Becklin Ward 5	3.6%	7.8%
Becklin Centre	6.9%	6.3%
Becklin Ward 3	11.6%	5.9%
Newsam Ward 4	1.8%	5.9%
Becklin Ward 1	4.5%	4.6%
Core service total	5.6%	7.6%
Trust Total	4.48%	5.3%

The following table shows the staff fill rates for registered nurses and care staff during July, August and September 2017. Ward one at The Newsam Centre, the psychiatric intensive care unit, had less than 90% of the planned registered nurses for almost all day and night shifts across the three months. The exception to this was the nursing rate for night shifts in July 2017 which was at 91.9%

Nearly all wards had more than 125% of the planned care staff for day and night shifts across the three months. This was attributed to additional staff for increased acuity on the wards and patients requiring extra observations. Where fill rates fell below required levels for nursing staff, this was mitigated in part by an increase of healthcare assistants.

Key:

> 125%	< 90%

	September 2017				August 2017				July 2017			
	Day		**Night**		**Day**		**Night**		**Day**		**Night**	
	Nurses	Care staff	Nurses	Care staff	Nurses	Care staff	Nurses	Care staff	Nurses	Care staff	Nurses	Care staff
Becklin Ward 1	88.9%	262.0%	100.0%	148.6%	94.6%	187.6%	100.0%	115.0%	81.2%	196.2%	100.0%	119.1%
Becklin Ward 3	95.9%	161.3%	101.7%	119.7%	96.0%	161.5%	96.6%	109.6%	85.4%	151.9%	98.7%	120.9%
Becklin Ward 4	76.8%	269.5%	103.1%	198.3%	72.8%	163.0%	90.5%	141.1%	87.4%	159.4%	92.1%	143.5%
Becklin Ward 5	166.0%	76.8%	101.4%	138.8%	86.7%	182.0%	90.8%	163.6%	93.8%	181.4%	99.0%	163.0%

Newsam Ward 1PICU	80.4%	194.0%	84.3%	316.1 %	77.2%	195.0%	77.0%	314.0 %	76.6%	218.3 %	91.9%	333.8 %
Newsam Ward 4	82.4%	176.1%	98.3%	125.0 %	72.8%	171.3%	96.8%	121.7 %	101.2%	124.7 %	100.8 %	109.8 %

Staffing levels at the service were on the trust risk register and it was recognised that vacancies had led to a reliance on bank and agency staff. The trust had a recurring recruitment program underway and other initiatives included inpatient staff working with local universities to recruit newly qualified staff. Senior managers had monthly meetings to discuss the progress against vacancies.

Managers aimed to arrange appropriate staff cover by planning to cover leave and holidays in advance. If substantive staff were not able to cover, they would look to use bank and agency staff in order to maintain safe staffing levels. Wards tried to retain the same bank and agency workers so they were familiar to the ward and patient group which helped maintain continuity of care. Bank and agency staff new to the ward undertook a formal induction process.

Ward managers could adjust staffing levels to meet demand. If they needed extra staff, for example due to the acuity of the ward, this could be facilitated and senior managers supported their decisions.

At the time of our inspection, ward one, a female acute ward, at The Becklin Centre had recently increased provision for two additional beds taking this from 18 to 20 due to increased demand. The ward manager and staff did not know whether this was to be a permanent plan and what the impact upon staffing would be. The trust informed us their plan was to reduce the bed numbers back to 18 within the following six months. They had increased staffing numbers by one extra member of staff on each shift. The practice development nurse and clinical lead time had been increased to support staff within the ward. The trust said they would use information from staffing reports, sickness levels and staff and patient feedback to monitor any impact on quality and safety.

Most staff on the all wards felt staffing levels were safe and managed appropriately. They acknowledged that acuity and unwell patients caused an increase in demand on staffing levels. Staff felt supported from their colleagues and were aware of actions to address vacancies such as ongoing recruitment. Two staff said there were instances where patient one to ones could not be facilitated due to high acuity on the ward. Some staff said occasionally patient leave was postponed but this was where several patients may want escorted leave at the same time rather than a shortage of staff. Wards tried to manage this by planning for leave at times during shift changes when there was an additional amount of staff due to the crossover. Ward one at The Becklin Centre had a member of staff whose primary role was to help facilitate patient leave and appointments.

Most patients reported no concerns with access to staff or leave and activities not taking place. Twenty patients said they could always find staff to speak with and staff were visible on the wards. Three said they struggled to find staff or did not feel they were visible. Most had never had any activity or leave cancelled due to staff shortages. Six told us they had had a period of leave cancelled or delayed and had to wait for these to take place at a later time.

Carers we spoke with who visited their relatives on the ward said there were staff present and visible when they attended. They could not recall any instances of their relative having leave and events cancelled. One carer did recall this happening several times but said staff always rearranged the leave.

There were enough staff present on the wards to carry out physical interventions such as restraints and enhanced observations. Managers could plan for such interventions in advance to help ensure they had sufficient resources to meet the needs of patients.

Medical staff

There was adequate medical cover on the wards and there was a procedure in place for staff to access medical support for patients out of hours. Doctors were able to attend the ward quickly in the event of an emergency.

Between 1 September 2016 and 30 September 2017, 5.6% of shifts were filled by agency staff to cover sickness, absence or vacancy for medical locums.

Ward/Team	Staffing Type	Available shifts	Shifts filled by agency staff	Shifts NOT filled by bank or agency staff
Newsam Ward 4	Consultant	528	62	-
Newsam Ward 4, Newsam Ward 1 PICU	Doctor in Training	600	-	-
Newsam Ward 1 PICU	Consultant	240	-	-
Newsam Ward 1 PICU	Middle Grade Doctor	24	-	-
Becklin Ward 1, 3, 4, 5	Consultant	1296	-	-
Becklin Ward 1, 3, 4, 5	Middle Grade Doctor	960	-	-
Becklin Ward 1, 3, 4, 5	Doctor in Training	2808	-	-
Newsam Ward 4	Middle Grade Doctor	-	189	-
Newsam Ward 3	Doctor in Training	-	111	-
Core service total		6456	362 (5.6%)	-
Trust Total		45168	1037 (2%)	84 (<1%%)

* Percentage of total shifts

Mandatory training

The trust provided mandatory training in a range of key skills which staff were required to complete. The overall compliance rate for mandatory training at 30 September 2017 for core service was 90%. This exceeded the trust target of 85%. Of the training courses listed there were nine where the trusts target of 85% was not met, of those three failed to score above 75%. This included food safety level 2 with 67% compliance, infection control, clinical with 73% and safeguarding children level one with 60%. Where staff are not compliant with required key training there is a risk they may not have the necessary skills to provide safe care and treatment. The trust had a rolling month on month basis for training. Where training was lowest, ward managers said staff had been booked onto upcoming courses where these were available.

Key:

Below CQC 75%	Between 75% & trust target	Trust target and above

Training course	This core service %	Trustwide %	Trust target %

Safeguarding children level 1	60%	93%	85%
Food Safety Level 2	67%	88%	85%
Infection Control – Clinical	73%	81%	85%
Safeguarding children Level 2	76%	82%	85%
Safeguarding children Level 3	76%	81%	85%
Fire – Level 3	78%	81%	85%
Immediate Life Support	83%	78%	85%
Clinical Risk	83%	82%	85%
Moving and Handling Principles	83%	90%	85%
Moving and Handling Essentials	87%	80%	85%
Mental Capacity Act and DoLs – Level 2	89%	85%	85%
Mental Health Act – Inpatient – Level 2	89%	78%	85%
High Level Physical Interventions with PSTS and Breakaway Skills	90%	89%	85%
Essential Life Support	91%	87%	85%
Mental Health Legislation Awareness – Level 1	93%	90%	85%
Information and Governance	94%	92%	85%
Health and Safety	97%	96%	85%
Equality and Diversity	97%	96%	85%
Safeguarding Adults	98%	95%	85%
Trust Induction	98%	99%	85%
Food Safety Level 1	98%	97%	85%
Duty of Candour	99%	98%	85%
Personal Safety with Breakaway Skills	100%	85%	85%
Fire – Level 2	100%	91%	85%
Fire – Level 1	100%	95%	85%
Infection Control – Non-Clinical	100%	97%	85%
Core Service Total %	90%	90%	85%

Assessing and managing risk to patients and staff

Assessment of patient risk

Staff completed a risk assessment for each patient admitted to the ward. The trust used a recognised risk assessment tool known as the functional analysis of care environments. Staff regularly reviewed and updated patients' risk assessments including in response to changes. All records we saw contained a current risk assessment for the patient.

Management of patient risk

There was information to help staff manage and mitigate patient risk. Each patient had an associated risk management plan with details about what support patients needed to help reduce

their risks. If patients had specific risk issues, such as risk of falls or pressure areas, then staff included this as part of the risk assessment. Staff responded to changing risks in patients where these were identified. For example, we saw instances of patient's observations levels changing in accordance with their risk level and presentation.

The trust had a policy for the observation and engagement of people using their services which staff followed. There were differing levels of observations in place for patients dependent on their individual risks which were agreed by a multidisciplinary team. Senior qualified nursing staff were able to increase observation levels if they believed that risks had increased. A senior qualified nurse was able to decrease observations where there was clear rationale and this had to be communicated to the responsible clinician.

Staff took actions to help mitigate risk of patient harm from ligature risks in the environment. This included monitoring the computer rooms at set intervals on wards three and four at The Becklin Centre when in use due to the ligature risks present. Ligature risks in the environment were included and highlighted on handover information in the ward offices.

The trust was trying to address risks relating to the use of illicit drugs at the service. There had been an increase of instances of illicit drugs being used by patients on the wards. The trust had arranged a 'day of action' in March 2017 as part of joint working between the trust and the local police service to act as a visible deterrent. This involved police attending the premises with search dogs. Police attended the sites monthly to collect any drugs staff found. Some staff had been trained in dual diagnosis and staff signposted people to the local substance misuse team for support. However, this was a recurring issue and staff were still identifying the use of illicit drugs which suggested the actions were not fully effective to address the problem.

The trust had a policy for the searching of patients and their rooms. Staff searched patients on the basis of individual risk assessment and they would be asked to consent. A number of staff had recently completed search training provided by the trust. Staff recorded patient searches on the incident reporting system. Incident reports showed where staff suspected patients of illicit drug use, searches took place.

Staff did not implement blanket restrictions where these were not necessary and justified. The service had a list of barred articles that were not allowed on the wards. The trust had a reducing restrictive intervention group which met quarterly to look at reducing restrictive practices including blanket restrictions.

The trust had adhered to best practice and had implemented a smoke free policy in 2016. This had been temporarily ceased at the time of our inspection due to an increase of patients smoking on wards and smoking-related incidents. Senior managers said longer term strategies were required to successfully implement this policy. Staff were encouraged to report all incidents of smoking, but some managers felt this was under reported. During our inspection, we could smell smoke on some of the wards. Incident reports showed instances of patients smoking still occurred.

Informal patients could leave the ward at will and there were signs on the acute wards to advise of this. Patients, both informal and detained, had access to their own swipe cards to leave the ward unless a risk assessment showed this was not appropriate. The trust produced a leaflet about the rights and responsibilities of informal patients on the ward.

Trust policy was that patients leaving the ward should let their allocated worker know they were leaving. This did not happen in all instances as some staff told us patients did not always inform them. This meant staff would not always have knowledge about how many people were on the ward at a particular time. This could pose a risk in the event of an emergency in circumstances where a sudden evacuation may be required.

Use of restrictive interventions

This core service had 624 incidents of restraint (on 335 different service users) and 79 incidents of seclusion between 1 October 2016 and 30 September 2017. Of the 79 incidents of seclusion, 72 (91%) occurred on the psychiatric intensive care unit, Newsam ward one.

Over the 12 months, there was an increase in the incidence of restraints, with a peak of 95 instances in June 2017. The table below focuses on the last 12 months worth of data: October 2016 to September 2017.

Ward name	Seclusions	Restraints	Patients restrained	Of restraints, incidents of prone restraint	Rapid tranquilisations
Becklin Ward 1	0	112	50	20 (18%)	20 (18%)
Becklin Ward 3	0	72	48	19 (26%)	19 (26%)
Becklin Ward 4	2	80	52	31 (39%)	33 (41%)
Becklin Ward 5	2	172	80	46 (27%)	39 (23%)
Newsam 1PICU	72	140	74	69 (49%)	36 (26%)
Newsam 4	3	48	31	16 (33%)	33 (69%)
Core service total	79	624	335	201 (32%)	180 (29%)

There were 201 incidents of prone restraint which accounted for 32% of the restraint incidents. Over the 12 months, there was a peak in the use of prone restraint in June 2017, where there were a total of 34 incidents. This dipped over the next three months and there was a total of 22 incidents in the month of July 2017 and eight in August 2017 before increasing to 11 incidents in September 2017.

All staff received training in the prevention of management of violence and aggression. Staff told us they were taught to try to avoid the use of prone restraint. They said this was always used a last resort and for the shortest amount of time possible. In most cases this type of restraint was used to administer medication via rapid tranquilisation and then patients would be removed from the prone position. We reviewed ten episodes of recent restraints that had taken place on the wards. Three of these included the use of prone restraint to administer rapid tranquilisation. The maximum length of usage of prone restraint was three minutes and the minimum was 30 seconds. The prevention of management of violence and aggression team at the trust reviewed incidents of restraint and were able to give feedback if they felt necessary. Staff could also contact them for advice about restraint. There were no instances of mechanical restraint over the reporting period.

Managers told us about work that was underway as part of the reducing restrictive interventions program to look at reducing prone restraint. This included looking at the use of alternative sites to administer rapid tranquilisation.

Staff used restraint only if other de-escalation techniques had not been successful. Most restraint records included information about what strategies staff had employed prior to using restraint. This was also included in patients' case notes in descriptions of events leading up to the incident. However, care plans did not make clear what strategies staff should employ to support patients who may be in crisis and what techniques worked best for them . Where patients needed medication 'as required' to help manage behaviours such as agitation and distress, there was no

information to show how the patient may present with these behaviours. This meant there was a risk staff may not have all available information about how best to support individual patients in distress and maintain their safety.

Incidents resulting in rapid tranquilisation for this core services had been fluctuating, with the highest numbers in May 2017 and June 2017 of 21 and 22 incidents respectively.

Staff did not always follow best practice and national guidance where patients had been administered rapid tranquilisation. The trust's rapid tranquilisation policy said that following intramuscular use, staff should check the patient's vital signs at certain intervals for a specific length of time. Where this could not be completed, staff were required to document the reason along with a visual observation. We reviewed the records of 12 recent episodes of rapid tranquilisation. Three included evidence of staff undertaking post monitoring checks as required. Four records included visual checks only, with no record of whether the patient had refused physical observations. One record had an observation recorded at 15 minutes post tranquilisation and then a gap of almost 8 hours before the next observation. Four records contained no evidence that any post monitoring had taken place and staff were not able to locate evidence of this. The lack of adequate monitoring meant staff may not have been in a position to assess if a patient's health was deteriorating and seek help in a timely manner.

There were 79 incidents of seclusion within the core service between 1 October 2016 and 30 September 2017. Of the 79 incidents of seclusion, 72 (91%) occurred on Newsam ward one, the psychiatric intensive care unit. Over the 12 months, there was a decrease in the use of seclusion in March 2017, where there were a total of three instances. This increased to eight instances in July 2017 and to nine in September 2017.

Seven seclusions were reported to have occurred on the acute wards. Two of these occurred on ward four at The Newsam Centre and involved patients who were taken to appropriate seclusion rooms on other wards within the centre. Three were recording errors by staff and were not seclusions. Two episodes were where staff had tried to de-escalate incidents but this had not been successful and they had taken further action to prevent risk of severe harm. This involved restricting the patient in a room to ensure the safety of other patients and staff. In both instances the police were called due to the severity of the incident. Staff recognised and had recorded that the actions they had taken amounted to seclusion and said this course of action would always be avoided where at all possible.

Staff kept appropriate records of seclusion episodes. We viewed the latest records of a seclusion episode on the psychiatric intensive care unit and information was present and complete.

There were no instances of long term segregation in the reporting period of 1 October 2016 to 30 September 2017. No patients were in long term segregation at the time of this inspection.

Safeguarding

A safeguarding referral is a request from a member of the public or a professional to the local authority or the police to intervene to support or protect a child or vulnerable adult from abuse. Commonly recognised forms of abuse include: physical, emotional, financial, sexual, neglect and institutional.

Each authority has their own guidelines as to how to investigate and progress a safeguarding referral. Generally, if a concern is raised regarding a child or vulnerable adult, the organisation will work to ensure the safety of the person. An assessment of the concerns should also be conducted

to determine whether an external referral to children's Services, adult Services or the police should take place.

This core service made 26 safeguarding referrals between 29 September 2017 and 1 October 2017, of which 17 concerned adults and nine children.

Referrals		
Adults	Children	Total referrals
17	9	26

There were two peaks in adult referrals in March and August 2017 with four identified for both months. There was a peak in child referrals in April 2017 with five reported .Referrals were also made in October 2016, February 2017 and August 2017.

Staff undertook mandatory safeguarding training and were confident about identifying and reporting safeguarding concerns. The trust had a safeguarding team who staff could consult for advice and guidance. Staff spoke positively about the team and we saw evidence of their input included in patients records. However, this was not consistent. One patient on the psychiatric intensive care unit was alleged to have acted inappropriately toward another patient. Their risk management plan said staff should document any allegations of this nature and discuss with the safeguarding team. There was no evidence of any such safeguarding discussion taking place, or any rationale for not consulting with safeguarding, in relation to the allegation or of any advice given. Although we saw that staff acted upon the concerns at the time there was a risk that additional actions to safeguard the patient could have been missed.

Staff knew how to identify adults and children at risk of harm. Each patient's treatment plan included a section for plans to address any safeguarding concerns. This included ongoing and external safeguarding issues and consultation with other agencies where required, such as the police and local authorities.

There were procedures in place for children visiting the ward. No children were allowed to visit patients on the psychiatric intensive care unit at The Newsam Centre as these took place off the ward. Patients at ward four at The Newsam Centre also had access to the family room off the ward. Accompanied children were permitted to visit patients on the four wards at The Becklin Centre. The trust had a policy and guidance for staff about children visiting patients on the ward and the circumstances in which this could be refused if it was unsafe.

The trust did not submit details of any serious case reviews commenced or published in the last 12 months (29 September 2016 and 1 October 2017) that relate to this core service.

Staff access to essential information

Patient information was mainly stored electronically but some was recorded in paper format also. Staff completed care plans and risk assessments using the electronic patient record system. Staff on the wards at The Becklin Centre also printed these out and kept a paper version in the staff office. Information held in paper format consisted mostly of records of physical observations, observation care plans and seclusion records.

Information to deliver patient care was not always accessible to all relevant staff. Agency staff, and some bank staff, did not have access to the electronic patient record system. Some wards kept daily case notes handwritten by these staff in paper format which were later scanned on to the system. On some wards there was a backlog of notes to be scanned on. There were examples on all wards where staff had typed a number of case note entries on to a document covering a period of several days which was then uploaded onto the system as one entry. This meant that

when reviewing patient case notes it appeared as if there were gaps of several days with no case notes recorded. This caused some confusion and delay, such as in trying to establish what care interventions or events had taken place on a specific day. Having separate handwritten case notes not stored on the system also contributed to this same issue.

Although staff were able to locate information, it often took time to find the necessary data we requested to see as they often had to check in several different areas of the records.

Medicines management

The trust had procedures in place to help ensure staff followed good medicines management. We saw systems in place for the transporting, storage, dispensing, reconciliation and recording of medicines information. The trust used an electronic prescribing system which helped to reduce the risk of errors.

Staff did not always follow good practice with regards to administration. The trust's policy stated that prior to administering any medicines, nurses must check the prescription was legal and where consent to treatment under the Mental Health Act applied, that it was covered by the T2 or T3 authorisation certificate. The Mental Health Act Code of Practice also requires that people administering medicines should take reasonable steps to assure themselves that the treatment is authorised by the certificate. We observed instances of, and staff told us about, nurses not routinely checking the patient's authorisation prior to administration. Staff audited T2s and T3s on a weekly basis which is what staff relied upon. These were all correct and matched with the records on the electronic patient recording system when we checked these. However, without the nurse checking this was still valid at the time of administering the medicine, there was a risk the patient may receive treatment which was unauthorised.

The practice for storage of patients' own medicines was not in line with trust policy and safe practice. Staff told us some patients had their own medicines to administer such as creams and mouthwashes and kept these in their own rooms. However, patients did not have lockable facilities in their rooms to store their medicines. In two clinic rooms we saw that two prescribed medicines were not stored in the refrigerator in accordance with their storage instructions.

The wards had input from pharmacists and dedicated pharmacy technicians who attended and could also join multidisciplinary discussions if necessary. The pharmacists and staff reviewed the effect of patient's medication, including where they were on high dose antipsychotics. Pharmacy staff were available to assist staff and patients with any queries about medication.

Track record on safety

Providers must report all serious incidents to the Strategic Information Executive System (STEIS) within two working days of an incident being identified. Between 1 October 2016 and 30 September 2017 there were three serious incidents reported by this core service. All three incidents reported fell under the category apparent/actual/suspected self-inflicted harm.

A 'never event' is classified as a wholly preventable serious incident that should not happen if the available preventative measures are in place. This core service reported no never events during this reporting period.

We asked the trust to provide us with the number of serious incidents from the past 12 months. The number of the most severe incidents recorded by the trust incident reporting system was comparable with STEIS. The number of serious incidents reported during this inspection was lower than the five reported at the last inspection.

Type of incident reported on STEIS	Number of incidents reported						
	Becklin Ward 1	Becklin Ward 3	Becklin Ward 4	Becklin Ward 5	Newsam Ward 1 PICU	Newsam Ward 4	Total
Apparent/actual/suspected self-inflicted harm meeting SI criteria	0	0	1	1	0	1	**3**

The trust had investigated these incidents and had submitted their findings to the local clinical commissioning group. Two were deaths of patients who were not on the ward at the time and one patient death which occurred on the ward. The trust had a policy on learning from deaths and these were discussed by senior management team and any learnings fed down to ward staff.

Reporting incidents and learning from when things go wrong

The Chief Coroner's Office publishes the local coroner's 'Reports to Prevent Future Deaths' which all contain a summary of Schedule 5 recommendations made by the local coroners with the intention of learning lessons from the cause of death and preventing deaths. In the last two years, there has been one 'prevention of future death' reports sent to the trust, however it was not related to this core service.

All staff knew what incidents to report and how to report these via the trust's electronic incident reporting system. These were submitted to ward managers who could review the reports to determine whether any further action was necessary.

The trust had duty of candour policy and staff had received training in this. Staff told us they were open and honest with patients and carers if mistakes occurred.

There were differing experiences amongst staff about learning and feedback from incidents. Many staff told us about various forums for incident feedback including debriefs, reflective practice, ward meeting and emails about lessons learned. The trust held monthly learning from incidents and mortalities meetings. One ward manager had taken their management team to one of the meetings. Five staff out of those we spoke with reported a lack of feedback from incidents, including ones they had been directly involved in or requested feedback about. Two of these felt that unless they were involved in an incident they would not necessarily find out about other incidents which took place.

There was evidence that the trust made changes in response to feedback from, and about, incidents. The staff survey had identified that staff reported an increase of violent incidents on the wards. The trust had taken action to try to address this. This included an environmental action plan, extra security on the hospital sites at night and questionnaires for staff to help measure the effectiveness. The service had arranged for some nurses, along with a junior doctor, to undertake some research to try to identify the cause of the increase.

Staff told us that debriefs took place and they received support following serious incidents. Staff told us managers and colleagues provided reassurance and they were supported to report incidents to other authorities if necessary. Meetings and debriefs took place where staff reviewed if there were things they could have done differently and to look at any learning to avoid repeat incidents.

Is the service effective?

Assessment of needs and planning of care

Care and treatment interventions were not always personalised. Staff completed an assessment of the patient's needs upon their admission. These were incorporated into an inpatient treatment plan which covered a variety of areas. Most of the care plans we reviewed had sections which contained generic statements not individualised to the patient. For example, 'attend to personal care', 'monitor physical health care', 'monitor dietary intake' and 'observe as required' with no measurable or specific information. This meant it was unclear exactly what support the patient required in these areas.

Most patients had had prior admissions to the wards and had existing treatment plans which staff updated and regularly reviewed. However we found occasions where information had not been updated and did not reflect the current care provision for the patient. For example, where patients did have observation levels recorded, there were instances when the patient was on another level of observations to the one recorded in the care plan. Two patient's care plans referred to staff recording and monitoring their food and fluid. However, staff said the patients no longer required this and the information was historic. Where information about patients' needs did not always reflect practice, there was a risk that patients could receive inappropriate care.

Discussions with staff and observations of multidisciplinary meetings evidenced that staff were knowledgeable and familiar about patients' needs. We also saw evidence of very individualised detailed care plans, particularly where patients had complex needs. These reflected information that staff told us about the patients.

Staff did not monitor patients' physical health consistently. The trust's 'physical improvement procedure' stated patients should receive a full physical examination as soon as possible after admission and always within 24 hours. Within the care records we reviewed, there were nine instances where physical health monitoring had not taken place in accordance with this guidance. In six records there were gaps of between four and ten days following admission until a physical health check was completed. There was no evidence of a physical health check in three records and nothing documented to state whether the patient had refused this. Following our inspection, the trust informed us they had recently changed their process for recording evidence of physical health assesments. Prior to this change, they advised that some physical health checks may have been held in separate records. Although this may have been the case for instances where we observed no evidence, we still observed gaps that were not in accordance with policy.

There were differences in the frequency of staff monitoring patients' physical observations. The psychiatric intensive care unit staff completed these on admission and discharge unless circumstances warranted otherwise. Staff on the acute wards completed physical observations on a weekly basis using an early warning score tool to help monitor patients and improve how quickly a patient experiencing decline received clinical care. Where weekly monitoring took place, we found gaps in care records where results were not documented. Staff told us that sometimes patients refused checks, however this was often not stated in the record. Two patients on one ward had diabetes which was documented in their care plans. There was information about the frequency staff needed to monitor their blood glucose levels. We looked at the records where staff told us these were recorded and found this had not taken place at the required frequencies. There was no information to state that the patients had refused this. Where there were inconsistencies and omissions of physical health monitoring, there was a risk staff may not have been able to identify concerns in a timely manner and ensure patients received necessary treatment.

Best practice in treatment and care

There was access to care and treatment interventions suitable for the patient group and as recommended in guidance from the National Institute for Heath and Care Excellence. Psychology input was available to patients. The post of psychology lead was vacant and impact upon resources meant there was limited availability to undertake one to one work with patients on the wards. The service was working to help support ward staff to become enabled to deliver psychosocial interventions. Occupational therapy input was available on all wards. Members of the occupational therapy team delivered various sessions such as mindfulness and educational groups.

The trust had a healthy living team and members of this team visited the wards weekly. The team included dietitians, physiotherapists and healthy living advisors. Representatives from the local substance misuse service attended the wards to speak with patients. Some ward staff were trained to offer smoking cessation advice, nicotine replacement therapy and training in dual diagnosis. Information about healthy living and support available was displayed around the wards. Each site had a gym that patients could use whilst supervised.

Patient care records showed input from other professionals and specialists in relation to their health needs. Some patients had ongoing, complex pre-existing physical health conditions. There was evidence of patients receiving appropriate care and support where this was the case and discussions between staff at the service and other specialists.

Staff were able to support patients nutritional needs. Nutritional risk screening was part of the admission assessment staff undertook with patients. Where staff identified patients with risks relating to their nutrition or hydration they were able to seek involvement from dietitians within the trust.

Staff used recognised rating scales to measure patient outcomes. This included the health of the nation outcome score and occupational therapy staff using the model of human occupation screening tool. Staff had formulation meetings to undertake a structured approach to understanding the factors underlying patients' complex needs and behaviours.

The acute and psychiatric intensive care wards participated in the following seven clinical audits as part of their clinical audit programme for 2016 and 2017.

Audit name	Audit scope	Audit type	Date completed	Key actions following the audit
Antimicrobial prescribing	All services	Clinical	13/10/2016	"1. Start Smart amended flow chart to be redesigned and circulated to wards and doctors. 2. To improve prescribing in skin infections (especially duration): a) Start smart follow chart b) Doctor education sessions and e-learning c) Policy review to 7-10 days. d) Prompt on EPMA for review on day 3 & 7. 3. EPMA quick lists to be promoted Compliance to be monitored in antimicrobial stewardship group. 4. To improve documentation of omitted doses of

				antibiotics. 50% of courses had an omitted dose: a) EPMA will prompt missed doses b) Guidance to be developed on how to avoid missed doses c) Rate to be monitored at antimicrobial stewardship group. 5. To improve clinical review of response to treatment (currently 60%). Review of cultures to be included in this: Look into prompt at 72 hours on EPMA."
Prescription Chart Audit	All services	Clinical	01/12/2016	"1. The introduction of EPMA (electronic prescription chart) will solve the identified problems; 2. Mental Health Act has been added to the Alert Section on the EMPA"
Assessment of capacity in patients admitted to The Becklin Centre	Acute (Adult & PICU)	Clinical	28/03/2017	"To discuss whether to develop a local guidance for admitting teams, including higher trainee's out-of-hours, highlighting the undertaking and recording assessments of capacity in those detained under the MHA and those admitted informally. For those admitted informally, this guidance may include the addition of providing information pertaining to fully informed consent for admission to hospital Present the audit at local audit and teaching meetings to raise awareness of the issue and bring attention to the specific capacity assessment tool on PARIS"
Audit of compliance with Trust VTE prophylaxis guidelines	Acute (Adult & PICU)	Clinical	16/02/2017	The audit to be presented at the Junior Doctor's teaching at The Becklin Centre with the inclusion of teaching regarding VTE risk factors and management. The inclusion of the importance of VTE prophylaxis and assessment to be included at the induction for junior doctors To discuss with Pharmacy regarding the inclusion of VTE risk assessments on EPMA for all patients admitted to inpatient wards as a mandatory requirement. The assessment tool to also include the recommended treatment for individuals deemed at risk of VTE as per NICE guidelines
Audit of compliance with Trust VTE prophylaxis guidelines	Acute (Adult & PICU)	Clinical	1 1/08/2017	To discuss with clinicians and Pharmacy on how location of VTE in EMPA can be improved
				"1.When admitting a patient for the first time on MedChart, staff to ensure patient demographics complete and correct. Record then saved for all future admissions

Clinical audit of patient medication treatment plans in the LYPT Women's acute inpatient	Acute (Adult & PICU)	Clinical	15/03/2017	2.Prescribers and pharmacists to ensure demographics correct on prescribing or review of the drug chart on EPMA 3. Prescribers to update allergy status electronically on MedChart before prescribing any medications – system will alert to do so 4. Section and date of 3-month rule to be documented as alert and flagged up 5. Treatment certificates – T2/T3/S62 should be filed in folder of all patients and available in clinic room for prescribing and administration of medication Shift coordinator (nurse) to review all 'alarm clocks' on MedChart at the end of shift and use appropriate coding for doses that are not given, and sign for those that have been administered 6. To present at local audit meeting "
Documentation of contraceptive and Pregnancy information given to patients on antipsychotics	Acute (Adult & PICU)	Clinical	16/01/2017	"1. To circulate results to the MDT on ward 1 at The Becklin Centre to make them aware of the poor concordance with the NICE guideline CG192 and potential risks to patients and the possible medicolegal implications that might arise; 2. One of the ways to improve pregnancy and contraception advice is to include a column on pregnancy test/ contraception advice on the ward PIPA board to encourage the involvement of the MDT and that this is added unto the ward review template; 3. Trust Pharmacy department should be made aware of the finding of the Audit: the general MDT might play an important role in improving the current practice (report to be sent via email) 4. Junior doctors should be made aware of the importance of discussing and documenting such discussions on contraception by their clinical supervisors especially in patients on Antipsychotics with a child bearing potential. To be covered during induction session. 5. To discuss at the MDT to consider the use of leaflets which could be given alongside verbal information with staff ensuring that this is done prior to discharge especially if patient was to unwell earlier in the admission. To discuss whether the leaflet could be available more freely on the ward (e.g. clinic room). "

Skilled staff to deliver care

The team had access to a full range of staff required to meet the needs of patients on the wards. This included consultant psychiatrists, doctors, qualified nurses, healthcare assistants, pharmacists, psychologists occupational therapists and assistants. Staff had access to other specialists within the trust such as speech and language therapists and physiotherapists.

