Requires Improvement

Leeds and York Partnership NHS Foundation Trust

Quality Report

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Core services inspected	CQC registered location	CQC location ID
Acute admission wards and PICU	The Becklin Centre The Newsam Centre Ward 40, Brotherton Wing, Leeds General Infirmary Bootham Park Hospital	RGD02 RGD03 RGD08 RGD04
Services for Older People -inpatient	Peppermill Court Community Unit for the Elderly Meadowfields Community Unit Worsley Court Community Unit for the Elderly Bootham Park Hospital The Mount	RGDY3 RGD09 RGDY6 RGDX4 RGD04
Children and adolescent mental health services -inpatient	Lime Trees Child, Adolescent and Family Unit	RGDX8
Forensic Secure Services	Clifton House The Newsam Centre Field View Trust Headquarters	RGDX5 RGD03 RGDX7 RGD01
Long stay/Rehabilitation services	Millside Asket House Townsgate The Newsam Centre Acomb Garth	RGD07 RGD06 RGDX1 RGD03 RGDX2
Specialist Eating Disorder Services	The Newsam Centre	RGD03
Learning Disabilities - Inpatient	St Mary's Hospital	RGD05

Summary of findings

	White Horse View Parkside Lodge Acomb Learning Disability Unit	RGDY5 RGD09 RGDX3
Supported Living Service	St Mary's Hospital	RGD05
Children and adolescent mental health services -community	Trust Headquarters	RGD01
Integrated (Adult and Older Peoples) Community Mental Health services	Trust Headquarters	RGD01
Crisis and Health Based Place of Safety	Trust Headquarters The Becklin Centre Bootham Park Hospital	RGD01 RGD02 RGDX4
Learning Disabilities - Community	Trust Headquarters	RGD01

This report describes our judgement of the quality of care at this provider. It is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from people who use services, the public and other organisations.

Summary of findings

Ratings

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

Overall rating for mental health services at this provider	Requires Improvement 
Are mental health services safe?	**Requires Improvement** 
Are mental health services effective?	**Requires Improvement** 
Are mental health services caring?	**Good** 
Are mental health services responsive?	**Requires Improvement** 
Are mental health services well-led?	**Requires Improvement** 

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

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

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

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Overall summary

When aggregating ratings, our inspection teams follow a set of principles to ensure consistent decisions. The principles will normally apply but will be balanced by inspection teams using their discretion and professional judgement in the light of all of the available evidence. This statement should be in all provider level reports.

Bootham Park Hospital, despite significant work having been taken around ligature points and further work planned is not fit for purpose as a modern inpatient setting. The building no longer meets the needs of psychiatric patients in acute distress. Staff could not observe all parts of the wards due to the layout and design of the building. Bedrooms were large and airy, but doors opened out into corridors. There were sash windows in bedrooms and bathrooms. There were other features of a building that was built in the 18th century meaning that ligature points could not be fully eliminated.

In York specifically, the facilities and premises at Bootham Park Hospital were not appropriate for the services being provided. The trust during and subsequent to the inspection provided documents that outlined their engagement and documented concerns about the premises with the relevant parties from July 2013 to find a solution, including Vale of York commissioning group, the NHS area team and NHS property services. Solutions were put in place and included English Heritage, but have not as yet been implemented.

We saw that this had been the case with Lime Trees child and adolescent unit but that the trust had worked collaboratively with the specialised commissioning team and NHS England to make immediate changes and move the service to another location.

Staff did not always identify safety concerns about ligature points quickly enough. We identified ligature points across the Leeds' inpatient areas that were not all recorded on the trust risk register.

We found the use of patient group directions was unlawful in the crisis assessment service in Leeds. The trust suspended their use before the end of the inspection.

Staffing levels were usually maintained at the level set by the trust. The expected qualified nurse staffing levels at Field View were not maintained on the week of our inspection. There was limited medical cover in some locations in the trust and this meant that it could be difficult to get medical assistance in an emergency.

Safeguarding vulnerable adults, children and young people had a raised profile in the trust as they had just appointed a non – executive director lead. Training for all staff was in place. Policies and procedures were easily accessed and staff understood them.

The trust did not meet the Department of Health guidance on same sex accommodation and did not comply with the Mental Health Act Code of Practice. Four wards including one rehabilitation ward, Acomb Gables and three older people's wards Meadowfields, Worsley Court and ward 6 did not comply. These were all wards in York. We concluded that the trust was not promoting sexual safety and not ensuring patient privacy and dignity was being maintained at all times.

Prior to our inspection, we heard that patients, carers and relatives did not find it easy or worried about raising concerns and complaints. We found during our inspection that when issues were raised locally, they were dealt with at ward/team level. However, corporately there was a backlog of complaints. Patients', carers' and relatives' were in receipt of unsatisfactory responses after waiting for a response for a long time. The trust was not meeting its own targets for response times. Information on how to make a complaint was not displayed in all ward areas or areas of public access. We concluded that patients' concerns and complaints do not always lead to improvements in quality of care.

Staff had access to learning and development opportunities. The learning opportunities offered to staff did not fully meet their needs. Mental Capacity Act training was not in place. The trust did not monitor the number of people who had undertaken Mental Health Act training. We concluded that the trust cannot be assured that the relevant staff had up to date knowledge regarding Mental Capacity Act, Deprivation of Liberty

Summary of findings

Safeguards and Mental Health Act legislation. Specialist training was limited in York. Training programmes were held both in Leeds and York although staff in York told us they found it difficult to attend.

Representatives from the York commissioning groups told us that the trust did not engage positively with them and did not involve the local communities or other organisations in how services were planned or designed. The trust also told us that the relationship between them and the commissioning groups in York was a difficult one. We were concerned that this might adversely affect the provision of high quality patient care.

After the inspection, the York commissioning groups informed us that there had been improvements in the three months post inspection. They identified that the context of their discussions with CQC had all previously been shared with the trust. This included their view that the trust had been the provider of services for over two years but had not progressed key estates issues including actions relating to ligature points despite the resource being identified prior to the trust taking over the contract.

The trust submitted documents after the inspection that showed a timeline of partnership and engagement within the York localities of which the first dated evidence is January 2013. There were a number of pieces of evidence that supported the trusts view that they had actively engaged with the clinical commissioning group through a variety of different groups and meetings. They also included several pieces of evidence demonstrating how they had engaged and involved local communities in how services were designed and planned. The trust included a document that detailed the different partnership groups that members of the trust attend. Minutes were provided that demonstrated that the trust had engaged in a board to board meeting with the Vale of York commissioning group in February 2014 followed by an executive to executive meeting in April 2014. These meetings included discussions on the way forward with Bootham Park Hospital and the respective roles and responsibilities going forward.

The arrangements for governance and performance management did not always operate effectively below senior management level. As a result it was not clear that the trust had the full range of information from the care teams to manage current and future performance. However the structures had been seen to be working well and embedded at senior management and board level. We saw that performance issues were escalated to the board through the relevant committees. Financial pressures were not compromising the quality of care.

Staff planned and delivered care and treatment in line with evidence based practice. They undertook comprehensive assessments of needs. However they did not always collect or monitor measures or outcomes of patient care and treatment regularly or robustly. The eating disorder service was an exception to this. Participation in external benchmarking was limited, although we could see that plans were in place to develop this approach. The trust had undertaken national benchmarking for the first time in 2013.

Overall the application of the Mental Health Act was good. However we found some practices did not always meet the Mental Health Act Code of Practice. We raised these at the time with the ward staff. Staff appeared to be knowledgeable about the application of the Mental Health Act. We found mail being withheld for one patient contrary to the rules in the Mental Health Act. There was inconsistent practice in giving people copies of section 17 leave forms and some evidence of scrutiny of documents not always taking place, in as short a period of time as possible, following the application for detention.

Staff understood and fulfilled their responsibilities to report incidents. When things went wrong, there was a thorough investigation that involved all the relevant staff, patients' and their carers'. Lessons were learnt, however it was not clear from the investigation reports how widely they were communicated.

Despite the lack of available training, we saw that the requirements of the Mental Capacity Act and Deprivation of Liberty Safeguards were met where its use was required. However we found inconsistencies in staff understanding of the application of the Mental Capacity Act.

Patients were supported, treated with respect and were involved in their care and treatment. Prior to the inspection, we were told that patients were not always involved with or have their care plans reviewed, however during the inspection the majority of patients told us they had been actively engaged in reviews of care. There was variation between services in Leeds and York, with Leeds services engaging patients, carers and or relatives more

Summary of findings

proactively. Staff had a good understanding of the different needs that patient's had on the basis of gender, race, religion, sexuality, ability or disability within services.

Patients could access the right care at the right time. Bed occupancy was marginally higher than that of the national average. The introduction of single point of access had improved response times to referrals. Patients did not have problems contacting services when they needed to.

In Leeds, we saw and heard that other organisations and the local community were involved in planning and delivering services to meet patients' needs.

A clear statement of vision and values had been developed through engagement with internal and external stakeholders including patients and governors. A strategy had been developed with clear objectives that were reviewed regularly. The board and the non-executive directors had the experience and capability to ensure that the strategy was delivered. Staff understood the vision and values but did not always understand how that related to them at a more local level.

We heard that not all of the managers and clinical leads in York had the necessary experience, knowledge, capacity or capability to lead effectively. As a result, the trust had recently moved a number of senior managers across from the services in Leeds to address some of the challenges that this had created.

Staff felt supported and valued. We saw that there was good collaboration between teams.

There had been the introduction of the Mental Health Act committee in the preceding 12 months. This meant that CQC Mental Health Act reports were reviewed by non executive board members and the board was made aware of any outstanding actions. Statistical information on the MHA was being monitored.

Summary of findings

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

We always ask the following five questions of the services.

Are services safe?

Requires Improvement

There was an increased risk that patients may be harmed. Bootham Park Hospital, despite significant work having been taken around ligature points and further work planned is not fit for purpose. The hospital was built in 1777 and is a Grade 1 listed building. It is owned by NHS Property Services.

Staff did not always identify safety concerns about ligature points quickly enough. We identified ligature points across the Leeds inpatient areas that were not all recorded on the trust risk register. We found that the furniture in the health based place of safety in Leeds was not fixed to the floor. Medicines management was safe; however we found that the use of patient group directions was unlawful in the crisis assessment service in Leeds. The trust suspended their use before the end of the inspection.

Some of the other wards were located in old buildings but, in general, they were clean and reasonably well maintained. Ward 40, the Yorkshire centre for psychological medicine, based at the Leeds General Infirmary was the exception as it was poorly decorated and maintained.

The trust had systems in place to report and monitor incidents. The trusts risk management team collated all incident form information which was reviewed to identify potential learning and improvements. Staff told us they reviewed incidents as part of the ward meetings and we saw that patients and carers were involved where appropriate in the reviews.

Risks to patients were assessed, managed and reviewed at regular intervals. Where a risk to patients had been identified, individualised plans had been put in place to reduce or manage the risk.

There were clear safeguarding policies and procedures. Staff had received training at the required level for their roles and areas of responsibility.

The trust did not fully comply with same sex accommodation guidance. Three out of the five rehabilitation wards were mixed sex accommodation but only two complied with the requirements. We also identified concerns in the older people's services. These were all services located in York. This meant that patient's sexual safety could be compromised.

Staffing levels were usually maintained at the level set by the trust. The trust was maintaining safe staffing levels in inpatient services

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and where needed was using temporary staff. The trust was actively recruiting staff to vacant posts. The expected qualified nursing staffing levels at Field View were not maintained on the week of our inspection.

There was limited medical cover throughout the rehabilitation and recovery service (out of hours), ward 2 at The Newsam Centre and in the older people's services in York.That meant that in an emergency situation it could be difficult to access medical assistance.

Are services effective?

Requires Improvement

Patients' care and treatment was planned and delivered in line with evidence based practice. This was monitored through local audits and up to the board through the quality committee.

Patients had comprehensive assessments of their needs in place and care plans detailed specific interventions to reduce or prevent the risk of relapse. Across all services, physical health assessment took place. We saw that with the exception of some of the rehabilitation wards, physical healthcare needs were clearly documented and managed through care plans.

The trust participated in some national clinical audits and ran local audits. The trust participated in external peer review and service accreditation. However the trust had only recently begun to take part in national benchmarking.

Activities were available across the inpatient areas. We particularly noted that at the Newsam Centre on ward 2 (female) activities were extensive in range and scope and were available in the evenings and weekends. We identified that planned activities could not always take place in the forensic areas when staffing levels were affected by short term absence.

