

Good 

Bradford District Care Trust

Services for older people

Quality Report

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Locations inspected

Name of CQC registered location	Location ID	Name of service (e.g. ward/unit/team)	Postcode of service (ward/unit/team)
Airedale General Hospital	TADY6	Ward 24	BD20 6TD
BDCT Headquarters, New Mill	TADHQ	Older people's community mental health teams	BD18 3LD
Airedale Centre for Mental Health	TAD54	Bracken Ward	BD20 6TA

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

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

Where applicable, we have reported on each core service provided by Bradford District Care Trust and these are brought together to inform our overall judgement of Bradford District Care Trust.

Summary of findings

Ratings

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

Overall rating for services for older people

Good 

Are services for older people safe?

Good 

Are services for older people caring?

Good 

Are services for older people effective?

Good 

Are services for older people responsive?

Good 

Are services for older people well-led?

Good 

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

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

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

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

Summary of findings

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Summary of findings

Overall summary

Bradford District Care Trust provides inpatient and community services for older people with a functional mental illness, such as depression, and organic conditions, such as dementia.

Services for older people were safe. Staff understood and implemented safeguarding procedures well. In addition, community caseloads were well managed and there were good systems in place to manage risk on a day-to-day basis.

People's care and treatment was planned effectively, which helped to achieve good outcomes. Older people's needs were also comprehensively assessed. Staff provided person-centred care and treatment that was in line with people's individual care plans. We also found that the way in which the multidisciplinary team worked together was excellent, and that information was shared appropriately. Staff were supported well by managers and colleagues, and received appropriate training, supervision and professional development. This enabled them to deliver safe and effective care.

Staff provided kind and compassionate care. Older people and their carers were treated with respect, and their dignity and privacy were maintained. Although

carers were involved in the planning and delivery of care, this was not always recorded. Staff were, however, committed to providing good quality care and treated people as individuals.

Services were responsive to older people's and carers' needs. The teams understood people's needs and wishes, and could respond to these. Services were planned and delivered in a way that met the different needs of the local communities. For example, we saw a range of services provided that addressed the different cultural needs of people using the service. In addition, the service provided an extended seven-day service in the community. This meant that they could respond more effectively to people's needs. There also were good arrangements in place to support effective working with other agencies.

Services for older people were joined-up and well-led. Managers were visible and accessible to people who use the service, carers and staff. The trust encouraged development of the service development and also involved people who use the service and their carers. The trust's governance structure also supported the delivery of the service.

Summary of findings

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

Are services safe?

The service had a good track record on safety and provided a safe service for older people. Staff understood and implemented safeguarding procedures well. Community staff caseloads were also well-managed. This helped staff to deliver safe and effective care and treatment. In addition, there were good systems in place to manage risk on a day-to-day basis and make sure that lessons were learnt from any incidents.

Good



Are services effective?

People's care and treatment was planned effectively, which helped to achieve good outcomes. Older people's needs were also comprehensively assessed. Staff delivered care that was in line with people's care plans, and that reflected people's individual needs. Staff received training, supervision, support and professional development that enabled them to deliver effective care. We also found that the way in which the multidisciplinary team worked together was excellent, and that information was shared appropriately.

Good



Are services caring?

Staff provided kind and compassionate care and support to older people and their carers. They responded calmly and sensitively to people in distress and respected people's dignity and privacy. Staff provided person-centred care and there was clear evidence that carers were also involved. We found that the services were interested in the people they cared for as individuals, and that staff were committed to providing good quality care.

Good



Are services responsive to people's needs?

Services for older people were responsive to people's needs. There were clear care pathways in place, and the teams understood people's needs and wishes and could respond to these. Services were also planned and delivered in a way that met the different needs of the local communities. In addition, there was an extended community service, which operated seven days week and ensured that services were responsive.

Good



Are services well-led?

The trust's vision and direction was communicated effectively to staff. The governance structure in place also supported the delivery of the service. Services for older people were joined-up and well-led,

Good



Summary of findings

and managers were visible and accessible to people who use the service, carers and staff. The trust encouraged development of the service and also involved people who use the service and their carers.

Summary of findings

Background to the service

Bradford District Care Trust provides inpatient and community services for older people with a functional mental illness, such as depression, and organic conditions, such as dementia.

Ward 24 is an inpatient ward for older people with organic conditions. It has 19 beds and is based at Airedale General Hospital. Bracken Ward provides services for older people with functional conditions and is based at Airedale Mental Health Centre.

The service has four community mental health teams (CMHTs) that provide a specialised service to older people. In addition, the service provides memory assessment and treatment services and day services.

We inspected Airedale Mental Health Centre and Ward 24 in July 2013. We found that the service was compliant with the regulations.

Our inspection team

Our inspection team was led by:

Chair: Angela Greatley, Chair, The Tavistock and Portman NHS Foundation Trust

Team Leader: Jenny Wilkes, Head of Inspection – Hospitals Directorate (Mental Health), Care Quality Commission (CQC)

The team included CQC inspectors and a variety of specialists: a consultant psychiatrist, a specialist dementia nurse, a care home manager, an occupational therapist (clinical lead), a social worker, a Mental Health Act commissioner, and an Expert by Experience, who had experience of care.

Why we carried out this inspection

We inspected this core service as part of our Wave 2 pilot 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?

We carried out announced visits to Bradford District Care Trust's older people's services on 17, 18 and 19 June 2014.

We also carried out a further short-notice, announced visit to Bracken Ward on 3 July 2014. Before visiting, we reviewed a range of information we held about the core service and asked other organisations to share what they knew. During the visits, we held focus groups with a range of staff who worked within the service, including nurses, consultant psychiatrists and therapists. We talked with people who use services, their carers and/or family members. We observed how people were being cared for and reviewed their care or treatment.

What people who use the provider's services say

Before our inspection, we held listening events, including one at the Airedale Centre for Mental Health. Patients

with experience of older people's services were exceptionally complementary about the care they

Summary of findings

received and the environment of Bracken Ward. They also complemented the staff on how well managed the move of Bracken Ward from Lynfield Mount Hospital to the Airedale Centre had been. However, carers told us that they felt that they had not been listened to fully as part of the consultation about the move.

We spoke with people and carers on Ward 24, Bracken Ward and those using community mental health services for older people. In addition, we spoke with people during home visits, when we accompanied community psychiatric nurses. We also spoke with people in a memory assessment and treatment service clinic, and day centre.

People using the service and their carers told us that staff treated them well and with respect, and that they felt supported. Everyone told us they felt safe on the ward. One person we visited in the community told us they were very happy with the service they received from their community psychiatric nurse. Others told us that they enjoyed visits from the community team. This was typical of what people and carers told us about the services for older people.

People using the memory assessment and treatment service were very enthusiastic and positive about the service they received from the team.

As several people on Ward 24 and Bracken Ward were unable to speak with us directly, we observed people's experiences on the ward using the short observational framework for inspection (SOFI 2).

We observed staff interacting with people in a caring and compassionate way. They also responded to people in distress in a calm, gentle and respectful manner. Staff appeared to be interested in people and anticipated their needs. During our observations on Ward 24, we saw many examples where staff treated people in a kind, caring and sensitive manner. Care was person-centred and people received care and support based on their individual needs.

