Leeds and York Partnership NHS Foundation Trust

Quality Report

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

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

Core services inspected	CQC registered location	CQC location ID
Acute wards for adults of working age and psychiatric intensive care units	The Becklin Centre The Newsam Centre	RGDBL RGD03
Wards for older people with mental health problems	The Mount	RGD04
Long stay/rehabilitation wards for working age adults	Asket Centre The Newsam Centre	RGD10 RGD03
Forensic/Inpatient secure wards	Clifton House The Newsam Centre	RGDT5 RGD03
Wards for people with learning disabilities or autism	St Mary's Hospital Parkside Lodge	RGD05 RGDPL
Wards for children and young people with mental health problems	Mill Lodge	RGDY1
Mental health crisis services and health based places of safety	Trust Headquarters The Becklin Centre	RGD01 RGDBL
Integrated Community based mental health services for adults of working age and for older people	Trust Headquarters	RGD01
Community mental health services for people with learning disabilities or autism	Trust Headquarters	RGD01

Summary of findings

Specialist community mental health services for children and young people	Trust Headquarters	RGD01
Supported Living Service	St Mary's Hospital	RGD05
Yorkshire Centre for Psychological Medicine	Leeds General Infirmary	RGD08

This report describes our judgement of the quality of care at this provider. It 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.

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 services at this Provider	Requires improvement 
Are services safe?	**Requires improvement** 
Are services effective?	**Requires improvement** 
Are services caring?	**Good** 
Are services responsive?	**Good** 
Are services well-led?	**Requires improvement** 

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 Leeds and York Partnership NHS Foundation Trust overall as Requires Improvement because:

- The trust did not have robust governance arrangements in place in relation to staff training, supervision and appraisal, medication management and audit, application of the Mental Capacity Act, systems and guidance to support the application of the Mental Health Act, the delivery of seclusion, restraint and rapid tranquilisation in line with the trust policy, accurate and contemporaneous records, the timely reporting of incidents, the crisis assessment unit's service provision, policies and procedures being sufficiently embedded. The trust did not have a systematic approach in place with regard to the documentation required to assure themselves, or the Care Quality Commission, that the directors met the fit and proper person requirement, regulation 5 of the Health and Social Care Act (Regulated Activities) Regulations 2014.
- Systems and guidance were either not in place, not sufficiently embedded, or not operated effectively to ensure the delivery of safe and quality care. Incidents were not reported to the National Reporting and Learning System in a timely way and systems were not robust enough to ensure that incidents were reported to the trust from some services, including the supported living service and the forensic and secure inpatient services. The trust did not always meet its own targets or those agreed with the commissioners, for example the clustering targets. The trust did not return the data requested by the Care Quality Commission during the inspection in a timely way. Records were not always accurate and contemporaneous and did not always include all decisions about patient's care and treatment within their care record.
- The provider failed to ensure that all people receiving a service were protected from potential harm because the emergency equipment and medication checks were not sufficiently robust on some wards, including the inpatient wards for older adults and the long stay and rehabilitation wards, where items were out of date or missing and equipment like blood glucose testing meters were not being recalibrated. The trust compliance was low for training courses including essential life support, intermediate life support, and safeguarding children level two and three. The low compliance with essential and immediate life support meant that the service could not guarantee that all staff could respond to patients in a medical emergency.
- We had concerns about the management of medicines in some settings. Medicines across the trust were not being stored at the correct temperatures to remain effective. Staff in many of the clinical areas throughout the trust were not monitoring ambient room temperatures and where they were, temperatures were exceeding the room temperature recommended by the World Health Organisation guidelines. Staff in clinical areas were either not recording the fridge temperatures or not always taking action when temperature readings were outside of the required range. The internal audit systems were not always sufficiently robust to identify missed doses or other medication issues and errors in some services.
- The trust did not ensure that staff received appropriate training, supervision and appraisal. The trust had not met its target of 90% compliance for appraisals and some services had low compliance. The trust compliance for clinical supervision was low across the trust except for the mental health services for children and young people.
- Compliance in the mandatory level two Mental Health Act community and inpatient level two training was low and five teams or services had below 75% compliance in the Mental Capacity Act training, including Deprivation of Liberty Safeguards. The application of the Mental Capacity Act in some services was not in line with the trust policy or the Act and the trust did not always ensure that patients who did not have the capacity to consent to their care and treatment were detained using the appropriate legal authority such as by Deprivation of Liberty Safeguards. The systems and guidance in place did not fully support, or ensure, the application

of the Mental Health Act across the trust and the code of practice was not sufficiently embedded across all the services or detailed in the trust policies.

- Not all ward environments were safe or clean. There were concerns in relation to the trusts management of mixed sex environments and maintaining the patients' dignity and privacy at three of the inpatient services we visited including the Yorkshire Centre for Psychological Medicine, Two Woodland Square and the crisis assessment unit. We did not accept that the Yorkshire Centre for Psychological Medicine met the requirements of the Department of Health guidance on same sex accommodation (2010), or the Mental Health Act code of practice at the time of the inspection. The provider had outstanding actions on the trust's reducing restrictive interventions action plan and the use of seclusion; restraint and rapid tranquilisation were not always completed in line with the trust policy. In the community services systems were not in place in all services to manage risk effectively. This was in relation to supporting patients whilst they were on the waiting lists to access the service, managing the premises, and employing sufficient lone working systems to protect staff and patients. Also, there were delays above 20 weeks for patients to access some psychological therapies identified in the integrated community services for working age adults and older adults with mental health problems.

However:

- The community services that supported deaf and hearing impaired children and young people, as well as children and young people with mental health problems whose family had hearing impairments, was rated as an outstanding service.
- The trust was committed to improving and developing its services, using information from the local population and through working in partnership with the commissioners, other statutory, third-sector and voluntary organisations. Patient involvement appeared to be embedded in the trust's approach to shaping its services and informing care and treatment. It had a well-established service user network and involved patients in research projects, delivering training and recruitment.
- The trust had implemented a new recruitment strategy in 2016 and had implemented a number of measures to attract new staff to work in the trust. It had successfully recruited newly qualified and experienced staff through its recruitment events and its work with the universities, using values based recruitment. Whilst there continued to be regular use of bank and agency staff across the trust, the staff used were either substantive staff who worked extra shifts, or staff who worked regularly in particular areas but who chose not to take substantive posts to ensure the continuity of care for patients. Staff were respectful, caring and compassionate towards patients, relatives and carers and mindful of the best way to communicate with patients in order to support them.

  The trust did not own all the premises it delivered care or treatment from. It had identified this as one of its strategic risks and was committed to improving working arrangements with its private finance initiative partners and NHS Property Services Ltd, to improve response times for maintenance and repairs and the overall management of its estate. The trust had completed a significant amount of work in relation to the identification and removal or mitigation of ligature risks across all its wards and services. They had robust systems in place to assess, report and communicate any ligature risks, supported by the trust's ligature risk procedure.
- In the majority of services and teams, comprehensive assessments were completed using recognised assessment tools, care plans were holistic and person centred, risk was assessed and addressed. Staff produced different versions of care plans in accessible formats, for example in the community services for deaf children and adolescents and the community services for learning disabilities or autism. Care and treatment was delivered by a multidisciplinary team and was reviewed regularly. Patients told us that they were involved in their care and most of the patients spoken to during the inspection told us they could have a copy of the care plan if they wanted one.
- A range of information was available to patients in accessible and appropriate formats for the patients in the wards or services. The trust had a robust and

Summary of findings

effective complaints process and almost all the wards and services we visited during our inspection demonstrated a positive culture of reporting complaints and learning from complaints. Patients knew how to complain if they wanted to and were supported to do so.

Summary of findings

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

We always ask the following five questions of the services.

Are services safe?

Requires improvement

We rated Leeds and York Partnership NHS Foundation Trust as requires improvement for safe because:

- The emergency equipment and medication checks were not sufficiently robust on some wards, including the long stay and rehabilitation wards, where items were out of date or missing. Equipment like blood glucose testing meters were not being recalibrated.
- The trust could not provide assurance that medicines were being stored at the correct temperatures to remain effective. Staff in many of the clinical areas throughout the trust were not monitoring ambient room temperatures and where they were, temperatures were exceeding the room temperature recommended by the World Health Organisation guidelines. Staff in clinical areas were either not recording the fridge temperatures or not always taking action when temperature readings were outside of the required range.
- The trust compliance was low for mandatory training courses including essential life support, moving and handling advanced, food safety level two, fire level three, intermediate life support, safeguarding children level two and three. This placed patients at risk of receiving care that was unsafe. The low compliance with essential and immediate life support meant that the service could not guarantee that all staff could respond to patients in a medical emergency.
- The ligature cutters were not readily available for all staff in an emergency on the inpatient wards for people with learning disabilities or autism and the crisis service were kept in the locked medication room or clinic room.
- The wards for patients with learning disabilities or autism' including the respite services and the psychiatric intensive care unit, were not clean and maintenance issues had not been attended to. Infection control principles in these services were poor and compliance in a number of services across the trust for the mandatory infection control training was below 75%.
- There were concerns in relation to the trusts management of mixed sex environments and maintaining the patients' dignity and privacy at three of the inpatient services we visited including the Yorkshire Centre for Psychological Medicine, Two Woodland Square and the crisis assessment unit. We did not

Summary of findings

accept that the Yorkshire Centre for Psychological Medicine met the requirements of the Department of Health guidance on same sex accommodation (2010), or the Mental Health Act code of practice at the time of the inspection.

- Concerns were identified in the seclusion facilities, the high dependency rooms and de-escalation rooms at the Newsam Centre, Mill Lodge and Parkside Lodge. Issues were identified with the local working protocols to support staff in their decisions to seclude patients and the rooms themselves did not fully meet the requirements of the Mental Health code of practice.
- Actions on the reducing restrictive interventions action plan remained outstanding. As such, restraint incidents, including prone restraint, remained high and the staff were not always operating within the trust policy. Staff on Parkside Lodge told us that they always used prone restraint to give medication via an injection when a patient refused it, which was not in line with the trust rapid tranquilisation policy.
- Blanket restrictions were identified in some inpatient services including the observation procedures on the acute wards and psychological intensive care unit and the routine searches following unescorted leave on the forensic and secure wards. A blanket restriction is a rule that applies to all patients on a ward and restricts their freedom regardless of individual risk assessments.
- Caseloads were high in the integrated community services for older age adults and working age adults with mental health problems and teams did not actively manage the risk for patients waiting to access the service. They relied on information from referring services, patients, relatives or carers to inform them of any escalating risk.
- In the community services for adults with mental health problems the lone working procedure could not always guarantee the safety of the staff.
- The timely reporting of incidents to the National Reporting and Learning System and the commissioners remained a risk for the trust and we identified that reporting incidents was a concern in both the supported living service and the forensic and secure inpatient services.

However:

- The trust was committed to improving its estates and response times and the management of its estate was included in its strategic objectives.

Summary of findings

- The trust had completed a significant amount of work in relation to the identification and removal or mitigation of ligature risks across many of its wards and services. They had robust systems in place to assess report and communicate any ligature risks, supported by the trust's ligature risk procedure. Wards had completed ligature risk and environmental audits and identified ligature points. Risk assessments were in place to mitigate these risks.
- Almost all wards and community services had either fixed call points or access to personal alarms to summon assistance in an emergency. Where alarms were not in place, the needs for these were mitigated.
- The senior executives and non-executive directors recognised staffing as one of the key risks for the organisation. The trust had implemented a successful recruitment strategy in 2016 to attract candidates and raise the profile of the organisation, including both experienced staff and newly qualified staff. The trust's recruitment plan targeted the roles and services where there was the highest number of vacancies. The trust also had a safer staffing task and finish group to lead on all issues related to safer staffing and dashboard including safer staffing figures was available at ward level.
- Whilst the use of bank and agency staff was high across the trust, bank staff were either substantive staff who worked extra shifts or staff who worked regularly in particular areas but who chose not to take substantive posts. This ensured a continuity of care for the patients.
- All wards and services reported good access to consultant psychiatrists, specialist doctors and junior doctors as required meeting the patients' needs in a timely way.
- Risk assessments were in place in all services and reviewed regularly at all services except the respite services.
- Although there was low compliance with safeguarding children training, staff were clear about the procedures to follow for both adult and child safeguarding and knew how to access safeguarding guidance.

Are services effective?

We rated Leeds and York Partnership NHS Foundation Trust as requires improvement for effective because:

Requires improvement

Summary of findings

- Care records in the respite services at Woodland Square for patients with a learning disability or autism had not been reviewed for significant periods and did not always identify the patients' needs whilst at the services. The care plans at these services did not always contain health action plans.
- Patient records were not always accurate and contemporaneous and did not include all decisions about patient's' care and treatment within their care record. The use of paper records as well as electronic records could cause confusion for the wider teams accessing the system, as the most up to date information may not be held in the central electronic record.
- The inpatient wards for older people with mental health problems did not use any standardised occupational therapy tools to measure interventions and outcomes. Staff in the crisis assessment unit were unclear of the National Institute of Health and Care Excellence guidance that would apply to the service.
- The internal audit systems were not always sufficiently robust to identify missed doses or other medication issues and errors were identified in the supported living service, on the inpatients wards for older people with mental health problems and the inpatient wards for patients with learning disabilities or autism.
- There were no robust systems in place to ensure that the physical health monitoring for antipsychotic medication was completed. There was a lack of clarity regarding who should take responsibility for ensuring that these physical health checks were completed.
- The trust average clinical supervision rate as of the 30 June 2016 was 70% and was below 50% in some services, including the Yorkshire Centre for Psychological Medicine, Parkside Lodge and Three Woodland Square and the inpatient wards for older adults with mental health problems.
- The appraisal rate for the trust as of the 30 June 2016 was 82% and did not meet the trust target of 90%.
- Compliance in the mandatory level two Mental Health Act community and inpatient level two training for the trust were also below 75%. Five teams or services had below 75% compliance in the Mental Capacity Act training, including Deprivation of Liberty Safeguards.
- We found that second opinion appointed doctors were not requested in a timely manner in some cases when the three

month rule was approaching. This means other authority, such as treatment in an emergency, needed to be used. Section 62 authorises treatment in an emergency and was used widely throughout the trust.

- We found some issues with the documenting of section 132 rights, including on the wards for older people and in the crisis and health based place of safety.
- We found delays in identifying errors with detention documents, despite the systems to receive and check Mental Health Act documentation and the internal audits to identify errors that were in place. This could result in patients being deprived of their liberty without the legal authority.
- Patients in the respite services for patients with learning disabilities and autism did not have capacity to consent to their respite care and treatment and were subject to continuous supervision and control and were not allowed to leave. The services had carried out capacity assessments but had not made applications for Deprivation of Liberty Safeguards. These safeguards are a lawful requirement to ensure the service upholds the human rights of patients. Staff on the acute wards and the wards for older people with mental health problems, were unclear about their responsibilities under the Mental Capacity Act and were not adhering to the trust policy.

However:

- In the majority of services and teams, comprehensive assessments were completed using recognised assessment tools and care plans were holistic and person-centred and were reviewed regularly.
- Staff followed guidelines from the National Institute of Health and Care and Excellence when providing care and treatment, including for prescribed medication and psychosocial interventions.
- There was a comprehensive audit programme across the trust and in the teams and services we inspected and the trust pharmacy team completed a number of medicines related audits to assess quality and to assist in the identification of areas for improvement.
- All teams consisted of a wide range of disciplines, included consultant psychiatrists and junior doctors, nurses and health

Summary of findings

support workers, occupational therapists and regular input from pharmacy. Other professionals were engaged as required. Regular team meetings took place in all teams and services and all members of the multidisciplinary teams attended these.

- There were good examples of integrated partnership working and local partnership arrangements between the trust and other agencies, as well as between internal trust services.
- Staff and patients told us there was good access to independent mental health advocates.

Are services caring?

Good

We rated Leeds and York Partnership NHS Foundation Trust as good for caring because:

- Staff were respectful, caring and compassionate towards patients, relatives and carers. Patients, relatives and carers told us that staff were kind, visible and approachable.
- Staff were mindful of the best way to communicate with patients in order to support them. Communication was appropriate to the patients' level of understanding or appropriate to their age.
- We observed examples on the wards and during home visits where staff maintained patients' dignity, privacy and confidentiality. The trust scored higher than the England average on the patient led assessment of the care environment for privacy, dignity and well-being.
- Patients were orientated to all wards and services and were involved in decisions around their treatment and care. Where patients were unable to attend multidisciplinary meetings directly, their views and opinions were communicated in other ways.
- Patients told us that they were involved in their care plans and most of the patients we spoke with during the inspection told us they could have a copy of the care plan if they wanted one. Staff produced different versions of care plans in accessible formats, for example in the community services for deaf children and adolescents and the community services for learning disabilities or autism.
- We observed good examples of patient involvement in the service. Patients were involved in the central recruitment of staff and volunteers had been recruited in the intensive community services and the community services for working

age adults and older age adults with mental health to support and engage patients. A patient in the Leeds Autism Diagnostic Service was involved in the training videos to explain their experiences of living with autism.

- Staff supported patients to use advocacy services and the wards and services we inspected had established good links with adult advocacy services.
- Patients were able to feedback on the majority of wards through weekly community or forum meetings on the inpatient wards. Whilst staff, patients, relatives and carers all found collecting and providing feedback more of a challenge in the community services, there were some proactive initiatives to gain feedback in these services, including the use of electronic devices to gather patient experiences.

However:

- We heard patients detained with Ministry of Justice restrictions referred to in an appropriate way.
- On the inpatient wards for children and adolescents with mental health problems, the advocacy services offered by the trust were not specifically for children and adolescents.
- There were no patient meetings at the respite services for people with learning disabilities or autism. This meant that opportunities for patients to feedback about their stay were limited.

Are services responsive to people's needs?

Good

We rated Leeds and York Partnership NHS Foundation Trust as good for responsive because:

- The trust used information about the local population when planning and delivering services through working in partnership with the commissioners, other statutory, third-sector and voluntary organisations. These stakeholders told us that the trust was 'aspirational' and 'forward thinking' with regard to new ways of working to deliver care and treatment.
- Bed occupancy and high numbers of out of area placements for the trust had been identified as strategic risks by the trust and the trust had implemented a bed management improvement plan, including a number of initiatives like piloting the proactive purposeful admissions to inpatient care model. At the time of the inspection, the trust had nine patients placed out of area.

Summary of findings

- The trust worked proactively and in partnership with other organisations and community services at all levels to reduce the number of patients delayed in being discharged and the number of days that patients are delayed by.
- Information on the wards and services, other local services, patients' rights, access to advocacy, medicines and treatment and how to complain was observed in almost all services. The information was in appropriate and accessible formats, for example in child friendly formats in the mental health services for children and young people and in easy read formats in the services for people with learning disabilities or autism.
- Patients were able to personalise their bedrooms on the wards and in the respite services and were encouraged to do so. They had access to lockable storage.
- Patients on the wards were able to make phone calls in private.
- Patient's individual needs and preferences were central to the planning and delivery of treatment and care at the trust. Staff respected and provided support to meet the diverse needs of their patients including those related to disability, ethnicity, faith and sexual orientation. Staff in all the services we inspected were respectful of people's cultural and spiritual needs.
- Since the last CQC inspection in 2014, the trust committed to improving its response to the complaints it received. There was a robust and effective complaints process. Almost all the wards and services we visited during our inspection demonstrated a positive culture of reporting complaints and learning from complaints and had local arrangements to discuss these in their team meetings.

However:

- There were delays for patients in the community services for working age adults and older adults with mental health problem to access some psychological therapies. Patients waited for up to 20 weeks to receive psychological therapy from a psychologist.
- Parkside Lodge, the inpatient ward for people with learning disabilities and autism, had reduced bed occupancy due to staffing concerns and so a bed was not always available for the local population. There was no bed management strategy and the bed management procedure was at the early stages of discussions.

Summary of findings

- There was a lack of clarity of the current service provision in the crisis assessment unit at the time of the inspection. Patients were admitted who required treatment and not extended assessments, which the unit was not currently equipped for. Staff in the unit and in other trust wide services were unclear of the role of the crisis assessment unit, including the referral criteria.
- The crisis assessment service was not regularly meeting the four hour target for response times for crisis assessments.
- The Section 136 suite for children and young people was formerly the service's Section 136 suite for adults. Although the suite was designated for children and adolescents, we did not note any specific adaptations to make it a child-centred environment.
- Staff and carers raised concerns that patients at 2 Woodland Square were unable to attend activities that were not pre-planned and part of the patient's normal routine prior to attending the respite service. They told us that this was due to staffing levels, the lack of a mini-bus driver, and the lack of access to specially adapted transport. The trust told us that activities were available for all patients and that appropriate transport could be arranged
- Access to the outside space and the outside environment itself was a concern at The Mount and the Becklin Centre. Not all the wards at these sites had direct access to the gardens and outside areas and patients were unable to access these unescorted. The paths in the garden at The Mount where the wards for older adults with mental health problems were situated were gravel and therefore not ideal for patients with limited mobility and those who needed to use mobility aids. Patients were smoking in the hospital grounds and wards at the Becklin Centre. This put staff and patients at risk of the effects of passive smoking.
- There was limited choice on the inpatient wards for children and young people with mental health problems for patients' dietary requirements relating to their culture or religion, or to meet their preferences for food. Patients on these wards and the forensic wards told us that they did not like the food.

Are services well-led?

We rated Leeds and York Partnership NHS Foundation Trust as requires improvement for well-led because:

Requires improvement

Summary of findings

- The trust did not have robust governance arrangements in place in relation to staff training, supervision and appraisal, medication management and audit, application of the Mental Capacity Act, systems and guidance to support the application of the Mental Health Act, the delivery of seclusion, restraint and rapid tranquilisation in line with the trust policy, accurate and contemporaneous records, the timely reporting of incidents, the crisis assessment unit's service provision, policies and procedures being sufficiently embedded.
- Staff in some services and teams reported that senior managers were not always visible; including staff in the supported living service, the inpatients wards for older people and the respite services for people with learning disabilities or autism reported that this was not the case. Also, at the time of the inspection, the non-executive directors or the board of governors did not gain additional assurance from visiting the services discussed at board level.
- Senior managers told us that quality improvement methodology was not always applied consistently.
- The trust was unable to provide data requested during the inspection in a timely way and some of the data we received conflicted with previous data provided, and with the views of some clinical teams.
- The trust did not always meet its own targets and those agreed with the local commissioners, for example their own appraisal target and the required clustering targets agreed with commissioners.
- The trust did not have a systematic approach in place with regard to the documentation required to assure themselves, or the Care Quality Commission, that the directors met the fit and proper person requirement, regulation 5 of the Health and Social Care Act (Regulated Activities) Regulations 2014.
- The trust had not updated all the polices following the updating of the Mental Health Act code of practice and there was no overall plan detailing how the trust was implementing the changes to the code. Senior management did not have a good understanding of which policies required updating or which one's had been reviewed and updated. This meant it was difficult for staff to know if their practice was in line with the revised code of practice and as such patients' rights may not be upheld.

However:

Summary of findings

- The trust had adapted their recruitment process to include values based recruitment and recently adapted the appraisal process to include the behavioural aspects that demonstrate the trust values. Most staff were aware of the trust's vision and values.
- The trust complied with the duty on public bodies to publish equality objectives. The objectives were developed collaboratively with the community and other stakeholders and priority actions were identified. The trust recognised that the experience of black minority ethnic staff members was an important challenge and had introduced a Workforce Race Equality Standard Ideas and Implementation Group and worked with the Yorkshire and Humber Equality and Diversity Leads Network to work collectively on priority areas for action and to share best practice.
- The trust worked proactively to address sickness and had introduced additional sources of support for the most common reasons for absence.
- The trust held an annual nursing conference, which offered development and networking opportunities for nursing staff across the trust. Staff achievements, linked to trust values were recognised through a monthly 'STAR' awards and an annual awards celebration.
- The trust was committed to working with people who use services to inform treatment and care and shape their services. It had a well-established service user network and involved patients in research projects.
- The trust participated in national audits and national quality improvement programmes in some of its services, including accreditation schemes and peer review. It was committed to research and the development of care and treatment and also worked in collaboration with the local universities to develop its workforce and to create training courses.

