Good

Leeds and York Partnership NHS Foundation Trust

RGD

Forensic inpatient/secure wardsLong stay/forensic/ secure services

Quality Report

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Locations inspected

Name of CQC registered location	Location ID	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
Clifton House	RGDT5	Westerdale ward Riverfields ward Rose ward Bluebell ward	YO30 5RA
The Newsam Centre	RGDAB	Ward 2 - male Ward 2 - female Ward 3	LS14 6WB
Field View	RGDX7	Field View	YO30 5RQ

Summary of findings

Trust Headquarters	RGD01	Community Forensic Team (York) Community Forensic Team (Leeds)	YO30 5RA 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.

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 Long stay/forensic/ secure services	Good 
Are Long stay/forensic/secure services safe?	**Good** 
Are Long stay/forensic/secure services effective?	**Requires Improvement** 
Are Long stay/forensic/secure services caring?	**Good** 
Are Long stay/forensic/secure services responsive?	**Good** 
Are Long stay/forensic/secure 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 findings

Overall summary

The low secure services were safe; effective systems were in place to assess and manage risks to individuals. The newer women's wards at Clifton House provided a safe environment. There continued to be some environmental safety and ligature risks especially at the Newsam Centre but the risks were mitigated. There were appropriate actual and relational security arrangements within the low secure environment.

Whilst there were examples of good practice, we found that the low secure services were not always as effective as they could be. Many patients commented that activities, leave and access to fresh air was cancelled or curtailed due to the high levels of vacancies and sickness levels. We found good Mental Health Act adherence but there were issues with capacity to consent and seclusion recording; as well as one incident of mail being withheld inappropriately. Staff at Field View were not fully supported to provide effective care.

Overall the trust was providing a caring service for patients across the low secure wards. Throughout the inspection we saw examples of staff treating patients with kindness, dignity and compassion. Patients commented favourably on the quality of care and support they received. The service had outstanding examples of how it involved patients in their care and engaged in how the services were designed.

The service was responsive to patients' needs. Restrictions were usually kept to a minimum. Patients' individualised needs were met. Complaints were managed locally, but there were no systems in place to monitor these complaints held at local level.

We found that the service was well led with effective management of the service through regular audit and a commitment to provide high quality care and continuous improvement in line with the trust's stated values and strategy.

We found a breach of regulations relating to staffing levels. We have issued a compliance action. This was because nursing staffing levels at one location, Field View which provided four beds for patients to step-down to lesser restrictions, were not maintained at expected levels at all times and therefore detained patients were not safeguarded. We were given assurances after the inspection promising improvements.

Summary of findings

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

Are services safe?

Good

Overall, there were effective systems in place to assess and monitor risks to individuals.

The newer women's wards at Clifton House provided a safe environment. There continued to be some environmental safety and ligature risks especially at the Newsam Centre. Whilst these were being mitigated by higher observation levels and other measures, the trust should continue to address these. There was good awareness of the importance of maintaining effective actual and relational security arrangements. Incidents were reported through the trust's reporting system and managers reviewed incidents and identified potential learning and improvements.

Staffing levels were usually maintained at the level set by the trust. However, the expected nursing staffing levels at Field View were not maintained on the week of our inspection. We requested immediate assurance that there was sufficient skilled staff to deliver care at Field View. Following the inspection, we were given those assurances.

Are services effective?

Requires Improvement

Planned activities could not always take place and section 17 leave was sometimes cancelled when staffing levels were affected by short term absence on the low secure wards. This was because staffing levels were stretched and patients' needs were not always effectively met on the low secure services. Whilst expected staffing levels were usually maintained, this was through utilising bank or agency staff who could not carry out the full range of clinical tasks. There were no systems to fully monitor the impact on patients' leave or activities being cancelled or curtailled. Staff at Field View were not supported to provide effective care to patients in the service as they did not have ready access to the intranet for updates and operational policies; they could not readily access up-to-date care plans and had not received specialist training.

Patients did not always have access to full multi-disciplinary input with some patients still not registered with a GP, shortfalls in social work provision at Clifton House and a temporary lack of junior doctor cover at the Newsam Centre. Whilst MHA and MHA Code of Practice adherence was mostly good we did find some issues. We found mail being withheld from one patient contrary to the requirements of the Mental Health Act and human rights, records relating to seclusion did not always detail the safeguards required and patient's capacity to consent to treatment for mental disorder was not always recorded.

Summary of findings

Care plans were well documented and described how patients' needs were being met at each stage of their care. Staff were working within national guidance and good practice in providing care and treatment in secure environments. The service had been peer reviewed by Quality Network for Forensic Mental Health Services with many positive aspects of the service noted.

Are services caring?

Good

Overall the trust was providing a caring service for patients across the low secure wards. Throughout the inspection we saw examples of staff treating patients with kindness, dignity and compassion. The feedback received from patients and their visitors was generally positive about their experiences of the care and treatment provided by the staff in the low secure wards.

Staff were knowledgeable about patients' needs and showed commitment to provide patient led care. Patients had access to advocacy when they were in-patients, including specialist advocacy for patients detained under the Mental Health Act. Patients felt that they were involved in their care. We saw examples of outstanding involvement initiatives in some of the low secure services, especially within the low secure ward for women with personality disorder in York.

Are services responsive to people's needs?

Good

Patients were appropriately placed within low secure care and the service ensured that patients received care which was responsive to their needs. Patients were cared for in an environment that promoted their dignity and respected their privacy. The restrictions placed on patients were kept to a minimum within the context of providing care to patients who required low secure care. The exception to this was on Bluebell ward where there were currently blanket restrictions on the use of mobile phones rather than more individualised approaches to managing concerns.

Patients' individualised needs were met. The service was developing multi-faith rooms at each location to better meet the needs of patients from different cultural and religious backgrounds. The service had outstanding examples of how it involved patients in their care and how the services were designed. The wards were considering complaints locally but did not have systems to record the number, nature and outcome of complaints being dealt with at local resolution stage. We saw one significant complaint that had not been looked at properly or escalated appropriately.

Are services well-led?

Good

The service was well led with effective management of the service. There were regular audits of the service held at ward and service

Summary of findings

level and these were used to drive change. There was a commitment to provide high quality care in line with the trust's stated values and strategy. Staff morale was good despite the vacancy and sickness rate. Continuous improvement was evident through the development of the women's service at Clifton House, improvements in security to address issues from recent incidents and action to address issues identified in the peer review by the Quality Network for Forensic Mental Health Services.

Summary of findings

Background to 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, who require management under conditions of low security. Services are provided at Clifton House in York and The Newsam Centre in Leeds, Field View and Elmfield Terrace Residential Home in York and two forensic community teams; one in Leeds and one in York.

Clifton House in York includes four low secure wards:

Westerdale ward a 13-bed male low secure ward for admissions, assessment and rehabilitation

Riverfields ward a 14-bed male low secure ward for continuing care and rehabilitation

Rose ward a 10-bed female low secure ward for women with a diagnosis of personality disorder to receive assessment, treatment and rehabilitation

Bluebell ward a 12-bed female low secure ward for patients with functional mental disorders to receive assessment and treatment and rehabilitation

The Newsam Centre in Leeds includes three low secure wards:

Ward 2 - male a 11-bed male low secure ward for assessment and treatment

Ward 2 - female a 11-bed male low secure ward for assessment, treatment and recovery

Ward 3 a 14-bed male low secure ward for treatment and recovery

Field View in York provides a four bed step down forensic ward. It provides male patients with rehabilitation to be treated in less restrictive conditions and live more independently with a view to work towards discharge from low secure services.

Elmfield Terrace Residential Home in York provides a four bed step down forensic ward. It provides male patients with rehabilitation to be treated in less restrictive conditions and live more independently with a view to work towards discharge from low secure services. At the time of our inspection, there were no patients being treated at Elmfield Terrace Residential Home so we did not inspect this service.

The Forensic community teams

The forensic community teams in place in both Leeds and York provide assessment, support and treatment of mentally disordered offenders for Leeds and York residents who are discharged from the low secure wards.

Leeds and York Partnership NHS Foundation Trust has been inspected on a number of occasions since registration. In terms of forensic and secure in-patient services we have visited Newsam Centre but have not inspected any of the other locations which provide forensic and secure in-patient care. We have carried out regular Mental Health Act monitoring visits at all wards and locations with all wards visited within the last 12 months.

When we carried out the inspection visit at the Newsam Centre in January 2014, we looked at outcomes relating to consent and care and welfare. We found that the service was complying with the regulations relating to these outcomes. The report of the inspection was published in March 2014. We also looked at quality assurance and clinical governance arrangements across the trust and at trust headquarters in December 2013 and found improvements were required in these areas. The trust provided an action plan to show how it would improve its clinical governance processes.

Our inspection team

Our inspection team was led by:

Chair: Michael Hutt, Chief Operating Officer, Cumbria Partnership NHS Foundation Trust

Team Leader: Jenny Wilkes, Head of Inspection – Hospitals Directorate (Mental Health), Care Quality Commission

Summary of findings

The team included an inspection manager, a Mental Health Act reviewer, a pharmacist inspector and an analyst. We also had a variety of specialist advisors which included senior nurses, social workers, and senior managers with experience of forensic settings.

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 get to the heart of patients who use services' experience of care, we always ask the following five questions of every service and provider:

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

Before visiting, we reviewed a range of information we hold about the forensic inpatient secure wards and asked other organisations to share what they knew, including speaking with local Healthwatch, Independent Mental Health Advocacy Services and NHS specialist commissioners who purchase forensic and secure beds. We held a public listening event, as well as listening events at each main hospital location for current in-patients including detained patients. We reviewed comment cards left by patients.