All the interactions we observed between staff and people using the service were positive, and showed warmth and real engagement. The atmosphere on Ward 24 was calm and people appeared relaxed in the company of staff. One person who wished to walk around the ward was often accompanied by staff and this appeared to reassure them.

Good practice

- The design of Ward 24 was carefully considered. The team had worked hard to identify the best evidence in terms of designing a safe and therapeutic environment for older people with dementia.
- Some local integration meetings, which involved community psychiatric nurses, GPs, district nurses and others, were working particularly well. There was good communication and partnership working, which made sure that older people's needs were being met.
- There was a high level of investment in staff training and development across the service. This benefitted the service, people using the service and their carers.
- The service had successfully integrated the Chief Nursing Officer's 6Cs of nursing (care, compassion, competence, communication, courage and commitment) into the delivery of care on Ward 24. The 6Cs had been clearly explained to staff in the context of the care environment. This meant that they could be implemented effectively, which benefitted people and their carers.
- Staff at the memory assessment and treatment service clinic we visited provided excellent person-centred care to people and families who were attending for an assessment and diagnosis of memory impairment. The service was aware of, and responsive to, the needs of local communities and staff showed exceptional skill and sensitivity in the way they communicated with people.

Summary of findings

Areas for improvement

Action the provider **MUST** or **SHOULD** take to improve

- The service should ensure that all duplicate and multiple electronic records held about the same person using the service are removed from the system.
- The trust should improve the recording of people's views in care plan documents to show fully the participation of people in their care and recovery.
- The trust should provide people detained under the Mental Health Act 1983 with copies of section 17 leave more consistently.
- The trust should provide people seen at home by the community mental health team staff with information on how to make a complaint, or how to contact the patient advice and liaison service (PALS), as a matter of routine.
- The trust should offer people access to psychology services more consistently. Some community mental health teams for older people reported difficulty in accessing a psychologist, while others had a psychologist in the team, which was reported to be very beneficial to people using the service.

Bradford District Care Trust

Services for older people

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Ward 24	Airedale General Hospital
Older people's community mental health teams	BDCT Headquarters, New Mill
Bracken Ward	Airedale Centre for Mental Health

Mental Health Act responsibilities

The use of the Mental Health Act (MHA) 1983 was generally good in Ward 24 and Bracken Ward, the older people's inpatient wards. Statutory duties under the Act were being fulfilled and the MHA documentation we reviewed on the

wards was up-to-date and reflected the lawful detention of people. Care plans and risk assessments were documented although there was little formal record of people's and carers involvement in care planning.

Mental Capacity Act and Deprivation of Liberty Safeguards

The mental capacity of people using the service was assessed and discussed routinely in multi-disciplinary reviews of care. Staff demonstrated a clear understanding of the Mental Capacity Act 2005 and documentation was completed by the multidisciplinary team. Care plans were

in place for some people using the service that explicitly addressed issues of capacity and consent. There was no recorded use of Deprivation of Liberty Safeguards (DoLS) on Ward 24 or Bracken Ward in the last six months.

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

The service had a good track record on safety and provided a safe service for older people. Staff understood and implemented safeguarding procedures well. Community staff caseloads were also well-managed. This helped staff to deliver safe and effective care and treatment. In addition, there were good systems in place to manage risk on a day-to-day basis and make sure that lessons were learnt from any incidents.

Our findings

Airedale General Hospital

Track record on safety

Ward 24 had a good track record on safety. There was a clear system for the reporting of incidents. Staff were able to explain the process to us and described how they reported incidents via the trust's electronic reporting system. Staff knew the type of incident they were required to report and how to report them. All incidents were reviewed by the ward manager and the governance team who maintained oversight.

Information on safety was collected from different sources and used to monitor performance. A range of performance indicators were monitored every month and reported centrally. Information was collected on all incidents, including the number of falls that occurred on the ward. The ward manager told us that falls were the most frequently occurring incident and described action taken to reduce falls, which often related to a specific individual. The majority of falls had usually resulted in minimal or no harm to people. The overall reporting of incidents from April 2013 to March 2014 in the service for older people, as a whole, was low.

The governance and quality committee met monthly and reviewed all compliments, complaints, serious incidents and progress on action plans as well as risk registers.

Learning from incidents and improving safety standards

The ward manager maintained an overview of all incidents reported on the ward. Incidents were investigated and the outcome shared with staff on the ward and more widely at locality governance meetings. Staff told us incidents were discussed in team meetings and changes were made to the care of people as a result of any learning identified.

The manager provided us with examples of changes that had been made to services as a result of learning from incidents. Falls were the most frequently occurring incident and investigation of these had included a mapping of where falls had occurred to determine whether there were any common factors in the ward environment that increased or decreased the likelihood of falls. However, no clear pattern had emerged. All reviews of falls involved a review of the person's medicines and we saw a post-fall protocol on display on the staff office

When safety alerts were issued by the trust, these were shared with staff by the ward manager at team meetings and through individual supervision.

Reliable systems, processes and practices to keep people safe and safeguarded from abuse

We spoke with people using the service and carers we met on Ward 24. Everyone told us they felt confident in relation to the safety of people on the ward.

Staff had received training in safeguarding vulnerable adults and staff we spoke with knew how to recognise a safeguarding concern. Safeguarding was discussed at ward team meetings and during individual supervision to ensure staff had sufficient awareness and understanding of safeguarding procedures. Staff we spoke with were aware of the trust's safeguarding policy. They knew who to inform if they had safeguarding concerns. Staff provided examples of safeguarding referrals that had been made.

There was good, clear information available for staff and visitors to the ward with a dedicated noticeboard for safeguarding information. Some staff had completed train the trainer training in recognising and responding to abuse allegations.

We found that people's medicines were being managed safely. For example, when we checked the medicine

Are services safe?

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

management arrangements on Ward 24 we found all medicines stored in locked clinic room and the medicine cupboards and refrigerators were locked. The medicine keys were held by a nurse. Fridge temperatures were monitored to ensure that medicines requiring cold storage remained effective. We noted all recorded temperatures were within the required range.

Staff were aware of the trust's whistleblowing policy and told us they felt able to raise any concerns they had about the care and treatment of people who use the service with senior managers. Some staff gave us examples of when they had raised about concerns or suggestions for improvements in the care of people and said this had been received positively by senior staff.

Assessing and monitoring safety and risk

Staff were aware of the needs of people using the service and were able to explain how they were supporting them. Appropriate nursing handover took place between shifts. We observed a handover on Ward 24. The meeting included detailed discussion of people's needs, including any potential risks to their safety and how these should be managed or mitigated.

Staffing levels on the ward were sufficient to meet the needs of people using the service. The ward manager told us they were able to obtain additional staff when the needs of people changed and more staff were required to ensure their safety. The few staff vacancies were being actively recruited to. A new occupational therapist (OT) was due to start as a replacement for the OT who had recently left.

Bank and agency staff were used to cover any shortfalls in staffing. Regular 'bank' staff were used wherever possible so that care and treatment was provided by staff who were familiar with the ward routines and people's needs. Bank and agency staff were given a brief induction to the ward, which included orientation to the layout of the ward, an introduction to trust policies and procedures and where to access them and records management.