Staff were experienced and had the right skills and knowledge to meet the needs of the patient group. New staff undertook an employee induction and this included local team induction and a corporate induction workshop.

Staff had access to team meetings which took place on each ward. We observed a team meeting on ward three at The Becklin Centre. This was informative, detailed and staff discussed a variety of topics including training and supervision, changes within the trust and acknowledgement and praise to individual staff. The service had recently introduced ward clinical improvement forums which were designed to review, and implement improvements across the service. The female acute wards one and five at The Becklin Centre held these jointly as did the male acute wards three and four. At The Newsam Centre these were held between ward four and ward one and the psychiatric intensive care unit. The psychologist held a weekly reflective practice meeting on each ward which staff were able to attend. Managers said these were normally well attended by staff.

The trust's target for appraisal compliance was 85%. As at 8 November 2017, the overall appraisal rate within this core service was 89%. There was no medical appraisal information provided for this core service.

Ward name	Total number of permanent non-medical staff requiring an appraisal	Total number of permanent non-medical staff who have had an appraisal	% appraisals
Becklin Ward 1	27	23	85%
Becklin Ward 3	30	26	87%
Becklin Ward 4	28	25	89%
Becklin Ward 5	29	27	93%
Newsam Ward 1PICU	30	27	90%
Newsam Ward 5	25	23	92%
Core service total	169	151	89%
Trust wide	2028	1596	79%

Managers provided staff with regular supervision which was used to help review and identify any areas for development and good practice. Staff told us they found supervisions useful and they were able to be open about all areas of their work and wellbeing.

For clinical supervision, between 1 April 2017 and 1 October 2017 the average rate across all four teams in this core service was 47% against the trust's target of 85%, with Becklin Ward four at 15% and Newsam Ward 4 at 20%. The rate of clinical supervision reported during this inspection

was lower across all wards at the last inspection, except Newsam Ward One, which reported 60% at the last inspection.

Ward name	Clinical supervision sessions required	Clinical supervision sessions delivered	Clinical supervision rate (%)
Becklin Ward 4	148	22	15%
Newsam Ward 4	123	25	20%
Becklin Ward 5	146	65	45%
Becklin Ward 1	147	86	59%
Newsam Ward 1PICU	164	101	62%
Becklin Ward 3	119	97	82%
Core service total	847	396	47%
Trust Total	11598	6674	58%

However, the system for recording clinical supervision had recently changed as staff now recorded this themselves on their individual learning account. This had impacted upon the recording data as at the time of our inspection, managers held records which showed clinical supervision was higher than the figures reported and all staff reported receiving clinical supervision. Managers were encouraging staff to ensure they recorded this in the correct system when it took place.

Staff had opportunities to develop their skills and knowledge within their roles. Staff were encouraged to take on lead roles and act as champions in key areas and supported to undertake additional training. Staff had access to further training and some were completing specialist training in the areas of personality disorders, alcohol and substance misuse and other subjects. Staff told us they felt supported and able to access further training to aid their personal development. Some staff were able to have dedicated time to use for their own development.

Managers were able to deal with poor staff performance when necessary. Dependent on the issues, they would seek to identify whether the staff member had any additional training needs or required extra support. Where cases required disciplinary action, the trust had a policy and procedures to help managers ensure due process was followed. Managers also received training to support them with the disciplinary process.

Multi-disciplinary and inter-agency team work

Staff held regular multidisciplinary meetings to discuss and inform the needs of patients receiving support at the service. We observed three separate multidisciplinary meetings on the psychiatric intensive care unit, ward four of The Newsam Centre and ward one of The Becklin Centre. These included a range of professionals from the service and patients, and carers, were able to attend. We observed that staff were respectful and knowledgeable about patients' care needs and the meetings were centred on the needs of patients. Staff told us there were some challenges in including all relevant people at such meetings. This included community co-ordinators, caseworkers and sometimes nursing staff on the wards. Where nurses were not able to attend patient reviews, doctors felt this led to changes to care not always being recorded in patient care plans.

The service also used the purposeful inpatient admissions process which helps ward teams and patients to understand what has to happen to lead to discharge. This involved a daily review of care so that staff could plan for necessary interventions at the right time to reduce delays and barriers to discharge and help ensure patients were only there for as long as they needed to be. Each ward had a display board which showed what stage each patient was at.

The wards had a system for handover of patient information to help ensure effective care. Staff handovers occurred at each shift change where staff relayed information about patients' care needs. We observed three handovers on different wards. Staff discussed a range of useful information where there was significant information to report. This included patient risk, safeguarding matters and incidents. Staff did not discuss every patient in the handover. Whilst we did not identify any issues at our inspection as a result of this, there was a potential risk that information may get missed between shifts.

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

The trust provided mandatory training for staff in the Mental Health Act. The trust required staff to undertake this every two years. As of 30 September 2017, 89% of staff in this core service had received training in the Mental Health Act inpatient level two and 93% of staff had received training in the Mental Health Legislation Awareness level one. Registered staff were required to undertake training to level two and healthcare assistants required to complete level one. The training compliance reported during this inspection was higher than the 80% and 87%, respectively for level one and two, reported at the last inspection.

Staff had access to administrative support and legal advice from the trust's Mental Health Act administration office. Staff knew who the administrators were and how to make contact with them. There were copies of the Mental Health Act code of practice on wards and staff could access this electronically and access guidance via the trust intranet.

Patients had access to information about advocacy support available to them. Information was displayed around the wards about how to contact the service and advocates attended the wards. Some individual patients told us about their experiences with the advocacy service which were positive.

Staff explained detained patients' rights to them in accordance with the provisions of the Mental Health Act in a way they could understand. There was evidence of staff making repeat attempts where a patient did not understand their rights and also referring them to an advocate. Patients told us they were aware of their rights and these had been explained by staff. Records showed patients had all been informed of their rights recently and their understanding of these was documented.

Staff ensured patients were able to take section 17 leave from hospital where this had been granted. We reviewed the leave forms of the detained patients' care records we reviewed. These were mostly in order however we did find recording errors and omissions. This included two forms which stated the incorrect section. These were corrected by the responsible clinician during the inspection. Three records had old leave forms still present which were not scored out and two leave forms did not include the number of escorts required for escorted leave. There was a risk that patients may not be appropriately supported if information was not current and clear about leave requirements.

Staff requested an opinion from a second opinion appointed doctor when necessary. We saw evidence of doctors making requests for this service where required.

Staff stored copies of patients' detention papers and associated records so they were available to all staff that needed access to them. Copies were kept on the electronic patient record but staff also kept a paper copy in the office so all staff could access this. Wards also scanned and sent copies of detention paperwork to the main Mental Health Act office for their records.

The acute wards displayed a notice to tell informal patients that they could leave the ward freely. The psychiatric care unit did not have this notice on display. All patients on the unit were detained at the time of our inspection.

The Mental Health Act team completed regular audits to ensure that the Mental Health Act was being applied correctly and to establish whether there was any learning from these. Managers told us that any results and actions would be fed back for them to review and act upon.

Good practice in applying the Mental Capacity Act

The trust provided mandatory training for staff in the Mental Capacity Act. As of 30 September 2017, 89% of staff in this core service had received training in the ‘Mental Capacity Act and Deprivation of liberty safeguards’, level two. This was higher than the 75% compliance reported at the last inspection. The trust required staff to undertake this every two years.

Most staff had an understanding of the Mental Capacity Act and associated principles. Five staff demonstrated a limited understanding of the Act and in what circumstances it may be relevant. Three staff thought it was the role of doctors to assess capacity and several others said that whilst they could undertake an assessment, it was usually a doctor who did this. There were resources available to provide advice and guidance to staff on the Mental Capacity Act via trust policies and procedures.

The trust told us that one deprivation of liberty safeguard application was made to the local authority for this core service between 1 October 2016 and 30 September 2017 in the month of February. There were no authorisations in place at the time of our inspection.

The application of the Mental Capacity Act and principles was not consistent and did not always evidence the patient’s wishes. We saw evidence of some specific decisions for which staff had completed capacity assessments with the patients. These included discussions with relevant individuals and professionals to ascertain what was in the patient’s best interests. However we saw evidence of capacity assessments which did not accord with all principles of the Act. For example, staff had placed restrictions on one patient in relation to their diet and finances. Staff told us that the rationale for the restrictions had been determined via a capacity assessment and were in the patient’s best interests. There was a capacity assessment for one of these decisions but the second assessment of capacity was recorded as an entry in the patient’s case notes. There was little information in any of the documentation about the patient’s wishes or what attempts staff had made to try to maximise their capacity. It was not evident exactly who had been involved and consulted with in the decision making process. There was no reference to the person lacking capacity in these areas recorded in the patient’s care plan.

On another ward, a doctor had assessed a patient as lacking capacity to manage some of their health needs. They had not completed the assessment of capacity form but there was evidence of a discussion in the patient’s case notes. This did not demonstrate fully how the decision had been reached and what support was provided to the patient to help aid decision making. Nothing about the person lacking capacity in this area was recorded in the patient’s care plan.

These findings demonstrated that whilst assessments did take place for decisions where staff had concerns that patients lacked capacity, there was a lack of evidence of the patient's views and how they were supported in the process. This meant there was a risk that patients were not being fully supported in accordance with their wishes.

Is the service caring?

Kindness, privacy, dignity, respect, compassion and support

Staff interactions and attitudes towards patients were caring and respectful. We saw that staff provided emotional support for patients when they needed this. They spoke with patients discreetly and supportively about their care. Staff helped people to understand their care and treatment and encouraged them to ask any questions and checked their understanding during care discussions. Patients each had a primary care team made up of specific staff members as their first line of support.

Staff directed patients to other services where appropriate and supported them to access these. For example, staff could help signpost patients to activity groups within the trust and external specialist services with the patient's consent and where it was felt beneficial.

The majority of patients spoke highly about the staff that supported them. Several patients named individual members of staff they wished to praise and whom they found especially caring and helpful. One patient described staff as being their lifesavers. Many told us staff were helpful, dedicated, brilliant, great, lovely and two patients said they felt staff were genuinely interested in them and their wellbeing. Two patients said although some staff were really good, there were some that were not so good or not as caring. One new patient said they did not feel staff were interested in them.

Carers spoke highly about the staff on the wards and described them as polite and respectful. They felt assured their family member was safe and looked after by supportive staff.

Staff understood the individual needs of patients including their cultural, social and religious needs which was evident from discussions with staff. Staff were able to raise concerns about disrespectful and discriminatory behaviour towards patients and were open about doing so.

Staff respected patients' privacy and dignity. They demonstrated this by actions such as knocking on bedroom doors before entering. All except two patients said staff consistently did this. Staff did not discuss personal information about patients where this could be overheard by others. This helped to maintain and protect patient confidentiality.

The 2017 patient-led assessments of the care environment (PLACE) score for privacy, dignity and wellbeing at both core service locations scored better than similar organisations.

Site name	Privacy, dignity and wellbeing
Becklin Centre	95.31%
Newsam Centre	95.55%
Trust overall	93.96%
England average (mental health and learning disabilities)	89.64%

Involvement in care

Involvement of patients

Staff used the admission process to inform and orient patients to the ward and to the service. Most patients told us that staff showed them around the ward and gave them information about what to

expect. This included information leaflets about the ward. Three patients said that staff had not explained anything about the wards when they were admitted.

Staff did not always fully involve patients in their own initial care and risk planning. Most patients told us they did not have a copy of their care plan and could not recall being offered this. They were unclear about being involved in, or asked about contributing to, any care plan. Several said this could be because they were unwell at the time they were admitted. Two patients thought they did have a copy of a care plan at one stage but no longer had this. Six told us they did have a care plan and/or could recall being involved in producing this.

There were opportunities where patients could be involved in, and give their views about their care and treatment. This included multidisciplinary meetings and care programme approach meetings. We saw patients were involved in these processes and could discuss their care needs.

Patients were enabled to give feedback on the service. Each ward held regular ‘your views’ meetings where patients could speak about any issues affecting them or items they wished to raise. Staff then discussed these in their meetings to look to address any actions where possible. We observed staff discussing the patients ‘your views’ requests in one team meeting and saw reference to them in staff meeting minutes.

Patients had the opportunity to be involved in, and help influence, decisions about the service. This included instances of some patients being involved in the recruitment of new staff. Another example was refurbishment of wards and patients choosing the materials and colours.

Staff ensured that patients could access the independent mental health advocacy service. Staff referred patients they felt would benefit from having input from an advocate. The advocate visited the wards on a regular basis and some patients we spoke with told of their involvement with an advocate.

Involvement of families and carers

Staff involved carers and families in patients care where appropriate. This included attendance at ward rounds and meetings which some carers attended regularly. Carers were aware of who their relative’s keyworkers were and said that they would always be able to speak with a staff member who could update them about how their relative had been.

Staff enabled carers and families to give feedback about the service. This included a friends and families test where they could rate the service. Carers had access to other specialist support such as groups for carers of people with personality disorders. The trust also worked in partnership with an independent charity who provided support to carers in Leeds. Staff could refer and signpost carers to this service for a carers assessment.

The service was starting to implement the triangle of care approach which consisted of a set of principles to improve carer engagement in mental health services.

Is the service responsive?

Access and discharge

Bed management

The trust provided information regarding average bed occupancies for all wards in this core service between 1 October 2016 and 30 September 2017. Four of the wards reported average bed occupancies ranging above the provider benchmark of 85% within this period. Becklin Ward five reported below the provider benchmark for the month of January, however ranged above the provided benchmark for all other months in this time period. The psychiatric intensive care unit, ward one at The Newsam Centre, reported average bed occupancies ranging below the benchmark of 85% over this period, except for the months October, June and July.

Ward name	**Average bed occupancy range (**October 2016 – September 2017**) (current inspection)**
Becklin Ward 1	87.10% - 99.46%
Becklin Ward 3	95.00% - 99.27%
Becklin Ward 4	93.11% - 99.27%
Becklin Ward 5	84.02% - 99.41%
Newsam Ward 1 PICU	69.94% - 94.62%
Newsam Ward 4	93.55% - 100.32%

The trust provided information for average length of stay for the period between 1 October 2016 and 30 September 2017. The average length of stay ranged from nine days to 273.86 days. The next average length was130.2 days suggesting that the average length of stay was due to an outlier and not an accurate representation for the overall service.

Ward name	**Average length of stay range (**October 2016 – September 2017**) (current inspection)**
Becklin Ward 1	26.4 days – 96.5 days
Becklin Ward 3	25.4 days - 60.2 days
Becklin Ward 4	24.4 days - 273.9 days
Becklin Ward 5	23.5 days - 92.2 says
Newsam Ward 1PICU	9.0 days – 76.2 days
Newsam Ward 4	34.0 days – 130.2 days

The trust reported 105 out of area placements between 17 October 2016 and 1 October 2017 for the acute and psychiatric intensive care wards. As of 10 October 2017 there were seven ongoing out of area placements. There were no placements that lasted less than one day and the placement that lasted the longest amounted to 69 days.

Ninety-six out of 105 out of area placements were due to capacity issues, while nine placements were due to another provider better suiting the patient's needs. The service recognised there were concerns with the numbers of people being placed out of area. In 2016 the care group had an intensive look at patient flow and undertook a rapid improvement event bringing all the partners together to reduce number of out of area placements. Since this time, the figures had started to increase again and the trust was looking at ways to improve this. This included working in

partnership with others, such as commissioners, and re-aligning the pathways within the service which was being undertaken at trust level.

Number of out of area placements	Number due to specialist needs	Number due to capacity	Range of lengths (completed placements)	Number of ongoing placements
105	9	96		7

There were 81 reported readmissions within 28 days between 1 October 2016 and 30 September 2017. Twenty three readmissions (28%) were readmissions to the same ward that the patient had been discharged from.

The average number of days between discharge and readmission was 12 days. There were three instances where patients were readmitted on the same day as being discharged and two instances where patients were readmitted the day after being discharged.

Ward	Number of readmissions (to any ward) within 28 days	Number of readmissions (to the same ward) within 28 days	% readmissions to the same ward	Range of days between discharge and readmission	Average days between discharge and readmission
Becklin Ward 1	19	10	53%	2-25	13
Becklin Ward 3	19	4	21%	0-26	9
Becklin Ward 4	18	1	6%	1-28	14
Becklin Ward 5	14	6	43%	0-24	12
Newsam Ward 1 PICU	1	0	0%	3	3
Newsam Ward 4	10	2	20%	0-28	14

The acute and psychiatric intensive care wards were primarily for people of working age who had been assessed via the trust's crisis assessment services. These were people who required assessment and treatment for their mental health needs.

When patients were moved or discharged, staff tried to ensure this took place at an appropriate time of the day. There were 21 ward moves at night reported for this core service between 1 October 2016 and 30 September 2017. There were no ward moves reported for this core service between 1 October 2016 and 30 September 2017 for non-clinical reasons. Staff did not admit any patients into beds of patients who were on leave.

If patients moved wards, this was due to clinical need and in the best interests of the patient. During our inspection one patient on ward one at The Becklin Centre was transferred to the psychiatric intensive care unit at The Newsam Centre. Staff had identified the patient required a higher level of support and was the reason for the transfer which had been agreed by the multidisciplinary team.

Discharge and transfers of care

Between 1 October 2016 and 30 September 2017 three wards experienced delayed discharges. Across these three wards, there were 443 discharges, of which 11 were delayed. This amounted to 37% of the total delayed discharges from the trust overall (30).

The table below shows the trend of delayed discharges across the 12 month period. Two per cent (11) of discharges in this core service were delayed across the 12 month period.

Location/Site	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12
Becklin Ward 1	0	0	0	0	0	0	1	0	0	0	0	0
Becklin Ward 4	0	0	1	0	0	1	1	0	0	0	0	2
Newsam Ward 4	0	3	0	2	0	0	0	0	0	0	0	0

Staff planned for patients' discharge and liaised with appropriate individuals. This included the patient's care co-ordinator, community teams and other support networks. Each patient's care plan included a section on their discharge information. In most records, this was not detailed and gave generic information which meant it was not clear what the patient's discharge goals were. However, we saw evidence of discharge planning through patient's case notes, team discussions and via the purposeful inpatient admission system.

The trust's acute discharge manager and operations manager for clinical capacity and patient flow has weekly meetings with the consultants about the discharge dates for patients. They discussed any other needs around this, such as if the discharge date had changed and what the treatment plan was. Any concerns were escalated to the inpatient services manager and acute inpatient matron to see how these could be progressed. The discharge manager told us involvement from community teams also helped to enable safe and suitable discharges

Some delayed discharges occurred for reasons that were not due to clinical need. Managers said the main cause of delayed discharges was a lack of suitable placements for patients to move on to and bed availability in other services. Several patients were on waiting lists for other services.

Facilities that promote comfort, dignity and privacy

All patients had their own bedrooms and were able to personalise these if they chose to. Rooms were not ensuite but each included a washbasin for the patient's use. Patients had access to bathrooms and showers situated on the wards.

There was storage available for patients' possessions. The psychiatric intensive care unit had individual patient lockers located in the ward office. At The Becklin Centre, each patient had their own plastic tub, kept in the laundry room, for storage of items. Patients did not have their own secure storage facilities.

Staff and patients had access to a range of rooms on the ward to support treatment and care. The Becklin Centre had a therapy suite on site to accommodate the four wards where the occupational therapists held activities. This included a kitchen and a gym. The two wards at The Newsam Centre had an activity area. Each ward had a dining area, lounges, communal areas and laundry facilities.

There were quiet areas on the wards where patients could spend time. Some patients preferred to use their own bedrooms which they had access to at all times via their own keys. Visitors, including accompanied children, were able to visit patients in the visitors room located on the wards. Staff told us they individually risk assessed such situations. One patient told us their relative and child had visited them on the ward, but it had been unsettling for the child due to hearing other patients nearby banging and making noise.

Patients could keep their own mobile phones with them on the ward. If there were any concerns with this arrangement for individual patients, staff would risk assess this. The wards had a cordless portable phone that patients were also able to use if they required.

Patients had access to outside space in a courtyard area at both hospital sites. Where some detained patients were not able to have unescorted leave from the ward, a staff member had to facilitate their access to the courtyard.

Patients we spoke with thought the food was adequate. Most described it as good or ‘OK’ and said there was a suitable amount of choice. Five patients described the food negatively saying it was not nice and there was a lack of variety. Patients had access to hot drinks and snacks on the ward at any time of the day or night

The 2017 patient-led assessments of the care environment score for ward food at The Becklin Centre and The Newsam Centre scored better than similar trusts.

Site name	Ward food
Becklin Centre	95.31%
Newsam Centre	95.55%
Trust overall	95.66%
England average (mental health and learning disabilities)	92.92%

Patients’ engagement with the wider community

Staff took into account patient’s needs in relation to education and work opportunities. Patients care plans included a section specifically about work, training and education. As the wards were for acutely unwell patients, the main focus was on their current treatment. Staff provided opportunities for patients to access activities in the community where they had the appropriate leave.

Patients had access to activities on the ward primarily delivered by the occupational therapy team who worked each day of the week. Activity rooms were open for patients to use and patients told us about various activities they could participate in. This included table tennis, pool, arts and crafts, cooking groups and health walks.

Staff supported patients to maintain contact with families and carers. Carers were able to visit patients on the wards and patients also went on periods of home leave to spend time with their family and friends.

Meeting the needs of all people who use the service

The service made adjustments for patients with disabilities and specific communication needs. Each ward had an accessible bathroom and rooms to help accommodate patients with limited mobility. Several patients on the wards were wheelchair users and required mobility aids and we saw patients mobilising around the wards. Where patients required additional adjustments staff had accommodated these.

Staff ensured patients could obtain information on their rights, local services and other relevant information. Notice boards on the wards and around the sites included information about local services, patients’ rights, how to complain and advocacy services. Staff told us they would be able to provide such information in alternative formats if necessary. For example if patients required easy read information, there were resources within the trust to accommodate this. Staff were able to access materials in other languages and a translation service for patients whose first language was not English.

Staff could accommodate patients' individual dietary requirements to meet their religious and cultural needs. Patients had access to spiritual support. The trust had a chaplaincy, spiritual and pastoral care team. Both hospital sites had a faith room with provision for different religious texts so that people were able to practice their faith.

Listening to and learning from concerns and complaints

This core service received 37 complaints between 1 October 2016 and 30 September 2017. This was a similar amount to our last inspection where 36 complaints had been received.

Ward name	Total Complaints	Common subject type
Becklin Ward 1	11	Patient Care (4) Values and Behaviour (4)
Becklin Ward 3	7	Patient Care (3)
Becklin Ward 4	4	Patient Care (2)
Becklin Ward 5	11	Patient Care (4)
Newsam Ward 1PICU	1	Prescribing (1)
Newsam Ward 4	3	Other (1) Patient care (1) Values & Behaviours (1)

Patients knew how to complain and raise concerns. There was information on display around the wards about how to make complaints, including contacting the Care Quality Commission where patients were detained. Most said they would speak to staff and feel comfortable in raising any issues. Carers also told us they knew how to make any complaints and would try to resolve any issues with staff locally in the first instance.

We saw evidence of staff acting upon patient complaints and concerns. Staff meeting minutes showed discussion about patient complaints. Staff tried to resolve any concerns locally if the circumstances were appropriate. They supported patients to make formal complaints if required.

This core service received 13 compliments during the last 12 months from 1 October to 30 September 2017 which accounted for 4% of all compliments received by the trust as a whole.

Is the service well led?

Leadership

Leaders had the skills, knowledge and experience to perform their roles. Ward managers had a good understanding of the services they managed. Staff told us that team leaders were visible on the wards and we observed this also. Ward staff told us senior staff such as the clinical manager and inpatient services manager also spent time on the wards. Some staff were not aware of anyone else senior at the trust, attending the wards. However, some referred to individuals at board level having visited in the past.

Leadership development opportunities were available and staff were encouraged to develop. The trust provided ward management and leadership courses for managers. There were opportunities for staff below this level to develop and managers had succession plans which took into account staff progression.

Vision and strategy

The trust values were summarised in three words: integrity, simplicity, caring. Staff knew and understood the values and how they applied in their work and team. They had been able to contribute their views to decide on what the final trust values should be. The values and behaviours were included within the staff appraisal process so staff could demonstrate how they worked in accordance with these.

The trust's visions and values were evident throughout the wards. There were displays communicating what the values were. The values were included on the trust intranet. The trust used values-based recruitment to help identify suitable staff to work within the trust.

Staff had the opportunity to contribute to discussions about the strategy for their service. The teams held away days where staff were encouraged to identify and discuss any improvements or developments.

Senior managers told us there had been an overspend for the service and a large part of this was due to staff expenditure. They were looking at initiatives and cost improvements to try to address this. We did not identify, and staff did not report, any impact upon patient care due to financial pressures.

Culture

The majority of staff we spoke with felt respected, supported and valued. Staff were positive about working for the trust and many staff had long lengths of service. Most teams reported good morale whilst acknowledging this could fluctuate in changing circumstances.

Staff told us they were able to raise concerns without fear and would be confident of doing so. The trust had a whistleblowing policy accessible to staff and a Freedom to Speak Up Guardian. Most staff knew who the guardian was and how to make contact. The trust had sent communications to staff and the Freedom to Speak Up Guardian had been attending team meetings. Although staff were confident about speaking out, not all staff had heard of, or were aware of, the role of the Freedom to Speak Up Guardian. This meant they were not fully aware of all available resources about how to report concerns.

Managers were able to deal with poor staff performance when necessary. There were processes and policies in place to support this and the trust had a human resources department which would be involved where necessary.

Teams worked well together and managers were able to appropriately deal with any difficulties. A number of staff we spoke with said they felt supported by their ward manager and felt they worked well to manage the team.

Staff had the opportunity to talk about their careers, personal development and objectives within their appraisals. Some individual staff were undertaking further courses to help their career progression and the trust was supportive of this.

Staff had access to support for their own physical and emotional health needs. The trust had an employee assistance programme which provided counselling and other support to staff and an occupational health service.

The trust had schemes to recognise and reward staff success. This included a monthly staff achievement and recognition award and an annual trust awards event. In 2017, the inpatient services clinical manager and inpatient services manager were nominated in the category of leader of the year at the annual event.

Governance

There were systems and processes in place to assess and monitor the quality of care delivery and the environment. However we identified some areas of concern from our inspection findings. This included a lack of consistent post-observation monitoring; inconsistent physical health checks and monitoring, a lack of evidence of patient involvement in care planning and decision making and records not always reflective of care needs. Within the environment we identified areas of poor cleanliness and maintenance.

However, the service had already identified many of these areas to improve via their clinical audit process. Audits that had either been completed, were ongoing, or had been proposed, included; measuring practice for rapid tranquillisation in accordance with guidance from the National Institute for Heath and Care Excellence; improving the recording and usage of capacity assessment forms; improving evidence and consistency of blood glucose monitoring; improvements in physical health checks on admission and ongoing physical health monitoring. Each audit, when completed, generated an action plan, with timescales to re-audit to measure improvements. Therefore whilst there were concerns within the service, these were issues already known to the trust and they had started to try to address and improve these.

There was a clear framework about what issues should be discussed at senior management meetings and clinical improvement forums. These included discussions about service feedback and ward updates, audits, training and development, safety and risk, feedback and complaints and safeguarding issues. Minutes showed staff discussed incidents and any learning from these and looked at actions and measures to improve the service.

Staff participated in local clinical audits. These included reviews of medication documentation, clinic room and equipment checks, environmental checks and other areas. The wards also participated in trustwide audits.

Management of risk, issues and performance

The trust provided a document detailing their 128 highest profile risks. The following relate to this core service and each of these has a current risk score of at least high (score of 8).

Key:

Extreme (15-20)	High (8-15)	Moderate 3-6	Low (0-2)

ID	Description	Risk level (initial)	Risk score (current)	Risk level (target)	Last review date
486	"There is an increase in incidents in the service relating to illicit substances that have resulted in physical emergencies and in one case a death. Service users are bringing substances on to the ward and search and other restrictions often prove ineffective (our wards except PICU are open). Service users are offering each other substances with no understanding of their vulnerability/treatment. Our units are in areas where substances are easily accessible. We have little support from agencies specialised in working with substance misuse. We have received complaints from staff, service users and carers in incidents where there is clear evidence of use of drugs on the ward. There have been instances of violence (service users towards staff and service users towards each other) relating to substance misuse."	High	Not stated	Low	24/07/2017
547	"There has been an actual increase in the incidents of violence and aggression within the acute inpatient service in the last year. This has been service user on Service user and service user on staff.	High	High	Moderate	05/11/2017

Injuries have been sustained and there is a potential that a serious injury may occur."