Summary of findings

Our inspection team

Our inspection team was led by:

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

Head of Hospital Inspection: Nicholas Smith, Care Quality Commission

Team Leaders: Kate Gorse-Brightmore, Inspection Manager, mental health services, Care Quality Commission

The team included CQC inspectors and a variety of specialists: experts by experience who had personal experience of using or caring for someone who uses the type of services we were inspecting, consultant psychiatrists, Mental Health Act reviewers, social workers, pharmacists, registered nurses (general, mental health and learning disability nurses), psychologists, occupational therapists and senior managers.

Why we carried out this inspection

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

How we carried out this inspection

To get to the heart of 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 the inspection team:

- Requested information from the trust and reviewed the information we received.
- Asked a range of other organisations for information including Monitor, NHS England, clinical commissioning groups, Healthwatch, Health Education England, Royal College of Psychiatrists, other professional bodies and user and carer groups.
- Sought feedback from patients and carers through attending 14 detained patient and carer groups and meetings.
- Received information from patients, carers and other groups through our website.

During the announced inspection visit from the 11 July to 15 July 2016 the inspection team:

- Visited 41 wards, teams and clinics.
- Spoke with 166 patients and 72 relatives and carers who were using the service.
- Collected feedback from 107 patients, carers and staff using comment cards.
- Spoke with more than 44 ward and team managers, modern matrons, community clinical managers or service managers.
- Spoke with more than 293 staff, including doctors, nurses, health support workers, consultant psychiatrists, dieticians, speech and language therapists, teachers, junior doctors, physiotherapists, psychologists, psychotherapists, occupational therapists, occupational assistants, student nurses, social workers, care co-ordinators, pharmacists and a pharmacist technician, independent mental health act advocates, administrators, administration support workers, healthy living workers and activity co-ordinators.
- Attended more than 19 focus groups attended by staff.
- Interviewed over 40 senior staff and board members.
- Attended and observed over 57 hand-over meetings, multidisciplinary meetings and reviews.
- Joined care professionals for 40 home visits, clinic appointments and observations.
- Looked at over 217 care and treatment records of patients.

Summary of findings

- Carried out a specific check of the medication management across a sample of wards and teams, including 141 medication charts and records.
- Looked at a range of policies, procedures and other documents relating to the running of the service.
- Requested and analysed further information from the trust to clarify what was found during the site visits.
- Observed a board meeting.

Information about the provider

Leeds Partnerships NHS Foundation Trust was awarded NHS foundation trust status on 1 August 2007. It merged with the mental health and learning disability services from NHS North Yorkshire and York on 1 February 2012, becoming Leeds and York Partnership NHS Foundation Trust.

As of 1 October 2015 the trust continue to provide specialist mental health and learning disability services in Leeds However, following a re-tender exercise the trust now only provide the specialist services in York, including forensic services and inpatient wards for children and young people with mental health problems. The remaining mental health and learning disability services in York are now delivered by Tees, Esk and Wear Valley NHS Foundation Trust.

The trust works closely with related organisations to provide effective, accessible and modern mental health and learning disability services.

The trust provides the following core service:

- Acute wards for adults of working age and psychiatric intensive care units.
- Long stay/rehabilitation mental health wards for working age adults.
- Forensic inpatient/secure wards.
- Wards for older people with mental health problems.
- Wards for people with learning disabilities or autism.
- Wards for children and young people with mental health problems.
- Mental health crisis services and health-based places of safety.
- Specialist community mental health services for children and young people.
- Community-based mental health services integrated for older people and adults of working age.
- Community mental health services for people with learning disabilities or autism.

In addition the trust also provides supported living services, eating disorder services, perinatal services, gender identity services and psychology and psychotherapy services. The trust delivers holistic care for people with complex medically unexplained symptoms and physical - psychological comorbidities at its Yorkshire Centre for Psychological Medicine. It also provides substance misuse services as part of the consortium Forward Leeds.

The trust delivers services from 39 locations and has 424 beds and has a turnover of £167 million. It employs a total of 2,547 substantive staff in both clinical and non-clinical support services. It also employs 465 bank staff.

As of the 1 June 2016, the trust had 10 active locations registered with the CQC, serving mental health and learning disability needs. These locations in Leeds include the Asket Centre, Parkside Lodge, St Mary's Hospital, The Becklin Centre, The Mount, The Newsam Centre, Trust Headquarters and the Yorkshire Centre for Psychological Medicine (previously known as Ward 40). The locations in York include Clifton House and Mill Lodge.

The trust had a comprehensive inspection between 30 September and 2 October 2014 where it was rated as 'requires improvement' overall. In this inspection, four of the five domains were deemed as 'requires improvement'. These were safe, effective, responsive and well led with caring rated as good. We issued 21 compliance actions in the inspection against seven locations. The provider took steps to respond to these actions. However, as of the 27 June 2016, there were still a number of actions that were only partially complete, including the trust achieving its own target for mandatory training and appraisal, the relocation of the Yorkshire Centre for Psychological Medicine and the final agreement of the contract with local clinical commissioning group to ensure that patients in the low secure setting have timely access to a GP.

Leeds and York Partnership NHS Foundation Trust has had 17 Mental Health Act reviewer visits between 1 June 2015 and 1June 2016, of which all were unannounced. The main issues highlighted were in the 'purpose, respect

Summary of findings

participation, least restrictive' category. This had 16 issues and equated to 33% of the total concerns. This category included concerns that the care plans were not completed in collaboration with the patient and did not reflect the patients' goals or views and patients were unsure of their rights and these were not been repeated on a regular basis. Concerns were highlighted in the 'leave of absence domain' with eight issues highlighted. This was 16% of the total concerns. Three quarters of the issues in this domain attributed to section 17 leave forms not being completed to evidence of the patient and relevant others had been given a copy of their form. Ward one at the Becklin Centre (the acute ward) and ward one at the Newsam Centre (psychiatric intensive care unit) had the most issues in a single visit, with five each.

What people who use the provider's services say

We received 107 comments cards during the inspection, of which 28 were positive and 15 were negative. The positive comments from patients we received included feedback that staff were nice, kind, helpful and go that extra mile. Patients felt that they were treated with dignity and respect. They said that service was good and the environment was safe. Patients also said that the food was good. Negative feedback on the comment cards included patients feeling too restricted, that medication was not always available and that patients were smoking on the wards.

We spoke with over 166 patients and 72 relatives and carers. On the whole feedback was positive from patients, relatives and carers.

Patients told us that the treatment and care they received was good and that they felt safe in the services and on the inpatient wards. They told us that they felt involved in the decisions about their care and treatment and their recovery, including any changes. Patients told us that they were aware of their care plan and were offered copies. Most patients thought the food was good. Patients knew how to complain and would feel comfortable approaching staff to do so.

Patients, relatives and carers told us that staff were supportive and empathic. They said that staff were approachable and kind and treated them with dignity and respect. They said that staff took the time to listen to them and were calm in a crisis or a difficult situation. Patients told us that staff were flexible in their approach, considered their opinions, thoughts and feelings and aimed to support them in the best way that suited them.

Carers were generally complimentary about the staff and the wards and services. They said that wards and teams worked closely to support families as well as patients. They told us that staff included them in decisions about their care and treatment. Patients and carers told us they could contact the team or ward and speak to staff promptly. Some carers confirmed that they were involved in the patient treatment decisions and care plans, received copies of care plans, as well as any information requested. Relatives and carers said that they felt their family member was safe and received high quality care. They also felt that they were supported with and involved in, their family member's discharge from treatment.

There was some negative feedback from patient and carers, which was specific to individual services, relating to food, staffing at night, involvement in leave decisions and transport for patients to activities.

Good practice

- The Leeds autism diagnostic service completed assessments and diagnosis for some patients in additional languages. Where patients' spoken language was not English the teams had completed assessments in the language spoken by the patient. Staff had completed assessments in Shona and Persian to accommodate the needs of patients as an alternative to using interpreter services.

Summary of findings

- The Yorkshire Centre for Psychological Medicine won a trust award for improving health and improving lives in 2015. The service was a very good example of how positive outcomes can be achieved using the bio-psychosocial model.
- The rehabilitation and long stay inpatient wards for people with mental health problems had introduced individual digital tablets to patients. The tablets contained an 'I' motif and allowed patients to take more control over their care through a platform that enabled communication with their clinician. This was launched in January 2016 and each patient could keep the tablet they used. They could also use it for the internet as Wi-Fi was available. This meant the patient could keep in touch with their friends and family.
- A Person Centred Recovery course has been developed in collaboration with Leeds Beckett University. Clinicians from the service deliver this training. It is open and free of charge to employees of the trust and their partner organisations. Patients are helping deliver this training.
- Staff were able to access a personal health budget to manage the health of the inpatients on the rehabilitation and long stay wards for people with mental health problems. This is a pilot and involvement is agreed as part of the multidisciplinary team. As an example, a patient with self-esteem issues due to their appearance was able to access this money to get some dentistry work done to their teeth.
- The rehabilitation and long stay inpatient services for people with mental health problems was involved in a Photo Elicitation Research Project. Once a participant has been assessed and accepted in to the research group, they were encouraged to take photographs to help them express their experience of being a patient. The aim of the research was to improve the understanding of the experience of the patient
- The culture within the community mental health services for deaf children and young people was to deliver research-based practice to young people and their families. The teams used their meetings to reflect on their practice in ways that fed into service development. Team members spoke of feeling valued and being proud to work within the specialist service that had a culture that encouraged all staff to work together and further develop expertise.
- Team members in the community mental health services for deaf children and young people consistently tailored interventions to meet the communication needs of young people and their families. This meant the development of bespoke care tools for individual sessions. Service information contained quick response codes (machine-readable codes consisting of an array of black and white squares, used for storing information) that allowed documents to be scanned into smartphones enabling access to British sign language.
- The community mental health service for children and young people were embedded in the deaf communities it served with links that were both professional and social. This had broken down barriers and reduced stigma for deaf users of the child and adolescent mental health teams. Supervision and support were available to and accessed by all staff in these services, including the freelance interpreters who worked with the teams.
- The forensic and secure services for people with mental health problems at Clifton House engaged in a peer review of its services, which was published in Royal College of Psychiatrists Quality Network for Forensic Mental Health services in March 2016. They also undertook a clinical service review of Rose ward and had implemented an action plan to improve its services for women with personality disorder.
- The trust had implemented a pilot project using the 'purposeful admissions to inpatient care' model on the acute wards for adults with mental health problems. This meant that staff regularly monitored the patient journey. The 'purposeful admissions to inpatient care' reduced the time staff needed to spend in the multidisciplinary process therefore freeing up time to spend with patients.

Summary of findings

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that the governance systems are established to assess, monitor, and improve the quality and safety of the service, and manage risk, operate effectively and are embedded in the service.
- The provider must ensure that the systems and processes in place with regard to the documentation that confirms that the directors meet the fit and proper person requirement, regulation 5 of the Health and Social Care Act (Regulated Activities) Regulations 2014, provides assurance to themselves and the Care Quality Commission.
- The provider must ensure all its services comply with the Department of Health guidance on same sex accommodation and the code of practice.
- The provider must ensure that incidents are identified and reported in teams and services across the trust and that the systems are in place to enable them to do so.
- The provider must ensure that they respond to requests for information from the Care Quality Commission and report all incidents to the national reporting and monitoring systems, in a timely way.
- The provider must ensure that records are accurate and contemporaneous, including all decisions about patient's care and treatment within their care record.
- The provider must ensure that the emergency equipment and medication checks are sufficiently robust to ensure that equipment for providing care and treatment is safe for use and are in sufficient quantities to ensure the safety of service users and meet their needs.
- The provider must ensure that they monitor fridge and ambient room temperatures and ensure that medicines are stored at the correct temperatures to remain effective.
- The provider must ensure that physical health monitoring of antipsychotic medication is completed in line with the National Institute of Health and Care Excellence guidelines and clarify responsibilities.
- The provider must ensure that all staff have sufficient training, supervision and appraisal to enable them to carry out their role.
- The provider must ensure internal medication audit systems are sufficiently robust.
- The provider must ensure staff have a good understanding of the Mental Capacity Act and their responsibilities under the Act and those patients are detained using the appropriate legal authority such as by Deprivation of Liberty Safeguards.
- The provider must ensure that the systems and guidance in place supports the application of the Mental Health Act and ensures that the code of practice is sufficiently embedded across all the services and detailed in the trust policies.

Action the provider SHOULD take to improve

- The provider should ensure that the outstanding actions on the trust's reducing restrictive interventions action plan are addressed and that the use of seclusion, restraint and rapid tranquilisation are in line with the trust policy.
- The provider should ensure that they continue to build on the existing work completed to continue to reduce bed occupancies and out of area placements.
- The provider should ensure that patients have a choice of meals that meet their dietary requirements and take into account cultural and individual preferences.
- The provider should ensure that patients have access to advocacy that is relevant to their specific requirements.
- The provider should ensure that the community services have systems in place to manage risk effectively with regard to supporting patients whilst they are on the waiting list, managing the premises, and employing sufficient lone working systems to protect staff and patients.
- The provider should ensure all patients receive psychological therapies in a timely manner and within national guidelines.

Summary of findings

- The provider should ensure that all inpatient wards are clean and that ligature cutters are easily accessible in an emergency.
- The trust should consider privacy and dignity with regards to gender of patient in all its services including the section 136 suite and crisis assessment unit, and the respite services.

Leeds and York Partnership NHS Foundation Trust

Detailed findings

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 compliance for the mandatory training in the Mental Health Act level level one and two overall was 76%. At service level training compliance ranged and ranged from 41% in wards for older people to 89% in specialist community deaf child and adolescent mental health service. However, staff generally understood their responsibilities under the Mental Health Act and how it related to their service.
- The trust had a central Mental Health Act legislation team based at the Beklin Centre who provided support for Mental Health Act, Mental Capacity Act and Deprivation of Liberty Safeguards to the wards and community. The team supported training, detention documentation and advice.
- The revised Mental health Act code of practice came into effect in April 2015.The trust had not updated all of its polices in relation to the updated Mental Health Act code of practice and there was no overall plan detailing how the trust was implementing the changes to the code.
- Consent to treatment under the Mental Health Act was generally well documented in the patients' records except for some inpatient wards where capacity to consent to treatment assessments and treatment certificates were not fully completed. This meant that the patients' capacity and consent to treatment and was not clear and treatment may be given without the appropriate consent.
- Second opinion appointed doctors were not requested in a timely manner in some cases when the three month rule was approaching. The trust had not implemented a system to monitor the use of section 62 authorisation.
- Rights under the Mental Health Act were explained to patients on admission and revisited when required at regular intervals. There were also information leaflets available in easy read and other languages, which staff used. We found some gaps in the documenting of this process.
- We saw evidence that patients had access to appeals against their detention.
- Staff and patients told us there was good access to independent mental health advocates and patients were able to refer themselves or be referred by staff.

Mental Capacity Act and Deprivation of Liberty Safeguards

- Compliance for the mandatory training on the Mental Capacity Act and Deprivation of Liberty Safeguards was 76%. We had concerns that five teams or services had below 75% compliance in the Mental Capacity Act training, including Deprivation of Liberty Safeguards, including the wards for older adults with a mental

health problem which had a compliance of 43% for this training. Staff understanding of the Mental Capacity Act and the Deprivation of Liberty Safeguards and their use in practice was variable in the core services..

- The trust had a central mental health legislation office which staff contacted for advice and guidance in relation to the Mental Capacity Act and Deprivation of Liberty Safeguards. However, advice from the office was not always followed by clinical staff and the office found it difficult to address this with senior management.
- The trust had a Mental Capacity Act 2005 protocol which had recently been updated to include procedural changes in the trust and described recording of capacity and best interest decisions. We found little evidence that capacity assessments and best interest decisions were being completed in most of the core services, or evidence of attempts to support people to make a specific decision for themselves before they were assumed to lack the mental capacity to make it, which meant we could not ensure the Act was being used correctly.
- The trust had a Deprivation of Liberty Safeguards protocol which was due to be reviewed in June 2016. The protocol gave details of deprivation of liberty, how to apply for an authorisation and how this was managed in the trust. However, some patients were subject to continuous supervision and control and were not allowed to leave but had no authorisation for detention in place.
- Both Mental Capacity Act and Deprivation of liberty protocols had audit requirements
- The trust information for Deprivation of Liberty Safeguards applications showed they had made 13 Deprivation of Liberty Safeguards applications between 1 October 2015 and 31 March 2016.

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

Summary of findings

We rated Leeds and York Partnership NHS Foundation Trust as requires improvement for safe because:

- The emergency equipment and medication checks were not sufficiently robust on some wards, including the long stay and rehabilitation wards, where items were out of date or missing. Equipment like blood glucose testing meters were not being recalibrated.
- The trust could not provide assurance that medicines were being stored at the correct temperatures to remain effective. Staff in many of the clinical areas throughout the trust were not monitoring ambient room temperatures and where they were, temperatures were exceeding the room temperature recommended by the World Health Organisation guidelines. Staff in clinical areas were either not recording the fridge temperatures or not always taking action when temperature readings were outside of the required range.
- The trust compliance was low for mandatory training courses including essential life support, moving and handling advanced, food safety level two, fire level three, intermediate life support, safeguarding children level two and three. This placed patients at risk of receiving care that was unsafe. The low compliance with essential and immediate life support meant that the service could not guarantee that all staff could respond to patients in a medical emergency.
- The ligature cutters were not readily available for all staff in an emergency on the inpatient wards for people with learning disabilities or autism and the crisis service were kept in the locked medication room or clinic room.
- The wards for patients with learning disabilities or autism' including the respite services and the psychiatric intensive care unit, were not clean and maintenance issues had not been attended to. Infection control principles in these services were poor and compliance in a number of services across the trust for the mandatory infection control training was below 75%.
- There were concerns in relation to the trusts management of mixed sex environments and maintaining the patients' dignity and privacy at three of the inpatient services we visited including the Yorkshire Centre for Psychological Medicine, Two Woodland Square and the crisis assessment unit. We did not accept that the Yorkshire Centre for Psychological Medicine met the requirements of the Department of Health guidance on same sex accommodation (2010), or the Mental Health Act code of practice at the time of the inspection.
- Concerns were identified in the seclusion facilities, the high dependency rooms and de-escalation rooms at the Newsam Centre, Mill Lodge and Parkside Lodge. Issues were identified with the local working protocols to support staff in their decisions to seclude patients and the rooms themselves did not fully meet the requirements of the Mental Health code of practice.
- Actions on the reducing restrictive interventions action plan remained outstanding. As such, restraint incidents, including prone restraint, remained high and the staff were not always operating within the trust policy. Staff on Parkside Lodge told us that they always used prone restraint to give medication via an injection when a patient refused it, which was not in line with the trust rapid tranquilisation policy.
- Blanket restrictions were identified in some inpatient services including the observation procedures on the acute wards and psychological intensive care unit and the routine searches following unescorted leave

on the forensic and secure wards. A blanket restriction is a rule that applies to all patients on a ward and restricts their freedom regardless of individual risk assessments.

- Caseloads were high in the integrated community services for older age adults and working age adults with mental health problems and teams did not actively manage the risk for patients waiting to access the service. They relied on information from referring services, patients, relatives or carers to inform them of any escalating risk.
- In the community services for adults with mental health problems the lone working procedure could not always guarantee the safety of the staff.
- The timely reporting of incidents to the National Reporting and Learning System and the commissioners remained a risk for the trust and we identified that reporting incidents was a concern in both the supported living service and the forensic and secure inpatient services.

However:

- The trust was committed to improving its estates and response times and the management of its estate was included in its strategic objectives.
- The trust had completed a significant amount of work in relation to the identification and removal or mitigation of ligature risks across many of its wards and services. They had robust systems in place to assess report and communicate any ligature risks, supported by the trust's ligature risk procedure. Wards had completed ligature risk and environmental audits and identified ligature points. Risk assessments were in place to mitigate these risks.
- Almost all wards and community services had either fixed call points or access to personal alarms to summon assistance in an emergency. Where alarms were not in place, the needs for these were mitigated.
- The senior executives and non-executive directors recognised staffing as one of the key risks for the organisation. The trust had implemented a successful recruitment strategy in 2016 to attract candidates and raise the profile of the organisation, including both experienced staff and newly qualified staff. The trust's recruitment plan targeted the roles and services where there was the highest number of vacancies. The trust also had a safer staffing task and finish group to lead on all issues related to safer staffing and dashboard including safer staffing figures was available at ward level.
- Whilst the use of bank and agency staff was high across the trust, bank staff were either substantive staff who worked extra shifts or staff who worked regularly in particular areas but who chose not to take substantive posts. This ensured a continuity of care for the patients.
- All wards and services reported good access to consultant psychiatrists, specialist doctors and junior doctors as required meeting the patients' needs in a timely way.
- Risk assessments were in place in all services and reviewed regularly at all services except the respite services.
- Although there was low compliance with safeguarding children training, staff were clear about the procedures to follow for both adult and child safeguarding and knew how to access safeguarding guidance.

Our findings

Safe and clean care environments

The trust addressed the management of its estate in its strategic objectives that underpin the trust's overall strategy 2013 to 2018. The trust acknowledged several risks with regard to its estate, including the provision of services from premises that it did not directly own which resulted in delays in responses to maintenance requests or environmental changes. The trust was working to resolve these or identify a more efficient way forward, including formal partnerships working with its private finance initiative partners, improved working arrangements with NHS Property Services Ltd. An Estates Strategy Steering group reviewed all the processes linked to reactive and

planned maintenance, including ligature assessment process and change request processes. The trust had undertaken 12 environmental projects in the last 18 months. We observed the trust's estates action plans, as well as meeting minutes that demonstrated the trust's commitment and insistence with its private finance partners and NHS property services to improve its estates and response times.

Following the 2014 CQC inspection, the trust reviewed its approach to the management of ligature risks and over the past 18 months had developed a new procedure through joint work between Care Services, the Risk Management team and the Estates and Facilities team. All clinical environments had completed ligature risk assessments in accordance with the trust's procedure and standards. The oversight of the ligature risk assessment process was led by the matrons and clinical service managers, supported by a monthly operational trust-wide clinical environments group. The clinical environments group reported to the estates strategy steering group.

A significant amount of work had been undertaken across the clinical areas and a number of larger refurbishment programmes were ongoing. The trust told us that they had also significantly focussed on ensuring that the identified local risks had mitigating action and were known to the clinical teams within each clinical area through the use of the risk register process and local team communication systems.

As such, ligature risk and environmental audits were in place and in date on all wards we visited. All wards had identified ligature points and risk assessments were in place to mitigate these risks. Where ligature risks remained, these were identified on the trust risk register. A ligature point is a place where a patient intent on self-harming might tie something to in an attempt to strangle them self. However, we were concerned that there were ligature risks in both communal bathrooms at Parkside Lodge and no viewing point for staff. This meant that staff would need to remain in the bathroom while patients were using it, or that staff would need to keep the door open. This presented an issue with privacy and dignity for patients. Also at Woodside Square, Parkside Lodge and the crisis service, the ligature cutters were kept in the locked medication room or clinic room and so were not readily available to all staff in an emergency.

The Patient Led Assessment of the Care Environment (PLACE) 2015 score for Leeds and York Partnership NHS Foundation Trust is 97%. This figure is 2% above the national. The Mount scored the highest for cleanliness with 100%. Three locations scored below the national average including Asket House (now included in the Asket Centre), Clifton House and the Becklin Centre. The Becklin Centre scored the lowest of all the trust locations with 92% for cleanliness.

Most of the wards and services we visited were clean and well maintained. We observed health and safety checks and action identified to correct any issues identified. Where some furnishings were tired, the trust, for example at the Newsam Centre, the Yorkshire Centre for Psychological Medicine and in some of the community services. The trust confirmed that they were currently completing a programme of refurbishment. The majority of wards and services adhered to infection control principles including hand washing, maintaining cleaning schedules and records and having personal protective equipment readily available.

However, we had concerns around the cleanliness of the psychiatric intensive care unit at the Newsam Centre, where the flooring on the corridors was unclean even despite the cleaning contractors having cleaned the floors on the morning of our inspection. Some toilets required further cleaning and there were areas of staining that had been present for some time. Bathroom tiles were stained, as were some of the shower curtains.