Overall, the wards had the full range of input by mental health disciplines including occupational therapists, social workers, dieticians, pharmacists, psychologists, physiotherapists and speech and language therapists.

The trust had identified that compulsory training and appraisals were not taking place consistently across services. In some areas we could see there was good uptake of appraisal and compulsory training whist in others the numbers remained lower that the trust target. This was recorded on the trust risk register and reviewed on a monthly basis by the board. The trust had developed an action plan. There was poor uptake of specialist training in York for older peoples services; there was training in both Leeds and York but staff in York identified that training was always in Leeds and was not accessible.

Summary of findings

Across most teams, there was regular and effective multi –disciplinary team working and meetings. There were effective handovers of care and good working relationships with other agencies including the local authority, police and third sector providers.

Patients who were detained under the Mental Health Act (MHA) had the appropriate documentation in place for consenting to their treatment for mental disorder including medicines. Overall across the inpatient wards, most aspects of the MHA and MHA Code of Practice were adhered to including completion of section 17 leave forms. There were some discrepancies which we highlighted to ward staff. We found mail being withheld for one patient contrary to the rules in the Mental Health Act and their human rights within the forensic service.

Mental Health Act training was not identified as compulsory training by the trust. We were informed that MHA training was known as priority training and the trust did not report or calculate the level of compliance with this training. We have concluded that staff were not in receipt of regular MHA training. In addition it was clear that the trust did not monitor which staff had undertaken MHA training and could not be assured that the relevant staff had up to date knowledge regarding mental health act legislation.

We found that the majority of staff had not received training regarding the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) as this was not part of the compulsory training. However in most cases when we reviewed the application of the MCA and DoLS, they appeared to be completed in line with current best practice.

Are services caring?

Good

Before our inspection, patients and people who used services told us that most staff treated them with kindness, dignity and respect.

Throughout the inspection we saw examples of staff treating patients with kindness, dignity and compassion. Patients commented favourably on the quality of care and support they received.

Staff had a good understanding of the different needs that patient's had on the basis of gender, race, religion, sexuality, ability or disability within services.

The majority of patients we spoke with told us they had been involved in reviews about their care.

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We saw that there was variation between the services in York and Leeds, with Leeds services involving patients and their carers or relatives much more proactively.

Carers told us they had mixed experiences of being involved and being able to provide support to people using services

We saw examples of outstanding involvement initiatives in some of the low secure services, especially within the low secure ward for women with personality disorder in York. An advocacy service was available across all services and steps had been taken to ensure all patients were made aware of this service and how it could be contacted.

Are services responsive to people's needs?

Requires Improvement

Information about how to make a complaint or how to raise concerns was not always displayed across the wards or in public areas. Local resolution of complaints took place on most wards. The wards did not have a consistent approach for recording the number, type and outcome of complaints that were considered at local resolution stage. This meant that the trust were not clear as to the number and type of complaints received and how many were being upheld or not upheld at a local level. Corporately the trust was not meeting its own policies and procedures in terms of timeframes for responding to complaints and we saw that there was a backlog of complaints. The trust confirmed that a high number of complainants were not satisfied with the responses given as part of the initial response to the complaint. There was no training provided to staff handling complaints that had not been resolved locally.

Across the trust, over the six months prior to our inspection, bed occupancy exceeded 90% on 17 out of 39 wards/locations. Despite this, patients were nearly always admitted to the ward or hospital that looked after the area in which they lived.

Patients could readily access services and since the introduction of the single point of access 12 months ago, referral times had improved. Staff and patients told us when a patient went on leave, a bed was always available on their return.

There was evidence of delayed discharge at Bootham Park Hospital but the recent introduction of bed managers had reduced the incidence of delayed discharges and out of area bed usage but it was too soon to see sustained levels. In the older people's services, there were a number of delayed discharges. There was no active discharge planning by the wards and some patients did not have identified care co-ordinators. We were told and saw that there was a

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difficulty in finding placements for patients in the community. As part of their role, bed managers liaised with the local authority to find suitable placements and plan for patients discharge from hospital.

The development of the section 136 suites in Leeds and York had significantly reduced the numbers of people being assessed in police cells and had been strongly welcomed by the police.

At Bootham Park Hospital, we found patient therapy/ activity groups were being delivered in patient corridors and lounges as specific rooms were not available on the wards. A quiet room was available although this was also used for patient reviews when required. At other locations, we found there was a full range of rooms to support treatment and care.

The trust did not fully comply with same sex accommodation guidance. We saw that in the older people's services, patients sometimes walked into the wrong gender toilet/bathroom and were not always redirected by staff or observed by staff.

We observed good use of easy read signage or information displayed on the wards. Information was available on advocacy services for patients to access help and support. Interpreters were available throughout the trust and care documentation or leaflets could be translated into a range of different languages so that patients, family members or carers could understand what care and treatment was being provided. Staff were sensitive in responding to and meeting the cultural needs of patients.

Are services well-led?

Requires Improvement

The trust had a clear vision and strategy. We found there was a disconnect in some of the ward and community teams we visited in relation to how the trust visions and values linked into those at local level. This was particularly apparent within wards and teams which were geographically isolated or, 'stand-alone' services.

Staff were aware of who the chief executive officer and director of nursing and governance were but not who the other members of the leadership team at board level were. Many staff told us the senior management and executive members were not visible at the remote locations where rehabilitation, learning disability and older people's services were based.

The trust had developed its governance structure over the last 18 months. Staff informed us during interviews and focus groups that

the governance structures were now embedded at senior management level and above. However below this level, the trust were still developing the governance structures and supporting staff to take ownership and engage in the approach being taken.

In most clinical environments and teams, managers had regular meetings where lessons from complaints, incidents, audits and quality improvement projects were discussed. However the agenda was not consistent across wards and it was not clear how these meetings fed into the three care group governance meetings.

There were differences in the leadership and culture of services in York compared to the services in Leeds. Senior staff told us and we saw reflected in minutes of meetings up to board level, that there had been a lack of effective leadership and governance in the York services. Senior members of the Trust Board recognised that they could have managed this more effectively when they first acquired the York services. Leadership, management and governance has now been strengthened across the York services.

The trust was introducing quality dashboards for teams which included information regarding other quality indicators such as staff sickness rates, mandatory training compliance and appraisals. However this had not been embedded in all the teams we visited.

Across the trust, staff were positive about their experiences of working in the service. They reported that they felt confident in and supported by their colleagues and managers. We were told by staff that the uncertainty of the forthcoming re-tendering process for the services to a new provider by the Vale of York CCG, had affected staff morale.

Staff were aware of and engaged in a number of initiatives and felt the trust were moving in the 'right direction' in relation to engaging and listening to staff.

There were opportunities for patient engagement including the service user network and locally based groups. Carers we spoke with had mixed experiences of their ability to engage with the trust.

The commissioners of health care services reported differences in the way they felt the trust responded to them. Leeds based commissioners told us they had a positive working relationship with the trust. They provided examples of how the trust had been innovative in the planning and delivery of services and reported they were open and transparent in their dealings with them. The York based commissioners told us that they had a poor relationship with the trust. They felt services had deteriorated over the last two years.

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They identified that the trust had not been open in their dealings with them and had not included other local stakeholders including the local authority in discussions about service planning and delivery.

During and subsequent to the inspection, the trust informed us and submitted copies of letters from June 2014 where they outlined their concerns relating to quality and the relationship with the clinical commissioning group.

The trust aims to deliver better care over the next five years. They planned to achieve this through three transformational programmes which will be delivered in collaboration with patients, carers, voluntary sector partners and health and social care partners.

The trust participated in a number of external peer review and service accreditation schemes.

They reward and recognise achievements by staff either individually or as a team.

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 Inspection (Hospitals –Mental Health) Care Quality Commission

The team included CQC inspectors and a variety of specialists: consultant psychiatrists, consultant nurses, nurses, mental health social workers, occupational therapists, MHA reviewers, experts by experience who had personal experience of using or caring for someone who uses the type of services we were inspecting, student nurses, psychologists, advocates, junior doctors, senior managers and specialist registrars.

Why we carried out this inspection

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

How we carried out this inspection

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?

Before visiting, we reviewed a range of information we hold about the trust and asked other organisations to share what they knew. We held a public listening event in York and one in Leeds, as well as listening events at each main hospital location for detained patients. We also arranged focus groups in both York and Leeds prior to the inspection, facilitated by voluntary organisations. We carried out announced visits to all core services on 30 September and 1 and 2 October 2014. We carried out a short notice visit to the learning disability community team on the 15 October and an unannounced visit to Peppermill Court on 16 October 2014.

During the visit we held focus groups with a range of staff who worked within the service, such as nurses, doctors, psychologists, allied health professionals, and administrative staff. We met with representatives from other organisations including commissioners of health services and local authority personnel. We met with 173 people who use services who shared their views and experiences of the core services we visited. We observed how patients were being cared for and talked with carers and/or family members and reviewed care or treatment records of 95 patients who use services. We looked at a range of records including clinical and management records.

Information about the provider

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

Leeds and York Partnership NHS Foundation Trust provides specialist mental health and learning disability services to people within Leeds, York, Selby, Tadcaster, Easingwold and parts of North Yorkshire.

It provides the following core services:

Mental health wards:

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- Acute wards for adults of working age and psychiatric intensive care units.
- Long stay/rehabilitation mental health wards for working age adults.
- Forensic inpatient/secure wards.
- Child and adolescent mental health wards.
- Wards for older people with mental health problems.
- Wards for people with learning disabilities or autism.

Community-based mental health and crisis response services:

- Integrated community-based mental health services for adults of working age and older people.
- Mental health crisis services and health-based places of safety.
- Specialist community mental health services for children and young people.
- Community mental health services for people with learning disabilities or autism.

In addition the trust also provides eating disorder services, perinatal services, IAPT (Improving access to psychological therapies), gender identity services, psychology and psychotherapy services and community substance misuse services.

The trust has a total of twenty-four active locations serving mental health needs registered with CQC:

Trust Headquarters, The Becklin Centre, The Newsam Centre, The Mount, St Mary's Hospital, Asket House, Millside, Ward 40 - Leeds General Infirmary, Parkside Lodge, Asket Croft, Worsley Court community unit for the elderly, Cherry Tree House elderly assessment unit, Towngate House, Acomb Garth, Acomb Learning Disability Units, Bootham Park Hospital, Clifton House, Elmfield Terrace Residential Home, Field View, Lime Trees child, adolescent and family unit, Meadowfields Community Unit, Mill Lodge Community Unit for the Elderly, Peppermill Court Community Unit for the Elderly, and White Horse View. However during the inspection, senior staff informed us that both Cherry Trees House Elderly Assessment Unit and Elmfield Terrace

Residential Home were both closed to in-patients and community services. Mill Lodge Community Unit for the elderly was also closed as it was being refurbished to provide the new child and adolescent inpatient services.

The trust serves a combined population of 1,547,912, from Leeds, York and North Yorkshire. The trust told us that they help 30, 304 service users per year. They have an annual turnover of £180 million and employ 3,270 staff. As a foundation trust, they have 17,700 members.

The Care Quality Commission has inspected Leeds and York Partnership NHS Foundation Trust on 19 occasions. The 19 inspections covered 12 locations. The most recent inspection took place on 16 January 2014 at the Newsam Centre, The Mount, and St Mary's Hospital. These locations were found to be compliant with the Health and Social Care Act regulations.

We issued compliance actions (this is when there is a breach of Health and Social Care Act regulations) at Bootham Park Hospital, Lime Trees child, adolescent and family unit and Trust Headquarters during inspections in December 2013. The compliance actions related to assessing and monitoring the quality of service provision, records and the safety and suitability of premises of specifically Bootham Park Hospital and Lime Trees children's and adolescent in patient unit. The trust took positive steps to address these areas of concern, but in relation to the premises some of this was outside their span of control.

What people who use the provider's services say

We spoke with 173 patients during our inspection. The majority of the patients we spoke with were happy with the quality of the care and treatment they were receiving and with the approach of the staff. They told us that they felt involved in decisions about their care. We include their comments in the core service reports.

Community Mental Health Patient Experience survey

The CQC Community Mental Health survey is sent to people who received community mental health services from the trust. This survey was conducted to find out about the experiences of people who receive care and treatment. Those who were eligible for the survey were receiving specialist care or treatment for a mental health condition, aged 18 and above and had been seen by the trust between 1 July 2012 and 30 September 2012. There

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were a total of 250 responses, which was a response rate of 31%. 50% of respondents to the 2013 survey stated that in the preceding 12 months they had not had a care review meeting to discuss their care.

