Requires improvement

Leeds and York Partnership NHS Foundation Trust

Forensic inpatient/secure wards

Quality Report

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

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

Locations inspected

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

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

Summary of findings

Ratings

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

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

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

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

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

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

Summary of findings

Contents

Summary of findings

Overall summary

We rated forensic inpatient secure wards as requires improvement because:

- Compliance with mandatory training was poor, especially training in clinical risk, intermediate life support, and the Mental Health Act. Staff knowledge and understanding of these legal requirements in relation to the Mental Health Act was variable across the service. Rates for clinical supervision were low and appraisal rates did not meet the trust target.
- Restrictive practice was not based on individual risk or need and was not proportionate or person-centred.
- The trust had not investigated incidents in a timely manner or taken adequate and effective actions to prevent further incidents in some cases. Systems in place were not utilised effectively to ensure lessons learnt were shared across the service. Not all the governance arrangements in place provided assurance that systems were effective.

However,

• Overall, patient experience of the forensic service was positive. Staff treated patients with kindness, dignity and compassion. Patients felt safe and relationships were built on mutual respect. Opportunities for patient and carer involvement were evident.

• Patients' individual needs were met through the effective assessment and monitoring of both mental and physical health. Patients were at the centre of their care and supported to contribute to multidisciplinary discussions. The service was responsive to the needs of patients. Allied health professionals and clinical staff worked collaboratively to ensure patients' individual needs and interests were met through a range of psychological and occupational therapies.

• Complaints across the forensic service were low.

Summary of findings

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

Are services safe?

Requires improvement

We rated safe as requires improvement because:

- Monitoring and recording of required checks for essential medical equipment was inconsistent. This meant equipment may not be fit for purpose when it was needed.
- Security between ward two (male) and ward three at Newsam Centre was not maintained. This meant patients could have had accessed both wards.
- There is no local working protocol at Newsam Centre regarding the seclusion of female patients. This meant staff had no guidance to support their decision making regarding the seclusion of females.
- The service did not record individual hours of activity for all patients consistently. This meant that patients were not all reaching their potential for recovery and rehabilitation.
- There was low compliance with eight of the trusts identified mandatory training courses, including training in clinical risk and intermediate life support. These are essential for ensuring that patients are safe.
- Blanket restrictions for searching and access to outside space were not based on individual risk. The staff approach to ensure the environment was smoke-free was not proportionate or person-centred
- Opportunities to identify and share learning following incidents were missed. This meant potential risks to patients and service remained.

However,

- The thorough induction of bank and agency staff was focussed and relevant to the ward environment
- The service used Functional Analysis of Care Environments and Historical Clinical Risk Management – 20 risk assessments and reviewed these during multidisciplinary meetings and in response to patient need
- Patients were supported by the multidisciplinary team to self-medicate

Are services effective?

Requires improvement

We rated effective as requires improvement because:

Summary of findings

- Four out of seven wards failed to reach the trust target for appraisals. This meant staff did not have the opportunity to address their personal and professional development formally.
- Clinical supervision rates were low on five out of seven wards. This meant that staff did not formally have the opportunity to reflect on and improve their practice.
- Compliance in the mandatory training for the Mental Health Act was low, ranging between 47% and 74% compliance.
- Mental Health Act documentation was not always thoroughly completed.

However,

• Multidisciplinary pre-admission assessments including a physical health assessment were completed and physical health monitoring was continuous throughout a patients stay. This meant that patients' physical health care was part of the holistic approach to their health.

• Care plans were holistic, individualised and reflected patients' views.

• Patients had access to a wide range of psychological and occupational therapies based on individual need or interest.

• Multidisciplinary team approach put the patient at the centre of their care.

• Audit activity was effectively planned and monitored.

Are services caring?

Good

We rated caring as good because:

- Patients we spoke with stated they were treated with dignity and respect. They were positive about their experience of the service and they felt safe.
- We observed a mutual respect between patients and the multidisciplinary team. This meant patients had a supportive relationship with their care team.
- Proactive patient led community meetings provided opportunities to resolve ward based issues. This meant patients felt involved in decisions related to their care and community.
- Patient and carer involvement was embraced by the service.

However,

- During the inspection we heard patients who were detained under the Mental Health Act with Ministry of Justice restrictions being referred to as prisoners. This did not treat patients in a dignified manner.

Summary of findings

Are services responsive to people's needs?

Good

We rated responsive as good because:

- All wards were accessible and some had bedrooms with accessible en suite bathrooms.
- The service was able to meet the cultural and religious needs of patients through the provision of a multi-faith room and links into the local community.
- The admission process was robust and patients were at the centre of this. This meant that patients were involved in their care prior to and during the admission onto the ward
- The service provided a variety of rooms and facilities. A range of therapies were delivered in appropriate spaces based on individual risk and need.
- Individual and group activities were relevant to the patient group. This meant patients could engage in activities that were purposeful and of interest.
- Activity planning involved both occupational therapy staff and ward staff. This meant patient activity continued at weekends.
- Patients were able to have access to their own room and have a key based on individual risk assessment.
- Patients told us they knew how to make a complaint.

However,

- Bed occupancy rates and average length of stay were just below NHS England expectation of 90%. Two wards were above this at 98% and 99%. This meant the daily demand on the service was constant and length of stays increased, as accessing move on services was difficult.
- Nine patients told us the quality of food was poor.
- Feedback from formal investigation of complaints was inconsistent. This meant improvement in practice or service delivery were limited.

Are services well-led?

Good

We rated well led as good because:

- Staff we spoke to knew the values of the trust and this was evident in the interactions we saw between patients, staff and wider multidisciplinary team.
- Morale within the ward-based teams was very positive. Teamwork was at the centre of this and provided staff with an immediate support network.
- Access to key performance indicator data was good. This meant ward managers could review the performance of their service immediately.

Summary of findings

- Commitment to service development was evident across all services. This meant services are trying to improve and deliver better quality experiences for patients and staff.

However,

- The service was not effectively monitoring training data. This meant mandatory training compliance was below the trusts benchmark.
- Contact with senior managers was variable across the service. This meant engagement from ward to board was minimal.
- Feedback and learning from formal investigation of complaints and incidents was inconsistent. This meant improvement in practice or service delivery was limited.