There were also concerns around the cleanliness of the wards for patients with learning disabilities or autism. At Parkside Lodge, some of the ward areas were not clean. In the female communal bathroom, the flooring was stained and the shower hose was dirty. In bedroom three on the male corridor, the window frame on the door was broken and staff had held it together with medical tape. At Three Woodland Square the ward was not safe because infection control practices were poor. There was mould on the base of the shower in the communal bathroom and the shower curtain was dirty. The bathroom light did not have a long enough pull string and staff had tied a plastic balloon rod to it. The manager had reported these problems to the estates department but the service had not dealt with them. The staff replaced the shower curtain during our visit. We saw that decoration throughout both sides of the ward was tired, as was the furniture. Similarly at Two

Woodland Square, staff kept coats and lockers in the communal patient bathroom. We found three mattresses stored in the bathroom. Staff told us that this was because the building did not have enough storage space. When things are not stored correctly, it increases the chance of the spread of infection. This risk was high for this patient group due to their complex health needs. The trust completed an infection control audit in May 2016 and there were outstanding issues from this audit on our visit. Staff told us that they completed a deep clean of every bedroom after each patient left, however cleaning records were not available to confirm this. Infection control training was mandatory and compliance was variable across wards and service. For example, compliance was below 75% in the crisis assessment unit and the intensive community service, Three Woodland Square, as well as the Yorkshire Centre for Psychological Medicine and the supported living service.

The trust had a number of wards that had mixed sex accommodation. We had some concerns in relation to the trusts management of mixed sex environments and maintaining the patients' dignity and privacy at three of the inpatient services we visited including the Yorkshire Centre for Psychological Medicine, Two Woodland Square and the crisis assessment unit. The Yorkshire Centre for Psychological Medicine provided mixed sex accommodation for seven females and one male on the day of the inspection. Bedrooms for males and females were not en suite and situated on either side of a long corridor. Patients did not have segregated bathroom facilities and would have to pass through areas occupied by the opposite sex to reach their bathroom facilities. We were told that, following discussions with the local Clinical Commissioning Group and an internal review in May 2016, instructions were developed to manage the bathroom requirements and to ensure that there were always staff in the vicinity to offer added protection. Nevertheless, and contrary to the trust's own assessment, we do not accept that such arrangements meet the requirements of the Department of Health guidance on same sex accommodation (2010), or the Mental Health Act code of practice. At Two Woodside Square the male and female bedrooms were on the same corridor, there was a mixed sex communal bathroom and the service did not have a female only lounge. In addition, during our feedback to the trust we raised concerns that the crisis assessment unit was not fully compliant with this guidance or the code of practice as on two of the occasions we visited the crisis assessment unit we noticed that the door separating the male and female sections of the unit was left open. Staff told us this was for ease of access and so male patients could access the staff in the nurse's office. However it meant that there was potential for male patients to be in the female section of the corridor as female patients accessed the toilet and shower facilities. The trust responded and showed us a local operating procedure that demonstrated the door being shut was the normal operating procedure, with this being open when only patients of the same sex were on the ward. The trust operating procedure did not match what was happening locally in the service, which was the opposite. The section 136 suite did not have bathrooms designated specifically male and female and patients had to walk past bedrooms to access bathrooms.

The trust did not have seclusion facilities on all the inpatient wards that we visited. Of the seclusion facilities we observed, we identified a concern for the forensic services at the Newsam Centre. The seclusion room for female patients was situated on a male ward and there was no local protocol in place to support staff in making decisions around secluding female patients to ensure their dignity was maintained whilst escorting them to this seclusion room.

We also identified a number of concerns with the seclusion room at the Newsam Centre for the forensic wards. The patients could not see a clock and as a result may not be orientated to time, the intercom functioned but with significant interference that made communication difficult. The de-escalation room was adjacent to seclusion and they could not be in use at the same time. Similarly, there was no clock in the high dependency room used at Mill Lodge, the inpatient service for children and young people with mental health problems, as required by the Mental Health Code of Practice.

Parkside Lodge, an inpatient ward for patients with a learning disability or autism, had a seclusion room that the trust had re-fitted following concerns raised at our previous visits. This seclusion room did not meet all seclusion guidance from the Mental Health Act Code of Practice. The door was not wide enough to bring a patient safely into the room in restraint holds, which increased the risk of injury to staff and patients. The room had a communication system, but this was not two-way. Staff could speak to patients

through the system, but patients could not reply. The room had no natural light and no access to fresh air. There was also a de-escalation room at Parkside Lodge, which staff used with patients as a less restrictive environment than seclusion when they needed to spend time away from the ward. The room was sparse and was not a therapeutic environment for patients, as it did not contain activities or relaxation equipment. Staff told us that this was because patients could use the equipment for self-harm, but this was not individually risk assessed for patients. The only item in the room was a plastic couch and it looked like a second seclusion room. There was a glass panel in the door and the room was in the middle of the corridor between the male and female bedrooms so other patients could see in the de-escalation room.

All wards and community services had emergency alarm provision: either fixed service alarms, access to personal alarms, or both. Where alarms were not in place, the need for these were mitigated, except at two Woodside Square where there were no alarms and the service had not considered the use of the alarm in a medical emergency. This may have been beneficial to the patient group whom the service supports.

The clinic rooms we observed were fully equipped locked clinic rooms which contained a medicines fridge, resuscitation equipment, emergency drugs and a 'grab bag'. A grab bag is a small, accessible bag which contains emergency equipment for first aid. The acute ward areas had access to oxygen cylinders and we saw that there were 'flammable' signs on doors where oxygen was stored. Some clinic rooms did not have an examination couch and these services used the patient's rooms, like the crisis assessment unit.

Emergency equipment and medication was checked regularly to ensure that they were fit for use and in sufficient supply. These checks were not sufficiently robust on the long stay rehabilitation service, the wards for older people with mental health problems, where there was out of date items like oxygen and dressings, half full oxygen cylinders, missing items that either had not been identified, or identified but no action taken and equipment like blood pressure monitors that had not been recalibrated since September 2015. We also found some areas were not calibrating the blood glucose testing meters and that some of the control solution to do this was out of date. This meant that the trust could not provide assurance of accurate results when conducting blood glucose tests for diabetic patients. However, we did not identify any patients that this could have affected during this inspection.

Safe staffing

The executive directors and the non-executive directors that we spoke to during the inspection all stated staffing as one of the key risks for the organisation. This included both staffing levels, as well as the skills staff required to deliver the models of care. The senior managers spoke with clarity about the staffing issues and where they were most prevalent, the rationale for these issues and the trust response to them.

The trust had implemented a new recruitment strategy in 2016. It focussed on three areas: to improve the trust recruitment process, to improve the trust profile to attract candidates using social media and other recruitment platforms and for the trust to develop partnerships with universities, colleges and other partners. Initially the recruitment plan supported by the executive team targeted the areas where there were the greatest number of vacancies, including band 5 and 6 nurses and band 3 health support workers. Using NHS job sites and social media, the trust held two recruitment events in January and April this year, using an assessment centre approach. The trust had worked in partnership with the local universities to recruit newly qualified nurses. At the time of the inspection the trust had recruited 143 clinical staff, including 105 qualified nurses and 38 health support workers. The trust recruited the nurses in volume and then allocated the nurses and health assistants to the wards and services were the demand at the time was the greatest, rather than recruiting to specific services. The trust had additional recruitment events planned and have been using real life stories and media to support their recruitment campaign. In an attempt to retain staff the trust had introduced enhanced preceptorship and talent management programmes to support front-line staff and to attract new staff. In this way the strategy was successful at recruiting new staff during a period where nationally recruitment of qualified nurses is challenging. Some of the staff criticisms regarding this recruitment were that the trust had only held recruitment events in Leeds and not in York so nurses and health support workers local to these York services may not have the same opportunities to attend the events. Also, managers in some of the local

services felt that they had no input on the staff that were being recruited to their services and were concerned that some of the staff recruited did not have the enthusiasm or the skills for the specific specialisms required on certain wards.

Full details about the trust staffing levels were reported to the public meetings of the trust Board of Directors and also made it accessible to the public via NHS Choices as required nationally. The trust also displayed planned and actual staffing levels on each ward at the start of every shift. The Director of Nursing completed the nationally required six month staffing review. This review was due for completion in July 2016. The trust had also developed weekly dashboards for staffing, with the aim of triangulating patient safety data to understand the impact of staffing on patient safety and experience in the future. The trust also had a safer staffing task and finish group to lead on all issues related to safer staffing. This was led by the Assistant Director of Nursing with the Director of Nursing, with support from the workforce planning and operational managers and the Professor of Mental Health Nursing from the University of Leeds. Current trust staffing levels had been agreed with the Director of Nursing and wards had been budgeted to staff to these level, with guidance in place for wards which sets shift patterns and minimum staffing levels for these shifts. However, the task and finish group identified six pilot areas to test and trial changes to staffing ratios and levels to determine their effectiveness and had developed a tool which is being used to scrutinise use of local staffing against defined criteria and measures. These measures include skill mix, newly qualified mix, bank and agency hours, vacancy factor and budgets. Further work is on-going to refine this tool, with the trust contributing to the wider Yorkshire and Humber safer staffing work stream for mental health. These measures were routinely reported to the Trust Board, as well as detailed exception reports for each of the inpatient wards against planned and actual staffing. As part of the inspection, we attended a board of directors meeting and observed this exception reporting. The Director of Nursing presented the findings, including whether the wards met the safer staffing requirements and how this was mitigated. For example, concerns were reported on the acute inpatient female wards at the Becklin Centre and the learning disability acute assessment and treatment wards at Parkside Lodge. This reporting allowed the trust to identify where the staff were required to be deployed following the recruitment events and so eight staff for example were being employed in stages to Parkside Lodge.

As of the 30 June 2016, he trust employed 2,546 substantive staff. This included 842 whole time equivalent qualified nurses and 661 whole time equivalent health support workers. At the time of the inspection, the trust also employed 67 consultant psychiatrists, 119 doctors, 175 allied health professionals, 25 pharmacists, 21 psychotherapists and 76 psychologists.

The total number of substantive staff leavers between the 1 April 2016 and the 30 June 2016 was 69, which was 3% of the workforce. The total number of vacancies overall in the trust, excluding seconded staff, was 9%. The number of whole time equivalent vacancies for qualified nurses was 145 and the number of whole time equivalent nursing assistants was 78. The forensic and secure inpatient wards had the highest qualified nurse vacancy rate for the trust of 20% and have a nursing assistant vacancy rate above the trust average of 6%. The acute wards and psychiatric intensive care unit had the highest qualified nurse vacancy rate with 17% and adult social care had the highest nursing assistant vacancy rate of 46%.

The permanent staff sickness rate was 5%.

The trust calculated the use of bank and agency staff use, including those staff used that was in excess of the budgeted establishment. Bank and agency staff were used to cover vacancies, sickness and other leave, increased levels of acuity and for increased engagement and observation. The number of shifts filled by bank and agency staff in the last three months was 2,780. Two hundred and twenty-four shifts were not covered in the same time period. Adult social care services had the highest total number of shifts filled by bank or agency staff to cover sickness, absence or vacancies with 2170. They also had the highest number of shifts not filled with 138. The forensic and secure inpatient wards had the second highest total number of shifts filled by bank and agency with 1582. They also had the second highest number of shifts not filled by bank and agency staff with 120.

The trust acknowledged that they used bank and agency staff on a regular basis. They told us that many bank staff were either substantive staff who worked extra shifts or staff who worked regularly in particular areas but who

chose not to take substantive posts. This was corroborated by the trust's analysis of bank and agency staff that the use of staff who work less than an average of 15 hours per week over a three-month period did not go above 10% for any inpatient ward. However, there were some comments from patients on the inpatient wards for children and young people with a mental health problem that they were not always familiar with the staff who were covering the shifts at night. Also, during the focus group at the same service, it was noted that the staff were not familiar with the needs of one of the patients who required additional support.

In response to the high use of bank and agency staff, the trust had recently employed a lead nurse with the responsibility for ensuring that bank and agency staff received the same levels of support and supervision as substantive staff. Bank staff were also expected to have completed appropriate compulsory training. Both bank and agency staff received a local induction in the areas in which they worked. This included information on local working practices.

There was adequate medical cover across the trust, despite some vacancies identified. All wards and services reported good access to consultant psychiatrists, specialist doctors and junior doctors as required meeting the patients' needs in a timely way.

The trust had difficulties in recruiting pharmacists at band 7 and band 8a levels. In response the trust had created split band 7 posts with the local Clinical Commissioning Group to try to help with this. The Chief Pharmacist chaired a collaborative work force group, which included staff from the local acute trusts and the local Clinical Commissioning Groups. They were in the process of developing a proposal to ensure long-term sustainability of pharmacists by offering a three-year rotational programme for band 6 and band 7 pharmacists.

In the community services for people with learning disabilities or autism, the average caseload across the three community learning disability teams was 18. The average caseload for the service as a whole in the period January to June 2016 in the intensive community service was 25 patients and at the time of the inspection staff felt that this was manageable.

However, in the integrated community services for older age adults and working age adults with mental health problems, we saw caseloads were high across all the teams. They ranged from 40 to 50 patients per care coordinator. National guidance from the Department of Health in 2002 suggested that average caseload size for community mental health teams should be around 30 to 35 patients per care coordinator. High caseloads were identified on the local risk register.

Management did not use a weighting tool to manage caseloads in any of the community services that we inspected; instead, the clinical leads and team managers had oversight and distributed the caseloads accordingly. Caseloads were regularly reviewed through supervision. A caseload weighting tool is a tool used to review caseloads and look at complexity of cases against amount of cases on staff caseloads.

However, information provided by the trust stated from July 2016 that allied health professionals would be piloting a caseload weighting tool across community learning disability services for six months.

The mandatory training compliance target for the trust was 90% but the trust mandatory training compliance across the trust at the time of the inspection was 80%. Mandatory training compliance was a concern at the previous inspection in 2014 and the trust continued to be unable to meet their training compliance target at this inspection. In addition, there appeared to be confusion regarding the timescales for the trust to meet the trust's compliance target of 90%. Three senior managers reported different timescales ranging from the end of July 2016, to December 2016, to April 2017.

The trust compliance was below 75% for training courses on essential life support, moving and handling advanced, food safety level two, fire level three, intermediate life support, safeguarding children level two and three, mental health act community and inpatient and duty of candour. This placed patients at risk of receiving care that was unsafe and the low compliance with essential and immediate life support meant that the service could not guarantee that all staff could respond to patients in a medical emergency.

The trust compliance was 90% and above for training in fire safety level one, equality and diversity, health and safety, safeguarding children level one, food safety level one, information governance, personal safety theory, safeguarding adults, as well as for the trust induction.

Requires improvement

Are services safe?

Low compliance in mandatory training, including essential and intermediate life support, was a concern in number of individual wards and services, including the wards for people with learning disabilities or autism, the crisis services, the forensic services and the Yorkshire Centre for Psychological Medicine. For example, at the Yorkshire Centre for Psychological Medicine, the compliance with essential life support, intermediate life support, infection control, clinical, moving and handling, safeguarding children and duty of candour training was all below 75%. Staff on the ward dealt with percutaneous endoscopic gastrostomy (feeding a patient using a tube), wound care and the use of hoists on a regular basis so it was essential that staff remained up to date with these skills to provide safe care and treatment.

Staff received a monthly email from the trust notifying them that a particular element of mandatory training needed updating. They were responsible for booking their own training using an online programme. We checked the availability of training courses for both Leeds and York on the training dashboard and found there was sufficient availability for staff to access mandatory courses in both geographical areas.

Assessing and managing risk to patients and staff

We looked at the quality of individual risk assessments across the wards and teams we inspected. We reviewed 217 records during the inspection. These identified and addressed risk in most of the care and treatment records that we reviewed. The trust used two recognised risk assessments; the functional analysis of the care environments risk profile and a gate assessment. However, there were concerns at two and three Woodland Square that risk assessments, as well as the fire evacuation plans at two Woodland Square, were not being reviewed regularly for people with learning disabilities or autism. Some risk assessments had not been reviewed in under six months, whilst other risk assessments and the fire evacuation plans had not been reviewed since 2013 and 2014.

We saw good use of crisis planning in the community services, except in the community services for patients with learning disabilities or autism, where the use of crisis plans was more variable. All staff provided patients with a crisis card in case of an emergency, which contained emergency contact numbers for support.

In the community teams where there were waiting lists, teams were reliant on the referring service's ongoing monitoring of the patient risk, or on the self-report form patients, relatives or carers. Teams discussed the waiting lists on an ongoing basis as a multidisciplinary team and made regular contact by letter to patients on waiting lists. Where there had been an increase or sudden change in the presenting risk of a patient on the waiting list, the teams responded positively offering support, guidance or appointments.

Recognised tools for areas such as nutrition and pressure care were not used when they were required in the supported living service. In comparison, the Yorkshire Centre for Psychological Medicine and the wards for older people with mental health problems were vigilant to the additional risks these patients presented, for example, developing pressure ulcers and falls. The ward had pathways into tissue viability, endoscopy, stoma care and other physical health services, which they could access locally when required.

There had been no episodes of long-term segregation recorded across the trust between 1 January 2016 and 30 June 2016. In this time period, there were 88 incidents of seclusion recorded. Fifty of these seclusion incidents were recorded on the acute wards and psychiatric intensive care unit which had the highest number of seclusion incidents. This service that recorded the second highest use of seclusion was the forensic and secure wards, which recorded 18 incidents of seclusion.

On the inpatient wards for children and young people with mental health problems, there was confusion amongst staff regarding the use of seclusion. Staff were not clear on whether seclusion was used or not, or what constituted seclusion, where patients were transferred to the high dependency unit following long periods of restraint and were prevented from leaving the room. There was also confusion about the procedure following a patient being transferred to the high dependency unit and seclusion being used. The manager informed us that they used some documentation from the trust seclusion policy but did not carry out medical reviews. We asked the trust for the number of seclusion episodes from 1 March 2016 to 30 June 2016 and they informed us that there were 10 occasions when a patient was secluded. Staff were unable to provide us with any clear seclusion records as specified

in the trust policy. This meant that when restrictions placed on a patient that resulted in seclusion, not all of the safeguards required by the Code of Practice and the trust policy were put in place.

In the forensic and secure services, two of the eight seclusion records were reviewed on Rose ward. Both records were not compliant with the Mental Health Act Code of Practice. There were no seclusion care plans 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.

There were 808 uses of restraint on 254 different patients between 1 January 2016 and 30 June 2016. One hundred and thirty-four of those interventions resulted in the use of prone restraint. In addition 69 of the prone restraints resulted in rapid tranquilisation. When medicines were administered for rapid tranquilisation, we saw that staff attempted physical health monitoring after the dose was given. The Care Quality Commission defines prone restraint as 'holding chest down whether face down or to the side'. Rapid tranquilisation is defined by the National Institute for Health and Care Excellence as when 'when medicines are given to a person who is very agitated or displaying aggressive behaviour to help quickly calm them to reduce any risk to themselves or others and allow them to receive the medical care that they need.' National Institute for Health and Care Excellence guidance states that staff should only use prone restraint when it is unavoidable. This is because of the risk to patients of coming to harm due to the compression of the chest used in this technique.

The highest number of restraints was recorded for the acute wards and the psychiatric intensive care unit in this time period. Three hundred and nine restraints were recorded on 130 patients, 82 were recorded as prone and 43 of those prone restraints resulted in rapid tranquilisation. This second highest use of restraint was recorded on the wards for patients with learning disabilities and autism which recorded 213 restraints on 14 patients. Ten were in the prone position and two resulted in rapid tranquilisation. This was followed by the wards for older people with mental health problems which recorded 148 restraints on 50 patients. Eight were in the prone position and five resulted in rapid tranquilisation.

Staff on Parkside Lodge told us that they always used prone restraint to give medication via an injection when a patient refused this. The trust rapid tranquilisation policy (May 2015) did not state that rapid tranquilisation should be given in prone restraint. Staff could use other techniques for rapid tranquilisation. Therefore, staff were working outside of the trust policy.

The trust was working towards reducing the use of restraint, particularly prone restraint, as recommended by the Department of Health Guidance: Positive and Proactive Care: reducing the need for restrictive interventions (2014). We observed the trust's action plan for its reducing restrictive interventions programme (2014 to 2016), minutes from the reducing restrictive interventions working group and details of 'safe ward' development day. All inpatient services worked towards using the safe ward interventions and each ward had their own development plan to update quarterly. The trust had a managing challenging behaviour policy as a guide for staff. Ninety percent of trust staff had completed personal safety theory training and over 75% were compliant in the low and high-level physical interventions training with breakaway techniques. We observed the preventing and managing violence and aggression training and noted that central to this training was recognising changes in patients' behaviour that may indicate an escalation in behaviour, followed by the use of de-escalation techniques, before the use of any restrictive interventions. In the reducing restrictive interventions action plan, completing the post incident review in 72 hours, consulting with patients for their experience on their restraint and the Board of Directors and Senior Management Executive Team making the decision on the type of restrictive interventions that were to be used going forward in line with national guidance and were documented in the trust's policy, were all still outstanding despite some progress being made. As such, restraint incidents, including prone restraint, remained high, prone restraint was still prominent in the trust's training package to manage challenging behaviour and the staff were not always operating within the trust policy.

There was an observation and engagement of people policy in place. Observation levels on almost all wards were dependent on the risk the patient presented and would be more frequent where they had been assessed as high risk.

The trust had a policy for searching of patients. Staff did not routinely search patients on most of the wards we

visited. They carried out searches when they felt it to be necessary due to risk to self or others. Staff obtained consent from the patient and conducted the search in line with the Mental Health Act code of practice.

Blanket restrictions were identified in some inpatient services, including the observation procedures on the acute wards and psychological intensive care unit and the routine searches following unescorted leave on the forensic and secure wards. A blanket restriction is a rule that applies to all patients on a ward and restricts their freedom, regardless of individual risk assessments.

We saw adequate signage on the doors advising informal patients that they were free to leave the unit at will, or leaflets on patients' rights and responsibilities, in line with the Mental Health Act Code of Practice, except at Parkside Lodge where a patient did not have their right to leave the ward clearly explained to them.

Good personal safety protocols were in place in the community services for patients with a learning disability or autism and the specialist community services for children and young people with a mental health problem. However, in the community services for adults with mental health problems, the lone working procedure could not always guarantee the safety of the staff.

The trust contributed at both Board and operational levels of the Leeds Safeguarding Children's Board and were fully engaged in the Leeds Domestic Violence Hub and the operational steering group.

Adult safeguarding training and child safeguarding training, level one, two and three, was mandatory for the trust. Adult safeguarding training compliance was 90% and child safeguarding training level one had a 92% compliance rate. Compliance for these two courses met the trust mandatory training target of 90%. However, child safeguarding training level two and three were below the trust compliance target of 90% and below 75%, with a compliance rate of 51% and 66% respectively for those staff eligible to complete it.

Although there was low compliance with safeguarding children training, staff said they were clear about the procedures to follow for both adult and child safeguarding and knew how to access safeguarding guidance. All said they would report any concerns directly to a manager in the first instance. Incident reports showed that staff had consulted with the trust safeguarding team, including the named child and adult safeguarding nurses and made safeguarding referrals where they believed potential or actual abuse had occurred. This was demonstrated in the ten safeguarding cases that we reviewed during the inspection. We observed evidence of staff liaising with social care co-ordinators in the community and attendance at multidisciplinary meetings with the local authority.

However, at Two Woodlands Square, the respite service for patients with a learning disability or autism, we saw evidence in two patient files of staff completing body maps on admission after finding bruising on a patient. Staff had written about these in daily notes but had not taken advice or recorded that they had made or discussed safeguarding referrals in these cases.

Staff working in the adult services, were expected to discuss child and safeguarding within clinical and management supervision. Named nurses facilitated safeguarding supervision in the mental health services for children and young people, the perinatal services and the substance misuse services. Assurance was provided to the Trust Safeguarding Committee, though the trust did not collect discreet data on safeguarding supervision at the time of the inspection. An adult and child safeguarding policy and procedure was available to staff on the staff intranet to guide and support staff in their work. The safeguarding children policy had been recently ratified on the 1July 2016 prior to the inspection. Staff communications on safeguarding via the intranet, the safeguarding bulletin and attendance by the trust safeguarding team at team meetings provided additional guidance for staff.

