Good

Leeds and York Partnership NHS Foundation Trust

Long stay/rehabilitation mental health wards for working age adults

Quality Report

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

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Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RGD10	Asket Centre	Asket Croft Asket House	LS14 1PP
RGD03	The Newsam Centre	Ward 5	LS14 6WB

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

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

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

Summary of findings

Ratings

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

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

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

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

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

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

Summary of findings

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Summary of findings

Overall summary

We rated Long stay/rehabilitation mental health wards for working age adults as good because:

- Staff treated patients with kindness and respect. Interactions between staff and patients were warm and supportive. Patients were actively involved in the development of their care plans. Patients and staff told us that there were good links with the advocacy service.
- Staff ensured that patients engaged in meaningful activities whilst on the wards. Patients had a range of activities they could participate in and some patients were able to cater for themselves. Staff provided a range of activities and were instrumental in applying for local community grants that were available for groups wanting to encourage people to walk more.
- Medication was prescribed in line with best practice and National Institute for Health and Clinical Excellence guidelines.
- The service had introduced individual digital tablets to patients. The tablets contained an app called U- Motif and allowed patients to take more control over their care through a platform that enabled communication with their clinician.
- Staff were knowledgeable in the application of the Mental Health Act. They received support from the central Mental Health Act administration team where appropriate. Staff also understood the principles of the Mental Capacity Act.
- Staff were skilled in de-escalation techniques and this meant there was a low level of restraint used in the service.
- The service provided a pathway for unregistered staff to gain a national vocational qualification level 3 in health and social care.
- There was strong local leadership across the wards, which staff and patients confirmed. All staff we spoke with felt supported by their colleagues and held them in positive regard. The ward managers had enough autonomy to run their wards.

However

- Compliance with mandatory training was below the trust requirement of 90% for the long stay and rehabilitation services.
- Capacity assessments for treatment for detained patients were not always recorded in their file.
- Supervision was not always provided in line with the trusts policy.
- Oxygen cylinders were not checked regularly and replaced when they had been used.

Summary of findings

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

Are services safe?

Good

We rated safe as good because:

- All wards were clean and well maintained with good standards of hygiene and infection control practice.
- Staff were skilled in de-escalation techniques, which meant the service had low levels of restraint.
- The ward managers had enough autonomy to run their wards so they could ensure they were staffed to safe levels.
- Medication was stored securely and medication records were up to date.
- Staff and patients held a debriefing session following any incidents to see how they could have managed it differently.

However

- Compliance with mandatory training was below the trust requirement of 90% for the long stay and rehabilitation services.

Are services effective?

Good

We rated effective as good because:

- Staff prescribed patients their medication in line with best practice and the National Institute for Health and Clinical Excellence Guidelines.
- The service used protected engagement time to actively engage with patients, facilitate their leave and encourage activities.
- The service provided a pathway for unregistered staff to gain a national vocational qualification level 3 in health and social care.
- Staff were knowledgeable in the application of the Mental Health Act and received support from the central Mental Health Act administration team where appropriate.
- Staff understood the principles of the Mental Capacity Act and were able to give us examples of how they had assessed people's capacity.

However:

- Capacity assessments for treatment for detained patients were not always recorded in their file.
- Supervision was not always provided in line with the trusts policy.

Summary of findings

Are services caring?

Good

We rated caring as good because:

- Staff treated patients with kindness and respect. Interactions between staff and patients were warm and supportive. During the morning meetings, staff were attentive and flexible to patients' needs.
- Staff communicated positive, empowering and hopeful messages throughout the day.
- Patients were actively involved in the development of their care plans and acknowledging any associated risks with their behaviour
- Patients and staff told us that there were good links with the advocacy service.

Are services responsive to people's needs?

Good

We rated responsive as good because:

- Patients received support for six months post discharge from the same team they had worked with whilst in hospital.
- There was a range of food to meet patient's dietary and religious requirements and patients were able to cater for themselves.
- The occupational therapy team provided a range of activities. The healthy living advisor (LYPFT) and Peer Support worker (Leeds Mind) were instrumental in applying for local community grants that were available for groups wanting to encourage people to walk more.
- The service had introduced individual digital tablets to patients. The tablets contained an app called U-Motif and allowed patients to take more control over their care through a platform that enabled communication with their clinician.
- All the wards had well organised display boards that contained information about treatments, local services, patients' rights and how to complain.

Are services well-led?

Good

We rated well led as good because:

- Staff were aware of the trusts' vision and values and they were embedded within their practice.
- Staff reported incidents appropriately and received feedback and lessons learned at team meetings or during individual supervision.

Summary of findings

- The Datix system included a risk register for each ward; this meant managers could add to the risk register when they needed to. It also produced a monthly report so that managers could monitor their risks.
- There was strong local leadership across the wards, which staff and patients confirmed. All staff we spoke with felt supported by their colleagues and held them in positive regard.
- The service was involved with several projects looking at ways patients could be supported more positively.

However

Supervision was not being completed in line with trust policy.

Summary of findings

Information about the service

Leeds and York Partnership NHS Foundation Trust provide a long stay/rehabilitation service. This service provided rehabilitation and recovery for working age adults with mental health problems. We visited two hospital sites -

the Newsam Centre and the Asket Centre.

Ward five at the Newsam Centre is an 18 bedded locked rehabilitation ward, for male patients. Referrals and admissions are received from a number of sources such as low secure, acute services and open rehabilitation units.