There were seven different consultant psychiatrists providing care and treatment to people on the ward. The manager told us that consultants contacted the ward everyday which enabled discussion of any concerns about people's care and treatment.

Staff told us current staffing levels were safe but they were not clear how the established staffing levels on each shift had been determined particularly in relation to skill mix of

qualified and unqualified staff. Staff told us that nights were particularly challenging as there was no cover provided for the qualified nurse to take a break. Action was being taken by senior managers to assess the optimal staffing needs of the ward using a clustering tool to measure the acuity and needs of people using the service.

Training records showed that most staff had been trained in how to restrain people safely. Training included the use of breakaway techniques and how to physically restrain a person. Staff told us they rarely needed to restrain people but sometimes used 'safe holds'. This was confirmed by trust records which showed there had been two records of incidents of use of restraint in the last six months. Supportive or safe holding of people had been reported on more than 30 occasions within the same time period. There was written guidance for staff on the use of restraint. This helped ensure the practice was lawful, carried out safely and was not excessive.

There was a policy in place addressing the covert administration of medicines which staff told us they occasionally needed to follow. However, we noted that the policy had been due for review in 2011 but this had not taken place.

We saw that individual risk assessments had been conducted in respect of people using the service. Staff told us that where particular risks were identified measures were put in place to ensure the risk was managed. Individual risk assessments we reviewed took account of people's previous history as well as their current mental state. Most risk assessments had been updated recently.

When a person was admitted to the ward a number of assessments of risk were conducted. For example, risks in respect of nutrition, skin integrity and falls were assessed. Where a risk was identified plans were put in place to support the person and minimise the risk.

We observed a staff handover between shifts at lunchtime on the ward. Communication about people's individual needs was clear and the handover included discussion of individual risks to people including any additional safety checks needed.

The ward manager was aware of the risks entered on the risk register for the ward and confirmed they were being managed effectively.

Are services safe?

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

Understanding and management of foreseeable risks

Regular environmental safety checks were carried out on Ward 24. This helped identify the need for any repairs and protect people from general risks in the ward environment. A ligature risk assessment was conducted annually.

Modifications had been made to the ward to make it safer, such as collapsible curtain rails. The ward manager told us there was a balance between managing existing ligature risks and having an environment that was helpful and appropriate for people with dementia.

There were good systems in place for infection prevention and control. The infection prevention and control lead nurse paid regular visits to the ward. All staff uniforms were laundered on site to ensure they were cleaned at the correct temperature. Senior managers maintained oversight of housekeeping staff. There were audits of infection control and prevention and staff hand hygiene to ensure that people who use the service and staff were protected against the risks of infection.

We saw that the ward was clean and people and carers told us that standards of cleanliness were usually good. The ward was well-maintained and the corridors were clear and clutter free. Staff disposed of sharp objects such as used needles and syringes appropriately in yellow bins. We saw these were not over-filled. People were provided with hygienic wipes to clean their hands prior to eating their meals which helped minimise the risk of infection.

Emergency equipment, including automated external defibrillators and oxygen, was in place and checked regularly to ensure it was fit for purpose and could be used effectively in an emergency. Medical devices were also checked regularly to ensure they were working correctly. Staff had undertaken training in life support techniques and this was due to be updated the day after our visit to the ward.

Regular fire risk assessments and fire tests were carried out including practice evacuations of the ward. This helped protect people from the risk of harm.

When staffing shortages needed to be filled, this was generally done through the use of bank staff. This was well managed on the ward, and regular staff, who were familiar

with the ward, were used to cover shift vacancies where possible. This meant most staff had knowledge of the ward and people using the service and were able to understand and manage foreseeable risks as a result.

Older people's community mental health teams

Track record on safety

The service for older people had a clear system in place for the reporting of incidents. Staff we spoke with clearly explained the process for reporting incidents through the electronic reporting system. Staff were confident in being able to report incidents appropriately. Information on safety was collected from a range of sources to monitor performance, this included information on incidents and trends were identified. The service had a good track record on safety. The overall reporting of incidents from April 2013 to March 2014, in the service for older people as a whole, was low.

Learning from incidents and improving safety standards

Staff told us that reporting incidents was encouraged. Incidents were investigated and the outcome shared with staff and more widely at local governance meetings. Staff told us that presentations of learning from serious incident investigations were delivered in culture of openness. Incidents were discussed in team meetings and changes were made to the care of people as a result of any learning identified. We found that both learning within and across teams took place. Staff told us, and we observed, that safety and risk was always discussed in team meetings.

Reliable systems, processes and practices to keep people safe and safeguarded from abuse

Staff had received training in safeguarding vulnerable adults. Staff we spoke with had excellent knowledge of safeguarding issues and knew how to recognise a safeguarding concern. Safeguarding was discussed at team meetings and during individual supervision to ensure staff had sufficient awareness and understanding of safeguarding procedures. Staff were aware of the trust's safeguarding policy. They provided examples of safeguarding referrals that had been made and we observed discussion of safeguarding concerns in a community team meeting. Caseload management discussions covered areas of risk such as child protection and adult safeguarding. Flow charts of safeguarding procedures were available to support staff and contained a list of important contacts in different local agencies.

Are services safe?

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Protocols were in place for the safe transfer of people from adult services to older people's services.

Staff were aware of the trust's whistleblowing policy and told us they felt able to raise any concerns they had about the care and treatment of people who use the service with senior managers.

When reviewing people's health care records we found examples of where duplicate or multiple electronic records had been created for the same person. In most cases this had been identified and the duplicate records had been closed. However, in one community team we noted that a person had multiple records in their name. This could have caused confusion for staff about the current care planned for the person, particularly those staff unfamiliar with the service and individuals using the service.

Assessing and monitoring safety and risk

Staffing in the community teams was sufficient to meet the needs of people using the service. The community teams had effective systems in place to manage caseloads. Community staff told us that caseloads were generally between 20 and 25 people although some staff told us they had less than 20. Individual caseloads were based on people's level of needs rather than being a specific number. Team members were supportive of each other and shared new referrals to ensure that staff were able to manage their work load safely and effectively. Staff told us how allocations of people using the service were sometimes changed depending upon the person's needs and who was best able to support them. Staff normally assessed new people to the service in pairs.

Staff were aware of the needs of people using the service and were able to explain to us how they were supporting people. We saw that individual risk assessments had been conducted in respect of people. Staff told us that where particular risks were identified measures were put in place to ensure the risk was managed. Individual risk assessments we reviewed took account of people's previous history as well as their current mental state. Most risk assessments had been updated recently, although we noted in one community team that a few risk assessments were not completed or were out of date. We observed a discussion of a new referral to a community team and saw that discussion of current and historical risk factors formed a prominent part of the overall assessment process.

Acute liaison team staff, who were part of the community mental health teams for older people, prioritised referrals based upon risk.

Community team staff were confident in risk management and used positive risk management in the community in order to prevent unnecessary admissions to hospital and to support people's wishes to be cared for and treated at home where this was possible and safe.