The overall risk register included other trustwide risks which were also pertinent to the service. For example, staffing levels and quality of information and data within the electronic patient record system.

Ward managers had their own risk registers which fed into the main risk register held at trust level. The environmental ligature risks were included on the ward risk registers. Managers had access to all of the risk registers and were able to add new risks. The trust risk register included risks relevant to all wards, which matched the concerns raised by staff such as increased violence and illicit drug use. Staff were able to discuss and escalate any risks where necessary.

There were plans in place in the event of an emergency or significant adverse event. Ward managers had produced their own business continuity plans about how they would continue to provide a service in these circumstances.

Where cost improvement plans had been put forward, these included a quality impact assessment which reviewed the impact upon patient safety. There were no cost improvements plans operating at the service at the time of our inspection.

Information management

The trust had information management systems to collect data from wards about the service. This helped inform senior managers about the performance of the wards and where improvements were required.

Staff had access to the equipment and technology necessary to undertake their role. They had access to computers and laptops to access patient records. There was a team of staff who could respond and support staff with any information technology issues. The trust were in the process of sourcing a new patient recording system and were looking at other systems they felt may be more able to meet their needs

Information governance systems included confidentiality of patient records. Records could only be accessed by staff with the appropriate authority from the trust by way of a personal log on and password. Paper records were kept in the main staff office in a back room. When staff were not present in the room, or were completing confidential information they locked the door so patients could not enter. The service reported information governance breaches as serious incidents.

The service made notifications to external bodies where required. This included notifying agencies such as local authorities, community teams and the police where necessary.

Engagement

Staff, patients and carers had access to current information about the trust and the service. Staff had access to a trust intranet which provided current information relating to the trust. The trust had a website so people with access to the internet could find out information about the services provided. The trust could provide information in alternative formats.

Staff could meet with members of the leadership team. The service manager told us about an example where a healthcare assistant and registered nurses were going to attend a board meeting to talk about delayed discharges from their perspective.

Patients could give feedback about the trust and their experience by completion of an inpatient survey. However, there had been a low response to the latest survey and senior managers wanted to try to improve patient engagement. The service had previously had a service user representative attend the care group clinical improvement forums and senior managers felt this had been beneficial.

The inpatient service manager had good links and engagement with external stakeholders. This included meetings with the local clinical commissioning group, links with nearby hospitals and mental health trusts and working with the local police services.

Learning, continuous improvement and innovation

Staff had the opportunity and time to consider and engage in opportunities for making improvements. This included personal development such as extra training and undertaking research initiatives.

Innovations were taking place within the service. Two practice development nurse posts were employed by the service. This post was a new role created at the end of 2016. They had joined the safewards network and started to roll out some of the modules on the wards. Safewards is a model that uses various interventions that aim to reduce conflict and containment in inpatient mental health settings. We observed a mutual self help meeting take place on ward five of The Becklin Centre between staff and patients as part of this. Nurses and healthcare assistants worked in pairs to champion one area of the safeward initiatives. Staff also had protected time to help develop safewards.

Ward three of The Becklin Centre had a display board as part of the safewards initiative. This included a staff photo board and the display portrayed a very caring message about the ward. Staff on this ward also developed a ‘float your boat’ initiative in team meetings whereby they could highlight other staff members for individual praise.

NHS trusts are able to participate in a number of accreditation schemes whereby the services they provide are reviewed and a decision is made whether or not to award the service with an accreditation. A service will be accredited if they are able to demonstrate that they meet a certain standard of best practice in the given area. An accreditation usually carries an end date, or review date, whereby the service will need to be re-assessed in order to continue to be accredited.

The table below shows that no services have been awarded an accreditation within this core service.

Accreditation scheme	Service accredited	Comments and date of accreditation / review
Accreditation for Inpatient Mental Health Services (AIMS)	No services accredited	The trust expects to apply for AIMS accreditation in the next 10 months.

The psychiatric intensive care unit was in the process of becoming registered with the National Association of Psychiatric Intensive Care Units.

National Inpatient Centre for Psychological Medicine

Facts and data about this service

Location site name	Ward name	Number of beds	Patient group (male, female, mixed)
Leeds General Infirmary	**National Inpatient Centre for Psychological Medicine**	8	Mixed

Leeds and York Partnership NHS Foundation Trust provides one specialist service for people with complex medically unexplained symptoms and physical and psychological healthcare needs. The service was situated on one ward called the National Inpatient Centre for Psychological Medicine at Leeds General Infirmary. The term ‘medically unexplained symptoms’ is used to describe symptoms which cannot be fully explained with medical tests or investigations. They may occur in any bodily system, and include symptoms such as pain, nausea, fatigue, and weakness, as well as a variety of other possible symptoms and illness. Some people with medically unexplained symptoms also have mental health conditions such as anxiety or depression, which are caused by, or exacerbate their physical health concerns.

The ward has eight beds that provide accommodation for male and female patients over the age of 18 who are treated informally or under the Mental Health Act. Four beds are commissioned for patients in the local area and four beds are commissioned for patients nationally.

We last inspected the ward in July 2016 when it was called The Yorkshire Centre for Psychological Medicine and rated the service as ‘good’ overall with a rating of ‘requires improvement’ We rated the service as requires improvement in one key question (safe) and rated the service as ‘good’ in effective, caring, responsive and well-led.

We gave the service two requirement notices because it was in breach of two regulations under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014:

Regulation 10: Privacy and Dignity because the ward did not adhere to same sex guidance in relation to patients’ privacy and dignity

Regulation 18: because compliance with mandatory training was low in several areas, including essential lifesaving, immediate lifesaving, moving and handling and infection prevention and control.

Is the service safe?

Safe and clean care environments

There were eight patients on the ward at the time of the inspection. We checked the environment and documentation about the environment to consider if it was safe and clean.

Safety of the ward layout

The National Inpatient Centre for Psychological Medicine is situated in Leeds General Infirmary. The ward manager reported that any necessary work was completed in a timely manner and patients gave us examples of how quickly staff attended to any problems. The ward had made improvements to their security checks following a recent security check by Leeds and York Partnership NHS Foundation Trust. Staff monitored the ward entrance via an intercom system and checked identification before allowing people onto the ward. All visitors signed a visitor's book to comply with security and fire procedures. All staff received mandatory fire training and training compliance was above 75%. The ward had the required fire equipment, staff knew about the fire safety procedures, and all patients had a personal evacuation plan. However, the ward had not had a fire drill to test out their procedures in the event of a fire.

The trust had undertaken a ligature risk assessment on the ward on 4 August 2017. No high level risks were identified.

The ward layout consisted of eight bedrooms, communal rooms, and staff rooms along one straight corridor. This meant there were clear lines of sight and staff could observe all parts of the ward. We observed ligature anchor points throughout the ward. These are places where people intent on self-harm might tie something to strangle themselves. Staff mitigated ligature risks through their referral and admission process, individual patient risk assessments and observations. Staff reviewed risks daily and would arrange transfer of any patient whose presentation meant that staff could not keep patients safe on the ward. Staff kept the ligature risk assessment and management plan in their handover file and referred to it at handovers. We reviewed the most recent ligature and environmental ligature risk assessment and saw that staff kept this up to date.

There were no mixed sex breaches reported by the trust for this ward between 1 October 2016 and 30 September 2017.

The ward complied with the Department of Health guidance on same sex accommodation. It provided mixed sex accommodation and staff put measures in place to maintain patients' safety, privacy, and dignity. During our inspection the ward had four female and four male patients admitted. The ward provided eight single bedrooms, none of which provided en-suite facilities. All eight bedrooms accessed one corridor that meant that male and female patients had to leave their bedrooms and cross the corridor to access toilet and bathing facilities. Patients did not pass through rooms occupied by the opposite sex to reach the toilet and bathing facilities. Staff considered patients' clinical needs when allocating bedrooms and arranged bedrooms to achieve as much gender separation as possible.

The ward had two toilets, one designated for males, and one designated for females in addition to three separate bathing facilities. The bathing facilities offered patients a choice of one assisted bath, one assisted shower, and one non-assisted facility. Nurses supported patients to use any of the three bathing facilities depending on their individual treatment goals and recovery. Staff managed all three bathrooms with appropriate signage that they changed depending on male or female use. Staff ensured patients were suitably clothed when accessing the facilities and staff were always in the vicinity to offer support. The ward provided a female only lounge in addition to communal rooms where male and female patients mixed.

The staff induction information and patient information booklet informed people about the accommodation arrangements. All staff we spoke with understood the need to provide gender sensitive care in a mixed sex ward. We saw minutes from one patient forum meeting where staff clearly explained the management of the accommodation to patients on the ward. During the

inspection, staff planned bathing arrangements for two patients and managed this according to their guidelines. All five patients we spoke with were aware of, and satisfied with, the arrangements. All patients said that they felt safe on the ward.

Senior managers told us that improvements to the same sex accommodation provision were included in plans for a new ward. However, a suitable location had not yet been identified. We saw this was included on the ward risk register.

Nurses did not have access to personal alarms, however the ward had an integral nurse call system in every room, and staff ensured that all patients knew how to use the system. Staff encouraged patients to reduce their reliance on the nurse call system as part of their recovery. Staff could also call for emergency security assistance through the ward phones. The ward reported no incidents of violence or aggression and all patients and staff felt safe on the ward.

Maintenance, cleanliness and infection control

The ward had reliable systems and processes to keep people safe in the environment. The ward was clean, well maintained and provided comfortable furnishings. All patients and carers we spoke with told us the ward was clean and comfortable. We saw domestic staff present on the ward and cleaning records demonstrated that staff regularly cleaned all ward areas.

Staff adhered to infection control principles and carried out quarterly infection control audits. They protected people from getting a healthcare-associated infection by using hand-washing facilities and hand sanitiser. We reviewed the most recent infection control audit where the ward reached 92% compliance against a trust target of 85%. We saw staff use hand sanitiser and wash their hands as they moved around the ward and administered medication.

Patient led assessments of the care environment are carried out by local people who visit services and assess the care environment. For the most recent patient-led assessments of the care environment assessment (2017), the location scored better than similar trusts for two of the three aspects overall and worse than other trusts for one. The location received a score worse than other similar trusts for condition appearance and maintenance scoring 94.07% compared to 95.13% nationally.

Site name	Cleanliness	Condition appearance and maintenance	Dementia friendly	Disability
National Inpatient Centre for Psychological Medicine	99.75%	94.07%	-	89.33%
Trust overall	99.37%	98.30%	99.72%	93.96%
England average (Mental health and learning disabilities)	98.40%	95.13%	85.53%	86.94

Seclusion room

The ward did not have any seclusion facilities and did not seclude patients.

Clinic room and equipment

The ward had one small clinical room where staff stored medication, equipment, and stock supplies. The room was too small for an examination couch that meant staff carried out physical examinations with patients in their bedrooms. Staff regularly checked resuscitation equipment, and other ward equipment such as hoists and beds to ensure they were safe to use. The service had improved the arrangements for checking clinical room and fridge temperatures following recommendations from our previous inspection in 2016. We saw the most recent medicine management assessment audit tool that now included checks on the medicine fridge and room

temperatures. The ward manager and pharmacy staff monitored the results of the audit and the ward manager took any appropriate action.

Safe staffing

Nursing staff

The ward manager planned and reviewed staffing levels and skill mix so that there was enough adequately trained and skilled staff on duty. Qualified nurses and support staff worked across three shifts. The ward manager worked between Monday and Friday during the day and complemented the staffing establishment. The ward establishment was set at three staff per shift with a minimum of two qualified nurses per shift. The manager told us that they could adjust staffing levels easily and used regular bank staff if required. Bank staff received the same mandatory training as regular staff before they could work on the ward. The ward did not rely on regular use of agency staff. However, if agency staff worked, they received a local induction to the ward.

Staff said there was usually two qualified staff available and there was always enough staff on duty. At the time of the inspection, the ward had no qualified nurse vacancies and two full time support worker vacancies. The manager was in the process of recruiting to these vacancies. We reviewed the previous three months' staff rota that demonstrated senior staff adequately planned the skill mix and staffing numbers. Staff never cancelled patient activities and patients told us that familiar staff were always visible and available when needed. The ward displayed the planned staffing daily. We saw there was enough nursing staff on duty and that nurses had enough time to spend with individual patients.

In addition to nurses and support staff, other professionals provided support to patients on the ward. This included occupational therapy, physiotherapy, and medical staff who worked Monday through Friday during the day.

Medical staff were always available. The ward provided adequate and accessible medical cover that included one full time consultant psychiatrist, one specialist doctor, and one trainee doctor. Medical staff documented clear plans in the medical notes and provided a verbal handover to colleagues who provided cover. The ward was situated close to the local general hospital facilities that meant staff could easily access other specialist advice and facilities. Staff used the trust on call system for medical advice out of hours if required.

The trust provided details of staffing in the table below. Substantive staff refers to how many staff are currently working in the service. The establishment level refers to how many staff the service needs in post i.e. substantive staff plus any vacancies.

Substantive staff figures			**Trust target**
Total number of substantive staff	30 September 2017	17.80	N/A
Total number of substantive staff leavers	1 October 2016 – 30 September 2017	3.60	10%-15%
Average WTE* leavers over 12 months (%)	1 October 2016 – 30 September 2017	19%	10%-15%
Vacancies and sickness			
Total vacancies overall (excluding seconded staff)	30 September 2017	3.37	N/A
Total vacancies overall (%)	30 September 2017	14%	N/A
Total permanent staff sickness overall (%)	30 September 2017	6%	3.7%
	1 October 2016 – 30 September 2017	5%	3.7%

Establishment and vacancy (nurses and care assistants)			
Establishment levels qualified nurses (WTE*)	30 September 2017	15.60	N/A
Establishment levels nursing assistants (WTE*)	30 September 2017	4.10	N/A
Number of vacancies, qualified nurses (WTE*)	30 September 2017	3.00	N/A
Number of vacancies nursing assistants (WTE*)	30 September 2017	0.50	N/A
Qualified nurse vacancy rate	30 September 2017	19%	N/A
Nursing assistant vacancy rate	30 September 2017	12%	N/A
Bank and Agency Use			
Shifts bank staff filled to cover sickness, absence or vacancies (qualified nurses)	1 October 2016 – 30 September 2017	303	N/A
Shifts filled by agency staff to cover sickness, absence or vacancies (Qualified Nurses)	1 October 2016 – 30 September 2017	221	N/A
Shifts NOT filled by bank or agency staff where there is sickness, absence or vacancies (Qualified Nurses)	1 October 2016 – 30 September 2017	46	N/A
Shifts filled by bank staff to cover sickness, absence or vacancies (Nursing Assistants)	1 October 2016 – 30 September 2017	460	N/A
Shifts filled by agency staff to cover sickness, absence or vacancies (Nursing Assistants)	1 October 2016 – 30 September 2017	49	N/A
Shifts NOT filled by bank or agency staff where there is sickness, absence or vacancies (Nursing Assistants)	1 October 2016 – 30 September 2017	50	N/A

*Whole-time Equivalent

The ward has reported a vacancy rate for all staff of 14% as of 30 September 2017.

The ward reported an overall vacancy rate of 19% for registered nurses and 12% for nursing assistants at 30 September 2017.

	Registered nurses			Health care assistants		
Ward/Team	Vacancies	Establishment	Vacancy rate (%)	Vacancies	Establishment	Vacancy rate (%)
National Inpatient Centre for Psychological Medicine	3.00	15.60	19%	0.50	4.10	12%
Trust total	120.06	765.64	16%	89.65	614.56	15%

NB: All figures displayed are whole-time equivalents

	Overall staff figures		
Ward/Team	Vacancies	Establishment	Vacancy rate (%)
National Inpatient Centre for Psychological Medicine	3.37	23.80	14%
Trust total	257.28	2028.82	13%

NB: All figures displayed are whole-time equivalents

Between 1 October 2016 and 30 September 2017, bank staff filled 303 shifts to cover sickness, absence or vacancy for qualified nurses. Agency staff filled 221 shifts and 46 shifts were not filled.

Ward/Team	Available shifts	Shifts filled by bank staff	Shifts filled by agency staff	Shifts NOT filled by bank or agency staff
National Inpatient Centre for Psychological Medicine	570	303	221	46
Trust Total	10125	6391	3013	721

Between 1 October 2016 and 30 September 2017, bank staff filled 460 shifts to cover sickness, absence or vacancy for nursing assistants. Agency staff filled 49 shifts and 50 shifts were not filled.

Ward/Team	Available shifts	Shifts filled by bank staff	Shifts filled by agency staff	Shifts NOT filled by bank or agency staff
National Inpatient Centre for Psychological Medicine	559	460	49	50
Trust Total	53303	38319	10899	4085

The ward had 3.60 (19%) staff leavers between 1 October 2016 and 30 September 2017.

Ward/Team	Substantive staff (At September 2017)	Substantive staff Leavers (between October 2016 – September 2017)	Average % staff leavers
National Inpatient Centre for Psychological Medicine	18.50	3.60	19%
Trust Total	1801.83	166.73	9%

The sickness rate for this ward was 5% between 1 October 2016 and 30 September 2017. The most recent month's data (September 2017) showed a sickness rate of 6%.

Ward/Team	Total % staff sickness (at latest month)	Ave % permanent staff sickness (over the past year)
National Inpatient Centre for Psychological Medicine	6%	5%
Trust Total	4%	5%

The table below covers staff fill rates for registered nurses and care staff during July 2017, August 2017 and September 2017.

Key:

> 125%	< 90%

	Day		Night		Day		Night		Day		Night	
	Care Staff	Nurses	Care Staff	Nurses	Care Staff	Nurses	Care Staff	Nurses	Care Staff	Nurses	Care Staff	Nurses
	September 2017				August 2017				July 2017			
National Inpatient Centre for Psychological Medicine	120.0	96.8	100.7	101.5	129.7	91.9	100.3	100.2	109.4	101.2	126.7	101.8

Medical staff

The trust reported that between 1 October 2016 and 30 September 2017, 4% of shifts were filled by agency staff to cover sickness, absence or vacancy for medical locums. Please note that data for filled shifts was provided for 'doctor in training' only.

Ward/Team	Available shifts	Shifts filled by bank staff	Shifts filled by agency staff	Shifts NOT filled by bank or agency staff
National Inpatient Centre for Psychological Medicine – Doctor in training	600	-	25	-
National Inpatient Centre for Psychological Medicine – Middle grade doctor	480	-	-	-
National Inpatient Centre for Psychological Medicine – Consultant	552	-	-	-
Core service total	1632	-	25 (4%*)	-
Trust Total	45168	-	1037	84

* Percentage of total shifts

Mandatory training

The trust had mandatory training requirements for all staff to complete. At the time of the inspection, staff had improved their mandatory training compliance to reach above 75% and achieve the trust target for all training. We reviewed the mandatory training compliance with the ward manager and saw that safeguarding children level two training had improved to 100%. Staff

told us that the trust had made changes that improved their access to mandatory training. The overall training compliance remained higher than 90%.

The trust reported the compliance for mandatory and statutory training courses at 30 September 2017 was 92%. Of the training courses listed, staff had failed to achieve the trust target in four. Of those, one failed to score above 75% which was 'Safeguarding children level two with 67%.

Key:

Below CQC 75%	Between 75% & trust target	Trust target and above

Training course	This core service %	Trust wide %
Duty of Candour	100%	98%
Trust Induction	100%	99%
Safeguarding Adults	100%	95%
Moving and Handling Advanced (LD)	100%	91%
Fire - Level 1	100%	95%
Infection Control - Non-Clinical	100%	97%
Personal Safety Theory	100%	99%
Safeguarding children Level 1	100%	93%
Infection Control – Clinical	100%	81%
Personal Safety with Breakaway Skills	100%	85%
Moving and Handling Principles	100%	90%
Essential Life Support	100%	87%
Mental Health Act - Inpatient - Level 2	100%	78%
Health and Safety	95%	96%
Mental Health Legislation Awareness - Level 1	94%	90%
Clinical Risk	93%	82%
Mental Capacity Act and DoLs - Level 2	93%	85%
Information Governance	90%	92%
Equality and Diversity	90%	96%
Low Level Physical Interventions with PSTS and Breakaway skills	88%	85%
Safeguarding children Level 3	87%	81%
Immediate Life Support	86%	78%
Fire - Level 3	83%	81%
Food Safety Level 2	81%	88%
Moving and Handling Advanced (OPS)	76%	83%
Safeguarding children Level 2	*67%*	82%
Core Service Total %	92%	90%

Assessing and managing risk to patients and staff

During the inspection, we reviewed care records for five of the eight patients admitted to the ward.

Assessment of patient risk

Staff assessed, managed, and monitored patients to keep people safe. Staff used a recognised risk assessment tool and completed comprehensive risk assessments and management plans with patients. These were available to all staff either electronically or on paper. The multi-disciplinary team reviewed the risk assessment and management plans weekly or more frequently if risks changed. Staff were aware of the additional risks that their patients may present with, such as pressure ulcers and complex physical health issues. Staff used care pathways and recognised assessment tools to identify and manage risks related to nutrition and hydration, skin condition and mobility.

Management of patient risk

All five records demonstrated that staff completed timely and comprehensive risk assessments that staff reviewed regularly and kept up to date. We observed a multi-disciplinary meeting and a staff handover that included thorough staff discussion about patient risk and any incidents. Staff used standard agendas in their meetings that ensured staff consistently discussed patients' risks.

During our inspection, staff observed all eight patients on general observation level. This meant that staff checked on patients' safety at regular times during the day and night. Staff followed the trust observation policy and increased the frequency of observations if risks changed. All five patients we spoke with told us they felt safe on the ward.

Staff did not apply any blanket restrictions to patients. These are restrictions on patients that staff have not individually risk assessed. Staff did not routinely search patients or their bedrooms. Staff asked patients not to have certain sharp implements on their possession as part of their admission process. All eight patients were informal and all the patients we spoke with knew how they could leave the ward. The ward implemented a smoke free policy. If patients wished to leave the ward to smoke or for any other reason, they could do so freely at any time. If patients did not want to leave the ward at night to smoke, staff provided treatments such as nicotine patches for overnight use.

Use of restrictive interventions

All staff received mandatory training in low-level physical intervention and breakaway. However, staff told us that they did not use seclusion, any form of restraint or rapid tranquillisation. Patients we spoke with had not experienced or witnessed seclusion, restraint, or rapid tranquillisation on the ward.
The trust reported that staff did not use restrictive interventions with patients 1 October 2016 and 30 September 2017.

Ward name	Seclusions	Restraints	Patients restrained	Number of prone restraint	Rapid tranquilisations
National Inpatient Centre for Psychological Medicine	0	0	0	0	0

Safeguarding

A safeguarding referral is a request from a member of the public or a professional to the local authority or the police to intervene to support or protect a child or vulnerable adult from abuse. Commonly recognised forms of abuse include physical, emotional, financial, sexual, neglect and institutional.

Each authority has their own guidelines as to how to investigate and progress a safeguarding referral. Generally, if a concern is raised regarding a child or vulnerable adult, the organisation will

work to ensure the safety of the person and an assessment of the concerns will also be conducted to determine whether an external referral to children's services, adult services or the police should take place.

Staff received mandatory training in adult and children safeguarding and knew how to raise and report safeguarding concerns. At the time of the inspection, safeguarding training compliance was 100% with the exception of safeguarding children level two at 75%. However, this was an improvement from the information provided by the trust and our last inspection in 2016. The trust reported that the ward made no safeguarding referrals between 29 September 2016 and 1 October. When we spoke with staff, they gave examples of when they discussed and raised safeguarding concerns with the trust safeguarding team in order to protect patients. Staff took advice from the trust safeguarding team and knew how to make a referral if required.

The ward had limited space available for visitors, including any children visiting. The ward had no access to alternative child visiting provision. This meant that visits with children occurred in patient bedrooms or rooms used for other purposes such as meeting rooms or lounge areas. Staff were clear about child visiting arrangements and informed patients that an adult had to be present at all times to be responsible for the child during the visit. The multi-disciplinary team assessed and managed any risks associated with child visiting.

Staff access to essential information.

All information needed to deliver care safely was readily available and accessible to all staff including bank staff and visiting specialists. Not all staff could access the electronic record (such as new staff) until they completed the required training. To mitigate this, staff used a combination of electronic and paper records. Staff kept all records securely, and up to date which meant all staff accessed the same information. Staff knew how to access the information they needed. Staff shared and recorded essential patient information from the previous 24 hours at their staff handovers and provided comprehensive information at weekly multi-disciplinary meetings. At every handover, staff used a handover file that held patient and safety information about the ward.

Medicines management

The ward followed good practice in relation to medication management and storage. Staff stored medicines correctly and securely, and only authorised staff accessed medications. The ward had appropriate arrangements for the management of controlled drugs. These medicines require extra checks and special storage because of their potential for misuse. Staff used an electronic prescribing system that included patient photographs so that staff could easily identify patients. Staff accessed this information before they prescribed and administered medication to patients.

We reviewed the medicines management arrangements and observed staff administering medications to patients. One patient was self-administrating an ointment at the time of our inspection. However, we found that patients had nowhere to store medications securely in their rooms. Staff told us that patients had to use the clinical room to access and store their medications.

We saw that staff recorded and administered medication in line with current legislation, national guidance, and best practice. The ward had good access to pharmacy staff who were involved in discussions about patients' medication before their admission. Patients could be taking different prescribed medications for their physical and mental health as well as herbal and over the counter medications before admission. Staff advised patients about their medications before admission and planned appropriate medicines interventions such as pain management if needed.

Medical staff reviewed patient's medication at the weekly multi-disciplinary team meeting, including any 'as required' medication. We reviewed five medication prescription charts and saw that staff documented care plans for specific 'as required' medications, but did not routinely

complete care plans for all required medications. This is recommended good practice so that advice on administration and monitoring effectiveness is available for staff and patients.

The ward had regular support from pharmacy staff. Pharmacy staff offered advice and information to staff and patients about their medications before and during their admission. They carried out medicines reconciliation on admission, attended multi-disciplinary team meetings with patients every two weeks, and assessed a patient's safety for self-administration as part of their recovery.

The ward reported all medication errors via the trust electronic reporting system. The ward manager supported individual staff to learn from their mistakes and addressed this through individual staff supervision and management plans. The service demonstrated learning from mistakes and made improvements in response to a medication errors. Any staff administering medication wore a tabard that identified they were not to be disturbed to reduce the risk of errors. We saw that staff always wore the tabard during our inspection.

The ward manager had recently identified that staff did not check patients' leave medication, which meant staff could not monitor compliance when the patient returned to the ward. Therefore they had implemented a system to check patient's medication on return from leave. They trust provided the details of this system in their response to the factual accuracy of the draft report.

Track record on safety

Providers must report all serious incidents to the Strategic Information Executive Information System within two working days of an incident being identified. Between 1 October 2016 and 30 September 2017 there were no Strategic Executive Information System incidents reported by this service.

We asked the trust to provide us with the number of serious incidents from the past 12 months. The number of the most severe incidents recorded by the trust incident reporting system was comparable with the Strategic Information Executive Information System.

Although there were no serious incidents in relation to the service, managers informed staff about lessons learned from other areas within the trust. The trust governance systems and processes shared information about serious incidents and managers cascaded relevant information at team meetings.
We asked about what safety improvements the service had made in the previous 12 months. The manager explained how the ward improved security arrangements for entry to the ward following an unannounced security check. The manager planned to make further improvements to security arrangements by recruiting additional administration staff. This meant that administration staff would be more available to meet and greet visitors and perform security checks.

Reporting incidents and learning from when things go wrong

The Chief Coroner's Office publishes the local coroner Report to Prevent Future Deaths which all contain a summary of Schedule five recommendations, by local coroners with the intention of learning lessons from the cause of death and preventing deaths.

In the last two years, there has been one 'prevention of future death' report sent to the trust but it did not relate to this ward.

The service had a thorough system for reporting and reviewing incidents. All staff knew how to report incidents through the electronic incident reporting system. Duty of candour was part of the staff mandatory training requirement and training compliance was 100%. The Duty of Candour regulation is in place to ensure that providers are open and transparent with people who use services. It also sets out some specific requirements that providers must follow when things go wrong with care and treatment, including informing people about the incident, providing reasonable support, providing truthful information and an apology when things go wrong.

Staff understood their duty of candour and the importance of being open and transparent with patients and their families and apologising if things went wrong. The ward manager gave examples of incidents that staff reported such as falls and medication errors. We reviewed one incident report where staff apologised to one patient following a drug administration error. This demonstrated that staff were open and transparent with patients.

Staff received feedback and learning about incidents and investigations through the trust and ward governance arrangements. The manager discussed all relevant incident reports and any learning at the weekly team meeting. We reviewed the minutes from the previous five team meetings where incident reporting appeared on the standing item agenda for discussion. At the first staff meeting of every month, staff reviewed all the incident reports for any themes and trends to support improvements to the service. Staff had made changes to their medication administration to improve safety and had identified one further medication issue that the manager was already addressing.

The ward had embedded a range of opportunities for staff and patients to de-brief following any incidents. This included discussion at the multi-disciplinary meeting, one-to-one support with the ward manager and team reflection. Any member of staff could attend the monthly team reflection meeting to discuss any ward issues and included time for de-briefing.

Is the service effective?

Assessment of needs and planning of care

The service had a holistic approach to assessing, planning and delivering care and treatment. The service assessed and planned for patients' needs prior to admission. This was important because patients admitted to the ward had severe and complex medically unexplained medical conditions such as pain, nausea and fatigue that required multi-disciplinary assessment and specialist advice. The multi-disciplinary team conducted home visits and contacted patients by telephone pre-admission to inform their assessment. They thought proactively about what interventions they could offer to meet patients' needs. For example, if a patient had pressure ulcers, staff planned for the equipment and advice they needed so that it was available to the patient on admission. The ward had good working relationships with other specialty staff such as tissue viability staff and medical specialists for pre-admission advice if required. Everyone worked collaboratively to provide joined up care to patients and their carers. Staff formulated a full understanding of the patient's presentation during the assessment process that supported their treatment interventions. Staff shared this with patients and their carers in a timely and sensitive way.

