Good

Leeds and York Partnership NHS Foundation Trust

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

Quality Report

2150 Century Way,
Thorpe Park,
Leeds,
West Yorkshire,
LS15 8ZB
Tel:(0113) 305 5000
Website:http://www.leedspft.nhs.uk

Date of inspection visit: 11-15 July 2016
Date of publication: 18/11/2016

Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RGDBL	The Becklin Centre	Ward 1	LS9 7BE
RGDBL	The Becklin Centre	Ward 3	LS9 7BE
RGDBL	The Becklin Centre	Ward 4	LS9 7BE
RGDBL	The Becklin Centre	Ward 5	LS9 7BE
RGDAB	The Newsam Centre	Ward 1 PICU	LS14 6WB
RGDAB	The Newsam Centre	Ward 4	LS14 6WB

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

Summary of findings

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

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

Summary of findings

Ratings

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

Overall rating for the service	Good
Are services safe?	Requires improvement
Are services effective?	Good
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Good

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

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

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

Summary of findings

Contents

Summary of this inspection

Page

Overall summary 5

The five questions we ask about the service and what we found 6

Information about the service 9

Our inspection team 9

Why we carried out this inspection 9

How we carried out this inspection 9

What people who use the provider's services say 10

Good practice 10

Areas for improvement 10

Detailed findings from this inspection

Locations inspected 11

Mental Health Act responsibilities 11

Mental Capacity Act and Deprivation of Liberty Safeguards 11

Findings by our five questions 13

Action we have told the provider to take 25

Summary of findings

Overall summary

We rated acute and psychiatric intensive care services as good because:

- There were sufficient numbers of staff to keep patients safe. The trust had upgraded patient areas and had made a start in replacing fixtures and fittings that had been identified as a ligature risk. Where ligature risks remained, staff managed them through completing risk assessments and using appropriate patient observation levels.
- The wards we inspected were effective. Staff had a good understanding of the Mental Health Act and the trust had a central office that staff could contact if they had any queries. Ward staff had regular supervision, appraisals, training, staff meetings and weekly reflective practice meetings.
- Staff on the wards were caring and responded to patients' needs. Patients said that they felt involved in their care and treatment and they had the opportunity to comment on the service through weekly 'your views' meetings. Patients knew how to complain and they said they thought staff would take their complaints seriously. Staff offered various activities to patients and on some wards there was good access to activities over the weekend. Patients could attend group sessions and were able to spend time with their keyworker. Wards had communal lounges, activity rooms, rooms for interviews, and areas where they could spend time with their visitors, and patients told us the food was good and met their dietary and cultural requirements.
- Staff felt supported by their managers and morale was good on most wards.

However:

- Staff at the Becklin Centre did not manage some risks well. Staff at the Becklin Centre did not always monitor the temperature of the medicine fridge. Also, when the maximum temperature was exceeded, they did not act to ensure that medicines were stored safely. Patients smoked in the hospital grounds and on wards at the Becklin Centre despite the trust's commitment to a smoke-free environment. On ward three at the Becklin Centre, a patient was smoking cannabis in their bedroom. This put staff and patients at risk of passive smoking. Following the inspection the trust confirmed that this patient was seen by the psychologist and their care and treatment reviewed. Staff at the Becklin Centre told us that all patients were subject to 15 minute observations when admitted to wards. However, information provided by the trust after our inspection evidenced that this was not the case. We were concerned that this meant staff did not appear to have a good understanding of the trusts policies and procedures in relation to patient observation levels.
- Wards at the Newsam Centre were not visibly clean in some areas.
- Staff did not always follow the requirements of mental health legislation. They did not always store Mental Health Act documentation about medication correctly.
- The e-prescribing and medication administration electronic flag did not always accurately reflect the most up to date authorisation certificate. This meant staff could not be sure the correct medication had been authorised. Staff were not clear about their responsibilities under the Mental Capacity Act. All mental capacity assessments were carried out by consultants. The wards at the Becklin Centre did not display a poster to inform informal patients of their right to leave the ward.
- Managers were unable to describe what key performance indicators were used to ensure the service delivery was safe and high quality and the mandatory training compliance for staff did not meet the trust target of 90%. There was low compliance with 11 of the trusts identified mandatory training courses, including training in clinical risk, essential life support, intermediate life support and personal safety with breakaway techniques. These are essential training courses for ensuring that patients and staff are safe.

Summary of findings

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

Are services safe?

Requires improvement

We rated safe as requires improvement because:

- There was low compliance with 11 of the trusts identified mandatory training courses, including training in clinical risk, essential life support, intermediate life support and personal safety with breakaway techniques. These are essential training courses for ensuring that patients and staff are safe.
- Wards at the Newsam Centre were dirty in some areas.
- Medicine fridge temperatures were not always monitored and when maximum temperatures were exceeded action was not taken to ensure medicines were stored safely.
- Staff told us patients were all subject to 15 minute observations when first admitted. Information provided by the trust evidenced that this was not the case. We were concerned that this meant staff did not appear to have a good understanding of the trusts policies and procedures in relation to patient observation levels.Observation charts were not fully completed.

However:

- There were sufficient numbers of supported staff on the wards to keep patients safe.
- Patients felt safe on the ward. Staff followed safeguarding procedures.
- Environmental and ligature risk assessments had been carried out. The trust were in the process of refurbishing wards and reducing ligature risks.

Are services effective?

Good

We rated effective as good because:

- There was a good multidisciplinary team process. The trust were trialling a system called ‘purposeful inpatient admission' which was a daily review of all patients. This included plans for discharge.
- Wards delivered care in line with National Institute for Health and Social Care Excellence guidance. Staff regularly carried out physical health monitoring.
- Supervision was carried out and there were weekly reflective practice meetings for staff. Staff were offered support in a monthly compassionate group.
- Care records were up to date and personalised.