The Chair of the Leeds Safeguarding children's Board completed an audit in 2014 and was assured that the whole trust accepted and shared responsibility for safeguarding children, or that it was integrated into part of everyday mainstream practice for all practitioners. Since that visit the trust had developed and promoted the Leeds 'Think Family, Work Family' approach to safeguarding. This ensures that practitioners that work with adults adopt a holistic approach and consider wider issues for the family that may affect the health and well-being of other vulnerable members of the family. 'Think Family, Work Family' was included in the trust's level three safeguarding children training, though compliance was low despite the audit being completed in 2014. The trust was also developing a new Safeguarding Supervision Policy in line with the Leeds Safeguarding Children's Board minimum

standards, requiring eligible staff to participate in separate safeguarding supervision every 3 months. This was still in draft format, despite the audit being completed in 2014, with the plan to launch the policy and the monitoring arrangements at the October 2016 trust safeguarding conference. The child safeguarding records we reviewed confirmed that concerns were identified in a range of adult services, including the substance misuse services, the community services for adults of working age with mental health problems, as well as the memory services.

The trust visitors' procedure included guidance about how staff should manage situations of children visiting the wards to maintain safety as not all wards and services had a child-friendly visiting room. The trust safeguarding team was due to complete an audit on the provision of visiting rooms appropriate for children across the trust.

There were three pharmacy dispensaries in the trust. Medicines were delivered to all trust sites by courier. The pharmacy dispensary service was extended in April 2016 to provide cover on weekends and bank holidays. Out of hours, staff could access emergency drug cupboards and an on call pharmacist. The trust was in the process of identifying a building that was big enough to enable the merging of the two Leeds-based pharmacy dispensaries. The current facilities were not deemed fit for purpose and are mentioned on the trust risk register.

Medicines were stored securely across the trust. However, the trust could not provide assurance that medicines were being stored at the correct temperatures to remain effective. Whilst staff in some clinical areas recorded medicines fridge temperatures, staff did not always take action when temperature readings were outside of the required range. One ward fridge had numerous readings of 11 degrees centigrade and staff had not taken any action. On other wards, fridges were broken, were not monitored or had missed temperature readings. Pharmacy staff did not always check to ensure that ward fridge temperatures were being monitored properly. In addition to this, we found that the temperatures of the fridge in one of the pharmacy dispensaries had not been monitored since the 17th February 2016.

Staff in many of the clinical areas throughout the trust were not monitoring ambient room temperatures where medicines were stored to ensure that the temperature remained below 25 degrees centigrade in line with the trust's policy. Medications stored at room temperature should not exceed this limit as recommended in the World Health Organisation guidelines for the storage of essential medications. There were no thermometers in most of the clinical areas and where they were introduced during the inspection, for example in the crisis unit at the Becklin centre, the temperature recorded 29 degrees centigrade. Therefore, the trust could not provide assurance that medicines that needed to be stored at room temperature were being stored below 25 degrees centigrade.

These issues were brought to the attention of the immediate attention chief pharmacist during the inspection. A trust wide action plan was implemented during the inspection.

Staff handled pharmaceutical waste appropriately throughout the trust.

Controlled drugs were stored securely and managed appropriately across the trust. All the controlled drug cupboards that we saw complied with legal requirements. The controlled drug accountable officer (who was also the Chief Pharmacist) sent regular reports of controlled drugs related incidents to the controlled drug local intelligence network.

The trust had recently implemented electronic prescribing in some areas using the MedChart clinical system. We saw that all prescriptions (both paper and electronic) included patient identifiable data and information on allergies. In some areas, photographs were included with the prescription charts to aid the identification of patients. On the inpatient ward for children and young people with mental health problems; all prescription charts included the weight of the patient. Where appropriate, the documentation regarding legal authority to administer medicines to individual patients (for example, T2 and T3 forms) was readily available.

The paper prescription charts had a section at the back relating to medicines for minor ailments (e.g. paracetamol tablets, gaviscon advance liquid, senna tablets). We saw that prescribers and pharmacists were very good at ensuring that this section was crossed off if these medicines were not suitable for individual patients.

Pharmacists usually screened prescription charts on the ward. If nurses needed a medicine when the pharmacist

was not on the ward, the prescription charts were sent via secure nhs.net email to the pharmacy department. If the prescription was electronic, the pharmacists were able to screen them by logging into the MedChart system remotely.

We saw that Clozapine was managed appropriately throughout the trust. The trust had outpatient clozapine clinics twice a week that were run by members of the pharmacy team. Staff used these clinics as an opportunity to gather information on side effects being experienced as well as the smoking status of the patients.

This trust no longer used patient group directions (PGDs). However, staff within the occupational health department work under a patient group directive written by a neighbouring trust to administer influenza vaccines to trust staff during flu season. The governance of the patient group directive was managed by the trust that produced it.

Previously, there were patient group directive used in the crisis team. The trust employed doctors and nurse prescribers within the crisis team so that medicines could be prescribed in the traditional way if needed.

Whilst the trust was starting to implement a system for supporting patients to self-administer their medicines, we saw that this system was not robust. Pharmacy staff were involved in monitoring and assessing patients; however, the information that they gathered was kept in the pharmacy department and not on the wards. This meant that not all members of the multidisciplinary team could access it.

The trust had a clear process for managing medicines alerts. Information was sent via the trust communication system, ensuring that all members of staff were informed of any action required.

Pharmacists and pharmacy technicians conducted medicines reconciliation for each patient admitted to a ward. (Medicines reconciliation is the process of identifying the most accurate list of all medications that the patient is taking, including name, dosage, frequency and route, by comparing the medical record to an external list of medications obtained from a patient, or GP). Pharmacy staff used smart cards to access GP held 'Summary Care Records'. This meant that pharmacy staff could provide quality advice about medicines use.

We saw that nurses on some wards were able to dispense small amounts of medicines for patients going on short-term leave. The process required two nurses to check the medicines before giving them to the patients. This was used when pharmacy staff were not present on the ward. The majority of short-term leave was planned and the pharmacy department usually supplied the medicines. On the inpatient unit for children and young people, the Consultant wrote FP10 prescriptions for a patient who was going on leave at short notice. This enabled the family to go to a local community pharmacy and get the medicines dispensed immediately.

Medicines information was sent to GPs and community pharmacies on discharge. The trust had identified that some of the discharge information being sent was ambiguous. To rectify this, the trust had pharmacy staff based in five GP practices. They had access to the trust information technology systems so that they could deal with any medicines queries.

Track record on safety

We analysed data about safety incidents from three sources: incidents reported by the trust to the National Reporting and Learning System and to the Strategic Executive Information System and serious incidents reported by staff to the trust's own incident reporting system. These three sources were not directly comparable because they used different definitions of severity and type and not all incidents were reported to all sources. For example, the National Reporting and Learning System does not collect information about staff incidents, health and safety incidents or security incidents.

Providers are encouraged to report all patient safety incidents of any severity to the National Reporting and Learning System at least once a month. The trust was an outlying reporter to the National Reporting and Learning System. The most recent report covering 1 April 2015 to 30 September 2015 identified that Leeds and York Partnership NHS Foundation Trust, reported 50% of incidents more than 71 days after the incident occurred this is outside the average rate, which is 27 days.

For the period 1 June 2015 and 31 May 2016, 4,929 incidents were recorded by the National Reporting and Learning System for the trust. Of these incident, 68% were recorded as resulting in no harm, 29% recorded as resulting in low harm, 2% recorded as resulting in moderate harm, 0.4% recorded as resulted in death and less than 0.1% resulted in severe harm. The National Reporting and

Requires improvement

Are services safe?

Learning System considers that trusts that report more incidents than average and have a higher proportion of reported incidents that are no or low harm have a maturing safety culture. Patient accident was the most reported incident to the National Reporting and Learning System, accounting for over a quarter of all the incidents reported, with a total of 1,408 patient accidents reported. This was followed by 22% of incidents reported by the trust relating to self-harming behaviour and 20% relating to disruptive and aggressive behaviour (including patient to patient).

Trusts are required to report serious incidents to the Strategic Executive Information System. These include never events which are serious patient safety incidents that are wholly preventable. The trust reported 49 serious incidents between 1 March 2015 and 29 February 2016 to the Strategic Executive Information System and requested that one incident be de-logged as a serious incident. Thirty of these incidents occurred in the adult community mental health teams, with just over two-thirds, attributed to apparent, actual or suspected self-inflicted harm. There were no 'never events' recorded in this time frame. However, the performance framework data submitted by the trust, identified a 'never event' occurring in March 2016. The 'never event' related to an attempted suicide on one of the acute inpatient wards, where a collapsible rail had failed to collapse.

The trust also records serious incidents. Between 1 March 2015 and 23 February 2016 the trust recorded 48 incidents. This was the same for the number of incidents recorded on the Strategic Executive Information System which recorded accounting for the serious incident that the trust asked to be de-logged. Thirty-five of the trust serious incidents were categorised as incidents that were unexpected or avoidable death or severe harm of one or more patients. Of the 13 remaining serious incidents, nine were in relation to a fall, two in relation to an information governance breach and one in relation to property damage by a service user and one in relation to the Mental Health Act.

The overall number of deaths for the trust decreased between 2014 and 2016, from 274 to 241. However the unexpected deaths doubled in 2014 to 2015 in comparison to 2013 to 2014. Of the 163 unexpected deaths reported in the last three years, 121 were investigated by the trust with 89 categorised as a serious incidents requiring investigation. Eighty-four were recorded on the Strategic Executive Information System. Mental health community services for adults had the most unexpected deaths in the three year period between 2013 and 2016 with 86 unexpected deaths. The trust provided data to confirm that they had investigated 74% of unexpected deaths. Eight unexpected deaths were not investigated by the trust including four in the community services for older adults with mental health problems, three in the specialist community mental health services for children and young people and one on the inpatient wards for people with a learning disability or autism.

The NHS Safety Thermometer measures a monthly snapshot of four areas of harm including falls and pressure ulcers. In the period April 2015 to April 2016, the safety thermometer data showed that the trust reported eight new pressure ulcers. Two pressure ulcers were reported in both June 2015 and July 2015, with a prevalence rate of 0.6% and 0.7%. This was the highest number of pressure ulcers reported in a month. Again in the period between April 2015 and April 2016, the trust reported 28 falls with harm. The highest monthly numbers reported were five each in May 2015 and August 2015, with prevalence rates of 1% and 2% respectively. In this same period, the trust did not report any new catheter and urinary tract infection cases.

Some of the responses to questions in the NHS Staff Survey 2015 provided circumstantial evidence about the culture of safety and incident reporting. The trust was higher than the national average for mental health trusts with regard to the responses to the survey for staff reporting that they had witnessed potentially harmful errors, near misses or incidents in the last month. Thirty per cent of staff reported this, compared to 26% nationally. The trust was one percent lower than the national average for staff actually reporting these near misses, errors and incidents, with 90% of staff reporting this in the survey. Staff's confidence and security in reporting unsafe clinical practice was lower than the national average for mental health trusts.

In the NHS Staff Survey 2015, 26% of staff said they experienced physical violence from patients, relatives or the public in the last 12 months, which is five percentage points higher than the national average of 21% for mental health trusts. Thirty-two percent had experienced harassment, bullying or abuse from patients, relatives and the public in the last 12 months, which is the same as the national average for mental health trusts.

Requires improvement

Are services safe?

Reporting incidents and learning from when things go wrong

A web based reporting system was used for reporting incidents called Datix. The trust used the incident reporting system to record incidents, accidents and near misses and had been using this system since April 2015. Prior to this, incident reports were made using handwritten forms. Staff across the trust had a good understanding about the types of incidents they should report and the incident reporting procedure.

As part of our inspection we reviewed information relating to incidents reported. We found that a range of different types of incidents were reported and the incidents were reported appropriately. Some of the types of incidents reported included safeguarding concerns, patient deaths, accidents, information governance issues and medication errors.

All medicines errors were reported on the Datix incident reporting system and reviewed by the trust Medicines Safety Officer. Staff that we spoke with had an awareness of how to report medicines incidents.

All deaths were reported as an incident on the Datix system and were reviewed by the Mortality Review Group weekly to confirm whether a full fact find report was required. The Mortality Review Group was started in June 2016 in response to an external independent review of deaths of people with learning disabilities or mental health problems at the Southern Health NHS Trust by Dr Mazar. A full fact find report was not currently completed for expected deaths. However, the trust was changing its process so that a full fact find report was completed for every death of patients in contact with their services, or recently discharged. The trust had a weekly mortality and fact find review meeting to agree the levels of investigation required.

Staff recorded all hands-on interventions as an incident. They recorded all these incidents in detail and completed body maps to note any injuries from restraint. The restrictive interventions working group, which reported to the Mental Health Legislation Group, reviewed all incidents of restraint and identified any learning. They confirmed that they then may work with staff on an individual basis, or certain teams and services, but would cascade relevant learning trust-wide via the intranet.

Where a death was identified as a serious incident, the trust followed the same process as it would for all serious incidents. The death was reported on the Strategic Executive Information System and to the National Reporting and Learning System. An investigator was allocated from outside of the service where the incident occurred. Independent external investigators were appointed for the most serious incidents. The Risk Management Team oversaw the management of the investigations. A draft investigation report was discussed by the Care Group Risk Forum and recommendations and actions were developed. Relevant staff members were involved throughout. We were told that immediate learning may be shared in advance of the final report where changes to practice were needed without delay.

The report was presented to Trust Incident Review Group. This Trust Incident Review Group was chaired by the Medical Director and membership included the clinical directors and professional leaders. Recommendations were agreed at this meeting and actions finalised. The Trust Incident Review Group considered whether findings were root causes, contributory factors or incidental findings; and recorded them as such, agreeing the required oversight to completion. The investigator or appropriate member of staff would meet with the family, to discuss the report and any findings.

Reports were fed back into care groups via the clinical governance forums. The treatment incident review group minutes were shared with Care Group Risk Forums and the Quality Committee.

All action plans were implemented by the team where the incident occurred, governed by care group clinical governance forums. Trends and themes arising from actions were analysed and shared through the 'Learning to Improve' process. For cross-care group learning, the trust also circulated Lessons Learned communications, as well as through the Clinical Team Managers' Forums and Consultants' Committees. The Board of Directors and the Governors received reports on the serious incidents and the lessons learnt. The trust submitted completed reports to commissioners and other relevant external bodies.

The timely reporting of incidents was identified as a risk factor for the trust and the commissioners raised concerns about the timeliness of these incidents, including suicides and falls, being investigated and information being fed back to them. The trust told us that they had accumulated a significant backlog of paper incident forms awaiting input to the electronic system from 2013 due to a gap in

administrative support, exacerbated by the resource impact of implementing the new electronic system. The trust had made some recent changes prior to the inspection to improve the timeliness of their reporting, the completion of their investigations and the feedback to staff and commissioners. They were also in the process of recruiting two dedicated Root Cause Analysis investigators to join the Risk Management Team, to improve capacity and consistency in investigation management. They were also investing in a new training package for investigators and for members of the Trust Incident Review Group to support them in critiquing investigations and providing feedback.

During the inspection we attended a Trust Incident Review Group meeting, a Mortality Review meeting, the trust Board of directors meeting and reviewed trust-wide incidents reports and investigations, including the 'never event' that occurred in March 2016. We observed timely investigations and comprehensive records. The meetings we attended were robust with appropriate, discussion, challenge, recommendations and actions.

Staff confirmed in almost all services that information regarding best practice and lessons learnt following investigations of incidents was shared with teams. Teams received feedback about incidents internal and external of the service through team meetings, handovers and emails sent out to staff. Staff told us that incidents were discussed in their supervision. Staff told us that changes to practice have been put in place following investigations of incidents. Reports from incidents including lessons learnt were available on the trust intranet. Staff told us that they received a formal de-brief following incidents from their manager and were supported by their colleagues. However, staff did not show an understanding of lessons learned specifically from medicines incidents or how feedback was relayed to members of staff who had reported incidents.

We had concerns about the reporting of incidents at the supported living services, as well as the learning from incidents. The electronic reporting system had not been implemented in this service, despite being implemented across the other trust services and teams. This meant the house managers and operations manager no longer received feedback from the provider on trends in accidents and incidents. This meant issues could be missed because the data was not being routinely analysed and people therefore may not receive changes in support which may have been required to minimise the risk of the issue reoccurring. Following the inspection they told us a formal plan had been devised for this to happen in 2016.

The provider is legally responsible to report all safeguarding concerns to the National Reporting and Learning Monitoring System. However, at this same service, we looked at the data held locally and cross referenced this to the NHS report of all incidences reported. We found that five incidences were not reported. The provider immediately looked at how this had happened and changed the system in place to ensure this did not happen again. The operations manager told us once the Datix system is introduced, reporting errors will not happen.

In addition, staff in the forensic and secure inpatient services did not always follow the trust procedures for investigating incidents and complete the investigations in the timescales required. When a patient went absent without leave from the service the service completed its initial fact find six days after the incident, rather than within 12 hours as per the policy.

Duty of Candour

In November 2014, the Care Quality Commission introduced Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This regulation requires the trust to be open and transparent with people who use services and other 'relevant persons' in relation to their care or treatment, specifically when things go wrong. This specifically includes suspected or actual reportable harm incidents that resulted in moderate or severe harm.

The Board of Directors received training on the requirements of the duty of candour through a board workshop in November 2014. The Quality Committee, a sub-committee of the board, had the oversight of the implementation of the duty of candour regulation and we observed information discussed at the board in April and July 2015.

The trust had developed a procedure to guide staff in their duties in relation to duty of candour and also updated their electronic management system to include prompts for staff regarding duty of candour and if it was appropriate.

We observed a duty of candour presentation for staff during their induction and a page specific to this on the

trust intranet. Training on duty of candour was classified as mandatory in June 2016. At the time of the inspection the trust compliance rate was 42%, with an expected compliance rate of 90% by the end of March 2017.

Staff worked with a culture of openness and transparency and knew their responsibilities when things went wrong. We reviewed case records where there had been a notifiable event to check that staff had been open and honest in their approach to patients, relatives and carers. All incidents were discussed at the Trust Incident Review Group, including their appropriateness for duty of candour. We found that the trust was meeting its duty of candour responsibilities.

Anticipation and planning of risk

The Board of Directors had identified the strategic risks that may adversely affect trust business. The trust's board assurance framework identified the trust's principle risks for each of its five strategic objectives. Risks identified included failing to meet deadlines for implementing systems, impacts of funding and tendering on delivering care, cyber-attacks, workforce vacancies and capability, defective detentions and risk with the providing services from premises that are not in direct ownership of the trust. The board assurance framework we observed included information on how the trust were mitigating these risks, how they were assured these controls were effective and highlighted any gaps and further action required.

Requires improvement

Are services effective?

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

Summary of findings

We rated Leeds and York Partnership NHS Foundation Trust as requires improvement for effective because:

- Care records in the respite services at Woodland Square for patients with a learning disability or autism had not been reviewed for significant periods and did not always identify the patients' needs whilst at the services. The care plans at these services did not always contain health action plans.
- Patient records were not always accurate and contemporaneous and did not include all decisions about patient's' care and treatment within their care record. The use of paper records as well as electronic records could cause confusion for the wider teams accessing the system, as the most up to date information may not be held in the central electronic record.
- The inpatient wards for older people with mental health problems did not use any standardised occupational therapy tools to measure interventions and outcomes. Staff in the crisis assessment unit were unclear of the National Institute of Health and Care Excellence guidance that would apply to the service.
- The internal audit systems were not always sufficiently robust to identify missed doses or other medication issues and errors were identified in the supported living service, on the inpatients wards for older people with mental health problems and the inpatient wards for patients with learning disabilities or autism.
- There were no robust systems in place to ensure that the physical health monitoring for antipsychotic medication was completed. There was a lack of clarity regarding who should take responsibility for ensuring that these physical health checks were completed.
- The trust average clinical supervision rate as of the 30 June 2016 was 70% and was below 50% in some services, including the Yorkshire Centre for Psychological Medicine, Parkside Lodge and Three Woodland Square and the inpatient wards for older adults with mental health problems.
- The appraisal rate for the trust as of the 30 June 2016 was 82% and did not meet the trust target of 90%.
- Compliance in the mandatory level two Mental Health Act community and inpatient level two training for the trust were also below 75%. Five teams or services had below 75% compliance in the Mental Capacity Act training, including Deprivation of Liberty Safeguards.
- We found that second opinion appointed doctors were not requested in a timely manner in some cases when the three month rule was approaching. This means other authority, such as treatment in an emergency, needed to be used. Section 62 authorises treatment in an emergency and was used widely throughout the trust.
- We found some issues with the documenting of section 132 rights, including on the wards for older people and in the crisis and health based place of safety.
- We found delays in identifying errors with detention documents, despite the systems to receive and check Mental Health Act documentation and the internal audits to identify errors that were in place. This could result in patients being deprived of their liberty without the legal authority.
- Patients in the respite services for patients with learning disabilities and autism did not have capacity to consent to their respite care and treatment and were subject to continuous supervision and control and were not allowed to leave. The services had carried out capacity assessments but had not made applications for Deprivation of Liberty Safeguards.

Requires improvement

Are services effective?

These safeguards are a lawful requirement to ensure the service upholds the human rights of patients. Staff on the acute wards and the wards for older people with mental health problems, were unclear about their responsibilities under the Mental Capacity Act and were not adhering to the trust policy.

However:

- In the majority of services and teams, comprehensive assessments were completed using recognised assessment tools and care plans were holistic and person centred and were reviewed regularly.
- Staff followed guidelines from the National Institute of Health and Care and Excellence when providing care and treatment, including for prescribed medication and psychosocial interventions.
- There was a comprehensive audit programme across the trust and in the teams and services we inspected and the trust pharmacy team completed a number of medicines related audits to assess quality and to assist in the identification of areas for improvement.
- All teams consisted of a wide range of disciplines, included consultant psychiatrists and junior doctors, nurses and health support workers, occupational therapists and regular input from pharmacy. Other professionals were engaged as required. Regular team meetings took place in all teams and services and all members of the multidisciplinary teams attended these.
- There were good examples of integrated partnership working and local partnership arrangements between the trust and other agencies, as well as between internal trust services.
- Staff and patients told us there was good access to independent mental health advocates.

Our findings

Assessment of needs and planning of care

We reviewed 217 care records. Generally, comprehensive assessments were completed, using recognised assessment tools. The care records we reviewed were individually tailored to each patient's needs and showed the patients' involvement in completing and agreeing the care plan. Information in the assessments and care plans covered a range of areas including mobility, nutrition, activities, health needs and support with any challenging behaviour. They were holistic, recovery orientated and included patients' views. However, not all records were sufficiently detailed, for example on the inpatient wards for older adults with mental health problems, a number of patients' nutritional needs were being monitored by way of food and fluid intake charts and not all records were fully completed in relation to what patients had consumed.

We observed good practice, for example in the inpatient services for patients with a learning disability or autism at Two Woodland Square, where care plans were person-centred and included the likes and dislikes of the patient. Each patient had brief communication guides in place, showing how they communicated with staff. However, whilst we found that care plans were regularly reviewed and updated in the majority of teams and services, in this same respite service, we identified concerns that the nurses did not document when they updated care plans, so it was unclear whether the care plan contained the most recent information. For example, a patient had an administration care plan for an emergency epilepsy rescue medication written in January 2010. Also, during the inspection we saw that staff had written in patient care plans that they liked to go to bed between 6.00pm and 7.00pm. We questioned this, because this was not person centred. One patient told us that they did not like respite, because they had to go to bed before the day shift left and went to bed much later at home. The carer of another patient told us that their relative did not like the early night time routine. After we raised this concern on our first visit, we re-visited the ward at night one week later, practices had changed and staff had amended care plans to include a more person centred description of each patient's preferred night time routine. Both patients were up in the lounge at the time of our night time visit.

In addition at Three Woodland Square, whilst all the patients had care plans present, the service had not always written these and took them from the community team's electronic system. This meant that the care plans were not specific to the respite service and not updated after each respite stay. Also, less than half of the care records we reviewed at this service contained health action plans. A health action plan should be in place for all learning

disabled adults. It is a personal plan about what a patient needs to stay healthy. It lists any help people may need and is a record of all information about a patient's health needs. Similarly, at Parkside Lodge only one of the four patient records reviewed contained a health action plan.

The majority of patients' records were stored securely on an electronic system. This electronic system contained all the records and information from the multidisciplinary teams, for example psychology, occupational therapy and speech and language therapists. Hand written records, for example the medical notes, were typed up by the administration teams and scanned on to the electronic system.