We carried out an announced visit over three days between 30 September and 2 October 2014. During the visit we held focus groups with a range of staff who worked within the service, such as nurses, doctors, therapists. We talked with 35 patients who use services who shared their views and experiences of the service. We observed how patients were being cared for. We talked with three carers and/or family members of patients in the low secure services. We reviewed care or treatment records of 21 patients who use services. We reviewed Mental Health Act documentation. We observed 5 multi-disciplinary and clinical meetings. We spoke with 32 staff which included ward managers, qualified and non-qualified staff, occupational therapists and social workers. We spoke with senior managers and looked at the environment of the wards.

What people who use the provider's services say

We spoke with 35 patients over the three days of our inspection. Patients commented favourably on the quality of care and support they received, including both medical and nursing care. Patients were aware of their rights as detained patients. Patients on Rose Ward commented on the support they received during the admission process to support them during the transition. Many patients commented that activities, leave and access to fresh air was cancelled or curtailed due to the high levels of vacancies and sickness levels. Patients on Ward 2 Female ward commented positively on the range of activities available. Recent restrictions on mobile phone use were causing patients on Bluebell ward problems and patients felt this was unfair. We received one negative comment about staff attitude which we discussed with the manager of the ward this related to.

We received nine comment cards from patients within secure services. Five out of six comment cards received

Summary of findings

from Clifton House highlighted staffing issues; with four of these commenting particularly on the adverse impact that low staffing levels had on agreed section 17 leave. One comment card commented favourably on the womens' ward treating patients with dignity and respect even when seclusion was used. Two out of three comment cards received from the low secure wards at the Newsam Centre commented positively on staff attitude; one less favourable comment was received that patients weren't listened to.

Good practice

We found the following areas of good practice:

• The individualised tailored processes for admission for women with personality disorder onto Rose ward effectively supported patients safely during change and transition.

• The extent of meaningful patient involvement for women with personality disorder on Rose ward to participate in their individual care as partners and to be involved in the running of the ward.

• The range and scope of meaningful and extensive patient activities at the Newsam Centre on Ward 2 female ward which was patient-led and extended into the evenings and weekends.

Areas for improvement

Action the provider MUST or SHOULD take to improve

Action the provider MUST take to improve:

The trust must ensure that there is sufficient nursing cover and sufficiently trained and supported staff at Field View whilst this location continues to care and treat detained and restricted patients and be registered for regulated activity 'Assessment and Treatment under the Mental Health Act', including ensuring staff have access to up-to date trust information and policies.

The trust must ensure that comments and complaints are handled appropriately.

Action the provider SHOULD take to improve:

The trust should continue to address staff vacancy rates and sickness levels and improve the monitoring of its impact on patient care by measuring care and treatment which has been cancelled or curtailed (leave of absence, one to one nursing sessions, activities, access to fresh air).

The trust should address identified environmental issues including within the seclusion rooms, continue to address the identified ligature risks across low secure services and ensure that patients on Riverfields ward are afforded further dignity by improved screening into the bedrooms which overlook the staff and visitor car park.

The trust should ensure that patients have access to timely physical healthcare by ensuring patients are registered with a GP and, for patients at the Newsam Centre ensure that timely medical care is available.

The trust should ensure that clinicians and staff adhere to the MHA and MHA Code of Practice to ensure that:

- staff are aware patient mail can only be withheld in very limited circumstances;
- there is improved recording of consent and capacity to consent decisions for treatment for mental disorder;

Leeds and York Partnership NHS Foundation Trust

Forensic inpatient/secure wards

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Westerdale ward Riverfields ward Rose ward Bluebell ward	Clifton House
Ward 2 - male Ward 2 - female Ward 3	The Newsam Centre
Field View	Field View
Community Forensic Team (York) Community Forensic Team (Leeds)	Trust Headquarters

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.

We looked at the rights of patients detained under the Mental Health Act (MHA) 1983. Overall we found good evidence to demonstrate that the MHA was being complied with.

Overall patients were aware of what section they had been detained under, understood their rights to appeal and told us they had access to an independent mental health advocate (IMHA).They confirmed they had been told about their medication and the side effects. Patients told us about the unescorted and escorted leave they had from the ward and said they were involved in their care planning and setting goals to work towards. The secure services had good systems in place to

undertake MHA responsibilities properly. We found that risk assessments were reviewed or undertaken prior to a person, detained under the MHA, commencing leave.

Whilst MHA and MHA Code of Practice adherence was mostly good we did find some issues. We found mail being withheld from one patient contrary to the requirements of the Mental Health Act. We found that records relating to seclusion did not always detail the safeguards required. We found that medication for mental disorder was administered to patients within the rules of the Mental Health Act. However we found that, on occasions, patient's capacity to consent to treatment for mental disorder was not always recorded.

Mental Capacity Act and Deprivation of Liberty Safeguards

Overall we found that services were compliant with the requirements of the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS).

Staff took practicable steps to enable patients to make decisions about their care and treatment wherever possible. Staff understood the process to follow should they have to make a decision about or on behalf of a person lacking mental capacity to consent to proposed decisions, in accordance with the MCA.

All of the patients on the low secure wards were detained under the Mental Health Act with the exception of one person who was subject to DoLS on the low secure wards. This person had recently been made informal and was subject to a DoLS urgent authorisation whilst awaiting a determination for a standard authorisation and an aftercare package to be put in place prior to discharge.

Good

Are services safe?

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

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

Summary of findings

Overall, there were effective systems in place to assess and monitor risks to individuals.

The newer womens wards at Clifton House provided a safe environment. There continued to be some environmental safety and ligature risks especially at the Newsam Centre. Whilst these were being mitigated by higher observation levels and other measures, the trust should continue to address these. There was good awareness of the importance of maintaining effective actual and relational security arrangements. Incidents were reported through the trust's reporting system and managers reviewed incidents and identified potential learning and improvements.

Staffing levels were usually maintained at the level set by the trust. However, the expected nursing staffing levels at Field View were not maintained on the week of our inspection. We requested immediate assurance that there was sufficient skilled staff to deliver care at Field View. Following the inspection, we were given those assurances.

Our findings

Clifton House (Low secure wards: Westerdale ward, Riverfields ward, Rose ward and Bluebell ward)

Safe and clean ward environment

The wards provided a safe environment for the care of patients within a low secure environment. There had been significant attention to addressing ligature risks throughout the units such as anti-ligature taps and showers; curtain and blind rails were held with strong magnets which made them collapsible. The wards felt relaxed and comfortable. The wards were clean and well maintained. Patients commented favourably on the cleanliness of the wards. Patients told us that they felt safe and whilst some patients had caused management issues on the wards, patients felt that staff did what they could to keep patients safe.

Access and egress (exiting) from the wards and the unit was controlled by staff. Egress from the unit was through an air lock door which helped to ensure patients were kept safe. The wards had access to outside space which had the appropriate level of fencing for a low secure facility. One area of the courtyard had been taken out of use whilst additional work was carried out to further improve the integrity of the secure perimeter. This meant that continued efforts were made to ensure that patients who require low secure care were not able to go absent without leave from the wards. There had been no incidents of patients going absent without leave from the wards at Clifton House and absence without leave episodes whilst on agreed escorted or unescorted leave were minimal.

The clinic rooms in each ward were clean and tidy. Appropriate checks were maintained of necessary equipment such as resuscitation equipment and fridge temperatures.

The wards had a designated security nurse that carried out robust and written daily checks across the wards to ensure that the low secure wards operated effectively, and make sure that there were no breaches of the security arrangements. This ensured that the ward environment remained a safe place to care for patients requiring low secure care. This included ensuring items not permitted or permitted under supervision were accounted for. We found that some metal panels on door closures could, by determined effort, be pulled apart and highlighted this to the managers.

Staff were aware of their responsibilities to undertake searches and checks on patients balancing the need to promote patients' dignity and safety. Staff told us they felt safe on the wards and supported by colleagues to maintain appropriate relational and actual security arrangements. Staff understood key messages from 'See, Think, Act' which is the national guidance on maintaining appropriate actual and relational security within mental health secure settings.

We saw that the seclusion rooms met many of the requirements of the MHA Code of Practice in relation to providing a safe environment for the management of patients presenting as a risk to others, including providing spacious comfortable environments with ventilation,

heating and lighting managed remotely. Clocks were situated so that patients in seclusion could orientate themselves to the time. The seclusion room between Rose and Bluebell wards had a blind spot behind the toilet door when the door was opened. The room had CCTV facility but we were told that this was not operational as the policy for its use had not been ratified. The CCTV would not pick up the blind spot but it could be addressed by installing a parabolic (curved) mirror. The managers of the hospital agreed they would look into this. The seclusion room on Westerdale ward had a significant window ledge above head height which was not angled and could present as a risk to patients from self-harming. The trust should consider altering the window ledge in the seclusion room to ensure that it is flush with the wall or adapted to reduce the risk of patients harming themselves.

Safe staffing

The wards displayed the expected and actual staffing levels on each ward. The actual staffing levels matched or exceeded the expected staffing levels. Ward managers told us they were empowered to take professional decisions about the staffing needs of the patients in their care, for example if patients were in seclusion or required higher levels of observation.

Whilst the wards were holding higher levels of staff vacancies and sickness, these issues were generally managed through utilising overtime, bank and agency staff to manage the need of the wards. There were very limited occasions when staffing may have fallen slightly below expected levels due to unexpected sickness and when this occurred an incident record was completed to highlight this. Whilst staffing levels were kept safe – the higher use of bank and agency staff did cause difficulties at times because not all tasks could be delegated to these staff members.

Assessing and managing risk to patients and staff

Overall, the wards had effective systems to assess and monitor risks to individuals. We found that risk assessments were comprehensive and holistic. Risk assessments were carried out by staff during patients' initial assessment and reviewed or updated during care review meetings or if patients' needs changed. We looked at care records and saw there were appropriate risk management plans for patients. The service had a good system to ensure risks were reviewed or undertaken prior to a detained patient commencing leave from the ward. This included a number of factors that may flag that the patient could be at higher risk, for example, if the patient had recently been refused discharge from detention by a first tier tribunal.