Community mental health team managers monitored the quality of risk assessments and addressed any shortfalls directly with individual staff. Community staff were aware of the risks entered on the risk register for their team. We observed a discussion of a new risk that had been identified in the team and systems put in place to prevent a reoccurrence of the situation.

Understanding and management of foreseeable risks

Systems were in place to maintain staff safety. The service had good lone working practices in the form of a buddy system, where staff informed another identified staff member of their whereabouts at all times and checked in with them at the end of the day. If there were any concerns about risk two staff carried out visits together.

We observed good discussion and consideration of risk and safety in the day to day management of people's care.

Airedale Centre for Mental Health

Track record on safety

Bracken ward had a good track record on safety. Staff were trained in safeguarding vulnerable adults and children. Staff we spoke with were knowledgeable about their responsibilities in regards to the safeguarding process. They described the process for referring any identified potential or actual concerns to the relevant department. Staff reported that ordinarily they would undertake this process via the support of their manager. The trust's safeguarding policy and procedure was available on the trust's intranet site and was easily accessible. Staff were able to provide appropriate examples of the type of safeguarding concerns they would report and described the process for completing this. Staff said they were encouraged to be open and transparent. They felt confident that if they raised a concern it would be listened to and dealt with appropriately.

Are services safe?

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

There was a clear system for reporting incidents. Both the manager and ward staff were able to explain the process to us and described how they reported incidents via the trust's electronic reporting system. Staff were aware of the types of incident they were required to report and the process for reporting it. The ward manager maintained oversight of all reported incidents and received a monthly report from the risk management team. We found a range of performance indicators were monitored every month and reported centrally. The manager was aware of any patterns and emerging themes for the ward, and we saw action plans in place to address these. The overall reporting of incidents in the service for older people as a whole was low between the period from April 2013 to March 2014.

Learning from incidents and improving safety standards

The trust's serious incident data demonstrated that trust-wide learning from serious incidents had been reviewed by the governance team and shared with staff throughout the trust. The manager informed us that learning from incidents was shared by the senior management team and disseminated via email. This was then forwarded to ward staff and/or discussed at team meetings where appropriate. Staff reported that incidents were discussed at team meetings and we saw minutes that confirmed this. If any learning had been identified, this was then reflected in changes made to people's care. Staff told us that reporting of incidents was encouraged.

We found evidence of learning taking place at a local level. For example, the ward identified gaps in information in regards to people's diet and fluid intake. In order to address this, Bracken Ward implemented protected meal times, whereby all staff attended the dining area at meal times in order to assist and support people who used the service. We observed this process on the day of our inspection and noted staff were available and responsive to people's needs. The manager reported that since introducing this new way of working the recording of diet and fluid intake had improved and this has had a consequent positive impact for the health of people who used the service.

Reliable systems, processes and practices to keep people safe and safeguarded from abuse

We found appropriate systems in place for the safe receipt, storage, handling and disposal of medication. Medicines were stored within locked cupboards in a secure clinic

room. The fridge in the clinic room contained certain medications. We found these medications were in date and that fridge temperatures were being maintained within the required range. We noted in the preceding three months there were a number of days when the fridge temperature had not been monitored. This oversight had been captured by an audit and we saw the issue had been discussed at a team meeting. We looked at a sample of medication administration records and found that these had been completed appropriately and corresponded with the medication stock levels.

We found evidence of reliable systems, processes and operating procedures in place for infection prevention and control. Training in this area was a mandatory requirement. We reviewed the policy and procedure in place and found it contained detailed guidance for staff to be able to follow. The trust has a 24-hour contact number for an infection control nurse should any member of staff have an emergency situation they needed guidance and advice on. Recently, the ward had a norovirus and all procedures were followed in relation to the outbreak and management of the virus to minimise the risks of spreading further. Measures put in place included: closing communal toilets; informing relatives; additional cleaning; and closing the ward to all but essential visits.

Staff had received training in safeguarding adults and staff we spoke with knew how to recognise a safeguarding concern. Staff were aware that some people may struggle to communicate concerns and needed to be mindful of more subtle evidence of abuse having potentially taken place. This included noting changes in behaviour, an example provided was a person becoming more withdrawn. Staff were aware of the trust's whistleblowing policy. They told us they felt confident to raise any concerns they had about the care and treatment of people who used the service with senior managers. Staff also confirmed that they would challenge poor practice at a local level with colleagues and broach any concerns with their manager where appropriate to do so.

People we spoke with told us they felt safe on the ward and were happy to discuss any concerns they had with staff should the need have arisen. Information on how to report abuse was on display in communal areas of the ward.

Assessing and monitoring safety and risk

Staffing levels on the ward were sufficient to meet the needs of the people who used the service. We observed

Are services safe?

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

that while staff were kept busy, they responded quickly to individual requests from people. When providing one-to-one support, people were not rushed and staff spent time supporting people at relaxed pace in order to ensure people were fully understood what was happening. The ward manager told us they were able to secure additional staff when the needs of people changed and more staff were required to ensure their safety. Staff told us that if a person needed increased observation, additional staffing would be arranged. This was usually accommodated by regular bank staff who had a working knowledge of the ward and understood the needs of the patient group. Staff confirmed that bank staff were appropriately inducted and orientated to the ward.

Bracken Ward operated staffing levels of five staff during the day (two qualified nurses and three healthcare support workers) and four staff at night (one qualified nurse and three healthcare support workers). Appropriate staffing levels for the ward were clearly displayed on a wall in the communal area and had the appearance of a traffic light system. We observed that staffing levels had remained 'green' since the opening of Bracken Ward approximately eight weeks before our inspection, indicating that appropriate and safe staffing levels had been maintained.

We found evidence of the service assessing and responding to individual risk. Risk assessments had been undertaken for each person who used the service. Where a risk was identified, a plan was put in place to ensure the risk was managed. Risk assessments took account of the current presentation as well as historical risk factors. Risk assessments were reviewed regularly and we found evidence of this in care records. The RIO electronic records system allowed for multiple teams to be involved in people's care via access to a central system. This meant that assessments undertaken in the community were accessible by ward staff and vice versa. This allowed for the timely transfer of information and ensured that risk issues were communicated in real time to the people that needed to know.

We observed a staff handover between shifts after lunch on the ward. The handover was comprehensive and included an overview of each patient's progress as well as any changes in terms of risk management. Staff had a good

understanding of each patient and used the meeting as a frank and open exchange to discuss progress what needed to be improved. Risk was considered more globally and not just in terms of how each person was presenting in the ward environment. Staff were aware of the individual social circumstances of each person discussed and used this information to inform discussions about discharge planning and any associated risks at home.

Understanding and management of foreseeable risks

We found evidence of regular environmental safety checks being carried on Bracken Ward. This included a monthly 'walk around' by the estates department to identify the need for any repairs and protect people from general risks in the ward environment. Estates and facilities staff undertook a Health and Safety assessment on 1 July 2014. This outlined areas of work still to be completed following the move to the Airedale site. The manager informed us that due to the building being new there had been a number of minor issues in regards to the fabric of the building and electronic systems that needed attention. These repairs and modifications had been undertaken swiftly in order to maintain safety and ensure the smooth running of the ward.