The electronic system could be accessed by all members of the multidisciplinary team, including the social workers and so was readily available when required. However, agency staff were unable to access or input on to the electronic recording system. Services had systems in place to ensure that these staff had access to the current patient information, including through handovers and printed care plans. The ward managers or nurses would input information onto the system for agency workers, or the agency workers would write paper notes which would be scanned on to the system. For those services where agency workers wrote paper notes that were later scanned on, like on the inpatient wards for older people with mental health problems, this meant that notes on the system were not contemporaneous.

Staff in a number of services told us that navigation around the system could be difficult as information was not always stored in the same part of the record. Pharmacy staff admitted that they too found it difficult to access information relating to physical health monitoring using the clinical system. The trust had a formulary available to staff via the intranet.

Some teams used paper record as well as the electronic records, for example the respite services, as well as the community services for people with learning disabilities or autism and adults with mental health problems. These paper files were stored securely in most cases, except at the respite services the cabinet containing these paper records was not locked and the door was wedged open to the nurse's office containing these files during our inspection.

The use of paper records as well as electronic records could cause confusion for the wider teams accessing the system, as the most up to date information may not be held in the central electronic record. For example, in the community services for adults with mental health problems, information was recorded on paper in addition to the electronic system. This meant that some teams may not have real time access to the information that had been recorded on the paper patient records. This included crisis teams and inpatient wards that may need information to deliver care outside of operating hours. The chief information officer recognised that it was a challenge for staff not working on site to access and update electronic records, including providing remote access and that the PARIS electronic system was a challenge in itself. The interim Chief Executive Officer confirmed that they were aware of these challenges and as a trust they were considering the way forward with regard to the patient information systems.

The electronic record system was a challenge for the specialist community services for deaf children and young people with mental health problems so these services either kept electronic and paper records, or just paper records. The documents within the electronic system were adult and hearing based and so not necessarily appropriate for these services.

Best practice in treatment and care

The Clinical Audit and Effectiveness Team coordinated the implementation of the National Institute of Health and Care Excellence guidance throughout the trust. The effective care committee ensured that the guidance was relevant to the trust and following dissemination through the trust's governance structures, the committee ensured that the appropriate action had been taken. Compliance declarations were sent to the commissioners, including any action plans, for National Institute of Health and Care Excellence guidance implemented. For example, to ensure that access across the trust to psychological therapies and family therapies was compliant with the National Institute of Health and Care Excellence guidance, action had been taken to integrate the psychological therapies with the community mental health services. Psychological therapies were available to all patients.

The care plans we reviewed referenced current guidance from the National Institute of Health and Care Excellence except at Two Woodland Square where staff had included

outdated guidance in care plans, for example, a patient had gastrostomy guidelines in their file, which professionals had written in in 2003 and 2004 and the same patient had dietician guidelines from 2005 in their file. This put patients at risk because new staff, who did not know the patient, might follow outdated care plans with misleading guidance.

Patients were offered a choice of prescribed medication and regular medication reviews were carried out with the support of the trust pharmacist. Staff were aware of the requirement for physical health monitoring in patients taking high dose antipsychotics, however, there were no robust systems in place to ensure that this monitoring was completed. There was a lack of clarity regarding who should take responsibility for ensuring that physical health checks were completed. This meant that local GPs sometimes refused to monitor physical health in patients known to the trust. National Institute of Health and Care Excellence guidance states that for some medicines, clinical responsibility remains with the Consultant Psychiatrist and this has been the source of debate regarding who should take responsibility for physical health monitoring.

Smoking cessation therapy was offered to patients throughout the trust.

Within all teams and services, there were good procedures in place to monitor the physical health of patients and to ensure that patients' physical health needs were being met. Staff updated adult modified early warning scores and baseline physical health observations. The Modified Early Warning Score is a tool used to record consistently blood pressure, heart rate, temperature, respirations and oxygen saturations. A physical health screening tool which staff completed with patients, included information about alcohol consumption, substance misuse, smoking and nutrition. Monitoring of physical health throughout a patients stay was evident. Patients' weights were recorded. There was also evidence of ongoing health monitoring during treatment, except on the crisis assessment unit. Staff worked with other health professionals such as tissue viability nurses and physiotherapists to help patients with their health needs and in particular with the acute trusts and the primary care GPs.

Recognised models, tools and interventions were used by the occupational therapy teams, for example the model of human occupation and the associated screening tool.

However, no recognised standardised occupational therapy tools were being used to measure interventions and outcomes for patients on the inpatient wards for older people with mental health problems.

Staff in the memory service routinely used tools specifically aligned to the dementia pathway to inform patients about their recovery. This included the Addenbrooke's Cognitive Examination tool for memory testing, Assessment of Motor and Process Skills and the Pool Activity Level tool for assessing patients' function and abilities.

We had a concern that the service manager in the crisis assessment unit told us that the service was unable to find any guidance from the National Institute for Health and Care Excellence that would apply to the service. Guidance that would apply to the service would include such areas as best practice in medication and assessment and referral in a crisis.

In the specialist community service for deaf children and young people with mental health problems, members of the team were involved in developing national quality standards for working with deaf children for the National Institute for Health and Care excellence. Care pathways, 'working with deaf parents' and 'self-harm' were being submitted to the National Institute for Health and Care Excellence from the service.

Staff used various rating scales to assess and record severity and outcomes. These included the health of the nation outcome scale, which covers a wide range of health and social domains, psychiatric symptoms, physical health, functioning, relationships and housing. In the children's and young people's mental health services, the trust used health of the nation outcome scales specifically for children and adolescents.

Across the teams and services we inspected, staff also used the shortened version of the Warwick-Edinburgh Mental Well-being scale, the Liverpool University Neuroleptic Side Effect Rating Scale, the Goal Attainment Scale, the Beck's Depression Inventory and the Clinician Outcomes in Routine Evaluation assessment.

The trust pharmacy team completed a number of medicines related audits to assess quality and to assist in the identification of areas for improvement. These included audits of:

- < >

Rapid tranquilisation as (part of POMH-UK audits)

- High dose antipsychotics audit (as part of POMH –UK audits)
- Medicines reconciliation
- Antibiotic use
- Drug chart audits (which included missed doses – have asked if there is a critical drugs list in the trust)
- Dispensing errors
- Medicines storage

However, the medication audits completed at individual team and ward level were varied. We saw that there were some missed doses on the paper prescription charts. The MedChart system made it difficult to review missed doses of medicines. The internal audit systems were not always sufficiently robust to identify missed doses or other medication issues. At The Mount on wards one and four for older adults with mental health problems, we identified missed doses and nursing staff did not understand the impact that a missed dose of a medicine for Parkinson's disease could have on a patient. Missed doses of medication were also identified on the inpatient wards for children and young people with mental health problems at Mill Lodge. Similarly in the supported living service the internal medication audit systems had not identified issues that we found during the inspection around the storage and administration of medicines. On the inpatient wards for patients with learning disabilities or autism, during the inspection, we found four drugs errors at Two Woodlands Square and two errors at Parkside Lodge during the inspection relating to medication administration. On theses wards, staff told us that they did not do medication audits and so they had not picked up these errors, despite the trust stating that weekly medication audits took place. Medication errors were also identified in the respite services for patients with learning disabilities or autism.

There was a comprehensive audit programme across the trust and in the teams and services we inspected; though the staff who were not involved in these audits were not always aware of them. A robust clinical audit procedure provided guidance for staff participating in clinical audit and all clinical audits were supported and monitored by the Clinical Audit and Effectiveness Team. We observed an overview of the audit action plans, which included 49 audits and detailed the progress made. Audit subjects included improving information systems, adherence the National Institute of Health and Care Excellence guidance and to other national standards, medication administration, Mental Health Act application, incident reporting and lessons learnt and creative ways to improve pathways in the trust.

The trust participated in the National Audit of Schizophrenia and the National Audit of Psychological Therapies.

Skilled staff to deliver care

All teams consisted of a wide range of disciplines, included consultant psychiatrists and junior doctors, nurses and health support workers, occupational therapists and regular input from pharmacy. Other professionals were engaged as required, for example social workers, housing officers, speech and language therapists, dieticians, physiotherapists and specialist doctors. Other staff members important to the operation of the wards although not involved in direct care included the administration workers, receptionists, housekeeping and domestic staff.

The managers and staff we spoke with told us they had regular supervision. This included managerial and clinical supervision. The trust's supervision policy required that all full-time clinical staff undertook clinical supervision for a minimum of an hour every two months. However, the trust average clinical supervision rate as of the 30 June 2016 was 70%. The services that had the highest compliance for clinical supervision were the mental health services for children and young people. The specialist community services for deaf children and young people had 83% compliance rate and the inpatient wards for children and young people had a compliance rate of 82%. The only other services that had a compliance rate over 75% for clinical supervision were the community services for adults with mental health problems and the community services for people with learning disabilities or autism. Clinical supervision compliance was below 50% in some services, including the Yorkshire Centre for Psychological Medicine, Parkside Lodge and Three Woodland Square and the inpatient wards for older adults with mental health problems.

Staff also received an annual appraisal. The appraisal rate for the trust as of the 30 June 2016 was 82%. The trust target for appraisals was 90%. Improving the appraisal rate and achieving the trust target was an outstanding action

from the previous inspection in 2014. The trust did not meet their own target for the percentage of appraisals completed across the trust. Though most teams and services did not meet the 90% compliance rate for appraisals, the compliance was generally high and above 75%. There were a few exceptions including Parkside Lodge, the crisis assessment unit and intensive community service, all of which were below 60%. In the NHS staff survey 2015, 87% of staff in the trust reported that they had completed an appraisal. The national average for similar organisations was 89%.

All staff received a trust induction, including training and local working instructions. Induction training met with the Care Certificate standards for care. Staff had access to their own training record on the electronic training system that the trust used. This was called the 'I Learn' system where staff could see their own training compliance and available training courses. In addition, on the Yorkshire Centre for Psychological Medicine, there was a specific four-month ward preceptorship package, which all staff completed. This prepared them for working with patients who had complex mental and physical health conditions.

During trust induction, pharmacy staff were used to deliver medicines management sessions; however, this had stopped happening due to changes in the induction programme schedule. This meant that junior doctors did not receive any teaching sessions from the pharmacy team on induction.

There was an e-learning package aimed at junior doctors, however it was not specific to mental health. An education and training pharmacist within the trust had offered to develop a module specific to mental health to assist with this.

We were told that student nurses shadowed pharmacy technicians for half a day to gain some understanding of medicines management.

Pharmacy staff completed competency checks before they were allowed to do final checks on dispensed medicines.

Mandatory training compliance for the trust was 80% which was below the trust compliance target of 90%. Outside of this mandatory training, staff could undertake various specialist training courses appropriate to their role.

The trust had a Medicines Safety Officer who was also the Lead Pharmacist for Medicine Risk Management, Community & Gender Identity. This pharmacist was also a prescriber and the only person in the country who has a specialist practice in gender identity.

Regular team meetings took place in all teams and services and all members of the multidisciplinary teams attended these.

According to the General Medical Council, as of the 22 July 2016, 113 doctors at the trust had been revalidated. Revalidation is the process by which licensed doctors are required to demonstrate on a regular basis that they are up to date and fit to practise. Revalidation aims to give extra confidence to patients that their doctor is being regularly checked by their employer and the General Medical Council. However, only 101 doctors revalidated had connections to the trust. This meant that revalidation rates for the trust were more than 100%. The reasons for this provided by the trust were that this data included all revalidation recommendations made since the introduction of medical revalidation, as well as for doctors who had since retired or left the trust.

We observed 20 personnel records of staff with different professional roles. All the records we reviewed held the information required in line with the trust's reference procedure. These records demonstrated that the trust had completed the necessary checks to ensure that the staff they had employed were of good character and had the appropriate qualifications, skills, experience and competency to fulfil their role and the sufficient health to complete their role with necessary adjustments.

The trust was committed to addressing poor performance. At the time of the inspection, there was an improvement plan at the forensic services in York to address concerns with staff attitude and performance. The trust had a personal performance policy which set out what the trust expected from staff and what the staff could expect from the trust. There was a procedure to manage poor staff performance and disciplinary issues. Team managers were able to access support from the trust's human resources team when required. During the inspection, we observed five disciplinary records, including two dismissals, two final written and a first written warning. The records demonstrated a fair process including a thorough

investigation, involvement of the human resources team, evidence that additional support was offered for example from occupational health and evidence of union involvement from Staff Side.

Multidisciplinary and inter-agency team work

The results of the NHS staff survey 2015 showed that the trust scored 3.74 for effective team working. This was slightly worse than the average score for other mental health trusts of 3.82.

We observed effective multidisciplinary working. Staff held regular multidisciplinary meetings on both the inpatient wards and in the community services where staff considered all aspects of the patient's care and new patient referrals. Multidisciplinary meetings included a discussion about risk, treatment, discharge, detention and the mental capacity of each patient. The multidisciplinary team invited other professionals such as social workers and advocates to these meeting where appropriate.

Patients were invited to participate in the multidisciplinary meetings, or teams ensured that patient's views were included in these meetings. For example on the inpatient wards for older aged adults with mental health problems, on the inpatient wards for children and young people with mental health problems and the inpatient wards for people with learning disabilities or autism, patients were given the opportunity beforehand to contribute their views in a format appropriate to the individual.

Staff told us that they felt supported to make decisions about patients care and treatment within these meetings.

We observed handovers between shifts in the inpatient areas and observed each patient being discussed in turn to ensure the nurses and the health support workers on the new shift were aware of the treatment requirements and status of each patient.

There were good examples of integrated partnership working between the trust and other agencies. For example, mental health crisis triage teams had two nurses to work within the police control centre based in Leeds to support them in identifying the most appropriate course of action for people with mental health problems. Also, the Yorkshire Centre for Psychological Medicine operated from within the Leeds Teaching Hospital Trust and therefore had to be mindful of local working practices as well as their own trust policies. The staff had built effective working relationships with the hospital where the service was based. In addition, the memory support worker was employed by the Alzheimer's society and worked together with the memory service team to offer support and advice to patients and carers after they received a diagnosis. Also a consultant geriatrician from the acute trust held weekly reviews on the inpatient wards for older adults with mental health problems and accepted referrals for patients who required support with their physical health

The service had good working relationships with other internal trust services, for example the crisis teams and pharmacy support, despite some staff describing local working issues. For example the intensive support team did not always have a clear understanding of the crisis assessment unit criteria and there were complaints that the crisis teams did not always fully explain to patients, relatives and carers about the inpatient service they were being referred to.

The inpatient wards and services had good relationships with the external professionals, agencies and services. This included GP surgeries, the police, adult social care, child safeguarding, schools, colleges, befriending services and other voluntary organisations.

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

Training in the Mental Health Act was mandatory for all staff and the trust had set a target for 90% to be achieved by July 2016. The 90% target had not been achieved trustwide or in any of the services. The trust compliance for the mandatory training in the Mental Health Act level two was 62% for the inpatient setting and 63% for community setting, the overall trust compliance was 76% combined for level one and level two. At service level training compliance ranged from 41% in wards for older people to 89% in specialist community deaf child and adolescent mental health service. However, in most services staff understood their responsibilities under the Mental Health Act and how it related to their service.

The Mental health Act code of practice came into effect in April 2015.The trust had not updated all of its polices in relation to the updated Mental Health Act code of practice and there was no overall plan detailing how the trust was implementing the changes to the code. Some polices had been updated such as search of service users effective 8 July 2016; procedure for use of seclusion and long term

segregation effective 8 July 2016. Some other policies were in draft form and others required amendments to be compliant with the code. Senior management did not have a good understanding of which policies required updating or which one's had been reviewed and updated. This meant it was difficult for staff to know if their practice was in line with the revised code of practice and as such, patients' rights may not be upheld.

The seclusion policy had been updated three days before the inspection and It was further updated during the inspection. In the child and adolescent mental health services ward staff did not have a clear understanding of what constituted seclusion or the procedures they needed to follow to ensure patients were protected by the safeguards of the Mental Health Act code of practice. In Parkside Lodge staff had not followed the guidance in the code of practice while patients were in seclusion.

The doors to many of the wards we visited were locked. On Parkside Lodge however, there was no information displayed to inform patients of the process to enable them to leave the ward. This was especially important for informal patients. Some wards had arrangements in place for informal patients to leave the ward. At the Becklin Centre and two wards at The Mount informal patients were assessed to have a swipe card to leave the ward. On another older person's wards there were keypads next to the door with the number to open the door clearly displayed.

Consent to treatment under the Mental Health Act was generally well documented in patient records. However, in long stay rehabilitation mental health wards capacity and consent to treatment assessments were only in three of the ten patient records we looked at. In acute & psychiatric intensive care units we found the electronic prescribing system did not always accurately reflect the most up to date authorisation certificate. On ward three at the Becklin Centre we saw eight patients had more than one authorisation certificate. In learning disability inpatient wards staff had assessed and recorded capacity to consent to medication but had not revisited the capacity assessment three months after the start of treatment. This meant that the patients capacity and consent to treatment and was not clear and treatment may be given without the appropriate consent.

Second opinion appointed doctors provide a safeguard after three months of treatment for patients who lacked capacity to consent to treatment or those who refused treatment. We found that second opinion appointed doctors were not requested in a timely manner. This means other authority, such as treatment in an emergency, needed to be used. Section 62 authorises treatment in an emergency if these reviewed more timely there would be no need to use section 62. The Mental Health Act code of practice states this should be monitored but the trust had not implemented a system to monitor the use of section 62 authorisation.

Section 132 rights were explained to patients on admission and revisited when required at regular intervals, information leaflets were available in easy read and other languages. In learning disability inpatient wards staff used easy read versions with patients who had learning disabilities. In child and adolescent mental health services we saw an example of a recently detained patient with limited understanding having their rights explained three times in one day. Staff also gave written information to the patient and their relative or carer. We found some issues with the documenting of this process. In wards for older people we looked at four patient's records specifically in relation to their rights. Two of these records showed gaps despite a lack of patients' understanding. In one case, the gap was over three months. In crisis and health based place of safety a recent audit indicated that staff were not routinely documenting this in care notes.

We saw evidence that patients had access to appeals against their detention.

The trust had a central Mental Health Act legislation team based at the Beklin Centre who provided support to the wards and community. The team supported training, detention documentation and advice in relation to Mental Health Act, Mental Capacity Act and Deprivation of Liberty Safeguards. The trust had improved systems to support the process of receiving and checking Mental Health Act documentation and the trust was able to provide data regarding errors and internal audits. However, we found there were delays in identifying errors with detention documents which could result in patients being deprived of their liberty without the legal authority. Between January and June 2016, 36 detention files were audited and errors were identified on seven of these. These related to the

completion and the content of the detention papers including insufficient reasons recorded for detention, nearest relative not being consulted and administration errors such as a missing address.

Section 17 leave was authorised on a standard form. These forms were generally completed in a clear and concise way across the trust with the exception of older people's wards where old forms were not clearly cancelled. On wards one and two some patients had more than one form still in date and staff were not clear which was in use, this could lead to confusion.

Staff and patients told us there was good access to independent mental health advocates. Patients were able to refer themselves and we saw posters on wards with contact details. Staff would also refer patients should they prefer it. In forensic wards advocates visited the wards on a weekly basis. In wards for older people staff told us they referred all detained patients to the service and the advocate visited the wards on a regular basis.

Good practice in applying the Mental Capacity Act

Compliance for training on the Mental Capacity Act and Deprivation of Liberty Safeguards was 76%. This training was identified as mandatory training in February 2015 and the training schedule was implemented in July 2015. The trust assured us that the compliance for Mental Health Act and the Mental Capacity Act would meet the trust compliance target of 90% by July 2016. We had concerns that five teams or services had below 75% compliance in the Mental Capacity Act training, including Deprivation of Liberty Safeguards. Four of these services had compliance above 70% including the long stay and rehabilitation wards, the forensic and secure wards, the acute wards and psychiatric intensive care unit and the community services for adults of working age with a mental health problem. However, the wards for older adults with a mental health problem had a compliance of 43% for this training. Staff understanding of the Mental Capacity Act and the Deprivation of Liberty Safeguards and their use in practice was variable in the core services. On the acute wards staff were not clear about their responsibilities under the Mental Capacity Act. Capacity assessments were only carried out by consultants.

The trust had a Mental Capacity Act 2005 protocol which had recently been updated to include procedural changes in the trust. The protocol described how to carry out an assessment of capacity, a best interest decision and how to record these on the trust's patient electronic record system either in the records or using a specific form. Recording forms were also available on the trust's intranet for staff to download. We found little evidence of capacity assessments and best interests decisions being completed in most of the core services. On the inpatient wards for older adults with mental health problems, staff were not completing Mental Capacity Act capacity assessments as required by trust policy, which meant we could not ensure the Act was being used correctly.

The trust had a Deprivation of liberty safeguards protocol which was reviewed in June 2016. A revised policy was awaiting review by the Mental Health Legisltation operational steering group and subsequent ratification by the policies and procedures group. However, the protocol gave details of deprivation of liberty, how to apply for an authorisation and how this was managed in the trust. Deprivation of Liberty Safeguards were not well understood or used in some of the core services. Patients at 2 and 3 Woodland Square lacked capacity to consent to their respite care and treatment. They were subject to continuous supervision and control and were not allowed to leave. The service had carried out capacity assessments but had not made applications for Deprivation of Liberty Safeguards. These patients had also been identified by the mental health legislation office as being deprived of their liberty. We were informed that the clinical team were awaiting advice from the local authority before taking action. There was no process in place to deal with this type of conflict in the trust guidance or protocol. These safeguards are a lawful requirement to ensure the service upholds the human rights of patients. The mental health legislation office kept a detailed central record of all Deprivation of Liberty Safeguards assessment outcomes.

Where capacity was impaired, we did not find that capacity to consent was constantly assessed. We saw evidence of decision specific assessments in the care records but these were usually completed by medical staff, other disciples of staff, such as nursing, looked to medical staff to carryout capacity assessments. We did not see attempts to support people to make a specific decision for themselves before they were assumed to lack the mental capacity to make it.

We saw evidence of best interests being made for people but these were not always accompanied by a capacity assessment.

Requires improvement

Are services effective?

Staff understand and where appropriate work within the Mental Capacity Act definition of restraint.

The trust had a central mental health legislation office which could be contacted for advice and guidance in relation to the Mental Capacity Act and Deprivation of Liberty Safeguards and staff knew how to contact this office. However, advice from the office was not always followed by clinical staff and the office found it difficult to address this with senior management.

Both Mental Capacity Act and Deprivation of liberty protocols had audit requirements However, we could not find any evidence that addressed these audit requirements. The trust had recently carried out an audit into clinician knowledge of the Mental Capacity Act, clinical audit number 12, which showed more than 70% of the staff self-reported that they were confident in their knowledge of the Mental Capacity Act and Deprivation of Liberty Safeguards. However, 45 % of staff were not familiar with policy, procedure or processes for the Deprivation of liberty safeguards.

The trust provided information around the Deprivation of Liberty Safeguards applications they have made between 1 October 2015 and 31 March 2016.There were 13 Deprivation of liberty safeguards applications made with the majority in mental health wards for older people by ward 1 and ward 3 with 4 applications each.

Good

Are services caring?

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

Summary of findings

We rated Leeds and York Partnership NHS Foundation Trust as good for caring because:

- Staff were respectful, caring and compassionate towards patients, relatives and carers. Patients, relatives and carers told us that staff were kind, visible and approachable.
- Staff were mindful of the best way to communicate with patients in order to support them. Communication was appropriate to the patients' level of understanding or appropriate to their age.
- We observed examples on the wards and during home visits where staff maintained patients' dignity, privacy and confidentiality. The trust scored higher than the England average on the patient led assessment of the care environment for privacy, dignity and well-being.
- Patients were orientated to all wards and services and were involved in decisions around their treatment and care. Where patients were unable to attend multidisciplinary meetings directly their views and opinions were communicated in other ways.
- Patients told us that they were involved in their care plans and most of the patients we spoke with during the inspection told us they could have a copy of the care plan if they wanted one. Staff produced different versions of care plans in accessible formats, for example in the community services for deaf children and adolescents and the community services for learning disabilities or autism.
- We observed good examples of patient involvement in the service. Patients were involved in the central recruitment of staff and volunteers had been recruited in the intensive community services and the community services for working age adults and older age adults with mental health to support and engage patients. A patient in the Leeds Autism Diagnostic Service was involved in the training videos to explain their experiences of living with autism.
- Staff supported patients to use advocacy services and the wards and services we inspected had established good links with adult advocacy services.
- Patients were able to feedback on the majority of wards through weekly community or forum meetings on the inpatient wards. Whilst staff, patients, relatives and carers all found collecting and providing feedback more of a challenge in the community services, there were some proactive initiatives to gain feedback in these services, including the use of electronic devices to gather patient experiences.