Community Focus Groups

Before the inspection, we held two hosted focus groups; one in Leeds hosted by Volition and one in York hosted by the Richmond Fellowship. We did this so that people who use, or have used, the services provided by the trust, could share their experiences of care. The groups provided a wide range of responses to the five questions we always ask about services.

At the Leeds group hosted by Volition, most participants highlighted excellent care and support from Leeds and York Partnership Foundation Trust staff.

People were concerned about their experiences at A&E, and the interface with Leeds and York Partnership NHS Foundation Trust services. Concerns were also raised around accessing support from the crisis team, who were seen as the gatekeepers for the single point of access to Leeds and York Partnership NHS Foundation Trust services.

Where people returned to services following a period of not using them, the process of returning was rarely simple or streamlined; people often felt like they were starting all over again. Information and communication were key issues: information for people who were new to mental health services; information about other services and support systems. Where communication about treatment between Leeds and York Partnership NHS Foundation Trust and the person using services had been open and effective, this was appreciated and valued highly.

People were wary of making a complaint of any kind, as there was a feeling it would affect care in some way and there was a lack of confidence that the trust would respond effectively to a complaint.

People had noticed and been affected by recent changes at Leeds and York Partnership NHS Foundation Trust and were concerned about further reductions in funding and what this would mean for services in the future.

At the focus group in York, most participants felt that the services were not safe and that people do not take them seriously. Of specific concern was the lack of understanding of staff at the A&E department where most people go in a crisis.

Most people told us that their care was effective, but only because of their GPs. They found that if they had a good GP it meant that their care was better and they had to rely less on community teams. Some people felt that their care and treatment had been effective.

Most people told us that they found services were not caring. People told us that it all depended on the person who was looking after you; there was no consistency in staffing and the way they treated people. In particular carers found staff to be uncaring and not responsive to their needs as carers.

Some but not all of the people at the meeting did feel that the trust was responsive to their needs as patients or people using services.

People did not feel the services in York were well led. They didn't know who the senior people were in the trust. They felt that CMHT's were particularly not well led.

Patient Opinion

Patient Opinion and NHS Choices offer people who use services a forum for honest and meaningful conversations between patients and providers. Taking into account duplicate entries across both Patient Opinion and NHS Choices websites, 54% of comments were wholly or largely negative, 43% were wholly or largely positive and 2% contained a roughly equal mix of both positive and negative. Issues highlighted include a lack of appropriate support, waiting times for urgent appointments, staff attitude and poor communication between staff and patients.

Comment cards

Before the inspection, we left comment cards in various places throughout the trust for people to write their comments down about their experiences of the trust services. People posted their comments in sealed boxes which we opened and looked at as part of the inspection.

- 59 comment card boxes were received from the trust
- 23% (42) of the boxes contained comment cards equalling 178 cards.

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- 9% (17) of them contained no cards at all.
- Of the 178 comments received 21% (38) had not been completed/written on – were blank.
- Top five ranking sites which had the most returned cards were;
  - Newsam Centre 24% (44) – 15 positive, 3 negative & 23 blank
  - The Mount 15% (27) – 21 positive, 1 negative & 5 mixed
  - Becklin Centre 10% (18) – 2 positive, 6 negative, 3 mixed and 7 blank.
  - Bootham Park 10% (8) – 7 positive, 10 negative & 1 blank.
  - St Mary's Hospital 7% (14) – 11 positive and 3 blank.
- Of the 178 cards received back 44% (80) were positive, 16% (30) were negative and 16% (30) cards contained negative and positive elements.

Top three positive comments

- 51% (41) were positive comments about staff (caring, helpful, listened to, respect & dignity, made to feel welcome, understanding, 1st class care)
- 36% (29) were positive comments about the services that the trust provided to patients.
- 6% (5) were positive comments about the environment (relaxing, clean, bright, spacious, stained glass windows, mature gardens, therapeutic & safe).

However

- 50% (41) were negative comments about staff (lack of respect & dignity, staff attitudes & behaviours, changing the rules to suit, don't listen, lack of care & compassion).
- 10% (3) were negative comments about the facilities (dirty wards, lack of fresh air, bedding too hard, lack of en-suite facilities, no Wi-Fi and building).
- 6. % (2) were negative comments about the lack of activities.

Good practice

- The individualised tailored processes for admission for women with personality disorder onto Rose ward at Clifton House effectively supported patients safely during change and transition.
- The extent of meaningful patient involvement for women with personality disorder on Rose ward at Clifton House to participate in their individual care as partners and to be involved in the running of the ward.
- The range and scope of meaningful and extensive patient activities at the Newsam Centre on Ward 2 (female).
- 2 Woodland Square provided an excellent short term care service and we were impressed with their dedication and skill.
- Parkside Lodge had been innovative in developing their patient daily activity plans.
- The eating disorder service in Leeds had developed a research framework specific to their service, which made sure that staff were involved in the development of research based practice and had a programme to better learn and understand issues specific to people with eating disorders.
- The eating disorder service in Leeds undertook exit interviews for patients leaving the service which underpinned the review of outcome measures which the service used to quality assure service delivery.
- The crisis assessment service in the Becklin Centre, Leeds operated a pilot scheme called the Street Triage Team (STT) which had reduced admissions into the 136 suite by 28% since its introduction in April 2014.
- The crisis assessment service in the Becklin Centre, Leeds worked closely with West Yorkshire Police and had provided joint training within the trust.
- In York, the CMHTs had developed excellent partnership working with York St John University through the, 'Converge' partnership. Converge provides support and access to courses specifically designed for people who use mental health services.
- The WNW community learning disability team had developed a bereavement package to use when working with patients.
- Both community learning disability teams had developed a training package for use with student nurses.

Summary of findings

- The supported living service includes people who use the service in all decision making processes. They recognise the value of people's involvement and review annually how they enable people to take part in a meaningful way. There is no limit on involving people because of their disability, capacity to fully understand what is being suggested or asked of them. However, staff trial different methods of communication such as the drumming, on person has special equipment on their computer, others use pictures or Makaton.
- The child and adolescent inpatient ward in York provided mobile phones to young people. These phones did not have a camera facility on them, but allowed young people to put their own SIM cards in them. This meant young people were able to keep contact with friends and family whilst ensuring the privacy of others on the ward was being protected.
- The rehabilitation wards in Leeds 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.
- The NDCAMH service made good use of the technology which had been made available to them, so that the needs of children, young people and their parents who were deaf could be better met.
- Swipe cards were available at some hospital locations allowing free egress to informal patients, allowing them to leave the acute wards as they liked.
- Staff within the assertive outreach teams escorted patients to visit their general practitioner if required to ensure they received their annual health check.
- Staff met patients at a community based dementia café as a social event to enable patients to access a nurse in a more informal, less stressful environment.
- At Linden House, the team had established a specialist training link with Leeds bereavement forum specifically in relation to dementia.

Areas for improvement

Action the provider MUST or SHOULD take to improve

Action the provider MUST take to improve

- The trust must ensure that their facilities and premises are appropriate for the services being delivered at Bootham Park Hospital and Yorkshire centre for psychological medicine.
- At Peppermill Court, Worsley Court, Meadowfields and ward 6 at Bootham Park hospital the provider must ensure there are sufficient skilled staff at all times to meet the treatment and care needs of patients.
- The provider must ensure it adheres to the guidelines for mixed sex wards under the MHA Code of Practice at Meadowfields, Worsley Court, ward 6 at Bootham Park hospital and Acomb Gables.
- At Worsley Court the trust must ensure that there no delays to the administration of patients medication.
- The provider must ensure that there is sufficient nursing cover and sufficiently trained and supported staff at Field View whilst this location continues to care and treat detained and restricted patients and be registered for regulated activity 'Assessment and Treatment under the Mental Health Act', including ensuring staff have access to up-to date trust information and policies.
- The provider must ensure that comments and complaints are handled appropriately.
- The provider must ensure that the seating is appropriate at the health based place of safety at the Becklin Centre, Leeds, as this could potentially be used to cause injury.
- The provider must ensure that the ligature points (sink taps and door handles) in the bathroom at the health based place of safety at the Becklin Centre, Leeds are removed.
- The provider must ensure that the patient group directions (PGD) medication at the crisis assessment service – Becklin Centre, Leeds is reviewed and brought in line with the trust policy and legal requirements.
- The provider must ensure consent to care and treatment is obtained in line with legislation and guidance including the Mental Capacity Act 2005.

Summary of findings

- The provider must take action to ensure rehabilitation wards are both adequately and safely maintained.
- 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.
- The provider must take action to ensure children and young people who require inpatient care are cared for in an appropriate environment
- The provider must take action to ensure that all staff receive their mandatory training
- The provider must take steps to ensure all appropriate staff receive training in relation to the Mental Capacity Act and Mental Health Act
- The provider must take action to ensure that all medication charts, observation records and records of Gillick competency and mental capacity assessments are always fully documented.
- The provider must ensure that adequate medical cover is available, both within and out of working hours that meets the needs of the patients across the trust.
- The provider must ensure that the supported living service reports all safeguarding incidents to the national reporting and learning system (NRLS).

Action the provider SHOULD take to improve

- The provider should ensure care plans for patients subject to Community Treatment Orders (CTO's) provide sufficient details about the conditions relating to the CTO and ensure consent to treatment forms are regularly reviewed and reflect current medication prescribed to patients in CMHTs.
- At Peppermill Court, Meadowfields, Worsley Court, The Mount and Bootham Park Hospital ward 6 the provider should ensure the environment is reviewed to ensure staff have clear lines of sight throughout the wards to ensure patients safety.
- At Peppermill Court the trust should ensure that there are clear arrangements in place to provide patients with the appropriate physical health monitoring and treatment.
- At Peppermill Court, and Worsley Court staff should follow the trust policy in regards to the recording of restraint.
- At Peppermill Court, Meadowfields, Worsley Court, the trust should ensure they continue to implement the 'Quality improvement plan for the community unit elderly services (CUES)' and provide CQC with a monthly update of the progress.
- The provider should continue to address staff vacancy rates and sickness levels and improve the monitoring of its impact on patient care in low secure services by measuring care and treatment which has been cancelled or curtailed (leave of absence, one to one nursing sessions, activities, access to fresh air).
- The provider should address identified environmental issues including within the seclusion rooms and ensure that patients on Riverfields ward are afforded further dignity by improved screening into the bedrooms which overlook the staff and visitor car park.
- The provider should ensure that patients in low secure services have access to timely physical healthcare by ensuring patients are registered with a GP and, for patients at the Newsam Centre ensure that timely medical care is available.
- The provider should ensure that clinicians and staff within low secure services adhere to the MHA and MHA Code of Practice to ensure that:
  - staff are aware patient mail can only be withheld in very limited circumstances;
  - there is improved recording of consent and capacity to consent decisions for treatment for mental disorder;
- The provider should review the processes for checking emergency equipment at the crisis and access service – Bootham Park Hospital, York and the rehabilitation wards across the trust.
- The provider should review the provision of dedicated medical input into the services of the crisis and access service – Bootham Park Hospital, York.
- The provider should review the systems for informing people how to raise concerns and complaints at the crisis assessment service at the Becklin Centre, Leeds.
- The provider should ensure all unit staff are aware of where all resuscitation equipment and accessories are located on Lime Trees
- The provider should carry out a risk assessment in relation to the free standing wardrobes within young people's bedrooms on Lime Trees.

Summary of findings

- The provider should take steps to ensure that independent scrutiny of Mental Health Act documentation takes places in a timely manner at Lime Trees
- 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 Gables have a system in place to support 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 ensure that a robust system is in place for the monitoring of safety of food items in fridges across the trust.
- The provider should review systems at trust level for recording and monitoring training uptake.
- 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 and in public areas.
- The provider should review the information technology requirements of the NDCAMH service; this is because whilst the service was making good use of the technology they had been provided with, staff using the equipment said the systems could be slow and were not always cost effective for communicating using sign language.
- The provider should ensure effective monitoring arrangements are in place at Hawthorne ICST for people accessing the building.
- The provider should ensure that staff at Hawthorne ICST are using the personal alarm system provided.

Leeds and York Partnership NHS Foundation Trust

Detailed findings

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

There was an increased risk that people may be harmed. Bootham Park Hospital, despite significant work having been taken around ligature points and further work planned is not fit for purpose. The hospital was built in 1777 and is a Grade 1 listed building. It is owned by NHS Property Services.