The Asket Centre has two community inpatient units called Asket Croft and Asket House. These units offer a stepped pathway in order to meet the individual needs of the patients. Both units are mixed sex and in total have 22 male and 14 female beds.

Asket Croft is the 'supported unit' and is able to provide support to patients who have a higher level of need in the early stages of their recovery. This unit had higher staffing levels and catering in order to maintain the health and safety of the patients, and to enable them to work towards their recovery goals.

Asket House is the 'independent unit' and supports patients with a lower level of need who are further along their journey of recovery, but still require the 24 hour support provided by the multi-disciplinary team. This unit is for patients who have the ability to cater for themselves and have more significant involvement in the decision making process about how they budget and cater for themselves.

Our inspection team

The team was led by:

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

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

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

Chris Watson, Inspection Manager, Care Quality Commission

The team inspecting long stay rehabilitation mental health wards for working age adults comprised an inspector, a consultant psychiatrist, an expert by experience, a nurse and an occupational therapist. An expert by experience is someone who has developed expertise in relation to health services by using them, or through contact with those using them, for example, as a former patient or carer.

Why we carried out this inspection

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

How we carried out this inspection

How we carried out this inspection

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

Summary of findings

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

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

During the inspection visit, the inspection team:

- visited the Asket Centre,
- visited the Newsam Centre ward five
- spoke with three managers
- spoke with a relative
- spoke with six patients
- spoke with 22 staff, including consultant psychiatrists, psychologists, nurses, health support workers, an admin support worker, an activity coordinator; a healthy living worker; a care coordinator and three occupational therapists
- looked at 12 care plans
- attended three multi-disciplinary meetings
- looked at 15 drug charts
- observed a community meeting and received two comment cards.

What people who use the provider's services say

We gave patients the opportunity to give feedback on the service they received prior to our inspection via comment cards left at both units. We received two comment cards back from this service. The feedback on these comment cards was positive. We held a focus group that two patients attended .

We spoke with six patients who received care and treatment in the rehabilitation and long stay services. Patients praised the relaxed environment and friendliness of the staff. Four patients stated that staff explained information to them in a way they could easily understand. Patients also valued the time staff spent with them, encouraging them to have a structured day to help with recovery. They told us that leave, for them had never been cancelled and they felt safe on the ward.

A relative told us that staff kept them informed about the support the patient was receiving and involved them in some of the planning for the future.

Good practice

The service had introduced individual digital tablets to patients. The tablets contained an app called U-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 patients could keep in touch with their friends and family.

The service had developed a Person Centred Recovery course in collaboration with Leeds Beckett University. Clinicians from the service delivered this training. It was open and free of charge to employees of the trust and their partner organisations. Patients were helping to deliver this training.

Staff were able to access a personal health budget to manage the health of the inpatients. This was a pilot and involvement is agreed as part of the multi-disciplinary 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 service was involved in a photo elicitation research project. Once a participant has been assessed and accepted in to the research group, they were encouraged

Summary of findings

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.

Areas for improvement

Action the provider SHOULD take to improve

Action the provider SHOULD take to improve

The trust should improve compliance rates with mandatory training, including essential and immediate life support training, in line with their own targets.

The trust should ensure that capacity assessments for treatment for detained patients are recorded in their file.

The managers should continue their positive approach to clinical and managerial supervision in line with trust policy.

The trust should ensure that oxygen cylinders are regularly checked and replaced when used.

Leeds and York Partnership NHS Foundation Trust

Long stay/rehabilitation mental health wards for working age adults

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Asket House Asket Croft	Asket House
Ward 5	The Newsam Centre

Mental Health Act responsibilities

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

The Mental Health Act training was compulsory and the target was 90% compliance for all staff by July 2016. The compliance rate was 66% for the long stay rehabilitation wards at the time of the inspection. However, information found during the inspection showed that the shortfall was due to long-term sickness.

Staff were knowledgeable in the application of the Mental Health Act and received support from the central Mental Health Act administration team where appropriate.

We reviewed 10 out of 24 detained patients' records. The system for recording patients' section 17 leave was thorough. Detained patients received treatment authorised by the appropriate certificate. Copies of the certificates were kept with the patients' prescription cards. The patient's capacity and consent to treatment was not recorded in all patient records.

Staff regularly explained to patients their rights under section 132 and recorded their understanding.

Copies of the patients' detention papers and the reports by the approved mental health professionals were in order.

Patients had access to independent mental health advocates.

Detailed findings

Notice boards at both units clearly displayed information about patients' legal status and rights under the Mental Health Act.

Mental Capacity Act and Deprivation of Liberty Safeguards

Training in the Mental Capacity Act 2005 was mandatory. Data provided by the trust showed that only 64% of staff on the long stay rehabilitation wards had completed this training. During the inspection, we saw evidence that more staff had completed this training although this still left them below the trusts target of 90% at 80%.

Staff we spoke to understood the principles of the Mental Capacity Act. Staff discussed the use of a Deprivation of Liberty authorisation with a patient who was ready to move in to the community. There were difficulties finding suitable accommodation and staff felt it was the least restrictive to use a Deprivation of Liberty order rather than let the patient discharge themselves without proper support.

