Requires Improvement

Leeds and York Partnership NHS Foundation Trust

Rehabilitation services

Quality Report

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

Date of inspection visit: 30 September – 2 October 2014
Date of publication: 16 January 2015

Locations inspected

Name of CQC registered location	Location ID	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
Millside	RGD07	Millside	LS6 4EP
Asket House	RGD06	Asket House	LS14 1PP
Towngate	RGDX1	Townsgate	LS20 9PQ
Ward 5	RGD03	Newsam Centre	LS14 6WB
Acomb Garth	RGDX2	Acomb Gables	YO24 4LZ

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 Rehabilitation and Recovery Services	Requires Improvement 
Are Rehabilitation and Recovery Services safe?	**Requires Improvement** 
Are Rehabilitation and Recovery Services effective?	**Requires Improvement** 
Are Rehabilitation and Recovery Services caring?	**Good** 
Are Rehabilitation and Recovery Services responsive?	**Good** 
Are Rehabilitation and Recovery Services well-led?	**Good** 

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

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

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

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

Summary of findings

Contents

Summary of findings

Overall summary

The trust had a clear vision for the rehabilitation and recovery services for Leeds. It had plans to reduce the bed availability in Leeds from 69 to 54. This was planned for three wards, a locked rehabilitation setting with 18 beds, a supported living ward with 24 hour rehabilitation for 20 beds and an independent living ward with 24 hour rehabilitation for 16 beds. This is planned to be supported by a rehabilitation and recover community service team. This was due to be implemented by January 2015.

Throughout our visit we observed good interactions between staff and patients across the wards. Staff engaged with patients in a caring, compassionate and respectful manner. Patients appeared to be comfortable approaching staff when they required support.

Patients we spoke with shared their experience with us of the care and treatment they received within the rehabilitation and recovery wards throughout Leeds & York Partnership NHS Foundation Trust.

In the Leeds wards we saw evidence of well documented care plans which described how individual needs were met at each stage of their care. Care records where electronically managed and audits completed on a monthly basis to ensure essential documentation was maintained.

In York, the ward had paper care records. We saw evidence of out of date documentation and in some cases the "my recovery pathway" and "recovery star" were not completed. We did not see evidence of patients' physical health needs being managed within the care plan documentation. This meant that up to date information was not available to enable staff to know how to meet patients' needs and support their recovery.

We received feedback from patients across the wards confirming they felt involved in decisions about their care. The wards proactively sought feedback from the patients via the ward weekly community meetings. Patients were also included in their care programme approach review meetings were a multi-disciplinary team would discuss the patients' progress and goals.

The links with the community services were disconnected in Leeds. Some patients had been discharged from the community services during their stay within rehabilitation inpatients. This meant that making adequate arrangements for an appropriate discharge back to the community could encounter difficulties. A new referral would need to be made for those patients who had been discharged by the community team. A new referral to the community team had an impact on continuity of care co-ordinators as the patient's original care co-ordinator was not always available to support them. This meant the patient would need to build relationships with another care co-ordinator.

All of the wards had access to occupational therapy, psychology and other specialist input when required. Staff worked with patients to promote independent living skills and social inclusion.

The wards in Leeds had strong governance arrangements in place to monitor the quality of service delivery. They had regular meetings for management staff to consider issues of quality, safety and standards. This included oversight of risk areas in the service such as incidents.

In the York ward the governance arrangements had recently been implemented. The ward manager reported to the acute admission matron. Locally the ward manager monitored quality, safety and standards and highlighted concerns on the risk register as appropriate. For example the ward manager had reported that the accommodation at Acomb Garth was breaching same sex accommodation guidance as specified in the Mental Health Act (1983) Code of Practice. This meant that male and female patients were using the same shower room, with male patients having to pass by female bedrooms to get to the shower room which was on the female corridor.

Staff told us that they had sufficient numbers of staff on duty to meet the needs of the patients on the ward but acknowledged that they also had reduced numbers of admissions in some areas due to the transition of services. Staff we spoke with told us they had access to mandatory training and some specialty training to enable them to carry out their roles.

We saw evidence staff supervision and appraisals were routinely undertaken and this was confirmed by staff when we spoke with them.

Summary of findings

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

Are services safe?

Requires Improvement

Three out of the five wards were mixed sex accommodation but only two met with the mixed sex accommodation requirements. Acomb Garth did not meet the same sex accommodation guidance as specified in the Mental Health Act (1983) Code of Practice.

At Acomb Garth we saw the paint and plaster on the walls was in need of repair, it was falling off around the building as we completed our ward tour. There was heavily stained walls and a broken window which had happened the previous night before our visit. The bedrooms had old furniture and the floors were heavily marked. This meant the up keep of the ward environment was not respectful to the patients who lived there

There was limited medical cover throughout the rehabilitation and recover service. This was provided by the medical cover used at the main hospital sites. Doctors on call at the main hospital sites were not able to leave the site to attend to remote locations such as the rehabilitation units. That meant that in an emergency situation it could be difficult to access medical assistance out of hours.

The rehabilitation wards visited had effective systems to assess and monitor risks within the ward environment and to individual patients.

Staff told us they were encouraged to report incidents and explained how the process of lessons learnt from all incidents within the trust are fed back via team meetings. The trusts risk management team collated all incident form information. This was reviewed by management to identify potential learning and improvements. Staff informed us that the use of restraint was low.

Overall staff across the wards said they had sufficient numbers of staff on duty to meet the needs of people on the wards. It was acknowledged there were a number of vacancies which had not been advertised due to the service redesign. This was being managed by offering overtime to current staff or the use of bank staff when necessary.

The trust had policies and procedures in place for effective the management of administration of medication.

Are services effective?

Requires Improvement

The Leeds wards used electronic patient records. We saw evidence of well documented care plans which described individual needs which centred on providing a recovery and outcome based approach to the care pathway. The ward in York had paper patient

Summary of findings

records which we reviewed and saw evidence of the care documentation not being maintained. In some files “my recovery pathway” and “recovery star” was blank. We could not see evidence of patients’ physical health needs being managed within the care plan documentation.

Mandatory training was not achieving the trust’s target performance in all wards. Millside and Towngate House were achieving 85% and were monitored to promote compliance.

We saw good management of the Mental Health Act 1983 Code of Practice and supporting documentation.

The application of Mental Capacity Act and Deprivation of Liberty safeguards was not being practiced in adherence with the guidance.

Are services caring?

Good

Patients spoke positively to us about their experience of the rehabilitation and recovery services.

We observed good interaction between staff and patients across the wards. Staff engaged with patients in a caring, compassionate and respectful manner. The wards were calm and patients appeared comfortable in approaching staff when they required support.

We received feedback from patients across all of the wards confirming they felt involved in decisions about their care.

Are services responsive to people's needs?

Good

The wards had a referral and admission criterion which supported the bed management process and management of inappropriate referrals for admission. Staff told us care planning approach (CPA) meetings took place before a patient was discharged to ensure they were supported during and after their discharge from the ward. Whilst patients lived in the rehabilitation service staff supported them to feel empowered through promotion of independent living skills and social inclusion. This underpinned the recovery model of rehabilitation.

Staff at Acomb Gables told us there were some inappropriate referrals for admissions to their ward due to bed management pressures within the York locality. We discussed this with the ward manager, who confirmed there had been occasions were an admission had been made for patients who were not meeting the admission criteria. They explained risk assessments and monitoring was undertaken and appropriate referrals were made back to the acute wards if the rehabilitation ward was not able to fully meet the patient’s needs.

Summary of findings

The patients had limited access to psychological therapies. This meant patients requiring this intervention had to wait significantly long periods of time before they could access the service. As a result some patients were not able to receive the appropriate treatment in a timely manner.

Ward managers told us how they had raised an incident log after a doctor had refused to attend the ward to provide support when requested.

Complaints were resolved at a local level by ward staff which meant the formal complaints policy and procedure was not followed. This meant shared learning and understanding on a trust wide level was not always being achieved as a large proportion of complaints were not formally logged. This was a trust wide theme and is reflected in the low level of complaints received by the trust in 2012/13 at 103 complaints.

Are services well-led?

Good

The trust had a clear vision for the rehabilitation services with the transition to the new service redesign due for completion between December 2014 and January 2015. The service involved a provision for a rehabilitation and recovery community service and working to the least restrictive way with patients which promoted the recovery aspects of patient's care. The strategies for the services' future were evident and staff had a good understanding and knowledge of them.

There was little knowledge about the trust's overall vision and strategy. Some staff told us the senior management and executive members were not visible at the remote locations were rehabilitation was based.

Staff told us they felt well supported by the management and their peers. Supervision and appraisals were up to date.

Summary of findings

Background to the service

Leeds & York Partnership NHS Foundation Trust rehabilitation and recovery units were based across four locations within Leeds and one location in York. The rehabilitation and recovery units provided inpatient mental health services for adults to enable patients to be supported to leave hospital and continue their rehabilitation and recovery pathway. The units provided a comprehensive assessment process which would then determine the right care plan for each individual. This took into consideration the patients' needs to support their to recovery. The wards provided recovery focused care and treatment with a clear pathway of care through the service.

At the time of our visit the service was going through the change process within the Leeds units. This meant that some of the wards visited had reduced admissions to enable the service transition planned for the end of the year. The Leeds services are managed by a matron dedicated to rehabilitation and recovery services. The Leeds services at ward level had standard procedures in place across all four wards. This meant that the service was managed and governed using the same systems and processes. These similarities are reflected in the ward level reports.

The York unit was overseen operationally by the matron who was responsible for acute admission wards in York.

Services

- Millside is a 17 bedded mixed sex accommodation open inpatient recovery unit based in Leeds. At the time of our visit there were 13 patients on the ward. At this service we spoke with one detained patient and three informal patients. We reviewed four care plans and associated Mental Health Act documentation. We spoke with five members of staff which included one ward manager, one support worker, one qualified nurse and a junior doctor. We reviewed four medication charts. We also observed a "goal setting" activity group which patients attended.
- Asket House is a 16 bedded mixed sex accommodation open inpatient recovery unit based in Leeds. At the time of our visit there were 16 patients on the ward. At this service we spoke with four informal patients, we reviewed six care records, interviewed two carers or family members and reviewed the handover documentation which staff used at the change of shifts. We spoke with nine members of staff. These included one ward manager, one occupational therapist, two support workers, four qualified nurses and a consultant. We reviewed 12 medication charts.
- Towngate House is an 18 bedded male only accommodation open inpatient recovery unit based in Leeds. At the time of our visit there were 10 patients on the ward. At this service we spoke with two detained patients, we reviewed eight care records and 10 medication charts. We spoke with four members of staff. These included one ward manager, one support worker and two qualified nurses.
- Ward 5 is an 18 bedded male only accommodation locked inpatient recovery unit based in the Newsam Centre in Leeds. At the time of our visit there were 18 patients on the ward. At this service we spoke with one detained patient and two informal patients. We reviewed three care records and observed a multi-disciplinary team meeting. We spoke with five members of staff. These included one ward manager, two support workers and two qualified nurses.
- Acomb Garth is a 16 bedded mixed sex accommodation open inpatient recovery unit based in York. At the time of our visit there were 15 patients on the ward. At this service we spoke with two detained patients. We reviewed three care records and a pharmacy inspector supported the review of medication charts. We spoke with five members of staff. These included one ward manager, two support workers and two qualified nurses.

The Millside and Newsam Centre had previously been inspected by the Care Quality Commission.

The Millside inspection was completed in February 2014. The service was compliant in the regulations reviewed.

The Newsam Centre inspection was completed in March 2014. The service was compliant in the regulations reviewed.

Summary of findings

Our inspection team

Our inspection team was led by:

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

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

The team included CQC inspectors and a Mental Health Act reviewer looking at the rights of patients sectioned under the Mental Health Act 1983. A variety of specialists including a junior doctor, an occupational therapist, a community mental health team manager with social worker experience, a mental health student nurse and a charge nurse from a rehabilitation care setting.

Why we carried out this inspection

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

How we carried out this inspection

Before visiting, we reviewed a range of information we held about the service and asked other organisations to share what they knew. We carried out an announced visit on 30 September through to 2 October 2014. During the visit we held focus groups with a range of staff who worked within the service, such as senior managers, doctors, nurses, support workers and allied health professionals. We spoke with staff on the wards that we visited within the service which included consultants, ward managers, qualified nurses, care support workers and occupational therapists. We observed how patients were being cared for and reviewed care or treatment records of patients. We met with patients and carers, who shared their views and experiences of the rehabilitation and recovery service with us.