Summary of findings

Information about the service

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

Clifton House in York provides four low secure wards. These are:

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

The Newsam Centre in Leeds provides three low secure wards. These are:

- Ward 2 (male) a 12 bed male low secure ward for assessment and short term treatment
- Ward 2(female) a 11 bed female low secure mental health service
- Ward 3 a 14 bed male low secure treatment and recovery unit

We have inspected Leeds and York Partnership NHS Foundation Trust on a number of occasions since registration. We have carried out regular Mental health Act monitoring visits. With the exception of Newsam Centre, ward 3, all wards were visited between August 2015 and March 2016. We inspected forensic /secure services between 30 September and 2 October 2014. The inspection report was published 16 January 2015. Improvements were required in the systems for identifying, handling and responding to complaints. The trust provided an action plan to show how it would improve the management of complaints. We have confirmed at this inspection that the trust has met this action.

Our inspection team

The team was led by:

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

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

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

The team comprised of two CQC inspectors and five Specialist Advisors. These were from different professional backgrounds such as nursing and occupational therapy. As part of our inspection we also had access to a mental health act reviewer, pharmacist and expert by experience.

Why we carried out this inspection

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

Summary of findings

How we carried out this inspection

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

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

Before the inspection visit, we reviewed information that we held about these services, asked a range of other organisations for information and sought feedback from patients at two focus groups.

During the inspection visit, the inspection team:

- visited all seven of the wards at the two hospital sites and looked at the quality of the ward environment and observed how staff were caring for patients
- spoke with 25 patients and 5 relatives of patients.
- spoke with the managers or acting managers for each of the seven wards
- spoke with 31 other staff members; including doctors, nurses and occupational therapists
- interviewed both acting matrons
- attended and observed one hand-over meeting and five multidisciplinary meetings
- collected feedback from seven patients using comment cards
- looked at 26 care records of patients
- reviewed 27 prescription charts
- looked at a range of policies, procedures and other documents relating to the running of the service

What people who use the provider's services say

- During the inspection we spoke with 25 patients and 5 relatives of patients.
- We received feedback from one patient focus group and seven comments cards.
- All the patients we spoke with said the environment was clean and well maintained.
- Patients said they felt safe and supported by staff.
- Patients said they were treated with dignity, respect and kindness by staff.
- Patients said they felt cared for by staff.
- Patients raised concern about the quality of food.

The majority of relatives said the staff were kind and they felt involved in their relatives care. However, one relative said they were not happy with the lack of regular staff and felt this affected the quality of care patients received and the effectiveness of communication with relatives.

Good practice

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that all staff on all wards have received up to date mandatory training.
- The provider should ensure that all staff on all wards receive clinical supervision.
- The provider must ensure that restrictive practices, when required, should be evidence based, lawful, in the patient's best interest, proportionate , dignified

and be and individual response to an identified risk. Governance arrangements should be in place that enables them to monitor for any misuse of restrictive practices.

Action the provider SHOULD take to improve

- The provider should ensure that appraisals meet the trust target
- The provider should ensure that governance arrangements in place are managed and monitored to provide assurance that systems are effective.
- The provider should commit to completing the ongoing recruitment into management and clinical posts to provide stability and leadership.
- The provider should ensure that incidents are investigated in a timely manner and that adequate and effective actions are taken to prevent further incidents. Systems in place should be utilised effectively to ensure lessons learnt are shared across the service.
- The provider should ensure that their approach to a smoke-free environment is proportionate and person-centred.

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
Bluebell Ward	Clifton House
Rose ward	Clifton House
Westerdale Ward	Clifton House
Riverfields Ward	Clifton House
Ward 2 Female	Newsam Centre
Ward 2 Male	Newsam Centre
Ward 3	Newsam Centre

Mental Health Act responsibilities

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

- The trust made Mental Health Act training mandatory in July 2015 and the trust set the compliance rate at 90%. All seven forensic wards failed to achieve this target by July 2016 with an average completion rate of 64%.
- Many clinical staff demonstrated a good understanding of the Mental Health Act but some staff demonstrated basic awareness.
- The rights of patients detained under the Mental Health Act were explained on admission and consistently throughout their care.
- Treatment was authorised correctly and treatment certificates were attached to all prescription charts we reviewed.

Detailed findings

Mental Capacity Act and Deprivation of Liberty Safeguards

- During our inspection we looked at adherence to the Mental Capacity Act and the code of practice. We found that:
- There were no Deprivation of Liberty Safeguards applications made by the service in the last 12 months prior to the inspection.
- All patients were detained under the Mental Health Act with the exception of one informal patient.
- The trust made Mental Capacity Act and Deprivation of Liberty Safeguards training mandatory in July 2015. Within the forensic service, average compliance rates were between 60 and 70%.
- Several staff demonstrated a good understanding of Mental Capacity Act but some staff only demonstrated awareness.
- Recording of capacity assessment outcomes was varied.

Requires improvement

Are services safe?

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

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

Our findings

Safe and clean environment

On two of the seven wards we visited staff could not always see all patients. Westerdale ward had a blind spot in the toilet area of the seclusion room. Seclusion is the supervised confinement of a patient in a room, which may be locked. Its sole aim is to contain severely disturbed behaviour likely to cause harm to others. On Riverfields ward there was a division between the lounge and dining area, this created a blind spot from the nursing office. However, this was mitigated by regular staff presence on the communal areas of the ward.

We saw completed and up to date ligature risk assessments on each ward and these were reviewed regularly. The trust was undertaking comprehensive work on their estate to address the risk of potential ligature points. Ligature points are places where those intent on self-harm could tie something to strangle them self. Although the trust was removing ligature points from the wards, this was not happening in a systematic way. We saw examples of collapsible shower rails and curtain poles in bathrooms and bedrooms and the service had changed some tap fittings to the push button system but other risks remained. For example, on Newsam ward two female, sink fittings had been replaced with anti-ligature taps but handles remained on both the bidet and toilet. The clinical team manager was unclear how the estates team prioritised work.

All of the forensic wards complied with same-sex accommodation guidance.

Clinic rooms were organised and clean. We saw "I'm clean" stickers on equipment, identifying when it was cleaned and by whom. Only four wards had examination couches and this meant not all patients could be examined in a clinical room. A blood pressure monitor, weighing scales and resuscitation equipment were available in all wards. We saw the required checks of resuscitation equipment on most wards. However, on Westerdale, there were several missed checks and there were two items not on the inventory in the resuscitation bag, one of which were scissors. This could make it hard for staff to find the right equipment in an emergency and increase the risk that these items could be used as weapons.

We were not able to prove on all wards when the portable appliances had last been electrically tested as many of the stickers had expired dates on them. On Westerdale ward, the stickers indicated that the electrocardiogram monitor should have been last tested in August 2012, and the automated external defibrillator in May 2016. On Ward 2 (female) at the Newsam Centre, the stickers on the automated external defibrillator indicated that it should have been last tested in August 2011. The acting matron at the Newsam Centre checked the asset register and confirmed that this equipment was due for electrically testing in September 2016, and that the stickers on the equipment were incorrect. Patients' lives could be put at risk if essential equipment is not maintained as required.