Staff had a good awareness of safeguarding procedures and knew how to raise alerts where necessary when they knew or suspected abuse was occurring. There were information posters for patients informing them about raising safeguarding issues.

The wards had systems to deal with foreseeable emergencies including medical emergencies. We saw the emergency equipment for the low secure wards were accessible. Staff were trained in the prevention and management of violence and aggression. Records showed that emergency equipment was checked regularly to ensure it was fit for purpose. Staff were equipped with alarms and would use these to call for assistance from other team members and there were systems in place for responding to an emergency.

Reporting incidents and learning from when things go wrong

The wards had a system in place to capture safety performance. Staff explained to us the process they used to report incidents through the trust's reporting systems. Staff felt that incidents were reduced by the therapeutic relationship they had with patients such as knowing patients well, reducing triggers and identifying early warning signs. The unit had a security manager who provided continuous advice and checked on safety and security issues across the wards.

We saw that when incidents occurred there was a behaviour chain analysis which looked at what led up to the incident, focusing on vulnerability, the prompting event, behaviour, consequences and solution focused ways to help patients cope in different ways when faced with a similar problem or issue. We saw detailed chain analysis forms which showed that staff and service users worked in partnership to learn lessons from incidents. Staff and patients also had reflective sessions led by psychology to help them consider issues that had arisen, how staff reacted and how things could be done differently next time.

The Newsam Centre (Low secure wards Ward 2 - male , Ward 2 - female and Ward 3)

Good

Are services safe?

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

Safe and clean ward environment

The wards provided a safe environment for the care of patients within a low secure environment. There had been some attention to addressing ligature risks throughout the wards however there continued to be ordinary taps which were not anti-ligature in the toilet areas and bathrooms. These risks were mitigated by staffing levels and observation levels. We case tracked a small number of cases where patients were deemed as higher risk and were on higher level of observations. For example, one patient had been recently admitted from prison with high risk of self-harm and they were on continuous arm's length observations.

The wards felt relaxed and comfortable. The wards were clean and well maintained. Patients commented favourably on the cleanliness of the wards. Patients told us that they felt safe and whilst some patients had caused management issues on the wards, patients felt that staff did what they could to keep patients safe.

The wards had access to outside space with the appropriate level of fencing for a low secure facility. Some of the courtyards had significant low level bushes which could be used to secrete contraband items. One area of the courtyard on one ward had been taken out of use to extend the car parking facility. Patients commented that this occurred without consultation.

There had been one significant incident of a patient going absent without leave from a ward at the Newsam Centre. This incident had been investigated and changes made to try and prevent a reoccurrence, for example, improvements were made to the access and egress to the wards. Access and egress from the wards and the unit was controlled by staff. Egress from the unit was through an air lock door which helped to ensure patients were kept safe. Absence without leave episodes whilst on agreed escorted or unescorted leave were minimal.

The clinic rooms in each ward were clean and tidy. Appropriate checks were maintained of necessary equipment such as resuscitation equipment and fridge temperatures.

The wards had a designated security nurse that carried out written daily checks across the wards to ensure that the low secure wards operated effectively, to make sure that there were no breaches of the security arrangements. This ensured that the ward environment remained a safe place to care for patients requiring low secure care. This included ensuring items not permitted or permitted under supervision were accounted for. The forms used for these checks at York services were more comprehensive and the trust could consider using these across services for consistency.

Staff were aware of their responsibilities to undertake searches and checks on patients balancing the need to promote patients' dignity and safety. Staff told us they felt safe on the wards and supported by colleagues to maintain appropriate relational and actual security arrangements. Staff understood key messages from 'See, Think, Act' which is the national guidance on maintaining appropriate actual and relational security within mental health secure settings.

Safe staffing

The wards displayed the expected and actual staffing levels on each ward. The actual staffing levels matched or exceeded the expected staffing levels. Ward managers told us they were empowered to take professional decisions about the staffing needs of the patients in their care, for example if patients were in seclusion or required higher levels of observation.

Some of the wards were operating with higher levels of sickness levels and some staff vacancies. The impact of these issues was being managed by holding recruitment days and utilising additional bank staff and occasional agency staff. Whilst staffing levels were kept safe – the higher use of bank and agency staff did cause difficulties at times because not all tasks could be delegated to these staff members.

There was no junior doctor cover at the Newsam Centre as the organisation responsible for providing and supervising junior doctors – the Deanery – had withdrawn junior doctor cover following an incident. The wards were unclear when this position would be resolved despite the investigation being completed. On Ward 2 male ward, the consultant psychiatrist only worked part time. This meant that staff at the Newsam Centre were expected to call the general on-call doctor available across the wards at the Newsam Centre when medical support was required. Whilst this was reported as not causing significant issues and had been managed, the lack of medical cover on an ongoing basis may impact on patient care, especially when the seclusion room becomes operational.

Good

Are services safe?

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

Assessing and managing risk to patients and staff

We saw good arrangements for the management of medicines across the low secure wards at the Newsam Centre. There were appropriate arrangements in place for storing medicines appropriately and systems to ensure proper storage and appropriate stocks were kept, for example though controlled drugs arrangements and monitoring of fridge temperatures. On occasions patients may be prescribed medicines to help with extreme episodes of

agitation, anxiety and sometimes violence known as rapid tranquillisation. We saw

information about the use of rapid tranquillisation and the trust had an up to date policy

covering this type of treatment. Following rapid tranquilisation, nursing staff were required

to record regular observations of the patient's blood pressure, temperature, oxygen

saturation and respiratory rate. However, when we checked the care records for patients on two wards who had been given rapid tranquillisation, we found one example where it was not clear that these observations had been recorded.

Risk assessments were carried out by staff during patients' initial assessment and reviewed or updated during care review meetings or if patients' needs changed. We looked at care records and saw there were appropriate risk management plans for patients.

Reporting incidents and learning from when things go wrong

The wards had a system in place to capture safety performance. Staff explained to us the process they used to report incidents through the trust's reporting systems. Staff felt that incidents were reduced by the therapeutic relationship they had with patients such as knowing patients well, reducing triggers and identifying early warning signs.

We saw that there had been a significant incident on Ward 2 – male ward late last year where a patient had escaped from the ward and threatened staff. There had been a serious untoward incident investigation to look at what happened and what lessons could be learnt. We saw that recommendations had been drawn up and these had led to changes on the wards including improving the security of the unit and making forced egress from the ward much more difficult.

We also saw that lessons learnt were part of staff meetings – for example a recent lessons learnt newsletter on needle stick injuries had been highlighted to staff.

Field View

Safe and clean ward environment

Field View had a number of safety and ligature risks throughout the unit such as domestic taps, curtain and blind rails which were not collapsible and domestic restrictors on windows. These risks were mitigated by the admission assessment process to ensure that only those patients who could safely be managed with these risks accepted for admission. The unit felt relaxed and comfortable.

Safe staffing

On the week of our visit there was no qualified nursing staff on duty as the unit was holding two nursing vacancies and the other nurse was on annual leave. No bank or agency nursing cover was arranged. The unit's staffing establishment stated that there should be one Registered Mental Nurse (RMN) on duty at all times across the unit during the day with on call arrangements after 8.30 pm. We recognised that patients at Field View were stable and there were no reported management problems. However, patients who were detained under the Mental Health Act and subject to further restrictions by the Ministry of Justice were under the care of unqualified staff without the supervision of a qualified staff member for significant periods during the week of our inspection.

The recorded incidents did not indicate that there was an increase in incidents or trends during the times when staff were working without nursing cover. Any unit registered to assess and treat patients detained under the Mental Health Act should have a qualified nursing member of staff available at all times. We did not receive adequate explanation why the unit had been left without qualified nursing staff during the daytime for the week of our inspection. There were sufficient numbers of unqualified nursing staff on duty to meet patients' needs for non-nursing care and supervision.

Assessing and managing risk to patients and staff

Good

Are services safe?

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

The patients in Field View had been known to services for some time and their needs had not changed significantly over time. Staff knew patients well and assessed and managed risk on an ongoing basis. Patients had up-to-date risk management plans for patients, which had been developed by nursing staff and were held electronically. Care staff were working to an older version of care plans which were available in paper records. However; the unqualified staff providing care on a day to day basis did not have ready access to the most recent risk management plan in place. The unqualified staff had to be shown how to access the electronic care plan and risk assessments. This was addressed on the day of the inspection by printing the current care plan into the paper records. Staff accepted the need to have the risk management plans more accessible for staff to access and to refer to for each patient.

We saw that equipment was properly checked, for example fire extinguishers and electronic devices were tested annually.

Reporting incidents and learning from when things go wrong

We reviewed recent incidents and saw that there had been no significant incidents on Field View. Staff at Field View did not have full opportunities to learn from incidents that occurred elsewhere in the trust because they were not on the same electronic systems and could not access the intranet so they did not automatically receive safety alerts.

Community forensic teams in Leeds and York

The community forensic teams provided multi-disciplinary post discharge support, care and treatment to patients discharged from the low secure wards. Each team were of differing size based on the demands on the service. The York community forensic team were managing an active caseload of 12 community patients; the Leeds community forensic team were managing a caseload of 69 active cases. The community forensic teams accept care co-ordination for people for up to two years post discharge from low secure care. Caseloads were regularly reviewed to ensure that staff could manage people safely in the community.

Retention of staff was good within the teams. Whilst there were vacancies in these teams managers told us that these were being recruited to. Staff within the forensic teams were experienced practitioners and were managing patients well in the community.

Members of the team liaised with other agencies according to the locally agreed Multi-Agency Public Protection Arrangements (MAPPA) to ensure risks posed by mentally disordered offenders were understood and managed.

Are services effective?