We reviewed the care plans of five of the eight patients admitted to the ward. All care plans were up to date and regularly reviewed by staff.

All care plans were entirely personalised and covered a range of needs that included physical and mental health, and social needs. Plans contained clear person centred and recovery-focused goals that staff completed with the patient. Patients identified their treatment goals from admission as part of their recovery and discharge plan. All members of the multi-disciplinary team carried out specific assessments within one week of admission that supported patients' short-term and long-term goals. The multi-disciplinary team reviewed goals with each patient and their families every week. This was important because patient goals changed significantly from admission to discharge. Patients gave us examples of their progression from managing to get out of bed to achieving goals such as going to the cinema.

The service planned for discharge at the earliest opportunity in the patient's admission. The multi-disciplinary team reviewed discharge arrangements with patients at their weekly meeting. This meant that as patients recovered staff could plan for the most appropriate support that patients needed to fully reflect their circumstances and preferences.

Physical health care was high quality and was a priority for the service. The ward employed one dual-qualified nurse with responsibility for meeting patient's physical health care needs and monitoring long-term conditions such as diabetes and epilepsy. The nurse provided training to other staff to use the national early warning scores that records patient' respiratory rate, temperature, blood pressure and heart rate. This highlights warning signs of physical ill health so that nurses can seek early medical support. Nurses also supported patients by liaising with other health care professionals such as dietary, speech and language therapy, dental, chiropody and neuropsychology staff.

All patients we spoke with said they were fully involved in their care plan and had a copy. Patients said they were pleased with their progress that sometimes exceeded their expectations. Patients felt confident about all aspects of the care they received including their physical health. Carers felt supported, involved, and well informed by staff.

Best practice in treatment and care

Staff used national best practice and best available evidence that achieved good outcomes and improved patients' quality of life. Their performance was recognised by external bodies such as the Joint Commissioning Panel for Mental Health and the British Association for Chronic Fatigue Syndrome and Myalgic Encephalomyelitis (CFS/ME). It was fully compliant with the guidance set by the National Institute for Health and Care Excellence.

The ward provided a range of group and individual treatment programme that supported patients' recovery. Patients told us how staff supported them to achieve goals, which were important to them such as graded activity and graded exposure programmes that improved their physical functioning. Staff offered a full range of psychological therapies to patients on an individual basis. This included cognitive behavioural and related approaches such as graded exposure including anxiety management techniques, mindfulness, compassion-focused therapy and eye movement desensitisation and reprocessing. This was in addition to pharmacological and social interventions. We saw the group activity schedule that supported patients physical, mental health and social recovery with activities such as circus skills workshops, cooking, relaxation and social activities. Patients told us about the therapies that were helpful for them such as sleep therapy, relaxation, pain management and graded exposure to help them deal with their fears and anxieties. One patient told us how their individual therapy had; "helped them so much to adapt to their illness and use coping skills".

All staff were actively engaged in activities that monitored and rated outcomes for patients. The service had a defined model that took account of biological, psychological and social factors. Staff used a range of recognised patient and clinician reported outcome measures. This included the Clinical Global Improvement Scale, Chalder Fatigue Scale, Hospital Anxiety and Depression Scale, and Therapy Outcome Measures. During the multi-disciplinary meeting, we observed how staff used outcome measures in a meaningful way that supported individual patient's recovery. The service reported consistently good outcomes for patients who were admitted to the service in 2016-2017. For example, overall 83% of patients had improved fatigue scores and 82% of patients reported improvement in their mobility, self-care, activities, pain and anxiety or depression. Patients completed a self-reported questionnaire on admission and discharge that compared their level of psychological distress. Overall, 78% of patients reported improvements on discharge. This included improvements in patient's well-being, problems and symptoms, life functioning, risk and harm. Patients told us about the improvements they had made with their particular problems and how this had made a real difference to their lives.

Staff ensured that patients had good access to physical health care that included access to specialists when required. Staff worked collaboratively with other health care professionals such as dietary, speech and language therapy, dental, chiropody and neuropsychology staff. Staff incorporated the advice from specialists in patients care plans that staff delivered fully integrated care. Nurses carried out specific rating scales to monitor patients' physical health such as the Braden scale to predict the risk of pressure sores and followed the European Pressure Ulcer Advisory panel guidelines to manage pressure areas. Nurses also supported patients to live healthier lives such as offering smoking cessation and advice on healthy eating and alcohol consumption.

Staff used some technology to support patients effectively such as an electronic medication system that supported effective medication management. Staff identified that access to patient information on the local general hospital electronic system could be improved. This would provide more timely access to important information such as scans and blood results.

Staff participated in a range of audits to monitor the quality and safety of the service. These included infection control audits, moving and handling audits, ligature and environmental audits, fridge temperature checks and medication audits. The manager discussed audit results and changes required at staff meetings. They ensured that any concerns or good practices were recognised, and action plans were developed and shared with the team. The clinical lead produced an annual report about the service that included information about the outcomes and quality of the service. The service published this report that was available on the internet for public information.

Skilled staff to deliver care

Patients had access to a full range of specialists within the multi-disciplinary team that supported their care and treatment. This included; a consultant in liaison psychiatry, specialist doctor and trainee doctor, qualified nurses, occupational therapy staff, physiotherapy, psychotherapists, cognitive behaviour therapists, dietitians, pharmacists and administration staff. The ward team also used the expertise of specialists from the general hospital such as medical and surgical staff when required.

The service has experienced and qualified staff that had the right skills and knowledge to meet their patient's needs. In addition, the ward had preceptor nurses and students. The service provided all staff with opportunities for continuing development of skills, competence, and knowledge that ensured high quality care. Following a training needs analysis, the manager arranged for one nurse to receive wound care training and established a peer education group for all staff to participate. The training forum provided 15 specialist-training packages relevant to the ward such as the biopsychosocial model, medically unexplained symptoms, chronic fatigue syndrome, and psychotherapeutic interventions. The ward had an arrangement with the local general hospital to provide reciprocal training to share knowledge and best practice relevant to the service. In addition, staff had identified champion roles such as infection control and moving and handling. Staff we spoke with felt supported to develop their knowledge and skills.

The manager ensured that all new staff received an appropriate induction to the ward that included the arrangements in place with the local general hospital such as fire safety. This was important because the ward was situated on the general hospital site. A buddy system supported all new starters with a clinical supervisor who was experienced and familiar with the ward. New staff always worked the day shifts with regular staff for the first month before they worked night shifts. This was the minimum requirement which the manager extended depending on the staff member's progress.

Between 1 April 2017 and 1 October 2017, the clinical supervision rate for the ward was 54% against the trust's target of 85%.

Ward name	Clinical supervision sessions required	Clinical supervision sessions delivered	Clinical supervision rate (%)
National Inpatient Centre for Psychological Medicine	109	59	54%
Trust Total	11598	6674	58%

At the time of the inspection, we found that the clinical supervision rate had improved and formal supervision compliance met the hospital policy requirements. The ward manager had real time oversight of clinical supervision compliance against the trust target. This was in addition to the trust reporting system because the manager said the electronic reports were not as up to date. During this inspection, the ward manager confirmed that supervision compliance was 89%. We reviewed the manager's record and spoke with staff about their supervision arrangements. All staff felt well supported in their roles.

We checked the arrangements the service had in place to deliver and record appraisal and clinical supervision. All staff had a range of opportunities for supervision to reflect on and learn from their practice. This included regular clinical and management supervision, staff meetings, and a team reflection group. During the inspection, we reviewed two management supervision records and five records of staff meetings. Management supervision was well documented against staff performance and development needs. The manager informed us there were no poor staff performance issues. A range of between seven and 11 staff attended team weekly meetings that addressed staff appraisal, supervision and training requirements. The manager shared minutes of the meetings with all staff that meant those who could not attend were informed.

The trust's target rate for appraisal compliance was 85%. As at 8 November 2017, the overall appraisal rates for non-medical staff within this service was 86%. The trust did not provide medical appraisal information for this service.

Ward name	Total number of permanent non-medical staff requiring an appraisal	Total number of permanent non-medical staff who have had an appraisal	% appraisals
National Inpatient Centre for Psychological Medicine	22	19	86%
Trust wide	2028	1596	79%

At the time of the inspection, we found that the service exceeded the trust target for appraisal compliance. The manager used an electronic dashboard that provided oversight of appraisal compliance against the trust target of 85%. The manager had an appraisal matrix that ensured all staff received a yearly appraisal. Staff we spoke with including medical staff told us they received a yearly appraisal that identified their training and development needs.

Multi-disciplinary and interagency team work

There was a full range of professional disciplines that comprised the multi-disciplinary team. This included medical and nursing staff, support staff, psychotherapists, occupational therapy and physiotherapy, dietician, administration staff and pharmacy support.

The team held effective weekly multi-disciplinary team meetings that fully involved patients and their families. We observed a multi-disciplinary meeting that was well chaired, structured and comprehensive. Staff focused entirely on the patient's recovery and successful discharge. The meeting demonstrated that the team had effective working relationships with other relevant teams. It is important that staff have good relationships with community teams to support patients' successful discharge. At this meeting, appropriate professionals from the community team had confirmed their attendance for the two meetings planned before the identified discharge date. All professionals present and the patient contributed equally during the meeting. Staff had a clear understanding about the patient's individual needs and the support required to help the patient achieve their goals. We spoke with patients and families about their experience of multi-disciplinary meetings. People told us they felt fully involved in meaningful and helpful meetings on a regular basis. Staff told us they felt valued and supported in a team that worked well together.

The ward team shared information effectively at three staff handovers every day. We observed one staff handover where staff discussed each patient's care and treatment over the past 24 hours in addition to other important issues such as any incidents and staff allocations. Staff used a standard handover document that ensured the shared information consistently at every handover.

The service had effective working relationships with people outside the service such as commissioners and other services involved in patient care. They made referrals to other professionals depending on patient needs such as social care, learning disabilities services and physical health specialists. The service had established links with three other similar services across the country to share information about their practice.

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

The trust provided details of two 'Mental Health Act' related courses for this service and the training compliance for each as of 30 September 2017. These were 'Mental Health Legislation Awareness - Level one' (94%) and 'Mental Health Act - Inpatient - Level two' (100%).

The service had no patients detained under the Mental Health Act at the time of our inspection and staff told us this had been the case for approximately five years. However, all staff were aware of the Mental Health Act and their responsibilities. One nurse who had more recent experience of working with the Mental Health Act and Code of Practice had provided a staff update as part of the ward learning forum. Staff knew how to access additional support and advice if required. This included access to relevant on-line policies, administrative support and information.

Good practice in applying the Mental Capacity Act

As of 30 September 2017, 93% of the workforce in this service had received training in the ‘Mental Capacity Act and Deprivation of Liberty Safeguards - Level two’.

The trust told us that no Deprivation of Liberty Safeguard applications were made to the local authority for this service between 1 October 2016 and 30 September 2017.

Staff had access to the trust Mental Capacity Act Policy and Code of Practice via the trust intranet. They understood their responsibilities under the Mental Capacity Act and Code of Practice and how to access additional support and advice if required.

We checked five care records and found that staff documented capacity for all five patients on admission. Medical staff documented capacity decisions with individual patients every four weeks that reflected their consent to treatment and admission. The capacity documentation was easily located within the patient records. Staff had a good understanding of the Mental Capacity Act and told us that they assessed capacity all the time in relation to gaining consent to provide care and interventions. If staff were concerned about patients’ capacity, they discussed this with the team.

Is the service caring?

Kindness, privacy, dignity, respect, compassion and support

The 2017 patient-led assessments of the care environment score for privacy, dignity, and wellbeing at the National Inpatient Centre for Psychological Medicine scored worse than similar organisations.

Site name	Privacy, dignity and wellbeing
National Inpatient Centre for Psychological Medicine	87.04%
Trust overall	93.96%
England average (mental health and learning disabilities)	89.64%

We offered all patients the opportunity to speak with us and left comment cards for patients to complete about their experience of the service.

We spoke with five of the eight patients admitted to the ward, reviewed six comment cards, spoke with three carers of people who used the service, and reviewed the feedback from patients and their carers who had been discharged from the service.

We received consistently positive feedback about the service and the way that all staff treated people. We received comments such as “I have nothing but praise about the care, service and treatment I received”, “the staff are the most approachable and caring people I have ever come across in the NHS”, “I genuinely believe that the staff care about me and this is the first time I have ever felt like this throughout a stay at hospital”. Patients commented on clinical and non-clinical staff in their feedback and said staff were professional, respectful, approachable, and genuinely caring people. Patients described staff as ‘amazing’, ‘like my own family’ ‘considerate’ and ‘supportive’. Patients felt that staff were professional, competent, and able to provide them with the help and emotional support they needed. Staff extended their support to patients who were on leave and patients told us they could make calls any time and staff gave them the time they needed. Staff had in-depth knowledge and understanding of patients and worked collaboratively with patients and their families to improve their lives. Patients said that staff “helped them to get their lives back on track” and exceeded their expectations in care. One patient described themselves as “a living corpse” before they were admitted to the service. The patient said that staff had “performed miracles and given them their life back and could now go out independently”.

We observed staff interactions with patients throughout the inspection, saw that staff maintained patients’ confidentiality and respected their wishes. All bedrooms had privacy panels that patients controlled from the inside and meeting rooms had screened door panels for privacy. Staff felt confident to raise any concerns about poor attitude or behaviour towards patients if the situation arose.

Involvement in care

All patients were fully involved in their care and staff always took account of patients’ needs, wishes, and aspirations throughout their admission. Staff valued their relationships with patients and their families and did all they could to support individual needs and preferences.

Staff provided patients and their families with information about the ward before admission and provided orientation to the ward on arrival. This information informed patients about what to expect on the ward and patients felt prepared and welcomed on admission.

Involvement of patients

Staff truly respected patients as individuals and empowered them as partners in their care. We saw that staff held meetings with patients that were entirely patient focused and empowered patients to take the lead in their care. Staff also met individually with patients to discuss any issues that were important to them. All five patients we spoke with told us they were active partners in their care and felt staff helped them to reach their potential. Patients told us how staff worked with them to agree their goals. This included graded exposure to light, noise and activity that staff individually tailored to their meet their preferences and choices. Patients were actively involved in discussions about their medication and other treatments and staff always involved patients in their care plans. All five patients knew about their care plans, which they signed and kept copies of.

All patients had the opportunity to be involved in decisions about the service at a weekly patients' forum meeting. We saw minutes from the most recent patient forum displayed on the ward and we reviewed minutes from two other patient forum meetings. Staff acted on patient's concerns and reported their actions for the minutes. If patients did not feel comfortable to raise their concerns in a meeting forum, the manager addressed their concerns individually. Patients told us that staff addressed any concerns quickly.

Staff invited patients to give feedback on the service they received via patient interviews and questionnaires. We reviewed information from patient feedback on discharge from July 2017 until November 2017. Patients provided consistently positive feedback for the care and treatment they received.

Involvement of families and carers

The service embedded family and carer involvement with patients care and treatment and involved carers with patients consent. The service viewed the involvement of families and carers as important for patients' recovery. The ward had an identified carers lead and had attempted to start a carers forum. However, this had not worked well because of the geographical location of some families. On admission, the patients' key worker offered carers an individual carer's assessment and completed a carer involvement and support plan. This enabled the key worker to help address any issues and concerns from the carers view and develop a supportive care plan. Although the ward had stated visiting times in the ward information, this was flexible to meet the needs of carers.

All three carers we spoke with felt informed and involved in their relatives care. They said that staff contacted them regularly by telephone and invited them to attend multi-disciplinary meetings. Carers were very complimentary about the service they received and felt staff supported their needs. We received comments such as 'they go above and beyond' and 'they ring me for updates and opportunities to ask questions' and 'I can't fault them, or the service, they have been really good'.

Staff invited carers to give feedback about the service when patients were discharged. The service had developed their own carer satisfaction survey to collect the views and experiences of carers and received consistently positive feedback. During 2016-2017, 86% of carers rated the service and the support and advice they received as excellent or good. We reviewed information from five carer's feedback forms from May 2017 until November 2017. The feedback from carers was consistently positive, three rated the service overall excellent, and two rated the service overall good.

Is the service responsive?

Access and discharge

Bed management

The trust provided information regarding average bed occupancies for the National Inpatient Centre for Psychological Medicine between 1 October 2016 and 30 September 2017. The ward

reported average bed occupancies, which largely ranged above the CQC benchmark of 85%. The bed occupancy was above 85% for seven of the 12 months.

Ward name	Average bed occupancy range (October 2016 – September 2017) (current inspection)
National Inpatient Centre for Psychological Medicine	63.31% - 100.00%

At the time of the inspection, there were eight patients admitted to the ward that meant the ward was full. The service accepted referrals from any professional including direct referral from a GP. Patients did not have to have a mental health team involved in their care.

When the service received a referral, the senior staff on the ward spoke with referrers directly for more information and reviewed the referral with the multi-disciplinary team. The multi-disciplinary team considered the patient's needs and any associated risks. If the team decided the referral was not appropriate they provided signposting information to the referrer about more appropriate services. Staff placed patients from the local catchment area on a waiting list. There were five people waiting at the time of inspection. Staff waited for funding approval from commissioners before they admitted patients from outside the Leeds area. The service had 25 people waiting for funding approval at the time of the inspection. This meant that patients might experience waiting times of up to four months to access the service. Staff contacted patients to inform them that they had received the referral and that the patient was on the waiting list for admission to the ward. Senior ward staff kept in regular contact with patients on the waiting list. They provided reassurance and gathered more information to assess the patient's needs in preparation for their admission whilst they waited. Senior managers had identified the need to improve waiting times for patients and planned to increase the number of beds in the new service.

The ward effectively planned and managed admissions and discharges to the service. The service held weekly admissions planning meeting that reviewed the waiting list and patients' discharge arrangements so that admissions could be arranged in a timely way. Staff contacted patients a few weeks before their planned admission and informed them of their admission arrangements. Staff carried out an initial meeting with patients either in the patient's own home, hospital or invited the patient to visit the service. This gave patients the opportunity to meet key members of the team and staff could adequately prepare for admissions, such as accessing any specialist equipment and pharmacist advice that was required. Patients we spoke with said they felt well prepared for their admission.

The trust provided information for average length of stay for the period 1 October 2016 to 30 September 2017. The ward had an average length of stay which ranged between 52 days and 144.5 days.

Ward name	Average length of stay range (1 October 2016 – 30 September 2017) (current inspection)
National Inpatient Centre for Psychological Medicine	52 days – 144.5 days

This service reported no readmissions within 28 days between 1 October 2016 and 30 September 2017.

Staff put measures in place that supported successful discharges from the ward. Staff planned and supported patients to go on home leave as part of their recovery and discharge plan. Staff

planned discharges with patients, their families where appropriate, and relevant community teams and professionals from admission. This meant that discharges were rarely delayed and always arranged to suit patient needs. The multi-disciplinary team also planned for patients who might want to leave the service earlier than expected. Staff reviewed any difficulties and risks on admission and included any discharge issues as a set item for discussion at their weekly meeting with patients. This meant that staff identified any problems early and could put management plans in place to support patients who wanted to leave the service early. The team approach was to support patients' re-integration back into their own community rather than discharge them. However if a patient chose to leave, the team took an individualised approach and linked with appropriate community teams to ensure that the appropriate care was in place.

Discharge and transfers of care

Between 1 October 2016 and 30 September 2017, the ward reported 21 discharges of which one was delayed. This amounts to 5% of the discharges being delayed.

	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12
Discharges	3	2	0	2	2	3	4	1	2	2	0	0
Delayed	0	0	0	0	0	0	0	0	0	1	0	0
% Delayed	0%	0%	0%	0%	0%	0%	0%	0%	0%	50%	0%	0%

The service acknowledged that a delayed discharge related to highly complex cases where it was necessary to delay the discharge until the right support was in place. This was not in the control of the service and depended on accessibility of appropriate social care and access to specialist assessments for example. In order to reduce delayed discharges the service had firmly embedded discharge planning in the patients' pathway. Discharge planning commenced pre-admission, and continued throughout the patients admission. All patients had discharge plans with goals and interventions to support their discharge and patients we spoke with were fully involved in their discharge plans.

There were no ward moves reported for this service between 1 October 2015 and 30 September 2017.

There were no ward moves at night reported for this service between 1 October 2016 and 30 September 2017.

Facilities that promote comfort, dignity and privacy

At the time of the inspection, we found that the facilities provided on the ward could be improved to promote patients comfort, dignity and privacy. All patients had their own bedrooms with a sink for washing and patients could personalise their rooms with their belongings. No bedrooms had en-suite facilities. All bedroom doors had privacy panels that patients could control from the inside, however patients did not have keys to their rooms because doors were not lockable. Some rooms did not have a lockable cabinet that enabled patients to store their possessions safely. Staff locked patient's possessions in a safe in the staff office if requested.

The clinical room was not large enough to keep an examination couch and the ward had limited room available for places for therapy and storage of equipment. Staff and patients used communal areas and rooms for multiple purposes. This included places for visitors and quiet areas. The ward phone was situated in the corridor that did not afford patient's privacy. However, all patients had access to their own mobile phones.

The ward had limited facilities to support occupational therapy, physiotherapy and recreational activities. The kitchen area did not suit the needs of people who required lowered facilities. Access

to outside space from the ward was limited to a balcony area that patients accessed from the conservatory. However, the conservatory served as a room for meetings, limiting access to the outside space. Patients commented that the ward environment was homely and calm but commented about the lack of facilities and space. Staff were aware of the limitations of the ward environment and made the best use of what was available. Senior managers recognised the limited space and facilities available on the ward. They had consulted with staff and included improvements that addressed issues with the environment in plans for an alternative environment.

Patient-led assessments of the care environment are carried out by local people who visit services and assess the care environment. The 2017 patient-led assessments of the care environment score for ward food at National Inpatient Centre for Psychological Medicine scored better than similar trusts.

Site name	Ward food
National Inpatient Centre for Psychological Medicine	95.30%
Trust overall	95.66%
England average (mental health and learning disabilities)	92.92%

Patients we spoke with were complimentary about the food and said that they could access hot drinks and snacks whenever they needed.

Nurses, occupational therapy and physiotherapy staff supported patients to access facilities away from the ward environment. This included access to educational and vocational opportunities as well as recreational and social activities.

Patients' engagement with the wider community

Staff worked proactively to deliver care to meet patients' needs that promoted equality and social inclusion. Some patients had not been able to maintain relationships and social or educational activities prior to admission because of the impact of their illness. The service supported patients from admission to improve engagement and activity levels so they could develop and maintain relationships that mattered to them. One patient reported that the service had helped them to 'feel human again'.

Meeting the needs of all people who use the service

The service was located centrally in Leeds which gave patients good access to local community facilities and transport that supported their recovery. The ward was on the ground floor with an accessible entrance to the ward. This meant that people with mobility difficulties could access the service. The ward provided hospital beds and equipment such as hoists and pressure relieving equipment if required. Staff ensured that patient who were bed-bound could access and understood how to use the nurse call alarm system. The ward had two accessible bathing and showering facilities that staff supported patients to access.

Throughout the ward, information leaflets and posters informed patients about important information about the service, health promotion information and information about the Care Quality Commission.

Staff could provide information in other languages if required and arranged interpreters and signers through the trust system. Patients had a choice of food that met their dietary and religious needs. During the inspection staff demonstrated they were knowledgeable about individual religious and spiritual needs and provided facilities for a quiet place to prey.

Listening to and learning from concerns and complaints

This service received one complaint between 1 October 2016 and 30 September 2017. This was regarding patient care.

Patients and relatives we spoke with knew how to complain and felt confident to complain if necessary.

Staff supported patients to raise complaints informally and formally and knew how to handle complaints appropriately. The ward held a weekly patients forum meeting that staff attended and encouraged patients to give their feedback about their care. Staff acted on patients' concerns and documented their actions on the meeting minutes that they displayed on the ward. This meant that staff provided feedback to patients when they raised concerns. Staff gave all patients a ward information booklet and displayed information that informed patients how to complain via the patient advocacy and liaison service. Staff shared information about complaints or patient concerns at multi-disciplinary meetings, team meetings and staff handovers.

This service had logged one compliment on the trust electronic system during the last 12 months from 1 October 2016 to 30 September 2017, which accounted for less than 1% of all compliments received by the trust as a whole.

Is the service well led?

Leadership

The service was part of the trust specialist and learning disabilities care group. The senior clinical team on the ward comprised one lead clinician and one ward manager who had worked in the service for a number of years. They had the skills and knowledge that supported them in their roles and they had a good understanding of the service. They attended regular care group meetings and shared relevant information with senior managers and the ward team.

Senior leaders were visible and accessible to staff and patients on the ward. They visited the ward and attended meetings to meet staff informally and formally.

All ward staff we spoke with knew their senior ward and service managers and said they were visible and approachable. Staff felt proud of the service and expressed high levels of satisfaction despite the challenges they faced.

Vision and strategy

The trust vision was:

To provide outstanding mental health and learning disability services as an employer of choice

The trust values were:
We have integrity:

We treat everyone with respect and dignity, honour our commitments, and do our best for our service users and colleagues.

We keep it simple:

We make it easy for the communities we serve and the people who work here to achieve their goals.

We are caring:

We always show empathy and support those in need.

Staff had access to the trust vision, values and strategy via the trust intranet and the service displayed information for staff and patients on the ward. All staff we spoke with were able to identify with the trust vision, values, and strategy. They demonstrated their understanding in the way that the service delivered care to patients. Staff had an open and honest culture, with a desire to deliver high quality care with outcomes that made a real difference to the lives of the people they cared for.

Staff mostly felt engaged with senior staff about service developments. However, the trust had re-configured and reduced ward administration support and the ward manager felt that the trust had not engaged sufficiently with staff to understand the impact on the quality of care. The ward manager had sufficient authority to manage the ward budget and planned to recruit administration staff. Senior managers had consulted with staff about improvements to the service but did not yet have a definite plan for an alternative environment. Staff hoped to expand and improve their service within a more suitable environment and felt frustrated by the limitations of the current environment and lack of a clear re-location plan.

Culture

Senior team members promoted a culture of high quality, person-centred care that all staff supported. The team were passionate about the service and worked towards making improvements in the quality of care and the environment. The ward had a range of audits and used feedback from people who used the service to monitor the quality of the service. People who

used the service consistently told us about the high quality and person-centred care they received. We observed staff deliver person centred care during the inspection.

Staff felt proud of the service and expressed high levels of satisfaction despite the challenges of the environment. Staff sickness and absence was similar to the trust average. All staff spoke highly of the service and felt proud to work with a supportive and effective team. Staff respected the senior managers on the ward and felt comfortable to raise any concerns about bullying, harassment or clinical practice. Staff knew about the trust arrangements for whistleblowing and the Freedom to Speak up Guardian should they need to use them. Trusts are required to have these systems in place to support staff to speak up about their concerns.

Governance

The service has clearly identified roles, responsibilities, and systems that supported robust management and governance arrangements. This included systems and processes that ensured the ward had sufficient audits and safety checks that ensured the ward was safe, clean and well maintained.

Senior ward staff monitored and supported staff effectively. This meant there was sufficient staff on duty, staff were highly motivated and received the training and support they needed to deliver safe care and treatment. Senior ward staff felt supported by senior managers, who were visible and approachable and understood the challenges of the service.

The service had developed clear frameworks for meetings at all levels that meant staff shared relevant information consistently about the service and the trust. This included information about patient feedback, complaints, and incidents that staff used to make improvements to the service.

The service had a defined care pathway and recovery focused model that all staff understood. The multi-disciplinary team met regularly and worked effectively with other teams and services to support patients’ recovery. The team worked collaboratively with patients to deliver high quality and evidence-based care. Interventions focused on outcomes and patient goals that made a positive difference to the lives of people who used the service. The service monitored the waiting list and effectively planned and manged admissions and discharges to the ward so that beds were rarely empty.

Management of risk, issues and performance

The trust has provided a copy of their most recent risk register. One of these risks relates directly to this service – details can be found below.

Key:

High (15-20)	Moderate (8-15)	Low 3-6	Very Low (0-2)

ID	Description	Risk level (initial)	Risk score (current)	Risk level (target)	Last review date	Action
41	LTHT have stated their intent to vacate the site currently used by National inpatient centre for psychological medicine, and there is currently no identified alternative location for the service to be housed (YCPM).	15	15	1	06/11/2017	Monthly YCPM working group set up which has included the formulation of business plan

The management of risk was important to the service. Senior managers and ward staff shared the same knowledge and awareness of the risks that were reflected in the trust and ward risk register. The service recognised the limitations of the environment and held regular meetings and consultations with staff about the plans to re-locate to a more suitable environment. All staff had access to a paper copy of the ward risk register that was kept with the daily handover information. We saw this was the most up to date version. Staff knew about the risks and what action the service had taken in relation to manage the risks. This included ligature audits and same sex accommodation guidelines.

Staff had access to the trust intranet and knew how to access information the trust provided about business continuity and contingency plans in an emergency.

The manager had responsibility for the ward budget and met regularly with finance staff to discuss budget management. The manager reviewed vacant posts before being advertised so that patient care was not compromised by any cost efficiency savings that the service needed to make.

Information management

The ward had developed systems that embedded the use of information into their practice. The service had identified responsibilities to collect certain data such as compliance against trust performance targets, audits and equipment and safety checks. The service discussed the information at team meetings and identified the improvements they needed to make to meet trust mandatory training and appraisal targets. The clinical lead produced a comprehensive annual report about how the service performed which included data about patient demographics, outcomes, and lengths of stay. The report was available on the internet that ensured the service shared information which was accessible and transparent.

Staff had access to sufficient equipment and information they needed to do their jobs. Electronic patient information was available for all staff. New staff could not access the patient electronic information system until they had completed appropriate training. This meant that some information held electronically such as patient care plans and risk assessments was not available immediately for new staff. To mitigate this, the ward manager ensured that up to date paper copies

of important patient information were available for all staff. This also meant that staff always had access to important information about patients if the electronic system failed.

Engagement

Staff received information about the trust and the service via the trust intranet, e-mails, and a range of meetings. Ward staff felt engaged with developments for the service but had become frustrated by the lack of progress with plans to re-locate. Senior staff felt supported by the senior leadership team who listened to their concerns and took them seriously.