Staff did not always identify safety concerns about ligature points quickly enough. We identified ligature points across the Leeds inpatient areas that were not all recorded on the trust risk register. We found that the furniture in the health based place of safety in Leeds was not fixed to the floor. Medicines management was safe; however we found that the use of patient group directions was unlawful in Leeds. The trust suspended their use before the end of the inspection.

Some of the other wards were located in old buildings but, in general, they were clean and reasonably well maintained with the exception of ward 40, the Yorkshire centre for psychological medicine, based at the Leeds General Infirmary.

The trust had systems in place to report and monitor incidents. The trusts risk management team collated all incident form information which was reviewed to identify potential learning and improvements. Staff told us they reviewed incidents as part of the ward meetings and we saw that patients and carers were involved where appropriate in the reviews.

Risks to patients were assessed, managed and reviewed at regular intervals. Where a risk to patients had been identified, individualised plans had been put in place to reduce or manage the risk.

Requires Improvement

Are services safe?

There were clear safeguarding policies and procedures. Staff had received training at the required level for their roles and areas of responsibility.

The trust did not fully comply with same sex accommodation guidance. Three out of the five rehabilitation wards were mixed sex accommodation but only two complied with the requirements. We also identified concerns in the older people's services. These were all services located in York. This meant that patient's sexual safety was potentially not always managed.

Staffing levels were usually maintained at the level set by the trust. The trust were maintaining safe staffing levels in inpatient services and where needed was using temporary staff. The trust was actively recruiting staff to vacant posts. The expected qualified nursing staffing levels at Field View were not maintained on the week of our inspection.

There was limited medical cover throughout the rehabilitation and recovery service (out of hours), ward 2 at The Newsam Centre and in the older people's services in York.That meant that in an emergency situation it could be difficult to access medical assistance.

Please refer to the 'Actions we have asked the provider to take' section of the report.

Our findings

Track record on safety

The Strategic Executive Information System (STEIS) records Serious Incidents and never events.

A never event is classified as such because they are so serious that they should never happen. Trusts have been required to report any never events through STEIS since April 2011.The trust had not reported any never events through STEIS.

Serious Incidents are those that require an investigation. A total of 27 serious incidents were reported by the trust via STEIS as having occurred between 1 April 2013 and 31 March 2014. These were spread across 5 location categories, with the largest proportion (59%) occurring in patients' homes.

The most common incident type for the trust was 'suspected suicide' which accounted for 44%. This was followed by 'unexpected death of community patient (in receipt of care)', which accounted for 22% of all incident types.

Overall, 26% of incidents related to unexpected deaths of patients (in and not in receipt of care) and 63% to suicides (actual, attempted or suspected).

Since 2004 trusts have been encouraged to report all patient safety incidents to the National Reporting and Learning System (NRLS) and since 2010, it has been mandatory for them to report all death or severe harm incidents to the Care Quality Commission (CQC) via the NRLS

There were 111 incidents reported by the trust to the NRLS between April 2013 and March 2014.

Below is a breakdown of the 111 incidents that were reported as having occurred between April 2013 and March 2014.

The trust told us just before the inspection that 11 of the incidents were removed by the NRLS as they were not patient safety incidents, so we report on 100 incidents.

Abuse

A minority (5%) of the 100 incidents were categorised as 'abuse'. All five 'abuse' incidents were categorised as 'physical'. More specifically, all related to 'disruptive, aggressive behaviour (includes patient-to-patient)'.

Death

There was a total of 22 deaths reported during the specified period, These can be broken down as 'other' (12) and self-harm (10).

Moderate harm

'Slips, Trips, Falls' accounted for 39% of all moderate harm incidents. 'Other' was the next highest at 26%. The largest proportion (68%) of incidents between April 2013 and March 2014 occurred within 'Inpatient areas'. The largest proportion (37%) of incidents occurred within the 'adult mental health' speciality.

An analysis of the number of incidents reported to the NRLS, against the number of incidents expected to occur at

Requires Improvement

Are services safe?

a trust, based on the number of bed days, can indicate any potential under-reporting. We found that the number of incidents reported by the trust was within expectations when compared with similar trusts.

During a previous inspection, we had identified a number of ligature risks within Bootham Park Hospital and Lime Trees child and adolescent inpatient unit. The trust developed a York anti ligature project group to review ligatures and develop action plans to mitigate these risks. The project group was responsible for ensuring and monitoring that all requested changes to the environment took place and escalated up to the trust wide risk registers where action could not be taken due to the Grade 1 listed status of Bootham Park hospital.

In relation to Lime Trees, the trust had worked with specialised commissioning and NHS England to identify a new unit where they could provide CAMHS services. Patients and carers were involved in the design of the new building and the CAMHS service will move to its new accommodation on the 15 December 2014. As mitigation of the risks, the trust had reduced the bed occupancy at Lime Trees and taken measures to reduce the risk of harm to children and young people using the service.

There were no concerns relating to the trust in the latest Schedule 5 Coroner's Rules report (October 2012 – March 2013).

Learning from incidents

The trust had systems in place to learn from incidents. The trust incident review group (TIRG) met monthly and had core representation from directors, senior managers and non-executive directors (NED's). We reviewed six months of minutes and it was evident that all serious untoward incidents (SUI) were reviewed, alongside any root cause analysis reports carried out that had not been reported as a SUI.

We reviewed seven SUI investigations as part of the inspection process. We saw that all the relevant people including staff and relatives/carers were given the opportunity to be included in the investigation process. During our review, we identified that in four reports, it was clear how recommendations and the reports were to be shared with the staff team, families and carers and external agencies. However, with only one exception, it was not clear how learning from incidents would be shared across the organisation.

Board summaries and minutes were also reviewed which confirmed board level review of serious incidents and lessons learned. The quality committee reviewed lessons learnt on a quarterly basis and reported by exception to the board.

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 send reports back to the ward managers. In Leeds the incident reporting was in a paper system. Learning from trust wide incidents was communicated to all staff by email from the communication team.

On the wards, staff told us that incidents were discussed in team meetings and changes were made to the care of patients in response. Minutes of team meetings confirmed this.

Safeguarding

The trust had systems in place to ensure safeguarding incidents were reported and investigated.

The trust had a safeguarding committee that reported to the board. We were informed that the trust had both an adults and children's safeguarding lead. There was a non-executive director (NED) who had recently been appointed as the safeguarding lead. Previously there was no lead at board level for safeguarding which we were told was an oversight. The NED informed us that he was unclear as to what training was in place for safeguarding and what their specific responsibilities were in relation to his role.

There were clear safeguarding policies and procedures in place that staff understood and were easily accessible on the trust intranet. Staff received training on safeguarding adults and children and at the required level of training for their role and responsibilities. At the time of our inspection 80% of staff had received safeguarding adults training and 81% had received training in safeguarding children. Staff were able to describe what actions would constitute abuse. They were able to apply this to patients and described in detail what actions they were required to take in response to any concerns. On all of the learning disability wards, a safeguarding flow chart from the trust described to staff how they would escalate and report any safeguarding concerns in relation to the patients on the wards.

Requires Improvement

Are services safe?

The Care Quality Commission had not been notified of 10 safeguarding incidents that took place within the supported living services. However the impact to people using the service was negligible as appropriate local safeguarding policies and protocols were enacted.

Assessing and monitoring safety and risk

The trust had a board assurance framework (BAF) in place and a strategic risk register and action plan. The strategic risk register and action plan detailed the responsible owner and the timescales for completion. The risks on the strategic risk register were placed into the BAF.

We saw evidence that the BAF had been presented for review to the executive team, the board and audit committee in March 2014 and was next due to be presented in September 2014. This meant that the trust board was regularly assessing and monitoring the BAF and the audit committee were reviewing the adequacy of assurance processes and the effectiveness of the management of principal risks and gaps.

In a focus group for service leads, we were told that there were local risk registers that feed into the corporate risk register. They were clear that they had the authority to put risks on to the trust register and discuss the issues at a locality level and record how they managed the risks.

The trust also had an estates strategic risk register in place which identified all of the estate risks related purely to the York services.

During a previous inspection, we had identified a number of ligature risks within locations in York. The trust developed a York anti ligature project group to review ligatures and develop action plans to mitigate these risks. The project group was responsible for ensuring and monitoring that all requested changes to the environment took place. Where action couldn't be taken, this was escalated to the trust risk register.

Bootham Park Hospital is owned by NHS Property Services and due to its Grade 1 listed status, English Heritage need to be consulted prior to and agree any modifications or changes within the building. Whilst we could see that significant work had been undertaken, the inspection teams that visited Bootham Park Hospital were concerned that it was not fit for purpose.

Historically there has been a significant lack of investment in mental health services in York. We were told and we saw that there are some plans to make some internal changes to the building in early 2015, but that these are seen by the trust as a temporary measure, until new purpose built psychiatric services can be developed.

We saw minutes of meetings and letters that identified how the trust had tried to work with commissioners, NHS Property Services and English Heritage to move things forward and reduce the risks to patients using the inpatient facilities at Bootham Park.

The trust had reliable systems in place to prevent and protect people from a healthcare-associated infection. There was a policy and associated procedures in place and we saw evidence that minutes of the infection control committee went to the health and safety committee quarterly. We were told that the trust's infection prevention and control nurse completed an audit on an annual basis and we saw evidence on the wards of these audits taking place. We also saw on wards that cleaning schedules were in place to support routine cleaning on a daily and ad hoc basis. However we found that only 67% of acute admissions staff were up to date with their infection control training in September 2014. We observed that the majority of wards were clean. However some wards were bare and in need of decoration.

The trust had structures in place to ensure that all risks were recorded and categorised. We saw evidence that all wards and clinical environments undertook regular environmental risk assessments particularly in relation to ligature risks. In the York services, there was evidence

to show that ligature risks for patients were being managed, this included increased or enhanced observations of patients where a risk had been identified. However our inspectors identified ligature concerns across a number of core services including adult admission wards, eating disorders and older people's inpatient wards. These were at the Leeds services. These risks had not been identified through the risk assessment process or escalated onto the wards risk registers. This meant that some systems were in place to protect people from the risk posed by ligatures however not all potential risks had been eliminated from the environment.

At the health based place of safety in Leeds, there was nowhere for people to rest or sleep. The furniture in the room was not fixed to the floor and did not meet national

guidance. This had not been identified in the trust's risk register. We identified unsafe practice in medicines management and emergency equipment at the crisis and assessment service at the Becklin Centre.

Medicines management was overseen by the medicines optimisation group (MOG), which was chaired by the chief pharmacist. The MOG reported to the medical director (MD) and via the MD to the board. The MOG included members from North Leeds clinical commissioning group (CCG) and primary care services in York to promote integrated care.

The trust assessed its performance in regard to medicines management and governance, using the Trust Development Authority tool, in 2013. The conclusion was that medicines were used safely and effectively. A prescribing competency assessment for clinicians was being developed and was due to be presented to the consultants' committee in November 2014. Guidelines for the documentation of medication in case notes had been produced for doctors because poor communication and documentation about medicines was identified as a significant contributory factor to medicine errors.

The trust did not have effective arrangements for the review and management of patient group directions (PGDs). PGD's are signed by a doctor and agreed by a pharmacist and can act as a direction to a nurse to supply and/or administer prescription-only medicines (POMs) to patients using their own assessment of the patients.

We found that the operation of PGDs in the crisis and assessment service in Leeds was unlawful because the required members of the executive team had not signed them. Nurses using PGDs to administer urgent medicines without a prescription were not named in the PGD and had not received the necessary training and assessment. This meant that medicines had been administered illegally on some occasions. The use of PGDs was suspended by the trust before the end of the inspection.

Overall, we saw that staffing levels were safe. Staffing levels were usually maintained at the level set by the trust. The exception to this was Field View, a step down rehabilitation facility from forensic services. There was a community houses' policy dated May 2010 for review March 2015 which identified the staffing requirements at Field View and another community house. The policy stated that three qualified staff would work across the two community houses. This meant that there should always be a qualified member of staff in each house. However we found that Field View did not always have a qualified nurse on duty and our review of rotas identified that this had happened on three occasions during the week of our inspection. This meant that at times, those patients who were detained under the Mental Health Act, were not always supported by appropriately qualified and skilled staff.

There was limited medical cover throughout the rehabilitation and recovery service, ward 2 at The Newsam Centre and the older people's services. That meant that in an emergency situation it could be difficult to access medical assistance. There was no dedicated medical input into the crisis and access service at Bootham Park Hospital, York.