Summary of findings

- Staff had a good working relationships with other services within the trust for example pharmacy, crisis teams and intensive home treatment teams.

However:

- Mental Health Act medication documentation was not always stored correctly. The e-prescribing and medication administration electronic system did not always accurately reflect the most up to date authorisation certificate. We found several copies of the medication authorisation stored with prescription charts. This meant staff could not be sure the correct medication had been authorised.
- Staff were not clear about their responsibilities under the Mental Capacity Act. Capacity assessments were only carried out by consultants.

Are services caring?

Good

- There was access to advocacy services.
- Patients said they thought care was good and they felt involved in their care. Staff respected patients' privacy and dignity. Care we observed was kind and respectful; it was obvious that staff knew patients well.
- There were weekly 'your views meetings', which were minuted.

However:

- One family member said they were not involved with their relative's care.

Are services responsive to people's needs?

Good

We rated responsive as good because.

- There were varied activities on wards and some wards had occupational therapists working over the weekend. Patients were able to take part in various groups including 'Emotional Survival Groups'.
- There was a process in place to manage complaints. Staff understood how to manage complaints and information was available.
- Patients had a choice of food for dietary and religious needs. Patients had access to spiritual support.
- Staff had access to translation services and leaflets could be provided in other languages.

However:

Summary of findings

- Patients smoked in the hospital grounds and on wards at the Becklin Centre. On ward three at the Becklin Centre there was one patient smoking cannabis in their bedroom. This put staff and patients at risk of the effects of passive smoking.
- There were a high number of out of area placements.

Are services well-led?

Good

We rated well led as good because:

- Staff felt supported by their managers and morale was good on most wards.
- Wards had methods of monitoring the quality of care including the mental health safety thermometer, safe staffing and clinical dashboard.
- Some staff knew about the trust's values although they were not included in staff objectives.

However :

- Managers were unable to describe what their key performance indicators were.

Summary of findings

Information about the service

Leeds and York Partnership NHS Foundation Trust provides inpatient services for men and women aged 18 years and over with mental health conditions.

Services

- Psychiatric intensive care unit
- Adult mental health inpatient service

The acute admission wards are based on two hospital sites. The Newsam Centre and The Becklin Centre in Leeds. They provide inpatient mental health services for adults aged 18-65 years. The Becklin Centre has four acute admission wards, two male and two female wards. The Newsam Centre has one male acute ward and one psychiatric intensive care unit which is a mixed sex ward.

They are purpose built facilities. The wards provide inpatient care and treatment for patients admitted informally and patients detained under the Mental Health Act.

CQC last inspected the trust and this core service between 30 September and 2 October 2014. During that inspection acute and psychiatric intensive care services were in breach of two regulations, however, only one breach of regulations relates to the current acute and psychiatric intensive care unit services managed by the trust. The trust were required to ensure consent to care and treatment was obtained in line with legislation and guidance in accordance with the Mental Health Act and the Code of Practice.

Our inspection team

The team was led by:

Chair: Phil Confue, Chief Executive of Cornwall Partnership NHS Foundation Trust

Head of Hospital Inspection: Nicholas Smith, Head of Hospital Inspection (North West), Care Quality Commission

Team leaders: Kate Gorse-Brightmore, Inspection Manager, Care Quality Commission

Chris Watson, Inspection Manager, Care Quality Commission

The team that inspected this core service comprised an inspector, two nurses, an expert by experience and an occupational therapist.

Why we carried out this inspection

We inspected this core service as part of our ongoing comprehensive mental health inspection programme.

How we carried out this inspection

To fully understand the experience of people who use services, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

Before the inspection visit, we reviewed information that we held about these services and asked a range of other organisations for information

During the inspection visit, the inspection team:

Summary of findings

- visited the acute and psychiatric intensive care unit services at the Becklin Centre and the Newsam Centre
- spoke with 36 patients
- spoke with the managers of each ward
- spoke with 37 members of staff including, doctors, nurses and other allied mental health professionals
- reviewed 25 patient records
- reviewed patient medication charts
- attended 19 meetings including patient reviews
- attended and observed hand-over meetings
- observed mealtimes and some patient activity groups
- looked at policies, procedures and other documents which related to the running of the service.

What people who use the provider's services say

We spoke with 36 patients and feedback from patients across all the acute and psychiatric intensive care services was good. Patients told us staff were very good and they felt safe.

Patients told us they were involved in their treatment and were able to make decisions about their care. Patients said they thought the facilities were comfortable and they were happy with the amount of activities on offer.

Good practice

The new daily 'purposeful inpatient admission' model meant that staff regularly monitored the patient journey. The 'purposeful inpatient admission' reduced the time staff needed to spend in the multidisciplinary process and therefore freeing up time to spend with patients.

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that the mandatory training compliance is in line with the trust target.

Action the provider SHOULD take to improve

- The provider should ensure that e-prescribing information matches the authorised Mental Health Act medication documentation.
- The provider should ensure that all acute and psychiatric intensive care unit wards at the Newsam Centre are clean.
- The provider should continue to refurbish wards and where possible remove ligature risks.
- The provider should ensure that all staff have a good understanding of the trusts policies and procedures in relation to patient observation levels.
- The provider should ensure staff monitor medicine fridge temperatures daily. Where temperatures are outside recommended levels action should be taken to rectify them.
- The provider should ensure staff have a good understanding of the Mental Capacity Act and their responsibilities under the Act.
- The provider should ensure notices with regard to the rights of informal patients to leave the wards are displayed on all wards.
- The provider should ensure that the managers have a good understanding of the key performance indicators used to ensure that a safe and high quality service is delivered on these wards.