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

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

What people who use the provider's services say

Patients told us the wards were clean and they had their own rooms which they could personalise if they wanted to. Patients said staff always knocked before entering their rooms but on occasions staff had opened the door immediately after knocking instead of waiting for the patient to acknowledge and invite them in.

Patients told us they had a number of communal rooms for them to socialise with other patients or have quiet time with family members or visitors. They said they had access to kitchens to make hot drinks and fresh fruit was available daily for them.

We were told by patients their family members were invited in for meetings regarding their care plan and review of treatment.

Patients told us that staff were responsive and supportive and the environment and staff were welcoming. They told us staff showed them respect and considered their privacy.

Summary of findings

Good practice

- The wards had a “you said, we did” feedback system for patients. If patients had raised a point within their weekly community meetings, the “you said, we did” provided them with communication on what action had been taken. This was displayed on notice boards within the wards and communicated at subsequent community meetings.

Areas for improvement

Action the provider MUST or SHOULD take to improve

- **Action the provider MUST take to improve**

- The provider must ensure that the requirements relating to separate facilities for men and women, according to paragraph 16.9 of the Mental Health Act Code of Practice, and national guidance regarding the provision of same sex accommodation, are adhered to.
- The provider must take action to ensure premises are both adequately and safely maintained. Acomb Garth is in need of maintenance, there was plaster falling off the walls and it was in need of refurbishment.
- The provider must ensure care records, at Acomb Gables, are kept up to date.
- The provider must ensure that Ward 5 Newsam Centre undertakes an environmental risk assessment, and acts upon any identified risks, particularly in relation to aspects of the environment which could potentially be used to self-harm.

Action the provider SHOULD take to improve

- The provider should take action to mitigate the blind spots on the stairwell within ward 5 at Newsam Centre. This stairwell is used for patients to access the garden area.
- The provider should take action to ensure Millside and Acomb Garth have a system in place to support that the physical health needs of patients and incorporate the information within the care planning. Evidence of physical health assessments on admission and continuous monitoring need to be recorded within the care file .
- The provider should make information available to patients and families regarding the complaints policy and procedure. This information should be displayed on notice boards throughout the wards.

Leeds and York Partnership NHS Foundation Trust

Rehabilitation services

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
• Millside	Millside
• Asket House	Asket House
• Townsgate	Townsgate
• Ward 5	Ward 5 Newsam Centre
• Acomb Garth	Acomb Garth

Mental Health Act responsibilities

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

Patients were aware of what section they had been detained under and understood their rights to appeal. Patients told us about how they could access advocacy services if they wanted assistance. They discussed consenting to their medication and the side effects. Patients told us about unescorted and escorted leave they had from the ward. Patients said they were involved in their care planning and setting goals.

Overall the wards had effective systems in place to assess and monitor risks to individual patients who were detained under the Mental Health Act 1983.

Detailed findings

Mental Capacity Act and Deprivation of Liberty Safeguards

Overall we found the services were not compliant with the requirements of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). We found evidence of administration of medication to a patient without capacity without a review of their capacity or a best interests meeting. There was a lack of recording and monitoring of capacity and consent and no regular review of capacity assessments. There was evidence of a DoLS application which demonstrated limited understanding of the implementation of the process.

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

Three out of the five wards were mixed sex accommodation but only two met with the mixed sex accommodation requirements. Acomb Garth did not meet the same sex accommodation guidance as specified in the Mental Health Act (1983) Code of Practice.

At Acomb Garth we saw the paint and plaster on the walls was in need of repair, it was falling off around the building as we completed our ward tour. There was heavily stained walls and a broken window which had happened the previous night before our visit. The bedrooms had old furniture and the floors were heavily marked. This meant the up keep of the ward environment was not respectful to the patients who lived there.

There was limited medical cover throughout the rehabilitation and recover service. This was provided by the medical cover used at the main hospital sites. Doctors on call at the main hospital sites were able to leave the site to attend to remote locations such as the rehabilitation units however this was compromised due to workload pressures at the main hospital sites. That meant that in an emergency situation it could be difficult to access medical assistance out of hours.

The rehabilitation wards visited had effective systems to assess and monitor risks within the ward environment and to individual patients. Three out of the five wards were mixed sex accommodation but only two complied with the mixed sex accommodation requirements. The Acomb Garth did not meet the standard guidance which is a breach in regulation.

Staff told us they were encouraged to report incidents and explained how the process of lessons learnt from all incidents within the trust are fed back via team meetings. The trusts risk management team collated all incident form information which was reviewed by management to identify potential learning and improvements.

Overall staff across the wards said they had sufficient numbers of staff on duty to meet the needs of people on the wards. It was acknowledged that there were a number of vacancies which had not been advertised due to the service redesign, this was being managed by offering overtime to current staff or the use of bank staff when necessary.

The trust had policies and procedures in place for effective management of medication administration.

Our findings

Millside is a 17 bedded mixed sex accommodation open inpatient recovery unit based in Leeds.

Safe and clean ward environment

The ward met with the mixed sex accommodation requirements. There was a central hub with line of sight down the three main corridors.

An environmental inspection and risk assessment was undertaken on a quarterly basis to monitor ligature points around the ward areas and assess positive risk taking and mitigate risks to patients as required.

A health and safety inspection checklist was completed on a monthly basis, this included checks on first aid, fire precautions, general hazards, equipment, personal protective equipment, gas cylinders, violence and aggression security, substance hazardous to health, notices and signage, facilities and the kitchen. This was an audit completed to ensure the processes and policies were followed to monitor such things as stock within the first aid equipment box and medicines, hazards of electric, water and gas supplies, compliance with COSHH and cleanliness of the kitchen and fridges.

The ward had business continuity plans in place to support the event of flood and electricity supplies to the building. These had been prepared following two separate incidents that had previously taken place at this building location.

The ward had systems in place to deal with foreseeable emergencies with medical emergency supplies. Staff told us the emergency resuscitation grab bag was checked but the monitoring forms had not been used since July 2014.

Requires improvement

Are services safe?

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

On checking the grab bag and medication we found it to be ready for use and in date. The system used at the ward was a diary prompt to remind staff to complete the checks but we saw some gaps within the recording which confirmed checks had been completed. Included in this process is a validation of the drugs expiry dates. This meant that risk to patients and staff was not being managed and monitored to minimise the risk of harm.

Information provided by the trust showed out of eight staff who had undertaken their resuscitation immediate life support (ILS) training five were not up to date with their refresher training, this is based on figures supplied on 1 September 2014.

We observed the ward was clean and tidy during our visit. We did not see evidence of cleaning schedules being used to confirm routine cleaning had been completed. The ward was pleasant with good quality furnishings and it was well maintained.

Out of 17 staff who had undertaken their infection control training we found that five were not up to date with their refresher training. This is based on figures supplied on 1t September 2014 by the trust.

Safe staffing

The ward manager told us the shift rota and number of staff skill mix for each shift pattern. The ward had 11.6 whole time equivalent (WTE) qualified and 7.7 WTE unqualified nurses at May 2014.

The trust had a workforce of 2962 at June 2014 with a vacancy rate of 8.8%. This included vacancies of 80 qualified nurse and 90 support worker positions trust wide. Millside had a total number of substantive staff of 18.4, with an overall vacancy level of 2.5% (excluding secondments) and two staff who had left within the last 12 months to June 2014.

The ward manager explained how a staffing escalation policy was in place which senior members of staff can follow to arrange additional or staff to cover sickness or holiday absence. The ward manager told us most shifts were offered to their own staff for overtime or to the internal bank staff. If bank staff were used, the ward would use consistent staff members to ensure continuity of care for patients. The ward had used bank or agency staff to cover 243 shifts between March to May 2014. This was due to covering sickness, absence or vacancies. There were a total of 2 shifts which had not been fully covered between March to May 2014.

Staff and patients told us they felt the staffing numbers were sufficient. Staff told us if there was a shift which needed to be covered it was usually managed effectively and prompt cover arranged. Both patients and staff told us that no activities or leave has been cancelled due to staff shortages.

There was limited medical cover throughout the rehabilitation and recovery service, particularly out of hours on call. Ward managers told us there had been an incident when they called for support and the on call doctor refused to attend. The ward manager contacted the local GP and raised an incident form internally to support the recording of no internal medical cover provided. That meant that in an emergency situation it could have been difficult to access medical assistance.

Assessing and managing risk to patients and staff

Within the care records we saw each patient had a FACE (Functional Analysis of Care Environments, FACE tools facilitate high quality and proportionate assessment, planning and review processes across community, residential and hospital settings) risk assessment completed on admission and this assessment was regularly reviewed to monitor any changes in risks.

As the ward was a rehabilitation and recovery service the observation of patients was more relaxed with a head count being taken each morning at 8am and each evening at 11pm. During the day the staff was aware of patients' activities and if they had left the ward.

The ward manager told us that patients were not restrained on the rehabilitation ward and de-escalation management techniques were used. Information provided by the trust prior to the inspection showed for the period November 2013 to July 2014 Millside reported no use of restraint.

Within the welcome pack booklet for patients there was a list of 'ground rules' which need to be adhered to by all patients. This included details around being respectful on mixed sex wards to the opposite sex, no smoking within their rooms but only in designated areas, management of lighters, no alcohol or illicit substances were permitted on the ward and noise levels. This meant the wards did not routinely need to search patients as the rehabilitation

Requires improvement

Are services safe?

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

wards were open wards where patients have access to most of their personal items. On occasions ward staff have searched a patient when they thought the patient was taking illicit substances into the premises.

Staff we spoke with had a good understanding around safeguarding and how to raise an alert. Staff told us that safeguarding was part of their mandatory training within the trust. Out of 18 staff who had undertaken the safeguarding adults' level 1 training, two were not up to date with their refresher training. This was based on figures supplied at 1 September 2014 by the trust.

The ward had one patient taking controlled drugs at the time of our visit. This was stored appropriately and processes were in place to manage administration of controlled drugs safely.

A pharmacy technician worked proactively on a weekly basis to ensure medicines management and the safe effective use of medicines. The technician supported the ward by reconciling medication, monitoring the patients' own drugs that they brought onto the ward and to prevent duplication of supply or waste. The technician checked all medication was clearly labelled and stored correctly. There was a pharmacy led medicines information drop in session to provide information to patients on their medication.

Reporting incidents and learning from when things go wrong

The ward manager told us all staff were encouraged to report incidents. The incidents were reported using a form (IR1), which was then sent through the trust's risk management team who analyse the data for themes and send reports back to the ward managers. In Leeds the incident reporting was currently a paper system. Learning from trust wide incidents was communicated to all staff by email from the communication team. The ward manager told us the learning from trust wide incidents was discussed in the ward team meeting and they also discussed the impact on their ward. This was confirmed when we spoke to staff about how the governance structure and learning from incidents was managed within the team. The ward manager advised that they had raised incidents in relation to not being able to access medical cover out of hours. The rota system for on call medical cover refused to respond to a call from Millside resulting in an incident being reported. In emergency situations the ward had used their own senior on duty or accessed the crisis team on call nurse.

Asket House is a 16 bedded mixed sex accommodation open inpatient recovery unit based in Leeds

Safe and clean ward environment

The ward met with the mixed sex accommodation requirements. Staff were unable to see into patients' bedrooms without opening their door. This meant observation of patients was limited unless the door was open. The ward was clean and well maintained.

An "environmental inspection and risk assessment" was undertaken on a quarterly basis to monitor ligature points around the ward areas and assess positive risk taking and mitigate risks to patients as required.

A "health and safety inspection checklist" was completed on a monthly basis, this included checks on first aid, fire precautions, general hazards, equipment, personal protective equipment, gas cylinders, violence and aggression security, substance hazardous to health, notices and signage, facilities and kitchen. This was an audit completed to ensure the processes and policies was followed to monitor such things as stock within the first aid equipment box and medicines, hazards of electric, water and gas supplies, compliance with COSHH and cleanliness of the kitchen and fridges.

This meant that risk to patients and staff were being managed and monitored to minimise the risk of harm.

The ward had systems in place to deal with foreseeable emergencies with medical emergency supplies. We saw the emergency resuscitation grab bag was checked nightly by the staff on duty and recorded to confirm it was fit for purpose. Included in this process was a validation of the drugs expiry dates. Out of 10 staff who had undertaken their resuscitation ILS training we found that three were not up to date with their refresher training, this is based on figures supplied to 1 September 2014.

The ward was clean and tidy during our visit and cleaning schedules were in place to support routine cleaning on a daily and adhoc basis. The ward was pleasant with good quality furnishings and it was well maintained.

The trust's infection prevention and control nurse completed an audit on an annual basis. Asket House had their environmental audit in October 2013 were they achieved an overall rating of 90%.

Requires improvement

Are services safe?