The trust had contracts in place to facilitate agency staff when staffing levels were below the required numbers. We requested copies of the contracts so that we could see that the trust were assured that agency staff were appropriately trained in line with the trust requirements for physical interventions, medication management and other compulsory training. These contracts were not made available and we were not informed how the trust assured staff that agency staff had received the appropriate training before commencing a period of duty. Subseqent to the inspection, the trust did submit copies of these contracts. They identified how the trust would be assured that agency staff had received the correct training before starting work.

Forty three incidents of seclusion and long term segregation were reported between November 2013 and July 2014. Our review of data identified that there were no incidents of long term segregation in this time period. Parkside Lodge had the highest use of seclusion, with 21 episodes reported, 17 of those incidents occurred between June and July 2014 and related to one patient.

The trust recorded 824 incidents of restraint between November 2013 and July 2014. Restraint occurred within 20 inpatient wards, units and teams across 11 locations.

Of the 824 incidents, 116 people were restrained using the prone position (face down) and patients were restrained in a prone position in 16 wards across 7 locations. Thirteen of the prone restraints resulted in the use of rapid tranquilisation.

Requires Improvement

Are services safe?

We saw, during our inspection, that the use of rapid tranquilisation followed NICE guidance. Rapid tranquilisation was rarely used on the wards. Staff completed an incident form if rapid tranquilisation was used.

New guidance published by the Department of Health in April 2014 called "Positive and Safe" included new guidance on the use of face down restraint which aims to ensure it is only used as a last resort. As a result the trust had restructured their physical interventions training to make sure that supine restraint is seen as the lead 'high level' response when undertaking physical interventions.

We were told that staff were not yet sufficiently trained or confident in using supine restraint and the trust would have concerns in regards to removing prone restraint from training immediately.

We saw a copy of a trust board paper that identified the use of physical interventions within the trust and included recommendations to work towards reducing the number of restraints and ensuring that there was an open and honest culture for reporting all restraint including 'prone restraint'. We saw that progress was monitored through the effective care committee meeting and minutes from that meeting fed into the quality committee.

Potential risks

Emergency equipment, including automated external defibrillators and oxygen, was in place in clinical areas. Staff checked the emergency equipment in line with the trust policy to ensure it was fit for purpose and could be used effectively in an emergency. Staff were trained in its use.

Systems were in place to maintain staff safety. The trust had good lone working policies and arrangements. We saw this was not consistently applied within the mainstream CAMHS community service.

The trust had not adhered to national guidance on same sex accommodation (SSA). This related to ward 6 at Bootham Park Hospital, Meadowfield CUE, Worsley Court and Acomb Gables. The trust was therefore not promoting physical and sexual safety through the elimination of mixed sex accommodation as recommended in the Mental Health Act Code of Practice. However, the trust had plans to move ward 6 to a purpose built facility which would meet SSA requirements.

Staff sickness rates have been about the same as the national average for the last two years.

The quality committee minutes noted that the trust had identified the a correlation between incidents on wards and sickness absences. There were found to be more incidents on 62% more days when regular staff were sick. This meant that patients and staff were potentially at risk when regular staff were off sick.

We saw that in older peoples and learning disability wards, there were problems with recruitment of staff and some wards were short staffed. This was being mitigated with the use of bank staff.

Requires Improvement

Are services effective?

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

Summary of findings

Patients care and treatment was planned and delivered in line with evidence based practice. This was monitored through local audits and up to the board through the quality committee.

Patients had comprehensive assessments of their needs in place and care plans detailed specific interventions to prevent a relapse. Across all services, physical health assessment took place. We saw that with the exception of some of the rehabilitation wards, physical healthcare needs were clearly documented and managed through care plans.

The trust participated in some national clinical audits and ran local audits. The trust participated in external peer review and service accreditation. However the trust had only recently begun to take part in national benchmarking.

Activities were available across the inpatient areas. We particularly noted that at the Newsam Centre on ward 2 (female) activities were extensive in range and scope and were available in the evenings and weekends. We identified that planned activities could not always take place in the forensic areas when staffing levels were affected by short term absence.

Overall, the wards had the full range of input by mental health disciplines including occupational therapists, social workers, dieticians, pharmacists, psychologists, physiotherapists and speech and language therapists.

The trust had identified that compulsory training and appraisals were not taking place and we saw that this was recorded on the trust risk register and reviewed on a monthly basis by the board. The trust had developed an action plan. However there was variation in uptake of training across the trust. In some areas we could see there was good uptake of appraisal and compulsory training whist in others the numbers remained lower that the trust target. There was poor uptake of specialist training in York for older peoples services; there was training in both Leeds and York but staff in York identified that training was always in Leeds and was not accessible.

Across most teams, there was regular and effective multi –disciplinary working and meetings. There were effective handovers of care and good working relationships with other agencies including the local authority, police and third sector providers.

Patients who were detained under the Mental Health Act (MHA) had the appropriate documentation in place for consenting to their treatment for mental disorder including medicines. Overall across the inpatient wards, most aspects of the MHA and MHA Code of Practice were adhered to including completion of section 17 leave forms. There were some discrepancies which we highlighted to ward staff. We found mail being withheld for one patient contrary to the rules in the Mental Health Act and their human rights within the forensic service.

Mental Health Act training did not appear to be offered through the trusts' compulsory training. We were informed that MHA training is known as priority training and the trust do not report or calculate the level of compliance with this training. We have concluded that staff were not in receipt of regular MHA training. In addition it was clear that the trust do not monitor which staff have undertaken MHA training and cannot be assured that the relevant staff had up to date knowledge regarding mental health act legislation.

We found that the majority of staff had not received training regarding the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) as this was not part of the compulsory training. However in most cases when we reviewed the application of the MCA and DoLS they appeared to be completed in line with current best practice.

Please refer to the 'Actions we have asked the provider to take' section of the report.

Requires Improvement

Are services effective?

Our findings

Assessment and delivery of care and treatment

The trust had an effective clinical audit strategy in place which was monitored by the quality committee, and fed into the trust board. The trust participated in national audit and had CQUIN targets for the upcoming year. Local audit programmes were in place that were linked to local NICE compliance, local risk, complaints and trends identified through incident reporting.

We found all wards assessed the needs of each patient before they were admitted. Care plans provided specific details of interventions, which should be put in place if the patient's mental health deteriorated, to prevent a relapse of their illness. Staff undertook a risk assessment of every patient on admission. This was to ensure that patient need could be safely met on the ward and that the level of security was consistent with the level of risk the individual posed.

Across most services, physical healthcare assessments took place. Clear assessment and physical health check was undertaken on arrival to both health based places of safety and any ongoing physical health problems were followed up appropriately. We could not see evidence of patient's physical health needs being managed within the care plan documentation on some of the rehabilitation wards.

We saw evidence that care plans were developed with patients to meet their identified needs under the framework of the Care Programme Approach (CPA). This is a particular way of assessing, planning and reviewing someone's mental health care needs. The care plans we looked at were centred on the needs of the individual patient and demonstrated a knowledge of current, evidence based practice. In the services we inspected, most teams were using evidence based models of treatment. Staff provided care to people based on national guidance, such as National Institute for Health and Care Excellence (NICE) guidelines and were aware of recent changes in guidance.

The majority of patients we spoke with both within the focus groups and during our visit to the teams told us they had been involved in developing their care plans with staff.

In the integrated community based services, all the teams worked in line with the principles of the recovery model. This was evidenced by the teams' focus on supporting patients to remain within the community and facilitating the early discharge of patients from hospital.

In the rehabilitation services there was a lack of sufficient information in some of the care plans we looked at to inform staff of the care needs of patients. This meant that staff could be providing care to patients which was not meeting their specific needs.

The trust's percentage of falls amongst mental health ward patients (over 70s) had fluctuated widely. It was above the England average in February 2014 with a rate of 3.7 compared to the national average of 1.3. However; the comparison of percentages is not statistically significant due to small sample sizes (fewer than 100 people), meaning a single fall may put the trust over the England average.

Each month the trust recorded the number of harmful falls within a three day period on their older people mental health wards. In the older people's wards, assessments were routinely carried out in relation to falls on admission. Worsley Court was an exception and we saw that there were gaps in the risk assessments. We also noted that although the initial falls assessment was completed on admission, management plans were not always in place at Bootham Park Hospital.

Outcomes for people using services

The trust had recently introduced a new performance dashboard to monitor performance across the organisation. This had a number of indicators to monitor outcome performance. At the time of the inspection it was in the process of developing its information system to provide more robust data on individual team performance.

The trust had recently started to take part in national benchmarking. We saw that this had been discussed at the quality committee in June 2014 and a report had been developed to share across the trust.

The trust also participated in some national clinical audits including the National Audit of Schizophrenia in 2013/14, the National audit of Psychological Therapies and the Prescribing Observatory for Mental Health (POHM-UK). POHM–UK run national audit-based quality improvement programmes open to all specialist mental health services in

the UK. The aim is to help mental health services improve prescribing practice in discrete areas. The trust undertook two audits in 2012/13, monitoring of patients prescribed lithium and the prescribing anti-dementia dugs national audit.

The trust also ran a number of local audits, some ongoing and others to look at specific issues.

In response to a POMH audit that was undertaken to examine the physical health monitoring of patients on high dose antipsychotics in the community, the trust identified that electrocardiographs (ECG's) were not routinely undertaken in line with national guidance. A review of the medicines optimisation group (MOG) minutes showed an action plan was implemented, which included the provision of ECG machines in all community team bases and training for staff.

The eating disorder service had developed research based practice on body awareness therapy (BAT) and were using this as a treatment programme in the unit. It also used a number of specialist outcome measures to ensure that its effectiveness was assessed.

In the learning disabilities service, the services we visited used a therapy outcome measure scale (TOMS) and also engaged in regular audits.

In the older people's services in York, the trust were undertaking a review of all services and this included the development of a dementia care pathway which had been agreed by the medical staff and managers but had yet to be implemented.

Staffing levels were affected by short term absence which impacted on outcomes for detained patients. It meant that planned activities and section 17 leave could be cancelled at short notice so patients could not always leave the ward as planned. The trust did not have in place a way to measure the impact of short term staffing shortages on activity levels of patients who could not leave the wards without a member of staff.

Staff skill

The 2013 Department of Health NHS staff survey was open to 416,000 NHS staff and had a response rate of 49%.The trust scored within the worst 20% of mental health trusts in England on the key finding relating to the percentage of staff appraised in the last 12 months, the trust was averaging 80% whilst the national average was 87%.

Staff in focus groups told us that the appraisal documentation had been cumbersome to complete and staff did not find it meaningful. Through a trust wide consultation, the appraisal documentation had recently changed and senior managers were focused on ensuring all staff received an annual appraisal. We saw that in September 2014, the percentage of all staff in the trust that had received an appraisal was 73%.

Discussion with senior managers identified that staff had been accessing and undertaking a range of different training which supported the clinical areas in which they worked and the needs of the people that they cared for. However the trust had identified that compulsory training and appraisals were not taking place and we saw that this was recorded on the trust risk register and reviewed on a monthly basis by the board.

As a result, the trust had identified that external training would no longer be authorised or approved until they met the key performance indicators for mandatory training and appraisals.

Service leads identified that clinical and nursing staff at Bootham Park hospital and other York locations were being upskilled to enable them to carry out their roles more effectively

The trust had a compulsory training procedure which detailed all statutory and compulsory training. We saw that the trust had set a target of 85% of staff to have completed up to date compulsory training between April 2013 and March 2014. The trust did not achieve these targets.

For the period April 2014 to March 2015 the trust had set a target of 90%. However, trust records showed that at the end of Quarter 1 (June 2014) compulsory training compliance stood at 78%. In August 2014 compulsory training compliance stood at 77%.

An action plan had been put into place to improve the trusts levels of compliance with compulsory training. In some areas, we could see that staff received a monthly email to identify their individual monthly compulsory training compliance report, however this was not consistent across the trust.

There were systems in place to enable local managers to track and ensure staff had completed their compulsory

training. Most staff told us they had received compulsory training. The compliance of compulsory training was an item that was monitored through the risk register and this was rated as 'high risk' at the time of the inspection.

In the older people's services in York, we asked about role specific training and found staff had not completed training in regards to physical health, dementia awareness, dementia care mapping, epilepsy or diabetes. This was in contrast to the services provided in Leeds where we could see and staff told us that role specific training was undertaken at regular intervals. We concluded that this variation in role specific training could impact on the effectiveness of the care and treatment received by patients in York.

In the learning disability service, specialist training had been provided for staff working in the short

term care ward at 2 Woodlands Square, to allow for specialist physical care including feeding and catheterisation.

We saw that there was no training in the Mental Capacity Act or Deprivation of Liberty Safeguards. Minutes of the Mental Health Act committee had noted this and the director of nursing informed us this was to be added to the compulsory training programme.