Leeds and York Partnership NHS Foundation Trust

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

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Ward 1	Becklin Centre
Ward 3	Becklin Centre
Ward 4	Becklin Centre
Ward 5	Becklin Centre
Ward 1 PICU	Newsam Centre
Ward 4	Newsam Centre

Mental Health Act responsibilities

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

- Eighty-seven percent of staff had completed mental health legislation awareness level 1 training and 80% of staff had completed Mental Health Act inpatient level 2 training. Staff demonstrated a good understanding of the Mental Health Act and code of practice.
- One patient's section 17 leave paper work was not applicable to the ward where the patient was detained. Staff immediately annulled the paperwork, as the consultant had not granted section 17 leave for the patient on that ward.
- Staff followed consent to treatment and capacity requirements and copies of consent to treatment forms were filed in the clinic room to review whilst administering medication.

Detailed findings

- Staff regularly advised patients of their section 132 rights and this was signed and documented in the patients' care records.
- Administrative support and legal advice on implementation of the Mental Health Act and code of practice was available from a central team within the trust. Staff said that they would seek this support when required.

Mental Capacity Act and Deprivation of Liberty Safeguards

Staff received Mental Capacity Act and Deprivation of Liberty Safeguards training, and 75% of acute and psychiatric intensive care unit staff were up to date with their training. However, not all staff had a good understanding of the Mental Capacity Act. Some staff told us only consultants could carry out mental capacity assessments.

Some patients' care records contained details of best interests meetings, which had been carried out where patients had been deemed to lack capacity to make a specific decision. Where it was required staff carried out mental capacity assessments with a view to considering administering medication covertly.

The trust had a Mental Capacity Act and Deprivation of Liberty policy, which staff could refer to. Staff said they could also speak with someone in the Mental Health Act office if they needed any assistance.

At the time of our inspection, there was one patient subject to a Deprivation of Liberty Safeguards authorisation. This was in place whilst the local authority were sourcing a suitable placement for the patient.

Requires improvement

Are services safe?

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

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

Our findings

Safe and clean environment

Most of the wards we visited had clear lines of sight, although the wards at the Becklin Centre had a small area at the end of corridors by an exit door that staff could not see from the central hub.

The Trust had started work on removing potential ligature points. At the Becklin Centre works had been started to upgrade patient bedrooms. We saw an example of a new bedroom which had upgraded wardrobes and beds and bathroom fittings were anti-ligature. However, until all the planned works had been completed there was still a significant amount of ligature risks. We saw the completed ligature risk assessment and where risks had been identified these were mitigated by patient observations and individual risk assessments.

Wards complied with same-sex accommodation guidance. Wards at the Becklin Centre were single sex as was ward four at the Newsam Centre. Ward one at the Newsam Centre which was the psychiatric intensive care unit was mixed sex. This ward was able to flex their accommodation dependent on the split of patients. There was a female only lounge and male patients did not need to walk past female bathrooms to access other areas of the ward.

Staff ensured clinic equipment was clean and well maintained. Stickers were in place showing when the equipment had last been cleaned and when it had last been checked. Clinic rooms contained an examination couch, an electrocardiogram machine, blood pressure monitor and resuscitation equipment. Staff checked emergency drugs and oxygen daily and these checks were recorded. However, we found on ward one at the Newsam Centre that medicine fridges were not always regularly checked. On all wards with the exception of ward five at the Becklin Centre there were several days where the fridge recordings showed temperatures above the recommended two to eight degrees. The only action taken was to on each occasion reset the fridge On the psychiatric intensive care unit at the Newsam Centre the daily handover sheet showed that the temperature was too high but again ward staff were not able to provide evidence about what had been done to address this.

There was only one seclusion room available to the acute and psychiatric intensive care units. This was located on the psychiatric intensive care unit at the Newsam Centre. The seclusion room was in use during out inspection so we were unable to adequately check the facility. However, based on what we did see the room allowed clear observations, two-way communication and had toilet facilities and a clock.

With the exception of the wards at the Newsam Centre, we found wards were clean and, due to the ongoing upgrade programme, they were reasonably well maintained. However, in areas where the work was yet to be completed, it was difficult to tell for example, if the walls were dirty or whether it was areas of damage. Wards at the Newsam Centre were not very clean. The flooring on the corridors on ward one were dirty even though the cleaning contractors had cleaned the floors the morning of our inspection. Some toilets required further cleaning and there were areas of staining that had been present for some time. Bathroom tiles were stained, as were some of the shower curtains. Furniture had dirty marks on it, particularly in the dining rooms. Staff at the Newsam Centre said they completed a form, which they sent to the cleaning contractor for any areas that they considered unclean. We spoke with the matron for the acute and psychiatric intensive care unit services about our concerns. The matron told us they discussed any issues relating to the cleanliness of the service at site meetings and they would discuss this again. The matron also described the escalation process to the trustwide clinical environments group which was part of the governance to ensure matters were addressed and monitored effectively.

We observed staff adhering to infection control principles, there were hand gel dispensers across all the wards and staff were seen to be regularly using the gel. There was personal protective equipment available to staff. On two of the wards we visited there were patients with Methicillin-resistant Staphylococcus Aureus and bathrooms had been designated solely for their use. Staff explained that single use personal protective equipment would be used when delivering any kind of personal care or physical interventions.

Requires improvement

Are services safe?

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

Patient bedrooms had working nurse call systems and staff carried personal alarms.