There was one Deprivation of Liberty Safeguards in place. There had been two previous occasions where deprivation of liberty safeguards were applied. A Deprivation of Liberty Safeguard application becomes necessary when a patient, who lacks capacity to consent to their care and treatment, has to be deprived of their liberty in order to care for them safely. It has to be demonstrated that this is in the patient's best interests and the least restrictive option.

Good

Are services safe?

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

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

Our findings

Safe and Clean Environment

The long stay/rehabilitation wards provided patients with a clean, comfortable, well-maintained environment. The service had carried out appropriate health and safety assessments on equipment throughout the wards, including checks on fire extinguishers and appropriate electrical testing.

Ligature risk and environmental audits were in place and in date on all wards. All wards had identified ligature points and risk assessments were in place to mitigate these risks. A ligature point is a place where a patient intent on harming themselves might tie something to in an attempt to hang themselves.

All mixed sex wards complied with Department of Health guidance on same sex accommodation. In each case, they achieved gender separation by accommodating male patients in a separate area to female patients. Female patients had access to a female only lounge.

None of the wards had a seclusion room. Information provided by the trust showed that they had not used seclusion in the long stay/rehabilitation services between1 April 2015 to 30 April 2016.

Across the service, clinic rooms were clean, tidy and well organised. Equipment for checking vital signs was present. There were adequate supplies of emergency equipment, including defibrillators, which staff checked regularly. The wards kept stocks of emergency medicines as per the trust resuscitation policy and a system was in place to ensure they were fit for use. However, at the Asket Centre we found one bottle of oxygen was out of date and another was only half-full. Actions were taken during our visit to ensure the oxygen was in date and full. Ligature cutters were available and easily accessible. Drugs cupboard were well arranged and labelled. Medicine fridges were clean and in order and staff checked temperatures daily.

The service was clean throughout with good standards of hygiene and infection control. There were systems in place to reduce the risk and spread of infection. For example, there were hand gel dispensers on each ward and personal protective equipment was readily available on wards.

Patient-led assessments of the care environment surveys are the national system for assessing the quality of the patient environment. These assessments are self-assessments undertaken by teams, with over half the team being members of the public (known as patient assessors, as well as NHS and private/independent health care providers. They focus on different aspects of the environment in which care is provided, as well as supporting non-clinical services such as cleanliness. For 2015, the assessors rated the long stay rehabilitation ward environments overall at 97%, which is below the England average of 98%.

Safe staffing

Staffing arrangements across the units differed, however there was a minimum of two qualified staff and two support workers on duty during the day and through the night. We saw rotas during our inspection and they matched the required levels of staffing. There was one vacancy on ward five for a qualified band five nurse. Bank or agency staff had been used at the Asket Centre for 318 shifts and on Newsam ward five for 123 shifts. The operations manager at the Asket Centre acknowledged that their sickness level was 10% and shifts needed covering.

On Newsam ward, five the manager told us that they approached known bank staff to cover shifts. In the last three months agency staff had been used three times to cover shifts and the rest had been covered by bank staff. The managers were able to increase staffing levels when the patients needed extra support. The clinical lead for a shift could authorise extra staff if it was out of usual working hours.

Occupational therapists, a healthy living advisor, a dietician and an activity coordinator supported the nursing and support staff. There was also input from psychology.

There was one junior doctor for Newsam ward five who provided cover during the day. They also provided cover for

Good

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another ward. Medical care was available from the doctor on call for the Newsam site. At the Asket Centre, patients were registered with a local GP and they responded to any requests for visits or appointments. In an emergency staff would call 999.

The trust had a compliance target of 90% for statutory and mandatory training. Training data provided by the trust showed that the service had achieved an average of 75% compliance. There were 26 elements to mandatory training including: equality and diversity, fire, health and safety, infection prevention and control, medicines management training, high level physical interventions, promoting safe and therapeutic services and breakaway skills and safeguarding.

Training records showed that 60% of staff had completed emergency lifesaving training, and 57% of staff had completed Mental Health Act training Other topics where staff had not achieved the 90% target were; personal safety with breakaway skills at 76%, Mental Capacity Act 64% and Deprivation of Liberty safeguards and safeguarding children level three 71%.

On Newsam ward five the average training rate was 81% However seven out of 29 staff needed to complete their fire awareness level three. Only 76% of staff were trained in high-level physical interventions, promoting safe and therapeutic services and breakaway skills.

Assessing and managing risk to patients and staff

We looked at 12 patient records during the inspection. Each record contained an up to date risk assessment and risk management plan. Staff discussed the risk status of each patient at the daily handover meetings and reviewed risk regularly. The trust used the functional analysis of care environments risk assessment tool, which looked at a set of risk indicators relevant to the patient. These included judgements of risk status in key areas including violence, self-harm, risk of offending and self-neglect, staff also considered patient and carer perspectives on risk and within the risk management plan.

We did not identify any blanket restrictions on the long stay/rehabilitation wards.

The Asket Centre was an open rehab environment and patients who were informal could come and go at will. The open wards had a controlled entrance for security reasons but an open exit for patients and they were able to get back on to the units independently.

The trust had a policy for searching of patients. Staff did not routinely search patients. 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.

Staff were skilled in the use of de-escalation techniques and gave examples of using distraction and low stimuli in the first instance. Staff gave examples of positive risk taking through graded exposure. For example they had enabled a patient on high observation levels to take some section 17 leave. Staff discussed situations where patients had been on leave and it had broken down because of the patient's behaviour. They held a debrief with the patient to see what the issues had been and how they could help support them further.