We found across most wards medicine fridge temperatures were not regularly checked. This could mean drugs are stored at the wrong temperature and may be less effective. Three wards had reported broken fridges and were waiting for these to be repaired. Emergency drugs were available, in date and checked regularly.

We saw all three seclusion rooms across the forensic service. At Newsam Centre, there was one seclusion room and at Clifton House, there were two. At Newsam Centre, the seclusion room was on ward two male and it was available for use by all three forensic wards. The seclusion room was between ward two (male) and ward three. A single wooden door connected the two wards and this was unlocked during our visit. This was a patient safety and security issue because patients could move from one ward to another when they should not. There was a mattress and bedding available. The room had natural light from two large windows. There was a separate bathroom with a toilet, sink and shower. There were no ligature points in the seclusion room. Staff told us clear observation could be compromised by misting from the shower on the observation mirror. Patients could not see a clock and as a result may not be orientated to time. The intercom functioned but when it was switched on, there was

Requires improvement

Are services safe?

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

significant interference. This created a high-pitched sound in the seclusion room, so communication would be difficult. The de-escalation room was adjacent to seclusion and they could not be in use at the same time.

If a female required seclusion they would need escorting through the male bedroom corridor on ward two but staff said this need was rare. Currently there is no local protocol to support staff in making decisions around secluding female patients; we spoke to the acting operational service manager and the service is now addressing this. This is an issue regarding the dignity of female patients.

We found all wards were clean and well maintained across the forensic service. The Patient Led Assessment of the Care Environment score for Clifton House was 96% and the Newsam Centre was 99%. The Patient Led Assessment of Care Environment score is an assessment made by patients and the public of how the environment supports patients' privacy and dignity, also covering food, cleanliness and general building maintenance. We checked four cleaning schedules with the contractor, all were current and accurately completed. Patients told us that they felt their wards were clean, particularly bathrooms and toilets. At Clifton House, wards were mostly light and spacious, offered comfortable seating areas with some choice in availability of rooms. Newsam Centre was less spacious, décor and lighting was not conducive to enhancing this. For example, the television lounge on ward two male was extremely dark, despite natural daylight. Patients used the main corridor as a communal area to sit together.

We observed staff following infection control principles. There were hand gel dispensers across all wards and we observed staff using these. Personal protective equipment was available and was stored securely. All staff carried personal alarms to activate if assistance was required. Nurse call systems were in place at the Newsam centre but Clifton House did not have these in all patient bedrooms.

Safe staffing

The trust had set the minimum daily staffing levels on each ward against their identified safer staffing levels. The nursing teams comprised of a band seven ward manager, band six clinical team leaders, band five staff nurses and bands two to four nursing assistants.

On 31 March 2016, the trust reported their average vacancy rate as 1.74 for whole time equivalent qualified nurses. Information provided by the trust prior to inspection indicated four of the seven forensic services were above this rate. The vacancy range was 2.2 to 6.2 whole time equivalent for qualified nurses, Rose ward had the highest number of vacancies at 6.2. The trust reported their average vacancy rate as 1.64 for whole time equivalent nursing assistants. Newsam ward two male was the only ward to exceed this rate at 2.2. Recruitment was ongoing by the trust. We visited Clifton House on 20 July 2016 and we had an update on current vacancies across the forensic services. All wards had seen a reduction in the number of vacancies, but recruited staff had not yet taken up post. Rose ward continued to experience a shortfall of 5.7 whole time equivalent qualified nurses and Bluebell ward 4. The female service at Clifton house had 9.7 of the 13.1 qualified nursing band five vacancies within forensic services.

The trust average sickness rate was 4%. Six of the forensic services were above this between 1 April 2016 and 30 June 2016. Sickness recorded at 15.6% for Newsam ward 2 male, Riverfields ward at 10%, Bluebell ward at 8% and Rose ward at 4%.

Forensic services employed bank and agency staff across its wards. In addition to the trust induction, each ward provided a local induction. We saw the objective based programme that addressed security, ward security and fire safety. Band six team leaders were responsible for supervising and completing this work with the member of staff. The induction was a comprehensive overview of information staff needed to know to do their job competently.

Between 1 April 2016 and 30 June 2016 bank and agency staff filled 1,714 shifts due to staff sickness, vacancies and clinical need. The service had a further 174 unfilled shifts. Westerdale ward filled 570 shifts due to clinical need, specifically acuity of patients and increased observations. Bluebell ward filled 111 shifts with bank and agency staff, 43 of these because staffing fell below establishment levels. Rose ward used bank and agency to cover 63 shifts and 48 of these were to cover vacancies. Shifts not covered by bank or agency were 73 on Westerdale ward, 32 on Rose ward and 26 on Bluebell ward. It was not clear from the statistics provided if the use of bank and agency staff was proportionate across the wards. We discussed this with staff and were informed that the recording of this information was not consistent, particularly in relation to the reason for booking bank or agency staff.

Requires improvement

Are services safe?

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

Staff minimised the frequency of cancelling escorted section 17 leave and activities by working flexibly throughout the day, and using regular bank and agency staff. However, staff and patients on all wards except Riverfields told us that there had been occasions when activities and section 17 leave had been cancelled. It is important for service users to participate in activities and section 17 leave as part of their recovery.

Patients had planned one-to-one time each week with their named nurse and additional time was available with nursing assistants. There was sufficient medical cover during the day and night. A doctor could attend in an emergency and available on call out of hours.

Managers told us they had the autonomy to adjust staffing levels to take account of case mix. This was supported by the role of forensic nurse co-ordinator, a band six nurse who had oversight of all staffing issues throughout the day and night. This role was effective and responsive in managing the changing clinical needs of each area.

We reviewed the forensic service activity report up to May 2016. Cancelled activity was recorded at 115, however there was no detailed information if this meant patients, sessions or minutes. Evidence of recording individual activity hours was minimal. The recording of 25 hours individual activity, as recommended by NHS England, had stopped at Clifton House and staff stated each ward was capturing activity information independently.

Each ward allocated a security nurse on a daily basis to take responsibility for completing environmental and security checks. Another member of staff was allocated the response role, in the event of an incident they would respond to alarms to support staff in carrying out physical interventions safely.

The current compliance rate for mandatory training in the forensic and secure services as of February 2016 was 79%. Of 19 mandatory courses for the trust, only five were above the 75% rate. These were safeguarding adults, information governance, health and safety, equality and diversity and trust induction.