Requires Improvement

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

Summary of findings

Planned activities could not always take place and section 17 leave was sometimes cancelled when staffing levels were affected by short term absence on the low secure wards. This was because staffing levels were stretched and patients' needs were not always effectively met on the low secure services. Whilst expected staffing levels were usually maintained, this was through utilising bank or agency staff who could not carry out the full range of clinical tasks. There were no systems to fully monitor the impact on patients leave or activities being cancelled or curtailed. Staff at Field View were not supported to provide effective care to patients in the service as they did not have ready access to the intranet for updates and operational policies; they could not readily access up-to-date care plans and had not received specialist training.

Patients did not always have access to full multi-disciplinary input with some patients still not registered with a GP, shortfalls in social work provision at Clifton House and a temporary lack of junior doctor cover at the Newsam Centre. Whilst MHA and MHA Code of Practice adherence was mostly good we did find some issues. We found mail being withheld from one patient contrary to the requirements of the Mental Health Act and their human rights, records relating to seclusion did not always detail the safeguards required and patient's capacity to consent to treatment for mental disorder was not always recorded.

Care plans were well documented and described how patients' needs were being met at each stage of their care. Staff were working within national guidance and good practice in providing care and treatment in secure environments. The service had been peer reviewed by Quality Network for Forensic Mental Health Services with many positive aspects of the service noted.

Our findings

Clifton House (Low secure wards: Westerdale ward, Riverfields ward, Rose ward and Bluebell ward)

Assessment of needs and planning of care

We saw evidence of well documented care plans that described how individual needs were met on admission and at each stage of patient care. Care plans were recovery focused and helped patients receive support to address both the symptoms of mental disorder as well as addressing any offending or management issues which led them to be admitted to secure care. Feedback from patients across the wards confirmed they felt involved in decisions about their care. Patient needs and care were reviewed on a regular basis at multi-disciplinary meetings and at allocated Care Programme Approach (CPA) meetings.

There were systems to ensure patients' physical health needs were met appropriately across the wards. We saw within patients' care records that they had a physical health assessment carried out on admission to the ward. This consisted of various assessments including falls, nutrition, adverse drug reactions/allergies and risks. A Registered General Nurse (RGN) visited the wards regularly or when required in order to discuss any physical healthcare issues. Following this each person had a physical health care plan in place which had been developed. We saw records which demonstrated patients were receiving various health checks on a regular basis. However as some patients were not yet registered with a GP this led to some ongoing health checks not routinely occurring, for example one patient with asthma had not had a recent formal asthma review.

Most of the wards were operating with higher levels of sickness levels and some staff vacancies. The impact of these issues was being managed by holding recruitment days and utilising additional bank staff and occasional agency staff. Patients on Westerdale and Bluebell ward commented about the lack of activities, curtailment or cancellation of agreed leave and reduced access to fresh air. Ward managers told us they managed patient needs – however they accepted that patients may be impacted on occasions, for example patients may only be able to access one period of escorted leave per day rather than two episodes. Whilst expected staffing levels were usually maintained, this was through utilising bank or agency staff who could not carry out the full range of clinical tasks. There was no developed system to monitor, record or co-ordinate information on the impact of ongoing staffing issues on patient care such as its' impact on leave, fresh air

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or activities. On occasions where the impact was deemed to be critical then an incident record would be completed. It was therefore unclear what impact these staffing issues were having on patient care.

Best practice in treatment and care

The wards used 'My Shared Pathway', which Centres on providing a recovery and outcomes-based approach to the secure care pathway. Yorkshire and Humber Specialised Commissioning Group were one of the pioneers in the 'My Shared Pathway' initiative with the services working in partnership to develop patient led recovery based care planning processes. My Shared Pathway is a recognised outcome measure used in secure care which utilises booklets of questions that clinicians and patients use to focus discussions in a number of important areas including awareness of the events leading to admission into secure care, health, relationships, safety, risks and recovery. We saw that patients were at varying stages of engagement with the 'My Shared Pathway' process. Care plans included relapse prevention and crisis planning.

Women patients with personality disorder had access to appropriate care and treatment to meet their needs. Patients received continuity of care through services arranged around patient rather than service needs, for example, staff worked long days which helped patients with personality disorder to receive continuity of care and prevent patients 'splitting' teams. Patients with personality disorder had access to dialectical behaviour therapy (DBT) work in line with national guidance. Staff held formulation meetings weekly with the psychologist to look at ways of working with individual women with other groups to promote evidence based care and treatment for patients with personality disorder such as a skills group, goal setting group and a mindfulness group. There were also plans to have a non-medical approved clinician from a psychology background for patients on Rose ward. This meant that patients on Rose ward would have access to an approved clinician providing overall co-ordination of care based on their principle therapeutic need for psychological (rather than pharmaceutical) interventions.

On the wards we visited we saw patients participating in on and off ward activities. Patients on Westerdale and Bluebell ward commented about the lack of activities on the ward; both wards had Occupational Therapy (OT) input. However; unlike the service in Leeds there was no occupational therapy assistant support attached to OT which meant that the activities were more limited. The activities on Rose ward were determined by patients on the ward in planning sessions and patients commented favourably on the range of activities.

Clifton House had a developing activities corridor which included a gym, a multi-faith room and a computer suite.

Where patients were receiving anti-psychotic medication above British National Formulary (BNF) limits either in a single or combined dose there were appropriate arrangements in place to ensure that the rationale for this was properly considered and the continuing treatment was subject to regular review and pharmacy input. This was in line with Royal College of Psychiatry guidance on the use of high dose anti-psychotics.

The low secure services at Clifton House had been subject to a Quality Network for Forensic Mental Health Services annual review in March 2014. The Quality Network provides peer review of services against criteria which have been developed from the Department of Health's best practice guidance on the specifications for adult medium-secure services and low secure services. This most recent review identified many areas of positive practice including areas of admission, physical healthcare and discharge arrangements with areas in need of focus identified as procedural and relational security, and governance. We saw improvements already made in these areas. For example we saw that a multi-faith room had been developed and relational security awareness had improved through speaking to staff and through 'See, Think, Act' posters and reminders being placed throughout the low secure services. 'See, Think, Act' is the national relational and procedural guidance for mental health secure services.

Skilled staff to deliver care

We spoke with a number of staff across low secure services including ward managers, deputy ward managers, registered nursing and non-registered nursing staff and other professionals including occupational therapists and psychologists. Staff we spoke with were positive and motivated to provide quality care.

Staff received appropriate training, supervision and support. Staff on the wards commented favourably on the support and leadership they received from the respective ward managers. Staff on the women's service commented positively on their induction and the designated time they had been given before the admission of any patients to

Are services effective?

Requires Improvement

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ensure that they had time to understand the ward philosophy and help develop the skills within the team to manage the patients in their care. Staff told us that they received supervision which consisted of both individual management supervision and group clinical supervision. Samples of records confirmed this.

Training for staff consisted of mandatory and more specialist training. The trust RAG rated the staff in relation to compliance with mandatory training. There were no red rated concerns with any aspect of mandatory training for specialist services overall. We saw that where staff were overdue training, systems were in place to provide prompts to ensure this occurred.

Multi-disciplinary and inter-agency team work

Patients received multi-disciplinary input including from managers, medical staff, registered nursing and non-registered nursing staff and other professionals including occupational therapists and psychologists. However patients had limited access to social work input whilst an in-patient. Patients registered as York residents had access to a social worker within the low secure services; those residing from other areas were reliant on contact and input from social workers from their home areas. This sometimes made it difficult for some patients to receive timely support in some areas such as in relation to family circumstances, housing, benefits, and aftercare support.

Some patients were not registered with a General Practitioner (GP) to access timely physical health checks and treatment, despite them being subject to longer admissions within hospital due to the secure care pathway they were on. We raised this recently on Mental Health Act monitoring visits to the Newsam Centre and saw some progress had been made but some patients were still not registered with the local GP although we saw there were plans progressing to ensure that everyone was registered. The trust should ensure that patients have access to timely physical healthcare by ensuring patients are registered with a GP.

Adherence to the MHA and the MHA Code of Practice

The wards had good systems in place to ensure that the responsibilities of the Mental Health Act (MHA) were being followed, including reminders to clinicians for consent to treatment provisions, patient rights and renewals. Mental Health Act documentation was in good order with evidence of appropriate detention documentation being in place, patients being informed of their rights and consent to treatment provisions being adhered to.

Many of the patients were subject to criminal proceedings so they were sent to hospital by the courts or transferred from prison. Some patients were also subject to restriction orders so were subject to further restrictions which meant that the Ministry of Justice (MoJ) was also involved in decisions about leave, transfer and discharge decisions. The Responsible Clinician completed annual statutory reports to the MoJ updating them on patient progress and, where patients had been given leave, this leave had been approved by the MoJ as required by the Mental Health Act.

Whilst the MHA and MHA Code of Practice was being followed in most areas, we saw some examples where there were no or limited recording relating to decisions regarding assessment of capacity to consent to treatment for patients receiving treatment for mental disorder. The Code of Practice states that the Responsible Clinician (RC) should make records of the decision to consent and evidence the proper consideration of the patients' capacity to consent. We have raised this on previous MHA monitoring visits. The trust responded by telling us how they will improve recording in this area.

There were seclusion rooms on the Clifton site – one for females between Rose and Bluebell ward and one for males at Westerdale ward. Records of seclusion showed that many of the safeguards and reviews required when seclusion was used were met. The reasons for seclusion were clearly recorded. However it wasn't always clear that the Code of Practice requirement that a doctor attended immediately following a period of seclusion was being met. The local form recorded whether the doctor had attended within an hour of seclusion starting which does not reflect the requirements of the Code. Many of the seclusion records either did not record the time the doctor was informed and attended or did not explain the reasons why the doctor was not able to attend immediately. This meant that it was unclear if patients placed in seclusion received a timely medical review. Bluebell and Rose wards also did not have a local register of seclusion episodes so it wasn't possible to quickly check how frequently seclusion was being used.

Good practice in applying the Mental Capacity Act (MCA)

Are services effective?