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

Out of 23 staff who had undertaken their infection control training we found that two were not up to date with their refresher training, this is based on figures supplied to 1 September 2014.

Safe staffing

The ward manager told us the shift rota and number of staff skill mix for each shift pattern. This was determined by patients' needs and a ratio of 1.8 qualified staff member to each patient. The services level of qualified nurses at May 2014 was 13 WTE with the level of support workers at 8.6 WTE.

The trust had a workforce of 2962 at June 2014 with a vacancy rate of 8.8%. This included vacancies 80 qualified and 90 support worker positions trust wide. Asket House had a total number of substantive staff of 21.5, with an overall vacancy level of 3.2% (excluding secondments) and 1 leaver within the last 12 months to June 2014.

The ward manager explained how a staffing escalation policy was in place which senior members of staff could follow to arrange additional or staff to cover sickness or holiday absence. The ward manager told us most shifts are offered to their own staff for overtime or to the internal bank staff. If bank staff were used the ward would use consistent staff members to ensure continuity of care for patients. The ward had used bank or agency staff to cover 63 shifts between March to May 2014. This was due to covering sickness, absence or vacancies. There was a total of 0.9 shifts which had not been fully covered between March to May 2014.

Staff and patients told us they felt the staffing numbers were sufficient. Staff told us that if there was a shift which needs to be covered it was usually managed effectively and prompt cover arranged. Both patients and staff told us that no activities or leave had been cancelled due to staff shortages.

There was limited medical cover throughout the rehabilitation and recovery service. This was provided by the medical cover used at the main hospital sites. Doctors on call at the main hospital sites were able to leave the site to attend to remote locations such as the rehabilitation units however this was compromised due to workload pressures at the main hospital sites. That meant that in an emergency situation it could be difficult to access medical assistance out of hours.

Assessing and managing risk to patients and staff

Within the care records we saw that each patient had a FACE risk assessment completed on admission and this process was regularly reviewed to monitor any changes in risks.

As the ward is a rehabilitation and recovery service the observations of patients were more relaxed with a head count being taken each morning at 8am and each evening at 11pm. During the day the staff were aware of patients' activities and if they have left the ward.

The ward manager told us restraint was not used on the rehabilitation ward and that de-escalation management techniques were only used. For the period November 2013 to July 2014 Asket House reported no use of restraint.

Within the "welcome pack" booklet for patients there was a list of "ground rules" which needed to be adhered to by all patients. This included details around being respectful of mixed sex wards to the opposite sex, no smoking within their rooms only in designated areas, management of lighters, no alcohol or illicit substances are permitted on the ward and noise levels. This meant that the wards did not routinely need to search the patients as the rehabilitation wards are open wards where patients have access to most of their personal items. On occasions ward staff had searched a patient when they thought the patient was taking illicit substances into the premises.

Staff we spoke with had a good understanding around safeguarding and how to raise an alert. Staff told us that safeguarding is part of their mandatory training within the trust. Out of 24 staff who had undertaken the safeguarding adults' level 1 training, three of them were not up to date with their refresher training, and this was based on figures supplied at 1 September 2014.

The ward did not store controlled drugs on the premises and had purchased a lockable transportation carrier to collect controlled drugs when required.

A pharmacy technician worked proactively on a weekly basis to ensure medicines management and safe effective use of medicines. The technician supported the ward by reconciling medication, monitoring the patients' own drugs they bring onto the ward and prevent duplication of supply or waste. The technician checked all medication was

clearly labelled and stored correctly. There was a pharmacy medicines information drop in session to provide information to patients on their medication or this can be arranged on a one to one basis.

Reporting incidents and learning from when things go wrong

The ward manager told us all levels of staff are encouraged to report incidents. The incidents are reported using an IR1 form which was then sent through the trust's risk management team who analyse the data for themes and send reports back to the ward managers. In Leeds the incident reporting was a paper system. Learning from trust wide incidents was communicated to all staff by email from the communication team. The ward manager told us that the learning from trust wide incidents was discussed in the ward team meeting and they also discuss the impact on their ward. This was confirmed when we spoke to staff about how the governance structure and learning from incidents was managed within the team.

Towngate House is an 18 bedded male only accommodation open inpatient recovery unit based in Leeds.

Safe and clean ward environment

The ward was a male only ward with well-lit wide corridors. The size of the building would mean it would be difficult to hear if there was anything wrong on the other side of the building. This was discussed with the charge nurse who advised alarms and walkie talkies were available for staff. The ward was clean and well maintained.

An "environmental inspection and risk assessment" was undertaken on a six monthly basis to monitor ligature points around the ward areas and assess positive risk taking and mitigate risks to patients as required.

A "health and safety inspection checklist" was completed on a quarterly basis, this included checks on first aid, fire precautions, general hazards, equipment, personal protective equipment, gas cylinders, violence and aggression security, substance hazardous to health, notices and signage, facilities and kitchen. This was an audit completed to ensure the processes and policies was followed to monitor such things as stock within the first aid equipment box and medicines, hazards of electric, water and gas supplies, compliance with COSHH and cleanliness of the kitchen and fridges.

This meant that risk to patients and staff were being managed and monitored to minimise the risk of harm.

The ward had systems in place to deal with foreseeable emergencies with medical emergency supplies. We saw the emergency resuscitation grab bag was checked nightly by the staff on duty and recorded to confirm it was fit for purpose. Included in this process was a validation of the drugs' expiry dates. Out of nine staff who had undertaken their resuscitation ILS training we found that three were not up to date with their refresher training, this was based on figures supplied to 1st September 2014.

The ward was clean and tidy during our visit. Cleaning schedules were in place to support routine cleaning on both a daily and ad-hoc basis. The ward was pleasant with good quality furnishings and it was well maintained.

Out of 20 staff who had undertaken their infection control training we found that one was not up to date with their refresher training, this was based on figures supplied to 1 September 2014.

Safe staffing

The services level of qualified nurses at May 2014 was 11.5 WTE with the level of support workers at 9.7 WTE.

The trust had a workforce of 2962 at June 2014 with a vacancy rate of 8.8%. This included vacancies 80 qualified and 90 support worker positions trust wide. Towngate House had a total number of substantive staff of 19.6, with an overall vacancy level of 9.9% (excluding secondments) and 2 leavers within the last 12 months to June 2014.

The ward manager explained how a staffing escalation policy was in place which senior members of staff could follow to arrange additional staff to cover sickness or holiday absence. The ward manager told us that most shifts were offered to their own staff for overtime or to the internal bank staff. If bank staff were used, the ward would use consistent staff members to ensure continuity of care for patients. The ward had used bank or agency staff to cover 31 shifts between March to May 2014. This was due to covering sickness, absence or vacancies. There were no shifts which were not fully staffed between March to May 2014.

Staff and patients told us they felt the staffing numbers were sufficient. Staff told us that if there was a shift which

Requires improvement

Are services safe?

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

needs to be covered it was usually managed effectively and prompt cover arranged. Both patients and staff told us that no activities or leave has been cancelled due to staff shortages.

There was limited medical cover throughout the rehabilitation and recovery service. The rehabilitation and recovery service did not have a dedicated on call service for out of hours medical cover. This was provided by the medical cover used at the main hospital sites. Doctors on call at the main hospital sites were able to leave the site to attend to remote locations such as the rehabilitation units however this was compromised due to workload pressures at the main hospital sitesThat meant that in an emergency situation it could be difficult to access medical assistance out of hours.

Assessing and managing risk to patients and staff

Within the care records we saw that each patient had a FACE risk assessment completed on admission and this process was regularly reviewed to monitor any changes in risks.

As the ward was a rehabilitation and recovery service the observations of patients were more relaxed with a head count being taken each morning at 8am and each evening 11pm. During the day the staff were aware of patients' activities and if they had left the ward.

The ward manager told us that restraint was not used on the rehabilitation ward and that de-escalation management techniques were only used. For the period November 2013 to July 2014, Towngate House reported no use of restraint.

Within the "welcome pack" booklet for patients there was a list of "ground rules" which needed to be adhered by all patients. This included no smoking within their rooms only in designated areas, management of lighters, no alcohol or illicit substances are permitted on the ward and noise levels. This meant that the wards did not routinely need to search the patients as the rehabilitation wards were open wards where patients have access to most of their personal items. On occasions ward staff had searched a patient when they thought the patient was taking illicit substances into the premises.

Staff we spoke with had a good understanding around safeguarding and how to raise an alert. Staff told us that safeguarding is part of their mandatory training within the trust. Out of 20 staff who had undertaken the safeguarding adults' level 1 training, two of them were not up to date with their refresher training, and this was based on figures supplied at 1st September 2014.

A pharmacy technician worked proactively on a weekly basis to ensure medicines management and safe, effective use of medicines. The technician supported the wards by reconciling medication, monitoring the patients own drugs they bring onto the ward and preventing duplication of supply or waste. The technician checked all medication was clearly labelled and stored correctly. There was a pharmacy medicines information drop in session to provide information to patients on their medication or this could be arranged on a one to one basis.

Reporting incidents and learning from when things go wrong

The ward manager told us that all levels of staff were encouraged to report incidents. The incidents were reported using an IR1 form which was then sent through the trust's risk management team who analysed the data for themes and sent reports back to the ward managers. In Leeds the incident reporting was a paper system. Learning from trust wide incidents was communicated to all staff by email from the communication team. The ward manager told us that the learning from trust wide incidents was discussed in the ward team meeting and they also discuss the impact on their ward. This was confirmed when we spoke to staff about how the governance structure and learning from incidents was managed within the team.

Ward 5 is an 18 bedded male only accommodation locked inpatient recovery unit based in the Newsam Centre in Leeds

Safe and clean ward environment

The ward was a male only ward with a staff station located to have good sight of the ward area from it. The ward was clean and well maintained. There were blind spots on the stairwell down to the garden area. This stairwell was designed as a fire exit and not intended for frequent use. However patients did use it frequently to access the garden area. This meant that the blind spot was an increased risk for safety of the staff and patients using the stairwell.

The ward manager told us that an "environmental inspection and risk assessment" should be undertaken on a six monthly basis to monitor ligature points around the

Requires improvement

Are services safe?

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

ward areas and assess positive risk taking and mitigate risks to patients as required. We reviewed the last risk assessment, this was completed May 2013 and no updated risk assessments were available for us to review.

A "health and safety inspection checklist" was completed on a monthly basis, this included checks on first aid, fire precautions, general hazards, equipment, personal protective equipment, gas cylinders, violence and aggression security, substance hazardous to health, notices and signage, facilities and kitchen. This was an audit completed to ensure the processes and policies were followed to monitor such things as stock within the first aid equipment box and medicines, hazards of electric, water and gas supplies, compliance with COSHH and cleanliness of the kitchen and fridges.

The ward had systems in place to deal with foreseeable emergencies with medical emergency supplies. We saw the emergency resuscitation grab bag was checked nightly by the staff on duty and recorded to confirm it is was fit for purpose. Included in this process was a validation of the drugs expiry dates. Out of 17 staff who had undertaken their resuscitation ILS training we found that four were not up to date with their refresher training, this was based on figures supplied to 1st September 2014.

The ward was clean and tidy during our visit. Cleaning schedules were in place to support routine cleaning on a daily and adhoc basis. The ward was pleasant with good quality furnishings and it was well maintained. The ward main television in the games room had been broken since January 2014 and this remained unfixed or replaced. This meant that patients were unable to utilise the video games or DVD's as there was only a small television available which was boxed in with no access to allow use of these facilities.

Out of 34 staff who had undertaken their infection control training we found that six were not up to date with their refresher training, this is based on figures supplied to 1st September 2014.

Safe staffing

The services level of qualified nurses at May 2014 was 20.5 WTE with the level of support workers at 16.3 WTE.

The trust had a workforce of 2962 at June 2014 with a vacancy rate of 8.8%. This included vacancies 80 qualified and 90 support worker positions trust wide. Ward 5 had a total number of substantive staff of 35.8, with an overall vacancy level of 5.9% (excluding secondments) and 2.8 leavers within the last 12 months to June 2014.

The ward manager explained how a staffing escalation policy was in place which senior members of staff could follow to arrange additional or staff to cover sickness or holiday absence. The ward manager told us most shifts were offered to their own staff for overtime or to the internal bank staff. If bank staff were used the ward would use consistent staff members to ensure continuity of care for patients. The ward had used bank or agency staff to cover 33 shifts between March to May 2014. This was due to covering sickness, absence or vacancies. There was a total of 7 shifts which had not been covered between March to May 2014.