There was low compliance with eight of the trusts identified mandatory training courses, including clinical risk, food regeneration, intermediate life support, duty of candour, Mental Capacity Act and Deprivation of Liberty Safeguards, moving and handling, safeguarding children and the Mental Health Act. We were particularly concerned that the clinical risk training compliance for the forensic and secure wards was only 52%, and that the intermediate life-support training compliance was 66%. This training is essential for ensuring that patients are safe.

During the inspection, we checked the training dashboard, and saw that availability was good for training places for the mandatory training, and that courses were run in the Mental Health Act and Mental Capacity Act. Clifton House staff had not booked onto the courses available.

Assessing and managing risk to patients and staff

We reviewed 26 patient records. Patient records included a comprehensive risk assessment completed on admission. Clifton House used the Safety and Management Plan, and Newsam Centre the Functional Analysis of Care Environments. Both locations also used the Historical, Clinical and Risk Management Scale and the Structured Assessment of Protective Factors for violence risk .Staff told us these tools were updated throughout the patients stay, during multidisciplinary meetings and in response to patient need. All 26 patient records reviewed had an up to date Functional Assessment of Care Environments or Safety and Management Plan risk assessment.

The service had one informal patient. The care record accurately reflected his informal status, a care plan with rights and responsibilities leaflet for informal patients were in the record. Discussion with the patient indicates that he was aware of the implications of being an informal patient. The patient had an advocate.

There were blanket restrictions on access to outdoor space. Patients could not use outdoor space without the supervision of staff. This was consistent across all seven wards. One patient told us that they could access the courtyard at half past the hour for 10 to 15 minutes. Routine searches following unescorted leave occurred on all seven wards. These practices did not reflect individual risk.

Smoke free status of the trust continued to be an issue for patients, who openly told us they continue to hide smoking equipment in the external grounds to use when on section 17 leave. Staff confirmed that any patient who brought these items on to the premises following leave, were asked to hand them in so that they could be returned on discharge. If a patient did not hand their tobacco products to the ward staff and it was suspected that a patient had “contraband items,” including tobacco products, the trust

Requires improvement

Are services safe?

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

search policy would be followed and the cigarettes or tobacco would be destroyed as drugs or alcohol would be. Each item destroyed was recorded on the electronic incident recording system. We were concerned that this procedure was disproportionate and not patient-centred. This was because cigarettes were only returned to patients when they were discharged. This appeared to be a disincentive to handing over tobacco products and resulted in patients being searched in line with the trust policy.

During our inspection, at the Newsam Centre we smelt smoke in a communal bathroom. There had also been an incident, a patient had used foil from yoghurt pots in a plug socket to light a cigarette this had subsequently ignited. There were also safeguarding concerns raised following an incident between patients. A patient without section 17 leave was charged £5 for a cigarette by another patient. We discussed this with the ward manager, and a referral was made to safeguarding for this patient.

Staff described in detail how observation levels were determined, recorded and how they linked with the management of risk. We observed this type of discussion in a clinical handover. This accurately reflected the trusts procedure for the observation and engagement of people. The searching of all patients following unescorted section 17 leave was not consistent with the trusts search of service users (detained and informal), visitors and their property procedure. Routine searching was not proportionate to the identified risk.

Between 1 January 2016 and 30 June 2016, restraint was used on 30 occasions across the seven wards. Staff told us verbal de-escalation was the primary intervention used when a patient's condition had deteriorated and they were a risk to themselves or others. Staff highlighted the importance of relational security in these situations. Relational security is the knowledge and understanding staff have of a patient and of the environment; and the translation of that information into appropriate responses and care. When this was not successful, staff were confident in the use of appropriate restraint techniques. Eighty four percent of staff were trained appropriately.

There were 12 incidents that involved the use of prone restraint, six of these occurred on Westerdale ward. Prone restraint occurs when patients are held face down on the floor. National Institute of Clinical and Healthcare Excellent guidance (NG10, Violence and aggression: short-term management in mental health, health and community settings, 2015) recommends this is used as a last resort due to the risk of injury.

Within the previous six months, rapid tranquilisation was used six times. Rapid tranquilisation is medicine given to a patient who is agitated or displaying aggressive behaviour. The aim is to quickly calm them and reduce any risk to themselves or others. Staff followed National Institute of Clinical and Healthcare Excellence guidance, as detailed above and the Mental Health Act code of practice guidance on physical observations following administration of rapid tranquilisation.

Within the previous six months, seclusion was used on 18 occasions. Rose ward accounted for eight of these. We reviewed two seclusion records. Both records were not compliant with the Mental Health Act Code of Practice. There were no seclusion care plan in place and the nursing reviews did not record a picture of the patients' presentation consistent with the medical reviews. Some observation sheets were missing in one record. One record was not in an ordered manner.

Most staff received safeguarding adult training. Staff described relevant examples of safeguarding issues and the process of making an alert. A safeguarding policy and procedure was available to staff on the staff intranet. We observed safeguarding guidance on noticeboards for staff to follow. However, we found evidence where staff had not followed this guidance and had not made referrals to safeguarding when necessary.

We reviewed 27 prescription charts. All charts were clear and legible. All charts had patient identifiable data, allergy status and the date of admission completed. To assist staff in the identification of the patient, 12 had a photograph of the patient with the prescription chart. Medicines were stored securely in locked cupboards within a locked clinic room. The management of controlled drugs was appropriate. A controlled drugs cabinet was available, which was compliant with legal requirements. Some patients received support with self- medication. The multidisciplinary team, including the pharmacist, reviewed this process regularly.

Track record on safety

There were no serious incidents reported within forensic services in the last 12 months.

Requires improvement

Are services safe?

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

The trust is undertaking an extensive programme of work on their estate to address potential ligature points.

Reporting incidents and learning from when things go wrong

We spoke to 31 staff in the multidisciplinary team; most staff knew how to report incidents through the electronic reporting system. Staff gave us examples of issues reported, such as smoking, patient behaviour, security issues and staff shortages. Staff received feedback through email and team meetings. However, some staff told us that feedback was not consistent following incidents. Staff told us debriefs did not always happen. The trust has governance structures in place to facilitate learning from incidents, ranging from ward to board level governance meetings. However, there was no standardised agenda for ward meetings to ensure managers shared the learning from incidents with staff and the frequency of meetings was inconsistent across the service. This meant opportunities to share learning were missed.

We found that the trust did not always follow trust procedures for investigating incidents. Staff reported a patient that went absent without leave from the service. The trust standard is to complete an initial fact find within 12 hours of an incident. In this case, the service completed its fact find six days after the incident. We discussed this with a senior manager and agreed there were missed opportunities to identify immediate learning. We requested further evidence to identify learning and change following other incidents and this could not be located. We returned to the unit the following week and we followed up to check if the incident had been discussed and any actions identified. We found that the ward clinical governance meeting had been completed the incident was discussed. We saw that actions to be completed had been recorded. Lessons learnt were not clear in the meeting minutes we reviewed.