Feedback from people who used the service was important to staff. The service offered a range of opportunities for patients and their families to feedback and be involved in changes to the service. Staff used this information to inform their practice and make improvements to the service where they could. Staff shared the action they took in response to feedback and displayed it in public areas on the ward.

Learning, continuous improvement and innovation

NHS trusts are able to participate in a number of accreditation schemes whereby the services they provide are reviewed and a decision is made whether or not to award the service with an accreditation. A service will be accredited if they are able to demonstrate that they meet a certain standard of best practice in the given area. An accreditation usually carries an end date (or review date) whereby the service will need to be re-assessed in order to continue to be accredited.

This service has not been awarded an accreditation.

Staff were committed to learning and making improvements to their service. The ward had developed an in-house training programme and shared learning with other services. In 2017, the Department of Health visited the service and awarded national identification in recognition of the specialist service provided. The British Association for Chronic Fatigue Syndrome and Myalgic Encephalomyelitis (CFS/ME) recognised the service as fully compliant with the guidance set by the National Institute for Health and Care Excellence.

The clinical lead explained that the service did not fit with existing accreditation schemes such as accreditation with the Royal College of Psychiatrists. This was because the ward was not typical of most mental health inpatient wards. The clinical lead shared good practice at Royal College of Psychiatrist seminars and national meetings. The clinical lead had been involved in producing many research papers that, although not directly linked to the service, provided research on conditions such as medically unexplained symptoms.

Mental health crisis services and health-based places of safety

Facts and data about this service

Location site name	Team name	Number of clinics	Patient group (male, female, mixed)
Becklin Centre	CAS/SPA 136 Team	-	-

The crisis assessment service is based at the Becklin Centre, on the grounds of St James University Hospital in Leeds. The service provides care and assessment to people 18 years and over who are having acute mental health problems and may pose a risk to themselves and/or others.

The crisis assessment service consists of the single point of access team which is for healthcare professionals to refer patients and for members of the public who feel they need help. The street triage team responds to requests for help from paramedics and police who believe someone is in mental health crisis. Section 136 suites are for people of any age who have been detained by the police under section 136 of the Mental Health Act, because there is a concern about their safety or the safety of others. There are separate section 136 suites for children and adolescents within the same service.

The crisis assessment unit is a six bed unit for adults experiencing mental health crises who require an extended period of assessment.

Is the service safe?

Safe and clean environment

The crisis assessment service is based at the Becklin Centre, which is situated on the site of St. James Hospital in Leeds. The service included the crisis assessment unit, children and adolescents section 136 suites, adult section 136 suites, street triage team, district control room nurses and the single point of access teams.

The crisis assessment unit was a ward area which was used for both male and female patients. There were six beds, and the male area was separated from the female area with double doors. The crisis assessment unit met the requirements of the eliminating mixed sex guidance. One section of the unit was identified for female patients and included three bedrooms with a shared shower room with toilet facilities, a female-only lounge and a communal area. The other section of the unit was identified for male patients and again included three bedrooms, a shared shower room and a communal area. The female and male section was separated by locked doors. If only patients of the same sex were on the unit, this locked door could be opened allowing patients to access both communal areas.

The crisis assessment unit local working instructions, which staff had access to, included this information to ensure the unit met the eliminating mixed sex guidance. The Leeds section 136 interagency guidance also included mixed sex considerations and vulnerabilities in relation to gender for the section 136 suites. It identified situations where an alternative place of safety may be required or an enhanced management plan was needed. The trust maintained oversight of any incidents in relation to the mixed sex environment in the 136 suite as staff were required to submit an incident form.

The adult section 136 area consisted of four individual rooms for patients and a staff office which was situated at the end of the corridor. The children and adolescents section 136 suites were situated in a different area and accessed via an external door which was in a different area to that of the adults.

All areas of the crisis assessment unit and section 136 suites were clean and tidy, with appropriate furnishings. There were anti-ligature curtain rails at the windows and anti-barricade doors which allowed staff to access rooms in the event of an emergency. Staff we spoke with told us risks to patients were mitigated through the use of risk assessments and observations.

Cleaning was carried out by staff from an external company. Staff attended to cleaning daily and additional tasks could be carried out if necessary. We saw copies of the cleaning rota for 1

December to 31 December 2017 and found that cleaning had been completed in line with the rota and had been checked by a supervisor to ensure it had been completed to the correct standard.

Regular environmental risk assessments were carried out which included the completion of ligature audits and infection control audits. Supplies of hand gel were positioned throughout the service. The section 136 suites and the crisis assessment unit environment did not allow for easy observation throughout. This was mitigated by the use of mirrors in the section 136 suites and staff presence in the crisis assessment unit.

Rooms used by staff to see patients were fitted with alarms which were linked to a central system and all rooms which patients accessed were fitted with nurse call systems. These were tested periodically by an external organisation to check they worked.

The crisis assessment service had a clinic room which was situated near the crisis assessment unit. The clinic room was clean and contained medical equipment for the purposes of carrying out physical health assessments and treatment of minor injuries, as well as housing medication used on the unit and in the section 136 suites. There was no medical couch in the clinic room which meant that patients who required a physical examination were required to have these carried out in their room. Medical equipment was calibrated and maintained. The medical equipment in the service was last calibrated in December 2017 and had visible stickers to show checks had been completed. Emergency equipment was accessible to staff and was checked regularly to ensure it was in date.

Furniture used in both the crisis assessment unit and section 136 suites was appropriate for their use. Section 136 suites had furnishings which were designed to be safe for vulnerable people and helped reduce risks to patients and staff.

Rooms and furnishings throughout the crisis assessment unit were clean and tidy. However, we found that the communal lounge and kitchen area was cluttered and there were some objects which could cause a risk to patients and staff, for example cutlery and plastic bags. These were not included on the unit risk assessment. We raised this issue with the clinical operations manager who advised us the changes had been implemented.

Safe staffing

Definition

Substantive – All filled allocated and funded posts.
Establishment – All posts allocated and funded (e.g. substantive + vacancies).

Substantive staff figures			**Trust target**
Total number of substantive staff	30 September 2017	72.99	N/A
Total number of substantive staff leavers	1 October 2016 – 30 September 2017	2.00	N/A
Average WTE* leavers over 12 months (%)	1 October 2016 – 30 September 2017	2.6%	10% - 15%
Vacancies and sickness			
Total vacancies overall (excluding seconded staff)	30 September 2017	2.10	N/A
Total vacancies overall (%)	30 September 2017	4%	N/A
Total permanent staff sickness overall (%)	30 September 2017	5%	3.70%
	1 October 2016 – 30 September 2017	6%	3.70%

Establishment and vacancy (nurses and care assistants)			
Establishment levels qualified nurses (WTE*)	30 September 2017	38.04	N/A
Establishment levels nursing assistants (WTE*)	30 September 2017	3.00	N/A
Number of vacancies, qualified nurses (WTE*)	30 September 2017	4.10	N/A
Number of vacancies nursing assistants (WTE*)	30 September 2017	1.00	N/A
Qualified nurse vacancy rate	30 September 2017	11%	N/A
Nursing assistant vacancy rate	30 September 2017	33%	N/A
Bank and Agency Use			
Shifts bank staff filled to cover sickness, absence or vacancies (qualified nurses)	1 October 2016 – 30 September 2017	0 (0%)	N/A
Shifts filled by agency staff to cover sickness, absence or vacancies (Qualified Nurses)	1 October 2016 – 30 September 2017	0 (0%)	N/A
Shifts NOT filled by bank or agency staff where there is sickness, absence or vacancies (Qualified Nurses)	1 October 2016 – 30 September 2017	0 (0%)	N/A
Shifts filled by bank staff to cover sickness, absence or vacancies (Nursing Assistants)	1 October 2016 – 30 September 2017	0 (0%)	N/A
Shifts filled by agency staff to cover sickness, absence or vacancies (Nursing Assistants)	1 October 2016 – 30 September 2017	0 (0%)	N/A
Shifts NOT filled by bank or agency staff where there is sickness, absence or vacancies (Nursing Assistants)	1 October 2016 – 30 September 2017	0 (0%)	N/A

*Whole-time Equivalent

This core service has reported a vacancy rate for all staff of 4% as of 30 September 2017.

	Registered nurses			Health care assistants		
Team	Vacancies	Establishment	Vacancy rate (%)	Vacancies	Establishment	Vacancy rate (%)
Crisis Assessment Service	2.60	28.54	9%	0.00	0.00	0%
Street Triage	1.50	9.50	16%	1.00	3.00	33%
Core service total	4.10	38.04	11%	1.00	3.00	33%
Trust total	120.06	765.64	16%	89.65	614.56	15%

NB: All figures displayed are whole-time equivalents

	Overall staff figures		
Team	Vacancies	Establishment	Vacancy rate (%)
Crisis Assessment Service	0.60	38.54	2%
Street Triage	1.50	12.50	12%
Core service total	2.10	51.04	4%
Trust total	257.28	2028.82	13%

NB: All figures displayed are whole-time equivalents

Between 1 October 2016 and 30 September 2017 this core service did not use any bank or agency staff to cover sickness, absence or vacancy for qualified nurses or nursing assistants.

Team	Ave. Substantive staff	Substantive staff Leavers	Average % staff leavers
CAS Consultants	1.08	0	0%
Crisis assessment Service	63.74	2	3.1%
CAS/SPA 136 Team including Crisis Assessment Unit	11.08	0	0%
Core service total	75.91	2	3%
Trust Total	1801.83	166.73	9%

The sickness rate for this core service was 6% between 1 October 2016 and 30 September 2017.

Team	Total % staff sickness (at latest month)	Ave % permanent staff sickness (over the past year)
CAS/SPA 136 team including crisis assessment unit	5%	6%
Core service total	5%	6%
Trust Total	5%	5%

Medical staff

Between 1 October 2016 and 30 September 2017, medical agency staff to cover sickness, absence or vacancy for medical locums filled 23% of shifts.

Ward/Team	Available shifts	Shifts filled by bank staff	Shifts filled by agency staff	Shifts NOT filled by bank or agency staff
CAS/SPA 136 Team – Consultant	288	-	66	-
Core service total	288	-	66 (23%)	-
Trust Total	45168	-	1037 (2%)	84 (<1%)

* Percentage of total shifts

Staffing levels for the service were assessed using the e-rostering tool. Staffing within the service was divided between the crisis assessment service, crisis assessment unit, and police control room and street triage team.

There were sufficient numbers of staff in the crisis assessment unit. The majority of the staff we spoke with told us there were no concerns around staffing. The establishment staffing level for the crisis assessment unit was two registered nursing staff and two support workers on each shift. The core service reported that they had not used any bank or agency staff to cover shifts due to sickness absence or vacancies between 1 October 2016 and 30 September 2017. If required permanent staff told us they would cover vacant shifts between them. Crisis assessment service

staff were also part of the Becklin Centre's emergency response team. The response team were deployed in emergencies across the wards and services located at the Becklin Centre site.

Staff sickness for the core service was an average of 6% for the period 1 October 2016 to 30 September 2017. Permanent staff within the core service covered short periods of absence.

This core service had two (3%) staff leavers between 1 October 2016 and 30 September 2017 which was the lowest for any core service at the trust.

This core service reported an overall vacancy rate of 11% for registered nurses at 30 September 2017 and 33% for nursing assistants for the same period.

Mandatory training

The compliance for mandatory and statutory training courses at 30 September 2017 was 83%. In 11 of the training courses listed, staff failed to achieve the trust target of 85% and of those, seven failed to score above 75%.

These seven were 'Fire – Level 3' (63%), 'Essential Life Support' (64%), 'Personal Safety with Breakaway Skills' (67%), 'Mental Health Act - Inpatient - Level 2' (68%), 'Infection Control – Clinical' (70%), 'Moving and Handling Essentials' (71%) and 'Safeguarding children Level 3' (73%).

Training compliance as at 30 September 2017 was above 63% for all courses, with three of the seven above 70%.

This is shown in the table below:

Key:

Below CQC 75%	Between 75% & trust target	Trust target and above

Training course	This core service %	Trust wide %
Fire - Level 1	100%	95%
Infection Control - Non-Clinical	100%	97%
Personal Safety Theory	100%	99%
Safeguarding children Level 1	100%	93%
Trust Induction	98%	99%
Health and Safety	97%	96%
Food Safety Level 1	96%	97%
Equality and Diversity	95%	96%
Duty of Candour	95%	98%
Safeguarding Adults	93%	95%
Information Governance	90%	92%
Moving and Handling Principles	86%	90%
Mental Health Legislation Awareness - Level 1	86%	90%
High Level Physical Interventions with PSTS and Breakaway skills	85%	89%
Clinical Risk	83%	82%
Safeguarding children Level 2	82%	82%
Immediate Life Support	81%	78%
Mental Capacity Act and DoLS - Level 2	76%	85%
Safeguarding children Level 3	*73%*	81%
Moving and Handling Essentials	*71%*	80%

Infection Control – Clinical	*70%*	81%
Mental Health Act - Inpatient - Level 2	*68%*	78%
Personal Safety with Breakaway Skills	*67%*	85%
Essential Life Support	*64%*	87%
Fire - Level 3	*63%*	81%
Core Service Total %	83%	90%

Training compliance for individual training modules was better than the last inspection in July 2016 for staff in the crisis assessment service, including the crisis assessment unit and the section 136 suite.

There was oversight of training compliance from ward level and above in the Leeds care group. We saw mandatory training discussed at the quarterly crisis assessment service clinical improvement forum.

Managers reviewed training compliance with staff at the team meetings. Team meeting minutes for December 2017 demonstrated that training compliance was discussed and that training compliance had improved in some areas since September 2017.

Training compliance data at the time of the inspection for January 2018 showed that training compliance for the crisis assessment service had improved further, as shown in the table below:

Requirement	Compliance status
Clinical Risk	78%
Duty of Candour	97%
Equality and Diversity	97%
Essential Life Support	73%
Fire - Level 1	100%
Fire - Level 2	100%
Fire - Level 3	73%
Food Safety Level 1	96%
Health and Safety	97%
High Level Physical Interventions with PSTS and Breakaway skills	88%
Immediate Life Support	83%
Infection Control – Clinical	72%
Infection Control - Non-Clinical	100%
Information Governance	90%
Mental Capacity Act and DoLs - Level 2	81%
Mental Health Act - Inpatient - Level 2	78%
Mental Health Legislation Awareness - Level 1	77%
Moving and Handling Essentials	67%
Moving and Handling Principles	100%
Personal Safety Theory	100%
Personal Safety with Breakaway Skills	60%

Safeguarding Adults	97%
Safeguarding children Level 1	100%
Safeguarding children Level 2	100%
Safeguarding children Level 3	76%
Trust Induction	98%
Overall:	**86%**

The trust also told us that staff in the crisis assessment services had been supporting the section 136 child and adolescent mental health provision prior to the specialist dedicated child and adolescent section 136 being opened. Therefore they had considerable experience of caring for children and young people. However, they confirmed that they were implementing formal training to strengthen the care and support they provided to children whilst they were waiting for a tier four, inpatient bed. This was being taken forward as part of the trust's clinical plan and was due to commence in quarter four 2017/18.

Assessing and managing risk to patients and staff

Assessment of patient risk

Risks to patients and staff were mitigated by the use of risk assessments. Staff in the service used the 'functional analysis of care environments' risk profile which they used to assess and manage risks that may be posed to patients and staff. The tool helps staff to determine risk based on patient's history and risk behaviours as well as other factors such as personal circumstances and protective factors.

Staff carried out risk assessments for everyone they came into contact with and used these to determine the level of support, if any, that was needed. Staff working at the police control room and as part of the single point of access team needed to make initial assessments via telephone calls. Information gathered was passed on to other staff within the service to enable people who were at risk or vulnerable to obtain the help and support they needed.

Staff were caring and knowledgeable about their role and the patients who were referred to them. Staff used questions and other indicators like body language, facial expressions and tone of voice to try and establish people's needs. Where needed, people were able to be admitted to services to receive more intensive treatment and support.

All five care records we looked at had a risk assessment in place. Where patients were discharged following assessment, a plan for care and support had been arranged for all of these. All 12 case notes we reviewed identified risks and observation levels were reviewed and amended in accordance with patient risk. Crisis plans were completed where appropriate and recorded in care records.

Management of patient risk

Staff were aware of and dealt with specific risk issues. Staff at the service worked closely with the local police and had good links with other services. This meant other services contacted them if they had concerns about someone in their area. Staff told us they had people they could call on if they needed any help, including psychiatrists and social workers.

Some of the patients on the crisis assessment unit were able to access the courtyard which was situated in the central area of the Becklin Centre. Access to this area was either with the supervision of a staff member or unsupervised and dependent on a risk assessment.

All rooms where patients were seen had alarms fitted and staff working in the service were issued with personal alarms which they could use to summon help if required.

Use of restrictive interventions

The trust provided data as part of the pre-inspection information in relation to the use of restrictive interventions in this service from October 2016 to September 2017.

(Prone restraint is face-down restraint; this can result in a compression of the chest or airways. Rapid tranquilisation is when medicines are given to a person who is very agitated or displaying aggressive behaviour to help quickly calm them).

Ward name	Seclusions	Restraints	Patients restrained	Of restraints, incidents of prone restraint	Rapid tranquilisations
Crisis assessment Unit	0	13	10	4 (31%)	3 (23%)
Crisis assessment service	0	3	3	3(100%)	2 (67%)
Section 136	-	50	43	27 (54%)	20 (40%)
Section 136 child and adolescent	-	8	4	0 (0%)	0 (0%)

There was no use of mechanical restraint in the crisis assessment services in this time period. There was no seclusion or long-term segregation on the crisis assessment unit this same time period.

The use of restraint and the use of rapid tranquilisation were about the same in the crisis assessment unit in the 12 months between 1 October 2016 and 30 September 2017 compared to the previous 12 months, however the use of prone restraint had halved.

The number of restraints, prone restraint and the use of rapid tranquilisation had increased in the adult section 136 suites between 1 October 2016 and 30 September 2017, compared to the previous 12 months.

There was no prone restraint or rapid tranquilisation in the child and adolescent 136 suites between 1 October 2016 and 30 September 2017. More recent data provided for the six months between the 1 July 2017 and 31 December 2017 showed that there had been one instance of rapid tranquilisation in the child and adolescent section 136 suites.

This data provided by the trust for 1 July 2017 and 31 December 2017also showed that there had been an increase in the number of restraint in the child and adolescent 136 suites compared to the previous six months, 1 January 2017 to 30 June 2017.

We spoke with staff about the use of rapid tranquilisation and restraint within the service. Staff told us that restraint was only used as a last resort and was only carried out by staff that were appropriately trained. Incident reporting evidence showed that staff knew how to report incidents including restraint.

Where patients were given rapid tranquilisation, paper records were used to record observations and scanned onto computer records later. We were unable to view records on rapid tranquilisation as none of the patients who were on the section 136 suite or the crisis assessment unit at the time of our inspection had been subject to this.

Staff were trained in the use of high level physical interventions, with promoting safe and therapeutic services and breakaway skills. Compliance with this training was 88% at the time of the inspection.

Safeguarding

Staff we spoke with were able to identify the safeguarding lead and knew how to get advice if needed. Staff knew the trust had a safeguarding policy and where it was located. Staff we spoke with were able to identify different types of abuse and how to identify potential abuse in their patients.

Staff had training on how to recognise and report abuse and they knew how to apply it. Staff working in the service were required to complete training in safeguarding for both adults and children. Information from given to us prior to the inspection showed compliance with adult safeguarding training was 93% and safeguarding children level one was 100%. As at December 2017 training compliance for safeguarding level one and two was 100% and 76% for safeguarding level three.

Staff demonstrated their knowledge of safeguarding and had made relevant referrals to local authority safeguarding teams. A safeguarding referral is a request from a member of the public or a professional to the local authority or the police to intervene to support or protect a child or vulnerable adult from abuse. Commonly recognised forms of abuse include: physical, emotional, financial, sexual, neglect and institutional.

Each authority has their own guidelines as to how to investigate and progress a safeguarding referral. Generally, if a concern is raised regarding a child or vulnerable adult, the organisation will work to ensure the safety of the person and an assessment of the concerns will also be conducted to determine whether an external referral to Children's Services, Adult Services or the police should take place.

This core service made 20 safeguarding referrals between 29 September 2016 and 1 October 2017, of which five concerned adults and 15 children.

Referrals		
Adults	Children	Total referrals
5	15	20

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff we spoke with knew how to identify adults and children who may be at risk of, or suffering, significant harm. Staff worked closely with other agencies to ensure concerns were investigated. We saw evidence of this while observing the work of the street triage team.

Staff received training in equality and diversity, which included protected characteristics as described in the Equality Act 2010. Staff told us, where possible, they would make adjustments for people who were protected under the Act.

Staff access to essential information

Staff kept appropriate records of patients' care and treatment. Records were clear, up to date and available to all staff providing care. Staff used an electronic system which allowed staff in other areas of the trust to access medical records and meant that information was easily accessible for staff completing assessments and for when patients were transferred between services. The Leeds section 136 interagency guidance confirms the trust's staff had access to relevant health and social care information, including information for children and adolescents.

The majority of records used within the crisis assessment service were electronic. However, staff used paper records in some areas, such as street triage assessments and observations following the use of rapid tranquilisation. Where paper records were used information was both scanned and saved with computerised records or, in the case of initial assessments, information typed into the electronic care record.

Medicines management

Staff followed good practice in medicines management and did it in line with national guidance. The clinic room was kept locked at all times and was only accessible to registered nursing staff and doctors. Medicines were stored appropriately and the temperatures of both medical fridges and the clinic room were checked and recorded regularly to ensure they were within the necessary limits. Emergency equipment and medicines were kept in a separate area which all staff were able to access. Regular checks were carried out to ensure this was in good working order and emergency medicines were in date.

Medicines stored in the clinic room were in date and correctly stored. Where medicines or topical creams were present, we found the date of opening had been recorded. Medical equipment had been cleaned and maintained in line with guidance and stock rotation had been carried out.

Audits were carried out by a trust pharmacist. Where patients brought their own medication from home, medicine reconciliation was carried out by the pharmacist and recorded in stock. Physical health checks were carried out on patients admitted to the crisis assessment unit and where possible, the section 136 suites. Staff recorded the outcomes of assessments in electronic records.

Where rapid tranquilisation was used, staff carried out physical health monitoring in line with the trust policy.

Medicines and their use were prescribed in line with guidance from the National Institute for Health and Care Excellence. Where staff had concerns regarding a patient or the effects of a medicine they were able to get advice and support from the medical staff who worked as part of the crisis assessment service.

Track record on safety

Providers must report all serious incidents to the Strategic Information Executive System (STEIS) within two working days of an incident being identified. Between 1 October 2016 and 30 September 2017 there were two serious incidents reported by this core service. Both incidents were categorised as 'apparent/actual/suspected self-inflicted harm'. The outcome had not been concluded for one of these incidents.

A 'never event' is classified as a wholly preventable serious incident that should not happen if the available preventative measures are in place. This core service reported no never events during this reporting period.

We asked the trust to provide us with the number of serious incidents from the past 12 months. The number of the most severe incidents recorded by the trust incident reporting system was comparable with STEIS.

	Number of incidents reported		
Type of incident reported on STEIS*	CAS	Street Triage / Crisis	Total
Apparent/actual/suspected self-inflicted harm	1	1	2
Total			

*Ward / Team names were determined by cross-referencing the STEIS entry with the SIRI data provided by the trust.

Reporting incidents and learning from when things go wrong

Patient safety incidents were managed well. Staff we spoke with knew which incidents should be reported and how to report them, including the use of restraint. We saw evidence of staff reporting incidents during our inspection and looked at the electronic records of incidents. Feedback from incidents was shared within the team and throughout the trust if relevant.

When things went wrong, staff apologised and gave patients honest information and suitable support. Staff we spoke with were aware of the provider's policy regarding the 'Duty of Candour'. Staff were able to identify when they would need to report under this policy. Where an incident was reportable, patients and their carers would be contacted and the incident would be discussed with them.

Debriefs were carried out following incidents. Staff we spoke with told us that investigations would be carried out and debriefs were held following any incidents. We were given details of specific incidents which had occurred and the process which had been carried out following these. Minutes of meetings showed that discussions about incidents were held and that managers made themselves available for individual debriefs if this was preferred.

The Chief Coroner's Office publishes the local coroner 'Reports to Prevent Future Deaths' which all contain a summary of Schedule 5 recommendations, which had been made, by the local coroners with the intention of learning lessons from the cause of death and preventing deaths.

In the last two years, there has been one 'prevention of future death' report sent to the trust but it did not relate to this core service.

The trust said it had been named in or involved in a serious case review in the last 12 months but it did not relate to this core service.

Is the service effective?

Assessment of needs and planning of care

Patients who used services had mental health assessments carried out. These assessments varied according to the service which was accessed. Due to the nature of the services offered patients were often given an initial assessment via the telephone and this was followed up with a face to face appointment.

Staff recognised signs and behaviours in the way patients reacted, or things they said, which would help them establish how acute the patient’s need was. Patients who required help immediately were taken to a location which was appropriate to their needs. Where patients were not thought to require immediate assistance, they could be referred to other services. Patients who were admitted to the crisis assessment unit or section 136 suites had further assessments carried out on admission. Staff we spoke with told us that patients had ongoing assessments with doctors visiting every morning.

Staff always had access to up-to-date, accurate and comprehensive information on patients’ care and treatment. All staff had access to an electronic records system that they could all update. We reviewed the care records of five patients in the crisis assessment unit, and the case notes of a further 12 who had been assessed by the crisis assessment service and in the section 136 suites. Care records for the five patients on the crisis assessment unit contained plans with clear evidence of the patient being involved in the formulation of the plan. However, in the case notes of the other 12 patients assessed by the crisis assessment service and the section 136 suites, the immediate plan of care had standard wording and phrases like, ‘you have agreed to an informal admission’ and ‘if you feel in crisis please feel free to approach staff’.

We found care records and care notes contained mental health assessments and the reason for referrals or admission. Relevant medical history and details of any medication currently being taken was recorded.

Immediate plans of care were completed whilst patients were on the crisis assessment unit. Complete care plans were written following transfer to another service or ward as the purpose of the crisis assessment unit was to carry out assessments for people who were thought to be suffering a mental health crisis, in order to determine the best course of treatment.
Care plans reviewed for those patients staying longer periods than the suggested time period of 72 hours for assessment, were detailed and comprehensive. We saw evidence of care plans showing a collaborative approach, with patients working to resolve their social issues, for example housing and preparing to return back to the community.

Best practice in treatment and care

Patients on the crisis assessment unit were also offered time with a psychologist once a week and one-to-one time with staff during their stay. An occupational therapist worked on the crisis assessment unit and spent time arranging activities for patients; some patients were also offered medicinal interventions but this was dependent on the reason for their stay.

Patients admitted to the crisis assessment unit and section 136 suites were offered some physical health checks including weight, blood pressure and routine blood screening tests. Patients did not have to accept these tests, although we found that offers were repeated if patients had declined initially.

Patients who required medical interventions for mental health or physical health problems were able to be referred to relevant services. We saw evidence of patients being taken to specialist appointments for physical health problems during our inspection. In an emergency patients were taken to hospital emergency departments for treatment.

Staff asked patients lifestyle questions when they carried out assessments. This included asking about alcohol consumption, illicit substances and smoking. Patients were provided with information about services which could help with if there was a concern. Where patients were admitted to the crisis assessment unit or the section 136 suites, they were offered nicotine replacement patches throughout their stay.

Patients in both the crisis assessment unit and the section 136 suites were provided with regular meals. If patients were admitted during the night there was a supply of foods available which staff were able to cook. Meals supplied to the crisis assessment service took account of patient's dietary and religious needs.

The service did not use any recognised rating scales to monitor health outcomes. However, the provider confirmed that audits were being carried out in areas like medicines management, physical health evaluation and section 136 documentation audits.
This core service participated in one clinical audit as part of their clinical audit programme 2016 - 2017.

Audit name	Audit scope	Audit type	Date completed	Key actions following the audit
Audit of clinical process for section 136 assessment and management	Crisis Assessment & 136 Suite	Clinical	2/06/2017	1. Discuss in s136 interagency meeting to be feedback to police 2. Liaise with police link re higher amount of missing data in police section of form 3. Introduce amended s136 form to team at Tues training – opportunity to increase awareness to all team, ensure any questions on correct completion answered 4. Include in new starters induction pack 5. Feedback to Higher Training Committee meeting

Skilled staff to deliver care

The service made sure staff were competent for their roles. The service had a multidisciplinary team that included psychiatrist, social workers, occupational therapist, pharmacist and nurses. There were good working links with external services and staff knew where who to call if they needed help. All the staff working in the service were appropriately skilled and experienced to carry out their roles.

Staff that were new to the service were required to undergo the trust induction training.

Staff received regular supervision and appraisal. Managers appraised staff's work performance and held supervision meetings with them to provide support and monitor the effectiveness of the service. Staff told us they discussed training needs during supervisions and appraisals.

The trust's target rate for appraisal compliance is 85%. As at 8 November 2017, the overall appraisal rates for non-medical staff within this core service was 91%. There was no medical appraisal information provided for this core service.

Team name	Total number of permanent non-medical staff requiring an appraisal	Total number of permanent non-medical staff who have had an appraisal	% appraisals
CAS/SPA 136 Team including crisis assessment unit	58	53	91%
Core service total	58	53	91%
Trust wide	2028	1596	79%

Between 1 April 2017 and 1 October 2017, the clinical supervision rate for this core service was 72% against the trust's target of 85%.

Caveat: there is no standard measure for clinical supervision and trusts collect the data in different ways, it is important to understand the data they provide.

Team name	Clinical supervision sessions required	Clinical supervision delivered	Clinical supervision rate (%)
CAS/SPA 136 Team including crisis assessment unit	144	103	72%
Core service total	144	103	72%
Trust Total	11598	6674	58%

Monthly crisis improvement forum meetings were held. These were used to discuss concerns, complaints, incidents and other issues relating to the delivery of the service. Information from these meetings was fed into the weekly crisis assessment service meetings. There was no standing agenda for these weekly meetings and this allowed for the discussion of varying topics. Staff were able to raise things to be discussed and minutes were taken of all meetings to allow staff who were not able to be present to see what had been discussed.