The moving of the ward to a new geographical area had caused some initial disruption to staffing levels, with eight staffing members having left due to the logistical difficulty of getting to the new unit. In order to manage and maintain appropriate staffing levels and to ensure safety, new staff were recruited and regular agency staff utilised to fill shortfalls in the interim.

Bracken Ward had a business continuity plan to manage the ward in a number of emergency situations. This included changes in demand as well as seasonal weather changes.

Staff were aware of what to do in a fire drill and where people should assemble. We did not see any personal emergency evacuation plans (PEEPs) in place for people who used the service. This was discussed with the ward manager who informed us they would amend the admission documentation to include this.

Are services effective?

Good 

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

Summary of findings

People's care and treatment was planned effectively, which helped to achieve good outcomes. Older people's needs were also comprehensively assessed. Staff delivered care that was in line with people's care plans, and that reflected people's individual needs. Staff received training, supervision, support and professional development that enabled them to deliver effective care. We also found that the way in which the multidisciplinary team worked together was excellent, and that information was shared appropriately.

Our findings

Airedale General Hospital

Assessment and delivery of care and treatment

Appropriate arrangements were in place to manage people's medicines effectively. We reviewed the medicine administration records of several people on the ward. Most had been completed appropriately and explained why any particular dose had been omitted. There was a regular audit of medicine records to ensure recording of administration was complete. The majority of medicines were administered as prescribed. Staff told us the pharmacist frequently reviewed medicine administration records to ensure that prescriptions and administration of anti-psychotic medicines were appropriate and not over-used.

People's needs were assessed and care was delivered in line with their individual care plans. Assessments included a review of the person's physical health with specific assessments of infection risks, skin integrity, and risk of falls and nutritional risks. Where physical health concerns had been identified care plans were put in place to ensure the person's needs were met. Records showed that risks to physical health were identified and managed effectively. We reviewed several care plans on the ward and these showed that individual plans were in place which addressed people's assessed needs. We saw that most of these were reviewed on a regular basis and updated or discontinued as appropriate.

When falls had occurred we saw that this was recorded in people's care records with reference to the incident report number. There was a falls protocol in place and evidence of medical assessment following falls.

Staff undertook training in the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS) every two years. Staff we spoke with demonstrated good understanding of the Mental Capacity Act. They were aware of recent legal decisions in respect of the Mental Capacity Act 2005. The legal status of the admission of people using the services had been reviewed as a result and action had been taken based on the legal advice obtained. There was no record of DoLS being used on Ward 24 in the last six months.

When we reviewed people's care records we saw that capacity assessments were discussed in multidisciplinary team meetings and documented, sometimes with good detail. Care plans were in place for some people using the service that explicitly addressed issues of capacity and consent.

Mealtimes on Ward 24 were protected, which meant that people were able to concentrate on eating and drinking without being disturbed by visitors including clinicians. They were able to eat and drink at any time and the ward kept stocks of tinned food and sandwich fillers in case anyone wanted a snack. This helped ensure people's nutritional needs were met. We saw that adapted cutlery had been provided to help people eat by themselves and a bright yellow plate was used by a person with a visual impairment as the contrast in colour allowed them to see their food more clearly.

The service responded promptly to ensure people's physical health needs were met. Ward 24 was located within an acute general hospital which facilitated access to physical health care services.

Outcomes for people using services

Staff provided care to people based on national guidance, such as National Institute for Clinical Excellence (NICE) guidelines, and were aware of recent changes in guidance. We saw evidence of discussion on NICE guidelines in people's health care notes.

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Ward staff carried out regular audits as a way of ensuring high quality care was provided to people. For example, we saw audits of people's care plans had been undertaken and detailed feedback provided to nurses to enable improvements.

The inpatient service was not formally benchmarked in relation to other services and no formal accreditation for the ward had been sought. However, the ward manager had visited other services, was aware of current research in the field of dementia care and actively sought to implement improvements in care and practice based on upon robust evidence.

Staff, equipment and facilities

Staff received appropriate training, supervision and professional development. Staff told us they had undertaken training pertinent to their role including in safeguarding vulnerable adults, fire safety and life support techniques. Records showed that most staff were up-to-date with statutory and mandatory training requirements and the training matrix was on display near the entrance to the ward. In addition, most staff had undertaken specialist training in dementia care. For example, several staff had attended training in 'Cornerstones of Person-Centred Dementia Care' at Bradford University and health care support workers had completed national vocational qualifications at levels two or three, following the dementia strand of the course. Health care support workers had been supported to develop competencies in physical health care

New staff undertook a period of induction before being included in the staffing numbers. Ward managers had access the electronic staff records which allowed them to maintain oversight of staff progress in respect of training completion. The training provided helped ensure staff were able to deliver care to people safely and to an appropriate standard.

All staff told us they had undergone a performance appraisal within the last year which confirmed performance figures on display in the ward. Individual supervision meetings took place every two months although formal records of the meetings were not kept. Most staff told us that supervision usually took place as planned although it was sometimes cancelled if the ward was particularly busy.

Equipment was checked regularly and monitored to ensure it was fit for purpose. Equipment was cleaned between uses, and labelled to show when it had last been cleaned. Service checks of equipment were carried out.

A range of meaningful activities were provided on the ward. We observed people taking part in group and one to one activities with staff. This included individual discussions about people's life histories and their likes and dislikes which were recorded in their own 'living well' folder. We also saw reminiscence work with people and quizzes and games where staff made active attempts to include everyone.

Multidisciplinary working

Assessments of people were multidisciplinary in approach, with involvement from medical, nursing and occupational therapists. There was evidence of effective multidisciplinary team (MDT) working in people's records. People who use the service had access to a range of professionals with specialist skills where needed. We saw that care plans included advice and input from different professionals involved in people's care. We observed a thorough discussion of a person's needs involving medical and nursing staff. Nursing staff described psychiatrists as "responsive and proactive".

Staff described good working relationships with community mental health teams and told us systems worked well in terms of effective discharge planning, care programme approach and seven-day follow-up post discharge.

Mental Health Act (MHA) 1983

Information on the rights of people who were detained was displayed in wards and independent mental health advocacy services were readily available to support people. Staff were aware of the need to explain people's rights to them. There was a leaflet providing information for people who were informally admitted to the ward about their legal rights, although we noted that this had not been updated for some time.

The use of the MHA was mostly good on the ward and we found people were being legally detained. Mental health documentation reviewed was generally found to be compliant with the Act and the Code of Practice in the detained patients' files we reviewed.

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We noted that although all section 17 leave was recorded in people's electronic records copies were not routinely provided to people who use the service. This practice did not comply with the MHA Code of Practice.

Older people's community mental health teams

Assessment and delivery of care and treatment

We noted during home visits that community psychiatric nurses routinely provided information to people about their medicines and potential side-effects.

The community teams used a duty system to ensure that calls to the teams could be responded to quickly. We noted that staff on duty were knowledgeable about the people being supported and cared for by the team and were able to respond effectively to enquiries from the police and other agencies. Staff on duty knew about on-going risks and how they were being managed.

People's needs were assessed and care was delivered in line with their individual care plans. A range of tools and scales were used to make assessments of people's mental health needs, such as, Becks Depression Inventory and the Young Schema Questionnaire. When we reviewed people's health care records we found detailed descriptions of people's issues with clear management plans in place. Comprehensive summaries of people's care were available and we saw evidence to show that people's physical health needs were assessed and responded to.