Mental Health Act training did not appear to be offered through the trusts compulsory training. We were informed that MHA training is known as 'priority' training and the trust do not report or calculate the level of compliance with this training. The trust demonstrated that staff were trained in the MHA through attendance lists. These identified that there had been 96 courses and 595 attendees between December 2012 and August 2014. We have concluded that staff are not in receipt of regular MHA training. In addition it is clear that the trust do not monitor which staff have undertaken MHA training and cannot be assured that the relevant staff have up to date knowledge regarding mental health legislation.

In the forensic services we saw that staff received appropriate training, supervision and support. Staff on the wards commented favourably on the support and leadership they received from the respective ward managers. Staff told us that they received supervision which consisted of both individual management supervision and group clinical supervision.

Multi-disciplinary working

Multi-disciplinary working varied across the Leeds and York locations. We observed multi-disciplinary team (MDT) meetings taking place as well as staff handovers on some of the wards.

Multi-disciplinary teams in Leeds worked well together to ensure coordinated care for patients. This was not always the case in York. Staff described an open and productive working environment with strong and effective communication between colleagues. However the links with some of the community services were disconnected in Leeds. Some patients had been discharged from the community services during their stay within rehabilitation wards.

The MDT meetings included all staff; support workers, nurses, occupational therapists, psychologists and doctors. Other professionals such as dietician or physiotherapist would attend as required. In York, the MDT also included some staff attendance from the community mental health teams however staff reported they did not routinely attend.

In Leeds services, pharmacy was represented at MDT meetings but this was not the case in York.

Patients told us they attended part of their MDT meetings, and some said they contributed to it.

Partner agencies also contributed where it was necessary. For example on the psychiatric intensive care unit and health based place of safety, the trust had developed monthly liaison meetings between the police and health services. In the child and adolescent services, a teacher would attend the MDT on a regular basis.

In the integrated CMHTs we saw that the teams had developed effective relationships with the local police, GPs, substance misuse service and a range of third sector providers.

There were clear and effective systems in place for handovers between nursing teams.

In the supported living services, staff sought specialist health advice from dieticians, physiotherapists and specialist dental care workers when it was needed.

We saw that there was effective communication between teams across both inpatient and community teams.

Information and Records Systems

Requires Improvement

Are services effective?

The trust told us that they used three information and records systems. The services in Leeds used PARIS, many York services used an electronic records system Core Patient Database and there were services that had paper based information and record systems. We were told that in the rehabilitation services in York, records were all paper based.

Staff told us that the dashboard reports were difficult to access and not always available. These were a recent introduction within the trust. Executive directors informed us that it was introduced to monitor local service performance against sickness absence, stress, nursing day and night hours, health care assistant day and night hours, budget control, serious incidents, CPA 12 month reviews, percentages of patients with an agreed care plan, nutritional screening within 72 hours and delayed discharges.

Datix was just being implemented and expected to be fully rolled out by November 2014. Datix was just being implemented and expected to be fully rolled out by November 2014. Datix is an electronic risk management information system.

Consent to care and treatment

There were policies and procedures related to the Mental Capacity Act and DoLs. The Mental Capacity Act has been enshrined in law since 2005 and it applies in any health and social care setting. It was of concern that training in the mental capacity act was not in place at the trust.

In the learning disability services where we saw that discussions around capacity for investigations and blood tests clearly explained the rationale for these investigations. Adherence to the Mental Capacity Act and Deprivation of Liberty safeguards was good across all of the learning disability wards. MDT meetings that we attended showed good understanding of the Mental Capacity Act and also its use.

We also found that in the forensic/secure services, staff took practical steps to enable people to make decisions about their care and treatment wherever possible. Staff understood the process to follow should they have to make a decision about or on behalf of a person lacking mental capacity to consent to proposed decisions, in accordance with the MCA.

Within the older people's services in York, we reviewed two patient's records where the patients had been referred for a Deprivation of Liberty Safeguard, (DoLS) assessment by the local authority and found them to be in order.

In the crisis teams we saw that capacity was recorded in people's care plans within the holistic assessment. However there was no evidence of recording the steps that had been taken to assess capacity.

We found that the majority of staff had not received training regarding the MCA and DoLS as this was not part of the compulsory training provided by the trust. The director of nursing told us that this had been discussed in the trust's Mental Health Act committee and it had been agreed that this training would be incorporated within the compulsory training matrix.

We found inconsistencies in staff understanding of the application of the MCA in other core services. Staff were not always able to tell us when the mental capacity act would be used. They could not tell us when a 'best interest' decision would be made and how that decision would be reached. This meant that there was a risk that staff would not always apply the MCA and DoLs correctly when its use was indicated. However all staff were aware that information was available on the trust website and how to access this.

Assessment and treatment in line with the Mental Health Act

We saw that most patients who were detained under the Mental Health Act (MHA) had the appropriate documentation in place for consenting to their treatment for mental disorder including medicines.

Patients told us that they had their rights explained to them by staff and that they had been informed of and used the Independent Mental Health Advocacy (IMHA) service. We saw that the correct paperwork had been completed regarding patients' rights.

Statutory paperwork had been independently scrutinised, however this did not always happens in as short as time as possible following the application for detention. Section 17 leave forms were mostly appropriately completed and took into account a risk assessment; old forms were cancelled to avoid confusion.

Requires Improvement

Are services effective?

We found mail being withheld for one patient contrary to the rules in the Mental Health Act and their human rights within the forensic service.

Please refer to the 'Actions we have asked the provider to take' section of the report.

Good

Are services caring?

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

Summary of findings

Before our inspection, patients and people who use services told us that most staff treated them with kindness, dignity and respect. Throughout the inspection we saw examples of staff treating patients with kindness, dignity and compassion. Patients commented favourably on the quality of care and support they received.

Staff had a good understanding of the different needs that patient's had on the basis of gender, race, religion, sexuality, ability or disability within services.

The majority of patients we spoke with told us they had been involved in reviews about their care.

We saw that there was variation between the services in York and Leeds, with Leeds services involving patients and their carers or relatives much more proactively.

Carers told us they had mixed experiences of being involved and being able to provide support to people using services. We saw examples of outstanding involvement initiatives in some of the low secure services, especially within the low secure ward for women with personality disorder in York.

An advocacy service was available across all services and steps had been taken to ensure all patients were made aware of this service and how it could be contacted.

Our findings

Dignity, respect and compassion

We observed positive interactions between staff and people who used the service throughout the inspection visits.

We spoke with staff that were clear about patients' needs and their treatment. Staff planned and provided care in a way that took into account people's wishes.

We observed staff speaking with patients and providing care and support in a kind, calm, friendly and patient manner.

Within the women's low secure services we saw that staff ensured that there was always at least one female member of staff on duty and only women staff did the night time checks.

People who received a service from the York crisis teams felt that they were listened to and valued the service.

Staff had a good understanding of the different needs that patients' had on the basis of gender, race, religion, sexuality, ability or disability within services.

Within the supported living services we saw staff supporting people with a variety of physical and learning disabilities. People were always offered a choice and were treated with respect and dignity throughout the interactions

Involvement of people using services

In the 2013 Community Mental Health Survey, 50% of respondents stated that in the last 12 months they had not had a care review meeting to discuss their care, against an expected rate of 38%. The trust had flagged this as a risk. The majority of patients we spoke with told us they had been involved in reviews about their care.

We saw that patients (where possible) carers and relatives were involved in planning their care from admission. We observed relatives were made welcome by staff when they visited patients on the ward. We found information in the care records which demonstrated patients views had been taken into consideration when planning for their care. We saw that there was variation between the services in York and Leeds, with Leeds services involving people and their carers or relatives much more proactively.

Within the learning disability services we saw that that good collaboration with family and carers took place.

Within the forensic services patients told us that care was planned and reviewed with them however in some cases this was not evidenced in the electronic patient notes (EPN). Community meetings were held regularly on the wards. We saw examples of outstanding involvement

Good

Are services caring?

initiatives in some of the low secure wards at Clifton House. Rose Ward had good systems for meaningful patient participation and involvement. Women with personality disorder were able to participate in their individual care as partners and be involved in the running of the ward.

In supported living services, people who used services told us they were involved in developing and reviewing their care plans. The staff told us the care plans were person centred and when they were reviewed; the review was led by the involvement coordinator. Staff felt that as this person was not involved in supporting the person over a 24 hour period they brought some independence to the process.

Emotional support for people

In the older people's wards we saw that the staff provided patients with the "room to be themselves." Staff provided patients with choices. Information about advocacy and community forums was available on the wards for patients and their relatives who were caring for patients with dementia.

There were community meetings across most of the inpatient wards where information about the ward was discussed and explained.

In the supported living services, staff told us that people were seen as individuals and were able to describe the needs of each person they helped support. We observed that where people were dependent on help from staff, the staff always included the person they supported. This included, but was not exclusive, to people collecting their own post. They were supported by staff when their room was being cleaned and encouraged to open the front door when visitors arrived.

An advocacy service was available within the CAMHS services. Steps had been taken to ensure children, young people and their families were made aware of this service and how it could be contacted.

Requires Improvement

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

Information about how to make a complaint or how to raise concerns was not always displayed across the wards or in public areas. Local resolution of complaints took place on most wards. The wards did not have a proper system for recording the number, type and outcome of complaints that were considered at local resolution stage. This meant that the trust were not clear as to the number and type of complaints received and how many were being upheld or not upheld at a local level. Corporately the trust was not meeting its own policies and procedures in terms of timeframes and we saw that there was a backlog of complaints. The trust confirmed that a high number of complainants are not satisfied with the responses given as part of the initial response to the complaint. There was no training given to staff handling complaints that had not been resolved locally.

Across the trust, over the six months prior to our inspection, bed occupancy exceeded 90% on 17 out of 39 wards/locations. Despite this, patients were nearly always admitted to the ward or hospital that looked after the area in which they lived.

Patients could readily access services and since the introduction of the single point of access 12 months ago, referral times had improved. Staff and patients told us when a person went on leave a bed was always available on their return. There was evidence of delayed discharge at Bootham Park Hospital but the recent introduction of bed managers had reduced the incidence of delayed discharges and out of area bed usage but it was too soon to see sustained levels. In the older people's services, there were a number of delayed discharges. There was no active discharge planning by the ward and some patients did not have identified care co-ordinators. We were told and saw that there was a difficulty in finding placements for patients in the community. As part of their role, bed managers liaised with the local authority to find suitable placements and plan for patient discharge.

The development of the section 136 suites in Leeds and York had significantly reduced the numbers of people being assessed in police cells and has been strongly welcomed by the police.

At Bootham Park hospital, we found patient therapy/ activity groups were being delivered in patient corridors and or lounges as specific rooms were not available on the wards. A quiet room was available although this was also used for patient reviews when required. At other locations, we found there was a full range of rooms to support treatment and care.

The trust did not fully comply with same sex accommodation guidance. We saw that in the older people's services, patients sometimes walked into the wrong gender toilet/bathroom and were not always redirected by staff or observed by staff.

We observed good use of easy read signage or information displayed on the wards. Information was available on advocacy services for patients to access help and support. Interpreters were available throughout the trust and care documentation or leaflets could be translated into a range of different languages so that patients, family members or carers could understand what care and treatment was being provided. Staff were sensitive in responding to and meeting the cultural needs of patients.

Please refer to the 'Actions we have asked the provider to take' section of the report.

Our findings

Planning and delivery of services

Between January and March 2014, the trust's bed occupancy for mental illness was 88% compared to an England average of 87% for all bed types and 88% for mental illness. It is generally accepted that when occupancy rates rise above 85%, it can start to affect the

Are services responsive to people's needs?

quality of care provided to patients and the orderly running of the hospital. We saw that across the trust, over the six months prior to our inspection, bed occupancy exceeded 90% on 17 out of 39 wards/locations.

During our inspection we spoke with two clinical commissioning focus groups. Commissioners of health care identify what the health needs of local populations are. They identify providers based on cost and quality to provide those services. They fund the provision of these services and are responsible for ensuring that they get best value for money and high quality services.

The information we received was positive from one of the commissioning focus groups who were predominately from Leeds clinical commissioning groups, NHS England specialised commissioning and the local authority. They identified that they had a positive working relationship and the trust were innovative in the planning and delivery of services. They gave some examples of this innovation including the rehabilitation and recovery model the trust had implemented.