Staff were able to request training that would help to expand their knowledge of the role. Staff we spoke with confirmed that they had taken part in additional training including cognitive behavioural therapy, drug and alcohol abuse and perinatal care.

Concerns about staff performance were brought to the attention of managers. Staff told us they felt able to speak with managers if they had concerns regarding another member of staff. Managers we spoke with told us that staff had previously identified where there had been concerns and spoken to them. Where staff were performing poorly, processes were in place for the support and management of staff.

The service did not have any volunteers in post. Staff we spoke with told us that patients were not involved with the service and did not have any input into how the service was run.

Multidisciplinary and interagency team work

Staff held regular and effective multidisciplinary meetings. Multidisciplinary meetings were held daily, with staff from all areas of the crisis assessment service attending these. Information about patients was shared effectively, allowing staff to gain the knowledge to allow them to work with all patients of the crisis assessment unit and section 136 suites.

Handovers were carried out twice daily for each of the areas within the crisis assessment service. Information shared during the handover was detailed and relevant and included enough information to allow staff to understand the needs of patients. Staff were also updated on events that had taken place with street triage and district control room nurses.

The crisis assessment service included the section 136 suite for children and adolescents. The staff at the trust followed the recommended plans of the child 136 assessors from the Leeds child and adolescent mental health services provided by one of the local acute trusts. Staff also had support from the trust's child and adolescent mental health service psychiatrists. The Leeds section 136 interagency guidance confirmed that if a young person under the age of 18 years was detained, the specialty trainee or consultant psychiatrist from the child and adult mental health services was contacted during both working and out of hours.

The teams within the crisis assessment service worked effectively together and with other professionals. There were good working relationships with police and approved mental health professionals and we witnessed communication with teams throughout the trust. Discussions were held in relation to bed management and patient care and arrangements were made to transfer care to other teams.

Staff from other organisations worked to ensure patients received a good level of care and support for things that were important to them. The crisis assessment service had representatives from drug and alcohol support and local housing based in the building and worked with social services, GPs and citizens advice to obtain advice and support for patients. In addition, we saw evidence of patients being supported to access benefits and legal advice.

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

Staff understood their roles and responsibilities under the Mental Health Act 1983. The trust provided details of two 'Mental Health Act' related courses for this core service and the training compliance for each as of 30 September 2017. These were 'Mental Health Legislation Awareness - Level 1' (86%) and 'Mental Health Act - Inpatient - Level 2' (68%). Mental Health Act – level 2 training compliance had increased to 78% at the time of the inspection in January 2018.
Staff we spoke with had a good understanding of the Mental Health Act, the code of practice and the guiding principles. Staff we spoke with were able to tell us about different aspects of the Act and how these may affect their patients.

Staff working in the police control room told us that they spent time giving the police training on mental health and the Mental Health Act. They also told us they were responsible for ensuring the police work within the remit of the code of practice and advise the police on compliance with the Act.

The provider had a Mental Health Act policy. Staff we spoke with were aware of the provider's policy and were able to tell us how they could access it. The trust had a mental health office that would provide help and support to staff in relation to the Act. The crisis assessment service also had approved mental health professionals working within the service and they also supported staff with legislation. Staff we spoke with were able to identify who they could speak with if they had questions about the Act.

We looked at the section 136 documentation for eight patients. We found these had been completed clearly with all relevant information. Mental Health Act documentation was correctly stored and patients had discussed the reason they were in the section 136 suite. Audits were carried out to ensure the section 136 documentation was correctly completed. Concerns regarding these audits were passed on to the manager to ensure corrections were made.

Mental Health Act documentation contained information about patient’s rights and when these had been explained to the patient. If staff thought a patient had not understood their rights, this was recorded on the care record and staff would explain them to the patient at a later time.

Patients were given information regarding independent advocacy services. There were posters on the walls in the crisis assessment unit and section 136 suites which gave patients information on advocacy services. If patients used an advocate the information regarding their advocate was recorded on the patient’s care record. Information was passed to advocates in line with patient requests. Patients who lacked capacity were routinely referred to advocacy services.

Informal patients were able to leave the ward if they wished. There were notices on the walls throughout the crisis assessment unit explaining to patients that if they were there informally and wanted to leave the ward they were able to do so.

Good practice in applying the Mental Capacity Act

Staff had a good understanding of the Mental Capacity Act, including deprivation of liberty safeguards. As of 30 September 2017, 76% of the workforce in this core service had received training in the Mental Capacity Act and Deprivation of Liberty safeguards - Level 2 ‘. This had increased to 81% at the time of the inspection in January 2018.
Staff we spoke with demonstrated a good understanding of the Mental Capacity Act and were able to tell us about how the five statutory principles were applied in their day to day work.

The provider had a Mental Capacity Act policy in place and staff we spoke with were able to tell us how this could be accessed. Staff were able to get help and support in relation to the Mental Capacity Act from the approved mental health professionals that were attached to the service, the Mental Health Act office and also from Mental Capacity Act leads within the trust.

Patients admitted to the section 136 suite were assessed for capacity and this was recorded in the immediate plan of care. Patients of the crisis assessment unit only had capacity assessments carried out if there was concern they may lack the capacity to make a decision regarding their care. Staff supported patients to make decisions and details were recorded.

Immediate plans of care contained evidence that patients had been asked for consent to have them admitted to the crisis assessment unit. Staff on other teams in the service also confirmed that they would try and get consent to treatment. Staff told us they would speak to patients about treatment needs and would ask them to spend some time in hospital or to agree to treatment from other services like the community mental health team.

Capacity was recorded in care records and capacity assessments were clearly recorded. Where best interest decisions were required meetings had been held and discussions were recorded on care records. The mental health office carried out annual audits of documentation to monitor compliance with the Act.

Is the service caring?

Kindness, privacy, dignity, respect, compassion and support

Staff cared for patients with compassion. We spoke with one patient, four former patients and the carers of two patients who had used the crisis assessment service. People we spoke with told us that staff were kind and seemed to genuinely care about them. One carer told us that staff were brilliant, kind and thoughtful and couldn't be faulted. Patients told us that staff were approachable, thoughtful and took time to speak to them and listen to their concerns. One former patient told us that although staff were very good the service didn't help them because of the way assessments were carried out and the involvement of so many staff that appeared to ask the same questions.

Staff treated patients with dignity and respect. Staff supported patients in an appropriate way and treated them with empathy. We saw staff giving advice to patients and discussing their concerns. Staff in the single point of contact team dealt with telephone calls from GPs, social services, families of patients and those in crisis. They adapted the way they spoke to people to ensure that they gave the right level of support and were able to get the information they needed to pass patients to the correct team.

Staff supported patients to understand and manage their care, treatment or condition. Staff on the crisis assessment unit and section 136 suites spent one-to-one time with patients to discuss the reason for their admission. Staff explored the reason for admission and the impact it had and where possible, discussed what treatment options were available. Where needed patients were advised of other services available and staff supported them to access these. For example, citizen's advice bureau, housing advice and employment support allowance.

Staff told us they were aware that patients had different personal needs, including cultural, social and religious needs. Food was available for patients with dietary and religious needs and we were told staff would purchase food if patients came into the service out of hours and there was nothing suitable for them.

Staff were aware of what would be considered disrespectful, discriminatory or abusive attitudes. Staff we spoke with told us that if they witnessed this type of behaviour they would report it to their manager. Staff told us that they were confident that any reports would be taken seriously and would have no concerns about negative consequences toward them.

The provider had systems in place to protect patients' personal information. Staff were aware of the need for confidentiality and when information had to be passed on. Staff advised patients that they would not disclose information to anyone without the patient's consent, except where they had a legal duty to do so because of a risk to the patient or other people. Care records we looked at contained information about who could be informed about the patient's care and any information which was disclosed as part of their treatment.

Involvement in care

Involvement of patients

Staff involved patients and those close to them in decisions about their care and treatment. We looked at the care records of five people in the crisis assessment unit and immediate plan of care for 12 people who used the crisis assessment service. We found that there was evidence of patient involvement in the care records however, the 12 immediate plans of care for patients contained standard sentences and phrases.

When patients were admitted to the crisis assessment unit or the section 136 suites staff spent time giving them information about the service and orienting them to the surroundings. Patients were provided with leaflets about the crisis assessment unit and we were told there was a folder giving more information in each of the rooms. However, we looked in three of the rooms on the crisis assessment unit and were unable to locate these folders, though we did find information on notice boards throughout the unit.

Patients were able to access advocacy services. Staff provided patients and those close to them with information regarding the crisis assessment service, this included information about advocacy services. Information was available in the crisis assessment unit and section 136 suites about advocacy services and staff would support patients to access these if they wished. Patients who were found to lack capacity were routinely referred to advocates. Staff referenced the use of independent mental health advocates during discussions about patients.

Patients were given information about how they could leave feedback on services. This information was provided as part of the leaflet on the crisis assessment service and the crisis assessment unit. All the staff we spoke with told us that patients and carers had a clear role in the service and their input was important. Patients and carers were approached by the trust for feedback on the crisis assessment service and this feedback was used to help decide where change was needed.

Involvement of families and carers

Staff involved patients and those close to them in decisions about their care. Where possible, staff discussed treatment with the families and carers of patients. Families and carers were supported by staff to understand the patient’s illness, the impact it could have on them and the treatment to be provided.

The trust carried out surveys regularly which enabled patients, families and carers to provide feedback on the service provided. We saw evidence of people providing feedback to the service and the trust recording and analysing this. Patients stayed on the crisis assessment unit for short periods of time and so carer’s assessments were not generally carried out while patients were on this unit.

Is the service responsive?

Access and discharge

Bed management

At the last inspection in July 2016, the trust was found in breach of the CQC regulations as the crisis assessment unit was not being used according to its statement of purpose which was to provide services for patients experiencing acute and complex mental health crises that require a period of assessment of up to 72 hours. There had been some role creep, with patients staying longer than this time period and staff at that time were unclear of the purpose of the unit which became operational in July 2015.

Following the last inspection the trust had reviewed the utilisation and purpose of the crisis assessment unit. These changes were approved and agreed within the Leeds care group and the trust governance structure. A revised statement of purpose and local working instructions were developed, and communication and engagement was undertaken with stakeholders to share the revised purpose including staff within the service.

The crisis assessment unit local working instructions from February 2017, clearly defines the purpose of the unit. All staff could access this document. The key groups of service user that this document cites the crisis assessment unit is beneficial for are:

- Service users presenting in an acute crisis following a significant event who need a brief period of support before their medium term needs can be accurately determined. It would be expected that this could be a community based service rather than inpatient admission.

- Service users who are attending intensive community services for on-going care however are experiencing an exacerbation of symptoms that requires further monitoring overnight. Without the crisis assessment unit these service users would require admission to an in-patient ward

- Service users with a social related crisis precipitator who can be both treated and safely supported whilst the situation which precipitated the crisis is resolved.

- Service users with other mental health problems who are likely to require short term assessment and treatment in a controlled and safe environment.

- Service users recalled using a community treatment order who will receive treatment in a supported environment, except if the service user is being recalled with a view to revoking the community treatment order. In that case they will be admitted to an in-patient ward.

The crisis assessment unit length of stay was dependent on the reason for the referral being made but the local working instructions stated that generally 72 hours should offer sufficient time to complete a holistic assessment of needs. There may be occasions when the assessment process requires longer than 72 hours in which case the service user and their family should be kept updated on the plan of care.

A range of measures including referrals, admissions, discharge and length of stay in the crisis assessment unit was monitored via the crisis assessment service clinical improvement forum quarterly, with operational measures discussed including admissions, discharge and length of stay.

The trust acknowledged that there may be an occasion where a patient was kept in the crisis assessment unit whilst they were waiting for a bed on the acute ward. This was outlined in the local working instructions and this was exception rather than the rule; it was based on a clinical decision as to whether the patient could be managed on the crisis assessment unit and whether it would be more detrimental to the patient to transfer them out of area. The trust reported that between 1 March 2017 to 31 August 2017 this accounted to 2 out of 163 patients, which is approximately 1% of the admissions.

At this inspection we identified that patients were admitted in line with this criteria, including assessment, community treatment orders, and patients with a social related crisis precipitator. We saw examples of patients on the crisis assessment unit who stayed longer than 72 hours. This was appropriate and in line with the crisis assessment local working instructions as these individuals for example were waiting for transfer to alternative social care placements or agencies, or having housing needs addressed. The trust reported that between 1 March 2017 to 31 August 17, that 13 patients out of 163 patients (8%) stayed for longer than 9 days, with the average length of stay for these patients being 12 days. This length of stay was increased by an outlier of 30 days for someone with safeguarding and immigration challenges.

The trust provided information regarding average bed occupancies for the crisis assessment unit in the pre-inspection information for the time period 1 October 2016 to 30 September 2017. Bed occupancy ranged from 36.6% to 74.7%, with an average of 58.4%. This is below the

recommended bed occupancy of 85% for a ward by the Royal College of Psychiatrists; it also meant that there would be a bed available for people in the community when they needed it.

The average length of stay on the crisis assessment unit between 1 January 2017 and 31 December 2017 was 4.5 days. The trust reported that between 1 March 2017 to 31 August 2017 the average length of stay in crisis assessment unit was 4 days.

The trust reported that during the period 1 March 2017 to 31 August 2017 there were 163 admissions to the crisis assessment unit, with little difference in the numbers between the genders of the service users admitted. This was an average of 27.1 admissions per month.

The crisis assessment service was the main point of referral to the crisis assessment unit. This was identified in the local working instructions. The operational metrics report identified that the referral routes into the crisis assessment unit complied with the local working instructions and identified other outlying referral routes, for example referrals through the intensive community services where staff make direct contact with the crisis assessment unit when they were seeking overnight support for a service user in crisis.

People could access the service when they needed it.

Discharge and transfers of care

There were no out of area discharges during the period 1 January 2017 and 31 December 2017.

Staff ensured that patients who were discharged or transferred to other services were able to do so during daytime hours. This meant patients were able to get continuing care and support on their discharge from hospital. Most patients were discharged to their own residence. The trust’s data showed that the crisis assessment unit was having a positive impact on the length of stay and the discharges on the acute wards compared to before the crisis assessment unit opened.

Managers we spoke with told us they started planning a patient’s discharge from the day of their admission. We saw care plans included information regarding patient discharge and transfer to other services. Patient records showed that relevant information was passed on to the service that would be supporting the patient on discharge. Prior to discharge patients were able to meet with staff at the service that was taking over their care. We saw evidence in care records of patients meeting with care co-ordinators and plans being made in preparation.

Patients who left the crisis assessment unit to go for a period of leave had their bed on the unit kept for them to ensure they were able to return to the unit.

This core service reported 19 readmissions within 28 days between 1 June 2016 and 28 February 2017. This figure included patients who were admitted to other core services. The trust reported the crisis assessment unit, for the period of the 1 March 2017 to 31 August 2017, identified six patients readmitted to any ward in 28 days. This data indicates that the crisis assessment unit had a positive impact on the readmissions within 28 days following discharge.

The trust’s section 136 monitoring report and action plans were discussed at the quarterly crisis concordat meetings which included other partners like the Police, commissioners and the acute trust. The section 136 monitoring report for the 1 December 2016 to 30 November 2017 showed that there were 727 detentions in the section 136 suites out of 2747 mental health triage referrals. The report detailed the demographics of the people triaged and detained, and the reason for the detention. This report also showed that in the same time period 44 children and adolescents between 0 and 17 years had been detained in the child and adolescent 136 suites. None of these children were detained in the section 136 suite for longer than 24 hours.

The trust had identified the services in the table below as measured on ‘referral to initial assessment’. The core service met the (local) referral to assessment target of four hours.

Team	Days from referral to initial assessment	
	Target	Actual (mean)
CAS/SPA 136 Team including Crisis Assessment Unit	4 Hours (Local)	0.09

The facilities promote comfort, dignity and privacy

Patients of the crisis assessment unit and section 136 suites each had their own bedrooms. Patients on the crisis assessment unit were provided with keys which allowed them to store their possessions safely and promoted privacy. Patients in section 136 suites who had possessions which needed to be kept securely were able to give these to staff who would store them.
Staff and patients had access to rooms and equipment to support treatment and care. The crisis assessment unit and section 136 suites shared the use of a clinic room, which had appropriate equipment in place. There were several rooms which could be used for one-to-one time, assessments and other therapies. A member of staff planned activities and encouraged patients to participate.

Visits from friends and family members were encouraged. Patients were encouraged to leave the hospital for visits. However, if this was not possible there were areas within the crisis assessment unit which could be used. There was a communal area which included a communal lounge with a television and seating area. There was also a separate kitchen area with a microwave and kettle for hot drinks and an interview room which doubled as a visitor’s room for patients in the crisis assessment unit only. Children were only allowed to visit by prior arrangement. There was a designated space which was used for children to visit.

There was no public telephone on the crisis assessment unit or the section 136 suites but patients were given access to a telephone. Risk assessments were carried out and used to determine whether patients would be able to access their own mobile phones or the cordless phone that was held on the unit.

Patients were encouraged to leave the crisis assessment unit for short periods of time. Some patients were supported by staff to access outside areas. Patients who were detained under the Mental Health Act required section 17 leave in order to go off the unit. There were notices throughout the unit which stated that informal patients wishing to leave the ward should speak with a member of staff first. Patients in the section 136 suites weren’t able to access outside space without being escorted through the crisis assessment unit.

Patients on the crisis assessment unit had access to facilities which allowed them to make hot drinks and snacks. Patients in the section 136 suites were able to request drinks and snacks which staff would make for them.

Patients’ engagement with the wider community

Staff supported patients to maintain contact with family and friends. Staff encouraged patients to speak with those close to them about their illness and how they could help.

Meeting the needs of all people who use the service

The crisis assessment unit was all on one level making it more accessible to people who required disabled access. The unit was separated into male and female areas with a female only lounge area in the female part of the unit.

Information leaflets were available to patients and their family on a variety of things, including advocacy, complaints and local services. All the leaflets we saw on the crisis assessment unit and section 136 suites were written in English however, there was information printed on the back of these giving details on accessing alternative formats. When required, patients were provided with interpreters and signers.

Patients had a choice of foods. Options were available for all dietary, cultural and religious needs. The unit kept a small supply of foods for patients that were brought in throughout the night and staff told us they would buy food from local shops if there was nothing suitable.

Listening to and learning from concerns and complaints

This core service received 23 complaints between 1 October 2016 and 30 September 2017.

Team name	Admin/policies/ procedures (inc patient record)	Admissions and discharges	Communications	Patient Care	Values & behaviours (staff)
CAS/SPA 136 Team including Crisis Assessment Unit	1	1	3	6	12

This core service received 11 compliments during the last 12 months from 1 October 2016 to 30 September 2017 which accounted for 3% of all compliments received by the trust as a whole.

All the patients we spoke with told us that they knew how to complain. Information was on display throughout the unit and in the leaflets that were given to patients.

The trust had a complaints procedure in place and all formal complaints were dealt with using this. The complaints procedure ensured that all complaints were logged and investigated. Feedback was provided to people who made complaints and to staff.

Is the service well led?

Leadership

The clinical operations manager had day to day responsibility for the running of the crisis assessment service with clinical team managers responsible for the crisis assessment unit and section 136 suites, street triage and district control room nurses and the single point of access team. All of these were based in the crisis assessment service and had good knowledge and oversight of the service.

Staff we spoke with told us they felt supported in their roles and felt that their views were listened to. Staff told us they felt able to speak to managers about concerns and believed these would be taken seriously and acted upon.

Staff told us they felt supported by the senior leadership team for the service. They told us they visited regularly and spent time at the service.

Vision and strategy

All the staff we spoke with knew of the trust's values. Staff told us that the trust had asked them to submit their ideas about what values were important and what they should be. Staff feedback had been used to formulate the new values and staff displayed these values in their day to day working practices.

Managers kept staff informed of proposed changes to the service and encouraged staff to participate in discussions around these. Staff were aware of the budgetary constraints that were in place and how these impacted on the running of the service.

The trust was planning with commissioners and the acute trust for the children's section 136 service to be incorporated into the new Tier 4 inpatient mental health unit for children and adolescents, which was being developed for the region as part of the sustainability and transformation plans.

Culture

Staff morale throughout the service was good. There was a positive, supportive culture and staff spoke highly of their managers. Staff told us that they were proud of the job they were doing and of the service in general. Staff were clear about their role and how they supported patients to improve their mental health.

Staff we spoke with told us that they felt able to speak with managers about any concerns they had. Managers told us staff came to them when they had been concerned about colleagues and their practice. We were told by all the staff we spoke with those concerns would be taken seriously and would be dealt with in confidence.

All the staff we spoke with were aware of the trust's whistle blowing policy and the role of the Speak Up Guardian. Staff told us they did not feel the need to use the guardian as managers were supportive and they would approach them first.

Managers we spoke with were aware of the trust procedure for managing poor performance. Poor performers were identified and supported to improve their work. A number of support options were available to staff including occupational therapy and counselling.

Staff took part in appraisals which evaluated the work they had carried out throughout the year. Staff appraisals included discussions about training, performance and career progression and development. This gave staff an opportunity to discuss what support they needed to move forward with their career and how this could be supported.

Staff success was recognised and there was an annual awards ceremony carried out where staff who had contributed to the success of the service were awarded staff stars in acknowledgement.

Governance

The crisis assessment unit is predominantly an assessment unit with overnight facilities and a place of respite for those experiencing acute and complex mental health crises for whom an in-patient admission is being considered.
The service had systems in place to monitor performance. Regular meeting were carried out to ensure senior managers were aware of what was happening in the service and any concerns that may have arisen.

Regular team meetings were held and minutes recorded for staff that were not able to attend. There were also regular meetings with other stakeholders to discuss and respond to emerging trends, performance and changes to legislation. The section 136 interagency guidance, version 11, which was reviewed and revised in December 2017, outlined the governance arrangement and responsibilities of the partner agencies in the crisis concordat including the police and the acute trust in the assessment of children and adolescents in the section 136 suites. It also outlined the responsibilities of staff.

There were systems in place to ensure the service was clean, tidy and safe for staff and patients. Staff were aware of the Mental Health Act and Mental Capacity Act and some staff carried out training for local police.

Incidents were reported when required and investigations were carried out. Where incidents occurred debriefs were carried out and lessons learnt discussed.

Recommendations made following reviews of incidents, complaints and safeguarding concerns, were implemented and shared throughout the trust.

Staff participated in various clinical audits. Audits were carried out regularly and action plans were formulated following the findings.

Staff were aware of the arrangements for working with other teams. There were local agreements in place for working with police, social services and housing and teams worked closely and collaboratively to ensure the best outcome for patients.

Management of risk, issues and performance

The trust has provided a copy of their most recent risk register. Two of these risks relate directly to this core service – details can be found below.

Key:

High (15-20)	Moderate (8-15)	Low 3-6	Very Low (0-2)

ID	Description	Risk level (initial)	Risk score (current)	Risk level (target)	Last review date	Action
469	Since 2012 the number of referrals to SPA has increased by 40%. This impacts on the CAS function as large number of these referrals need triaging. General activity across CAS/s136/Mental Health Crisis Triage and District Control Room nurses continues to increase year on year.	9	9	3	01/08/2017	For CAS to continue to monitor the data on number of referrals coming through the service and escalate to senior managers as

	The financial budget of the service creates the following staffing configuration: CAS assessment: Day shift (8.30am -9pm) - 6 Night (8.30pm – 9am) - 5 MHCT: Day shift (8.30am -9pm) - 2 Night (8.30pm – 9am) - 2 DCR: 2 nurses working the following shifts patterns: 08.30 – 21.00 (1 hour break time) 10.00 – 22.30 (1 hour break time) 12.30 – 01.00 (1 hour break time) Predominantly, the shifts are 10.00-22.30 during the week and the twilight (12.30-01.00) on a weekend. The staffing assigned to CAS is a particular concern as in the day this only offers 1 staff member as shift coordinator, 2 assessment teams (as need 2 staff per team) and 1 person to triage. As the triage function has become a key intervention for the team in order to make an appropriate decision on next steps this is not enough.					appropriate. To ensure that we engage in recruitment processes to keep vacancies to a minimum.
563	Entrance to CAMHS 136 suite is next to the loading bay at Becklin Centre. When lorries/workman are using this area then access to the suite by police van and/or ambulance is compromised.	9	-	3	21/06/2017	Delivery vehicles have been asked to report to interserve desk who will ensure they are not blocking the entrance. Bollards are available to isolate area - COM to monitor use. Issue is on the agenda for the Clinical Environments Group. COM to gain feedback on how this issue can be addressed environmentally.

Staff were able to access the trust risk register and the clinical operations manager for the service was able to submit items to be included on the risk register. The service had a business continuity plan in place which meant patients would continue receiving care in the event of an emergency. Changes were due to be made to the service which would improve the quality of the service delivered. Plans were in place to ensure that patient care would not be compromised during the service transition period.

The trust had delegated responsibility for collating all performance indicators in relation to the use of the section136 suites for the services in the crisis concordat partnership. The section 136 report was discussed at quarterly crisis concordat meetings, with actions agreed in relation to performance and practice. Minutes and action plans from these meetings demonstrated changes as a result of the section 136 report, including improvements to the young people's pathway in September 2017.

Information management

Staff we spoke with told us they were able to access everything they needed to carry out their role. All staff were able to access information relating to patient care. Patient records were updated with details of treatments, assessments and plans for care. Where people were seen by members of the street triage team or district control room nurses, this could be recorded on care notes, allowing staff access to relevant historical information. All electronic systems which staff used were password protected to ensure that confidential information was only accessible to the right people.

Information was made available to team managers which allowed them to monitor performance, of both the staff and the service as a whole. Managers had access to key performance indicators and were able to evaluate the service using this information. Information provided was sent electronically meaning managers were able to save it easily and disseminate all or part of it to staff within the service.

Engagement

Staff, patients and carers were able to access the trust website to view information about the trust as a whole or the specific service they were interested in. People viewing the website were able to download information leaflets which related to the ward or service they wanted to know about.

Patients and carers were asked for their feedback on the service and this information was included in trust reports for services. We looked at the positive practice assessment of the crisis assessment unit dated January 2018 and found that concerns highlighted previously had been considered and changes made. Where patients made complaints or compliments, details were recorded.

Learning, continuous improvement and innovation

NHS trusts are able to participate in a number of accreditation schemes whereby the services they provide are reviewed and a decision is made whether or not to award the service with an accreditation. A service will be accredited if they are able to demonstrate that they meet a certain standard of best practice in the given area. An accreditation usually carries an end date (or review date) whereby the service will need to be re-assessed in order to continue to be accredited.
No teams in this core service have been awarded an accreditation.

The service participated in a national audit for section 136 suites and the completion of documents. Action plans were drawn up from these audits and remedial action was carried out as required. The service did not participate in any Commissioning for Quality and Innovation national goals.

Wards for people with a learning disability or autism

Facts and data about this service

Location site name	Ward name	Number of beds	Patient group (male, female, mixed)
Parkside Lodge	Parkside Lodge	12	Mixed
St Mary's Hospital	3 Woodlands Square	5	Mixed
St Mary's Hospital	2 Woodlands Square	5	Mixed

Leeds and York Partnership NHS Foundation Trust provides three inpatient wards for people over the age of 18 who have a learning disability and/or autism.

- Parkside Lodge: a 12 bed assessment and treatment ward for male and female adults who have a learning disability and/or autism.
- 2 Woodlands Square: a five bed planned care (respite) service for male and female adults who have a learning disability and/or autism; and severe or complex physical health needs.
- 3 Woodlands Square: a five bed planned care (respite) service for male and female adults who have a learning disability and/or autism; and severe or complex challenging behaviours.

Parkside Lodge is the only service which admits patients detained under the Mental Health Act. At the time of inspection there were seven patients admitted to Parkside Lodge and six were detained under the Mental Health Act. The seventh patient had agreed to informal admission.

We last inspected the wards for people with a learning disability and/or autism provided by Leeds and York Partnership NHS Foundation Trust in July 2016. We rated these services as requires improvement overall with ratings of requires improvement in the safe, effective and well-led domains, and ratings of good in the caring and responsive domains.

Is the service safe?

Safe and clean care environments

Safety of the ward layout

There were no mixed sex breaches reported by the trust for these wards between 1 October 2016 and 30 September 2017.

All wards now complied with guidance from the Department of Health on eliminating mixed sex accommodation. On Parkside Lodge there were designated female and male corridors and a female only lounge. There were communal bathrooms for males on the male corridor and a communal bathroom for females on the female corridor.

Admissions to 2 Woodlands Square and 3 Woodlands Square were planned in advance and neither service routinely accepted emergency admissions. Admissions were planned to alternate between male-only and female-only weeks. This system had been in place on 3 Woodlands Square for a number of years. The system had been newly introduced on 2 Woodlands Square prior to the inspection in January 2018. The newly introduced system of alternate weeks for male and female patients meant that the service now complied with the Department of Health's guidance on eliminating mixed sex accommodation in inpatient mental health and learning disability wards.

There were nurse call alarms on all three wards. On Parkside Lodge and 3 Woodlands Square, staff had access to personal alarms. During the inspection we received feedback that the personal alarm system on 3 Woodlands Square was not functioning. We raised this with the modern matron. The modern matron told us that all alarms were checked regularly and were rechecked following this feedback and were functioning.

Staff completed regular risk assessments of the environments. The trust had undertaken a ligature risk assessment on 2 Woodlands Square in December 2017, and 3 Woodlands Square and Parkside Lodge in August 2017. All three wards had a ligature risk assessment in place at the time of inspection. Each ligature risk assessment identified risks which were managed clinically by staff on the wards, as well as those which required the facilities department to identify solutions. The ligature risk assessment included a separate outcome report which tracked the actions taken by staff and facilities to rectify ligature risks.

None of the wards had a layout which allowed staff to observe all parts of the ward. Each ward had potential ligature risk anchor points. A ligature point is something which a patient intent on self-harm could use to tie something to in order to strangle themselves. Staff on Parkside Lodge and 3 Woodlands mitigated the risk of ligature and self-harm through observation levels based on an individualised risk assessment of each patient.