Staff told us there had been some issues with regards to the staffing levels in the previous few months. High levels of sickness and the main holiday period over summer had caused some difficulties in arranging cover. Despite this, staff and patients told us they felt the staffing numbers were sufficient. Staff told us if there was a shift which needed to be covered it was usually managed effectively and prompt cover arranged. Both patients and staff told us that no activities or leave has been cancelled due to staff shortages.

There was limited medical cover throughout the rehabilitation and recover service. This was provided by the medical cover used at the main hospital sites. Doctors on call at the main hospital sites were able to leave the site to attend to remote locations such as the rehabilitation units however this was compromised due to workload pressures at the main hospital sites. That meant that in an emergency situation it could be difficult to access medical assistance out of hours.

Assessing and managing risk to patients and staff

Within the care records we saw that each patient had a FACE risk assessment completed on admission and this process was regularly reviewed to monitor any changes in risks.

As the ward was a rehabilitation and recovery service the observations of patients were more relaxed with a head count being taken each morning at 8am and each evening at 11pm. During the day the staff were aware of patients' activities and if they had left the ward. Patients had their

Requires improvement

Are services safe?

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

own key fob for allowing them the facility to leave the ward. The ward manager told us the Trust's observation policy would be used should additional observations for an individual patient be required. The ward manager gave us an example of how a patient had been on 15 minute observations for a short period of time due to a change in their condition.

The ward manager told us that where possible de-escalation management techniques are used. In some incidents restraint was used on the ward but level 2 would be the highest restraint used. The manager told us no face down (prone) positions had been used. From the information provided to us for November 2013 to July 2014 ward 5 reported 13 incidents of use of restraint with one being in the "prone" or face down position.

The ward had a local policy around restraint in place which was in draft format. This was implemented to support the security protocol for this locked ward. There was also a leaflet being developed to outline the search procedure and policy for the ward. The search policy was not routinely implemented but the leaflet was being prepared to outline how and when it would be used.

Staff we spoke with had a good understanding around safeguarding and how to raise an alert. Staff told us that safeguarding was part of their mandatory training within the trust. Out of 35 staff who had undertaken the safeguarding adults' level 1 training two of them were not up to date with their refresher training, this was based on figures supplied at 1st September 2014.

A pharmacy technician worked proactively on a weekly basis to ensure good medicines management and safe effective use of medicines. The technician supported the ward by reconciling medication, monitoring the patient's own drugs they bring onto the ward and preventing duplication of supply or waste. The technician checked that all medication was clearly labelled and stored correctly.

Reporting incidents and learning from when things go wrong

The ward manager told us that all levels of staff were encouraged to report incidents. The incidents were reported using an IR1 form which was then sent through the trust's risk management team who analysed the data for themes and sent reports back to the ward managers. In Leeds the incident reporting was a paper system. Learning from trust wide incidents was communicated to all staff by email from the communication team. The ward manager told us that the learning from trust wide incidents was discussed in the ward team meeting and they also discuss the impact on their ward. This was confirmed when we spoke to staff about how the governance structure and learning from incidents was managed within the team.

Acomb Gables is a 16 bedded mixed sex accommodation open inpatient recovery unit based in York

Safe and clean ward environment

The ward was a mixed sex ward but it did not meet the requirements of the mixed sex accommodation guidance. The bedrooms had no en-suite facilities and both male and female patients shared a shower room. Male patients had to use the female corridor, passing by their bedrooms to be able to reach the shared shower room. This meant that privacy and dignity was not being considered on a daily basis due to the layout of the ward and sharing of a shower room by patients of both genders.

We saw the paint and plaster on the walls were in need of repair. There were heavily stained walls and a window which had been broken the night before our visit. The bedrooms had old furniture and the floors were heavily marked. This meant the up keep of the ward environment was not respectful to the patients who lived there.

An "environmental inspection and risk assessment" was undertaken on a six monthly basis to monitor ligature points around the ward areas and assess positive risk taking and mitigate risks to patients as required. We saw the assessment which had been completed in May 2014. This clearly raised concerns with regards to particular ligature points throughout the building. This included the door to access the CMHT offices upstairs and the beams in the activity room and adjoining corridor. The report also indicated the ward was not meeting the mix sex accommodation requirements. The ward manager told us there was a capital bid for the work to be undertaken had been completed and the ligature risks were on the risk register, along with the accommodation not being suitable for mixed sex accommodation.

A "health and safety inspection checklist" was completed on a monthly basis. This included checks on first aid, fire precautions, general hazards, equipment, personal protective equipment, gas cylinders, violence and aggression security, substance hazardous to health, notices

and signage, facilities and kitchen. This was an audit completed to ensure the processes and policies were followed to monitor such things as stock within the first aid equipment box and medicines, hazards of electric, water and gas supplies, compliance with COSHH and cleanliness of the kitchen and fridges.

The ward had systems in place to deal with foreseeable medical emergencies. We saw the emergency resuscitation grab bag was checked nightly by the staff on duty and recorded to confirm it is was fit for purpose. Included in this process was a validation of the drugs' expiry dates. Out of 12 staff who had undertaken their resuscitation ILS training we found that five were not up to date with their refresher training, this is based on figures supplied to 1 September 2014.

The ward was clean and tidy during our visit and cleaning schedules were in place to support routine cleaning on both a daily and adhoc basis. There were no cleaning schedules in place for the clinic room. Staff told us the domestic staff cleans the room on a regular basis but there was no evidence to support it had been completed.

Out of 26 staff who had undertaken their infection control training we found that 14 were not up to date with their refresher training, this is based on figures supplied to 1 September 2014.

Safe staffing

The ward manager told us the shift rota and number of staff skill mix for each shift pattern. The services level of qualified nurses at May 2014 was 11.5 WTE with the level of support workers at 11.6 WTE.

The trust had a workforce of 2962 at June 2014 with a vacancy rate of 8.8%. This included vacancies 80 qualified and 90 support worker positions trust wide. Acomb Garth had a total number of substantive staff of 21, with an overall vacancy level of 8.7% (excluding secondments) and 0.4 WTE leaver within the last 12 months to June 2014.

The ward manager explained how a staffing escalation policy was in place which senior members of staff can follow to arrange additional or staff to cover sickness or holiday absence. The ward manager told us most shifts were offered to their own staff for overtime or to the internal bank staff. If bank staff were used the ward would use consistent staff members to ensure continuity of care for patients. The ward had used bank or agency staff to cover 18 shifts. This was due to covering sickness, absence or vacancies. There were a total of 5.4 shifts which had not been covered during the three month period to May 2014. The ward manager told us how the staffing levels on the night shift had recently been increased in relation to the security of the premises, staff and patients. As the location was in a remote setting in York it was agreed that the service should have three staff on the night shift in case of an emergency.

Staff told us that there had been problems with staffing levels in the past but they said there was sufficient numbers usually on shift. Staff told us that if there was a shift which needed to be covered it was usually managed effectively and prompt cover arranged. Both patients and staff told us that no activities or leave has been cancelled due to staff shortages.

A staff member did tell us they felt unsafe due to incidents which had occurred on the ward due to the remote location of the ward and the numbers of staff. If a patient returned to the ward under the influence of alcohol it could lead to incidents which can be difficult to manage. We discussed this with the ward manager who explained that staffing levels had been increased to improve the safety of staff and patients on night shift to support them in feeling safe.

Assessing and managing risk to patients and staff

Within the care records we saw that each patient had a FACE risk assessment completed on admission and this process was regularly reviewed to monitor any changes in risks.

As the ward was a rehabilitation and recovery service the observations of patients were more relaxed with a head count being taken each morning at 8am and each evening at 11pm. During the day the staff were aware of patients' activities and if they had left the ward.

The ward manager told us that restraint was not used on the rehabilitation ward that de-escalation management techniques are used instead. For the period November 2013 to July 2014 Acomb Garth reported no use of restraint.

Within the "welcome pack" booklet for patients there was a list of "ground rules" which needed to be adhered to by all patients. This included details around being respectful of mixed sex wards to the opposite sex, no smoking within their rooms only in designated areas, management of lighters, no alcohol or illicit substances are permitted on the ward and noise levels. This meant that the wards did

Requires improvement

Are services safe?

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

not routinely need to search the patients as the rehabilitation wards are open wards were patients have access to most of their personal items. On occasions ward staff have searched a patient when they thought the patient was taking illicit substances or alcohol into the premises.

Staff we spoke with had a good understanding around safeguarding and how to raise an alert. Staff told us that safeguarding is part of their mandatory training within the trust. Out of 26 staff who had undertaken the safeguarding adults' level 1 training three of them were not up to date with their refresher training, this was based on figures supplied at 1st September 2014.

A pharmacy technician worked proactively on a weekly basis to ensure good medicines management and safe effective use of medicines. The technician supported the ward by reconciling medication, monitoring the patients own drugs they bring onto the ward and prevent duplication of supply or waste. The technician checked all medication was clearly labelled and stored correctly. There was a pharmacy medicines information drop in session to provide information to patients on their medication or this could be arranged on a one to one basis.

Reporting incidents and learning from when things go wrong

The ward manager told us all levels of staff are encouraged to report incidents. The incidents are reported using the Datix electronic incident system. The system enabled reports to be generated on the data reported to analyse for themes. Learning from trust wide incidents was communicated to all staff by email from the communication team. The ward manager told us that the learning from trust wide incidents was discussed in the ward team meeting and they also discuss the impact on their ward. This was confirmed when we spoke to staff about how the governance structure and learning from incidents was managed within the team.

Are services effective?

Requires Improvement

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

Summary of findings

The Leeds wards used electronic patient records. We saw evidence of well documented care plans which described individual needs which centred on providing a recovery and outcome based approach to the care pathway. The ward in York had paper patient records which we reviewed and saw evidence of the care documentation not being maintained, in some files "my recovery pathway" and "recovery star" was blank. We could not see evidence of patient's physical health needs being managed within the care plan documentation.

At Millside and Acomb Garth there was no evidence within the care records that physical health assessments had been undertaken and limited information to support on-going monitoring of patient's needs was incorporated within the treatment plans and care programme approach (CPA) reviews.

We saw good management of the Mental Health Act Code of Practice and supporting documentation.

The application of Mental Capacity Act and Deprivation of Liberty was not being practiced in adherence with the guidance.

Our findings

Millside is a 17 bedded mixed sex accommodation open inpatient recovery unit based in Leeds

Assessment of needs and planning of care

The ward used "my recovery pathway" which is centred on providing a recovery and outcomes based approach to the care pathway for patients. There are three parts to the documentation; starting from here, where I want to be and making plans. We saw evidence of well documented care plans which described how individual needs were met at each stage of their care. Patients told us they felt involved in making decisions about their care.

There was no evidence within the care records that physical health assessments had been undertaken and limited information to support on-going monitoring of patients' needs was incorporated within the treatment plans and care programme approach (CPA) reviews. The ward manager told us that where possible patients remained with their own local general practitioner (GP) for the physical health needs. If this is not possible due to the distance from the rehabilitation ward to their GP then a patient is signed up to a temporary local GP.

Best practice in treatment and care

The ward was able to access psychological therapies as part of the patient's treatment as recommended by National Institute for Health and Care Excellence (NICE).

Trust policies and procedures referred to NICE guidance and had key outlines from the guidance for staff to use to verify best practice. This was particularly evident within the medication policies. The ward manager also explained how the team research the changes in best practice to discuss within the team meetings on a fortnightly basis.

There were activities available for the patients to participate in, these were held throughout the day, evenings and weekends. There was a notice board to outline availability of groups and some patients also had particular interests which they wanted to undertake. All staff members were involved in leading on activities, these sessions were not managed solely by the occupational therapists.

Skilled staff to deliver care

The ward had a range of skilled mental health professional disciplines which included qualified nursing staff, support workers, occupational therapist who worked within the shift system of the ward. The ward also had access to a pharmacy technician on a weekly basis and they could be contacted as required.

Millside staff had an overall achievement of 72% for mandatory training. Mandatory training included moving and handling, fire safety, resuscitation, food safety, infection control, information governance, equality and diversity, health and safety, clinical risk management, safeguarding adults and safeguarding children. The trust had a target performance rating were mandatory training should be 85% or above. Millside was reported as amber, below target in September 2014.

Millside had a performance of 88% completed appraisals at September 2014. During our conversations with the staff they confirmed that regular supervision and appraisals were completed.

Are services effective?

Requires Improvement

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

Multi-disciplinary and inter-agency team work

Millside had two teams, a green and a blue team. There was a rota scheduled for the quarter for planned reviews of each patient by their appropriate care team. Staff included in the MDT meetings was support workers, nurses, occupational therapies, psychologists and doctors. Other professionals such as dietician or physiotherapist would attend as required. Each patient was discussed at length for approximately 45 minutes, this meant that each patient would be reviewed and discussed on a rolling three week basis or as required if something changed before the scheduled review at MDT.