Safe staffing

Ward managers from each ward advised us of the current whole time staffing establishment levels which were as follows:

Newsam Centre Ward One

- Qualified Nurses 16
- Health Care Assistants17
- Qualified Nurse vacancies1 (post filled and to commence employment in September)

Newsam Centre Ward Four

- Qualified Nurses 15
- Health Care Assistants 11.9
- Qualified Nurse vacancies 3

Becklin Centre Ward One

- Qualified Nurses 15
- Health Care Assistants 10
- Qualified Nurse vacancies 4 (3 posts filled awaiting registration details)

Becklin Centre Ward Three

- Qualified Nurses 15
- Health Care Assistants 11.9
- Qualified Nurse vacancies 1 (post recruited)

Becklin Centre Ward four

- Qualified Nurses 15
- Health Care Assistants 11.9
- Qualified Nurse vacancies 4

Becklin Centre ward five

- Qualified Nurses 15
- Health Care Assistants 11.9
- Qualified Nurse vacancies 2

Ward managers had authority to increase staff numbers dependent on the acuity of patients on wards.

The trust had the E-Rostering system which enabled them to monitor if staffing numbers and the skill mix was safe. We were provided with reports from April 2016 to June 2016, which showed how the staffing mix was broken down. On average wards were made up of over 72% permanent staff, on average 21% were bank staff and 7% were agency staff. Ward managers told us they would where possible make a block booking for agency staff to ensure patients were familiar with the staff used.

Information from the trust showed that there were occasions over the period April 2016 to June 2016 where establishment levels were not met. However, in our conversations with staff and patients there were no concerns raised about staffing levels.

Staff rarely cancelled escorted leave; staff said usually the only reason for cancelling escorted leave was if patients were too unwell to go out. Patients were able to have regular one to ones with their named nurse. Staff said the only time ward activities would be cancelled would be if there were patients who unexpectedly required one to one assistance.

There was adequate medical cover throughout the week with a rota of doctors on call out of hours. However, staff told us there could be a problem where staff thought it was appropriate to reduce a patients observation levels over the weekend. Staff said on call doctors who were unfamiliar with patients would not always authorise the reduction of observation levels. This meant patients would remain on the higher level of observation until Monday.

At the time of our inspection 82% of staff were up to date with their mandatory training. However, there was low compliance with 11 of the trust's identified mandatory training courses, these were:

Clinical Risk 69%

Duty of Candour 63%

Essential Life Support 69%

Fire - Level 2 68%

Fire - Level 3 70%

Immediate Life Support 72%

Mental Capacity Act and DoLs - Level 2 74%

Mental Health Act - Inpatient - Level 2 71%

Requires improvement

Are services safe?

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

Personal Safety with Breakaway Skills 72%

Safeguarding children Level 2 59%

Safeguarding children Level 3 61%

We were particularly concerned about the compliance with clinical risk, essential life support, intermediate life support and personal safety with breakaway skills which is essential for ensuring patients and staff are safe.

Assessing and managing risk to patients and staff

Staff carried out a risk assessment of every patient when admitted to the ward. The trust used the Functional Analysis of Care Environments risk assessment tool, which is a functional analysis of the care environment. Staff recorded information about patients' historical risk and their current risk. Each risk was scored in relation to the severity of the risk. Records we reviewed showed that staff regularly updated patients risk assessments. Risk assessments were updated when an incident occurred and when the risk had reduced.

We were concerned that staff did not appear to have a good understanding of the trusts policies and procedures in relation to patient observation levels. Staff at all levels at the Becklin Centre told us that all patients were subjected to 15 minute observations when first admitted to the ward regardless of the level of risk identified. This could have constituted as a blanket restriction. However, Information provided by the trust post our inspection evidenced that this was not the case.

The Mental Health Act code of practice states that 'blanket restrictions should be avoided unless they can be justified as necessary and proportionate responses to risks identified for particular individuals'.

Staff told us informal patients were able to leave wards when staff had assessed them as safe to do so. Ward managers told us that if they thought informal patients were at risk should they leave the ward they would invoke 5(4) of the Mental Health Act, which is a nurse's holding power.

Staff used restraint techniques across all the wards we inspected. On wards at the Becklin Centre patients would sometimes be escorted to the de-escalation room in restraint to keep them safe. Staff told us that patients not in restraint in the de-escalation room would be free to leave when they wished to do so. However, once staff suspended restraint, if the patient attempted to leave and was still agitated they would then commence a further period of restraint until it was safe for patients to leave the de-escalation room. Staff were very clear that rapid tranquilisation was always administered in accordance with National Institute for Health and Social Care Excellence guidance. Once rapid tranquilisation was administered, a period of patient observations would commence and an examination by a doctor would be carried out. Records we saw confirmed this.

Acute and psychiatric intensive care units had access to one seclusion room and this was on the psychiatric intensive care unit at the Newsam Centre. We reviewed the records of a patient who was in seclusion at the time of our inspection. We found that the seclusion was appropriate and records were detailed. We attended the review of the patient's seclusion; the patient was involved along with ward staff and the consultant.

There were 308 uses of restraint involving 129 different patients between 1 January 2016 and 30 June 2016, 125 of these involved the use of prone restraint. Forty-three of the prone restraints resulted in rapid tranquilisation. There were no recorded uses of long-term segregation.

In the same period, there were 50 episodes of seclusion; one of these did not take place on Ward one, Newsam Centre psychiatric intensive care unit.

The highest use of restraint also occurred on Ward one, Newsam Centre psychiatric intensive care unit with 90 instances. Staff used prone restraint 33 times and seven resulted in rapid tranquilisation.