There were individual relapse/crisis plans in place to support people using the service in case they were needed.

Staff had undertaken training in the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS), which was updated every two years. Staff we spoke with demonstrated good understanding of the MCA. They were aware of recent legal decisions in respect of the MCA and how this affected their practice.

When reviewing people's health care records we noted some good examples of very detailed and specific assessments of people's mental capacity, whereas some others lacked detail.

The promotion of good physical and mental health was evident in case discussions we observed in a community mental health team meeting. Staff had good knowledge of the physical as well as mental health needs of older people.

Outcomes for people using services

Staff provided care to people based on national guidance, such as National Institute for Clinical Excellence (NICE) guidelines, and were aware of recent changes in guidance. For example, a staff member told us about the NICE guidelines for delirium and how these were reflected in their practice.

The community mental health teams were using a number of measures to evaluate the effectiveness of the service for older people. Health of the nation outcome scales (HoNOS) and patient-reported outcome measures (PROMS) were used to measure clinical outcomes for people using the older people's service. Record keeping audits and audits of care planning were carried out regularly. Performance targets included a target of 12 months for conducting care programme approach (CPA) reviews and follow-up within seven days of people discharged from older people's inpatient services. A team manager told us the seven-day follow-up target was routinely met, although targets in respect of completion of carers' assessments were not. This was being addressed with staff in order to bring about improvement.

Staff, equipment and facilities

Staff received appropriate training, supervision and professional development. Staff told us they had undertaken training pertinent to their role including in safeguarding vulnerable adults and that the trust was very supportive in respect of staff training and development. Records showed that most staff were up to date with statutory and mandatory training requirements.

Staff were well supported to attend additional specialist training and development opportunities. For example, staff in one community team were to attend a course in using Montessori principles to work creatively with people with dementia. Another community team were due to undertake training on physical health care during the week of our visit and specific dementia training was being organised for those staff that needed it.

All staff told us they had undergone a performance appraisal within the last year. Appraisals were used to identify staff learning and development needs. Staff received regular managerial and clinical supervision.

Multidisciplinary working

Assessments of people were multidisciplinary in approach, with involvement from medical, nursing and occupational

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therapy. There was evidence of effective multidisciplinary team (MDT) working in people's records. People who use the service had access to a range of professionals with specialist skills, such as speech and language therapists, where needed. We saw that care plans included advice and input from different professionals involved in people's care. In some community teams we found that staff valued the different disciplines in the team and worked exceptionally well together.

Specific services, such as the memory assessment and treatment service clinics and day hospitals, had been developed to provide specialist assessment and care.

Information sharing between inpatient mental health wards and community services was effective and staff told us they worked well together. However, staff reported that communication about the discharge of people using the older people's service from acute hospital wards was poor. This was despite repeated reminders to acute hospital staff to inform the community mental health team when the person was discharged.

The community teams did not have social workers embedded within the team. This was a recent development for some teams although others told us there had never been a social worker in the particular community mental health team for older people. If social services involvement was required appropriate referrals were made. Staff told us this often resulted in a delay to people receiving social worker involvement. One manager described "struggling" to get social work input.

Community mental health teams for older people demonstrated good inter-agency working with other organisations. For example, the Alzheimer's society undertook some joint sessions with the teams at the day hospitals. Joint visits were undertaken with district nurses when relevant to the person's care. The care home liaison teams and acute liaison teams worked well with other services. The care home liaison team worked closely with community matrons and delivered support to people and staff in care homes. We observed a community psychiatric nurse give a clear and detailed handover of information to care home staff about a person they had assessed.

Local integrated care meetings took place, which involved community psychiatric nurses, GPs, district nurses and others. Some integrated care meetings were working particularly effectively to ensure older people's

comprehensive needs were being met through good communication and partnership working. Multidisciplinary care plans were produced with a focus on people most at risk of admission to hospital. Services were being designed around the individual rather than services.

Airedale Centre for Mental Health

Assessment and delivery of care and treatment

We reviewed records and found that staff had carried out comprehensive assessments of people admitted to the ward which covered both health and social care needs. These assessments informed the content of individualised care plans. Where physical and mental health care needs had been identified, care plans were put in place to ensure the person's needs were met. We observed care being delivered to people in line with their care plans. People we spoke with described feeling optimistic about their future and that the care and treatment they received gave them hope. One person commented, "Staff are working with me to get me home, I am holding on to that."

Records demonstrated that appropriate risk assessments had been undertaken and were reviewed regularly. We reviewed several risk assessments and found these were comprehensive and updated to take account of any changes in people's presentation and associated risks to themselves or others. Risk assessments were clearly set out and maintained a balance between the rights of people to make choices whilst appreciating the need to minimise risk and keep people safe.

We found that the provider was providing evidence-based assessment, care and treatment in line with recognised guidance, standards of best practice and legislation. Overall we observed good compliance with both the Mental Health Act 1983 and the Mental Capacity Act (MCA) 2005. We saw evidence of the staff team working within NICE (National Institute for Health and Care Excellence) guidelines. For example, 'CG178 Psychosis and schizophrenia in adults: treatment and management'. This included practices whereby staff listened to people and took account of wishes and preferences. We also saw staff who were competent in assessing people from diverse ethnic and cultural backgrounds. The multi-disciplinary team were aware of cultural and ethnic differences in treatment expectations and adherence to agreed treatment options. We observed plans put in place to address identified cultural needs which included liaising with specialist community-based services.

Are services effective?

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We observed people being supported to make choices and informed decisions about their care and treatment. Mechanisms were in place to seek consent, and to record and keep under review consent decisions. We reviewed care records and found that capacity assessments were discussed in multi-disciplinary team meetings and this was clearly recorded in care files. Staff were aware of and had undertaken training in the MCA and Deprivation of Liberty Safeguards (DoLS). They were able to tell us the circumstances in which they would seek assessment of a person's mental capacity. Staff were aware that mental capacity was issue and time specific and that irrespective of the outcome of the assessment, this would not preclude involvement by the person in decisions about their care and treatment.

Outcomes for people using services

We looked at how the delivery of care and treatment achieved positive outcomes for people who used the service. We saw that people's progress and needs were assessed daily and communicated effectively via staff handovers. These handovers covered significant issues as well as progress to agreed goals for each individual. Progress and outcomes were also discussed at ward rounds.

Bracken Ward was currently in the process of introducing PROMs (patient-reported outcome measures). This will involve collecting survey data from people who use the service in order to measure and understand the quality of the services that were being delivered and whether people were achieving positive outcomes. Staff were aware of the organisational change which promoted the planned introduction of PROMs and were able to understand the direct link between funding that the service received through their work to deliver high quality care and to achieve good outcomes.

We found evidence of patient feedback being collected and used to improve service provision. The ward were using a feedback form with 12 questions relating to patient experience on the ward. The information collected was communicated to the trust centrally and the ward was then given feedback on necessary improvements.