The ward has had some patients discharged from community services due to caseload and capacity within the community teams. This is not within the remit of the ward and is a capacity pressure within another service but has caused some problems with continuity of care co-ordinators being involved in patients discharge planning.

Asket House is a 16 bedded mixed sex accommodation open inpatient recovery unit based in Leeds

Assessment of needs and planning of care

The ward used "my recovery pathway" which is centred on providing a recovery and outcomes based approach to the care pathway for patients. There are three parts to the documentation; starting from here, where I want to be, and making plans. We saw evidence of well documented care plans which described how individual needs were met at each stage of their care. Patients told us they felt involved in making decisions about their care.

There was evidence within the care records that physical health assessments had been undertaken and that on-going monitoring of patients' needs was incorporated within the treatment plans and care programme approach (CPA) reviews. The ward manager told us that where possible patients remained with their own local general practitioner (GP) for the physical health needs. If this was not possible due to the distance from the rehabilitation ward to their GP then a patient was signed up to a temporary local GP.

Best practice in treatment and care

The ward was able to access psychological therapies as part of the patients' treatment as recommended by National Institute for Health and Care Excellence (NICE). The ward manager told us how there was a session one afternoon a week for a group or one to one sessions can be arranged. However, the consultant told us that there was a long waiting list for psychological therapies which meant it was not readily available at the right time for patients care pathway treatment.

Trust policies and procedures referred to NICE guidance and had key outlines from the guidance for staff to use to verify best practice, which was particularly evident within the medication policies.

There were activities available for the patients to participate in. These were held throughout the day, evenings and weekends. There was a notice board to outline availability of groups and some patients also had particular interests which they wanted to undertake. One member of staff had been supporting taking people out cycling. The ward manager also told us that a patient was the lead for an activity group; they were the facilitator which encouraged other patients to join.

Skilled staff to deliver care

The ward had a range of skilled mental health disciplines which included qualified nursing staff, support workers and occupational therapist who worked within the shift system of the ward. The ward also had access to a pharmacy technician on a weekly basis and they could be contacted as required.

Asket House staff had an overall achievement of 86% for mandatory training; mandatory training included moving and handling, fire safety, resuscitation, food safety, infection control, information governance, equality and diversity, health and safety, clinical risk management, safeguarding adults and safeguarding children. The trust had a target performance rating were mandatory training should be 85% or above. Asket House was reported as green, meeting the target in September 2014.

Asket House had a performance of 91% completed appraisals at September 2014. This was confirmed during our conversations with staff that regular supervision and appraisals were completed.

Multi-disciplinary and inter-agency team work

We reviewed the handover or shift co-ordinator sheets during our visit to Asket House. There were effective in providing a handover of each individual patient, any identified changes in risk, and medication requiring administration during the shift.

Are services effective?

Requires Improvement

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

The multi-disciplinary team (MDT) meetings included all staff, support workers, nurses, occupational therapies, psychologists and doctors. Other professionals such as dietician or physiotherapist would attend as required. Each patient was discussed at length for approximately 45 minutes, this meant that each patient would be reviewed and discussed on a rolling three week basis or as required if something changed before the scheduled review at MDT.

The ward has had some patients discharged from community services due to caseload and capacity within the community teams. This is not within the remit of the ward and is a capacity pressure within another service but has caused some problems with continuity of care co-ordinators being involved in patients discharge planning

We found that the ward was not compliant with the requirements of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguarding's (DoLS). We found evidence of administration of medication to a patient without capacity without a review of their capacity or a best interests meeting. There was a lack of recording and monitoring of capacity and consent; no regular review of capacity assessments. There was evidence of a DoLS application which demonstrated limited understanding of the implementation of the process.

Towngate House is an 18 bedded male only accommodation open inpatient recovery unit based in Leeds

Assessment of needs and planning of care

The ward used "my recovery pathway" which is centred on providing a recovery and outcomes based approach to the care pathway for patients. There are three parts to the documentation; starting from here, where I want to be, and making plans. We saw evidence of well documented care plans which described how individual needs were met at each stage of their care. Patients told us they felt involved in making decisions about their care.

There was no evidence within the care records that physical health assessments had been undertaken on admission but there was evidence that on-going monitoring of patients' needs were incorporated within the treatment plans and care programme approach (CPA) reviews.

Best practice in treatment and care

The ward was able to access psychological therapies as part of the patients' treatment as recommended by National Institute for Health and Care Excellence (NICE).

There was a "best practice" file available to all ward staff which was regularly updated and maintained.

Trust policies and procedures referred to NICE guidance and had key outlines from the guidance for staff to use to verify best practice; this was particularly evident within the medication policies.

The ward manager told us that where possible patients remained with their own local general practitioner (GP) for the physical health needs. If this was not possible due to the distance from the rehabilitation ward to their GP then a patient was signed up to a temporary local GP.

There were activities available for the patients to participate in. These were held throughout the day, evenings and weekends. There was a notice board to outline availability of groups and some patients also had particular interests which they wanted to undertake. The ward manager told us they were always trying to find innovative ways of engaging the patients with activities.

Skilled staff to deliver care

The ward had a range of skilled mental health professional disciplines which included qualified nursing staff, support workers, doctor, occupational therapist who worked within the shift system of the ward. The ward also had access to a pharmacy technician on a weekly basis and as required they could be contacted.

Towngate House staff had an overall achievement of 77% for mandatory training; mandatory training included moving and handling, fire safety, resuscitation, food safety, infection control, information governance, equality and diversity, health and safety, clinical risk management, safeguarding adults and safeguarding children. The trust had a target performance rating were mandatory training should be 85% or above. Towngate House was reported as amber, below target in September 2014.

Towngate House had a performance of 85% completed appraisals at September 2014. This was confirmed during our conversations with the staff that regular supervision and appraisals were completed.

Are services effective?

Requires Improvement

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

Multi-disciplinary and inter-agency team work

There were effective handovers. These provided a handover of each individual patient, any identified changes in risk, and medication requiring administration during the shift.

The multi-disciplinary team (MDT) meetings included all staff; support workers, nurses, occupational therapies, psychologists and doctors. Other professionals such as dietician or physiotherapist would attend as required. Each patient was discussed at length for approximately 45 minutes, this means that each patient was reviewed and discussed on a rolling three week basis or as required if something changed before the scheduled review at MDT.

The ward has had some patients discharged from community services due to caseload and capacity within the community teams. This is not within the remit of the ward and is a capacity pressure within another service but has caused some problems with continuity of care co-ordinators being involved in patients discharge planning.

Ward 5 is an 18 bedded male only accommodation locked inpatient recovery unit based in the Newsam Centre in Leeds.

Assessment of needs and planning of care

The ward used "my recovery pathway" which is centred on providing a recovery and outcomes based approach to the care pathway for patients. There are three parts to the documentation; starting from here, where I want to be, and making plans. We saw evidence of well documented care plans which described how individual needs were met at each stage of their care. Patients told us they felt involved in making decisions about their care.

There was evidence within the care records that physical health assessments had been undertaken and that on-going monitoring of patients' needs were incorporated within the treatment plans and care programme approach (CPA) reviews.

Best practice in treatment and care

The ward was able to access psychological therapies as part of the patients treatment as recommended by National Institute for Health and Care Excellence (NICE).

Trust policies and procedures referred to NICE guidance and had key outlines from the guidance for staff to use to verify best practice; this was particularly evident within the medication policies. The ward manager told us how best practice guidance was discussed at the MDT meetings with the team and how it would impact on their ward and patient's care.

The ward manager told us that where possible patients remain with their own local General Practitioner (GP) for the physical health needs. If this was not possible due to the distance from the rehabilitation ward to their GP then a patient was signed up to a temporary local GP.

There were activities available for the patients to participate in, these were held throughout the day, evenings and weekends. There was a notice board to outline availability of groups and some patients also had particular interests which they wanted to undertake. The ward manager explained how meaningful activities are an invaluable part of the care pathway for patients so gaining engagement and involvement in activities patients enjoy was vital.

Skilled staff to deliver care

The ward had a range of skilled mental health disciplines which included qualified nursing staff, support workers, occupational therapist who worked within the shift system of the ward. The ward also had access to a pharmacy technician on a weekly basis and as required they could be contacted.

Ward 5 staff had an overall achievement of 85% for mandatory training; mandatory training included moving and handling, fire safety, resuscitation, food safety, infection control, information governance, equality and diversity, health and safety, clinical risk management, safeguarding adults and safeguarding children. The trust had a target performance rating were mandatory training should be 85% or above. Ward 5 was reported as green, meeting the target in September 2014.

Ward 5 had completed 65% of staff appraisals at September 2014.

Multi-disciplinary and inter-agency team work

We attended a MDT meeting during our visit to ward 5. We observed the meeting was well structured. Good multi-disciplinary team discussions took place around patients, effective planning of goals for patients for a three week period took place and all aspects of care planning were reviewed.

Are services effective?

Requires Improvement

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

The MDT meetings included all staff; support workers, nurses, occupational therapies, psychologists and doctors. Other professionals such as dietician or physiotherapist would attend as required. Each patient was discussed at length for approximately 45 minutes, this meant that each patient was reviewed and discussed on a rolling three week basis or as required if something changed before the scheduled review at MDT.

The ward had good links with assertive outreach team. There were some patients discharged from community services due to caseload and capacity within the community teams. This had caused some problems with continuity of care co-ordinators being involved in patients discharge planning. The ward manager told us that care co-ordinators from the Community Mental Health team picked up their duty of care at discharge planning if required.

Acomb Garth is a 16 bedded mixed sex accommodation open inpatient recovery unit based in York

Assessment of needs and planning of care

The ward used "my recovery pathway" which is centred on providing a recovery and outcomes based approach to the care pathway for patients. There were three parts to the documentation; starting from here, where I want to be, and making plans. The ward has paper care records and we saw evidence of out of date or incomplete care documentation. There was no evidence within the care records that physical health assessments had been undertaken and there was no on-going monitoring of patient's physical health needs incorporated within the care plans. This meant that staff did not have access to up to date information on how to monitor or meet patient's needs.

Patients told us they felt involved in making decisions about their care; they told us they worked together with their care co-ordinator towards achieving discharge from the ward.

Best practice in treatment and care

The ward was able to access psychological therapies as part of the patient's treatment as recommended by National Institute for Health and Care Excellence (NICE).

Trust policies and procedures referred to NICE guidance and had key outlines from the guidance for staff to use to verify best practice. This was particularly evident within the medication policies. The ward manager had also signed up to the NICE notifications so they could be reviewed in relation to mental health and rehabilitation services and were appropriate shared at the team meeting.

The ward manager told us that where possible patients remained with their own local general practitioner (GP) for the physical health needs. If this was not possible due to the distance from the rehabilitation ward to their GP then a patient was signed up to a temporary local GP.

There were activities available for the patients to participate in. These were held throughout the day. At the weekend there was a breakfast club and a play reading group. Patients told us that some group activities get cancelled because patients did not choose to get involved.

Information resources included notice boards for PALs, Mental Health Act legislation board, star ward benchmarking, and information on infection control. There was a notice board to outline availability of groups and some patients also had particular interests which they wanted to undertake, there was a section dedicated to the garden for the ward. There was no information displayed about how to make a complaint.

Skilled staff to deliver care

The ward had a range of skilled mental health professional disciplines which included qualified nursing staff, support workers, occupational therapist who worked within the shift system of the ward. The ward also had access to a pharmacy technician on a weekly basis and as required they could be contacted.

Acomb Garth staff completed mandatory training. This included moving and handling, fire safety, resuscitation, food safety, infection control, information governance, equality and diversity, health and safety, clinical risk management, safeguarding adults and safeguarding children. The trust had a target performance rating were mandatory training should be 85% or above.

Acomb Garth had a performance of 100% completed appraisals at September 2014. This was confirmed during our conversations with staff that regular supervision and appraisals were completed.

Multi-disciplinary and inter-agency team work

The multi-disciplinary team (MDT) meetings included all staff; support workers, nurses, occupational therapies, psychologists and doctors. Other professionals such as

Are services effective?

Requires Improvement

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

dietician or physiotherapist would attend as required. Each patient was discussed at length for approximately 45 minutes, this means that each patient was reviewed and discussed on a rolling three week basis or as required if something changed before the scheduled review at MDT.

The ward had good links with the community services and care co-ordinators were continuously involved with patients during their stay on the ward and planning for discharge.