Staff had a good understanding of the trust's safeguarding adults and children policies and procedures. We reviewed safeguarding alerts and found staff had followed procedures. Staff had identified for example where a patient may be at risk of physical or financial abuse and had completed a safeguarding alert and added it to the trusts electronic reporting system. Wards one and four at the Newsam Centre had made six safeguarding alerts between April 2015 and July 2016 and wards one, three, four and five at the Becklin Centre had made 29 safeguarding alerts, with ward 1 at the Becklin Centre accounting for 20 of the alerts. Each ward had a policy in place for children to visit the ward; this was either in a visitor's room on the ward or a designated room off the ward.

Requires improvement

Are services safe?

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

Each ward had an appropriate controlled drugs cabinet available, which was compliant with legal requirements. Two members of staff conducted a weekly controlled drugs check. MedChart, which was the trusts e-prescribing system, had patient identifiable data, allergy status and the date of admission for all patients. The ward pharmacist screened all prescription charts.

Staff administered medicines in the clinic room on each ward. Staff encouraged patients to initiate their own medicines administration. Two nurses checked the administration of depot injections to prevent errors from occurring.

A pharmacist attended the ward numerous times each week and was contactable for advice. A pharmacy technician also attended the ward to stock up the medicines. Staff had access to an emergency drug cupboard and an on call pharmacist out of hours.

The trust had introduced a smoke free environment. Doctors had prescribed nicotine replacement therapy for patients wishing to give up smoking. Some members of nursing staff had been trained to enable them to prescribe nicotine replacement therapy. It was evident that patients were smoking within the hospital: both in the grounds and in their bedrooms. On ward three at the Becklin Centre, one patient was smoking cannabis in their bedroom. The ward manager said they would speak with the patient about it. Following the inspection the trust confirmed that this patient was seen by the psychologist and their care and treatment reviewed. We spoke with ward staff who told us they were having difficulty imposing the smoke free environment and preventing patients from smoking. Staff would ask patients to hand in their smoking paraphernalia but if patients refused, staff felt they were not able to enforce this. Staff said they removed cigarette lighters where patients were at risk of setting fires. Smoking on wards put patients and staff at risk of the effects from passive smoking.

Track record on safety

The trust reported five serious incidents requiring investigation in the period from 1 March 2015 to April 2016 where patients were under the care of acute and psychiatric intensive care services. Incidents included two limb fractures and two deaths. At the time of our inspection one of the patient deaths was still under investigation and awaiting an inquest.

There was evidence of learning from serious incidents. For example following an incident on an acute ward the trust had removed and replaced fixed curtain tracking and curtains had collapsible curtain hooks across all Leeds and York NHS Partnership Foundation Trust wards.

Reporting incidents and learning from when things go wrong

Staff were very clear about what type of incidents they should report and how they should report it. The trust's electronic recording system had several sections to complete; staff were able to report incidents of restraint, medication errors, breaches of the non-smoking policy and assaults on patients and staff.

Most staff told us they received feedback on the investigation of incidents where appropriate. Staff told us there would be a debrief after an incident which would involve staff and patients would have the opportunity to be involved. Staff discussed incidents in reflective forums and in one to one managerial and clinical supervision. The trust sent out emails to all staff with learning from incidents around the trust, although not all staff could recollect seeing these.

Staff said they thought they were open and transparent when things went wrong. Staff said they would speak with patients about the situation and would explain what had happened and how they would try to prevent it from happening again. Managers said they followed duty of candour and ensured they initially apologised verbally and then again in writing with a full explanation.

Are services effective?

Good

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

Our findings

Assessment of needs and planning of care

We reviewed 25 patient records. Patients' care files included details of the assessments carried out by staff when the patient was first admitted. Staff reviewed assessments regularly throughout the stay of the patient. Where appropriate this was being done on a daily basis. The trust had introduced a new daily assessment process called the 'purposeful inpatient admission'. This enabled nursing staff to update ward consultants with how the patient was settling into the ward.

Ward consultants carried out physical health checks when patients were first admitted to wards. These included blood pressure, temperature, an electrocardiogram and a urinalysis. The consultants also carried out a review of the patient's antipsychotic medication with ongoing high dose monitoring. Patients admitted with existing health conditions for example diabetes had their symptoms monitored. All the care records we reviewed had a physical health screening tool which staff had completed with patients. The tool included information about alcohol consumption, substance misuse, smoking and nutrition.

Care records we reviewed were regularly updated and were written in a person centred way. Care plans were individualised and included immediate mental health needs with discussions recorded of the patients long term goals. Staff recorded patient's strength and goals in reviews and care plans were devised in collaboration with patients.

Staff recorded patient information on the trust's electronic patient notes system and there were also paper notes which were scanned onto the electronic patient note. Staff reported some difficulties when bank and agency staff were on shift as they did not have access to the electronic patient note. This meant permanent staff would have to input the information. This had in some cases led to staff missing some entries.

Best practice in treatment and care

Medication was prescribed in line with the National Institute for Health and Care Excellence guidance. Patients were offered a choice of medication and regular medication reviews were carried out with the support of the trust pharmacist.

Psychological therapies were available on some of the acute and psychiatric intensive care units. Ward 4 and the psychiatric intensive care unit at the Newsam Centre shared a psychologist and they visited two days a week. However, ward managers at the Becklin Centre told us patients would be referred to psychology and often appointments would not be available until after the patient had been discharged.

Staff worked closely with Leeds Teaching Hospitals to ensure patients were able to attend physical healthcare appointments. Due to a number of falls, staff had referred one patient for physiotherapy and we saw they were temporarily using a Zimmer frame to assist with their mobility.