The wards had implemented the 'safer wards' initiative and there was a chill out room on Newsam ward five. Staff were aware of trigger points for some patients and used one to one time with patients to discuss how they could manage their moods and how they might express themselves without presenting a challenge to staff.

Between 1 October 2015 to 31 March 2016 on Newsam ward five, restraint was used six times on four different patients, two of these resulted in prone restraint and one in rapid tranquilisation. There had been no instances of seclusion. During the same period at the Asket Centre, there had been no restraint or seclusion used. Neither the Newsam Centre ward five nor the Asket Centre had seclusion rooms.

Staff had a good understanding across the service of safeguarding and were able to explain the safeguarding procedure. There was evidence of appropriate safeguarding referrals to local safeguarding teams and attendance at multi-disciplinary meetings with the local authority. Staff had access to police liaison contacts when needed. Safeguarding was discussed in the multi-

Good

Are services safe?

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

disciplinary meeting and the trust safeguarding team were available to provide support to staff. Newsam ward five at the Newsam Centre had a separate room that was used by families when visiting relatives.

Medicines were stored securely and were only accessible to authorised staff. We looked at the systems in place for medicines management across the long stay/rehabilitation wards at the Asket Centre and the Newsam Centre ward 5. We reviewed 15 prescription records and spoke with the nursing staff that were responsible for medicines. Medicines were stored appropriately and temperatures monitored daily in line with national guidance. Prescription records were fully and accurately completed, and medicines were prescribed in accordance with the consent to treatment provisions of the Mental Health Act for patients. Where patients were prescribed antipsychotic medication above British National Formulary limits extra physical health monitoring took place. However one patient was receiving antipsychotic treatment above British National Formulary limits, which carries additional risks for the patient. The risks of this medication determine that extra physical health monitoring should take place. One patient refused any interventions from staff and this meant they had not had any extra checks since 2014. This was discussed with the psychiatrists and they told us that they looked the medication at every review and had on occasion reduced it to the British National Formulary limits. The result of this was an increase in psychotic behaviour so they increased the medication again. We saw evidence that the patient's refusal was recorded in their progress notes. Staff confirmed they made sure when possible that patients received their health checks when necessary.

Some patients managed their own medications under the supervision of a nurse and staff discussed patients' progress at multidisciplinary team meetings. Risk assessments were available in patient notes.

Track record on safety

Following a trust wide audit of all inpatient detentions under the Mental Health Act, the trust identified 12 cases on inpatient wards where the detentions were felt to be unlawful.

As a result, all Mental Health Act paper work was now scrutinised by the mental health office. There had been no other serious incidents reported pertaining to the long stay/rehabilitation service in the period 1 March 2015 to 28 February 2016.

Reporting incidents and learning from when things go wrong

Staff knew what incidents to report using the online reporting system. Incidents recorded included medication errors, absconding, accidents, equipment problems and information governance among other categories. Staff involved in the incidents received a debrief using a supportive approach. This involved a discussion of what happened and what staff could have done differently. Ward managers cascaded any learning from these incidents through team meetings and a monthly bulletin devised by the manager of Asket Court which included updates of guidance. This included discussion and learning from other incidents via the trust central alert system. An example of this involved a patient transfer where the patient was able to grab the steering wheel whilst the car was moving and caused a crash. The trust changed their policy to include a full risk assessment for all patients undergoing a transfer.

Ward managers were aware of the importance of being open and transparent with patients and their families and apologising if things went wrong. The trust had just implemented training for staff in the Duty of Candour and staff understood their responsibility in duty of candour.

Are services effective?

Good

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

Our findings

Assessment of needs and planning of care

Patients admitted to the long stay rehabilitation service were assessed by the recovery team. They determined which rehabilitation service would be most suitable. Staff told us that community teams were beginning to recognise that a short rehabilitation stay could help support people in the community for a longer period. Patients admitted from another ward came with the assessment and care plan from that ward as well as information from the recovery team.

Staff used a variety of clinical assessment tools and outcome measures such as the hospital anxiety depression scale, the recovery star and the short Warwick-Edinburgh well-being scale. A consultant psychiatrist told us how the service worked with the patients to decide how best to support their recovery. We saw evidence that patients were involved in the care planning process. We observed three multi-disciplinary meetings and patients were involved in each meeting. We saw evidence that patients organised their own meetings and led the discussions. We reviewed 12 care plans and each plan contained detailed information about the support the patient needed to help achieve a good recovery. However only two care plans had a complete consent to treatment assessment. Patients received a copy of their care plan and this could be provided in a different format or language if necessary.

Occupational therapists gained a baseline assessment of patients' needs and highlighted specific interventions that patients may require using the model of human occupation screening tool. This was a recognised tool used by occupational therapists.

Staff considered and addressed patients physical health needs with good evidence of this recorded in patients' notes and of interventions when required. There was a focus on health promotion and healthy living evident for a number of patients. Patients using the services at Asket Croft were registered with a local GP and used community health services for their physical well-being. We saw that patients had completed drug and alcohol reduction programmes. The ward manager told us they had to be realistic about patients being able to achieve their goals.

Care records were stored on the computer with Mental Health Act documentation stored in a paper file. These were accessible to all trust staff. The wards had a printed copy of the current care plan available so that all staff, including agency staff could refer to it without needing to use the computer.