On 2 Woodlands Square there were a number of additional ligature anchor points in each room including patient bedrooms due to the additional physical health equipment such as hoists. Staff were aware of the additional ligature risks on the ward. Ligature risks were mitigated through individualised risk assessment which included an assessment of the severe and complex physical health needs of each patient. Staff told us that due to the intense support required to properly care for the physical health needs of each patient, the risk from ligature was low.

Maintenance, cleanliness and infection control

For the most recent patient-led assessments of the care environment (PLACE) assessment (2017) the location scored better than the similar trusts for all three aspects overall.

Site name	Cleanliness	Condition appearance	Dementia	Disability

		and maintenance	friendly	
1-5 WOODLANDS SQUARE	99.14%	96.18%	-	91.37%
Trust overall	99.37%	98.30%	99.72%	93.96%
England average (Mental health and learning disabilities)	98.40%	95.13%	85.53%	86.94

Patients and carers told us the wards were always clean and well-maintained. All three wards appeared clean and had good furnishings. Cleaning records were up to date and demonstrated that the wards were cleaned regularly. On 2 Woodlands Square staff maintained cleaning records for the additional equipment located on the ward. There were hand washing facilities available for staff. Hand sanitisers were present at the entrance of each ward. Staff undertook infection control audits.

On 2 Woodlands Square staff undertook additional more frequent audits of equipment such as mattresses. We were told this was due to the additional wear and tear which was expected due to the patient group.

Both 2 Woodlands Square and 3 Woodlands Square were well-maintained. On 3 Woodlands Square the ward had been stripped to provide a low stimulus environment. A number of staff told us that this was not routinely how the ward environment was maintained and was due solely to the need to provide a low stimulus environment for one patient. However, at Parkside Lodge there were areas where the environment had not been well-maintained. Some notice boards on the wards had been damaged and not replaced. There were doors and walls were the paintwork had cracked or peeled. The floor mat in the de-escalation room was broken and had not been replaced. We raised this with the modern matron and the clinical team leader on the day of inspection and this was replaced the next day.

Seclusion room

The service had one seclusion room which was at Parkside Lodge. The seclusion met the guidance of the Mental Health Act Code of Practice. There was a viewing panel which allowed clear observation of the room, toilet facilities, and a clock visible from the seclusion room. There was an intercom system.

Clinic room and equipment

Clinic rooms were tidy and clean on all three wards. Resuscitation equipment and emergency drugs were available in each clinic room and were checked regularly. Resuscitation equipment was checked weekly. Staff used ‘clean’ stickers on equipment which were visible and in date.

Safe staffing

Nursing staff

Definition

Substantive – All filled allocated and funded posts.
Establishment – All posts allocated and funded (e.g. substantive + vacancies).

Substantive staff figures			Trust target
Total number of substantive staff	30 September 2017	50.21	N/A
Total number of substantive staff leavers	1 October 2016 – 30 September 2017	5.00	10%-15%
Average WTE* leavers over 12 months (%)	1 October 2016 – 30 September 2017	9%	10%-15%
Vacancies and sickness			
Total vacancies overall (excluding seconded staff)	30 September 2017	16.39	N/A
Total vacancies overall (%)	30 September 2017	21%	N/A
Total permanent staff sickness overall (%)	30 September 2017	5.3%	3.7%
	1 October 2016 – 30 September 2017	3.2%	3.7%
Establishment and vacancy (nurses and care assistants)			
Establishment levels qualified nurses (WTE*)	30 September 2017	37.60	N/A
Establishment levels nursing assistants (WTE*)	30 September 2017	32.58	N/A
Number of vacancies, qualified nurses (WTE*)	30 September 2017	7.43	N/A
Number of vacancies nursing assistants (WTE*)	30 September 2017	6.16	N/A
Qualified nurse vacancy rate	30 September 2017	20%	N/A
Nursing assistant vacancy rate	30 September 2017	19%	N/A
Bank and Agency Use			
Shifts bank staff filled to cover sickness, absence or vacancies (qualified nurses)	1 October 2016 – 30 September 2017	966	N/A
Shifts filled by agency staff to cover sickness, absence or vacancies (Qualified Nurses)	1 October 2016 – 30 September 2017	345	N/A
Shifts NOT filled by bank or agency staff where there is sickness, absence or vacancies (Qualified Nurses)	1 October 2016 – 30 September 2017	69	N/A
Shifts filled by bank staff to cover sickness, absence or vacancies (Nursing Assistants)	1 October 2016 – 30 September 2017	3062	N/A
Shifts filled by agency staff to cover sickness, absence or vacancies (Nursing Assistants)	1 October 2016 – 30 September 2017	781	N/A
Shifts NOT filled by bank or agency staff where there is sickness, absence or vacancies (Nursing Assistants)	1 October 2016 – 30 September 2017	290	N/A

*Whole-time Equivalent

This core service has reported a vacancy rate for all staff of 22% as of 30 September 2017. The vacancy rate for all staff has been on an increasing trend for the 12 months.

This core service reported an overall vacancy rate of 20% for registered nurses and 19% for registered nursing assistants at 30 September 2017.

	Registered nurses			Health care assistants		
Ward/Team	Vacancies	Establishment	Vacancy rate (%)	Vacancies	Establishment	Vacancy rate (%)

2 Woodlands Square	1.10	7.55	15%	0.40	5.58	7%
3 Woodlands Square	3.52	8.52	41%	3.89	12.09	32%
CMIT	2.24	10.16	22%	-	-	-
Parkside Lodge	0.57	11.37	5%	1.87	14.64	13%
Core service total	7.43	37.60	20%	6.16	32.58	19%
Trust total	120.06	765.64	16%	89.65	614.56	15%

NB: All figures displayed are whole-time equivalents

	Overall staff figures		
Ward/Team	Vacancies	Establishment	Vacancy rate (%)
2 Woodlands Square	1.5	13.4	11%
3 Woodlands Square	7.41	20.61	36%
CMIT	4.04	15.26	26%
Parkside Lodge	3.44	27.01	13%
Core service total	16.39	76.28	21%
Trust total	257.28	2028.82	13%

NB: All figures displayed are whole-time equivalents

Between 1 October 2016 and 30 September 2017, bank staff filled 966 shifts to cover sickness, absence or vacancy for qualified nurses. Agency staff filled 345 shifts and 69 shifts were not filled.

Ward/Team	**Available shifts**	**Shifts filled by bank staff**	**Shifts filled by agency staff**	**Shifts NOT filled by bank or agency staff**
Parkside Lodge	769	490	211	68
2 Woodlands Square	375	251	124	0
3 Woodlands Square	236	225	10	1
Core service total	1380	966	345	69
Trust Total	10125	6391	3013	721

Between 1 October 2016 and 30 September 2017, bank staff filled 3062 shifts to cover sickness, absence or vacancy for nursing assistants. Agency staff filled 781 shifts and 290 shifts were not filled.

Ward/Team	**Available shifts**	**Shifts filled by bank staff**	**Shifts filled by agency staff**	**Shifts NOT filled by bank or agency staff**
Parkside Lodge	3729	2698	754	277
2 Woodlands Square	139	138	1	0
3 Woodlands Square	265	226	26	13

Core service total	4133	3062	781	290
Trust Total	53303	38319	10899	4085

This core service had five (9%) staff leavers between 1 October 2016 and 30 September 2017.

Ward/Team	Ave. Substantive staff	Substantive staff Leavers	Average % staff leavers
2 Woodlands Square	11.24	0.00	0%
Parkside Lodge	27.48	4.00	15%
3 Woodlands Square	14.47	1.00	7%
Core service total	53.19	5.00	9%
Trust Total	1801.83	166.73	9%

The average sickness rate for this core service was 4.7% between 1 October 2016 and 30 September 2017. The most recent month's data (September 2017) showed a sickness rate of 5.3%.

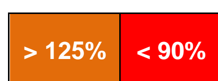
Ward/Team	Total % staff sickness (at latest month)	Ave % permanent staff sickness (over the past year)
2 Woodlands Square	0%	2.8%
Parkside Lodge	5.8%	2.8%
3 Woodlands Square	9.6%	4.3%
Core service total	5.3%	3.2%
Trust Total	4.48%	5.30%

The below table covers staff fill rates for registered nurses and care staff during July 2017, August 2017 and September 2017.

2 Woodlands Square had below 90% of the planned daytime nurses between July and September 2017, however had above 125% of the planned care staff.

Parkside Lodge and 3 Woodlands Square had below 90% of the planned daytime nurses between July and September 2017.

Key:



	Day		**Night**		**Day**		**Night**		**Day**		**Night**	
	Care Staff	Nurses	Care Staff	Nurses	Care Staff	Nurses	Care Staff	Nurses	Care Staff	Nurses	Care Staff	Nurses

	September 2017				August 2017				July 2017			
Parkside Lodge	176.8	78.4	186.5	95.0	243.1	82.9	207.5	100.0	225.7	77.1	209.9	103.4
2 Woodlands Square	69.5	112.4	96.7	100.0	82.3	94.8	100.0	100.0	71.7	112.2	100.0	100.3
3 Woodlands Square	95.4	66.8	110.0	100.0	103.0	67.4	112.9	100.0	84.1	63.4	94.0	90.3

Clinical team leaders told us that the staffing establishment was calculated based on a combination of predetermined commissioned staffing levels and the clinical needs of the ward each day. Staffing levels were reviewed regularly and clinical team leaders told us that they could bring in extra staff when required to take account of acuity on the ward.

Staff on each ward consistently told us that there was always at least one qualified member of staff on duty at all times. This was supported by staff fill rates which were consistently at or above target for each ward for night time shifts filled by qualified staff. During the day shifts, if qualified staff shifts fill-rate fell below planned levels then these would be supported by the clinical team leads dropping into the nursing numbers. The services sickness rate and turnover rate for the 12 months prior to inspection was 3.2% and 9% respectively which was below the trust's threshold targets of 3.7% for sickness rates and 10% for turnover rates.

The trust did not have a target for vacancy rates. The service reported an overall vacancy rate of 20% for registered nurses and 19% for registered nursing assistants at 30 September 2017. The high vacancy rates were mitigated through the regular use of bank and agency staff. The Clinical team leaders at 3 Woodlands Square and Parkside Lodge told us that the services tried where possible to use bank staff that regularly picked up shifts on the wards. On 2 Woodlands Square the clinical team leader told us that the service would only use known bank staff as the complexity of the patient group meant that only experienced staff could safely work on the ward.

Staff on Parkside Lodge and 3 Woodlands Square told us that there were enough staff to carry out physical interventions (for example; restraint, rapid tranquilisation and seclusion) safely. There was no use of these interventions on 2 Woodlands Square. Staff told us it was rare for staff shortages to result in cancelled activities or patient leave. None of the wards regularly gathered data in relation to cancelled activities or leave. On 2 and 3 Woodlands Square, a number of patients were supported to access community activities with staff funded through established adult social care packages.

Medical staff

Between 1 October 2016 and 30 September 2017, medical agency staff covered sickness, absence or vacancy for 3% of the total shifts.

Ward/Team	Available shifts	Shifts filled by bank staff	Shifts filled by agency staff	Shifts NOT filled by bank or agency staff
Parkside Lodge – Consultant	744	-	-	-
Parkside Lodge – Doctor in training	240	-	32	-
Core service total	984	-	32 (3%*)	-

Trust Total	45168	-	1037 (2%)	84 (<1%%)

* Percentage of total shifts

The units had adequate medical cover for both the day and night. Parkside Lodge had a full-time consultant psychiatrist and a junior doctor in post and these roles also covered 2 Woodlands Square and 3 Woodlands Square. The units were included within the trust wide on-call rota for consultant psychiatry. The trust had separate on-call rotas for medical staff for West Leeds and for East Leeds. The units were included in the trust's West Leeds on-call rota. The consultant psychiatrist told us that medical staff could respond and attend quickly in cases of psychiatric emergency.

Mandatory training

The compliance for mandatory and statutory training courses at 30 September 2017 was 92%. Of the training courses listed, staff failed to achieve the trust target of 85% for three and of those, one failed to score above 75% which was 'Mental Health Act - Inpatient - Level 2' with 73%.

The training compliance reported for this core service during this inspection cannot be compared to the last inspection as there was no data available for this core service. The methodology of CQC provider information requests has changed, so some data from different time periods is not always comparable. We only compare data where information has been recorded consistently.

Key:

Below CQC 75%	Between 75% & trust target	Trust target and above

Training course	This core service %	Trust wide %
Moving and Handling Advanced (LD)	100%	91%
Fire - Level 1	100%	95%
Infection Control - Non-Clinical	100%	97%
Safeguarding children Level 1	100%	93%
Personal Safety with Breakaway Skills	100%	85%
Moving and Handling Principles	100%	90%
Essential Life Support	100%	87%
Duty of Candour	98%	98%
Health and Safety	98%	96%
Food Safety Level 2	96%	88%
High Level Physical Interventions with PSTS and Breakaway skills	95%	89%
Clinical Risk	95%	82%
Infection Control – Clinical	94%	81%
Safeguarding Adults	92%	95%
Safeguarding children Level 3	91%	81%
Mental Capacity Act and DoLs - Level 2	90%	85%
Equality and Diversity	90%	96%
Mental Health Legislation Awareness - Level 1	89%	90%
Information Governance	88%	92%
Moving and Handling Essentials	86%	80%
Fire - Level 3	86%	81%

Immediate Life Support	82%	78%
Safeguarding children Level 2	82%	82%
Mental Health Act - Inpatient - Level 2	*73%*	78%
Core Service Total %	92%	90%

Compliance with mandatory training had improved since the previous inspection. During the previous inspection three courses in particular were highlighted as having below target compliance. These were clinical risk, Mental Capacity Act and Deprivation of Liberty Safeguards and high level personal safety training. Compliance with each identified module exceeded the trust minimum target at the time of this inspection. There were three modules below the trust's target of 85%. However, in each case the modules had low total numbers of eligible staff which meant that percentages for compliance were subject to exaggerated shifts in compliance due to one or two staff not completing the training. For example intermediate life support training had 15 staff eligible for training and 12 staff had completed the training. This meant that the compliance rate was 82% which was below the trust target. Overall mandatory training compliance was 92% which both above the trust's target of 85% and above the trust wide average of 90%.

Assessing and managing risk to patients and staff

Assessment of patient risk

During the inspection we reviewed 14 care records which included six care records for patients admitted to Parkside Lodge, and four care records each for patients admitted to 2 Woodlands Square and 3 Woodlands Square.

There was a risk assessment for each patient in all of the care records we reviewed. Staff used a recognised risk assessment tool. Staff completed the 'functional analysis of care environment' risk assessment tool. This was stored on the trust's electronic patient record system. On Parkside Lodge, four of the six care records showed evidence that the risk assessment was regularly reviewed and updated including after incidents. Staff on 2 Woodlands Square and 3 Woodlands Square told us that risk assessments were updated annually as a minimum during respite review meetings, and would be updated after significant changes in presentation or risk. All of the records we reviewed included a risk assessment which had either been completed or updated within the previous twelve months.

Management of patient risk

Staff were aware of and responded to specific risk issues such as the risk of falls or pressure ulcers. Where required, patients received a risk assessment in relation to moving and handling. This had recently been added to the risk assessments available to staff on the trust's electronic patient record system. Care records showed evidence that staff completed skin integrity assessments and falls assessments where required.

Staff demonstrated a comprehensive awareness of the individual observation levels of each patient. On 3 Woodlands Square and Parkside Lodge patients had a personal observations schedule within their care record. On 2 Woodlands Square there was a notice board in the clinical team manager's office which detailed the night-time observation levels for each patient. This showed that all patients were on 30 minute observations at night-time. Staff told us that patients were not routinely searched and that searches would only be carried out if there was a risk.

We identified blanket restrictions on each ward. On 3 Woodlands Square and Parkside Lodge the patient kitchen was kept locked. The clinical team leader told us that this was to manage the risk to the patient group. The wards had an individualised supervision plan for patients to use the kitchen which provided information on which patients could access the kitchens unsupervised and who would require staff support.

Whilst Parkside Lodge, 2 Woodlands Square and 3 Woodlands Square had access to enclosed outside space, the doors between the ward and the ward gardens were kept locked and patients had to ask staff to access the garden.

Parkside Lodge did not have a sign advising informal patients of their right to leave the ward. The clinical team manager told us that a sign was usually located by the main door, however along with other notices on the ward; this had been removed by a patient who was known to remove ward notices. The ward had one informal patient who was aware of the right to leave the ward at will.

Use of restrictive interventions

This core service had 272 incidents of restraint on 77 different service users and 28 incidents of seclusion between 1 October 2016 and 30 September 2017.

Ward name	Seclusions	Restraints	Patients restrained	Of restraints, incidents of prone restraint	Rapid tranquilisations
3 Woodlands Square	0	38	22	0 (0%)	1 (3%)
Parkside Lodge	28	234	55	23 (10%)	5 (2%)
Core service total	28	272	77	23 (10%)	6 (2%)

There were 23 incidents of prone restraint which accounted for 10% of the restraint incidents for the core service. All of the prone restraint occurred on Parkside Lodge. There were no instances of mechanical restraint over the reporting period.

Over the 12 months, there was a peak in the use of restraint in the most recent month, September 2017, where there were 53 incidents. The majority of these (49) occurred on Parkside Lodge. Staff explained that this was primarily related to one service user who had since been transferred from Parkside Lodge to a more secure ward.

Each restrained patient at Parkside Lodge was restrained an average of 10 times. The number of restraint incidents reported during the most recent 12 months was lower than the 395 reported for the previous 12 months. The use of restraint had decreased since the last inspection. At the time of the last inspection there were 212 uses of restraint in a six month reporting period. This was an average of 35 uses of restraint per month. Data provided by the trust showed that in a twelve month period there were 272 uses of restraint which was an average of 23 uses of restraint per month.

Restraint records were detailed and included evidence that restraint was used only after attempts to de-escalate situations had failed. Staff told us that restraint was only used as a last resort. Whilst staff told us that they would receive a debrief after a restraint this was not detailed in the restraint record. The modern matron told us that formalising and recording the debrief process for staff was a recognised area for improvement.

On 2 Woodlands Square the additional equipment including bed rails was highlighted by staff as a potential restraint. This demonstrated an awareness of the definition of restraint under the Mental Capacity Act.

Over the 12 months, there was an increase in the use of seclusion in June and August 2017, where there were a total of nine and eight instances respectively. This is more than double the number reported for any other months. All of the seclusion incidents (28) were at Parkside Lodge.

The number of seclusion incidents reported during the most recent 12 months was higher than the 16 reported in the previous 12 months. However, 24 of the 28 uses of the seclusion had occurred between June and September 2017. In our review of seclusion records we saw that the majority of the uses of seclusion were in response to the challenging behaviour of one patient. Staff explained that this patient had since been transferred from Parkside Lodge to a more secure ward.

We reviewed nine records of seclusion. Seclusion records were kept appropriately and securely. All records showed that staff had used seclusion appropriately and followed best practice. The records showed that the staff had completed the required nursing observations and medical reviews appropriately and ended seclusion episodes in line with the trust's procedure.

There have been no instances of long-term segregation over the 12 month reporting period.

Safeguarding

A safeguarding referral is a request from a member of the public or a professional to the local authority or the police to intervene to support or protect a child or vulnerable adult from abuse. Commonly recognised forms of abuse include: physical, emotional, financial, sexual, neglect and institutional.

Each authority has their own guidelines as to how to investigate and progress a safeguarding referral. Generally, if a concern is raised regarding a child or vulnerable adult, the organisation will work to ensure the safety of the person and an assessment of the concerns will also be conducted to determine whether an external referral to Children's Services, Adult Services or the police should take place.

This core service made three safeguarding referrals between 29 September 2016 and 1 October 2017, all of which concerned adults.

Number of referrals		
Adults	Children	Total referrals
3	0	3

Compliance with safeguarding children training was:

Training course	**This core service %**	**Trustwide %**
Safeguarding children Level 1	100%	93%
Safeguarding children Level 2	82%	82%
Safeguarding children Level 3	91%	81%

Compliance with safeguarding adults training was:

Training course	**This core service %**	**Trustwide %**
Safeguarding Adults	92%	95%

The core service was above the training target for safeguarding training with the exception of safeguarding children level 3. This module had 15 staff eligible for training and 13 had completed the course. Qualified staff consistently showed a good understanding of safeguarding and knew how to raise alerts with the trust's safeguarding department. Staff documented in care records if a safeguarding alert had been raised with the trust's safeguarding department. Nursing assistants could identify some of the different types of abuse however they were less clear on the process for raising concerns. The majority of nursing assistants told us that they would speak to the qualified staff. On 2 Woodlands Square and 3 Woodlands Square staff completed body maps of patients during their admission. This was to identify any potential physical health concerns, although staff told us that this may result in a safeguarding alert if they suspected potential physical abuse.

Each ward had procedures in place for children to visit. On Parkside Lodge children were not allowed on to the ward, however there was a separate room within the ward but off the ward which could be used for children to visit. On 2 Woodlands Square and 3 Woodlands Square staff told us that because the service was a respite ward it was rare for patients to have visitors however this would be managed by individual risk assessment. The clinical team manager told us that there were no restrictions on children visiting the ward, however this would be managed on a case by case basis and would depend on the risks.

The trust told us they had been named in or involved in a serious case review in the last 12 months but it did not relate specifically to this core service.

Staff access to essential information

Staff on each ward maintained a combination of electronic and paper records for each patient. Electronic records including progress notes, the functional analysis of the care environment risk assessment and additional risk assessments such as the moving and handling risk assessment were stored on the trust's electronic patient record system. Care plans and notes of multidisciplinary team meetings were stored on the trust's shared drive. Care plans were also printed and stored in patient's paper records. On Parkside Lodge, staff also maintained a separate paper medical record for each patient to store information related to ongoing physical health assessments.

On Parkside Lodge we identified that the complexity of the filing system used by the service meant that not all information was readily accessible to staff when they needed it. Care records were not maintained consistently which meant that some records had information stored in different or in multiple locations. We compared two records and saw that information related to weight measurements had been stored on the shared drive in one case and within the paper record in the other case. Discharge planning was recorded within multidisciplinary team meeting minutes and not within care records. Whilst staff could in most cases source documentation, it required staff to check in multiple locations.

Across all three wards we identified that not all staff had access to essential information. Nursing assistants including trust staff, bank staff and agency staff were not routinely trained to access the trust's electronic patient record system or shared drive. The modern matron told us that nursing assistants who were trust staff could be trained to use the systems if they requested it but that it was not a service requirement. Nursing assistants did have access to the paper records. Nursing assistants also participated in the ward handovers.

Qualified staff who were bank staff were not routinely trained to access the trust's electronic patient record system or shared drive unless they worked regularly on the ward. Qualified staff who were agency staff were not trained and had no access to the trust's electronic patient record system or shared drive. The variations and limitations in staff being able to access the trust's electronic patient record system and shared drive was a potential risk to patient care.

The trust told us that the electronic patient record system had a number of known weaknesses and so the trust had engaged in a procurement process for a new system. Staff were aware of the trust's intention to replace the current electronic patient record system. Staff working in the service had read-only access to the electronic patient record system used by the provider of community physical health services for Leeds.

Medicines management

We reviewed the medicine charts of all 12 patients admitted to the three wards at the time of inspection. Staff followed good practice in relation to medicines management. None of the patients were prescribed high-dose antipsychotic medication. On Parkside Lodge the consultant psychiatrist told us that the service rarely prescribed high-dose antipsychotic medication and that the service had not admitted a patient who was prescribed high-dose antipsychotic medication requiring specific physical health checks for a number of years. Medication was reviewed in weekly multidisciplinary meetings which had input from the consultant psychiatrist, junior doctor and pharmacist. The consultant psychiatrist told us that the service followed the principles of NHS England's 'call to action' in stopping over medication of people with a learning disability, autism or both (STOMP). As a result the service reviewed medication as part of the admission process and where possible tried to reduce and minimise the medication patients were prescribed. At the point of discharge the consultant psychiatrist produced a discharge summary which included the recommended next steps for patient's prescribed medication.

On 2 Woodlands Square and 3 Woodlands Square staff made contact with patient's families and carers, and with the patient's GP, to check medication prescriptions prior to admission.

Track record on safety

Providers must report all serious incidents to the Strategic Executive Information System (STEIS) within two working days of an incident being identified. Between 1 October 2016 and 30 September 2017 there were no serious incidents reported by this core service.

Reporting incidents and learning from when things go wrong

The Chief Coroner's Office publishes the local coroners' Reports to Prevent Future Deaths which all contain a summary of Schedule 5 recommendations which had been made, by the local coroners with the intention of learning lessons from the cause of death and preventing deaths.
In the last two years, there has been one prevention of future death' reports sent to the trust but it did not relate to this core service.

Staff reported incidents using the trust's electronic incident reporting system. All members of staff with the exception of agency staff had access to the trust's electronic incident reporting system. Staff were aware of the types of incidents that needed to be reported. Clinical team managers told us that staff received debriefs following incidents, however feedback from staff was inconsistent. Incident forms did not include information in relation to staff receiving feedback or debriefs from

incidents. Staff were not able to identify an incident which has led to changes or improvements in the service.

Using the electronic incident report system staff reported 216 incidents from 1 October 2017 to 31 December 2017. The most common incident was assault by patients on staff. All 65 incidents of patients assaulting staff were at Parkside Lodge. Meeting minutes for the monthly safety and risk meeting which was attended by the modern matron and the service manager for all learning disability services showed that incident themes and trends were discussed at senior management level. However, staff meeting minutes for each ward for the three months prior to inspection did not provide evidence that staff reviewed and discussed the same incident themes and trends at a local level.

The Duty of Candour regulation is in place to ensure that providers are open and transparent with people who use services. It sets out specific requirements that providers must follow when things go wrong with care and treatment, including informing people about the incident, providing reasonable support, providing truthful information and a written apology when things go wrong.

The trust had a policy and procedure for the Duty of Candour. There were also letter templates available for staff to use in relation to the duty which were available on the trust's intranet. The trust's policy required staff to follow the duty of candour for all incidents graded at severity level three or above, however staff could use discretion to follow the principles of the duty of candour for lower level incidents.

Most staff knew and understood the duty of candour. Training in the duty of candour was mandatory for all trust staff. Compliance with duty of candour training was 98% which was above the trust target. Staff were able to give examples of how the duty of candour had been followed for incidents below the severity rating of level three.

Is the service effective?

Assessment of needs and planning of care

We reviewed 14 care records during this inspection. This included the records of six of the seven patients admitted to Parkside Lodge and the records of the two patients admitted to 2 Woodlands Square and three patients admitted to 3 Woodlands Square. We also reviewed records of patients previously admitted to 2 and 3 Woodlands Square.

On Parkside Lodge we completed two reviews of six care records. During the second review of care records we were supported by staff working on the ward to locate specific documentation. Whilst staff were in most cases able to source the required documentation, it required staff to search in a number of locations. Care records were not maintained consistently. This was reflected in assessments of needs and planning of care which varied between records. In two of the six records there were assessments which were undated and incomplete. Staff used a number of templates to plan care including positive behavioural support plans, active treatment plans, physical health care plans and 'one page profiles'. The cumulative care planning in place was individualised to each patient, however none of the records included a single comprehensive, consistently recorded care plan which holistically addressed the totality of an individual's mental, physical and social needs.

On 2 Woodlands Square all patients had a comprehensive and personalised care plan which addressed the physical healthcare focus of the planned admission for respite. All patients had

received an ‘activities of daily living assessment’ in addition to their individualised risk assessment. Care plans were holistic and covered a range of needs including sleep, dietary requirements, personal hygiene and skin integrity. Where required staff had included photographs within care plans to provide clear and precise guidance on the correct positioning for patients. On 2 Woodlands Square, one care record also included a detailed ‘do not attempt cardiopulmonary resuscitation’ order which was dated and clearly located within the patient file.

On 3 Woodlands Square all patients had a comprehensive and personalised ‘planned care support plan’. Care records included a ‘one page profile’ which was individualised to each patient and covered a range of needs. Two of the four care plans we reviewed were overdue for review or did not have evidence of review. All four records included a health action plan for responding and monitoring patients’ physical health, although there were variations in the level of detail in these plans between different care records.

None of the wards routinely worked with patients to produce a communications passport. The modern matron told us that this was a recognised area for improvement. On 2 Woodlands Square staff had produced an ‘all about me’ booklet for each patient. These contained highly detailed and personal information related to each patient admitted to the service. The booklets covered communication needs, a pen portrait of the patient, information in relation to medication including the preferred and safe method of medicines administration, continence, mobility, meal times, personal care and sleep patterns.

Best practice in treatment and care

This core service participated in one clinical audit as part of their clinical audit programme 2016 - 2017.

Audit name	Audit scope	Audit type	Date completed	Key actions following the audit
Nutritional screening of the patients admitted to Parkside Lodge and Woodlands Square	Inpatients (Learning disabilities)	Clinical	20/12/2016	Completion of NST in 72hours to be added into 72hours admission paperwork Dietitian to communicate to all nursing staff that NST needs to be completed within 72hours of admission with as much data as possible Ensure repeat NST including in all CPA documents for all service users Dietitian to communicate to all nursing staff that NST needs to be completed every 3months as a minimum and sooner if additional data available or if concerned Creation of a centralised system for dietetic referrals. A named nurse to be involved in implementing the actions and involved in completing further audit cycles

On 2 and 3 Woodlands Square patients were admitted for a planned length of stay which was usually no more than a week. During this time patients were able to continue their access to activities in the community through established support packages with adult social care services.

Both services provided limited options in terms of treatment and care which were outside of the scope of a respite service and short period of admission.

On Parkside Lodge there was limited evidence that patients were able to access a full range of care and treatment options which would be within the scope of an assessment and treatment ward, which we raised with the service following the inspection. The service had one psychologist who worked on the ward for two days per week. Patients were not consistently offered one to one sessions with the psychologist. Instead, the service model relied on the psychologist providing an overall psychology input into the weekly multidisciplinary team meetings. The psychologist also worked with the occupational therapy and nursing staff to develop and revise positive behavioural support plans. We reviewed activity timetables for six patients admitted to Parkside Lodge. Timetables showed repeated examples of 'relax on the ward', 'music in bedroom' and 'one hour of 1:1 for activity of choice on the ward'. One patient timetable planned for a drive out with staff each morning and each afternoon for every day of the week. The evidence provided by the service confirmed our observations that patients did not consistently engage in therapeutic activities. The lack of therapeutic activities meant that the service was not providing a model of care in line with the principles of Transforming Care which seeks to rehabilitate patients, reduce inpatient admissions, and increase successful discharges into community settings.