We found that the ward was not compliant with the requirements of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguarding's (DoLS). We found evidence of administration of a Section 62 authorisation had been signed on 22/09/2014 but did not specify the treatment or the duration of the treatment. Another Section 62 form was signed on the day of our visit but this also did not describe what treatment was being authorised.

A Section 3 patient was due treatment which had been authorised on 21/08/2014 but there was no T2 or T3 form. This patient had been prescribed Lorazepam PRN without lawful authority.

We checked the records of two detained patients and saw evidence records to support that patients had been informed of their rights and it was appropriately signed by the responsible clinician.

We checked the records of an informal patient and we saw evidence of restrictions on their leave; the records stated "leave only at discretion of staff." This was a restriction which should not be applied as this patient had a status of informal therefore they would be free to leave the ward as they wished.

Good

Are services caring?

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

Summary of findings

We observed good interaction between staff and patients across the wards. Staff engaged with people in a caring, compassionate and respectful manner. The wards were calm and patients appeared comfortable in approaching staff when they required support.

We received feedback from patients across the wards confirming they felt involved in decisions about their care.

Patients spoke positively to us about their experience of the rehabilitation and recovery services.

Our findings

Millside is a 17 bedded mixed sex accommodation open inpatient recovery unit based in Leeds.

Kindness, dignity, respect and support

We observed good interactions between staff and patients within the ward. Staff engaged with patients in a caring, compassionate and respectful manner.

We saw staff treating patients with dignity throughout our visit and saw that staff knocked on patients' bedroom doors before entering.

One patient said "There is always someone around if I need them. On a Saturday and Sunday there are less staff about." Another patient told us "There are at least 3 members of staff on duty during the day and 2 at night." We spoke with four patients on the ward; they all spoke positively about their experience of care and treatment within the rehabilitation ward.

The involvement of people in the care they receive

The "my recovery pathway" documentation captured patients' personal, cultural, spiritual needs.

We spoke with the ward manager about how this could be translated in practice.

When a patient was referred to the rehabilitation ward and accepted, where possible an orientation pre-admission visit or several visits would be arranged. This was to enable the patient to feel involved in their recovery planning and next steps once they are moved to the rehabilitation ward. One patient told us that they had been integrated into the rehabilitation ward over the course of a month whilst they were still on the acute ward.

Each patient had a file with a copy of their care plan for their reference. We saw evidence within the care files that patients were involved in the MDT review meetings. This was also confirmed when we reviewed the MDT meeting records and when we spoke with patients.

Asket House is a 16 bedded mixed sex accommodation open inpatient recovery unit based in Leeds

Kindness, dignity, respect and support

We observed good interactions between staff and patients within the ward. Staff engaged with patients in a caring, compassionate and respectful manner.

We saw staff treating patients with dignity throughout our visit and saw that staff knocked on patient's bedroom doors before entering.

One patient said "staff are respectful, thoughtful and kind". Another patient told us "staff seem interested in me; they make you feel like they care about you." We spoke with four patients on the ward; they all spoke positively about their experience of care and treatment within the rehabilitation ward.

The involvement of people in the care they receive

The "my recovery pathway" documentation captured patients' personal, cultural, spiritual needs.

We spoke with the ward manager about how this could be translated in practice.

When a patient was referred to the rehabilitation ward and accepted, where possible an orientation pre-admission visit or several visits would be arranged. This is to enable the patient to feel involved in their recovery planning and next steps once they are moved to the rehabilitation ward.

Each patient had a file with a copy of their care plan for their reference. We saw evidence within the care files that patients were involved in the MDT review meetings. This was also confirmed when we reviewed the MDT meeting records and when we spoke with patients.

Good

Are services caring?

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

Towngate House is an 18 bedded male only accommodation open inpatient recovery unit based in Leeds

Kindness, dignity, respect and support

We observed good interactions between staff and patients within the ward. Staff engaged with patients in a caring, compassionate and respectful manner. Staff were observed playing pool with patients and chatting on the seating areas within the corridors.

We saw staff treating patients with dignity throughout our visit and saw that staff knocked on patient's bedroom doors before entering.

One patient said "Staff knock on my door and they always listen to me". We spoke with two patients on the ward; they all spoke positively about their experience of care and treatment within the rehabilitation ward.

The involvement of people in the care they receive

The "my recovery pathway" documentation captured patients' personal, cultural, spiritual needs.

We spoke with the ward manager about how this could be translated in practice.

When a patient was referred to the rehabilitation ward and accepted, where possible an orientation pre-admission visit or several visits would be arranged. This is to enable the patient to feel involved in their recovery planning and next steps once they are moved to the rehabilitation ward. One patient told us "I was shown around when I arrived but I did not come to visit before I was transferred."

Each patient had a file with a copy of their care plan for their reference. We saw evidence within the care files that patients were involved in the MDT review meetings. This was also confirmed when we reviewed the MDT meeting records and when we spoke with patients.

Ward 5 is an 18 bedded male only accommodation locked inpatient recovery unit based in the Newsam Centre in Leeds

Kindness, dignity, respect and support

We observed good interactions between staff and patients within the ward. Staff engaged with patients in a caring, compassionate and respectful manner. One patient told us "Staff are respectful at all times." Another patient told us "Staff are interested in me as a person; they (staff) have time for me."

We saw staff treating patients with dignity throughout our visit and saw that staff knocked on patient's bedroom doors before entering.

One patient said "There are plenty of staff around and they are all lovely". Another patient told us "The majority of times there are enough staff on the ward; I have had my leave cancelled just once due to problems with staff." We spoke with two patients on the ward; they all spoke positively about their experience of care and treatment within the rehabilitation ward.

The involvement of people in the care they receive

The "my recovery pathway" documentation captured patients' personal, cultural, spiritual needs.

We spoke with the ward manager about how this could be translated in practice.

When a patient was referred to the rehabilitation ward and accepted, where possible an orientation pre-admission visit or several visits would be arranged. This was to enable the patient to feel involved in their recovery planning and next steps once they are moved to the rehabilitation ward.

Each patient had a file with a copy of their care plan for their reference. We saw evidence within the care files that patients are involved in the MDT review meetings. This was also confirmed when we reviewed the MDT meeting records and when we spoke with patients. One patient told us "I have been involved in decisions about my care; they (staff) are great and spend time with me."

Acomb Garth is a 16 bedded mixed sex accommodation open inpatient recovery unit based in York

Kindness, dignity, respect and support

We observed good interactions between staff and patients within the ward. Staff engaged with patients in a caring, compassionate and respectful manner.

We saw staff treating patients with dignity throughout our visit and saw that staff knocked on patient's bedroom doors before entering.

One patient said "Staff always knock before entering my room. They are interested in my wellbeing and they are respectful". Another patient told us "Nurses are always

Good

Are services caring?

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

around and I have had nothing cancelled due to staff not being available." We spoke with three patients on the ward; they all spoke positively about their experience of care and treatment within the rehabilitation ward.

The patients told us that the food was "dull." They also told us how they shared a shower room with the opposite sex on the ward and how members of staff from the CMHT team upstairs walked through a corridor were some bedrooms were.

The involvement of people in the care they receive

The "my recovery pathway" documentation captured patient's personal, cultural, spiritual needs.

We spoke with the ward manager about how this could be translated in practice.

When a patient was referred to the rehabilitation ward and accepted, where possible an orientation pre-admission visit or several visits would be arranged. This was to enable the patient to feel involved in their recovery planning and next steps once they are moved to the rehabilitation ward.

When we reviewed care records we saw that patients had not been given a copy of their care plan but when we spoke with patients they told us they were involved in their care planning. We saw evidence within the care files that patients are involved in the MDT review meetings. This was also confirmed when we spoke with patients. One patient told us "I have been involved in my care plan and the CPA meetings."

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

The wards had a referral and admission criteria which supported the bed management process and management of inappropriate referrals for admission. Staff told us that care planning approach (CPA) meetings took place before a patient was discharged to ensure they were supported during and after their discharge from the ward. Whilst patients lived in the rehabilitation service staff supported them to feel empowered through promotion of independent living skills and social inclusion which underpinned the recovery model of rehabilitation.

Staff at Acomb Garth told us there was some inappropriate referrals for admissions to their ward due to bed management pressures within the York locality. We discussed this with the ward manager who confirmed there had been occasions were an admission had been made for patients who were not meeting the admission criteria. They explained that risk assessments and monitoring was undertaken and appropriate referrals are made back to the acute wards if the rehabilitation ward is not able to fully meet that patient's needs.

There was a limited service available for psychological therapies which meant patients requiring this intervention had to wait significantly long periods of time before they could access the service. This meant some patients were not able to receive the appropriate treatment in a timely manner.

Ward managers told us how they had raised an incident log following the request of a medic who refused to attend the ward to provide support.

Complaints appeared to be resolved at a local level by ward staff which meant that the formal complaints policy and procedure was not followed. This meant that shared learning and understanding on a trust wide level was not always being achieved as a large proportion of complaints were not formally logged. This was a trust wide theme and is reflected in the low level of complaints received by the trust in 2012/13 at 103 complaints.

Our findings

Millside is a 17 bedded mixed sex accommodation open inpatient recovery unit based in Leeds.

Access, discharge and bed management

The ward had a bed occupancy level of 79% at July 2014 for the previous 6 months. There was an arrangement in place to admit and discharge patients from the ward. Referral criterion was used to assess patients from acute wards who may be suitable for the next stage of their care pathway to recovery. The strict criterion enable the ward to assess if they are able to meet a patient's needs.

The ward manager told us that there are no movements between wards unless this is justified on clinical grounds and in the best interests of the patient. An example would be if a patient had a relapse and would be referred back to an acute ward.

There was a waiting list due to the reduction in beds and service redesign which is taking place. The waiting list had four patients on it.

The ward environment optimises recovery, comfort and dignity

The ward was calm and had a comfortable feel as we undertook the ward tour. We saw that there were a range of rooms to support patients' involvement in activities, therapy rooms, kitchenette, quiet rooms and main TV lounge areas. There were rooms where patients could take their family and visitors for privacy. The ward had access to a large garden area. The kitchen which provided meals for non-self-catering patients had been awarded a food hygiene rating of 5 by the Leeds City Council following their inspection undertaken on 26th September 2014.

The ward had a pay phone which had a door fitted to the room for privacy when patients were making private calls.

The ward complied with the guidance on mixed sex accommodation.

Patients had access to the kitchenette to make themselves hot drinks and snacks 24/7.

Ward policies and procedures minimise restrictions

With the ward being a rehabilitation ward it was an open ward for informal patient to leave as they liked. Detained patients also had leave which was unescorted, where section 17 leave procedures would be followed.

Good

Are services responsive to people's needs?

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

Patients told us how they could personalise their rooms and had a key to be able to lock their rooms when they were out of the ward.

Meeting the needs of all people who use the service

During the tour around the ward we observed information was available for patients, carers and family members. Information was available on advocacy services for patients to access help and support.

The ward manager advised us that interpreters are available through the trust and care documentation can be translated into a range of different languages so that patients, family members or carers can understand what care and treatment is being provided.

We were also told how a patients' cultural and religious requirements would be supported and this was confirmed when we spoke with patients. There was a choice of foods for particular religious requirements and cultural needs of a patient in relation to activity planning were taken into consideration.

On the ward there was a leaflet stand with information available to patients and carers. There was information about carers groups, dual diagnosis, Mental Health Act and how to appeal, accessing PAL's service or Independent Mental Health Advocate services. There was also a patient advisory liaison service notice board, this outlined how they can support patients with any concerns they have regarding the service they are receiving.

Listening to and learning from concerns and complaints

Within the information available to patients and carers there was information on how to complain. The complaints process is also included in the "Welcome Pack" for all patients to refer to.

Patients we spoke with told us they knew how to make a complaint if they needed to. One patient told us "There are signs all over the ward to tell us how to complain by getting in touch with PALs." Another patient told us "I have not had to complain but if I wanted to I would speak with my support worker."

Staff told us that they are not aware of any complaints recently made at Millside. Staff told us that complaints are always escalated through the shift co-ordinator or the ward manager. The staff told us that they are aware of the policy and process details which they would also advise to the patient if they wanted to make a formal complaint. We were told by staff that complaints would be discussed at their team meetings so they can share the learning locally within the team.

Complaints appeared to be resolved at a local level by ward staff which meant that the formal complaints policy and procedure was not followed. This meant that shared learning and understanding on a trust wide level was not always being achieved as a large proportion of complaints were not formally logged.

Asket House is a 16 bedded mixed sex accommodation open inpatient recovery unit based in Leeds

Access, discharge and bed management

The ward had a bed occupancy level of 78% at July 2014 for the previous 6 months. There were arrangements in place to admit and discharge patients from the ward. Referral criterion was used to assess patients from acute wards who may be suitable for the next stage of their care pathway to recovery. The strict criterion enabled the ward to assess if they were able to meet a patient's needs.