Best practice in treatment and care

The three wards provided care and treatment in line with best practice and the National Institute for Health and Care Excellence. For example, staff followed National Institute for Health and Care Excellence guidelines on prevention and management of psychosis and schizophrenia in adults, recognition and management of depression and anxiety and borderline personality disorder. We looked at 15 prescription records and found evidence of good practice. Patients with complex and potentially long-term needs were prescribed medication within British National Formulary limits, however four patients were on antipsychotic medication above the British National Formulary limits and we saw that regular health checks were offered and the medication was reviewed on a regular basis. The consultant and the ward manager reviewed prescription charts every month to ensure medication remained appropriate.

The service had access to four part time psychologists. There was a range of recovery-focused activities available at both units and a range of psychological therapies. The service offered patients psychosocial interventions and access to family therapy. Patients had the same psychologist through the rehabilitation services and for up to six months following discharge in to the community. Staff had protected time on the locked rehabilitation ward, staff used this time to engage with the patients and facilitate leave. On the open rehabilitation units; patients decided their own routines and approached staff when they needed support.

All care records we reviewed showed the patient had ongoing physical health monitoring using national early warning scores amongst others. National early warning scores focused on six simple physiological parameters: heart rate, respiratory rate, blood pressure, level of consciousness, oxygen saturation and temperature. Patients confirmed that they had physical observations taken weekly or more frequently if staff had concerns.

Staff used a variety of evidence-based tools to assess and record severity and outcomes such as the Beck Depression Inventory.

Are services effective?

Good

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

Staff participated in various clinical audits. For example, a senior nurse carried out a monthly audit of the wellbeing and recovery plans, which looked at a range of documentation issues. The findings were addressed during individual staff supervision sessions and discussed in team meetings. Other audits included daily equipment audits and infection control.

Skilled staff to deliver care

A range of professionals provided input to the service and supported patients. These included a psychiatrist, clinical psychologists, a pharmacist, an occupational therapist and assistants, a junior doctor, healthy living advisors, Leeds MIND, recovery workers form Touchstone and care-coordinators from Community Links, nurses and a nurse prescriber at Asket House, a social worker, keyworkers, administration and support staff. The pharmacist visited the wards weekly. The skill mix among staff at all the units was sufficient to meet patients' needs.

All staff had access to monthly supervision, alternating between clinical and managerial supervision. Information received from the trust showed that staff had not received supervision in line with policy. Ward managers were aware of this and had begun to address this shortfall. We saw evidence that staff who were supervisors had planned in the diary sessions for supervision. The manager showed us supervision records where they had addressed the shortfall and we saw that staff had been receiving supervision in line with the trust's policy since April 2016.

We saw evidence that supervision had begun to happen. All staff had received an appraisal. This meant that ward managers were able to support staff with their professional development to provide quality care and treatment for patients. Staff that had not had a performance appraisal and development reviews were either on maternity leave or on long term sick. Staff could also attend a range of regular peer support groups to look at and discuss situations that had happened within the service.

All staff attended monthly team business meetings. We looked at minutes from several meetings held during the last three months. Minutes showed standard items on the agenda included policy updates, environmental issues, safeguarding and training.

Staff could also be nominated for a 'star award' for outstanding practice within the trust and there was an annual awards celebration to recognise staff who had gone beyond in their role.

Ward managers encouraged and supported staff to undertake specialist training to enhance the skills within the team and lead to professional development. All unregistered staff had access to the National Vocational Qualification level 3 in health and social care through an apprenticeship scheme. Staff said managers were supportive of them accessing further training including but not exclusively training in; nurse prescribing, mindfulness, dual diagnosis, harm education, yoga for health care practitioners and two members of staff had received support to complete their master's degree.

There were structures in place for ward managers to manage performance within their teams. The trust had a Personal Responsibility Policy and this set out what the trust expected from staff and what the staff could expect from the trust. Where an issue had been identified with a member of staff through supervision then they would be sent a letter in conjunction with the human resources department reminding them of their responsibilities. This was the first stage of the disciplinary process. Several staff were currently being performance managed following complaints from patients.

Multidisciplinary and inter-agency teamwork

The multidisciplinary team held a weekly recovery meeting at each location. A range of healthcare professionals reviewed patients every three weeks. Patients attended these meetings and were able to say who they wanted to be present. Patients led the discussion and were able to express their wishes. They told us that they were supported to speak up by their named nurse and felt they were making positive steps towards recovery.

Adherence to the MHA and the MHA Code of Practice

Mental Health Act training formed part of the trust mandatory training programme. Information received from the trust showed that they were not meeting the trusts target of 90%.

Staff were knowledgeable in the application of the Mental Health Act and received support from the central Mental Health Act administration team where appropriate.

Are services effective?

Good

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

Overall, the service had 24 patients detained under the Mental Health Act at the time of the inspection. We reviewed patients' current leave forms and found the system for recording section 17 leave was thorough. Patients were aware of how much leave they could take and used it. Staff encouraged patients to discuss any leave requests they might have at the daily morning meeting and facilitated leave arrangements.

Ten of the 12 patient records we reviewed were for detained patients. These detained patients records showed they were receiving treatment authorised by the appropriate certificate. We saw that copies of the certificates were kept with the patients' prescription cards. We found that capacity and consent to treatment assessments were only in three patient records we saw.