In contrast, a group made up of members of the York clinical commissioning groups (CCG) and local authority, stated that they felt the trust had no ambition. They also believed they had not been included in discussions regarding the future of the York estate and had had to intervene by directly liaising with English Heritage about Bootham Park Hospital when the trust did not. The CCG were dissatisfied with the trust performance in York and felt that services had deteriorated over the last two years. This included more out of area treatments and longer lengths of stay in York services. The trust, subsequent to the inspection, informed us that they had not received a performance notice from the York clinical commissioning group. They saw this as an indication that all quality and performance matters had been addressed through constructive dialogue.

The trust introduced a, 'single point of access' (SPA) point for all new referrals into the service as part of the transformation of services process 12 months ago. The SPA team reviewed each new referral based upon the information they received and assessed which service was the most appropriate to meet the patient's needs.

All staff we spoke with told us that since the introduction of the SPA, response times to referrals had improved. Patients we spoke with told us they did not have any problems contacting the teams when they needed to.

As a result of the transformation project, the trust informed us that all the community based teams now provided an, 'ageless' service based on individuals' needs rather than their age. Since the transformation of CMHTs, the teams had developed two distinct care pathways to meet the needs of all patients. The CMHTs had split the teams into each of these pathways to enable staff to develop specialist skills and knowledge relevant to the pathway they were working with.

There was an ongoing review of all of the York older age services and this included the development of a dementia care pathway which had yet to be implemented.

There was inequity between the services provided in Leeds and York which we concluded may be a commissioner funding issue. The York services did not provide intensive community support (ICS) services or liaison psychiatry service for older people. This meant that patients in York were unable to access ICS services as an alternative to hospital admission or to facilitate their early discharge from hospital. This could result in patients spending longer in hospital than was necessary.

Service leads in York told us that quality improvement plans (QIP) had been developed and were being implemented in relation to Bootham Park Hospital and the community units for the elderly. They expressed concern that if the York CCG progressed the procurement programme, there would be disruption to the QIP. This would have a significant impact on the proposed service redevelopments and patients.

Different care pathways were in place to help ensure the needs of children and young people were met.

The trust had a clear vision for the rehabilitation and recovery services for Leeds. It had plans to reduce the numbers of beds in Leeds from 69 to 54. This would be across three wards, a locked rehabilitation setting with 18 beds, a supported ward with 24 hour rehabilitation for 20 beds and independent ward with 24 hour rehabilitation for 16 beds. This was planned to be supported by the rehabilitation and recovery community service team. This was due to be implemented in December 2014 to January 2015.

Requires Improvement

Are services responsive to people's needs?

In the supported living services people who used the service were encouraged to be as independent as possible and to be involved in all aspects of their lives. People were able to be involved in managing their own health conditions and involved in partnership board meetings for the service. People who used the service had also been involved in recruitment of some staff.

Restrictions were kept to a minimum within the trust. We noted this was the case in the context of providing care in a low secure environment. There was an appropriate balance between managing risks within low secure care and an appropriate level of positive risk taking. Patients were allowed simple mobile phones without cameras. There were no zonal restrictions within the wards so patients could access all areas of the ward including their bedrooms during the day.

On the acute admission wards, swipe cards were available for informal patients to allow them to leave as they liked. Detained patients were also provided with swipe cards when they had leave which was unescorted, following section 17 leave procedures.

Diversity of needs

During 2013/14 the trust had hosted a number of development forums for staff. These aimed to increase knowledge, skills and awareness of a number of identified communities in order to provide care and support to patients, carers and staff. The training included the needs of deaf/hard of hearing, refugees and asylum seekers and awareness of different faiths. From April 2013 to April 2014, 83% of staff had completed the compulsory equality and diversity training.

Patients' diversity and human rights were respected. The trust attempted to meet patients' individual needs including cultural, language and religious needs. Contact details for representatives from different faiths were on display in the wards. Local faith representatives visited patients on the ward and could be contacted to request a visit. Most of the larger locations had multi faith rooms. The multi faith rooms were not always equipped to meet patients' needs.

Interpreters were available to staff. Letters and communication to patients could also be provided in a patients 'own language' or in large print for patients with a visual impairment or easy read versions. Induction loops were available for patients using a hearing aid. In addition, the National Deaf Children and Adolescent Mental Health service had demonstrated the innovative use of technology which was available in order to communicate effectively with people with different levels of hearing loss.

Some of the older people's wards had pictorial signage which helped patients with dementia locate the bathrooms and toilets.

We saw that on most of the acute admission wards in Leeds, wards were single sex and had a full range of rooms and equipment to support treatment and care. There were quiet areas on the wards and a family room was available for children's visits.

The trust had a learning disabilities team that staff could contact if they needed advice.

A choice of meals was available. A varied menu enabled patients with particular dietary needs connected to their religion, and others with particular individual needs or preferences, to access appropriate meals.

Right care at the right time

Our intelligence monitoring identified that in relation to referral to treatment times:

- community mental health, 60% to be seen in 14 days over a quarter – last reported compliance for Q4 was 61%. (local key performance indicator with Leeds commissioners).
- Leeds psychological therapies – target is for 95% to be seen in 18 weeks over a quarter. Compliance is at 95% for Q4 13/14.
- Re-admissions – there were 107 re-admissions between January 2014 and June 2014, split over eight wards across four locations. The majority occurring at the Becklin Centre on Wards 1,3 & 5.
- Delayed discharges – there had been 55 delayed discharges between January 2014 and June 2014. Bootham Park ward 6 has had nine, followed by Nelson Court and Meadowfields Cue with eight.

We saw some variation between York and Leeds in relation to crisis services.

The crisis and access service in York advertised the telephone number for the single point of access (SPA) service in various community based settings such as local GP surgeries to enable people to contact the service directly. There was an open referral system in place

meaning that any person could self-refer and any external organisations could refer on. Referral could be made by telephone, fax or online. The team accepted referrals from a range of sources including self-referrals from people or their carers, GP, the inpatient wards and community mental health teams. The service operated 24 hours a day, seven days a week, 365 day a year. People who used crisis services in York rarely reported issues regarding access or being able to speak to a member of the team.

The SPA team were the gatekeepers for beds at Bootham Park Hospital, which meant they had oversight and control over admissions to beds. The team had daily contact with the acute wards to identify people who may be appropriate for early discharge with support from the team.

At the Leeds service, which operated a crisis and assessment service at The Becklin Centre, some people who used services told us they had trouble getting through to the team in a timely way, sometimes receiving an engaged tone. We were told by staff that the team had a target to answer 90% of calls within 30 seconds and waiting times for telephone calls were audited by the administrative staff on a monthly basis. Performance against targets had been consistently between 85% and 95%.

The development of the health based place of safety at York had significantly reduced the numbers of people being assessed in police cells and had been strongly welcomed by the police. Current arrangements mean there was seldom a delay in ensuring that people are assessed in a timely manner under Section 136.

There were clear policies and procedures for admission to adult admission wards. Patient care was planned and delivered to facilitate early discharge and was responsive to patients on a day to day basis. We saw that patients were able to access acute inpatient beds and that patients were only occasionally moved out of area. Staff and patients told us when a person went on leave a bed was always available on their return. There was evidence of delayed discharge at Bootham Park Hospital but the recent introduction of bed managers had reduced the incidence of delayed discharges and out of area bed usage but it was too soon to see sustained levels.

In the liaison psychiatry team for older people, the number of referrals to the service had increased significantly since the team was established. In 1999, the team received 210 referrals and in 2012, this had increased to 1,600. 67% of referrals were seen by the team within one working day of referral. The majority of the rest of the referrals were seen within three working days. The team had expanded to provide a service from five days a week to seven days a week in 2011 in response to the increase in demand for the service.

We identified that in the older people's services there were a number of delayed discharges. The modern matron told us there was a difficulty in finding placements for patients in the community. The trust had recently introduced bed managers who as part of their role liaised with the local authority to find suitable placements and plan for patient discharge.

Staff in the York rehabilitation services told us there was some inappropriate referrals for admissions to their ward due to bed management pressures within the York locality. There had been occasions were an admission had taken place when patients did not meet the criteria for admission.

It is a requirement that patients discharged from hospital who are subject to CPA should receive a follow up within 7 days of their discharge. The information the trust provided showed that 95% of patients discharged received a follow up within 7 days.

The National Audit of Psychological Therapies found that 75% of cases at the trust were meeting the standard that a person who was referred for psychological therapy did not wait longer than 13 weeks from the time at which the initial referral was received to the time of the assessment. This was slightly below that of national interquartile range of 77-99%. Data collection was carried out in a phased manner between April 2012 and January 2013.

Learning from concerns and complaints

The trust received 116 written complaints in 2012/13, 65 more than the previous year. 20% of complaints received in 2012/13 were upheld, a decrease from the previous year.

In 2012/13, 68% of complaints related to "all aspects of clinical treatment".

As part of our information gathering, comments were received about the quality of the investigations being undertaken and how they varied and whether the trust took complaints seriously. Concerns were also raised that complaints were not being dealt with by staff with sufficient

seniority and that people had lost confidence in the trust due to poor investigations of complaints. In contrast the feedback regarding the trust's patient advice and liaison service (PALS) function was that it was very good.

We saw evidence that complaints were reported to the board, this included response times, number of complaints and themes along with complaint actions. We saw that information on how to make a complaint was not displayed in all ward and public access areas. The feedback from patients and carers, received during the inspection, was that responses to complaints were not provided, or if they were, the response did not address the initial issues raised.

There was no evidence that written confirmation of the issue(s) to be investigated was sent to the complainant to review and agree. There was a back-log of complaints although the exact number was not available and it was confirmed by the trust that a high number of complainants were coming back after receiving the initial response as not all of their questions were being addressed by the trust. We were told that 68% of complaints were not meeting the 30 day response timescale, which was the trust standard response timescale as identified in the trusts complaints policy.

There was no training for handling of complaints or awareness of complaints within the trust. There were no assurances that staff involved in complaints were made aware that making a complaint should not compromise the care provided to the complainant.

We were told there are only two members of staff to cover the PALS, complaints and claims role within the trust and they had to cover each other during periods of leave. We were informed that the trust is reviewing the complaints/ PALS function to include staffing levels and complaints training.

We saw that across most of the core services, the wards and community teams had an effective system for managing complaints locally. This meant that local teams were managing complaints but learning was not being shared across the trust.

Inspectors on the forensic wards found complaints' correspondence contained within a medical record, complaints information should be kept separate from health records.

We saw that in the learning disabilities services, staff were able to describe how the lessons learnt from three locally resolved complaints had been embedded and how some changes were made to their practice as a direct result of these complaints.

Requires Improvement

Are services well-led?

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

Summary of findings

The trust had a clear vision and strategy. We found there was a disconnect in some of the ward and community teams we visited in relation to how the trust visions and values linked into those at local level. This was particularly apparent within wards and teams which were geographically isolated or, 'stand-alone' services.

Staff were aware of who the chief executive officer and director of nursing and governance were but not who the other members of the leadership team at Board level were. Many staff told us the senior management and executive members were not visible at the remote locations where rehabilitation, learning disability and older people's services were based.

The trust had developed its governance structure over the last 18 months. Staff informed us during interviews and focus groups that the governance structures were now embedded at senior management level and above. However below this level, the trust were still developing the governance structures and getting all staff to take ownership and engage in the approach being taken.

In most clinical environments and teams, managers had regular meetings where lessons from complaints, incidents, audits and quality improvement projects were discussed. However the agenda was not consistent across wards and it was not clear how these meetings fed into the three care group governance meetings.

There were differences in the leadership and culture of services in York compared to the services in Leeds. Senior staff told us and we saw reflected in minutes of meetings up to board level, that there had been a lack of effective leadership and governance in the York services. Senior members of the Trust Board recognised that they could have managed this more effectively when they first acquired the York services. Leadership, management and governance has now been strengthened across the York services."

The trust was introducing quality dashboards for teams which included information regarding other quality indicators such as staff sickness rates, mandatory training compliance and appraisals. However this had not been embedded in all the teams we visited.

Across the trust, staff were positive about their experiences of working in the service. They reported that they felt confident in and supported by their colleagues and managers. We were told by staff that the uncertainty of the forthcoming re-tendering process for the services to a new provider by the Vale of York CCG, had affected staff morale. Staff were aware of and engaged in a number of initiatives and felt the trust were moving in the 'right direction' in relation to engaging and listening to staff.

There were opportunities for patient engagement including the service user network and locally based groups. Carers we spoke with had mixed experiences of their ability to engage with the trust.