Requires Improvement

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Staff took practicable steps to enable patients to make decisions about their care and treatment wherever possible. Staff understood the process to follow should they have to make a decision about or on behalf of a person lacking mental capacity to consent to proposed decisions in accordance with the Mental Capacity Act. Staff had access to e-learning on their responsibilities in relation to the MCA.

All of the patients on the low secure wards were detained under the Mental Health Act (MHA) and treatment decisions for mental disorder were made under the legal framework of the MHA. Staff understood the limitations of the MHA, for example that capacity assessments were decision specific and the MHA could not be used for treatment decisions for physical health issues. We saw completed capacity assessments when important decisions needed to be made, for example, we saw assessments on two patient case records to consider whether patients were able to understand proposed criminal proceedings and police involvement.

The Newsam Centre (Low secure wards Ward 2 - male , Ward 2 - female and Ward 3)

Assessment of needs and planning of care

We saw evidence of well documented care plans that described how individual needs should be met on admission and at each stage of patient care. We saw that these care plans were recovery focused and helped patients receive support to address both the symptoms of mental disorder as well as addressing any offending or management issues which led them to be admitted to secure care. We received feedback from patients across the wards confirming they felt involved in decisions about their care. Patient needs and care were reviewed on a regular basis at multi-disciplinary meetings and at allocated Care Programme Approach (CPA) meetings.

There were systems to ensure patients' physical health needs were met appropriately across the wards. We saw within patients' care records that they had a physical health assessment carried out on admission to the ward. This consisted of various assessments including falls, nutrition, adverse drug reactions/allergies and risks. We saw records which demonstrated patients were receiving various health checks on a regular basis.

Some patients on Ward 2 and ward 3 male wards commented about the curtailment or cancellation of agreed leave and reduced access to fresh air. Ward managers told us they managed patient needs – however they accepted there was no developed system to monitor, record or co-ordinate information on the impact of ongoing staffing issues on patient care such as its' impact on leave, fresh air or activities. Whilst expected staffing levels were usually maintained, this was through utilising bank or agency staff who could not carry out the full range of clinical tasks. On occasions where the impact was deemed to be critical then an incident record would be completed. It was therefore unclear what impact these staffing issues were having on patient care.

Best practice in treatment and care

The wards used 'My Shared Pathway', which centres on providing a recovery and outcomes-based approach to the secure care pathway. We saw that patients were at varying stages of engagement with the 'My Shared Pathway' process. Care plans included relapse prevention and crisis planning.

On the wards we visited we saw patients participating in on and off ward activities. Patients commented favourably on the activities available for patients. The wards had both an occupational therapist and an occupational therapy assistant which helped to facilitate a full programme of meaningful activities on and off the ward. The patient activities at the Newsam Centre on Ward 2 female ward was extensive in range and scope and was available into the evenings and weekends.

Where patients were receiving anti-psychotic medication above BNF limits either in a single or combined dose there were appropriate arrangements in place to ensure that the rationale for this was properly considered and the continuing treatment was subject to regular review and pharmacy input. This was in line with Royal College of Psychiatry guidance on the use of high dose anti-psychotics.

The low secure services at the Newsam Centre had been subject to a Quality Network for Forensic Mental Health Services annual review in May 2014. The Quality Network provides peer review of services against criteria which have been developed from the Department of Health's best practice guidance on the specifications for adult medium-secure services and low secure services. The peer-review team commended several aspects of the service provided, in particular the unit scored highly on such areas as

Are services effective?

Requires Improvement

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discharge, workforce, recovery approaches and physical security arrangements; procedural security and governance arrangements were identified as areas in need of improvement. We saw improvements already made in these areas – for example we saw that there was work ongoing to develop a seclusion facility and awareness of relational security awareness had improved evidenced through speaking to staff and through 'See, Think, Act' posters and reminders being placed throughout the low secure services. 'See, Think, Act' is the national relational and procedural guidance for mental health secure services.

Skilled staff to deliver care

We spoke with a number of staff across low secure services including ward managers, deputy ward managers, registered nursing and non-registered nursing staff and other professionals including occupational therapists and psychologists. Staff we spoke with were positive and motivated to provide quality care.

Staff received appropriate training, supervision and support. Staff on the wards commented favourably on the support and leadership they received from the respective ward managers. Staff told us that they received supervision which consisted of both individual management supervision and group clinical supervision. Training for staff consisted of mandatory and more specialist training. The trust RAG rated the staff in relation to compliance with mandatory training. There were no red rated concerns with any aspect of mandatory training for specialist services overall. We saw that where staff were overdue training, systems were in place to provide prompts to ensure this occurred.

Multi-disciplinary and inter-agency team work

Patients received multi-disciplinary input including from managers, registered nursing and non-registered nursing staff and other professionals including social workers, occupational therapists and psychologists.

Due to the consultant psychiatrist establishment and current issues with junior doctors; staff at the Newsam Centre were required to call the general on-call doctor available across the wards at the Newsam Centre when medical support was required.

The wards liaised with other services both within the trust and other providers to assess patients on acute mental health wards and medium secure units to consider whether they required low secure care. Patients on discharge would be assessed for support by the community forensic team for ongoing support in the community.

Adherence to the MHA and the MHA Code of Practice

The wards had good systems in place to ensure that the responsibilities of the Mental Health Act were being followed, including reminders to clinicians for consent to treatment provisions, patient rights and renewals. Mental Health Act documentation was in good order with evidence of appropriate detention documentation being in place, patients being informed of their rights and consent to treatment provisions being adhered to.

However we found unopened mail in one patient's care record. The patient had written to the police on a number of occasions but the mail had been withheld. There were no records or systems to provide details of the decision to withhold mail, including why and when the mail had been stopped. Staff could not explain under what legal authority this patient's outgoing mail had been withheld. The contents of the letters were unknown. The Mental Health Act only permits mail to be withheld in very limited circumstances; it is only managers of high secure services that have wider powers to withhold outgoing mail. The patient had an advance statement for one particular element of their care and treatment; but senior ward staff accepted that this did not give them legal authority to withhold this mail. This meant that this patient's right to family and private life was interfered with without apparent justification or reasons given.

Whilst many of the consent to treatment provisions were being met, we saw a small number of medicine charts which did not have a copy of the current legal authority (for example T2 or T3) attached. This meant that it was not always clear that nurses were checking whether they had the appropriate legal authority to administer medication for mental disorder to detained patients as required by the MHA Code of Practice.

Many of the patients were subject to criminal proceedings so they were sent to hospital by the courts or transferred from prison. Some patients were also subject to restriction orders so were subject to further restrictions which meant that the Ministry of Justice (MoJ) was also involved in decisions about leave, transfer and discharge decisions.

Are services effective?

Requires Improvement

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 Responsible Clinician completed annual statutory reports to the MoJ updating them on patient progress and, where patients had been given leave, this leave had been approved by the MoJ as required by the Mental Health Act.

There were no seclusion rooms on the Newsam Centre site although this was being developed and was due to open later in the year. Patients that required seclusion had to be transferred to Clifton House. We did not find any concerns in relation to the use of 'de-facto' seclusion.

Good practice in applying the Mental Capacity Act (MCA)

All of the patients on the low secure wards were detained under the Mental Health Act (MHA) and treatment decisions for mental disorder were made under the legal framework of the MHA. Staff understood the limitations of the MHA, for example that capacity assessments were decision specific and the MHA could not be used for treatment decisions for physical health issues.

Staff understood the process to follow should they have to make a decision about or on behalf of a person lacking mental capacity to consent to proposed decisions in accordance with the Mental Capacity Act. Staff took practicable steps to enable patients to make decisions about their care and treatment wherever possible, for example, we saw assessments on one patient's care record to consider whether the patient was able to understand proposed decisions about their finances. Staff then supported this patient whilst they were well to produce an advance statement regarding future financial decisions. Staff had access to e-learning on their responsibilities in relation to the MCA.

We saw that staff had made an urgent and standard authorisation for Deprivation of Liberty Safeguards (DoLS) for one patient who was discharged recently from detention to enable staff a short period of time to formulate a proper aftercare package for this patient.

Field View

Assessment of needs and planning of care

We saw evidence of well documented care plans that described how individual needs were met within the open rehabilitation facility of Field View. Care plans were recovery focused and helped patients receive support to work towards discharge from secure care. Patient needs and care were reviewed on a regular basis at multi-disciplinary meetings and at allocated Care Programme Approach (CPA) meetings.

However the unqualified staff providing care on a day to day basis did not have ready access to the most up-to-date care plan, which had been developed by nursing staff as it was held electronically. The unqualified staff had to be shown how to access the electronic care plan and risk assessments. Care staff were working to an older version of care plans which were available in paper records. This was addressed on the day of the inspection by printing the current care plan into the paper records. The patients in Field View had been known to services for some time and their needs had not changed significantly over time but staff accepted the need to have the current care plan in place for each patient.

Best practice in treatment and care

At Field View patients were self-medicating. This meant they were following a programme which enabled them to be responsible for their own medication. Staff told us they felt this was very positive. Care records evidenced discussions taking place between staff and patients about medicines. Patients had a locked wall mounted cupboard for their medicines. The staff told us that although patients were self-medicating if they required over the counter remedies, such as paracetemol, they would require medical or nursing input – due to no nursing cover at night if this was out of hours this would require the patient attending Clifton House. This meant that if patients required PRN medication for common ailments these were not easily available.

Skilled staff to deliver care

On the week of our visit there was no nursing staff on duty as the unit was holding two nursing vacancies and the other nurse was on annual leave. No bank or agency nursing cover had been arranged. This meant that patients who were detained under the Mental Health Act and subject to further restrictions by the Ministry of Justice were under the supervision of unqualified staff only.

This situation was exacerbated further because the staff at Field View did not have access to the intranet to access guidance and policies. The written policies of Field View that were available on the unit were out of date as they had been drawn up by, and referred to, the previous provider.