When staff admitted patients to the acute and psychiatric intensive care units, a nutritional screening tool was used to assess if a special diet was required. This was scored and where concerns were identified, patients would be referred to a dietician or to other health professionals for further investigation.

Staff used various rating scales to assess and record severity and outcomes. These included the health of the nation outcome scales, which covers a wide range of health and social domains, psychiatric symptoms, physical health, functioning, relationships and housing. Staff also used the shortened version of the Warwick-Edinburgh Mental Well-being scale, which was developed to enable the monitoring of mental wellbeing.

Skilled staff to deliver care

Patients throughout the acute and psychiatric intensive care units had a range professionals involved in their care. These included consultant psychiatrists and junior doctors, nurses, occupational therapists, and regular input from pharmacy. Other professionals were engaged as required, for example social workers and housing officers.

Managers and staff we spoke with told us they had regular supervision. This included managerial and clinical supervision. Staff received an annual appraisal. The appraisal rates as of 30 June 2016 were:

- Newsam Ward One 80%
- Newsam Ward Four 100%
- Becklin Ward One 76%
- Becklin Ward Three 100%
- Becklin Ward Four 93%

Are services effective?

Good

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

- Becklin Ward Five 100%

Staff had the opportunity to have clinical supervision, the following are the percentage figures for each of the acute and psychiatric intensive care units for staff who have had clinical supervision in the period June 2015 to May 2016:

- Becklin Ward One 90%
- Becklin Ward Three 88%
- Becklin Ward Four 81%
- Becklin Ward Five 73%
- Newsam Ward One 60%
- Newsam Ward Four 73%

Each ward held team meetings and some wards had reflective practice meetings. This enabled staff to talk about their work experiences. The manager of ward four at the Newsam Centre told us they were involved in a project to introduce a 'compassionate care group' for staff on wards one, four and five at the Newsam Centre.

There was a trust policy in place to manage poor staff performance and disciplinary issues. Team managers were able to access support from the trust's human resources team when required.

Multi-disciplinary and inter-agency team work

The multidisciplinary team format had recently changed across the acute and psychiatric intensive care units. A new daily 'purposeful inpatient admission' model had been introduced. The model prompted daily reviews and planning during a patient's admission with the objective of reducing their length of stay. Each ward had a board which listed each patient down one side and then across the top various actions required for completion to support the patient in moving through treatment, for example the completion of physical health monitoring, referrals to the independent mental health advocate, housing options and occupational health, and treatment and discharge plans. There was a colour coding system for the actions that meant that at a glance staff could see where patients were in their journey. Staff reported that this was working well as it meant patients had involvement from their staff team every day.

Additional multidisciplinary team meetings would take place where there was a specific need, for example meetings with housing workers.

Staff held handover meetings at the start of every shift. Staff discussed any significant incidents and gave a brief overview of each patient. Staff discussed planned activities for the day and which patients were going out on either escorted or unescorted section 17 leave.

Staff reported good working relationships with other teams. Pharmacists visited wards every weekday. Patients were able to discuss any queries or concerns they had about their medication with the pharmacist. Crisis teams were often involved inpatient admissions to the acute and psychiatric intensive care units. The intensive home treatment teams were involved in some patient discharges.

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

Staff had a good understanding of the Mental Health Act and how it affected their work. The trust provided us with figures for Mental Health Act training which were as follows:

- Mental health legislation awareness level 1 87%
- Mental Health Act inpatient level 2 80%

None of the wards we visited displayed signs advising informal patients they could leave the ward when they wished to do so.

Acute and psychiatric intensive care units were piloting a new electronic medication prescribing system. Patient's electronic prescription charts showed which certificate of authorisation related to the medication prescribed. (A certificate of authorisation is required after the patient has received medication for the first three months of their detention and continues to require this. A T2 authorisation is used when a patient agrees to take medication and is able to consent. A T3 is issued by a second opinion appointed doctor when the patient refuses medication or is not capable of agreeing due to a lack of capacity in this area. This was to remind the nurse to check the certificate authorising treatment. Certificates were located next to the electronic system so staff could check them each time staff administered the medication. However, we found the electronic system did not always have the most up to date authorisation certificate flagged. On ward three at the Becklin Centre we saw eight patients had more than one authorisation certificate.Three patients out of those eight had three authorisation certificates. The others had two. There was a mixture of authorisations, for example, some patients had a T3 plus a section 62 that was in use before

Are services effective?

Good

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

the T3 was issued. We observed a member of staff using the system and found the authorisation certificate did not authorise the medication the member of staff was about to administer. However, the correct authorisation was located. Staff had not updated the electronic system when the certificate was replaced.

Patients told us staff explained their rights under the Mental Health Act to them on admission and on a regular basis thereafter. Patient records we reviewed confirmed this.

The trust had a Mental Health Act administrative office based at the Becklin Centre. Each ward had a named contact they could go to for advice. Staff at the Becklin Centre told us the administrative system worked well. However, staff at the Newsam Centre said it did not work so well. When a patient was admitted staff were required to scan all the Mental Health Act papers and email them to the Mental Health Act office at the Becklin Centre. They had to take a copy of the documentation for the ward and the originals were delivered to the Becklin Centre. Staff said there had been times when the documents had not arrived at the Becklin Centre which meant staff then had to try and locate the original documents. Staff said the system had worked much better when the medical records department at the Newsam Centre had done the scanning and copying.

Staff and patients told us there was good access to independent Mental Health Act advocates. Patients were able to refer themselves and we saw posters on wards with contact details. Staff would also refer patients should they prefer it.