However:

- We heard patients detained with Ministry of Justice restrictions referred to in an appropriate way.
- On the inpatient wards for children and adolescents with mental health problems, the advocacy services offered by the trust were not specifically for children and adolescents.
- There were no patient meetings at the respite services for people with learning disabilities or autism. This meant that opportunities for patients to feedback about their stay were limited.

Our findings

Kindness, dignity, respect and support

The Friends and Family Test was launched in April 2013. It asks people who use services whether they would recommend the services they have used; giving them the opportunity to feedback on their experiences of care and treatment. The trust scored below the England average for recommending the trust as a place to receive care for each of the six months October 2015 to March 2016. Eighty-one percent of patients would recommend the trust as a place

to receive care. This was below the national average of 87%. Patients who would not recommend the trust as a place to receive care was comparable to the national response for other trusts.

Patient led assessments of the care environment or PLACE assessments are self-assessments undertaken by NHS and private/ independent health care providers. At least 50% of the assessors are members of the public known as patient assessors. PLACE assessments focus on different aspects of the environment in which care is provided and non-clinical services. In relation to privacy, dignity and wellbeing, the 2015 PLACE score for the trust was 91%, which was above the England average of 86%. The Newsam Centre scored the highest on the PLACE assessment for privacy, dignity and well-being with 95%. The Asket Centre, the Mount and the Becklin Centre all scored above 90%. However, five locations scored below the England average, including Parkside Lodge, one of the wards we inspected for people with a learning disability or autism.

As part of the inspection, we spent time observing staff interactions with patients. We found that staff were respectful, caring and compassionate towards patients, relatives and carers. Staff worked in a flexible, person centred way. Person centred means maintaining the individual's choices, preferences and wishes so that people receive the support they want and how they like it. We noted that staff identified the best way to communicate with patients in order to support them. Communication was appropriate to the patients' level of understanding or appropriate to their age.

However, during the inspection on the forensic wards at Clifton House, 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.

Staff maintained patients' dignity, privacy and confidentiality and we observed examples on the wards and during home visits. For example, on the acute wards and the wards for people with learning disabilities or autism, we observed patients supported to a private space to discuss their concerns. In the community services for adults of working age and older age adults, we observed staff taking steps to protect patients' confidentiality by taking off their identification badges before seeing a patient in the community.

Almost all the patients, relatives and carers we spoke to confirmed that they were happy with the care and treatment delivered by the wards and services in the trust. They spoke highly of the support they received. They told us that staff were kind and caring, visible and approachable. Patients told us that they felt safe.

The staff Friends and Family Test was launched in April 2014 in all NHS trusts providing acute, community, ambulance and mental health services in England. It asks staff whether they would recommend their service as a place to receive care and whether they would recommend their service as a place of work. Sixty percent of staff would recommend the trust as a place to receive care. This was below the England average of 79%. Nationally 7% of staff would not recommend the trust they work for as a place to receive care. In comparison, 13% of staff working in the trust would not recommend it as a place to receive care. The trust also had a 3.4% lower staff response rate than the England average from 1 July to 31 September 2015, with only 8% of staff responding.

The trust scored slightly below the average for mental health trusts in the NHS staff survey 2015 for the staff satisfaction in the quality of their work and the treatment delivered at the trust. The trust scored 3.82 and the average was 3.84. Eighty-nine percent of staff agreed in the survey that their role made a difference to patients, which was the same as the national average.

The trust scored about the same as other mental health trusts in the Care Quality Commission survey in all ten questions asked, including questions about the workers in the trust and changes in who the patients see for their care, the organisation, planning and review of the care received, treatments and crisis care, other areas of their life and their overall views and experiences of the trust.

The involvement of people in the care they receive

On admission to all the wards we inspected, staff gave patients a tour of the ward and provided them with a welcome or admission pack, which contained information about the service.

On all the wards and in all the services we visited, we observed that patients were involved in decisions around their treatment and care. Where they could not attend multidisciplinary meetings directly, their views and opinions were communicated in other ways. For example in the inpatient wards for children and young people with

mental health problems at Mill Lodge, patients completed a form to record their thoughts, their progress and their wishes. Members of the multidisciplinary team discussed these in the meetings and we saw that the patient's named nurse provided feedback to the patient following this. On the inpatient wards for people with learning disabilities and autism, staff gave patients easy-read forms to complete to feed into their multidisciplinary team meeting and ensure the meeting listened to their view.

The friends and family test data collected between January and March 2016 provided by the trust, considered the views of 215 patients, relatives or carers. This data showed that patients felt safe, able to achieve their goals, listened to and that they were part of care planning. However, they reported that they had not all received a copy of their care plan.

Patients told us that they were involved in their care plans and most of the patients spoken to during the inspection told us they could have a copy of the care plan if they wanted one. We observed holistic, person centred care plans, including patient involvement in all care plans. However, in the community services for people with learning disabilities or autism, we found variable information about patient involvement in care planning, despite the patients' positive feedback about their involvement in their care plan. Of the 25 electronic patient records reviewed, we found that according to the patient electronic recording system that 11 of these patients had not received a copy of their care plan and five patients' care plans did not refer to the patients' views.

Staff supported patients to use advocacy services and the wards and services we inspected had established good links with advocacy services. Services invited the advocacy services to meetings like community meetings, multidisciplinary meetings and care programme approach meetings. Specific mental health advocacy was available through the British society for mental health and deafness in the community services for deaf children and young people who had mental health problems. However, the advocacy service used by the trust in the inpatient wards for children and young people with mental health problems was not specifically for children and adolescents.

We observed appropriate involvement of relatives and carers during the inspection and in the records reviewed. Relatives and carers supporting patients in the community services and respite services for people with learning disabilities all confirmed that the staff actively involved them in the patient's treatment and care. This was the same in the inpatient wards and community services for children and young people with mental health problems where relatives and carers were involved in the multidisciplinary meeting and at the Yorkshire Centre for Psychological Medicine where patients could choose the level of relative and carer involvement they would prefer. However, one family member on the acute wards and psychiatric intensive care unit told us staff did not take into account their concerns about their relative's care.

Patients were involved in the central recruitment of staff. The trust included patients, carers and stakeholder partners in 'community panels' to support the recruitment assessment centre activities for qualified nursing roles and health support worker roles below band seven, as well as for interviews for staff grades band seven and above.

The South, South East community mental health locality had recruited five volunteers who had previously used the service. They worked in the reception area meeting and greeting guests. One of the volunteers told us how important this role was for them and how it had empowered them to work and develop their confidence.

Patients were able to feedback on the service through weekly community or forum meetings on the inpatient wards. However, there were no patient meetings on the inpatient wards for people with learning disabilities or autism, except at Parkside Lodge which had recently started a patient involvement group. Staff said that this was because of the nature of respite, being a constant change of patients. However, that meant that opportunities for patients to feedback about their stay were limited.

Staff, patients, relatives and carers all found collecting and providing feedback more of a challenge in the community services. Relatives said it was a challenge to provide regular informal feedback, for example in the community services for people with a learning disability or autism and staff said that there was often a low response rate to feedback requests, for example in the crisis services.

However, there were some examples of proactive initiatives to gain feedback in these services, including the introduction of the on-line survey in addition to the family and friends feedback cards. An iPad project had been specifically designed that allowed service users to feedback on their experience. This was being utilised in the

Good

Are services caring?

community services for children and young people. The memory service routinely collected feedback about the cognitive stimulation group they offered to patients and used this feedback to improve their interventions.

Good

Are services responsive to people's needs?

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

Summary of findings

We rated Leeds and York Partnership NHS Foundation Trust as good for responsive because:

- The trust used information about the local population when planning and delivering services through working in partnership with the commissioners, other statutory, third-sector and voluntary organisations. These stakeholders told us that the trust was 'aspirational' and 'forward thinking' with regard to new ways of working to deliver care and treatment.
- Bed occupancy and high numbers of out of area placements for the trust had been identified as strategic risks by the trust and the trust had implemented a bed management improvement plan, including a number of initiatives like piloting the proactive purposeful admissions to inpatient care model. At the time of the inspection, the trust had nine patients placed out of area.
- The trust worked proactively and in partnership with other organisations and community services at all levels to reduce the number of patients delayed in being discharged and the number of days that patients are delayed by.
- Information on the wards and services, other local services, patients' rights, access to advocacy, medicines and treatment and how to complain was observed in almost all services. The information was in appropriate and accessible formats, for example in child friendly formats in the mental health services for children and young people and in easy read formats in the services for people with learning disabilities or autism.
- Patients were able to personalise their bedrooms on the wards and in the respite services and were encouraged to do so. They had access to lockable storage.
- Patients on the wards were able to make phone calls in private.
- Patient's individual needs and preferences were central to the planning and delivery of treatment and care at the trust. Staff respected and provided support to meet the diverse needs of their patients including those related to disability, ethnicity, faith and sexual orientation. Staff in all the services we inspected were respectful of people's cultural and spiritual needs.
- Since the last CQC inspection in 2014, the trust committed to improving its response to the complaints it received. There was a robust and effective complaints process. Almost all the wards and services we visited during our inspection demonstrated a positive culture of reporting complaints and learning from complaints and had local arrangements to discuss these in their team meetings.

However:

- There were delays for patients in the community services for working age adults and older adults with mental health problem to access some psychological therapies. Patients waited for up to 20 weeks to receive psychological therapy from a psychologist.
- Parkside Lodge, the inpatient ward for people with learning disabilities and autism, had reduced bed occupancy due to staffing concerns and so a bed was not always available for the local population. There was no bed management strategy and the bed management procedure was at the early stages of discussions.
- There was a lack of clarity of the current service provision in the crisis assessment unit at the time of the inspection. Patients were admitted who required treatment and not extended assessments, which the

Good

Are services responsive to people's needs?

unit was not currently equipped for. Staff in the unit and in other trust wide services were unclear of the role of the crisis assessment unit, including the referral criteria.

- The Section 136 suite for children and young people was formerly the service's Section 136 suite for adults. Although the suite was designated for children and adolescents, we did not note any specific adaptations to make it a child-centred environment.
- Staff and carers raised concerns that patients at 2 Woodland Square were unable to attend activities that were not pre-planned and part of the patient's normal routine prior to attending the respite service. They told us that this was due to staffing levels, the lack of a mini-bus driver, and the lack of access to specially adapted transport. The trust told us that activities were available for all patients and that appropriate transport could be arranged.
- Access to the outside space and the outside environment itself was a concern at The Mount and the Becklin Centre. Not all the wards at these sites had direct access to the gardens and outside areas and patients were unable to access these unescorted. The paths in the garden at The Mount where the wards for older adults with mental health problems were situated were gravel and therefore not ideal for patients with limited mobility and those who needed to use mobility aids. Patients were smoking in the hospital grounds and wards at the Becklin Centre. This put staff and patients at risk of the effects of passive smoking.
- There was limited choice on the inpatient wards for children and young people with mental health problems for patients' dietary requirements relating to their culture or religion, or to meet their preferences for food. Patients on these wards and the forensic wards told us that they did not like the food.

Our findings

Service planning

The trust used information about the local population when planning and delivering services. NHS England requires every area to produce a sustainability and transformation plan as part of the NHS Five Year Forward View. The trust were involved in the development of the Leeds and West Yorkshire sustainability and transformation plans, which included adult social care organisations and the acute trusts. The trust was also actively involved in the development of the West Yorkshire sustainability and transformation plan and the urgent and emergency care vanguard.

The trust told us that they had good working relationships with commissioners and other stakeholders, including third sector organisations. The trust had introduced a procurement framework to allow them to sub contract to voluntary and third sector organisations. The third sector organisations we contacted informed us that the trust was forward thinking and that they had good relationships with the trust and staff at all levels. The commissioners told us that the trust were aspirational and ambitious with regard to new ways of working. However, there were concerns regarding the trust's ability to manage and deliver on these projects and meet the targets set.

Access and discharge

In the community services, the trust overall had a mean referral to assessment of 52 days and a mean assessment to onset of treatment of 25 days. Referral time to treatment standards have been introduced for mental health trusts for a number of services. Prior to their introduction mental health services were exempt from the NHS constitution. The trust had a number of locally monitored access targets for key services as part of our contracts with commissioners. The trust measured time from referral to assessment and from assessment to treatment using activities recorded on the trust clinical information system. This measurement assumes that treatment does not begin at assessment whereas for many services there is the opportunity to begin delivery of a National Institute of Health and Care Excellence compliant treatment at the first contact with the patient.

The trust had identified eight services that breached the 18 week referral to treatment standard, including the rationale for this and taken appropriate action. For example, the trust had recently restructured the delivery of

psychological therapies and integrated this into the community services, in order to reduce the waits to psychological services in general, making it more accessible, in particular access to family therapy.

The trust was flagged as a risk for its bed occupancy ratio, looking at the average daily number of available and occupied consultant-led beds open overnight, as well as the number of detained patients allocated to a location compared with the number of available beds.

The trust had 424 beds in total and at the time of the inspection, the trust had 409 beds in operation due to refurbishment of a ward for older age adults with mental health problems at The Mount. The trust commissioned an independent report on bed capacity. The organisation that completed the review found that the trust was working at optimal bed capacity.

The trust provided details of their bed occupancy rates for 28 wards between 1 October 2015 and 31 March 2016. The average bed occupancy rate was 88% across all wards. Eighteen out of 28 wards for the trust had bed occupancies of 85% and above. The Royal College of Psychiatrists state that the optimal bed occupancy is 85% as this allows patients to be admitted to a ward that is local to them in a timely way. It also allows patients to leave the ward and return to the same ward following a period of leave. The highest bed occupancy rate was ward four at the Becklin Centre, the acute wards for adults of working age, with a bed occupancy rate of 99.9%. Wards three and five Woodland Square had the lowest bed occupancy with 24%.

The acute wards for adults of working age and psychiatric intensive care units had the highest bed occupancy with 98%. The lowest bed occupancy recorded was for the inpatient wards for patients with learning disabilities or autism with 48%. Bed occupancy was 48% at Parkside Lodge, 73% at two Woodland Square and 23% at three Woodland Square. The ward manager explained that bed occupancy was low at Parkside Lodge because they did not accept admissions if the ward was not safe due to staffing or the patient case-mix. This meant patients in the local area could not be admitted if this was required, regardless of the low bed-occupancy and the patient would be transferred out of area or admission to the ward would be delayed.

Between the 1 April 2015 and 31 March 2016, the average length of stay across all wards for discharged patients was 212 days. In the same time-frame, the average length of stay across all wards for current patients was 285. The forensic and secure inpatient wards had the highest 'average length of stay for patients discharged in the last 12 months with 498 days. This was followed by the long stay and rehabilitation wards for adults with mental health issues which had an average length of stay of 362 days for patients discharged in the last 12 months. As of the 13 April 2016, the average length of stay for current patients was the highest in these same two inpatient services. The long stay and rehabilitation inpatient wards had the longest average length of stay with 777 days, followed by the forensic services with an average length of stay for current patients of 570 days.

In the 12 months prior to March 2016, 127 patients had recived care in out of area placements. Ninty-six were patients using acute wards for adults of working age and the psychiatric intensive care unit, 24 for the long stay and rehabilitation mental health wards for adults of working age, five for wards for older people with mental health problems and, two for wards for people with learning disabilities or autism, in the 12 months prior to March 2016. Patients placed out of area, predominantly went to services in North Yorkshire, County Durham and Cheshire. However, about a fifth of patients were placed in services as far away as Nottinghamshire, Hertfordshire and London. The trust had the financial and clinical responsibility for the out of area placements. The commissioners had concerns that the trust did not have sufficient case managers to deal with the out of area placements. However, at the time of the inspection, there were nine patients being cared for in an out of area placement and we observed the Board of Governors reviewing the numbers of out of area placements at the meeting we attended.

The Quarterly Mental Health Community Teams Activity return collects data on the number of patients on a Care Programme Approach followed up within seven days following discharge from psychiatric inpatient care. Between January 2016 and March 2016, the trust achieved 96% for the number of patients on a Care Programme Approach who were followed up within seven days after discharge. This was above their target of 95% required by Monitor but 1% below the England average.

Between the 1 October 2015 and the 31 March 2016, the trust reported 129 readmissions within 90 days across 28 wards. The wards with the highest number of readmissions,

was the crisis assessment unit with 35 readmissions within 90 days. This was followed by the two acute wards for adults of working age at the Becklin Centre, ward five and ward four, with 22 and 15 readmissions within 90 days, respectively. The significant majority of readmissions within 90 days occurred on the acute wards for adults of working age and psychiatric intensive care units, with 66. This was 51% of all readmissions within 90 days.

From 1 October 2015 to 31 March 2016, there were three delayed discharges across three wards. Ward one at the Becklin Centre had one patient who was delayed for a total of 153 days and ward three at the Becklin Centre had another patient whose discharge had been delayed for 62 days. Both these wards are the acute wards for the adults of working age. The third delayed discharge reported by the trust was on ward four at the Mount, the wards for older adults with mental health problems, where a patient was delayed for a total of 43 days. The average delay across the three wards (in terms of days) for delayed discharges was 86 days. The reasons the trust provided for these three delayed discharges was that two people were waiting for residential care and one person waiting for accommodation.

The trust complies with the national guidance to determine numbers of service users whose transfer of care from hospital has been delayed. The guidance states that for a transfer to be delayed a multidisciplinary team decision that the service user is clinically fit for discharge must been recorded and it must be safe to discharge the service user.

Between May 2015 and April 2016, the total number of delayed transfers was 38. The trust's total number of delayed patients transferring peaked in May 2015, July 2015 and then April 2016, but remained at a relatively steady level in other months. The number that was the responsibility of social care was higher than the number that was the responsibility of NHS in every month. The number of delayed days in this time period was 1,131 days.

Between May 2015 and April 2016, the main reason for the delayed transfers for patients for ten months of that year was that patients were waiting for a residential home placement. Forty-seven percent of delayed transfers were due to patients waiting for a residential home placement and totalled 526 delayed days, 26% were due to patients waiting for a nursing home placement or availability which totalled 297 delayed days and 18% were due to housing issues that totalled 235 delayed days.

All admissions to the acute admission wards were gate kept by the crisis assessment service to ensure that the service user's needs could not be met by alternatives to hospital admission. Admissions to the psychiatric intensive care unit were gate kept by that team to ensure that the patients' needs could not be met in a less restrictive environment. The crisis assessment unit was a specialist unit within the crisis assessment service providing extended mental health assessments for people over the age of 18 years old for a period of up to 72 hours. This six-bedded unit opened in 2015. Since opening the unit had accepted around 250 admissions and has reduced admissions to acute inpatients by up to 4 admissions per week. In the period January 2016 to June 2016, 46% of patients referred to the crisis assessment service waited more than four hours for an assessment, 14% of patients were seen within four to eight hours, 5% of patients were seen within eight-twelve hours, 11% of patients were seen within 12-24 hours, and 16% of patients were seen after 24 hours.

Bed management was one of the strategic risks identified by the trust and a bed management improvement plan was in place. However, staff we spoke to were concerned that there was no bed management strategy, particularly with the concerns regarding the out of area placements. Also, the West Yorkshire sustainability and transformation plan includes a reduction in out of area placements by 50% by 2021. There were also concerns that there was no bed management policy. The trust confirmed that the bed management procedure was is in very early stages and was due to go to the bed management group for completion at the end of July before going through the trust governance processes for ratification.

The trust has a bed bureau team which included the capacity manager, four administration staff and a recently appointed housing support co-ordinator. The capacity manager worked across both care groups and was accountable to the chief operating officer. The team monitored admissions and discharges to ensure that beds were available to patients as soon as possible. They were proactive in following up out of area placements and searching for accommodation and social care placements. The housing support coordinator worked with patients to access options for housing at discharge, for example support patients through the bidding process and provides additional expertise.

Good

Are services responsive to people's needs?

All wards used purposeful inpatient admission boards to help plan discharge as soon after admission as possible. The boards highlighted actions to be taken to facilitate discharge and provide a structured and visible way of monitoring that these actions take place at the right time. There was a 'purposeful admissions to inpatient care' model being piloted on the acute wards for adults of working age, where staff regularly monitored the patient journey as a multidisciplinary team.

The trust had increased its joint working between the trust and partners from adult social care, the local commissioning groups and third sector organisations to work together to facilitate timely discharge and the provision of increased wrap-around support in the community, rather than admissions to residential settings or nursing homes.

We had concerns that the crisis assessment unit which provided a safe space for its purpose of undertaking extended assessments of adults experiencing acute and complex mental health crises which required a period of assessment of up to 72 hours, was also being used for other purposes for which it was not fit for purpose. Whilst the trust acknowledged that the crisis assessment unit had the provision to accept patients waiting for admission to acute wards to maintain their safety, we had concerns that there was a lack of clarity of the current service provision at the time of the inspection and that staff were unclear of the role of the crisis assessment unit.

The crisis assessment unit had, in some cases, admitted people who required treatment and not extended assessments. This was not the stated purpose of the unit and it was therefore not equipped for treatment interventions, including meaningful activities. The unit had admitted older people over the age of 65 including one with a diagnosis of dementia. However, because the unit was not designed for treatment, it did not meet the Department of Health's (2015) guidance 'dementia friendly health and social care environments'. We asked the service to clarify 'short term treatment in a safe space' and were told that the patients had been admitted for clozapine titration in one case and to manage the effects of electro-convulsive therapy in another.

We found that the additional roles the crisis assessment unit was undertaking had created a lack of clarity about the purpose of the unit both within the crisis assessment service and in other services within the trust. Staff in the intensive community service told us that they were not sure of the criteria for admitting people to the crisis assessment unit and provided examples of incidents where they had attempted referrals to the unit for people they believed matched the criteria to be told that the person was not acceptable for admission. The unit was opened in recognition of a gap in provision for the crisis assessment service to be able to undertake assessments over a longer time period, to fully assess risk and in so doing to reduce unnecessary admissions. However, the beds within the crisis assessment unit had become part of the overall system for bed management

Team meeting minutes from April 2016 indicated that the service adopted new referral criteria, which had significantly decreased the number of patients requiring unit-based treatment. However, the service manager was clear that the service did not have a set referral criteria. We asked the service to provide referral criteria but the service was unable to provide this.

The facilities promote recovery, comfort, dignity and confidentiality

Medicines information leaflets were available in different languages via the Choice and medication website, accessible via the trust intranet. Staff also had access to medicines information in formats that were suitable for patients living with learning disabilities and pharmacy staff attended a number of patient groups to provide information about medicines. They also attended carers meetings to them with medicines knowledge.

Information on the ward or community service, other local services, patients' rights, access to advocacy and how to complain was observed in almost all services. This information included information for detained patients under the Mental Health Act regarding appeals and tribunals and also information in the community services for patients subject to community treatment orders. The information was in appropriate and accessible formats, for example in child friendly formats in the mental health services for children and young people and in easy read formats in the services for people with learning disabilities or autism.

However, it was noted in the older people's service, the contact information for detained patients about their right to complain to the Care Quality Commission included an incorrect address. These were replaced with posters

displaying the correct address during out inspection. Also, there was no information on how to complain in an easy read format in the inpatient services for people with a learning disability or autism. In the east-north-east team, one of the community services for people with learning disabilities or autism, information about advocacy services and how to access them was not on display. We fed this back during our visit and the manager assured us they would address this immediately

The inpatient wards for people with mental health problems and learning disabilities or autism, had a range of rooms and equipment to deliver treatment and care to patients and to support their rehabilitation and recovery of patients. However, there were concerns identified on some wards, notably around sufficient space for visiting, examination and for meals and with access to outside space.

There was insufficient space at the Yorkshire Centre for Psychological Medicine, Two Woodland Square and the crisis assessment service to have a clinic room or an examination bed in order to deliver care and treatment and also to facilitate private visits that were not in the patients' rooms.