Are services effective?

Requires Improvement

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The trust has subsequently sent an up dated operational policy to guide staff at Field View. The unqualified staff had received mandatory training but this provided limited or no training in mental health awareness and working within forensic settings or with restricted patients; although one nursing assistant was being supported to work to NVQ level 3 in care. The staff meetings were limited to day to day practical matters with no ongoing learning evident as part of these meetings. Staff on duty on the day of our inspection were unsure how to access key information on the electronic records. This all meant that staff were not kept up-to-date; staff did not always have the complete information they needed before providing care and treatment and systems to manage and share key information were uncoordinated.

We requested immediate assurance that there was sufficient skilled staff to deliver care at Field View. Following the inspection, we were given assurances that a Registered Nurse now covers Field View across the 24 hour period.

Multi-disciplinary and inter-agency team work

Patients at Field View were working towards discharge in the community and were accessing community activities and facilities. One patient was subject to delayed conditional discharge – we saw attempts by the staff at Field View to address this issue with the home social work team and local housing authorities.

Adherence to the MHA and the MHA Code of Practice

Two out of three of the patients were subject to criminal proceedings and were also subject to restriction orders so were subject to further restrictions which meant that the Ministry of Justice (MoJ) was also involved in decisions about leave, transfer and discharge decisions. The Responsible Clinician completed annual statutory reports to the MoJ updating them on patient progress. It was unclear if the MoJ was aware that patients had been left without regular nursing input and had authorised transfer to the facility with the current level of nursing input, including no nursing input at night.

Good practice in applying the MCA

All of the patients on the low secure wards were detained under the Mental Health Act (MHA) and treatment decisions for mental disorder were made under the legal framework of the MHA. As the patients were working towards discharge, patients had a high degree of autonomy and independence to determine other aspects of their daily lives.

Community forensic teams in Leeds and York

We spoke with a small number of staff across community services. Staff we spoke with were positive and motivated to provide quality care. We heard that there was good retention of staff and most of the staff were very experienced in providing community support and treatment to patients with forensic histories.

The teams provided multi-disciplinary care including consultant psychiatrists, psychologists, social workers, community psychiatrists, social work and occupational therapy input. The community forensic teams were endeavouring to build links with community mental health teams to offer support, education and advice on managing and handing the care of patients back to community teams when the risk could be managed. Staff commented positively on the team rapport and supervision arrangements.

People under the care of the community teams had been subject to detention under the Mental Health Act and many had been discharged on a community treatment order or were subject to conditional discharge. Staff showed a good awareness of the Mental Health Act. People under the care of the community forensic teams were discharged from low secure care; patients therefore had a high degree of autonomy and independence to determine their daily lives.

Good

Are services caring?

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

Summary of findings

Overall the trust was providing a caring service for patients across the low secure wards. Throughout the inspection we saw examples of staff treating patients with kindness, dignity and compassion. Feedback received from patients and their visitors was generally positive about their experiences of the care and treatment provided by the staff in the low secure wards.

Staff were knowledgeable about patients' needs and showed commitment to provide patient led care. Patients had access to advocacy when they were in-patients, including specialist advocacy for patients detained under the Mental Health Act. Patients felt that they were involved in their care. We saw examples of outstanding involvement initiatives in some of the low secure services, especially within the low secure ward for women with personality disorder in York.

Our findings

Clifton House (Low secure wards: Westerdale ward, Riverfields ward, Rose ward and Bluebell ward)

Kindness, dignity, respect and support

We observed positive interactions between staff and patients. Patients were treated with compassion and empathy. We observed staff speaking with patients and providing care and support in a kind, calm, friendly and patient manner. We talked with many detained patients across all the low secure wards. The feedback received from patients and their visitors were positive about their experiences of the care and treatment provided by the staff in the low secure wards. The patients we spoke with were complimentary about staff attitude and engagement. We received a small number of negative comments about staff attitude on one ward during our inspection which we discussed with the ward manager. Staff within the wards for women patients ensured that there was always at least one female member of staff on duty and only women staff undertake night time checks.

Staff we spoke with felt that patients received good care on the wards. They told us they felt patients were given hope with regard to moving on and recovering.

The trust had a range of meetings in the inpatient services to ensure patients had an opportunity to explore issues and make decisions about their care. We observed two multi-disciplinary meeting; patients within these meetings were treated with dignity and respect, patient views were responded to and good interaction between the team and patient was observed.

The environment of the newer wards for women patients at Clifton House afforded dignity and respect to patients through the provision of individual en-suite bedrooms. There was access to fresh air via enclosed courtyards.

The involvement of patients in the care they receive

The care plan documents across the trust were found in the electronic patient notes (EPN) system and from reviewing this it was sometimes difficult to see how the involvement of the individual was recorded. Patients told us that care was planned and reviewed with them however in some cases this was not evidenced in the EPN.

Community meetings were held regularly on the wards. We looked at the minutes from some of these meetings. Discussions Centred on activities, the ward environment, comments about the food and use of the communal courtyard. The meetings were attended by patients using the service and staff on the ward. We saw examples where patients had raised issues or requested specific things and staff had responded to these and made changes where possible.

We saw examples of outstanding involvement initiatives in some of the low secure wards at Clifton House. Rose Ward had very good systems for meaningful patient participation and involvement for women with personality disorder to participate in their individual care as partners and to be involved in the running of the ward. This included assessing patient on a continuum of 'doing for' 'doing with' to 'doing by self' to help patients move towards greater autonomy in areas such as self-medication and running CPA meetings. Patients on this ward felt that they were fully involved in decisions with 'no decisions made about them without them'. There was a system of patients providing buddy support to other patients on admission. Patients had determined their own rules for using the computers and internet to ensure that there were proper ground rules

Are services caring?

Good

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

about using information technology. This meant that patients had good awareness and ownership of the rules; as well as evidencing the participation principle within the Mental Health Act Code of Practice.

We spoke with three family members of patients at Clifton House who were complementary about the quality of care their relatives received and their own involvement.

Patients had regular access to advocacy when they were in-patients, including specialist advocacy for patients detained under the Mental Health Act known as Independent Mental Health Advocates (IMHAs). Staff informed patients about the availability of the IMHAs and enabled them to understand what assistance the IMHA could provide. Patients we spoke with were aware of the IMHA service and complementary of the support received from the IMHA. The IMHA we spoke with felt that staff were generally receptive and supportive of independent advocacy input.

The Newsam Centre (Low secure wards Ward 2 - male, Ward 2 - female and Ward 3)

Kindness, dignity, respect and support

We observed good interactions between staff and patients. Patients were treated with compassion and empathy. We observed staff speaking with patients and providing care and support in dignified and respectful ways.

The feedback received from patients were positive about their experiences of the care and treatment provided by the staff in the low secure wards. The patients we spoke with were complimentary about staff attitude and engagement. Patients told us that staff knock before entering their rooms. One patient on higher levels of observations commented on the lack of continuity in staffing their observations.

Staff we spoke with felt that patients received good care on the wards. They told us they felt patients were given hope with regard to moving on and recovering.

The trust had a range of meetings in the inpatient services to ensure patients had an opportunity to explore issues and make decisions about their care. We observed multi-disciplinary meetings; patients within these meetings were treated with dignity and respect, patient views were responded to and good interaction between the team and patient was observed.

The involvement of patients in the care they receive

The care plan documents across the trust were found in the electronic patient notes (EPN) system and from reviewing this is was sometimes difficult to see how the involvement of the individual was recorded. Patients told us that care was planned and reviewed with them however in some cases this was not evidenced in the EPN.

Community meetings were held regularly on the wards. We looked at the minutes from some of these meetings. Discussions Centred on issues important to patients such as leave, activities, the ward environment, arrangements for food and use of the communal courtyard. The meetings were attended by patients and staff on the ward. We saw examples where patients had raised issues or requested specific things and staff had responded to these and made changes where possible. For example we saw "You asked…We did" sections in community meeting minutes clearly showing how issues were addressed or looked into.

Patients had regular access to advocacy when they were in-patients, including specialist advocacy for patients detained under the Mental Health Act known as Independent Mental Health Advocates (IMHAs). Staff informed patients about the availability of the IMHAs and enabled them to understand what assistance the IMHA could provide. Patients we spoke with were aware of the IMHA service.

Field View

Kindness, dignity, respect and support

We did not speak formally to any patients when we inspected Field View. We made brief contact with two of the patients who did not wish to speak with us. They did not have any comments or complaints and made brief positive comments.

Staff who worked on Field View knew patients' needs well and promoted patients' independence and autonomy. We saw positive and warm interactions between patients and the staff on Field View. Staff were respectful of patients' wishes and private space. We saw evidence of patient views being taken into account in the daily records.

The involvement of patients in the care they receive

Field View is an open rehabilitation unit so the doors were not locked. Patients within Field View were very independent, for example, patients had a lot of unescorted

Good

Are services caring?

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

leave and were self-medicating. Staff who worked on Field View promoted patients' independence and autonomy. Patients were encouraged to be involved in their local communities. Patients had access to an Independent Mental Health Advocacy service via a referral if required.

Community forensic teams in Leeds and York

We did not speak formally to any community patients when we inspected the community forensic teams in Leeds and York.

The community forensic teams provided ongoing specialist support to people with a mental disorder who had been subject to criminal proceedings. Staff who worked in the community forensic teams knew peoples' needs well and showed a commitment to providing good quality respectful care.

Through speaking to staff and looking in care records we saw that staff were committed to providing a patient-centred service which engaged people in their own care and recovery.

Are services responsive to people's needs?

Good

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

Summary of findings

Patients were appropriately placed within low secure care and the service ensured that patients received care which was responsive to their needs. Patients were cared for in an environment that promoted their dignity and respected their privacy. The restrictions placed on patients were kept to a minimum within the context of providing care to patients who required low secure care. The exception to this was on Bluebell ward where there were currently blanket restrictions on the use of mobile phones rather than more individualised approaches to managing concerns.