The ward manager told us that there were no movements between wards unless this is justified on clinical grounds and in the best interests of the patient. An example would be if a patient had a relapse and would be referred back to an acute ward.

The ward environment optimises recovery, comfort and dignity

The ward was calm and had a comfortable feel as we undertook the ward tour. We saw that there was a range of rooms to support patients' involvement in activities, therapy rooms, kitchenette, quiet rooms and main TV lounge areas. There were rooms where patients could take their family and visitors for privacy. The ward had access to a garden areas and smoking shelter. There was also a greenhouse and vegetable patch which were all well maintained.

The ward had a pay phone in the main reception area. Staff told us that patients could use the cordless handset in a quiet room if they needed to make private calls as the reception phone was not in an enclosed room which meant it was not private.

The ward complied with the guidance on mixed sex accommodation.

Good

Are services responsive to people's needs?

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

Patients had access to the kitchenette to make themselves hot drinks and snacks 24/7.

Ward policies and procedures minimise restrictions

With the ward being a rehabilitation ward it was an open ward for informal patient to leave as they liked. Detained patients also had leave which was unescorted, where section 17 leave procedures would be followed.

Patients told us how they could personalise their rooms and had a key to be able to lock their rooms when they were out of the ward.

Meeting the needs of all people who use the service

During the tour around the ward we observed notice boards with information available for patients, carers and family members. Information was available on advocacy services for patients to access help and support.

The ward manager advised us that interpreters were available through the trust and care documentation can be translated into a range of different languages so that patients, family members or carers could understand what care and treatment is being provided.

We were also told how a patients' cultural and religious requirements would be supported. There was a choice of foods for particular religious requirements and the cultural needs of a patient in relation to activity planning were taken into consideration.

On the ward there was a range of notice boards with information available to patients and carers. This particular ward had a section for carers, there was information particular to what carers may need to refer to or know about the ward. There was also a patient advisory liaison service notice board, this outlined how they can support patients with any concerns they have regarding the service they are receiving

Listening to and learning from concerns and complaints

Within the information available on the notice boards at the ward there was information on how to complain. The complaints process is also included in the "welcome pack" for all patients to refer to.

Patients we spoke with told us they knew how to make a complaint if they needed to. One patient told us "I would raise my concerns to the ward manager or staff." Another patient told us "I have seen the ward manager about things in the past and I have felt listened to."

Staff told us that they are not aware of any complaints recently made at Asket House but they felt the complaints would be discussed at their team meetings so they can share the learning locally within the team.

Complaints appeared to be resolved at a local level by ward staff which meant that the formal complaints policy and procedure was not followed. This meant that shared learning and understanding on a trust wide level was not always being achieved as a large proportion of complaints were not formally logged.

Towngate House is an 18 bedded male only accommodation open inpatient recovery unit based in Leeds

Access, discharge and bed management

The ward had a bed occupancy level of 91% at July 2014 for the previous 6 months. There were arrangements in place to admit and discharge patients from the ward. Referral criterion was used to assess patients from acute wards who may be suitable for the next stage of their care pathway to recovery. The strict criterion enable the ward to assess if they were able to meet a patient's needs.

The ward manager told us that there were no movements between wards unless this is justified on clinical grounds and in the best interests of the patient. An example would be if a patient had a relapse and would be referred back to an acute ward. Towngate House reported one readmission within six month period at July 2014.

The ward environment optimises recovery, comfort and dignity

The ward was calm and had a comfortable feel as we undertook the ward tour. We saw that there was a range of rooms to support patients' involvement in activities, therapy rooms, computer area, games room, two kitchenettes, quiet rooms and main TV lounge areas. There were rooms available where patients could take their family and visitors for privacy. The ward had access to an outside area.

The ward had a pay phone in a room with a door for privacy when patient's was making private calls.

Good

Are services responsive to people's needs?

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

Patients had access to the kitchenette to make themselves hot drinks and snacks 24/7.

Ward policies and procedures minimise restrictions

With the ward being a rehabilitation ward it was an open ward for informal patient to leave as they liked. Detained patients also had leave which was unescorted, where section 17 leave procedures would be followed.

Patients told us how they could personalise their rooms and had a key to be able to lock their rooms when they were out of the ward.

Meeting the needs of all people who use the service

During the tour around the ward we observed notice boards with information available for patients, carers and family members. Information was available on advocacy services for patients to access help and support.

The ward manager advised us that interpreters were available through the trust and care documentation can be translated into a range of different languages so that patients, family members or carers can understand what care and treatment is being provided.

We were also told how patients' cultural and religious requirements can be supported. There was a choice of foods for particular religious requirements and the cultural needs of a patient in relation to activity planning was taken into consideration

On the ward there was a range of notice boards with information available to patients and carers. This particular ward had a section for carers, there was information particular to what carers may need to refer to or know about the ward. Information included men's health information, smoking cessation and local services. There was also a board with details about the "recover star" pathway. There was also a patient advisory liaison service notice board, this outlined how they can support patients with any concerns they have regarding the service they are receiving.

Listening to and learning from concerns and complaints

Within the information available on the notice boards at the ward there was no information on how to complain. The complaints process was included in the "welcome pack" for all patients to refer to.

Patients we spoke with told us they knew how to make a complaint if they needed to. One patient told us "I have not felt the need to make a complaint but if I did, I would speak with staff."

Staff told us that they are not aware of any complaints recently made at Towngate House but said they would escalate any concerns to the ward manager.

Complaints appeared to be resolved at a local level by ward staff which meant that the formal complaints policy and procedure was not followed. This meant that shared learning and understanding on a trust wide level was not always being achieved as a large proportion of complaints were not formally logged.

Ward 5 is an 18 bedded male only accommodation locked inpatient recovery unit based in the Newsam Centre in Leeds

Access, discharge and bed management

The ward had a bed occupancy level of 98% at July 2014 for the previous 6 months. The ward manager told us how the wards do have pressures to take patient although there are arrangements in place to meet admission criteria for the ward. Referral criterion was used to assess patients from acute wards who may be suitable for the next stage of their care pathway to recovery. The strict criterion enable the ward to assess if they are able to meet a patient's needs. To support this further a "Gateway for admission" to the ward is being developed to help clarify the ward criteria for acute wards.

The ward manager told us that there were no movements between wards unless this is justified on clinical grounds and in the best interests of the patient. An example would be if a patient had a relapse and would be referred back to an acute ward.

The ward environment optimises recovery, comfort and dignity

The ward had a comfortable feel as we undertook the ward tour. We saw that there was a range of rooms to support patients' involvement in activities, therapy rooms, kitchenette, quiet rooms, music room, games room, sensory room and main TV lounge areas. There were rooms where patients could take their family and visitors for privacy. The ward had access to a garden area which had open access unless the patient was on enhanced observations.

Good

Are services responsive to people's needs?

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

The ward phone is mobile, on wheels and usually in the lounge area but can be taken to a private area for patients to make personal calls.

The patient rooms are kept locked but access is available to the patients 24/7.

Patients had access to the kitchenette to make themselves hot drinks and snacks.

Ward policies and procedures minimise restrictions

The ward was a locked rehabilitation ward but some patients had a pass to be able to leave as they desired. Detained patients had leave which was escorted or unescorted, where section 17 leave procedures would be followed.

Patients told us how they could personalise their rooms.

Meeting the needs of all people who use the service

During the tour around the ward we observed notice boards with information available for patients, carers and family members. Information about dual diagnosis group, meals and menus, physical health and a group board for daily communications meeting. Information was available on advocacy services for patients to access help and support.

The ward manager advised us that interpreters were available through the trust and care documentation can be translated into a range of different languages so that patients, family members or carers can understand what care and treatment is being provided.

We were also told how a patient's cultural and religious requirements would be supported. There was a choice of foods for particular religious requirements the cultural needs of a patient in relation to activity planning was taken into consideration.

On the ward there was a range of notice boards with information available to patients and carers. This particular ward had a section for carers, there was information particular to what carers may need to refer to or know about the ward. There was also a patient advisory liaison service notice board, this outlined how they can support patients with any concerns they have regarding the service they are receiving.

Listening to and learning from concerns and complaints

The ward manager told us that the complaints procedure was covered on admission and is also detailed in the "welcome pack" for all patients to refer to. We were advised by the ward manager that most issues were raised at the "your views" weekly meeting with a resolution being achieved at local level without it becoming a formal complaint.

Patients we spoke with told us they knew how to make a complaint if they needed to. One patient told us "I would raise my concerns with my care co-ordinator but I have never had any reason to complaint." Another patient told us "I know how to complain but I don't need to complain."

Staff told us that they are not aware of any complaints recently made at Ward 5. The ward manager explained that if any complaints was received staff would be debriefed and discussed at the team meeting to share learning locally within the team.

Complaints appeared to be resolved at a local level by ward staff which meant that the formal complaints policy and procedure was not followed. This meant that shared learning and understanding on a trust wide level was not always being achieved as a large proportion of complaints were not formally logged.

Acomb Garth is a 16 bedded mixed sex accommodation open inpatient recovery unit based in York

Access, discharge and bed management

The ward had a bed occupancy level of 91% at July 2014 for the previous 6 months. There were arrangements in place to admit and discharge patients from the ward. Referral criterion was used to assess patients from acute wards who may be suitable for the next stage of their care pathway to recovery. The strict criterion enabled the ward to assess if they are able to meet a patient's needs.

The ward manager told us that there are no movements between wards unless this is justified on clinical grounds and in the best interests of the patient. An example would be if a patient had a relapse and would be referred back to an acute ward.

The ward environment optimises recovery, comfort and dignity

The ward was calm on the day of our visit but it was in need of maintenance and repair, there was plaster and paint

Good

Are services responsive to people's needs?

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

peeling off the walls. We saw that there was a range of rooms to support patients' involvement in activities, therapy rooms, kitchenette, quiet rooms and main TV lounge areas. There were rooms where patients could take their family and visitors for privacy.

There was no pay phone available on the ward for patients to use; we were told there used to be a phone available in the reception area but it was out of use and was not in a private area so it wasn't replaced. Staff told us that patients could use the cordless handset in a quiet room if they needed to make private calls as the reception phone was not in an enclosed room which meant it was not private.

Patients had access to the kitchenette to make themselves hot drinks and snacks 24/7. One patient told us "we have just got a new cooker and microwave for the small kitchen. The others had been broken for months". Patients told us how the main kitchen was locked, it was opened at meal times and it could not be used after 21:00 hours. Patients told us they could access the small kitchen anytime to make a snack or a drink.

Ward policies and procedures minimise restrictions

With the ward being a rehabilitation ward it was an open ward for informal patient to leave as they liked. Detained patients also had leave which was unescorted, where section 17 leave procedures would be followed. The ward manager told us how patients may be searched if the staff feel that patient is under the influence or bringing into the ward alcohol or illicit substances.

Patients told us how they could personalise their rooms and had a key to be able to lock their rooms when they were out of the ward.

Meeting the needs of all people who use the service

During the tour around the ward we observed notice boards with information available for patients, carers and family members. Information was available on advocacy services for patients to access help and support.

The ward manager advised us that interpreters were available through the trust and care documentation can be translated into a range of different languages so that patients, family members or carers can understand what care and treatment is being provided.

We were also told how a patient's cultural and religious requirements would be supported. There was a multi faith room within the ward and menus can be adjusted to meet the patient's cultural needs. There was a choice of foods for particular religious requirements and the cultural needs of a patient in relation to activity planning were taken into consideration.

On the ward there was a range of notice boards with information available to patients and carers. This particular ward had a section for carers, there was information particular to what carers may need to refer to or know about the ward. There was a monthly family work / supervision group and a monthly carers group held on a Saturday to encourage family and carers to attend.

There was also a patient advisory liaison service notice board, this outlined how they can support patients with any concerns they have regarding the service they are receiving. In the reception area there was a comments box for patients, carers and family members to feedback any comments or suggestions to the ward manager. These are reviewed and discussed within the weekly community meeting held with patients.

Listening to and learning from concerns and complaints

Within the information available on the notice boards at the ward there was information on how to complain. The complaints process is also included in the "Welcome Pack" for all patients to refer to.

Patients we spoke with told us they knew how to make a complaint if they needed to. One patient told us "I would talk to staff who have been fantastic." Another patient told us "I haven't had to complain but would feel confident to go to the office to talk to the ward manager."

Staff told us that they are not aware of any complaints recently made at Acomb Garth but they felt the complaints would be discussed at their team meetings so they can share the learning locally within the team. Acomb Garth has had one complaint within the last 12 months; this was in relation to no hot water being available on the ward.