The trust had a policy on the duty of candour, most staff could explain the need to be open and honest with patients when things went wrong.

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.

Our findings

Assessment of needs and planning of care

We reviewed 26 patient records. Patient records included a pre-admission multidisciplinary assessment and assessments undertaken by staff on admission. Staff carried out a physical health assessment on all 26 patients upon admission. TheModified Early Warning Scoreis a tool used to record consistently blood pressure, heart rate, temperature, respirations and oxygen saturations. Monitoring of physical health throughout a patients stay was evident. Patients' weights were recorded.

During our inspection, we reviewed patient care and treatment records. We found that care records were reviewed, 23 care and treatment records were up to date with an inpatient treatment plan. Care plans were individualised, holistic and reflected patients' views. Care plans identified strengths, goals and barriers to discharge. Discharge planning was evident.

Patients' records were stored securely on an electronic system. These records are multidisciplinary. Staff told us that navigation around the system could be difficult as information was not always stored in the same part of the record. The computer system included the facility to scan and store paper documents. Psychology told us their treatment plan was in the letters section of the electronic system and separate from the patients care plan. This created a risk that staff might not be aware of a patients full care plan. Managers told us the service was aware of this and were looking to develop a multidisciplinary care plan. Patients also had separate paper files these were stored in a locked cupboard within locked offices.

Best practice in treatment and care

Staff told us when prescribing medication, National Institute for Clinical and Healthcare excellence guidance was followed, (CG76, Medicines adherence: involving patients in decisions about prescribed medicines and supporting adherence, 2009), along with recommendations from the Royal college of Psychiatrists, trust policy and British National Formulary limits was followed. We examined 27 prescription charts and all prescribed medication was within British National Formulary limits.

Psychological therapies recognised by the National Institute for Clinical and Healthcare Excellence were available. These included:

- cognitive behavioural therapy
- cognitive analytical therapy
- dual diagnosis
- psychosocial interventions
- family therapy
- eye movement desensitisation and reprogramming.

Occupational therapy was provided in line with the Model of Human Occupation the College of Occupational Therapists Forensic Practice Standards. Patients could access a range of activities including:

- walking group
- budgeting
- shopping
- cooking
- craft
- health and fitness.

We spoke with staff and found that nurse knowledge of best practice was limited. Staff stated National Institute for Clinical and Healthcare Excellence guidelines were followed but were unable to detail further. However, ward managers gave detailed evidence demonstrating care was underpinned by appropriate guidelines. Allied health professional staff showed a clearer understanding of best practice.

We saw evidence of best practice during multidisciplinary reviews. Staff worked inclusively with patients and promoted autonomy during discussion. This approach was in line with National Institute of Clinical and Healthcare Excellence guidance for schizophrenia and guidance on treating personality disorder.

We observed the occupational therapy team facilitate community meetings alongside ward staff. Patients told us they enjoyed going shopping and cooking their own food. This provided patients with meaningful activities to engage in. This was in accordance with National Institute of Clinical and Healthcare Excellence guidance, which recommends therapies to assist in promoting recovery.

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.

Staff used recognised rating scales to assess and record severity and outcomes for patients. This included the Health of the Nation Outcome Scale for secure services, Model of Human Occupation, Becks Depression Inventory and Hospital Anxiety and Depression scale.

Clinical staff completed clinical audits. These included documentation, nutritional screen, mental health act, prescription charts, physical health, and medication including above British National Formulary limit high dose anti-psychotics. Information from each audit was analysed, action plans generated and learning shared with staff. We observed a tracker system was in place to support the audit programme.

Skilled staff to deliver care

Each ward had access to a comprehensive multidisciplinary team. This included medical staff, occupational therapists/assistants, psychologists, nurses, activity co-ordinator and healthy living advisor. Each ward also had access to a pharmacist and pharmacy technician. The pharmacist attended the multidisciplinary team meetings when required and was contactable at other times. The pharmacy technician attended the ward to replenish stock and carry out audit activity. The pharmacy team also provided in-house training to both staff and patients. Staff reported to have a good relationship with the pharmacy team.

Staff were experienced and qualified in their various roles. Specialist training was available. Staff had accessed the following training: Knowledge and Understanding Framework for personality disorder, cognitive behavioural therapy, psychosocial interventions and non-medical prescribing. A member of staff was waiting to commence training in compassionate focus therapy.

Following a service review on Rose ward in 2015, service specific training for staff working with female personality disorders was to be made available to staff. The training was scheduled to be completed by end of October 2016.

All staff were expected to complete an induction programme, including corporate and local induction. Bank and agency staff completed a local induction; a senior nurse oversaw this. Areas included in the local induction were environmental, relational and operational security, policies and procedures. We saw evidence to support this. This meant that all bank and agency staff had an understanding of their work environment and expectations of their role.

The trust target for annual appraisal for staff is set at 90%. Of seven wards, three wards achieved this. The range for appraisals completed was between 65% and 100% across the wards that we visited. Rose ward and allied health professionals achieved 100%, information based on data from 1 July 2015 to 30 June 2016. We saw paper records for annual appraisal. Clear objectives were recorded and reviewed. The average clinical supervision rate for forensic and secure services was 57% as of 30 June 2016. Whilst Riverfields Ward at Clifton House had 100% compliance for clinical supervision, other wards, for example Ward 2 female and Ward 3 at Newsam Centre had clinical supervision rates of 36% and 19% respectively. Staff told us they also attended reflective groups and received informal supervision through peers. We saw paper records of staff supervision that showed supervision occurred. Staff who do not regularly access clinical supervision will not have the opportunity to talk about their clinical practice and development constructively. Each ward held team meetings.

The overall percentage of non-medical staff that had an appraisal in the last 12 months was 86% and this was below the trust target of 90%. However, we were concerned that Bluebell Ward at Clifton House had an appraisal rate of 65% and Ward three and Ward two male at Newsam Centre had an appraisal rate of 67% and 68% respectively.

We found that the trust dealt with poor staff performance appropriately. There were five instances of staff re-deployment or suspension from duty in the last 12 months. There was one ongoing investigation of staff at the time our inspection.

Multi-disciplinary and inter-agency team work

All patients had an allocated multidisciplinary team. Teams consisted of a psychiatrist, psychologist, occupational therapist, clinical staff and patients in York had a social worker

Ward round took place each week, patients were seen alternate weeks.