Patients' individualised needs were met. The service was developing multi-faith rooms at each location to better meet the needs of patients from different cultural and religious backgrounds. The service had outstanding examples of how it involved patients in their care and how the services were designed. The wards were considering complaints locally but did not have systems to record the number, nature and outcome of complaints being dealt with at local resolution stage. We saw one significant complaint that had not been looked at properly or escalated appropriately.

Our findings

Clifton House (Low secure wards: Westerdale ward, Riverfields ward, Rose ward and Bluebell ward)

Access, discharge and bed management

Admissions into the low secure beds at Clifton House were agreed by the NHS England specialist commissioning team following assessment by the multi-disciplinary team. This ensured that there was proper consideration whether patients require being cared for under conditions of low security.

The female wards at Clifton House had recently opened and appropriate assessments and transition processes had occurred. Women patients with personality disorder had been admitted to the newly opened Rose ward on a phased basis. Staff visited each woman in her previous environment to assess her needs. Staff viewed building a relationship prior to admission as essential and would visit each woman several times. The patients were also invited to visit Rose ward prior to their admission if that could be facilitated. The staff presented information to the whole team about the assessment outlining the patient strengths, needs and the formulation so that the new staff team worked consistently with new patients. This helped to ensure a continuity of care and helped to prevent patients with personality disorder 'splitting' the new team. The individualised tailored processes for admission for women with personality disorder onto Rose ward effectively supported patients safely during this change and transition.

Patients were reported to be appropriately placed with no significant issues with delays on discharge.

The ward environment optimises recovery, comfort and dignity

The ward environments were clean, spacious and comfortable, especially the newer female ward. Each ward and outdoor area within Clifton House was single gender which ensured that there were no concerns about gender separation. Patient dignity was maintained as each patient had their own individual bedroom across all the wards. The newer female wards had full en suite bedrooms with showers with bathing facilities on the ward. The male wards were not en suite and male patients only had access to a shower with no bath facility. The newer wards continued to be clinical with no pictures or decoration on the walls. A small number of bedrooms on Riverfields ward overlooked the staff and visitor car park and there was no screening into the bedrooms to maintain privacy. The wards had spacious communal areas and other quiet rooms which could be utilised as private interview rooms. There was a family visiting area off the wards but this area was stark and clinical with little effort to make the space appropriate for children and family visiting.

The wards had access to a developing activities corridor which included a gym, a computer suite, therapy rooms and a multi faith room. There was a good range of information across all the wards for patients on notice boards and via a range of leaflets on a range of matters. Patients had an opportunity to make a phone call in private through a designated patient phone on the wards.

Patients commented favourably on the quality and portions of the food. Some patients commented that the range of food can get repetitive especially as longer stay

Are services responsive to people's needs?

Good

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

patients. Food was provided via a cold or simple lunch option and evening meals provided through a 'cook, chill' system with food prepared off site until just cooked and then rapidly chilled. Patients were given choice of food including vegetarian options. Patients could make their own hot drinks and snacks with any risks managed on an individual basis.

Ward policies and procedures minimise restrictions

There were no zonal restrictions within the wards so patients could access all areas of the ward including their bedrooms during the day. Restrictions were kept to a minimum within the context of providing care in a low secure environment. There was a clear list of items which were not allowed on the low secure ward which were kept in the security cupboard with access to these items under supervision. There was an appropriate balance between managing risks within low secure care and an appropriate level of positive risk taking. This was achieved through ensuring proper regard to relational security such as ensuring good knowledge of individual patients and appropriate staffing levels. Patients were allowed simple mobile phones without camera and could use other phones under supervision. The exception to this was on Bluebell ward where there were currently blanket restrictions on the use of mobile phones limited to specific times of the day. It was unclear whether this decision had recently been reviewed to more individualised approaches to managing issues as we heard different accounts of the current position. Patients still reported that the restrictions were in place.

Meeting the needs of all patients who use the service

Patients' diversity and human rights were respected. Attempts were made to meet patients' individual needs including cultural, language and religious needs. The trust had developed a booklet to raise staff awareness of the different religious groups, common customs and festival days. There was a designated room within the unit assigned as a multi-faith prayer room. The room was bare with no real recognition in the decoration that it was designated as an area for different faiths. For example there were no decorations, no prayer mats available or any indication of which direction Muslim patients should pray. Contact details for representatives from different faiths were provided and local faith representatives visited patients on the wards. We were told that translation and interpretation service were available.

A choice of meals was available with effort made to ensure a varied range of cultural needs were met representing the needs of individuals and the multi-cultural nature of the communities the Trust serves.

Listening to and learning from concerns and complaints

Patients using the service knew how to raise complaints and concerns. Information on how to make a complaint was displayed in most areas. Information on the mental health advocacy services was also displayed. Informal complaints were often reported as being raised and resolved at community meetings for example patients on Rose ward commented that the laundry schedule was not working so the women themselves produced a rota for fair access to the laundry equipment.

One patient we spoke with who told us that they had recently complained. This complaint had not been logged as a formal complaint even though the patient had explicitly stated they wished to formally complain. The complaint was held in clinical records of this patient's notes which was not adhering to guidance on handling NHS complaints. The manager had looked at this complaint at local resolution stage but had accepted the patient withdrew the complaint. This was despite the fact that the patient was alleging a significant breach of relational security. The ward did not have a proper system for recording the number, type and outcome of complaints that were considered at local resolution stage. This was despite there being a pro-forma log record sheet within the trust policy. Formal complaints were discussed in various meetings including service and locality clinical governance meetings.

The Newsam Centre (Low secure wards Ward 2 - male , Ward 2 - female and Ward 3)

Access, discharge and bed management

Admissions into the low secure beds at the Newsam Centre were gate kept by the NHS England specialist commissioning team following assessment by the multi-disciplinary team. This ensured that there was proper consideration whether patients require being cared for under conditions of low security.

Patients were reported to be appropriately placed with no significant issues with delays on discharge.

Are services responsive to people's needs?

Good

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

The ward environment optimises recovery, comfort and dignity

The ward environments were clean and comfortable. Each ward and outdoor area within the Newsam Centre was single gender which ensured that there were no concerns about gender separation. However Ward 2 male and female wards were separated by only a locked door and patients reported that noise from the adjacent ward could be frequently heard. Patient dignity was maintained as each patient had their own individual bedroom across all the wards. The wards had full en suite bedrooms with showers with bathing facilities on the ward. The wards had communal areas and other quiet rooms which could be utilised as private interview rooms. Space on Ward 2 – male was more limited with patients congregating in the nursing station area in the middle of the ward. There was a family visiting area off the wards but this area but there was limited effort to make the space appropriate for children and family visiting.

The wards had access to an activities rooms off the wards which included a gym, a computer suite, therapy rooms and a multi faith room. There was a good range of information across all the wards for patients on notice boards and via a range of leaflets on a range of matters. Patients had an opportunity to make a phone call in private through a designated patient phone on the wards.

Patients commented favourably on the quality and portions of the food. Patients were given choice of food including vegetarian options. Patients could make hot drinks and snacks with any risks managed on an individual basis.

Ward policies and procedures minimise restrictions

Restrictions were kept to a minimum within the context of providing care in a low secure environment. There was a clear list of items which were not allowed on the low secure ward which were kept in the security cupboard with access to these items under supervision. There was an appropriate balance between managing risks within low secure care and an appropriate level of positive risk taking. This was achieved through ensuring proper regard to relational security such as ensuring good knowledge of individual patients and appropriate staffing levels. Patients were allowed simple mobile phones without camera and could use other phones under supervision. There were no zonal restrictions within the wards so patients could access all areas of the ward including their bedrooms during the day.

Meeting the needs of all patients who use the service

Patients' diversity and human rights were respected. Attempts were made to meet patients' individual needs including cultural, language and religious needs. The trust had developed a booklet to raise staff awareness of the different religious groups, common customs and festival days. There was a designated room within the unit assigned as a multi-faith prayer room. The room was bare with no real recognition in the decoration that it was designated as an area for different faiths. For example there were no decorations, no prayer mats available or any indication of which direction Muslim patients should pray. Contact details for representatives from different faiths were provided and local faith representatives visited patients on the wards. We were told that translation and interpretation service were available.

A choice of meals was available with effort made to ensure a varied range of cultural needs were met representing the needs of individuals and the multi-cultural nature of the communities the trust serves.

Listening to and learning from concerns and complaints

Patients using the service knew how to raise complaints and concerns. Information on how to make a complaint was displayed in most areas. Information on mental health advocacy services were also displayed. Informal complaints were often reported as being raised and resolved at community meetings. The wards did not have a proper system for recording the number, type and outcome of complaints that are considered at local resolution stage. This was despite there being a pro-forma log record sheet within the trust policy. Formal complaints were discussed in various meetings including service and locality clinical governance meetings.

Field View

Access, discharge and bed management

Patients were referred by the low secure wards at Clifton House. There was appropriate transition to ensure that patients could move to Field View when they could be

Are services responsive to people's needs?

Good

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

safely managed. One patient was awaiting the identification of an appropriate aftercare package following a recommendation from a first tier tribunal for conditional discharge.

The ward environment optimises recovery, comfort and dignity

Field View is a converted domestic dwelling for male patients who were moving towards discharge from low secure care. Patients had their own bedrooms and were encouraged to personalise their rooms. The layout of the unit was homely. Patients had unescorted leave to access community facilities and access to a large well maintained garden area. Patients were encouraged to self-cater. There was information available to patients on noticeboards about the trust and services available locally.

Ward policies and procedures minimise restrictions

The written policies of Field View that were available on the unit were out of date as they had been drawn up by, and referred to, the previous provider. The trust has subsequently sent an up dated operational policy to guide staff at Field View. The philosophy of Field View was aimed at promoting independence and working towards discharge, for example patients were self-medicating. Restrictions were kept to a minimum in keeping with an open rehabilitation unit.