Patients admitted to all three wards had good access to physical healthcare, including specialists when needed. The service had a visiting GP. Staff supported patients to attend specialist hospital appointments when required. This was observed on the day of inspection with staff supporting a patient to attend the local general hospital for physical health tests. The clinical team manager for Parkside Lodge told us that the service had developed good links with the local acute trust to jointly manage the physical healthcare needs of the patients.

On 3 Woodlands Square we found that there was an inconsistent approach to assessing risks related to patients with epilepsy. Patients with epilepsy did not routinely receive an individualised risk assessment and risk management plan for specific activities such as taking a bath. We raised this with the modern matron on the day of inspection. Following this feedback the modern matron told us that ward staff had ensured that patients now had an individualised risk assessment and risk management plan which included the risks posed by epilepsy.

Staff assessed patients' food and drink needs and need for specialist nutrition when required. Care records showed that patients were referred to dieticians when there was an identified need. The service did not employ a speech and language therapist and the service was in the process of finalising the recruitment process for this role. Care records showed that patients could be referred to the speech and language therapists working with the trust's community teams when required. We saw examples of rating scales used including the Braden Pressure Scale, the Modified Early Warning Score, and the Therapeutic Outcome Measures. On Parkside Lodge staff reviewed the Therapeutic Outcome Measures for each patient during the weekly multidisciplinary team meeting.

Staff used technology to support patient care in relation to the safe administration of medication. The trust used an electronic prescribing and medicines administration system. One of the benefits of the system was a reduced risk of drug errors due to errors in transcribing and ordering medication.

Skilled staff to deliver care

The trust’s target rate for appraisal compliance is 85%. As at 8 November 2017, the overall appraisal rates for non-medical staff within this core service was 86%. The ward failing to achieve the trust’s appraisal target was Parkside Lodge with an appraisal rate of 74%.

The rate of appraisal compliance for non-medical staff reported during this inspection was worse than the 89% reported at the last inspection.

Ward / team name	Total number of permanent non-medical staff requiring an appraisal	Total number of permanent non-medical staff who have had an appraisal	% appraisals
2 Woodlands Square	20	20	100%
3 Woodlands Square	12	11	92%
Parkside Lodge	27	20	74%
Core service total	59	51	86%
Trust wide	2028	1596	79%

The trust’s target rate for appraisal compliance is 85%. There was no medical appraisal information provided for this core service. The service employed one consultant psychiatrist who had undertaken revalidation.

Between 1 April 2017 and 1 October 2017 the clinical supervision rate across the core service was 15% based on the trust’s electronic reporting system. The rate of clinical supervision reported during this inspection is worse than the 52% reported at the last inspection.

Ward name	Clinical supervision sessions required	Clinical supervision sessions delivered	Clinical supervision rate (%)
2 Woodlands Square	72	11	15%
3 Woodlands Square	25	5	20%
Parkside Lodge	144	20	14%
Core service total	241	36	15%
Trust Total	11598	6674	58%

During the previous inspection we identified areas of concern in relation to staff receiving appropriate supervision. The supervision compliance rate at the time of the last inspection was 52%. Since the last inspection the trust had transitioned from a paper based system for recording clinical supervision to an electronic system. The system was introduced in April 2017 and the trust target for clinical supervision was set at 85% compliance. The clinical supervision compliance rate for the service had fallen since the last inspection to 15%.

During this inspection we undertook an in-depth review of clinical supervision records to ascertain whether the low clinical supervision rate was the result of recording issues or the result of staff not regularly receiving supervision. We found that some supervision was taking place although this varied in frequency and was poorly recorded.

- Qualified staff on all three wards were more likely to receive management supervision. The records for unqualified staff showed significant gaps between management supervision dates.
- One to one clinical supervision was not routinely offered on all three wards for both qualified and unqualified staff.
- There were variations in what was and was not group supervision. On 3 Woodside Square there was a weekly handover meeting where a new patient group was admitted to the ward. This was recorded as group supervision.

The service had continued to use a combination of paper and electronic systems for recording supervision and neither were fully embedded.

- The electronic system did not allow clinical team leaders to view all supervision and appraisal records for staff working in their team. Records could only be accessed by the supervisor and supervisee. This meant that clinical team leaders could not have effective oversight of the frequency of staff supervision.
- Different templates had been used to capture details of supervision sessions. The quality and detail of supervision records varied between supervisors.

Staff told us that they were supported to develop their skills and knowledge. On Parkside Lodge qualified staff told that they had been supported to visit other assessment and treatment wards which had been rated as outstanding by the CQC. The purpose of these visits was to learn good practice and introduce similar innovations to Parkside Lodge. Both Parkside Lodge and 3 Woodlands Square had sensory rooms on the ward, however nursing staff and nursing assistants had not received training in the application of sensory techniques. Care records did not include an individualised plan for each patient in relation to the use of the sensory rooms.

There were no staff engaged in performance management at the time of inspection. Managers were clear on the process for dealing with poor performance. Managers and senior managers were able to give specific examples of how they had addressed poor performance within the last year on Parkside Lodge.

Multi-disciplinary and interagency team work

The multidisciplinary team on Parkside Lodge met weekly and discussed all patients currently admitted to the ward. Staff shared information about patients at effective handover meetings within the team. There were three handovers per day on all three wards.

The ward teams had effective working relationships with other teams in the trust. The trust had recently launched a new out of hours service where staff trained in caring for people with learning disabilities could provide input into other services provided by the trust. This new service worked in close partnership with the trust’s mental health crisis services to ensure that the service responded appropriately to people with a learning disability. The service was staffed on a rotational basis by qualified nurses working at Parkside Lodge.

The ward teams had effective working relationships with teams outside the organisation. The trust’s learning disability services worked closely with the local Leeds Transforming Care Partnership. This partnership was made up of the three clinical commissioning groups and the local authority in Leeds. The associate director told us that the long term strategy for the service was based on the Transforming Care model and had been jointly developed in conjunction with the Transforming Care Partnership.

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

The trust provided details of two ‘Mental Health Act’ related courses for this core service and the training compliance for each as of 30 September 2017. These were ‘Mental Health Legislation Awareness - Level 1’ (89%) and ‘Mental Health Act - Inpatient - Level 2’ (73%). The trust stated that these training courses were mandatory, but not statutory, and should be renewed every two years.

Staff understanding of the Mental Health Act varied between the different wards. On Parkside Lodge, staff had a clear understanding of the Mental Health Act. Qualified staff could identify some of the five principles of the Mental Health Act. Staff had access to the trust’s Mental Health Act office for administrative support in relation to the Mental Health Act. There was a Mental Health Act Code of Practice available on the ward. An independent mental health advocate visited the service regularly. The independent mental health advocate also attended the weekly multidisciplinary team meeting.

Care records indicated that staff explained to patients their rights under the Mental Health Act. Care records did not provide evidence that staff used adaptive methods of communication to ensure that all patients received an explanation of their rights in a way that they could understand. The ward did not have a notice advising informal patients of their right to leave the ward, however staff explained that this had recently been removed by a patient. Staff told us that they would ensure informal patients were aware of their right to leave the ward. We interviewed one informal patient who was able to provide a comprehensive explanation of the right to leave the ward.

The nature of the respite services provided by 2 and 3 Woodlands Square meant that the wards did not routinely admit patients who were detained under the Mental Health Act. Staff on 2 Woodlands Square were required to undertake the Mental Health Legislation Awareness - Level 1 module only. Staff on 3 Woodlands Square were required to undertake both modules of training in the Mental Health Act provided by the trust. Staff on both wards had a limited understanding of the Mental Health Act including the guiding principles.

Good practice in applying the Mental Capacity Act

As of 30 September 2017, 90% of the workforce in this core service had received training in the ‘Mental Capacity Act and DoLs - Level 2 ‘.The trust stated that this training course was mandatory, but not statutory, and should be renewed every two years.

Qualified staff on all three wards had a mixed understanding of the Mental Capacity Act. The trust had a Mental Capacity Act policy in place at the time of inspection. The Mental Health Act office provided staff with support in relation to the Mental Health Act. The trust’s intranet also provided staff with guidance in relation to the Mental Capacity Act.

On all wards care records showed evidence of capacity assessments in relation to specific decisions which followed the framework of the Mental Capacity Act. Examples of capacity assessments included in relation to patients’ consent to treatment, consent to have photographs taken, and consent to medication. Care records showed that decisions were made in the patients best interest following capacity assessments.

The trust told us that 52 Deprivation of Liberty Safeguard (DoLS) applications were made to the Local Authority for this core service between 1 October 2016 and 30 September 2017. The greatest number of applications were made in February 2017 with 46 (88%).

CQC received 10 direct notifications from the trust between 1 October 2016 and 30 September 2017. The total number of applications made within the period was 56. The difference in the reported figures is due to the requirement that providers must notify CQC of Deprivation of Liberty Safeguard (DoLS) applications only once the outcome of the application is known.

Number of DoLS applications made by month

	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Total
Applications made	0	1	0	0	46	0	0	1	0	3	0	1	52
Applications approved	0	0	0	0	1	0	0	0	0	0	0	0	1

During the previous inspection we identified areas for improvement in relation to the trust's approach to Deprivation of Liberty Safeguards. We found that the trust had not made Deprivation of Liberty Safeguards applications for patients using respite services at 2 and 3 Woodlands Square who lacked capacity to consent to care and treatment. Patients were subject to continual supervision and control, not free to leave and there was use of restraint such as padded bedsides, wheelchair straps and sedating medication. At this inspection we found that the service had responded appropriately to the identified areas of concern. Prior to admission staff assessed a patient's capacity to consent to treatment. If a patient lacked the capacity to consent to treatment then staff ensured that an urgent and standard Deprivation of Liberty Safeguards application was made as part of the admissions process.

Is the service caring?

Kindness, privacy, dignity, respect, compassion and support

The 2017 patient-led assessments of the care environment (PLACE) score for privacy, dignity and wellbeing at 1-5 Woodlands Square scored worse than similar organisations.

Site name	Privacy, dignity and wellbeing
1-5 Woodlands Square	84.42%
Trust overall	93.96%
England average (mental health and learning disabilities)	89.64%

We observed a number of person centred interactions between staff and patients across all three wards during this inspection. Staff were supportive and displayed an attitude that was respectful and responsive to the patient group. On all three wards we found that staff were knowledgeable about the patients in their care. We received positive feedback in relation to staff attitudes and behaviours from patients admitted to Parkside Lodge and 2 Woodlands Square. The feedback from carers of patients admitted to all three wards was mainly highly positive about staff attitudes and behaviours.

On 2 Woodlands Square staff displayed a particularly caring attitude towards the patients. Our observations of activity on the ward showed that patients were constantly interacting with staff, even whilst staff continued to perform their other duties. Staff had worked to create information booklets about each patient which were individualised and captured the voice of the patients admitted to the service. Staff on 2 Woodlands Square displayed a person-centred attitude and a willingness to adapt to the multiple and complex conditions of patients admitted to the service.

Involvement in the care

Involvement of patients

Staff had a clear process for new admissions on all three wards. Staff on Parkside Lodge and 2 Woodlands Square had created easy-read information leaflets for newly admitted patients. Activity timetables were produced in easy-read format using pictures to represent activities.

On 2 Woodlands Square care records and the ‘all about me’ booklets used on the ward provided staff with detailed information on the preferred methods and effective means of communication between staff and patients. Examples included how to structure sentences and phrase questions for patients who communicated verbally and how to read alternative means of communication for patients who were non-verbal.

The approach on 2 Woodlands Square which captured and recorded details of how best to communicate with patients was not replicated on 3 Woodlands Square or Parkside Lodge. On Parkside Lodge in particular care records showed limited evidence that staff had involved patients in making decisions about their care or that staff had assessed and planned to address patients’ specific communication needs.

Patients admitted to Parkside Lodge were invited to multidisciplinary team meetings, however during in observation of a multidisciplinary team meeting we did not observe staff using adaptive communication strategies to ensure that the patients could fully participate in the meeting.

Throughout the meeting staff used clinical language which was difficult for non-clinicians to understand.

Patients admitted to Parkside Lodge were referred to the independent mental health advocacy service. The service was ‘opt-out’ which meant that all detained patients were referred to the service and they could then decide whether to engage with the advocate.

Involvement of families and carers

Staff informed and involved families and carers appropriately. The carers of patients admitted to Parkside Lodge told us that they felt appropriately involved in decisions made about the care provided by the ward. Carers told us that they were informed if there was a significant change or incident on the ward. On 2 and 3 Woodlands Square, due to the nature of the respite service, staff told us that during a period of admission staff would ensure that they maintained the balance between keeping carers informed about changes during a patient admission and providing an effective respite for the carers as well as the patients.

On 2 and 3 Woodlands Square staff had a clear process for involving carers prior to admission. Staff would contact carers prior to each admission to receive updated information to inform the patient’s admission for respite.

Parkside Lodge and 3 Woodlands Square had held a carer’s forum meetings in December 2017 however attendance was poor. The service told us that future meetings were planned for 2018. The clinical team leader, modern matron and service manager all told us that involving carers to be able to regularly give feedback was a priority for the service in 2018. On 2 Woodlands Square the ward held four carers meetings in 2017. The meetings allowed carers to provide feedback about the service and receive information about service changes.

The service had established links with Carers Leeds which was a support group and registered charity providing support for unpaid carers living in Leeds.

Is the service responsive?

Access and discharge

Bed management

All three wards had clear criteria for admissions. On Parkside Lodge there was a clear standard for admissions which set out the exclusion and inclusion criteria for a successful referral to the service. Whilst the admission criteria document was still in use, it had not been updated since December 2011. The document contained out of date information including the number of beds and wards available within the assessment and treatment component of the trust's wards for people with people with a learning disability and autism.

There were no ward moves reported for this core service between 1 October 2015 and 30 September 2017.

There were no ward moves at night reported for this core service between 1 October 2016 and 30 September 2017.

The trust provided information regarding average bed occupancies for three wards / teams in this core service between 1 October 2016 and 30 September 2017. Two of the wards reported average bed occupancies ranging below the CQC benchmark of 85% over this period. There was only one month where the bed occupancy rate was above 85% and this was for '2 Woodlands Square' in June 2017 where the rate was 88%. The bed occupancy for all wards and teams was otherwise below 85%.

Ward name	Average bed occupancy range (Oct 2016 – Sept 2017) (current inspection)
3 Woodlands Square	41.94% - 76.77%
2 Woodlands Square	43.87% - 88.00%
Parkside Lodge	32.50% - 68.28%

Admissions to 2 and 3 Woodlands Square were planned which meant that there was always a bed available when required. Parkside Lodge operated at a maximum of 68% capacity which meant that there was always a bed available when required.

The trust provided information for average length of stay for the period 1 October 2016 to 30 September 2017. The average length of stay in this core service ranged from 3.00 days to 519.33 days.

Ward name	Average length of stay range (Oct 2016 – Sept 2017) (current inspection)
3 Woodlands Square	6.20 days – 7.53 days
2 Woodlands Square	4.71 days – 8.36 days
Parkside Lodge	3.00 days – 519.33 days

This core service reported no out area placements between 17 October 2016 and 1 October 2017.

This core service reported one readmission within 28 days between 1 October 2016 and 30 September 2017. The patient was discharged from Parkside Lodge on 15 July 2017 and was readmitted to the same ward on Parkside Lodge on 27 July 2017. The patient was on a community treatment order.

Ward name	Number of readmissions (to any ward) within 28 days	Number of readmissions (to the same ward) within 28 days	% readmissions to the same ward	Range of days between discharge and readmission	Average days between discharge and readmission
Parkside Lodge	1	1	100%	12 days	12 days

Discharge and transfers of care

Between 1 October 2016 and 30 September 2017 there were no delayed discharges within this this core service. Admission and discharge from 2 and 3 Woodlands Square were planned in advance of the admission date.

We reviewed six care records for patients admitted to Parkside Lodge. There was good evidence of discharge planning with minutes of the multidisciplinary team meetings. We raised with the service following the inspection that discharge planning was not recorded within care records.

Facilities that promote comfort, dignity and privacy

The 2017 patient-led assessments of the care environment (PLACE) score for ward food at 1-5 Woodlands Square scored better than similar trusts.

Site name	Ward food
1-5 Woodlands Square	96.81%
Trust overall	95.66%
England average (mental health and learning disabilities)	92.92%

On all three wards patients had access to their own bedrooms and were not expected to share bed bays or dormitories. On Parkside Lodge patients could personalise their bedrooms. The short length of stay on 2 and 3 Woodlands Square meant that patients did not routinely personalise their bedrooms; however patients could if they wanted to. There was a safe in the nursing office which could be used to store patient’s possessions.

On 2 Woodlands Square there was a lounge area and sensory room. All patient bedrooms also included a television and music system.

On 3 Woodlands Square there was a computer room, lounge and dining room, and a quiet room. Staff told us that the quiet room normally had games and arts and crafts supplies however these had been temporarily moved off the ward. Staff supported patients to access these.

There was a space for visitors to attend the wards. There were facilities for patients to make a phone call in private.

All three wards had enclosed outside gardens which patients could be used.

We received only neutral or negative feedback in relation to the food provided at Parkside Lodge and 3 Woodlands Square. Staff and patients told us that the food was either adequate or could be improved. On 2 Woodlands Square the complex physical healthcare requirements of the majority of patients admitted meant that it was rare for the ward to provide the same menu options as the other two wards.

On Parkside Lodge and 3 Woodlands Square staff would support patients to access hot drinks and snacks. Patients did not have unsupervised access to hot drinks and snacks as the door to the patient kitchen was kept locked on both wards.

Patients’ engagement with the wider community

On 2 and 3 Woodlands Square patients were able to continue their access to activities in the community through established support packages with adult social care services. Examples included patients who were supported to attend further education courses during their respite admission. On Parkside Lodge the majority of patients were detained under the Mental Health Act. Staff supported patients to access the wider community through Section 17 leave. During our inspection we observed one informal patient accessing the community as part of a planned shopping and baking activity which was supported by staff.

Staff supported patients to maintain contact with their families and carers. Carers were invited to attend multidisciplinary team meetings and care programme approach meetings.

Meeting the needs of all people who use the service

All three wards were located on the ground floor of each ward. The wards were adapted for disabled people who used wheelchairs. On 2 Woodlands Square there were a number of information posters on notice boards around the ward.

On Parkside Lodge and 3 Woodlands Square the wards did not have information clearly displayed around the ward. None of the wards had information leaflets prominently displayed. Staff on Parkside Lodge and 2 Woodlands Square had created easy-read information leaflets for newly admitted patients. Activity timetables were produced in easy-read format using pictures to represent activities.

Staff could access an interpreter service and translation service within the trust if required. Staff told us that this was rarely used. There was a trust wide service for spiritual support. Staff also gave examples of supporting patients to access religious services in the community as part of their care plan.

Listening to and learning from concerns and complaints

This core service received two complaints between 1 October 2016 and 30 September 2017.

Ward name	Values & behaviours (staff)	Facilities
Parkside Lodge	1	1

Staff told us that they would support patients to make complaints if required. One patient told us that they knew how to make a complaint and gave an example where they had made a complaint which had been supported by staff.

On 2 Woodlands Square we received feedback from carers in relation to the service changes to meet guidance from the Department of Health on eliminating mixed sex accommodation. The service had newly introduced gender specific admission weeks with alternate weeks for male and female patients. All carers of patients admitted to 2 Woodlands Square we spoke with told us that they were not happy with this service change and had raised this as a complaint with the trust. In response the trust had provided focus groups for carers to attend to provide feedback.

This core service received seven compliments during the last 12 months from 1 October 2016 to 30 September which accounted for 2% of all compliments received by the trust as a whole.

Is the service well led?

Leadership

Managers and senior managers within the service and the trust had the right skills, knowledge and experience to fulfil their roles. Parkside Lodge and 3 Woodlands Square were managed jointly by one clinical team leader. There was a clinical team leader who managed 2 Woodlands Square. Both clinical team leaders were nurses who had trained specifically to care for people with a learning disability. Both clinical team leaders were line managed by an inpatient manager / modern matron. The modern matron was managed by the learning disability services manager. The three wards sat within the specialist and learning disabilities care group which was one of four care groups provided by the trust. The care group was led by an associate director.

The management team had established a number of regular meetings to monitor quality and safety within the service. Managers had a clear understanding of the service and were able to describe clearly both the good practice and areas for improvement within the service.

The clinical team leaders and modern matron were visible in the service. Staff told us that the modern matron regularly visited the wards. Not all staff could easily identify who was the learning disability services manager or the associate director responsible for the services.

Vision and strategy

Since the previous inspection the trust had introduced a new statement of trust values. The trust had launched three new values which were each underpinned by a definition statement. Each value also had three statements of how the expected behaviours from staff which would demonstrate the values in practice.

The three values and definition statements were:

- We have integrity
  - We treat everyone with respect and dignity, honour our commitments and do our best for our service users and colleagues.
- We keep it simple
  - We make it easy for the communities we serve and the people who work here to achieve their goals.
- We are caring
  - We always show empathy and support those in need.

Qualified staff and managers had a good understanding of the values of the trust and could describe how the values were used to guide team and individual practice. Most nursing assistants could describe one or more of the trust values.

The modern matron told us that managers engaged with staff in relation to service changes and performance challenges including budgets. Staff displayed an awareness of the need to work within a finite budget. Concerns in relation to high staffing as a result of increased patient acuity in 2017 had impacted on the service budget and this had been escalated to the service risk register. Staff also told us about how the service was using capital expenditure to improve the ward environment. On Parkside Lodge the ward was due to close the therapy kitchen for two weeks in January 2018 to allow for a refurbishment and the installation of new equipment.

The service was working in conjunction with the Transforming Care Partnership to produce a long term strategy for the trust’s learning disability services. Minutes of the learning disabilities services

clinical governance meetings showed that the service was developing a long term strategy for learning disability services which included a reduction in bed numbers and a change in the clinical model of the service. The associate director told us that the trust was exploring options to launch a 'locked rehabilitation' service which would include provision for patients with a learning disability who required a higher level of support than could be provided in a community placement but whose risks were low enough to not require a more secure environment.

Culture

Staff told us that within their teams they felt respected, valued and well supported. Staff were positive about their immediate line manager. Staff were positive about working in the service and told us that the teams worked well together. However we found a clear distinction between the descriptions provided by staff on how they felt respected, valued, and supported by their teams and how they felt respected, valued and supported by the trust. Staff on each ward described how they felt isolated from the trust both in terms of geography and relationships with other trust services. The service's focus on learning disabilities and not mental health was cited by staff as a reason for why the service was seen unique within the trust. Frontline staff told us that they felt the trust did not regard the service as a priority area.

Staff had a clear understanding of whistleblowing and could describe the process for raising concerns. None of the staff we interviewed could easily identify who the trust's Freedom to Speak Up Guardian was or how the role fitted within the trust's approach for encouraging staff to raise concerns. During the inspection we fed back to senior managers that whilst staff were clear in their understanding of whistleblowing, several staff told us that they would be reluctant to raise concerns without fear of retribution and that they were not sure they would be supported to do so. Three staff told us that staff who had previously raised concerns had been unfairly treated after doing so.

There were no staff under supervised practice or suspension at the time of inspection or in the previous 12 months prior to inspection. Managers were clear on the process for dealing with poor performance. Managers and senior managers were able to give specific examples of how the process for dealing with poor performance had been used within the last year on Parkside Lodge.

Staff worked in a way which promoted equality and diversity in the service. On Parkside Lodge senior managers had responded to an increase in reported incidents of racism from patients towards staff. This was discussed during the learning disability services clinical governance meeting in December 2017. The issue was considered by the meeting as requiring escalation to more senior management and was included on the chair's report of the meeting to the care group clinical governance meeting. The associate director told us that the trust had responded successfully to this issue, particularly in the trust's adult social care services, and that the aim was to learn from this and introduce similar initiatives within the learning disability services.

Absence rates were lower than the trust's threshold target and trust wide average. The service had a high vacancy rate for both qualified staff and nursing assistants. This was managed through ongoing recruitment and the regular use of bank and agency staff.

The trust had a number of internal and external services to support staff wellbeing. The trust provided an occupational health service provided independent and confidential support for both the physical and mental health of staff employed by the trust. The service also had a specific fast-track referral pathway for responding to staff experiencing work-related stress. Staff could also access external wellbeing services including counselling and short-term programmes to improve physical and mental wellbeing.

The trust recognised staff successes through internal awards. Two members of staff from Parkside Lodge had recently won one of the trust's 'Star Awards' after being nominated by their clinical team leader.

Governance

The management team had a system to monitor the quality and performance of each ward. The ward's clinical team leaders received a weekly performance report for compliance with mandatory training, clinical supervision and appraisal rates. Performance data was collated into a care group-wide performance report which included inpatient services and the trust's supported living adult social care services. This report included average compliance rates for mandatory training, clinical supervision rates, appraisal rates and vacancy rates across the care group. Managers and senior managers were clear on the need for improvements in the service's approach to providing and recording clinical supervision. Managers had not identified, assessed and mitigated risks in relation to not all staff being able to access the electronic patient record system.

Senior managers had a clear structure and regular meetings to review quality and safety within the service. There were monthly learning disability services clinical governance meetings which covered areas such as service development, clinical audit, clinical guidelines, and quality improvement. There were separate monthly learning disability services clinical safety and risk meetings which covered areas such as risk registers, clinical incidents (including themes and trends analysis), and safeguarding. Whilst these meetings were regular and well attended, ward staff meeting minutes did not show evidence that information from these meetings were fed back at team level. However, the associate director and learning disability services manager told us that all meeting minutes were freely available on the trust's shared drive which could be accessed by all trust employed qualified staff.

Management of risk, issues and performance

The trust has provided a copy of their most recent risk register. Three of these risks relate directly to this core service – details can be found below.

Key:

High (15-20)	Moderate (8-15)	Low 3-6	Very Low (0-2)

ID	Description	Risk level (initial)	Risk score (current)	Risk level (target)	Last review date	Action
614	5 inpatient wards do not have back-up generators in the event of a power outage. These are: • Asket House • Asket Croft • Woodlands Square 2	16	16	2	02/11/2017	Equip all wards with capability to receive external generator supply. This will involve an evaluation of all identified inpatient wards to identify that

	• Woodlands square 3 • Parkside Lodge					they can be powered by an external generator. For any ward not currently capable - install appropriate electrical gear to make capable.
583	There are insufficient numbers of Learning Disability (LD) Occupational Therapy (OT) staff needed to deliver the service. As a result of: 1 staff member on maternity leave, 1 staff member about to go on maternity leave, two staff members reducing their working hours following return from maternity leave. All of these staff are senior clinical staff at band 6 level which has a significant impact on the availability of senior staff to clinically supervise junior band 5 staff members. There is a band 6 vacancy on Parkside Lodge and 2 band 5 vacancies.	12	12	4	27/06/2017	Recruitment event to take place August 2017 to recruit to PSL B6 vacancy, CLDT B6 Vacancy and B5 vacancy
625	The level of service user need (and potential risk) at Parkside Lodge has increased over time, resulting in the need to significantly increase staffing beyond budget and creating a number of challenges in terms of increased incidents and the safety of the physical environment.	16	12	6	06/11/2017	Plan to jointly review all staffing models across the LD service to ensure these are safe and best meet the needs of service users in a proactive way (linked to Transforming Care agenda)

There was a risk register at service level. Minutes of the learning disability services clinical safety and risk meeting showed that the risk register was reviewed and updated on a monthly basis. Staff could escalate risks to the risk register using a separate module of the trust's electronic incident reporting system. Staff concerns in relation to high vacancies matched the risks identified on the risk register.

There was a clear business continuity plan for Parkside Lodge in the event of an emergency which threatened service delivery. This was introduced in November 2017 and was due for review on an

annual basis. The trust did not provide business continuity plans for 2 Woodlands Square and 3 Woodlands Square.

Information management

The trust centrally collated information in relation to key areas of performance, quality and risk including mandatory training, clinical supervision, staff appraisals, use of restraint, use of seclusion, use of rapid tranquilisation and use of long term segregation. Data in relation to the use of restrictive interventions was automatically collated from the trust's electronic incident reporting system. The system automatically reported all incidents to the ward's clinical team leaders. Clinical team leaders were required to review each incident before it could be closed on the system. Incidents and risks with a high severity rating were automatically reported to senior managers including the associate director for the care group.

Staff had access to the right equipment and technology needed to do their role. We received mixed feedback from staff in relation to the trust's electronic patient record system. The trust told us that the electronic patient record system had a number of known weaknesses and so the trust had engaged in a procurement process for a new system. Staff were aware of the trust's intention to replace the current electronic patient record system. Staff working in the service had read-only access to the electronic patient record system used by the provider of community physical health services for Leeds.

During the inspection we raised concerns that not all staff were trained in, and could access, the current electronic patient record system or the shared computer drive which stored information in relation to patient care.

Staff made notifications to external bodies as required. The trust had a clear process for raising safeguarding alerts with the local authority. Incident reports were reviewed by managers within the service. This included reviewing the incident for potential safeguarding concerns.

Engagement

In 2016/17 the specialist and learning disability services care group adopted carer engagement and involvement as a quality improvement objective. The associate director for the care group told us that whilst this quality improvement objective led to improvements in other services within the care group, this was not replicated within the wards for people with a learning disability. Improving service user engagement and involvement was a quality improvement objective for 2017/18 for the care group, with an additional expectation for wards for people with a learning disability to improve engagement with carers.

Information about the service was available to the public on the trust's website. The information available on the website was limited to the contact details for the service and a brief description of the specification for the respite services and the assessment and treatment service.

The service participated in the 2017 trust staff survey. Staff meeting minutes showed that managers encouraged staff to participate in the staff survey.

Learning, continuous improvement and innovation

NHS trusts are able to participate in a number of accreditation schemes whereby the services they provide are reviewed and a decision is made whether or not to award the service with an

accreditation. A service will be accredited if they are able to demonstrate that they meet a certain standard of best practice in the given area. An accreditation usually carries an end date (or review date) whereby the service will need to be re-assessed in order to continue to be accredited. This core service has not been awarded an accreditation.

Staff on Parkside Lodge told us that they had been able to visit similar assessment and treatment wards which had been rated as outstanding by CQC in order to learn and implement good practice on the ward.