Staff participated in regular and effective multidisciplinary team meetings. Staff told us these occurred on a weekly basis and that they were essential for good teamwork and

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.

supporting patients. We observed three multidisciplinary meetings. We saw that the patient was at the centre of their care and they were encouraged to express their opinion on what mattered to them. Communication was honest and open. Patients were aware that they could have an advocate. In one multidisciplinary meeting we saw that the patient's care co-ordinator was present. The focus of the meeting was reviewing risk and treatment plans.

We observed one handover and reviewed the daily handover documentation. Handover happened three times each day. The handover was effective. Information regarding patients' current mental state, medication and level of observation were some of the issues addressed. The handovers were timely, focussed and well attended by staff.

Patients' treated in York and Leeds also had access to a social worker, this enabled effective working relationships with community and social services. All wards had positive relationships with the local safeguarding authority and confident in accessing them. The trust had a good working relationship with the local GP service to meet the physical healthcare needs of the patients.

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

The trust set Mental Health Act training as a mandatory training requirement for all staff in July 2015 and the trust target is 90% compliance for all staff by July 2016. At the time of inspection compliance with Mental Health Act inpatient level two training ranged from 47% to 74%. Not all clinical staff had a good understanding of the Mental Health Act and the Code of Practice.

Compliance rates achieved were:

Newsam ward two female 74%

Newsam ward two male 73%

Rose ward 70%

Newsam ward three 69%

Riverfields ward 60%

Bluebell ward 53%

Westerdale 47%

Patient care records demonstrated that patients had their rights read at regular intervals consistently from admission and throughout their stay. Staff informed us that they diarised when this was next due. Managers told us that senior nurses regularly audited Mental Health Act documentation. We saw this evidenced in an audit tracker. This document was a quick glance guide to audit compliance on each ward. The use of colour made this particularly easy to use and identify when audits were due and where action was required. Senior nurses discussed actions to complete in supervision with staff and this meant there were opportunities for learning. Supervision rates are variable across the service, so learning opportunities could be limited.

There have been 17 Mental Health Act monitoring visits between 1 June 2015 and 1 June 2016 across the trust. There were 49 issues found and 19 of these issues were within forensic services. These were:

- Six issues related to purpose, respect and participation.
- Five issues related to leave of absence.
- Four issues related to consent to treatment
- Two issues related to control and security
- One issue for each of general healthcare and admission to the ward.

Both Westerdale and Rose wards had the most issues in a single visit with five each. Westerdale ward also had issues identified in five of the six areas examined.

We examined 27 prescription charts and all had a T2 or T3 certificate present. These forms are certificates showing that patients had consented to their treatment (T2) or that it had been properly authorised (T3) were completed and attached to prescription charts. These were the legal authority to administer medication to a detained patient. Many of the T2 certificates had printed copies of the assessment of patients' consent and capacity to consent to treatment.

We examined 11 patient records specifically in relation to detention paperwork. Most records were complete and included a copy of patients' rights, T2 or T3 certificate, section papers and historical section 17 leave forms. Current section 17 leave forms were in a dedicated folder on each ward. Three records were incomplete on Rose ward, information regarding who could escort and any restrictions such as alcohol were not stated.

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 trust had a central Mental Health Act administration office. Staff told us they were able to access information and guidance when required. Information was also available on the trust intranet to support staff.

Cloverleaf provided the independent mental health advocate services for York forensic services and In-Mind for Leeds forensic services. Advocates visited the wards on a weekly basis and patients told us they could also contact advocacy by telephone. Advocates were able to attend multidisciplinary team meetings, community meetings and speak individually with patients. Staff demonstrated understanding of the advocacy service and how to access these.

Good practice in applying the Mental Capacity Act

Mental Capacity Act training has been a mandatory training requirement since July 2015. Compliance rates across the service range from 60 to 70%. Two areas recorded 100% compliance. These were allied health professionals and Riverfield ward. We examined the data and this compliance rate is representative of three members of staff. The recording of staff eligible to do this training was not accurate.

Several clinical staff we spoke with had a good understanding of the Mental Capacity Act but many demonstrated basic awareness. Staff were aware of the trusts policy on Mental Capacity Act and Deprivation of Liberty Safeguards. Staff could easily access this via the trusts intranet and were confident in contacting the Mental Health Act administration office for further information.

The multidisciplinary team and clinical staff told us the assessment of capacity was completed on an individual basis when required. The recording of assessment outcomes varied. Generally the psychiatrist recorded if the patient had capacity or not but did not offer an explanation behind their assessment. Staff told us that decisions regarding capacity were not recorded in the same place, different professions recorded in different places on the electronic patient record system.

No Deprivation of Liberty Safeguards applications were made in the last 12 months for this service. One patient had informal status and all other patients were detained under the Mental Health Act.

Good

Are services caring?

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

Our findings

Kindness, dignity, respect and support

We spoke with 25 patients at the two locations that forensic services were provided. We reviewed feedback on seven comment cards and notes from two patient focus groups. One response on the comment cards was positive, five were negative and one was mixed. Feedback from patients in the focus group at Newsam Centre stated they liked staff and the hospital was good. Patients were positive about their care, felt that they were treated with respect and patients felt safe on the wards.

During the focus group meeting at Clifton House, patients raised concerns regarding their dignity not being maintained. Patients on the female wards were concerned about male bank staff undertaking observations and not always knocking on doors before entering bedrooms. We spoke with the ward manager on Bluebell ward and we were assured that at least one member of staff at night was a regular member of staff and a female carried out observations where practicable. Across the forensic service, we spoke to patients and 13 patients said staff always knocked on their door before entering.

Overall, patients reported that staff were respectful, polite and treated them with dignity. Patients were complimentary about staff attitudes. We observed positive interactions between staff and patients; mutual respect was evident in the rapport and engagement we witnessed. Patients told us “they banter with staff”; “they always go out of their way to help” and “always want the best for you.”

During our inspection, we heard a patient referred to in an inappropriate way. They were referred to as a “prisoner”. The patient was not present at this time. We discussed our concerns with the senior ward staff and we were assured that this would be addressed.

The involvement of people in the care that they receive

A multidisciplinary team undertook a pre-admission assessment for all new admissions. A multidisciplinary team is a group of doctors, nurses and other healthcare professionals. Staff would begin to build a relationship with the patient at this point. Patients told us they were introduced to the ward on arrival and given information relating to their care, treatment options and rights. Patients also received information on how to make a complaint and were informed about advocacy services. For those patients moving within services at Clifton House, staff told us they encouraged patients to visit their prospective new ward. This was to ensure a smoother transition for the patient.