Meeting the needs of all patients who use the service

Field View is a small unit which provides care for up to four patients. Care plans identified that patients' individual needs were met. None of the current patients had specific cultural needs requiring specialist input.

Listening to and learning from concerns and complaints

Details of complaints processes were available to patients through leaflets and a poster. We spoke briefly with two current patients and they did not have any complaints.

Community forensic teams in Leeds and York

The teams were commissioned to manage people discharged from low secure care under varying degrees of forensic input and social supervision. There was an identified gap in provision for patients discharged directly from prison with severe and enduring mental health needs as the service is not commissioned to provide this service.

There was an identified pathway for patients to receive support from the forensic community team, the community mental health team or both.

Staff on the in-patient wards talked positively about the effective liaison between the wards and the forensic team to support reflective discharge.

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.

Summary of findings

The service was well led with effective management of the service. There were regular audits of the service held at ward and service level and these were used to drive change. There was a commitment to provide high quality care in line with the trust's stated values and strategy. Staff morale was good despite the vacancy and sickness rate. Continuous improvement was evident through the development of the women's service at Clifton House, improvements in security to address issues from recent incidents and action to address issues identified in the peer review by the Quality Network for Forensic Mental Health Services.

Our findings

Clifton House (Low secure wards: Westerdale ward, Riverfields ward, Rose ward and Bluebell ward)

Vision and values

The trust had a strategy with the overall aim of improving health; improving lives. The trust had a number of high level values which included respect and dignity, a commitment to quality of care, working together, improving lives, compassion and everyone counts.

Staff within Clifton House showed professional commitment to these values as evidenced throughout our interviews with many staff. Patients commented favourably that they received high quality care which showed staff were working within the stated values of the trust.

Staff reported that there was regular presence on the ward from the secure service manager and the associate director for specialist services with more limited input from senior executive managers.

Good governance

The wards were overseen by committed managers who oversaw the quality and clinical governance agenda. Teams within the women's service had a period of time prior to the admission of patients to establish team cohesion and develop shared understanding of the philosophy of care provided within the service. Nursing staff on the wards had lead responsibilities for carrying out checks on various elements of clinical practice such as medicines management, Mental Health Act adherence, records checks, environmental and security checks. Identified issues from these had been shared through team meetings or other forums. The wards and service had a risk register which identified risks and how these risks were managed or addressed.

There were regular meetings for managers to consider issues of quality, safety and standards. This included oversight of risk areas in the service such as incidents. These were being monitored regularly by senior staff in the service. This helped ensure quality assurance systems were effective in identifying and managing risks to patients using the service.

All the wards have also been subject to a recent scheduled Mental Health Act monitoring visit by us to check adherence to the Mental Health Act and Mental Health Act Code of Practice. Where we found issues, the trust provided an action statement to show how it would improve its processes to help secure adherence to the Mental Health Act and Code of Practice.

Leadership, morale and staff engagement

Staff reported that morale was generally good. Staff told us they felt supported by the management across the services we visited. We saw evidence that staff at all levels had received regular supervision and appraisals. Staff spoke positively about their role and demonstrated their

dedication to providing quality patient care.

Staff told us that they felt well supported by their managers and peers. Most of the staff told us that senior managers were accessible, approachable and encouraged openness. Regular team

meetings were held with minutes recorded.

Commitment to quality improvement and innovation

The development of the new women's services at Clifton House had been achieved by the commitment of managers and staff to provide a quality service to patients who use the service. The service continued to listen and engage with patients on an ongoing basis to ensure that patients received good quality care that met patients' needs.

There was a range of clinical governance meetings to continuously raise standards and work towards best practice. The secure services had Commissioning for

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.

Quality and Innovation (CQUIN) targets to implement the routine use of specialised services clinical dashboards to drive quality and improve physical healthcare to reduce premature mortality in patients with severe mental illness (SMI). CQUIN targets are used to support improvements in the quality of services and the creation of new, improved patterns of care. The clinical dashboard showed that the managers were reviewing areas such as delayed discharges, never events and serious incidents, staff training and clinical supervision. The dashboard was RAG rated to clearly identify issues; there were no red rated concerns on the clinical dashboard for Clifton House. Where there were identified issues there was evidence of action to address these, for example, at Clifton House clinical supervision and safeguarding training were rated as amber. Training reports were provided to line managers on a monthly basis to ensure the trust's internal target of 85% was achieved and reminder emails were also sent to individuals whose training had elapsed.

The low secure services at Clifton House had been subject to a Quality Network for Forensic Mental Health Services annual review in March 2014. We saw improvements made in the areas identified by the peer review – for example we saw that a multi-faith room had been developed and relational security awareness had improved through speaking to staff and through 'See, Think, Act' posters and reminders being placed throughout the low secure services. 'See, Think, Act' is the national relational and procedural guidance for mental health secure services.

The Newsam Centre (Low secure wards Ward 2 - male , Ward 2 - female and Ward 3)

Vision and values

The trust had a strategy with the overall aim of improving health; improving lives. The trust had a number of high level values which included respect and dignity, a commitment to quality of care, working together, improving lives, compassion and everyone counts

Staff within the Newsam Centre showed professional commitment to these values as evidenced throughout our interviews with many staff. Patients commented favourably that they received high quality care which showed staff were working within the stated values of the trust.

Staff reported that there was regular presence on the ward from the modern matron, secure service manager and the associate director for specialist services with more limited input from senior executive managers.

Good governance

The wards were overseen by committed managers who oversaw the quality and clinical governance agenda. Nursing staff on the wards had lead responsibilities for carrying out checks on various elements of clinical practice such as medicines management, Mental Health Act adherence, records checks, environmental and security checks. Identified issues from these had been shared through team meetings or other forums. The wards and service had a risk register which identified risks and how these risks were managed or addressed.

There were regular meetings for managers to consider issues of quality, safety and standards. This included oversight of risk areas in the service such as incidents. These were being monitored regularly by senior staff in the service. This helped ensure quality assurance

systems were effective in identifying and managing risks to patients using the service.

All the wards have also been subject to a recent scheduled Mental Health Act monitoring visit by us to check adherence to the Mental Health Act and Mental Health Act Code of Practice. Where we found issues, the trust provided an action statement to show how it would improve its processes to help secure adherence to the Mental Health Act and Code of Practice.

Leadership, morale and staff engagement

Staff reported that morale was generally good. Staff told us they felt supported by the management across the services we visited. We saw evidence that staff at all levels had received regular supervision and appraisals. Staff spoke positively about their role and demonstrated their

dedication to providing quality patient care.

Staff told us that they felt well supported by their managers and peers. Most of the staff told us that senior managers were accessible, approachable and encouraged openness. Regular team

meetings were held with minutes recorded.

Commitment to quality improvement and innovation

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.

The service continued to listen and engage with patients on an ongoing basis to ensure that patients received good quality care that met patients' needs.

There was a range of clinical governance meetings to continuously raise standards and work towards best practice. The secure services had Commissioning for Quality and Innovation (CQUIN) targets to implement the routine use of specialised services clinical dashboards to drive quality and improve physical healthcare to reduce premature mortality in patients with severe mental illness (SMI). CQUIN targets are used to support improvements in the quality of services and the creation of new, improved patterns of care. The clinical dashboard showed that the managers were reviewing areas such as delayed discharges, never events and serious incidents, staff training and clinical supervision. The dashboard was RAG rated to clearly identify issues; there were no red or amber rated concerns on the clinical dashboard for the Newsam Centre. The report identified that there had been five serious incidents. We understand that the trust had commissioned a thematic review to look at common themes from these incidents.

The low secure services at the Newsam Centre had been subject to a Quality Network for Forensic Mental Health Services annual review in May 2014. We saw improvements already made in the areas identified in the peer review– for example we saw that there was work ongoing to develop a seclusion facility.

Field View

Vision and values

Staff were committed to provide high quality care in line with the trust's high level values. The trust's medical director was lead clinician within the service at Field View and regularly attended the unit. Due to the lack of the intranet staff did not always feel connected to the trust and did not receive key messages in relation from high level messages and objectives through to day to day matters.

Good governance

The service evidenced some checks and audits for example electrical testing of equipment, fridge temperatures and medicine checks for patients who were self-managing their medicines. As there was no lead clinician or regular qualified staff available on the inspection, we asked the trust for details of audits that had occurred at Field View. The trust provided audits relating to fire safety and health and safety. The team meeting minutes evidenced that discussions mainly related to specific operational issues with little evidence of standardised governance agenda items or clinical reflection. The audits and team meetings of Field View were therefore limited. This meant that there was little evidence of good clinical governance.

Leadership, morale and staff engagement

There was no nursing staff available on the day of our inspection. The unqualified staff were committed to providing a good quality service. The vacancy rate of the qualified staff meant that clinical leadership fell on the one current nursing staff left with occasional input from senior managers. Staff morale could be improved by ensuring better connectivity with the trust including through improved information technology.

Commitment to quality improvement and innovation

We were unable to see evidence of clinical leadership to guide staff in the best clinical practice. There was good commitment to ensuring the service met the needs of the patients within the service and encouraging patients to engage with their local community.

Community forensic teams in Leeds and York

The forensic community team were well led. Staff were committed to the strategy of the trust to provide care that improves patients' lives and their health. Morale was found to be good within the forensic community teams with well developed team working. The service had peer group reflection to help ensure continuous reflective practice. The proximity to the wards helped to ensure that the teams were fully connected and embedded within services.

Compliance actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983	Regulation 19 HSCA 2008 (Regulated Activities) Regulations 2010 Complaints The systems for identifying, handling and responding to complaints made by service users were not effective. This is because the systems currently in place did not identify, handle and record complaints being resolved at local resolution or ward level, complaints were stored and handled within patient care records contrary to published guidance and it was not clear that complaints were fully investigated. [Regulation 19(1) and 19 (2) (C)]