Patient records showed staff regularly explained to patients their rights under section 132 and recorded their understanding. We saw notice boards at both units that clearly displayed information about patients' legal status and rights under the Mental Health Act.

Copies of the patients' detention papers and the reports by the approved mental health professionals were in order.

Patients had access to independent mental health advocates. Staff knew how to refer and support patients to engage with the advocacy service. Independent mental health advocates help people who use services have their opinions heard and make sure they know their rights under the law. All patients we spoke with confirmed that they knew how to contact the independent mental health advocates should they require advocacy support. All wards displayed information on the advocacy service on their Mental Health Act notice board.

Good Practice in applying the MCA

Training in the Mental Capacity and Deprivation of Liberty Safeguards was mandatory. Figures supplied by the trust showed that overall 64% of staff had completed the training; this was not compliant with the trust target of 90% for Mental Capacity Act training. However, information found during the inspection showed that the shortfall was due to vacancies and long-term sickness.

Staff had a basic knowledge of the Mental Capacity Act and we saw examples of good practice. Staff discussed the process where they had used a best interest meeting to determine what course of action to taken in the patients interest. Patients' records contained decision specific capacity assessments and showed that staff held best interest meetings where appropriate

At the time of our visit, one patient was subject to a Deprivation of Liberty Safeguard and there had been two previous applications in the twelve months leading up to inspection. A Deprivation of Liberty Safeguard application becomes necessary when a patient who lacks capacity to consent to their care and treatment, has to be deprived of their liberty in order to care for them safely. It has to be demonstrated that this is in the patient's best interests and the least restrictive option.

Good

Are services caring?

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

Our findings

Kindness, dignity, respect and support

We observed two handovers, a ward round and interactions between staff and patients during the inspection. We saw positive and warm engagement with patients across the service. There was evidence of a positive therapeutic relationship between staff and patients. During the morning meetings, staff were attentive and flexible to the group needs and the agenda allowed for free flowing conversation. Staff communicated positive, empowering and hopeful messages throughout.

Patients said staff respected their privacy and spoke positively about the support and interactions they received from them. They commented that staff were highly visible and approachable.

Staff showed a good understanding of each patient's individual needs and how they were feeling during shift handovers. Staff spoke about patients in a professional, non-judgemental, and compassionate manner. There was evidence that staff considered carers' views and needs.

In relation to privacy, dignity and wellbeing, the 2015 PLACE score for Newsam Centre ward five was 95%; Asket Croft 91% and Asket House 95%. This was in line with the trust average of 91% and higher than the England average of 86%.

The involvement of people in the care they receive

Patients were encouraged to visit the rehabilitation wards prior to their admission where possible. They were also given informative welcome packs given to help orient them to the unit and explain the care and treatment provided. Staff encouraged patients to join in activities and events rather than remain in their rooms.

Patients were actively involved in the development of their care plans and acknowledging any associated risks with their behaviour. An example of this was around searching. Patients who were known to use none prescribed drugs or drink alcohol had a care plan around them being searched for contraband on return to the ward when they had been on leave. We saw one care plan where the rationale for the searches had been identified and the patient had signed it. A patient spoken with had changed their addictive behaviour to the point they had requested this portion of the care plan be reviewed. It had been reviewed and that element of the plan was changed. Patients were given a copy of their care plan but two of those we spoke with couldn't remember being given a copy. Patients were actively involved in the discharge planning process, viewing flats for suitability and expressing their preferences for discharge from the wards.

All patients could access an advocate. On Newsam Centre ward five, an advocate visited the ward on a daily basis and supported patients with their multi-disciplinary meeting and other meetings on request. An advocate told us that the ward worked closely with the advocacy service. We noted posters advertising advocacy services displayed on information boards at both services. Patients and staff told us that there were good links with the advocacy service.

The patient satisfaction survey for the service showed that all patients who responded found staff to be friendly and helpful. Patients told us staff involved them in the care planning process and they were able to express their wishes for discharge. Staff on Newsam ward five held a daily meeting to determine the routine for the day and to enable patients to organise their section 17 leave.

Patients were encouraged to give feedback on the service in a variety of ways. They could comment during the daily community meeting, complete the trust patient experience survey and friends and family test. 'You said we did' feedback from the monthly user group was visible on display boards at both units. Patients also left messages of hope about their experience on the Newsam ward five's 'discharge tree'.

Are services responsive to people's needs?

Good

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

Our findings

Access and discharge

Between 1 October 2015 and 31 March 2016, the bed occupancy at the Newsam Centre ward five was 98%; and 90% at Asket House and 86% at Asket Croft for the same period. There had been no readmissions to the wards within 90 days during this period.

The average length of stay for current patients for the period ending 1 April 2015 and 31 March 2016 was 362 days. For the period 1 April 2015 to 30 April 2016, the average stay was 777 days. This reflects the complexity of needs for patients on Newsam Centre ward five. The service admitted patients from the trust's forensic wards, acute wards, as well as patients known to the community mental health team.

Admissions to Newsam ward five included patients with complex needs who had been brought back from 'out of area' placements. Due to the complexity of their needs, their journey through to recovery was slower than for patients admitted from other trust wards or the community. Staff acknowledged there were difficulties in moving patients forward but they had been successful in getting patients to the point of discharge. When delays occurred it had been because of the lack of suitable housing within the local community. Admissions were planned and patients were admitted when a named worker was on duty who was allocated to spend time with them and help orientate them to the environment. Staff arranged discharge at a time that was convenient to patients, usually in the morning or afternoon during the working week. All patients were discharged with a risk and relapse plan developed with the recovery team pre-discharge. They also received support for up to six months from professionals who had been involved in their inpatient care.