Good practice in applying the Mental Capacity Act

Mental Capacity Act training was mandatory training for qualified staff. Staff had a variable understanding of the Mental Capacity Act and the principles, which applied to their roles. Most staff told us they thought it was the ward consultant who would carry out a decision related capacity assessment. All the staff we spoke with told us consultants would carry out a mental capacity assessment with regard to consent to treatment when first admitted to the ward. Some staff said they would support patients to make decisions, particularly where they thought the decisions they were making were unwise.

Most staff were aware that they could find the trust's Mental Capacity Act and Deprivation of Liberty Safeguards policies on the trust's intranet. Staff said there was a department within the trust where they could get advice on the Mental Capacity Act and Deprivation of Liberty Safeguards. Support was also available on an on call basis, out of normal working hours.

Some patient records contained mental capacity assessments. We saw staff had carried out mental capacity assessments where there were concerns of financial abuse.

One ward we visited had a patient who was subject to a Deprivation of Liberty Safeguards authorisation. This was a result of the person being no longer detainable under the Mental Health Act. The patient was awaiting a more suitable placement in the community.

Good

Are services caring?

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

Our findings

Kindness, dignity, respect and support

We spent time observing staff interactions with patients and found they were always respectful and appropriate to the needs of the individual patients. It was clear that staff knew the best way to communicate with patients. One patient became distressed and staff were sensitive with the patient and assisted them to their room where they could discuss their concerns without compromising the patients privacy and dignity.

Patients told us staff treated them well. Patients said that staff always knocked on their bedroom doors and waited to be invited in. We observed this during the inspection.

The involvement of people in the care that they receive

On admission to wards, staff gave patients a tour of the ward and provided them with a welcome and admission pack, which contained information about the service. Staff introduced patients to other patients and offered them food and drink.

Most patients told us they were involved in their care planning. The new 'purposeful inpatient admission' meant that patients were actively involved in their ongoing care. Patients told us consultants explained what type of treatment was on offer, what would happen and why changes to the treatment plan may be made. Patients received copies of their care plans, although one patient told us they had been on the ward for four weeks and had only just received a copy of their care plan. Staff asked patients if they agreed with their care plan. Care records showed where staff had offered patients a copy of their care plan and where patients had accepted copies.

An independent mental health advocate visited the service regularly and attended the patient's community meeting. The advocacy service also provided individual support to patients at multi-disciplinary and care programme approach meetings.

Involvement from family members and carers was evident in patient records. We saw in one patient's care record that their family member's view had been taken into account when care planning. However, one family member told us staff did not take into account their concerns about their relative's care.

Patients were able to give feedback on the service and make suggestions during weekly 'your views' meetings which were held on each ward. We reviewed minutes of the 'your views' meetings and found various items were discussed. These included patients asking for different types of groups, the provision of bananas and coffee mate, and a movie night. However, we were unable to see what the outcome of patients' requests were. The minutes we saw did not include action taken.

Staff said that patients used to be involved in assisting with the recruitment of new staff, however, due to the large recruitment drive that involved recruitment days this was not currently possible.

Are services responsive to people's needs?

Good

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

Our findings

Access and discharge

Figures provided to us by the trust for the six months prior to our inspection showed there had been 96 out of area placements for patients requiring a bed in either an acute or psychiatric intensive care unit in the Leeds area. This was 76% of the out of area placements for the trust. Twenty patients went to North Yorkshire, 19 to County Durham and 15 to Cheshire, whilst other patients had to go to areas as far away as London, East Sussex, Avon and Hampshire. Out of the 96 out of area placements, 15 were patients requiring a psychiatric intensive care unit bed. The bed management team monitored each of the placements and ensured they returned to a bed in the Leeds area as soon as a bed became available. We were not provided with information to show what on average the wait for a local bed was.

Occupancy levels across the six acute and psychiatric intensive care units was on average 96%. The highest bed occupancy was 100% % on ward four at the Becklin Centre. The lowest bed occupancy rate of 84% was ward one psychiatric intensive care unit at the Newsam Centre. The figures provided by the trust were from October 2015 to March 2016.

Patients and staff told us it would be very unusual for a bed not to be available when patients returned from section 17 leave. Patients were not moved between wards during an admission episode unless it was clinically assessed to be in the best interests of the patient. The main reason for patients moving wards was if they required a psychiatric intensive care bed. Staff said that where possible patients would be admitted during daytime hours and would always be discharged during the day. We looked at the delayed discharge rates for acute and psychiatric intensive care units and found there had been two during the period from 01 October 2015 to 31 March 2016. These delays were due to there not being a suitable place to discharge the patients to.

The facilities promote recovery, comfort, dignity and confidentiality

Each ward had various rooms to support treatment and promote recovery. The Becklin Centre wards had small lounges with limited seating; however, each ward had more than one area where patients could relax. We found on most of the Becklin Centre wards that patients congregated around the nurses' station, which was as you entered the ward. There were clinic rooms with examination couches and other necessary equipment to monitor patients' physical health. Each ward had a fully equipped activities room, patient kitchen, therapy and interview rooms for consultants and visiting professionals. Visiting facilities were available on each ward.

All of the acute and psychiatric intensive care unit wards had access to outside space. However, patients on wards on the first and second floors of the Becklin Centre needed staff to escort them as there was no direct access from the wards.

Most patients told us they were happy with the food although some said the portions were small but that they would always be given more if they asked for it. There were various options on the menu including, vegetarian, kosher, halal and Caribbean food. Patients had access to hot and cold drinks either from the patient kitchen or from jugs in the lounge areas, with fruit and snacks available throughout the day and night.

Patient bedrooms were bland and some of the beds had damage to the fabric covering the base of the bed. However, the bedrooms which had been upgraded with new wardrobes and beds were much more pleasant. Patients were able to personalise their bedrooms although we saw little evidence of this.