We reviewed 24 patient records; all showed evidence of patient involvement and most patients confirmed they had been involved in planning their care. We observed three multidisciplinary meetings, where three patients attended. In the meeting, staff worked collaboratively with the patients and encouraged them to express their views on their care. The multidisciplinary team completed the review and updated care plans and risk assessments.

We observed a community meeting with staff and patients. Patients led the meeting, patients took responsibility for reviewing previous minutes and recording new ones. We saw evidence of joint problem solving between patients and staff in relation to ward issues. For example, patients had requested the addition of a shower hose on a tap, which created a potential ligature risk. The service had agreed to the request and mitigated any risk through individual risk assessment and care planning.

We observed a meeting between a patient and support worker to plan activities. The patient and staff member worked together to plan activities for the week, taking into account requests for section 17 leave. Patients had a choice of activities and chose what they wanted to do; this was reflected in an individual timetable. There was minimal evidence to support the recording of 25 hours per week of meaningful individual activity time. This is a requirement of NHS England.

Prior to our inspection families and carers had the opportunity to attend a focus group meeting, however nobody attended. The opportunity to involve families and carers in patients care was available through a number of forums. These included attending multidisciplinary team meetings and care programme approach meetings. The allied health professional team were proactive in engaging with patients around their views, particularly through community meetings and undertaking the carer champion role. Clinical staff undertake this role and they provide an essential link between the ward, patients and carers.

The majority of relatives we spoke with said the staff were approachable and kind. Relatives felt they were involved in their relatives care and were able to provide feedback if

Good

Are services caring?

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

they were unable to attend meetings. However, one relative said they were not happy with the lack of regular staff and felt this affected the quality of care patients received and the effectiveness of communication with relatives.

Notice boards on wards displayed detailed family and carer information. At Newsam Centre, we saw information on monthly meetings of the service user network in Leeds. Patients were encouraged to attend, participate and listen to guest speakers. This strengthened their links with the local community.

Are services responsive to people's needs?

Good

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

Our findings

Access and discharge

Before admission, patients met staff during their initial assessment. Information about the service was discussed at this time. Patients also had the opportunity to visit the ward but this was not possible for prison transfers due to Ministry of Justice restrictions. Carers also received a letter from the carers lead on the ward to provide essential information.

At Clifton House, two of the four psychiatrists worked part time and were locums. On the female wards this affected patients recovery, particularly discharge planning. Patients stated that doctors needed to get to know them and this took longer as they were part time.

The average bed occupancy over the last six months was 84%. Four wards had bed occupancy rates of more than 85%. This could potentially affect the quality of patient care due to the constant demand on the service. At the time of our inspection Newsam ward 2 male and Newsam ward 3 had the highest occupancy rates at 99% and 98% respectively. Rose ward had the lowest occupancy at only 49%, however this was because there was a temporary closure to new admissions.

There were no patients placed out of area in the last six months.

When patients had leave away from the ward, they always returned to the same bed. Leave was generally for short periods and was seen as part of the patient's recovery.

Patients were only moved between wards during an admission episode due to clinical need and presentation. For example, staff told us that one patient had recently moved due to deterioration in mental state. Following discussion with the multidisciplinary team, it was agreed this was be the best way to provide additional support.

In the last 12 months across the trust, forensic wards had the highest average length of stay of patients at 498 days. Current patients were staying an average of 570 days. Information provided by the trust showed that up to 31 March 2016 there had been one readmission within 90 days and three delayed discharges that averaged a delay of 86 days. We discussed with managers obstacles to discharge. Common themes to emerge were waiting lists, availability of appropriate placements and meeting service criteria of step down
services.

The facilities promote recovery, comfort, dignity and confidentiality

We visited all seven wards and found that all had a range of facilities including:

- clinic room
- therapy rooms
- quiet room
- activity rooms

The quality and availability of rooms was variable across the service. Issues regarding natural day light, space and multi-use of rooms were concerns raised by staff. The location of toilet facilities within the communal lounge on Newsam female ward two were undignified. Occupational therapists and other therapy staff made good use of all space available to promote health and wellbeing. We saw several information boards focussing on healthy eating, lifestyle and stop smoking initiatives.

All wards had access to quiet areas but some patients told us they preferred their own rooms to relax. All wards were able to facilitate visits for patients. Visits with children always took place off the ward. Staff showed an awareness of the needs of patients that were restricted by the Ministry of Justice.

All patients had access to a payphone. Phones were in communal areas but privacy was maintained, as phones were portable. Patients could not use smart mobile phones on the ward but they could when on leave.

All wards had an outside space that patients could access under supervision. These areas provided patients with the opportunity to relax, take part in exercise and develop an interest in gardening.

We spoke with 25 patients and examined the food menu that was rotated on a four weekly basis. There was a variety of options and this included any special dietary needs and cultural requirements. However nine patients told us the quality of the food was poor. Cooking was an important part of treatment plans and with supervision, patients were able to cook for themselves. Patients spoke positively about this experience.

Are services responsive to people's needs?

Good

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

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

Patient bedrooms were spacious and some were en suite. All patients had keys to their own bedroom. Each bedroom had a secure cupboard/locker in which patients could keep their possessions. Based on individual risk assessments, patients could access their rooms at all times during the day and night. Patients were able to personalise their bedrooms.

A seven-day activity timetable was available on each ward. Activity co-ordinators and occupational therapy staff planned a range of activities with ward staff. These included a walking group, crafts, sports and baking. Other activities were determined by individual patient need or personal interest. One patient told us they have improved their ability to budget and go shopping to purchase food and prepare meals daily. Clinical staff provided activities at the weekend. Patients complained that activities were cancelled due to a lack of staff. Clinical staff and the multidisciplinary team confirmed this. This meant patients could not always engage in productive activities as part of their recovery.

Meeting the needs of all people who use the service

Patients with physical disabilities had access to appropriate facilities. These included disabled accessible bathrooms, grab bars and mirrors were placed lower down on walls. Some bedrooms had beds in the middle of the room to allow easy access for patients that used wheelchairs. A lift was available for use at Clifton House.

Patient information leaflets were readily available on all wards. Information was available on stopping smoking, advocacy, local services and mental health problems. Staff told us information regarding medication was discussed with patients throughout their care. Access to patient information leaflets about medication was through the internet. Staff would print these off to discuss with patients. Staff used the internet to provide information in different languages. Access to an interpreter was available for patients.

Patients' spiritual needs and preferences were considered as part of the initial assessment and subsequent care planning. All wards had access to a multi-faith room for patients to use. The service had links with the local community and could access different groups to support patients' spiritual needs.