Staff equipment and facilities

Staff described feeling competent and confident to fulfil their role and meet the needs of people who used the service. Staff told us they had undertaken training relevant to their role. This included additional role specific training

outside of the mandatory training program. Records we reviewed showed that most staff were up-to-date with their mandatory training and the ward manager had oversight of who had completed what and when on an electronic matrix. New staff and staff who had missed training due to absence for example were clearly identified on this matrix and plans were in place for the necessary training to be undertaken.

New staff undertook a period of induction before being included in the staffing numbers and were given an induction pack covering trust systems, policies and procedures. Staff described a process of 'shadowing' whereby new staff shadow an experienced worker in order to gain confidence and skills before providing any direct care and support.

All staff told us they had received an annual performance appraisal and we saw records which confirmed this. Staff described good support from their manager as well as peer support from the team. Staff reported that if they had a particular issue relating to their practice or were unsure about something they would broach this with their manager, who would make themselves available. Staff described a process of ad-hoc/informal supervision. We found limited evidence of regular planned clinical supervision or records which would support this. We discussed this with the manager and they confirmed that this had been given a lower priority in the context of the busy period due to the recent move to a new location. The manager assured us that plans were in place to recommence regular planned supervision.

There was a range of meaningful activities provided on the ward and a time-table was on display in the communal area. This included creative art groups as well as quizzes and bingo. Patients we spoke with described enjoying the activities on offer and said that staff encouraged them to get involved.

We found that equipment was checked regularly and monitored to check it was fit for purpose. Facilities on the ward were good and there was ample space both inside and outside the building for people to partake in various activities. Numerous rooms were available and we observed how these were utilised to support people to have private time with their families. The ward had access to an adapted kitchen and we were told how this was used to help people rebuild their skills and confidence as part of their recovery focused discharge planning. We saw in

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electronic records how this important work was followed up in the community and evidence of occupational therapists from the ward having undertaken assessments of people at home. People spoke positively about the new building and facilities. Comments included. "Nice to have my own bathroom" and "The rooms are nice, there have been some problems with it being a new build but they get it sorted quickly."

Multidisciplinary working

The staff team on Bracken Ward was multidisciplinary and comprised occupational therapists, nursing and medical staff. We found evidence of effective multidisciplinary working in people's records and observed a healthy working culture between the various professionals during meetings, ward reviews and staff handovers. Assessments generally involved the whole team, with each discipline contributing to each person's individual care plan. Information on patients subject to the Care Programme Approach was shared on the electronic system which all the different professions could access.

Staff described working within a cohesive team which had respect for each other's skills and respective background. We found positive links between the ward and community services and that communication between all the teams involved in an individual's care was good. We observed a ward review which was attended by a representative from the community mental health team (CMHT) as well as staff from Bracken Ward. We found that when people were admitted to the ward there was close liaison with the community team. This continued throughout the admission as well as when planning for discharge. The multidisciplinary working and coordination with community teams ensured a smooth transition between services and minimised any unnecessary blocks to the patient pathway. One person we spoke with commented, "They are sending me home next week and my CPN (community psychiatric nurse) will then take over."

Mental Health Act (MHA) 1983

On the day of our inspection to the ward, there were two people who were detained under the MHA. We found that these individuals had been lawfully detained and that their detention was founded on the required two medical recommendations as well as an application by the approved mental health professional (AMHP). People told us they had been informed of their legal rights when they were admitted to the ward and we found this recorded in care records. Staff were aware of the need to explain people's rights to them. There were leaflets available providing information to people who had been admitted informally as well as those people who had been detained under the MHA. These leaflets were available in multiple languages in order to meet the diverse population the ward serves.

We looked at leave granted under section 17 of the MHA. We found that this was recorded in people's electronic records. At our MHA monitoring visit in April 2014, we found that conditions were not being specified on leave forms. During this inspection the two leave forms we reviewed contained conditions which were clearly recorded. However, we found that copies of leave forms were not routinely provided to people who used the service which is not in line with the MHA Code of Practice.

We found evidence of assessments of capacity to consent to care and treatment. These were clearly recorded in electronic records.

We saw some good practice in regards to compliance with the MHA. Staff were well aware as to the guiding principles of the MHA Code of Practice such as 'participation' and 'least restriction' principles. We observed creative care planning which was person-centred, allowed for positive risk-taking and minimised the restrictions imposed on people's liberty.

Are services caring?

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

Summary of findings

Staff provided kind and compassionate care and support to older people and their carers. They responded calmly and sensitively to people in distress and respected people's dignity and privacy. Staff provided person-centred care and there was clear evidence that carers were also involved. We found that the services were interested in the people they cared for as individuals, and that staff were committed to providing good quality care.

Our findings

Airedale General Hospital

Kindness, dignity and respect

People's privacy and dignity were respected. People who use the service and carers told us staff treated them with respect. We observed staff interacting with people in a caring and compassionate way. Staff responded to people in distress in a calm, gentle and respectful manner. They appeared interested and engaged in providing good quality care to people and anticipated people's needs.

People using the service and carers told us they were treated well and supported by staff. For example, one relative told us "I have been fully supported by staff and involved in my relatives care." Staff were described and "always helpful" and "amazing."

As several people on Ward 24 were unable to speak with us directly about their experience of care we carried out several periods of observation in the lounge including one period where we used the short observational framework for inspection (SOFI 2) to help us understand people's experiences on the ward. During our observation we noted many examples of kind, caring and sensitive interactions between staff and people using the service. People were encouraged to take fluids regularly and assisted to sit comfortably in their chairs. Staff asked people how they were feeling. Staff positioned themselves at the same height as people using the service and used touch appropriately to gain and maintain people's attention. Those people who required help eating and drinking were given one to one assistance. Staff worked with people in a person-centred way.

All interactions we observed were positive and showed real engagement with people. The ward atmosphere was calm and people appeared relaxed in the company of staff. A person who wished to walk around the ward was often accompanied by staff and this appeared to reassure them. It was evident that staff had adopted the Chief Nursing Officer's '6Cs of nursing' and implemented them in their practice.

People were asked for their consent before observations were carried out. For example, we saw a nurse ask a person for their consent to taking a blood sample.

People using services involvement

Staff told us that they involved people and their carers in people's care as much as possible although there were no formal arrangements for this. Staff asked carers about people's likes and dislikes so as to be able to provide care appropriately. These were recorded in 'living well' folders although we found that the information in some people's folders was quite minimal. There was little recorded in people's care records to suggest that they or their relatives had been involved in developing the care plan.

Staff showed understanding of carers' needs and offered support as well as signposting them to local voluntary sector organisations for additional support. Carers were invited to care programme approach meetings and ward rounds to discuss people's care and progress.

Emotional support for care and treatment

Staff provided good emotional support to people on the ward at an individual level. We observed staff taking time to explain and support people in a sensitive manner. They responded to the needs of relatives and carers and took time to explain care and treatment and address any concerns.

Staff promoted self-care and people's independence. People were supported to maintain social contact through flexible visiting and the provision of regular social activities on the ward.

A productive wards initiative had led to the development of a carers information pack. Carers we spoke with confirmed they had received a pack and found it useful.

Older people's community mental health teams

Kindness, dignity and respect

We accompanied several community staff on visits to people, with their permission, and met with people and

Are services caring?