The Yorkshire Centre for Psychological Medicine did not have sufficient room in the clinic for an examination bed, or sufficient space on the ward for visits and the patient lounges doubled up as the activity rooms. This meant that patients were unable to use these rooms to relax when activities were in progress. Similarly, the wards for patients with learning disabilities and autism did not have a specific activity room. Two Woodland's Square did not have sufficient space in the clinic room for an examination bed and the design of the service did not meet the needs of the patient group. Boxes of medical equipment such as continence products and wipes were stored in patient bedrooms and on corridors. The ward only had one storage room, which also meant that patients were unable to bring all of their specialist equipment when they stayed. At both two and three Woodland Square, visitors would need to meet with patients in bedrooms or communal lounges, which did not promote privacy and dignity.

Ward one at The Mount for older age adults with mental health problems had direct access to the outside space with a garden and seating areas. However, patients from the other three wards did not have direct access to the garden as these wards were on the floors above, though staff were able to escort patients from these wards to use the garden. Also, the paths in the garden were gravel and therefore not ideal for patients with limited mobility and those who needed to use mobility aids. The modern matron said they hoped to address this in future as they had realised it did not promote safety. Similarly, patients on the acute and psychiatric intensive care unit wards had access to outside space. However, patients on the wards on the first and second floors of the Becklin Centre needed staff to escort them as there was no direct access from the wards. Patients on the inpatient wards for learning disabilities or autism had access to a garden but they could only use this with support due to ligature risks.

We found additional concerns regarding the environment of the crisis assessment service operated from a newly refurbished area within the Becklin centre which included the Section 136 suites for adults and for children and the crisis assessment unit. The service had one clinic room for both suites and the crisis assessment unit.

The Section 136 suite did not have a separate interview room for patients. There were no facilities for access to private outside space, other than the unenclosed hospital grounds. There were no facilities for access to quiet areas other than patient bedrooms and no facilities for patients to make a phone call in private.

The locked door between the female section of the corridor and the Section 136 suite had a glass panel which was approximately two thirds obscured with an opaque film. Staff told us that the panel was not fully obscured so that staff on the crisis assessment unit could see into the Section 136 suite when they were responding to incidents. However, it also meant that patients in the crisis assessment unit could potentially see and hear patients on the Section 136 suite as they were being admitted in a state of crisis. This impacted on the privacy and dignity of patients in the Section 136 suite. We raised this with the trust and on our return visit the service had added an additional screen to the door which, whilst reducing the vision through the panel further, had still left a gap through which people could see into the Section 136 suite.

The Section 136 suite for children and young people was formerly the services Section 136 suite for adults. Although the suite was designated for children and adolescents, we did not note any specific adaptations to make it a child-centred environment.

Good

Are services responsive to people's needs?

Patients on the inpatient wards had access to hot and cold drinks either from the patient kitchen or from jugs in the lounge areas, with fruit and snacks available throughout the day and night. However, staff locked kitchens at Three Woodland Square and Parkside Lodge which meant patients could not access the kitchen to make food and drinks without staff support. The kitchen at Two Woodland Square was open, however staff supervised patients at all times when in the kitchen.

Patients were able to personalise their bedrooms and were encouraged to bring photographs or belongings from home. There was lockable storage for patients to store their belongings securely. Patients were able to access payphones, portable phones on the ward or use their own mobile phones. There were some restrictions on internet access to maintain privacy and dignity, for example on the crisis wards patients were not able to use the camera function on their mobile phones. However, on the forensic wards, patients were not allowed to use smart mobile phones on the ward at all.

Activities including therapeutic, occupational, social and educational groups were delivered in all wards and services, including at weekends, appropriate to the patients' needs. Patients at two Woodland Square continued with their lives as they did when they were at home, so patients continued to attend school, college and day centres. Staff and carers raised concerns that patients at 2 Woodland Square were unable to attend activities that were not pre-planned and part of the patient's normal routine prior to attending the respite service. They told us that this was due to staffing levels, the lack of a mini-bus driver, and the lack of access to specially adapted transport. The trust told us that activities were available for all patients and that appropriate transport could be arranged.

The community services for people with mental health problems and for learning disabilities or autism, all had interview rooms with adequate soundproofing and blinds on the windows for privacy. Whilst most teams told us that there was sufficient space to complete assessments and interventions, some staff in the south-south-east community services for people with learning disabilities or autism told us that there was not enough interview rooms as facilities at Aire Court as these were shared with other teams that were based there.

Patient's individual needs and preferences were central to the planning and delivery of treatment and care at the trust. Staff respected and provided support to meet the diverse needs of their patients including those related to disability, ethnicity, faith and sexual orientation.

There were good examples of how the services considered the patients individual needs in the delivery of the service. For example, the Leeds autism diagnostic service had arranged the test of the fire alarm at Aire Court to take place between outside of their clinic opening hours. This had been requested in order to avoid unnecessary distress for patients attending clinic that may be hypersensitive to noise. Also, the crisis assessment service did not exclude people on the basis that they had used alcohol or drugs, in line with the crisis concordat. Data from the service indicated that a police station had been used as a place of safety for intoxicated people only twice from January 2015 to May 2016 whereas the Section 136 suite had been the place of assessment for 22 intoxicated people.

All wards and community services were accessible for patients, relatives and carers with mobility issues or disabilities, with accessible bathroom facilities appropriate to the type of service. In the community services, venues for appointments were considered carefully before booking both in terms of geographical and physical accessibility. The inpatient wards for older adults with mental health problems had adjustable profile beds on the wards for people with organic illnesses, like dementia and as required on the other wards for people with functional mental illness, like depression.

Almost all inpatient services were able to meet patients' individual dietary requirements for health and culture, requesting specialist diets for patients who needed them. This included meals for patients who required vegan, vegetarian or coeliac diets as well as kosher or halal meat if required. Patients who prepared their own food could plan for and buy any particular food that met their own dietary requirements. Patients and carers confirmed this and we observed healthy meal choices marked on the menus. However, the meal provider on the inpatient wards for children and young people with mental health problems could not sufficiently cater for a patient's cultural needs or preferences for food. Staff locally sourced food for one

Meeting the needs of all people who use the service

patient who was vegan, as their supplier could not meet this need. Additionally, a patient with dietary requirement relating to their religious groups had very limited choice in their menu.

The trust were in the process of implementing the statutory Accessible Information Standard to ensure that people accessing services who have a disability, impairment or sensory loss are provided with information that is accessible, easy to understand and meets any defined support needs. Information leaflets were available in different languages on request. All wards and services were able to access interpreters for other languages including sign language.

In the community services for children and young people with mental health problems who were deaf, skilled interpreters were available to work with young people using British sign language supported the therapeutic work offered by the team. Where a family spoke a different language to ensure communication was clear sessions had taken place using both language and signed interpretation. A range of leaflets about this service had QR codes that could be scanned on smartphones enabling access to information using British sign language. Communication with young people and their families included using plain English in letters, pictorial representations and video letters as required, for example pictures of the staff on the appointment letters.

The intensive community service told us that they were having difficulties procuring leaflets in languages other than English. Staff offered different explanations for this with some suggesting it was a trust wide issue, whilst others stated that it was related to the uncertainty surrounding the future of the service. During the inspection, we did not find difficulties in other areas accessing leaflets in other languages.

Staff in all the services we inspected were respectful of people's cultural and spiritual needs. Staff supported patients to practice their faith. For example, in the inpatient settings where there was no multi-faith room, patients were encouraged to pray in their bedroom, or staff arranged for the chaplain or different faith representatives to visit. In the Yorkshire Centre for Psychological Medicine, patients were able to attend the chapel in the infirmary. Where patients had authorised leave, were an inpatient on an informal basis, or attended community mental health services, patients were supported to attend local spiritual and religious support.

Listening to and learning from concerns and complaints

Since the last CQC inspection in 2014, the trust committed to improving its response to the complaints it received. The complaints and patient advice and liaison service, has more than doubled in size and the Head of Patient Experience and Engagement is now involved with the complaints team. The complaints team have worked hard to build relationships with the local advocacy services and to deliver training to the wider trust teams and demonstrate their accessibility. The Head of Patient Experience and Engagement informed us that over 120 people had attended complaints training in the last 12 months. The training advocates local resolution and contacting an investigator in the complaints team at the earliest convenience to support with the complaint process. The patient advice and liaison team visited the wards in Leeds and York on specified days of the week to maintain their visibility to staff, patient and carers and to encourage people to approach them if they have any concerns. We observed the patient advice and liaison team offer a compassionate and supportive approach towards patients during the inspection.

The trust received 199 complaints in the 12 months between the 1 April 2015 and 29 March 2016. Almost half of those complaints were either upheld or partially upheld, with 40 complaints upheld and 56 partially upheld. In the same 12 month period, just one complaint received in the acute wards and psychiatric intensive care unit has been referred to the Ombudsman.. The services that received the most complaints were the community based mental health services for adults of working age, which received 51 complaints between 1 April 2015 and 29 March 2016; a quarter of the total complaints. The long stay and rehabilitation wards received the lowest number of complaints for the trust, with just one received in this time period. For the month of May 2016, the trust received 13 formal complaints.

Five complaints records were reviewed. All five records demonstrated the comprehensive approach by the trust towards the complaints it received and the robust systems in place. The records indicated that all the complainants

were reassured that they had the right to complain and that they were made aware of the support available to them. All records demonstrated that people had been advised that their complaint would not compromise their care, or the care of their family. People were able to communicate their concern in a medium and time that suited them, including by email, letter or through the web-site. The Complaint's Manager confirmed that any complaints that were not clear would be followed up when the complaint was received to clarify the information and the resolution that was being sought. All five complaints reviewed demonstrated that complaints were acknowledged within the three day initial response time, with almost all being acknowledged the same day the complaint was received. We saw evidence that all those who complained were offered additional support, for example from advocacy and other relevant support groups. The complaint's team discussed with all those who complained, their preferred method of communication, including face-to-face meetings, as well as the timescales for the complaint to be dealt with. Where the complaint could not be resolved in the 30 day timescale detailed in the trust complaint's procedure, we saw evidence that the complainant was updated regularly regarding the delay, the reason for this and the proposed updated timescale. The complaints team circulated a weekly complaints tracker to the Care Groups, providing a summary of open complaints, with timeframes for completion.

There was a clear audit trail for all complaints, with the investigation report stored on the electronic recording system and all the communication regarding the complaint stored securely on the trust shared drive. All five investigations we observed were very detailed. They included detail about the complaints and the context, risk assessments and evidence including medical notes, interviews with patients and staff and statements. Three of the complaints were escalated to board level. For all the complaints we reviewed, a final letter was observed, which were detailed and thorough and signed by either the Chief Executive Officer or other appropriate staff member, like a consultant psychiatrist. Of the five complaints we reviewed, three were not upheld and two were partially upheld, with one of the complainants being offered compensation.

The trust routinely requested complainants' feedback. Previously they had enclosed a feedback questionnaire and prepaid envelope with each response letter. However, the 13% response rate between April 2015 and March 2016 was low. The complaint's manager and Head of Patient Experience and Engagement told us that they were attempting new methods to collect feedback, including telephone calls and emails.

The trust demonstrated a commitment to learning from complaints. Themes from complaints were fed in to the Care Group Clinical Governance Councils for local action, through a monthly CLIP (Complaints, Litigation, Incidents and PALS) report. To support organisational learning the trust completed thematic analysis of actions identified in response to complaints and claims in addition to serious incidents, safeguarding and Mental Health Act monitoring visits. On a 6-monthly basis this information is reported to the Care Services Strategic Management Group, for agreement of three priority issues for focused action. These priorities are reviewed by the Quality Committee for assurance that action is completed. Complaints information was also reviewed at the monthly or bi-monthly trust Board meetings. We observed compliments, complaints and claims information being presented by the Director of Nursing at the Board meeting we attended as part of the inspection and discussed by the executive and non-executive directors, including key themes, learning and proposed action, including training. The trust had also developed a quarterly review panel to involve service users in quality assessing complaints responses, with any learning from these reviews being fed into the complaints training sessions.

The trust took appropriate action where learning had been identified. For example, the trust had identified the attitude of staff as the most common complaint, with the predominant reason for these complaints being upheld highlighted as communication. The trust responded through commissioning the National Performance Advisory Group to deliver a workshop entitled 'Putting the Patient First – Communication and Customer Care'. A Complaints Management Training Package, including perception and communication, patient experience and basic customer service had been developed and Customer Service training for front-line support staff had been rolled out.

Other examples of service changes as a consequence of learning from complaints included a link established for admin staff to update clinical records where a relative had died in order to ensure deceased people would not be contacted, a community mental health team had

Good

Are services responsive to people's needs?

established meeting with GPs to improve relationships with people accessing services and a change in catering arrangements. in response to an issue about access to vegan food

Almost all the wards and services we visited during our inspection demonstrated a positive culture of reporting complaints and learning from complaints and had local arrangements to discuss these in their team meetings. Feedback from formal investigation of complaints was inconsistent only on the forensic and secure wards. This meant improvement in practice or service delivery on these wards were limited.

Requires improvement

Are services well-led?

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

Summary of findings

We rated Leeds and York Partnership NHS Foundation Trust as requires improvement for well-led because:

- The trust did not have robust governance arrangements in place in relation to staff training, supervision and appraisal, medication management and audit, application of the Mental Capacity Act, systems and guidance to support the application of the Mental Health Act, the delivery of seclusion, restraint and rapid tranquilisation in line with the trust policy, accurate and contemporaneous records, the timely reporting of incidents, the crisis assessment unit's service provision, policies and procedures being sufficiently embedded.
- Staff in some services and teams reported that senior managers were not always visible; including staff in the supported living service, the inpatients wards for older people and the respite services for people with learning disabilities or autism reported that this was not the case. Also, at the time of the inspection, the non-executive directors or the board of governors did not gain additional assurance from visiting the services discussed at board level.
- Senior managers told us that quality improvement methodology was not always applied consistently.
- The trust was unable to provide data requested during the inspection in a timely way and some of the data we received conflicted with previous data provided, and with the views of some clinical teams.
- The trust did not always meet its own targets and those agreed with the local commissioners, for example their own appraisal target and the required clustering targets agreed with commissioners.
- The trust did not have a systematic approach in place with regard to the documentation required to assure themselves, or the Care Quality Commission, that the directors met the fit and proper person requirement, regulation 5 of the Health and Social Care Act (Regulated Activities) Regulations 2014.
- The trust had not updated all the polices following the updating of the Mental Health Act code of practice and there was no overall plan detailing how the trust was implementing the changes to the code. Senior management did not have a good understanding of which policies required updating or which one's had been reviewed and updated. This meant it was difficult for staff to know if their practice was in line with the revised code of practice and as such patients' rights may not be upheld.

However:

- The trust had adapted their recruitment process to include values based recruitment and recently adapted the appraisal process to include the behavioural aspects that demonstrate the trust values. Most staff were aware of the trust's vision and values.
- The trust complied with the duty on public bodies to publish equality objectives. The objectives were developed collaboratively with the community and other stakeholders and priority actions were identified. The trust recognised that the experience of black minority ethnic staff members was an important challenge and had introduced a Workforce Race Equality Standard Ideas and Implementation Group and worked with the Yorkshire and Humber Equality and Diversity Leads Network to work collectively on priority areas for action and to share best practice.
- The trust worked proactively to address sickness and had introduced additional sources of support for the most common reasons for absence.
- The trust held an annual nursing conference, which offered development and networking opportunities

Requires improvement

Are services well-led?

for nursing staff across the trust. Staff achievements, linked to trust values were recognised through a monthly 'STAR' awards and an annual awards celebration.

- The trust was committed to working with people who use services to inform treatment and care and shape their services. It had a well-established service user network and involved patients in research projects.
- The trust participated in national audits and national quality improvement programmes in some of its services, including accreditation schemes and peer review. It was committed to research and the development of care and treatment and also worked in collaboration with the local universities to develop its workforce and to create training courses.

Our findings

Vision, values and strategy

The trust's purpose and strategy, 2013 to 2018, "improving health, improving lives" detailed the three strategic goals that the trust aims to achieve for the people who use it services and their relatives and carers. These three strategic goals include:

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

The strategy had five strategic objectives which describe how the trust will achieve its strategic goals, as well as the outcome measure used to demonstrate the trust's progress towards both its objectives and its goals. The strategic objectives focus on quality and outcomes, partnerships, workforce, efficiency and sustainability and governance and compliance. An operational plan for 2016 to 2017 set out the trust wide priorities for the coming year for each of these strategic objectives, including the challenges at service level and board level, the local commissioner requirements and the improvement and development objectives. The trust is currently involved in working with other commissioners and providers in Leeds to implement the NHS five year forward view and agree the local sustainability and transformation plan to meet the needs of the local population. This sustainability and transformation plan will supplement the trust's current operational plan.

The leadership team regularly monitored and reviewed its progress on delivering the strategy through attendance at the relevant committees in the trust governance structures and the monthly or bimonthly board of directors meetings. As part of the inspection, we attended a board of directors meeting and observed discussions relevant to the trust strategy and operational plan, including efficiency, quality and performance.

The values that underpinned the trust's approach and identified in the 2013 strategy and trust's priorities in the operational plan 2016-2017, were those identified in the NHS constitution, derived from extensive engagement with staff, patients and the public. These values included:

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

The trust had adapted their recruitment process to include values based recruitment and recently adapted the appraisal process to include the behavioural aspects that demonstrate the trust values. The trust values were displayed in the services that we visited. Whilst some of the staff we spoke to in all the trust services we inspected were able to demonstrate the trust values in their discussions and their behaviours, others told us that they were unclear about the trust vision and strategy. Also, staff in the forensic services at Clifton House did not demonstrate respect and dignity in their descriptions of the people who used their services. Staff in the crisis assessment service and the intensive community service did not know the trust vision and values.

At the time of the inspection the trust was undertaking a strategy refresh for 2016 to 2021 including staff, service users and other key stakeholders. This included working with the board of governors at the staff to identify the vision and values that were important to them. These were due to be agreed at the board and circulated to staff for their final input at the end of July 2016. This piece of work included a

programme of listening events led by the Chief Executive in March 2016 and the use of crowdsourcing digital platform to gain the trust stakeholder opinions, video and trust internet in order to increase stakeholder involvement.

Good governance

The trust board of directors were accountable for the running of the trust and had oversight of governance and quality issues through the four sub committees, including the quality committee, the mental health legislation committee, the audit committee and the finance and business committee. The remuneration committee and the nominations committee are also sub committees to the board of governors and part of the corporate governance structure. They oversee the recruitment and motivation of the senior executive team and the non-executive directors respectively.

The trust board of directors included a chief executive and five executive directors who were responsible for strategic leadership. A chairman and six non-executive directors also make up part of the board. They were not employed by the trust and their role was to provide advice and challenge to the executives. Non-executive directors were appointed to the sub-committees appropriate to their skills and experience.

The elected and appointed governors had a role in holding the non-executive directors to account for the performance of the board of directors. During the inspection we spoke with representatives from the board of governors and the non-executive directors, who spoke with clarity about their role, including examples where they had requested information and challenged decisions. In the board of directors meeting, we observed there was challenge from the non-executive directors regarding the out of area placements and suggestions offered.

A governance framework was in place within the trust which had a clear reporting structure for ward-to-board assurance. Professional leaders and matrons had each had particular focus on safety and quality and worked closely with their teams. They provided assurance through local leadership forums, local governance forums and clinical improvement forums. Quality and safety was discussed at these meetings and learning was shared and any risks identified.

These local leadership forums were represented on Care Group clinical governance and risk forums. Arrangements of these clinical governance and risk forums varied in order to align with the individual structures within the trust's two Care Groups but were well-established. The two Care Groups included the Leeds Group which included the crisis assessment services, rehabilitation and long stay, acute and older adults inpatient wards for people with mental health problems and the Specialist Services and Learning Disabilities Care Group, which included the forensic and secure services, the learning disability services and the child and adolescent mental health services.

The Medicines Safety Officer was a member of the clinical governance and risk forum. Medicines incidents were discussed there. Additionally, the Medicines Safety Officer produced a six monthly report with recommendations and this was sent to the trust board.

The Care Group clinical governance and risk forums were the key link between local and organisational clinical governance arrangements and fed into the Care Group Clinical Governance Councils chaired by clinical directors. These clinical directors were members of the Effective Care Committee and also the CQC Fundamental Standards Group which both reported to the trust's Quality Committee, a sub-Committee to the Board of Directors. In this way the Care Group Clinical Governance Councils were the link between the Care Groups and the organisational assurance mechanisms. The Medicines Optimisation Group also reported to the Effective Care Committee and the Chief Pharmacist attended this meeting.

The role of the Quality Committee was to ensure clear accountability for the quality of care throughout the trust, including the systems and processes for escalating and resolving quality issues and escalating to the board of directors where appropriate. The trust incident review group, the safeguarding committee, the health and safety committee and the medical revalidation and appraisals group, also reported into the Quality Committee.

The Board of Directors received assurance from its other sub-committees, including the:

- Mental Health Act Legislation Committee which reviewed the trust's compliance with all aspects of mental health legislation, including the Mental Health Act, Mental Capacity Act and Deprivation of Liberty Safeguards.

Requires improvement

Are services well-led?

- Audit Committee which ensured that the financial reporting, compliance, risk management and internal controls were appropriately applied and were, reliable and robust.
- Finance and Business Committee which oversaw the trust's financial planning, the estates strategy and the information technology strategies.

The executive directors confirmed that they gained additional assurance through spending time visiting the services and shadowing staff. The frequency was dependent on the role, for example the Chief Executive told us she visited the services weekly, where as the Chief Operating Officer confirmed that the majority of her work was spent within services. Staff told us that they knew the Chief Executive and received communication from them in the chief executive's blog. Whilst some staff reported that senior managers were visible in the services, others including staff in the supported living service, the inpatients wards for older people and the respite services for people with learning disabilities or autism reported that this was not the case.

The non-executive directors did not regularly visit the trust's services and this was not routine. The non-executive directors told us that it had happened on occasion and the Chief Executive told us that the non-executive directors visiting the wards and services had recently commenced. This position was the same for representatives on the board of governors. Therefore, at the time of the inspection, the non-executive directors or the board of governors did not gain additional assurance from visiting the services discussed at board level.

Both the strategy and the operational plan reflected the trust's financial position. The trust was committed to a number of financial efficiencies in 2016 to 2017, including workforce efficiencies, an estates review and improved procurement of services. This reflected the trust's commitment to achieve a surplus requirement of 2.1 million pounds in 2016/17. We attended a board meeting on the 23 June May 2016. We reviewed minutes from this meeting. The trust currently had a financial sustainability risk rating of 3. The trust identified that the current surplus at month two of the financial year was £67k behind the planned position. This was attributed to unfunded out of area placements and unidentified cost improvement plans. The Finance Officer identified a number of actions in the financial presentation to the Board in order to achieve the required surplus. This included negotiating funds with the Leeds Clinical Commissioning Groups and accelerating planned cost improvement schemes. The Chief Finance Officer and the Director of Nursing stated that quality impact assessments were completed to ensure that quality was not lost where there was a reduction in financial contribution. However, senior managers told that this improvement methodology was not always applied consistently.

In addition, despite these governance structures being in place, there were concerns identified across the trust with regard to key elements of the trust's governance, including:

- Low compliance for some essential mandatory training and training not meeting the trust targets. The senior managers were not clear on the timescales of the trust's trajectory to meet the 90% compliance for mandatory training.
- Compliance for clinical supervision was low and the trust had not yet implemented separate quarterly safeguarding supervision, despite the Leeds Safeguarding Children's Board identifying this as a requirement in 2014.
- Appraisal rates still that had not reached the trust target of 90%.
- Issues with regard to the storage of medication, the monitoring of antipsychotic medication, the systems to support the self-administration of medicines and the effectiveness of the medication audits.
- The application of the Metal Capacity Act in some services was not in line with the trust policy or the Act. This included the assessment and recording of capacity in some services and the use of the appropriate legal authority such as the Deprivation of Liberty Safeguards for all patients who lack the capacity to consent to their care and treatment.
- The systems and guidance in place did not fully support, or ensure, the application of the Mental Health Act across the trust. For example policies were not in line with the code of practice, section 132 rights were not always documented, second opinion appointed doctors were not always contacted in the appropriate timescales and audits did not always pick up the detention errors in a timely manner. There were also blanket restrictions in place in some services.