Patients had access to a bed on return from leave.

Patients were moved through the rehabilitation service when their acuity had decreased and they would benefit from a less structured environment. From Newsam Centre ward five, they moved to either Asket House or Asket Croft depending on how much or little support they needed. Patients were discharged in to the community from all the wards. Patients were not moved around the hospital to another service such as the acute or forensic wards unless they had been clinically assessed as needing a higher level of support.

There had been no delayed discharges in the six months prior to our inspection. The recovery team played an important role in a successful discharge as they worked with patients to organise accommodation, support and finances before leaving hospital. They also provided further support for six months post discharge before the patient was transferred to the community mental health team.

The facilities promote recovery, comfort, dignity and confidentiality

Newsam Centre, ward five and the Asket Centre had a range of rooms and equipment to support the rehabilitation and recovery of patients. For example, there were clinic rooms to examine patients, games rooms, art rooms, faith rooms and communal lounges. There were a number of small lounges where patients could go to spend time alone or to meet with staff. Patients on Newsam Centre ward five could access the external garden area when they had section 17 leave. Patients at the Asket Centre had unrestricted access to the garden and local community. There was one informal patient on Newsam five and they could leave the ward whenever they wanted.

The units provided each patient with an informative and comprehensive welcome pack to help familiarise them with the wards.

Patients had access to a public phone or used their own mobile phones to make phone calls in private. There was also access to the ward phone. In order to protect the confidentiality and dignity of patients, the service did not allow patients to use the camera function of their mobile phones.

Patients on Newsam ward five and at Asket Croft had their meals catered. There was a choice of food and special diets were provided. If someone was admitted to the ward who needed a specialised diet then staff would obtain something suitable either from the catering department or from the local shop until they could provide what was needed regularly.

Patients had the option of having a key to their room. Some patients declined the option of having a key. This was clearly care planned. Patients had access to bedrooms

Are services responsive to people's needs?

Good

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during the day depending on risk and capacity. We saw some patients had chosen to personalise their bedrooms. Patients had a lockable storage space for patients to keep possessions safe.

Staff on Newsam ward five at the Newsam Centre and Asket Croft held a morning meeting. This allowed for a level of planning to provide patients with meaningful activities and effectively using their days and time on the unit. Patients completed an interest checklist on admission, which allowed them to highlight areas of activity they had an interest in or would like to try. Patients at Asket Croft were much more independent and were able to plan their own days with minimal input from staff.

Staff, which included the healthy living advisor and the dietician arranged groups on a daily basis for patients at both units to attend. These included swimming, bowling, art group, yoga and the allotment. All activities were meaningful as staff used them as opportunities for patients to gain confidence with every day events such as crossing a road and finding a venue. Patients at Asket Croft prepared their own lunches, budgeted, and shopped for the ingredients themselves. Some patients on Newsam Centre ward five and Asket Croft cooked some of their own meals with support from staff.

On Newsam Centre, ward five activities were graded red, blue or green. The colour indicating the different patients. There was a quieter group of patients in the green and very active patients joined in with the red group. This enabled some of the quieter, more introverted patients to join in with activates and not be over whelmed by the louder, more assertive patients.

Newsam Centre ward five had a chill out room that patients could access had a recovery wall where patients could leave messages of encouragement for others. They also had a list of expectations for both patients and staff behaviours. Patients helped to develop this 'code of conduct' and allowed staff and patients to challenge each other when they felt behaviours were not in keeping with the code. Staff at the Asket Centre were planning to involve patients to develop something similar for the two wards there.

Staff provided a range of activities and were instrumental in applying for local community grants that were available for groups wanting to encourage people to walk more. They had previously been successful in obtaining grants for bicycles and pedometers to encourage patients to go out and exercise more. This was discussed in a staff meeting and staff were clear about setting achievable goals for patients. An example of this was around those patients who struggled to go outside and how they might be involved in a walking challenge. It was agreed to discuss the proposals at the next patient meeting.

The service had introduced individual digital tablets to patients. The tablets contained an app called U-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 patients could keep in touch with their friends and family.

Meeting the needs of all people who use the service

The service was able to accommodate patients and visitors with mobility issues. Both units had rooms adapted for use by patients with disabilities.

Information leaflets were available in different languages on request. The service had previously used an interpreter for a patient. They could access interpreters through the trust's legislation department.

All the wards had well organised display boards that contained information about treatments, local services, patients' rights and how to complain.

The service was 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.

Staff were respectful of people's cultural and spiritual needs. Staff supported external visits to places of worship and arranged for the chaplain or different faith representatives to visit if leave was not possible.

Staff gave us examples of how they provided support to meet the diverse needs of their patients including those related to disability, ethnicity, faith and sexual orientation. The ward managers were knowledgeable about equality

Are services responsive to people's needs?

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and diversity issues and knew how they could manage patients' needs within the service. Staff were aware of the trust policy for admitting patients who had been through gender reassignment.

Listening to and learning from concerns and complaints

Data provided by the trust showed that the rehabilitation services received one complaint in the period 1 April 2015 to 29 March 2016. This complaint was partially upheld and as a result, the transfer of patients is now completed in a more planned way, and families and carers are kept informed.