Complaints appeared to be resolved at a local level by ward staff which meant that the formal complaints policy and procedure was not followed. This meant that shared learning and understanding on a trust wide level was not always being achieved as a large proportion of complaints were not formally logged.

Are services well-led?

Good

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

Summary of findings

The trust had a clear vision for the rehabilitation services with the transition to the new service redesign due for completion by December 2014 / January 2015. The service involved a provision for rehabilitation and recovery community service and working to the least restrictive way with patients through the use of de-escalation which underpinned the recovery aspects of patient's care. The strategies for the services future were evident and staff had a good understanding and knowledge of them. Staff informed us that the use of restraint was low.

There was little knowledge about the trust's overall vision and strategy; some staff told us the senior management and executive members were not visual at the remote locations were rehabilitation was based.

Staff told us they felt well supported by the management and their peers. Supervision and appraisal process was up to date. Mandatory training was not achieving the trust's target performance in all wards; Millside and Towngate House was not achieving 85% but all wards were monitored to promote compliance.

Our findings

Millside is a 17 bedded mixed sex accommodation open inpatient recovery unit based in Leeds.

Vision and values

Locally staff were aware of the redesign of the Leeds service and the vision for the rehabilitation and recovery services. Staff told us about the recent restructuring of the services and that the risk procedure for staff jobs had been managed and communicated well. Despite these changes staff still told us that they felt supported by the management team and peers.

The wider trust's vision and strategic view was not as clear when we spoke with staff. Staff advised that there was no regular presence of the executive or senior management within their remote wards.

Good governance

There was a clear governance structure in place that supported the safe delivery of the service. Lines of communication from the senior managers to the frontline services were mostly effective and staff were aware of key messages, initiatives and priorities of the service.

The ward had strong governance arrangements in place to monitor the quality of service delivery. They had regular meetings for management staff to consider issues of quality, safety and standards. This included oversight of risk areas in the service. This helped ensure quality assurance systems were effective in identifying and managing risks to patients.

Mandatory training for Millside at September 2014 was 72% completed.

Leadership, morale and staff engagement

At a local level staff was positive about their experience of working within Millside. One staff member told us "It is the best job I have had since working within the NHS and we have a very good and approachable manager." All staff stated to us that they felt they could raise concerns to their management team and be listened to. One staff member said "I have no concerns about raising any issues but I have not had cause to raise anything." Another member of staff said "It is a good team we work well together."

Staff told us they felt supported by the management team within the ward. We saw evidence that staff at all levels had received regular supervision and appraisals. Millside had an 88% completion of appraisals for the staff within the ward at September 2014.

Sickness and absence rate at Millside from September 2013 to August 2014 was 11% for a head count of 18 staff.

Commitment to quality improvement and innovation

The ward had systems in place to monitor the quality of service delivery. A number of audits completed; this included care records audits, Mental Health Act Section 58, 132 and 17 audits, medication audit, ligature and environmental audits.

A review of the key indicators for care programme approach (CPA) was also conducted. At September 2014 Millside had a caseload of 12, with no breaches of CPA reviews and an achievement of 100% meeting CPA 12 monthly review

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.

target. The report also showed that 12 patients had FACE risk assessments completed within the previous 12 month period. There were four patients reported on CPA who had no assigned care co-ordinator.

Asket House is a 16 bedded mixed sex accommodation open inpatient recovery unit based in Leeds

Vision and values

Locally staff were aware of the redesign of the Leeds service and the vision for the rehabilitation and recovery services. Staff told us that the restructuring of the services had created some difficulties for staff with regards to job security. Through these changes staff still stated to us that they felt supported by the management team and peers.

The wider trust's vision and strategic view was not as clear when we spoke with staff. Staff advised that there was no regular presence of the executive or senior management within their remote wards.

Good governance

There was a clear governance structure in place that supported the safe delivery of the service. Lines of communication from the senior managers to the frontline services were mostly effective and staff were aware of key messages, initiatives and priorities of the service.

The ward had strong governance arrangements in place to monitor the quality of service delivery. They had regular meetings for management staff to consider issues of quality, safety and standards. This included oversight of risk areas in the service. This helped ensure quality assurance systems were effective in identifying and managing risks to patients.

Mandatory training for Asket House at September 2014 was 86% completed.

Leadership, morale and staff engagement

At a local level staff were positive about their experience of working within Asket House with many staff having worked there for a long period of time. All staff stated to us that they felt they could raise concerns to their management team and be listened to. One staff member said "I would never worry about saying something that was bothering me if I had to." Another member of staff said "It is a good team and we have the support of our manager."

Staff told us they felt supported by the management team within the ward. We saw evidence that staff at all levels had received regular supervision and appraisals. Asket House had a 91% completion of appraisals for the staff within the ward at September 2014.

Asket House sickness and absence rate from September 2013 to August 2014 was 10% for a head count of 24 staff. The ward manager told us that these figures had been elevated due to a member of staff being on long term sick.

Commitment to quality improvement and innovation

The ward had systems in place to monitor the quality of service delivery. There were a number of audits completed; this included care records audits, Mental Health Act Section 58, 132 and 17 audits, medication audit, ligature and environmental audits.

A review of the key indicators for care programme approach (CPA) was also conducted. At September 2014 Asket House had a caseload of 15, with no breaches of CPA reviews and an achievement of 100% meeting CPA 12 monthly review target. The report also showed that 13 patients had FACE risk assessments completed within the previous 12 month period. There were no patients reported on CPA who had no assigned care co-ordinator.

Towngate House is an 18 bedded male only accommodation open inpatient recovery unit based in Leeds

Vision and values

Locally staff were aware of the redesign of the Leeds service and the vision for the rehabilitation and recovery services. Staff told us that the restructuring of the services had created some unsettlement about job security and how a confidential phone line had been provide for staff to call for support. Through these changes staff still stated to us that they felt supported by the management team and peers.

The wider trust's vision and strategic view was not as clear when we spoke with staff. Staff advised that there was no regular presence of the executive or senior management within their remote wards.

Good governance

There was a clear governance structure in place that supported the safe delivery of the service. Lines of communication from the senior managers to the frontline services were mostly effective and staff were aware of key messages, initiatives and priorities of the service.

Are services well-led?

Good

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

The ward had strong governance arrangements in place to monitor the quality of service delivery. They had regular meetings for management staff to consider issues of quality, safety and standards. This included oversight of risk areas in the service. This helped ensure quality assurance systems were effective in identifying and managing risks to patients.

Mandatory training for Towngate House at September 2014 was 77% completed.

Leadership, morale and staff engagement

At a local level staff was positive about their experience of working within Towngate House. All staff stated to us that they felt they could raise concerns to their management team and be listened to. One staff member said "there is a strong team ethos and support structure here within the team." Another member of staff said "the ward manager has a good knowledge and understanding of rehabilitation and recovery service, they are hands on and very supportive to all staff."

Staff told us they felt supported by the management team within the ward. We saw evidence that staff at all levels had received regular supervision and appraisals.

Towngate House had an 85% completion of appraisals for the staff within the ward at September 2014.

Towngate House sickness and absence rate from September 2013 to August 2014 was 2.3% for a head count of 21 staff.

Commitment to quality improvement and innovation

The ward had systems in place to monitor the quality of service delivery. There were a number of audits completed; this included care records audits, Mental Health Act Section 58, 132 and 17 audits, medication audit, ligature and environmental audits.

A review of the key indicators for care programme approach (CPA) was also conducted. At September 2014 Towngate House had a caseload of 11, with no breaches of CPA reviews and an achievement of 100% meeting CPA 12 monthly review target. The report also showed that 11 patients had FACE risk assessments completed within the previous 12 month period. There were no patients reported on CPA who had no assigned care co-ordinator.

Ward 5 is an 18 bedded male only accommodation locked inpatient recovery unit based in the Newsam Centre in Leeds

Vision and values

Locally staff were aware of the redesign of the Leeds service and the vision for the rehabilitation and recovery services.

The wider trust's vision and strategic view was not as clear when we spoke with staff. Staff advised that there was no regular presence of the executive or senior management within their remote wards. One staff member told us that they knew the chief executive had a blog.

Good governance

There was a clear governance structure in place that supported the safe delivery of the service. Lines of communication from the senior managers to the frontline services were mostly effective and staff were aware of key messages, initiatives and priorities of the service.

The ward had strong governance arrangements in place to monitor the quality of service delivery. They had regular meetings for management staff to consider issues of quality, safety and standards. This included oversight of risk areas in the service. This helped ensure quality assurance systems were effective in identifying and managing risks to patients.

Mandatory training for Ward 5 at September 2014 was 85% completed.

Leadership, morale and staff engagement

At a local level staff was positive about their experience of working within Ward 5. Staff spoke about it being a good place to work and that their manager was supportive. Staff told said "Good leadership by the manager with a good team working together." All staff stated to us that they felt they could raise concerns to their management team and be listened to. One staff member said "Leadership on the ward is good and we do have regular visits from our matron."

Staff told us they felt supported by the management team within the ward. We saw evidence that staff at all levels had received regular supervision and appraisals.

Ward 5 had a 66% completion of appraisals for the staff within the ward at September 2014.

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.

Ward 5 sickness and absence rate from September 2013 to August 2014 was 4% for a head count of 35 staff. The ward manager told us that these figures had been elevated due to a member of staff being on long term sick.

Commitment to quality improvement and innovation

The ward had systems in place to monitor the quality of service delivery. There were a number of audits completed; this included care records audits, Mental Health Act Section 58, 132 and 17 audits, medication audit, ligature and environmental audits.

A review of the key indicators for care programme approach (CPA) was also conducted. At September 2014 Ward 5 had a caseload of 19, with no breaches of CPA reviews and an achievement of 100% meeting CPA 12 monthly review target. The report also showed that 16 patients had FACE risk assessments completed within the previous 12 month period. There were no patients reported on CPA who had no assigned care co-ordinator.

Acomb Garth is a 16 bedded mixed sex accommodation open inpatient recovery unit based in York

Vision and values

Locally staff were aware of the redesign of the Leeds service and the vision for the rehabilitation and recovery services.

The wider trust's vision and strategic view was not as clear when we spoke with staff. Staff advised that there was no regular presence of the executive or senior management within their remote wards. One member of staff told us that they did not know who the chief executive was.

Good governance

There was a clear governance structure in place that supported the safe delivery of the service locally. The lines of communication from the senior managers to the frontline services had recently been changed. The rehabilitation ward now reported through to the matron who was responsible for acute wards. The ward manager told us the governance was effective and staff were aware of key messages, initiatives and priorities of the local service.

The ward had strong governance arrangements in place to monitor the quality of service delivery. They had regular meetings for management staff to consider issues of quality, safety and standards. This included oversight of risk areas in the service. This helped ensure quality assurance systems were effective in identifying and managing risks to patients.

Leadership, morale and staff engagement

At a local level staff was positive about their experience of working within Acomb Garth. All staff stated to us that they felt they could raise concerns to their management team and be listened to. One staff member said "I would raise concerns if there was something bothering me." Another member of staff said "at York we feel disconnected from the organisation but locally our ward manager is supportive."

Staff told us they felt supported by the management team within the ward. We saw evidence that staff at all levels had received regular supervision and appraisals. Acomb Garth had a 100% completion of appraisals for the staff within the ward at September 2014.

Acomb Garth' sickness and absence rate from September 2013 to August 2014 was 7.2% for a head count of 26 staff. The ward manager told us that these figures had been elevated due to a member of staff being on long term sick.

Commitment to quality improvement and innovation

The ward had systems in place to monitor the quality of service delivery. There were a number of audits completed; this included care records audits, Mental Health Act Section 58, 132 and 17 audits, medication audit, ligature and environmental audits.

The ward was Accreditation for Inpatient Mental Health Services AIMS accredited. AIMS is a standards-based accreditation program designed to improve the quality of care in inpatient mental health wards. The accreditation program takes from six to nine months from the time a service registers with the AIMS program. Accreditation is completed in three phases: phase one is a self-review, phase two is a peer review visit by an external team and phase three is the decision on accreditation. The ward had achieved a level of excellent for the period January 2014 to July 2015.

Compliance actions

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010 Safety and suitability of premises The premises where regulated activity is carried on was not protected against the risks associated with unsafe or unsuitable premises by means of suitable design and layout, appropriate measures in relation to risks of the premises to patients and adequate repair or maintenance of the premises.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records The patients were not protected against the risks of unsafe or inappropriate care and treatment arising from a lack of proper information about them by means of the maintenance of an accurate record in respect of each service user which should include appropriate information and documentation in relation to their care and treatment.