Requires improvement

Are services well-led?

- The use of seclusion, restraint and rapid tranquilisation was not always in line with the trust policy. Seclusion rooms were not always in line with the requirement of the code of practice. Actions were also still outstanding on the trust's reducing restrictive interventions action plan. Therefore restraints remained high, including the use of prone restraint and prone restraint was still prominent in the trust's training package for managing challenging behaviour.
- Systems were not in place to report incidents in a timely manner and were not in place in some services.
- Not all patient records of care and treatment contained decisions about the patients' care and treatment, or were accurate and contemporaneous. Not all staff, and teams and services, had access to the electronic recording and incident systems, or used both paper and electronic records.
- Policies and procedures across the trust to support staff were either not embedded or not in place, for example the bed management procedure and there was a lack of clarity around the crisis assessment unit's service provision.

The Care Quality Commission requested data as part of the comprehensive inspection. The trust was unable to provide this in a timely way and some of the data we received was conflicting with previous data and information told to us by teams. In total, 411 additional data requests were sent to the trust between the dates of 16 June 2016 to 29 July 2016. As per the agreed process, these requests were asked to be returned within 48 hours except for where an extended timescale was identified by CQC. Where a request was sent after 17:00 by the Care Quality Commission to the trust, the following working day was recorded as the date it was sent. The trust returned 223 data requests, 61%, outside of this timescale (48 hours / two working days). The longest time taken for a data request to be completed was 17 days. During the inspection, the Head of Inspection had to contact the trust on several occasions to raise his concerns about the return of the data requests. The length of time taken was in part attributed to the fact that all the information supplied to the Care Quality Commission had to be overseen by the Director of Nursing before being sent.

The trust used key performance indicators to gauge the performance of each ward. Ward managers could access the trust dashboard to monitor team performance against key performance indicators that were relevant to the service. Across the trust, these included staff training compliance, staff absence, physical healthcare, supervision rates, restrictive practice, and length of stay on the ward or in the service, new patient admissions, time from referral to assessment, discharge, bed availability and occupancy. Not all the ward managers or staff we spoke to understood what key performance indicators were for their team or service. The crisis assessment unit did not have targets to measure and benchmark performance or to identify areas of concern. Also, the crisis assessment service did not collect data on the transportation used to for people brought to the section 136 suites.

The trust did not always meet the required commitment to quality and innovation targets or the targets agreed by commissioners, for example in March 2016, the trust failed to meet its clustering commitment to quality and innovation target and a financial penalty was applied by the commissioners. Also the trust did not meet its targets for the number of registered mental health nurses trained in autism, or the timely communication with GPs. The trust had agreed action plans in place to meet these. The commissioners commented that they had concerns regarding the trust's ability to and manage and deliver on the agreed projects and meet the targets set, for example nurses had not been recruited into the primary care pilot as agreed. The commissioners were also concerned regarding the lack of clinical representation at board level generally and at strategic meetings. It was felt that the Director of Nursing had a large portfolio to manage. The trust had recognised the need for a full-time medical director post.

Each ward had a risk register, the ward managers were able to input items on the risk register. The modern matron was able to put items onto the trust risk register following discussion with senior managers. The risks were each rated in relation to their severity and were subject to regular review. There was action documented as to what current control measures were in place to mitigate each risk.

As of the 15 March 2016, the trust identified nine strategic risks. Deteriorating financial standing, delivering from premises not owned by the trust, vacancies in care services, bed occupancy by patients fit for discharge and defective detentions were all identified as extreme risks for

the trust. We had concerns that the Board did not have oversight of the risks that were on the register below the strategic risk register, or the removal of these risks from the register.

Fit and proper persons test

The Fit and Proper Persons Requirement (Regulation 5 of the Health and Social Care Act (Regulated Activities) Regulations 2014) ensures that directors of NHS providers are fit and proper to carry out this important role.

The trust's fit and proper person requirements for directors procedure, ratified on the 17 December 2015 by the quality committee, confirmed that their procedure applied to executive and non-executive directors, including those who were permanent and interim posts. The trust and their procedure confirmed that the word 'director' where used included all individuals within this definition. The author, the head of corporate governance, acting as the trust board secretary, was responsible for disseminating the policy to the target audience identified in the procedure, including the human resources team and the board members.

The trust carried out enhanced checks without barred list checks for all its non-executive directors and executive directors in accordance with the law and the Care Quality Commission guidance.

We reviewed the personnel files of six executive directors on the board and seven non-executive directors, which included the Chair. Although, the personnel files we reviewed contained some evidence of the documentation to confirm the trust's compliance with the regulation, it was difficult for the trust to provide us with the complete information at our initial request on the 11 July 2016. On the 14 July 2016, there still remained some information that was outstanding. The trust has since told is that this was due to the fact that some of this evidence had to be drawn together from sources outside of the corporate governance office.

For example, as of the 14 July 2016, the information relating to the occupational health checks for one of the executive directors was still outstanding and one of the executive directors confirmed during the inspection week that they were still in the process of completing this report. Also, the disclosure and barring checks for a non-executive board member and an executive board member were still being processed, though the certificate numbers were available. Information since provided by the trust confirmed that one of these two non-executive director's certificate was held-up due to the Disclosure and Barring Service requesting further evidence and information about the role of the non-executive director. As of the 14 July 2016, the qualification certificates for one of the executive directors was also still outstanding and provided by the trust on the 15 July. The personnel file for the Chair was not available until the final day of the inspection week. The trust told us that this was due to a file corruption during the data transfer to the secure inpection team's portal. Also, the information we received had wrong dates recorded, for example they were dated December 2016, rather than 18 December 2015.

As such, the trust did not have a systematic approach in place with regard to the documentation required to assure themselves, or the Care Quality Commission, that the directors met the fit and proper person requirement, regulation 5 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Finally, the information received from the trust regarding these directors did not contain any detail concerning the managerial supervision received, the mandatory training undertaken, or the annual appraisals undertaken. However, the non-executive directors confirmed that they were provided with support to complete the role, including internal and external training courses, and an annual appraisal including 360-degree feedback.

Senior managers acknowledged the issues identified by the Care Quality Commission around providing complete documentation to evidence the fit and proper person checks completed by the trust. They acknowledged that improvements could be made in this area.

Equality and Diversity

The Trust complied with the duty on public bodies to publish equality objectives. The objectives were developed collaboratively with the community and other stakeholders and priority actions identified. The Equality and Inclusion Group reviewed the development and progress of equality priorities and were actively involved in the delivery of priority actions. This included the co-ordination of the engagement work, in line with the Equality Delivery System and the implementation of an annual work plan and reporting against the Trust Equality objectives. The trust had an equality, diversity and human rights procedure. The procedure was approved and ratified on the 8 July 2016 by

the Employment Policies and Procedures Group. This agenda was overseen by the Director of Workforce. Equality and Diversity training in the trust was mandatory and compliance across the trust was 95%.

The trust used the NHS Equality Delivery System framework as a performance and quality assurance mechanism to review and improve their performance for service users, communities and staff in respect to all characteristics protected by the Equality Act 2010. The annual 2015 assessment was undertaken with stakeholders and local interest groups to monitor the trust's progress for people with protected characteristics, against the four goals within the framework. The four goals include better health outcomes for all, improved patient access and experience, empowered, engaged and well supported staff and inclusive leadership at all levels. The 2015 assessment for the trust focussed on two of these four goals: improved patient access and experience and inclusive leadership. Out of the seven outcome grades, two were graded as 'developing' and the rest as 'achieving.'

In response to the outcome of this assessment against the Equality Delivery System framework, the trust identified four priority areas for 2015/16. These priority areas included collecting and analysing demographic data for the formal complaints received by the trust and identifying equality themes or trends. None were identified from the data collection over a six month period with a 41% response rate. The trust also made a commitment to improving the access and support for deaf and hard of hearing communities through staff development and improved technologies. Improved pathways of care for people with cognitive impairment and dementia was identified as an additional priority and was addressed through a dementia care training framework, including a three-day Cornerstones of Dementia Care course for 30 clinical staff, Dementia Friends information sessions to over 100 staff and E-learning dementia programmes accessed by 125 staff. Finally, the trust delivered six development sessions to 60 staff focusing on the specific needs of lesbian, gay and bisexual communities, refugees and asylum seekers and deaf and hard of hearing communities, in order to support staff to work in culturally competent ways.

To further support the trusts commitment to the implementation of the NHS Equality Delivery System framework, the trust had also committed to data collection, analysis and the identification of improvement actions in relation to the Workforce Race Equality Standard. The Workforce Race Equality Standard was introduced across the NHS from April 2015 to ensure that employees from black minority ethnic backgrounds have equal access to career opportunities and receive fair treatment within the workplace. The Census 2011 data showed that the black minority ethnic populations that the trust serves for Leeds is 17% and 13% for York. In line with the requirements of the Workforce Race Equality Standard, an initial baseline report was produced in July 2015. This was followed by the Workforce Race Equality Standard report providing the details of the trust performance in 2015/16. The nine indicators were based on the data collected between the 1 April 2015 and 31 March 2016, the staff survey information from 2015 and the Board composition. The total number of staff employed at the date of the 2016 Workforce Race Equality Standard was 2582 and the proportion of black minority ethnic staff employed was 15%, which was in line with the population the trust serves. All staff had reported their ethnicity.

In response to the findings of this Workforce Race Equality Standard report, the trust identified its priorities and actions for 2016/17 in order to improve their performance. Examples of outcomes and actions taken included:

- White staff appointed from shortlisting was 1.4 times greater compared to staff from a black minority ethnic background. The trust action to this included resolution through their recruitment strategy and having a revised centralised assessment centre, using values based recruitment.
- The prevalence of black minority and ethnic bank staff entering the formal disciplinary process was 4 times higher than for white staff in the staff bank. The trust completed a thematic analysis of the data to identify potential themes in relation to reasons for entering the disciplinary process and analysis by professional group and job role, as well as comprehensive bank staff improvement project for the support and development structures for bank staff.
- The Board members from a black minority ethnic community was 8%. This was lower than the black minority ethnic workforce of 15%. The trust action to improve the current under-representation included ensuring this is taken into account when recruiting and appointing new Non-Executive Directors and when

renewing terms of office. Actions also included ensuring that there was a central focus on supporting equality of opportunity, succession planning and associated criteria for appointments to the all Board positions.

Other outcomes where concerns were raised included increased bullying and harassment and lower career progression for black minority ethnic communities in comparison to white people. The trust addressed this through their current strategy development work, the development of a behavioural framework through this trust-wide engagement and consultation, and the introduction of values based recruitment and a values-based appraisal system.

However, in the NHS staff survey 2015, 87% of staff felt that the trust provided equal opportunities for career progression or promotion. This was better than the national average in comparison to other similar mental health trusts, which was 84%.

A number of the responses to the Workforce Race Equality Standard were still in their infancy, including the behavioural framework and the equality, diversity and human rights policy. The Director of Workforce acknowledged that work on these priorities was ongoing as the rationale for the outcomes of some of these indicators were still unclear, for example the conversion rate for black minority ethnic applicants being lower than white applicants and black minority ethnic staff feeling more likely to be bullied than white staff. Not all the staff we spoke to had a clear understanding on the actions taken in response to the outcomes from these Workforce Race Equality Standard indicators. However, the trust recognised that the experience of black minority ethnic staff members was an important challenge. Therefore the trust had introduced a Workforce Race Equality Standard Ideas and Implementation Group. This was led by a cross section of black minority ethnic staff with support from the Chief Executive and the Director of Workforce Development. The trust was also working with the Yorkshire and Humber Equality and Diversity Leads Network to work collectively on priority areas for action and to share best practice.

The trust completed a service evaluation of the patients' experience from a black minority and ethnic community of the psychology and psychotherapy services. This was called "Hear me out." It was a service user research project to identify barriers in access to these services for patients from these communities. Areas identified for development that were taken forward within the team included closer working with specialist outside agencies.

Leadership and culture

The Trust has conducted organisational wide local surveys two ways over the past 12 months: the delivery of an agreed programme of senior manager engagement in March 2016 and the staff friends and family test.

The programme of senior management engagement was designed to enable the staff voice to be heard and also for real change to be realised on the key recurring issues that were important to staff. The programme included the delivery of listening events with the interim Chief Executive Officer supported by an online engagement campaign utilising crowdsourcing, the analysis of the staff feedback by an external partner and key actions identified in areas including staff health and wellbeing, managing performance and appraisals, better recruitment, improving information technology systems, improving the physical environment and supporting and valuing individuals and teams and retaining people.

The staff Friends and Family Test, was conducted quarterly and the results were analysed by Quality Health. Narrative comments were analysed internally and key themes identified. Staff Friends and Family Test results were communicated quarterly to staff via the trust-wide email bulletin and also posted on the 'Your Voice Counts' pages of the trust intranet and on the external trust website.

The NHS staff survey 2015 overall outcome for overall staff engagement was below the national average for mental health trusts, as was staff motivation at work, staff feeling able to contribute towards improvements at work, staff satisfaction with their level of responsibility and involvement, effective team working and recognition and value of staff by managers and the organisation. In the same survey the percentage of staff who would recommend the trust as a place to work was 46%. This was 16% below the England average of 62% in comparison to other mental health services.

The trust was also below average for similar mental health services for the outcome off the NHS staff survey 2015 for the support staff received from their immediate managers and for the quality of their appraisals and the mandatory training, learning or development they received. The trust

was the same as the national average for the percentage of appraisals completed. The trust was also below the national average for staff reporting that they felt pressured in the last three months to attend work whilst feeling unwell. However, staff reporting suffering from work-related stress in the last 12 months was the same as the national average.

On the NHS staff survey 2015, staff reporting that they had experienced physical violence from other staff in the last 12 months was 3%, which was the same as the national average for other mental health trusts. The percentage of staff experiencing physical violence form patients, relatives and carers reported was above the national average. However, staff reporting abuse, harassment or violence from other staff recently and in the last 12 months, was below the national average in comparison to other similar mental health services.

There were no bullying and harassment cases at the time of our inspection. Staff were aware of the trust's whistle-blowing process and of the 'freedom to speak up guardian.' There were three whistleblowing enquiries raised to the Care Quality Commission between 1 January 2015 and 21 June 2016. However, the staff we spoke to stated they would feel comfortable in speaking in person to their manager if they had concerns, or were able to raise concerns via the trusts intranet. During the inspection, the staff we spoke to told us that they felt able to do this without fear of victimisation or recrimination. Whilst some staff still raised concerns about their involvement in the previous transformation plans for the trust over four years ago, staff and teams were generally positive with regard to their current involvement in the development of the service they worked in and the trust as a whole.

Despite the staff NHS survey outcome 2015, morale appeared positive overall in the teams and services. All the staff we spoke to spoke highly of their work colleagues and the support they received from all the members of the multidisciplinary team. However, staff acknowledged that there had been challenges prior to the inspection which at times had been stressful. For example the change of management on the forensic and secure services, the recent high caseloads and the proposed redesign in the community services for adults and older people with mental health problems, the recent staff investigations as a result of staff concerns raised at Parkside Lodge and the temporary merge of the inpatient wards for older adults with mental health problems during redesign of the wards at the Mount.

The turnover for all substantive staff in the 12 months prior to the 31 March 2016 was 10%. The trust vacancy rate was 9% excluding seconded staff. During the inspection we reviewed the trust's last five grievances. These followed the trust's procedure. We also reviewed 15 exit interviews. One third identified the reason for leaving as promotion, in comparison to just under a third highlighting lack of opportunities or a better reward package as the reason for leaving. The trust told us that they had assessed their reward packages and were competitive with other similar sized organisations. Staff were provided with opportunities for leadership training at ward management level.

The Trust held an annual nursing conference, which offered development and networking opportunities for nursing staff across the trust. Staff achievements, linked to trust values were recognised through a monthly 'STAR' awards and an annual awards celebration.

The trust sickness rate was 5%, similar to the national average. The trust had identified musculoskeletal concerns and mental health and stress, as the top two reasons for absence. In response, the trust had a full-time physiotherapist who staff could directly refer to. In supporting staff with mental health and stress, the trust had developed a managing stress toolkit and had plans to implement a first day absence occupational health intervention. The trust were also using the Health and Safety Executive stress risk questionnaire with staff to identify work-related issues and to support managers to address these as appropriate. Where there had been long-term sickness for staff in the teams or services, for example in the long stay and rehabilitation services for adults with mental health problems, we saw evidence of managers being proactive to support these individuals, including requesting support from occupational health.

Engagement with the public and with people who use services

The trust had over 1700 members which it consulted with in order to shape the future of its services to meet the needs of the trust's local communities with mental health and learning disability needs. The members received regular information about the trust, including a quarterly

magazine. Members were eligible to stand as a governor on the trust's Council of Governors and vote for other members to become governors. In this way, people with experience of the services were actively engaged in the planning and delivery of the services and also, as a governor, holding the trust to account. A number of governors on the Council of Governors had service user and/or carer experience.

The trust gained feedback from people who use their services through formal methods including the Patient Related Experience Methods, the Friends and Family Tests, NHS Choices and Patient Opinion and National Service User Surveys.

However, the response rate from patients on the friends and family test fluctuated between 0.1% and 0.3% from October 2015 to February 2015. This was low in comparison to the national average for responses. However, in March 2016 the trust responded by separating the patient related experience measures from the friends and family test and redesigning the postcard response. This resulted in a significant increase in responses to 36, which was three times more responses received in comparison to the 11 received in February 2016. In June 2016, the trust had 71 responses.

In addition, the trust had a well-established service user network. The network had monthly meetings and was led by the trust's recovery and social inclusion team. We observed minutes and a plan for the upcoming service user meetings and observed this as a space for people to give their views within a peer-supported environment and that senior managers were committed to attending. The staff we spoke to from the recovery and social inclusion team were passionate about their role and spoke of their creative ideas to involve the trust's service users in the different services. An Involvement Leads Network involving nominated individuals from each service area, facilitators and service user representatives to review policy and best practice to co-produce clinical services. Service users were also supported to attend the Board of Director's meetings to give direct feedback to the Board and their own experience of the trust. The trust were involving service users in their recruitment activities. The trust had a carers development manager who was responsible for increasing the level of carer involvement throughout the trust.

Seven clinical audits were completed in the trust involving collecting data on the experience of service users and carers. On completion of the audit, their feedback would be used to directly inform service changes. For example an audit was completed to compare the Leeds Autism Diagnostic Service compliance against the National Institute of Health and Care Excellence. Whilst compliance was good, actions included improving risk assessments and ensuring the purpose and process of the autism assessment is explained to the service user.

At ward and service level, people who use services and their carers and relatives were able to feedback into the service through comments boxes, their local community meetings and Patient Advice and Liaison meetings.

Quality improvement, innovation and sustainability

The trust participated in national clinical audits, including the National Audit of Schizophrenia, the National Audit of Psychological Therapies, Prescribing Observatory for Mental Health – UK audits and the national mental health commissioning for quality and innovation indicators for cardiometabolic screening. We observed the trust's action plans for each of these following the outcome of these audits.

The trust participated in national quality improvement programmes, including accreditation schemes and peer review. The trust provided documentation to confirm this, including actions identified where appropriate. The trust was:

- accredited as excellent in March 2016 with the Electro Convulsive Therapy Accreditation Service
- accredited in April 2016 with the Memory Service National Accreditation Programme following approval from the Royal College of Psychiatrists' Combined Committee
- accredited for four years with the Psychiatric Liaison Accreditation Network in March 2016.

In addition:

- Mill Lodge inpatient child and adolescent mental health service in York was registered with the Quality Network for Inpatient Child and Adolescent Mental Health Services. However, this service was yet to be accredited.
- The forensic and secure inpatient services at both the Newsam Centre and Clifton House were members of the Quality Network for Forensic Mental Health Services. Both services had been reviewed in the last six months.

Requires improvement

Are services well-led?

- The Yorkshire and Humber mother and baby unit was accredited in July 2014 with the Quality Network for Perinatal Mental Health Services for three years.
- The Yorkshire Centre for Eating Disorders was accredited in September 2015by the Quality Network for Eating Disorders.

The trust did not participate in the Accreditation for Inpatient Mental Health Service schemes at the time of the inspection.

The trust was committed to research and development. The trust recruited 842 participants into 27 nationally funded research projects. Research projects were completed in both child and adolescent mental health and the general psychiatric population.

The trust had worked in collaboration with the local universities to develop its workforce and to create training courses, for example the Person Centred Recovery course delivered by clinicians, with the support of patients, on the long stay and rehabilitation wards.

A number of pilot projects and initiatives were being undertaken across the trust at the time of the inspection to develop the workforce, improve practice and the patient experience. This included projects in the forensic services and on the acute wards, as well the publication of the arts and minds network 'creative pathways' guide to support staff in promote recovery and well-being in the services.

The trust had introduced current technology, including the provision of electronic tablet devices, to increase patient engagement and gather patient feedback to develop its services.

The trust completed an annual membership campaign to raise awareness of mental health and learning disabilities, reduce stigma and to signpost people to both trust and external support services. The 2015 campaign focussed on men's mental health and well-being, whilst the 2016 campaign, "This is me!" focussed on identity, labels and sense of self and how this impacts on a persons' mental health and well-being.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **How the regulation was not being met** The governance systems established to assess, monitor, and improve the quality and safety of the service, and manage risk, did not operate effectively and were not embedded in the service. The trust did not have a systematic approach in place with regard to the documentation required to assure themselves, or the Care Quality Commission, that the directors met the fit and proper person requirement, regulation 5 of the Health and Social Care Act (Regulated Activities) Regulations 2014. Incidents were not reported to the National Reporting and Learning System in a timely way. Incidents were not reported in both the supported living service and the forensic and secure inpatient services and the systems were not in place in all services to ensure incidents were reported and reported in a timely way. Systems were either not in place or sufficiently robust to ensure that records were accurate and contemporaneous, including all decisions about patient's care and treatment within their care record.

This section is primarily information for the provider

Requirement notices

The internal audit systems were not always sufficiently robust to identify missed doses or other medication issues and errors in some services.

The application of the Metal Capacity Act in some services was not in line with the trust policy or the Act.

The systems and guidance in place did not fully support, or ensure, the application of the Mental Health Act across the trust and the updated code of practice was not sufficiently embedded across all the services or detailed in the trust policies.

The trust did not return the data requested by the CQC during the inspection in a timely way.

This is a breach of regulation 17(2)(a) (b) (c)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **How the regulation was not being met:** The trust compliance was low for training courses on essential life support, moving and handling advanced, food safety level two, fire level three, intermediate life support, safeguarding children level two and three. The low compliance with essential and immediate life support meant that the service could not guarantee that all staff could respond to patients in a medical emergency. Compliance in the mandatory level two Mental Health Act community and inpatient level two training and the duty of candour, for the trust were also below 75%. Five teams or services had below 75% compliance in the Mental Capacity Act training, including Deprivation of Liberty Safeguards.

This section is primarily information for the provider

Requirement notices

The trust had not met its target of 90% compliance for appraisals and some services had low compliance.

The trust compliance for clinical supervision was low across the trust, except for the mental health services for children and young people.

This is a breach of regulation 18 (2) (a)

Regulated activity

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Diagnostic and screening procedures

Treatment of disease, disorder or injury

Regulation

Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

How the regulation was not being met:

The emergency equipment and medication checks were not sufficiently robust on some wards, including the inpatient wards for older adults and the long stay and rehabilitation wards, where items were out of date or missing and equipment like blood glucose testing meters were not being recalibrated.

Medicines across the trust were not being stored at the correct temperatures to remain effective. Staff in many of the clinical areas throughout the trust were not monitoring ambient room temperatures and where they were, temperatures were exceeding the room temperature recommended by the World Health Organisation guidelines. Staff in clinical areas were either not recording the fridge temperatures or not always taking action when temperature readings were outside of the required range.

There was no physical health monitoring of antipsychotic medication and staff in the community services were unclear who was responsible for physical health monitoring.

This section is primarily information for the provider

Requirement notices

This was a breach of regulation 12 (2) (e) (f) (g)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect **How the regulation was not being met:** The Yorkshire Centre for Psychological Medicine did not comply with the Department of Health guidance same sex accommodation (2010), or the code of practice, at the time of the inspection. This was a breach of regulation 10 (2) (a) and (c)

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.