The commissioners of health care services did not agree on the way in which they felt the trust responded to them. Leeds based commissioners had a positive working relationship with the trust, game examples of innovation in the planning and delivery of services and were open and transparent in their dealings with them. The York based commissioners told us that they had a poor relationship with the trust. They felt services had deteriorated over the last two years. They identified that the trust had not been open in their dealings with them and had not included other local stakeholders including the local authority in discussions about service planning and delivery.

During and subsequent to the inspection, the trust informed us and submitted copies of letters from June 2014 where they outlined their concerns relating to quality and the relationship with the clinical commissioning group.

Requires Improvement

Are services well-led?

The trust aims to deliver better care over the next five years. This would be achieved through three transformational programmes which will be delivered in collaboration with patients, carers, voluntary sector partners and health and social care partners.

The trust participated in a number of external peer review and service accreditation schemes.

The trust rewards and recognises achievements by staff either individually or as a team. The focus each year is on service improvement.

Our findings

Vision and strategy

The trust had a clear vision and strategy. The strategy was driven by three goals that people had told the trust were important to them. We were told that the trust had five strategic objectives to describe what they need to do to meet these goals. Members of the executive team and the non-executive directors explained that they had been developed by service users and governors. This had been achieved through workshops with the Council of Governors and consultation with service users via the service user network. In addition we were informed that partner organisations, commissioners of services, local authorities had all been invited to comment on the vision and strategy.

The three goals were identified as:

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

The majority of staff we spoke to during the inspection understood the trust's vision and values. However we found there was a disconnect in some of the ward and community teams we visited in relation to how the trust visions and values linked into those at local level. This was particularly apparent within wards and teams which were geographically isolated or, 'stand-alone' services.

Governance

The trust had a board of directors who were accountable for the running of the trust. There was also a council of governors who provided a link between the local community and the board of directors. Most of the governors were elected onto the council, whilst others were appointed from the trusts partner organisations for example; a local council or voluntary sector organisation. The governors met quarterly and held the non-executive directors to account for the way in which the board of directors performed. Governors observed sub committees of the Board.

There was a clear governance structure that included a number of committees that fed directly into the Board. There were four sub committees which were; an audit committee, quality committee; finance and business committee and the Mental Health Act (MHA) committee. All of the committees reported by exception to the Board.

The quality committee seeks assurance and opportunities to improve clinical quality: defined as issues looking at clinical effectiveness, patient experience and patient safety.

The quality committee was the lead body for clinical governance in the trust and it monitored compliance with those standards required for high quality delivery of care. The quality committee met quarterly and reviewed a number of reports and information. We were also told that non-executive board members occasionally undertook quality visits from time to time to the wards and community teams.

The MHA committee was the newest committee as the trust recognised it had no structure in which to review issues raised about trust wide adherence to MHA and associated audits and monitoring. It met quarterly and was chaired by a non-executive director. The committee considered policy, practice and procedures in relation to the management and administration of the Mental Health Act 1983 and related/relevant legislation They considered the trust's discharge of those functions under the Mental Health Act 1983 which had been delegated to officers. The committee reported directly to the Board and had been operational for a year.

Subsequent to the inspection, the trust informed us that there had previously been a Mental Health Legislation standing support group where these types of issues had previously been raised.

The trust had developed its governance structure over the last 18 months. Staff informed us during interviews and focus groups that the governance structures were now

embedded at senior management level and above. We saw evidence that minutes were escalated from the ward to the Board via the newly implemented care group structures and meetings.

The trust had developed three care groups and governance structures ran through these care groups to Board, however we were told that each care group determined how information was filtered down to ward level.

We saw that the governance structures were not as embedded from senior management level to the wards. We were told that this was 'phase 2' of the process, for the middle tier to be consistent in the governance structures across and down the organisation. We did see that in most clinical environments staff teams did discuss issues but there was no consistent format or approach. Locally good governance varied between core services and down to individual ward level. This included how effective managers were in ensuring staff received mandatory training, appraisal and supervision. There was variance in how staff across services learnt lessons from incidents and complaints and feedback from patients. We saw that in some areas, local governance arrangements were good whilst in others they were not effective.

We saw that issues raised earlier in this report regarding staff training and appraisal, were seen as an area of priority within the senior team. All of the executive and non-executive directors we spoke with were aware of the issues and the plans in place to address them.

A clear multi-agency protocol was in place to oversee the operation of the health based place of safety, with all necessary agencies involved in the monitoring of operations.

Leadership and culture

We found that the non-executive directors were a strong group who understood their role and exercised their duties effectively. Some had relatively recently been appointed and bought a range of skills and experience into the organisation that had enhanced the level of challenge and we found they displayed insight into the challenges the trust faces.

The executive and non-executive directors identified that there were differences in the leadership and culture of services in York compared to the services in Leeds.

We were informed by executive and non-executive directors that there had been a lack of effective governance or leadership of the services in York prior to 2012. We saw board papers that reflected these concerns. The trust board had moved senior staff and managers across to York to promote and demonstrate positive leadership. Simultaneously, the trust changed the leadership structure to include both an associate director and a clinical director for each care group.

Senior members of the trust board recognised that they had underestimated the scale of the challenge when they first acquired the York services and the impact of the lack of investment in these services, both in terms of buildings and people. However in the last 12 months they had made some leadership changes in York and believed that they were starting to see some improvements.

During the York CCG focus group, we were told that the trust had a strong focus on Leeds and senior managers were less involved in York. We were told front line staff were bullied by middle managers and they had undue pressure from top management. During our inspection, we found no evidence to support this statement either through discussion or direct observation. They went on to describe that decision making is short term and the trust do not work well with other organisations. The representative of North Yorkhire local authority supported this view and said the trust were difficult to engage in joint planning.

The majority of staff told us they had not met or seen the directors of the trust in York services.

A focus group of health care assistants, who worked in York, told us they were aware of whom the Chief Executive was but no one from the Board or executive team ever visited. Subsequent to the inspection, the trust produced evidence that a number of visits had taken place by members of the executive team.

At a local level staff across the trust were positive about their experience of working within the services and told us they felt supported by colleagues and their managers. All staff stated they felt able to raise concerns to their management team and were confident they would be listened to.

Some staff in York CMHT reported that staff morale had been low due to the transformation which led to some staff leaving.

Requires Improvement

Are services well-led?

We were told that changes were being discussed to the older people's services in York. The impact of the uncertainty of the forthcoming re-tendering process for the services to a new provider by the CCG, had affected staff morale.

In the supported living service, there was a registered manager but their role within the trust had changed and they now had more managerial responsibility within the organisation. This meant that the responsibility for managing the service on a day to day basis sits with an operational manager. It was not clear that the trust understood fully the role and responsibility of the 'registered manager'.

Engagement with people and staff

The trust carried out a full staff survey in May 2013 and provided a report containing the findings:-

- 71% felt that they receive all the information that they need.
- 59% broadly felt their time was not wasted
- 49% felt that staff help each other out (49% disagreed)
- 65% felt that the trust tries to improve
- 56% felt that they could change things
- 43% felt included in decisions (50% disagreed)
- 22% felt meetings were fully effective

In response to this, the trust had launched the, 'Your Voice Counts' initiative as a way of providing staff with an opportunity to feedback to the trust on issues they wished to comment on. Staff we spoke with were aware of this initiative and felt the trust were moving in the, 'right direction' in relation to engaging and listening to staff.

Executives and non-executives told us how difficult it is to be 'visible' across so many locations and sites. They had tried using different technology based methods to engage as many staff as possible. This included a blog and webinars. The trust produce a quarterly staff newsletter called 'Imagine' to distil and share information.

In the older peoples services at The Mount in Leeds, monthly inpatient pictorial questionnaires were carried out, these asked patients about their experience of the ward and covered areas such as food, staff, and activities. These were collated and the results were displayed on the ward notice boards. There was a patient involvement group where present and past patients were invited to be involved in the development of the service.

We held a focus group for carers and 14 people attended this group. The carers were from York and therefore their focus was the services provided in York. There were some positive experiences of care noted in the low secure services. The group was mostly critical over access to services and talked about the differences in Clinical Commissioning Group (CCG) funding between Leeds and York. The carers group were critical over the community mental health teams but found the crisis teams in York to be very good. They stated there were a lack of education or support groups available for carers and a lack of integrated working.

The York CMHT's told us they were raising the profile of the trust's, service user network in York to ensure patients views were represented in York at this forum as it was predominately attended by patients from Leeds.

In addition, the trust work in partnership with the Arts and Minds Foundation and run an annual 'Love Arts' festival which highlights the issues of mental health across the city. The festival has been operating since 2011.

Continuous Improvement

The trust participated in external peer review and service accreditation. This included:

- AIMS –Learning Disability accreditation at Parkside Lodge and Oak Rise
- ECTAS Accreditation for the Becklin Centre ECT clinic
- the Memory Services National Accreditation Programme (MSNAP) for services in Leeds only
- The Quality Network for Forensic Mental Health Services for Clifton House and the Newsam Centre
- The Quality Network for Perinatal Mental Health Services where the trust has been accredited as, 'Excellent'.

The trust was a member of the Quality Network for Inpatient CAMHS (QNIC) but was not accredited.

We concluded that the trust was committed to service improvement.

The trust told us of three transformational programmes that they had recently launched in order to deliver better care over the next five years. We saw in a booklet produced by the trust for our inspection which identified these as being:

Requires Improvement

Are services well-led?

- A recovery and person centred care programme which was being delivered in collaboration with service users and carers.
- A provider partnerships programme being delivered in collaboration with voluntary sector partners.
- An integration programme which was being developed in collaboration with health and social care partners.

The majority of planned improvements related to the services provided in York, although there were some that related to Leeds services.

We met with the service manager and the clinical service manager of older peoples services who told us there were plans in place to improve the older people's units in York. Following the inspection we were provided with an extensive action plan that the trust had developed prior to our inspection. Some of the aims of the action plan were to ensure that a systematic programme of work was undertaken to ensure patients received safe, effective, compassionate and high quality care; to build a shared recovery and person-centred culture of care on the wards and establish a multi-disciplinary forum to oversee and drive improvements in the quality and safety of care, fully co-produced with service users and carers.

In the older people's services at Leeds, we saw there was a dementia inpatient project steering group. Ward managers at The Mount told us they had secured further funding to improve the environment and they were benchmarking the service using recognised national guidelines. They were also aware of the work at Bradford and Sterling Universities in relation to best practice in environmental design for dementia care.

The eating disorders service produced an annual report on overall service delivery. This was produced in conjunction with information received from the trust's risk management department. The service also evaluated the treatment programme through patient exit interviews and satisfaction surveys. The governance process was able to collate outcome measures which looked at the effectiveness of the service. This information was then translated into the annual report. This meant that the team was focused on service improvement.

The trust run an annual staff award ceremony to recognise achievements by staff, either individually or as a team and the focus is on service improvement.

This section is primarily information for the provider

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
Treatment of disease, disorder or injury	Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010 Safety and suitability of premises How the regulation was not being met: Bootham Park Hospital and ward 40 at the Leeds General Infirmary did not have suitable facilities and premises for the services being delivered. Whilst the Lime Trees unit had an action plan in place to be relocated, the action plan had not yet been fully completed. This meant that children/young people continued to be cared for in a building which was not suitable. We found ligature points across a number of services in Leeds. These had not all been identified and put onto the risk registers. Regulation 15 (1) (a)

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 19 HSCA 2008 (Regulated Activities) Regulations 2010 Complaints How the regulation was not being met: The systems for identifying, handling and responding to complaints made by service users were not effective across the trust. This is because the systems currently in place did not identify, handle and record complaints being resolved at local resolution or ward level, complaints were stored and handled within patient care records contrary to published guidance and it was not clear that complaints were fully investigated. Regulation 19(1) (2) (C)

This section is primarily information for the provider

Compliance actions

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff How the regulation was not being met: The trust did not ensure that staff received mandatory training including Mental Capacity Act and Deprivation Of Liberty Safeguards, complaints training and Mental Health Act training. The trust did not ensure all staff received appropriate training, supervision and appraisal. Regulation 23 (1)(a)

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing How the regulation was not being met: The trust did not ensure that staff received mandatory training including Mental Capacity Act and Deprivation Of Liberty Safeguards, complaints training and Mental Health Act training. The trust did not ensure all staff received appropriate training, supervision and appraisal. Regulation 23 (1)(a)

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services How the regulation was not being met:

This section is primarily information for the provider

Compliance actions

The trust were not adhering to the guidelines for same sex accommodation under the MHA Code of Practice at Meadowfields, Worsley Court, ward 6 and Acomb Gables

Regulation 9 (1)(b)(iii)