There was information on how to complain displayed on notice boards and in the welcome packs, staff gave patients. The welcome pack explained that detained patients had the right to raise complaints about the Mental Health Act directly with the Care Quality Commission. It also explained how to make complaints and the support available from the patient advice and liaison services. Patients said they would complain either directly to staff, or at the daily morning meeting. If they wanted to make a formal complaint, they would use patient advice and liaison services.

Staff knew the complaints procedure and felt able to manage informal and formal complaints.

Are services well-led?

Good

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

Our findings

Vision and values

Staff were aware of the trusts' vision and values. These were:

Respect and dignity

Commitment to quality of care

Working together

Improving lives

Compassion

Everyone counts

We saw the values embedded within the teams. Staff treated patients with respect, dignity and acted with compassion. Staff were caring and worked with patients and their families to provide the best outcome possible for recovery. Patients told us that staff cared about them and involved them in their care. Open communication was taking place amongst colleagues and senior colleagues for advice and guidance.

Good governance

Data provided by the trust showed that mandatory training was only at an overall average of 75% below the 90% target the trust had set. However; the managers of the long stay rehabilitation service had identified the reasons for the shortfall and were addressing them. Staff were beginning to receive clinical and managerial supervision as stated by the trusts policy.

During the period 1 January 2016 and 31 March 2016, the vacancy rates were within trust averages of 1.7 whole time equivalent, with the exception of Newsam ward five as they had 3.4 whole time equivalent vacancies for trained staff. Both units were able to fill any staffing shortfall using regular bank staff. Staff reported incidents appropriately and received feedback and lessons learned at team meetings or during individual supervision.

The service was monitored using key performance indicators to measure performance in areas set around the health and safety matrix and clinical information such as recovery star. Ward managers received monthly key performance indicators reports, which identified any performance shortfalls. They used this information to address concerns and plan service delivery effectively. The manager at Asket House had devised a dashboard to review information about staffing, incidents and other information of interest on a daily basis. They had shared this with other managers and several were keen to adopt this approach.

The ward managers had enough autonomy to run their wards. Clinical leads on each shift could increase staffing levels if they felt the acuity on the ward had increased. There was a clear pathway for this and all staff said they were supported by the service manager and other senior staff.

Datix was the system used to record incidents and included a risk register for each ward; this meant managers could add to the risk register when they needed to. Ward managers had included issues around smoking, staff shortages, and managing patients in a rehabilitation service when there were no acute beds, and any safeguarding incidents. Once risks and the actions to mitigate the risks were added to the register the service manager reviewed them. The system produced a report every four weeks so that managers could review the register regularly to ensure it remained relevant.

Systems were in place for sharing information with staff around lessons learned. These included a team communication folder of a shared drive, information on the trust web site, emails and newsletters outlining lessons learned.

Leadership, morale and staff engagement

The management team were taking steps to reduce the level of sickness. Managers had contacted staff who were absent due to sickness, to determine if there was anything else, they could do to support them. Staff were reminded about the Personal Responsibility Policy and this was used in the first instance to encourage staff to identify what support they needed to return to work. Managers encouraged staff to access the staff occupational health support if they felt their physical or mental health was deteriorating whilst at work.

A 'keep in touch' day had been organised and this brought staff together to look at how everyone could be involved in the development of the service. An action plan was agreed which identified areas of development over the course of the next year. These included but were not exclusive to;

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engaging with staff, project 'compassion for staff' how sickness was dealt with and management issues. The service manager wanted these days to be a regular part of staff support and engagement.

Across the service, we saw that staff had been booked in to bring their mandatory training up to date. Where staff were resistant to completing the training, the managers were using the Personal Responsibility Policy and other human resources tools to ensure they completed the training.

The trust took part in the 2015 NHS national staff survey; they identified three areas of focus for the trust as a whole. These were; communication, appraisals, and reducing violence. The trust also carried out local staff surveys relating specifically to long-stay rehabilitation wards.

Staff morale was good and staff said they worked in happy teams. We observed strong local leadership across the wards, which staff and patients confirmed. Staff said they felt supported by their colleagues and held them in positive regard. They were enthusiastic about their roles and thought stress levels were healthy and manageable.

Staff knew the whistleblowing process and said they would be able to raise concerns if the need arose without fear of victimisation.

Commitment to quality improvement and innovation

The service did not take part in the accreditation for inpatient mental health services programme for rehabilitation services that has been developed by The Royal College of Psychiatrists. This programme was developed to improve the quality of rehabilitation services.

The rehabilitation and recovery services were restructured in January 2015. They introduced a recovery centre that gate-keeps the service, provides care coordination through the rehabilitation and recovery pathway and remains involved for up to six months post discharge. The aims of the reorganisation were to; improve the pathway with a reduced length of stay, evaluate the culture associated with partnership working, cost improvement.

The service 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. It is hoped that if successful this will be integrated in the service and help develop the skills of the participants and give them opportunities to display their work.

The service had developed a Person Centred Recovery course in collaboration with Leeds Beckett University. Clinicians from the service delivered this training. It was open and free of charge to employees of the trust and their partner organisations. Patients were helping deliver this training.

Staff were able to access a personal health budget to manage the health of the inpatients. This was a pilot and involvement was agreed as part of the multi-disciplinary 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.