Each ward had various activities on offer. These activities included a smoothie making group, movie group, Thai chi, pizza making, walking groups, an emotional survival group and a current affairs group. Some wards advertised activities over the weekend although on some wards these were limited and dependent on staff availability. On ward five at the Becklin Centre there was occupational therapy input over the weekend, this had been managed by staggering the occupational therapy team working hours.

Meeting the needs of all people who use the service

There was good access on all wards for patients requiring disabled access. Each ward had an accessible bathroom. There were lifts to the upper floors at both the Newsam Centre and the Becklin Centre. Information about the service was available in different languages. Staff had access to interpreter services. Staff said that amongst the staff group there were staff that spoke various languages.

Are services responsive to people's needs?

Good

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

There were multi-faith rooms at both hospitals. Patients could pray in their bedrooms, religious texts and idols were available for patients to use. Where leave was authorised staff supported patients to attend a place of worship, for example, a mosque, temple or church, should they wish.

Listening to and learning from concerns and complaints

Acute and psychiatric intensive care services received 36 complaints with six complaints either fully or partially upheld during the period 1 April 2015 to 29 March 2016. One complaint was referred to the ombudsman. This occurred at the Becklin Centre on Ward 4. The complaint was partially upheld and then referred to the ombudsman and was still being investigated. Ward 1 at the Becklin Centre had the highest number of complaints with eight. At the time of our inspection, there were four complaints, which were still under investigation, two of which were for Ward 5 at the Becklin Centre, one for Ward four at the Becklin Centre, and one for Ward 1 psychiatric intensive care unit at the Newsam Centre.

The service received 40 compliments during the last 12 months with Ward 4 at the Becklin centre receiving the highest number with 19.

Information on how to complain was in the ward information pack, which staff gave to patients when admitted to wards. Most patients knew how to complain, they said they would have no problem speaking with a member of staff or the ward manager. Staff told us they would try to resolve complaints but if they could not resolve the situation, they would advise the ward manager who they felt would take complaints seriously. Staff had the result of complaints fed back to them where appropriate. Ward managers discussed complaints in staff meetings or in some cases in individual supervision sessions.

Are services well-led?

Good

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

Our findings

Vision and values

Managers and staff had an understanding of the trust's values. Most staff were able to explain how their own values integrated with the trust's values. The trust's values were respect and dignity, commitment to quality of care, working together, improving lives, compassion, working together and everyone counts. However, these were not included in annual staff objectives.

Managers and staff knew the acute and psychiatric intensive care unit matron well and felt very supported by her. Staff said she often visited wards and was very approachable. Some staff said that more senior managers had visited wards.

Good governance

Ward managers were committed to ensuring mandatory training levels were in line with the trust's targets. Each ward manager had oversight of the supervision and appraisal rates and were making sure teams had time allocated to attend and carry out supervisions and appraisals.

The trust was in the process of recruiting staff across all wards. Staff retention on the acute and psychiatric intensive units was generally very good. Staff had worked on some wards for over 10 years.

There were systems and processes in place to monitor and assess the quality of care. The trust collected data from each ward. The trust dashboard recorded information which included:

- admissions
- average length of stay
- dishcharges
- available beds
- total occupied bed days
- detained occupied bed days
- patients new to services

We spoke with ward managers about key performance indicators and, whilst these were recorded on the trust's dashboard, not all ward managers were sure what the key performance indicators were for their wards. One manager said their key performance indicators were to do with the mental health safety thermometer and safe staffing; another ward manager said it was to do with the mental health cluster, care coordinator allocations, sickness levels and mandatory training levels. Another manager said quality indicators were completed and these were displayed in the ward reception and they were to do with training and health and safety compliance levels.

Ward managers had sufficient authority to carry out their role effectively. Administrative support was available on each ward. Ward managers were able to add items to the local risk register. The local risk register fed into the trust risk register.

Leadership, morale and staff engagement

Without exception, ward managers told us they were proud of their teams and they worked well as a team. Staff considered the wider multi-disciplinary professionals as part of the team and felt included with decisions made about patient care. Staff said they loved their job although it could be stressful at times. Staff all said they were able to make service improvement suggestions and they thought managers would consider their ideas.

Staff knew and understood the trust's whistleblowing policy. All the staff we spoke with said they would have no issue with raising concerns and were not in fear of victimisation and recrimination. We were not advised of any current bullying or harassment cases.

We spoke with staff and managers about their responsibilities under the duty of candour. Staff understood the duty of candour and explained that it meant apologising to patients and their families when things went wrong. Managers said apologies would be made verbally and in writing.

Ward managers told us they were involved in leadership programmes. Some managers had competed the Institute for Leaders and Managers level three programme. The Newsam Centre ward 4 manager told us they had recently arranged for the '360 leadership performance assessment team' to come onto the ward and give feedback on the team which they had found very useful (360 feedback is a system or process in which employees receive confidential, anonymous feedback from the people who work around them). Staff had the opportunity to develop. They were encouraged by managers to progress.

Are services well-led?

Good

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

Commitment to quality improvement and innovation

The trust had introduced the 'purposeful inpatient admission' model to replace the traditional multidisciplinary team meetings. This had freed up staff to spend more time with patients.

The trust told us that introduction of the e-prescribing and medication administration system had increased the overall safety for prescribing and had a number of benefits which included a doctor on call being able to prescribe remotely, the ability to flag interactions between medicines when prescribing, it lists medicines due on-screen, and reduces transcribing errors.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **How the regulation was not being met:** The trust did not ensure that staff were up to date with their mandatory training and in particular training to ensure patients and staff were safe. This is a breach of Regulation 18 (2)(a)