Listening to and learning from concerns and complaints

The service received eight formal complaints in the last 12 months ending 29 March 2016. Two complaints were fully or partially upheld. No complaints were referred to the ombudsman. Rose ward had the highest number of complaints with four, Bluebell had two, Newsam ward two male and female both received one. At the times of our inspection, one complaint on Bluebell ward remained under investigation.

The service received six compliments during the last 12 months. Riverfields ward at Clifton House receiving the highest number with two.

All wards displayed information on how to complain. Patients were given information on the complaints process when they were admitted to the ward. This information detailed how to make a complaint and told of the support available from the patient advice and liaison service.

The patients we spoke with said they would discuss their concerns with staff on the ward or the ward manager. Patients could also raise complaints during ward community meetings. Staff told us they would try to resolve a complaint directly with a patient at the earliest opportunity. The trust has trained nine members of forensic service staff in complaints management between May 2015 and June 2016. Staff trained included one staff nurse, two clinical lead nurses, three ward managers, two acting matrons and one psychologist.

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

Are services well-led?

Good

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

Our findings

Vision and values

The statement of purpose dated April 2016 for the trust has three goals that describe their commitment to providing excellent quality care. These were:

- People achieve their agreed goals for improving health and improving lives
- People experience safe care
- People have a positive experience of their care and support

The trust values included:

- Respect and dignity
- Commitment to quality of care
- Working together
- Improving lives
- Compassion
- Everyone counts

Staff we spoke with knew the values of the trust and felt they were relevant to their role. Ward managers told us that the new appraisal format was now value based. Staff would also discuss the values of the trust in managerial supervision and this ensures staff can link these to their practice. However, not all staff were routinely receiving supervision.

We saw staff working with colleagues and patients in a way that clearly demonstrated the trust values. Staff worked cohesively in teams during multidisciplinary team meetings and handovers. Staff engaged with patients in a caring and compassionate manner. Patients showed a mutual respect for staff.

All staff knew who their senior managers were within the trust. Contact with the senior management team was variable across the service. Staff told us ward managers and matrons were visible on the wards each day.

Good governance

The trust had adequate governance structures and this strengthened the quality of patient care. Dedicated ward managers took responsibility for the clinical governance agenda. Lead clinicians audited nursing documentation, medication charts and Mental Health Act adherence using standardised tools. Feedback regarding audit outcomes was shared with individual clinicians. This ensured that the quality of care was monitored. However, the governance structure in relation to ensuring appropriate actions were taken following incidents and lessons learned were shared across the service were not robust and did not routinely form part of team meetings.

We saw positive practice on Westerdale ward. A project was underway to examine the experience of patients following a period of seclusion. We saw the post seclusion de-brief documentation that supported this initiative. The project was ongoing and was awaiting evaluation.

The trust used key performance indicators to gauge the performance of each ward. Staff could access an online learning platform to access training and monitor their compliance. Ward managers could access the trust dashboard to monitor team performance against key performance indicators. These include but not exclusively:

- staff training compliance
- staff absence
- physical healthcare
- supervision rates
- restrictive practice
- length of stay
- discharge

However, despite the ward managers' ability to monitor performance, staff training and supervision rates remained below the trusts benchmark. The trust was aware of this and we saw evidence of service improvement plans which addressed areas of concern including the low mandatory training figures.

Ward managers told us they had autonomy and sufficient authority to run their wards. Admin support was variable across the service but recruitment was in progress.

All wards had risk registers and this information fed into the trust risk register. Ward managers were responsible for the risk register. The band seven operational managers meeting and the forensic senior management team meetings examined the risk registers. Items on the risk registered included ligature risk points and recruitment.

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.

Leadership, morale and staff engagement

The trust average sickness rate was 4%. Six of the forensic services were above this between 1 April 2016 and 30 June 2016. Staff phoned an external provider to register absence for their shift. Managers told us although they did not have to, staff would also ring the ward to inform the manager of their absence.

The forensic nurse co-ordinator managed absences on a daily basis and this involved moving staff across the wards to maintain safe staffing levels. Ward managers used bank and agency nurses to cover ongoing episodes of absence. Regular bank and agency staff were booked to maintain continuity for patients. Monitoring of absence was the responsibility of the ward manager and communicated to senior managers in service operational meetings.

There were no bullying and harassment cases at the time of our inspection. Staff had an awareness of the trusts whistle-blowing process and freedom to speak up guardian. Staff stated they could speak in person or raise concerns via the trusts intranet. Staff told us they were confident in speaking to their immediate ward managers without fear of victimisation. Morale within the teams was positive. Staff reported a cohesive working relationship with the multidisciplinary team. Teamwork underpinned this and was a positive support for joint decision making. We saw extensive mutual support within the different teams and this made a positive difference to staff.

Staff acknowledged that a lot of change had happened in the management structures across the service. One member of staff said 'We need stability and leadership but we are optimistic we can make it work.' Staff spoke highly about their teams and the ward managers.

There were opportunities for leadership development. Ward managers told us they had successfully completed leadership and management course at various levels. The service will extend this type of training to band six clinical lead nurses' to provide ongoing development opportunities.

Staff had the opportunity to feedback about services and service development. Information obtained was via supervision, appraisal and team meetings. However, access to these was not consistent. Trust staff surveys, although not specific to forensic services, also provided a platform for staff to provide feedback on the service.

Commitment to quality improvement and innovation

Each ward was committed to the safer wards programme and displayed information about the initiative. The programme aimed to minimise confrontation and promote collaborative work with patients to help improve safety for all. Each ward identified a person to lead on this.

Rose ward continued with its service improvement plan following the review of its clinical model. The trust planned to complete this by the end of December 2016.

Westerdale ward was undertaking a pilot project looking at interventions following a period of seclusion. The project aim was to provide a structure that supports the multidisciplinary team to safely explore why a seclusion event occurred, identify lessons learnt and if necessary change practice. This project was ongoing at the time of our inspection.

Between April 2015 and October 2015 four members of the forensic service team received staff recognition awards from the trust.

Clifton House and the Newsam Centre engaged in a peer review of their services. This was published in Royal College of Psychiatrists Quality Network for Forensic Mental Health services (March 2016). The trust had identified areas for improvement and ongoing development at Clifton House.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing How the regulation was not being met We found that the forensic and secure inpatient service did not ensure staff members were adequately trained in: Clinical risk Immediate life support Mental Health Act The average clinical supervision rate for forensic and secure services was 57% as of 30 June 2016, with Ward 2 female and Ward 3 at Newsam Centre having clinical supervision rates of 36% and 19% respectively This was a breach of regulation 18 (2) (a)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment How the regulation was not being met Blanket restrictions were in place for routine searching following periods of leave and access to outside space. This was a breach of regulation 13 (4) (b)

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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