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carers at a day centre and memory assessment and treatment service clinic. People we spoke with were very positive about the older people's service. For example, one person said, "I can't fault the service," and another described it as a "first class service." People told us they were always treated with respect.

A person we visited in the community told us they were very happy with the service they received from their community psychiatric nurse. Another person said community staff were "uplifting" and "got me out of a hole." This was typical of feedback we received from people using the service and carers.

When we observed staff interactions with people using the service, we saw they were kind, compassionate and respectful to people. They demonstrated a caring and understanding attitude. When people were discussed during referral and allocation meetings this was done respectfully and staff showed real empathy for the people they spoke about and worked with. Staff demonstrated respect for people's cultural beliefs.

People using services involvement

People were involved in their care. People's choices were respected and we saw examples of when care had been refused and this had been respected. When people had asked for a change of consultant or allocated community psychiatric nurse the request had been accommodated and a different nurse or consultant assigned. However, we found little information in people's care records about how they were being involved in care planning.

Day services for older people were developing a programme of activities in conjunction with people who used the day services, which included older people.

Emotional support for care and treatment

Community staff told us that they involved people and their carers in people's care as much as possible. They supported carers directly and signposted them to other organisations for additional support. Managers and staff acknowledged that formal carer assessments did not always take place and we observed this issue being discussed in one community team meeting.

We observed considerable emotional support provided to carers and people who use the service by staff. Staff were committed to working towards people's recovery.

Staff in the memory assessment and treatment service clinic we visited were sensitive to people's need for information on their diagnosis. People were asked before the assessment how much they wanted to know about their memory problems and whether they would like a diagnosis. Written information about diagnoses was given to people and carers to take away.

People's pets were included in their care plans when these were important to them. This reflected community team staff's understanding of people's individual needs.

Airedale Centre for Mental Health

Kindness, dignity and respect

People who used the service told us that staff were kind and treated them with respect. We observed positive interactions between staff and patients on the ward. When responding to people in distress, staff spoke softly and were both patient and calm. Staff were skilled at using key reference points individual to the patients that helped promote good communication and reduce levels of anxiety and distress. When responding to individuals in distress, staff respected privacy and dignity by encouraging people to walk with them to a quieter area of the ward. This was also the case when staff were planning and discussing aspects of their care with the individual concerned.

People told us that they had good relationships with the staff. For example, one person told us "The staff are excellent, second to none and nothing is too much trouble." Other comments included; "The staff got me well and cared for me" and "They know me well, I have known the staff a long time, they understand me when I am unwell."

Before people were provided with care and support their consent was sought. We noted that this consent was revisited throughout the care and support task. This demonstrated to us that staff were aware that consent is ongoing and can be withdrawn by the person at any time.

A number of people on Bracken Ward were unable to speak with us directly about their experience of care and treatment. To help us understand their individual experiences we used the Short Observational Framework for Inspection (SOFI 2). During our observation we noted that staff were warm and engaging in their manner. They demonstrated genuine affection and used touch appropriately to enhance interactions. We saw evidence of enabling practice whereby people were recognised and

Are services caring?

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encouraged to be active participants in their care and support. Furthermore, we observed appropriate self-disclosure by staff to encourage people to engage in talking about their families and wider social networks. Staff had a clear understanding of the care and support needs of the people who used the service as well as knowledge about people's circumstances in the community.

People using services involvement

People were involved in their care. We saw examples of staff working in partnership with people to formulate their care plan. People's choices were respected. We observed two multidisciplinary reviews on Bracken Ward. On each occasion the person was fully involved in decisions about their care and was actively encouraged to set out their personal wishes and goals. Staff had effective communication skills and conflicts of opinion were handled sensitively. When formulating plans for leave from the ward, there were open and frank discussions about the various options and choices available, as well as the associated risks and benefits of each option. One person we spoke with told us "I get involved with decisions about my care, they always ask my opinion."

While we found good evidence of involving people in decisions about their care, this was not reflected in care plan documents. We reviewed the records of six people who used the service and found that the 'service user view' section of the care plan was blank in three of them. The three that had been completed were brief and contained limited meaningful information in regards to the views of the person and how they wished to be supported.

People were supported to make informed decisions about their care. Where appropriate, the staff had sought the views of family and arranged interpreters for people whose first language was not English. We saw that staff supported people to access advocacy services and the services available were clearly displayed in communal areas. Staff were aware of and provided necessary support to people who appeared to require advocacy service but struggled to make appropriate arrangements for themselves.

Staff had a good understanding of the Mental Capacity Act (2005) and the fundamental principles of 'assumed capacity' and making decisions in people's 'best interest' for individuals deemed to lack capacity to make certain decisions. We saw documentary evidence of capacity assessments having been undertaken. Records of these were contained in individual care files.

Emotional support for care and treatment

Staff provided good emotional support to people on Bracken Ward. We observed staff encouraging people to get actively involved in caring for themselves. There was a good balance between the promotion of self-care and staff providing assistance where appropriate. This meant that people were supported to be as independent as possible and people's skills and attributes were maintained during their admission to the ward. When providing care or support staff did not rush people and took their time to explain what was happening in the context of each person's individual care plan.

We found evidence of staff supporting people to keep in contact with their family and social networks. During a review on the ward we observed staff supporting an individual who was struggling emotionally with their admission. The person was concerned about who was caring for his family whilst they were away from home. Staff worked closely with this patient to keep in contact with his family, provide reassurance and to develop a plan in partnership to facilitate their discharge home. Staff understood the cultural context of these concerns in terms of the temporary loss of role in respect of this person's position in the family.

Visitors to the ward were encouraged and supported with visiting times and we saw that meetings involving family for example were arranged at times to accommodate people's family and work commitments.

Are services responsive to people's needs?

Good 

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

Summary of findings

Services for older people were responsive to people's needs. There were clear care pathways in place, and the teams understood people's needs and wishes and could respond to these. Services were also planned and delivered in a way that met the different needs of the local communities. In addition, there was an extended community service, which operated seven days week and ensured that services were responsive.

Our findings

Airedale General Hospital

Planning and delivering services

Information from the trust showed there had been a mean bed occupancy rate of 74% on Ward 24 over the last six months. As a result people who needed to be admitted to an inpatient bed could do so in a timely way. On the day of our visit to Ward 24, we noted there were 12 people admitted to the 19-bed ward. There was an average length of stay of six to eight weeks on the ward.

Male and female sleeping areas were separate on the ward and there were separate bath/shower and toilet facilities.

Right care at the right time

Care was delivered in the ward by a multidisciplinary team. Most admissions to the ward came via a consultant psychiatrist or the older people's community mental health teams. The aim of the service was to discharge people once they had reached an optimal level of functioning. Occupational therapists carried out home assessments and were able to ensure necessary arrangements were in place before people were discharged. Staff told us that discharge from the ward was sometimes delayed while a package of care for the person was agreed or when a person needed a greater level of support than they had been receiving before admission. Data we received from the trust showed that there had been 23 delayed discharges in the last six months.

Staff described the discharge process to us for a person who had been on the ward for an extended period of time.

The discharge plan in place aimed to achieve a smooth transition of care from the ward to a care home. The person's specific individual needs had been considered and planned for by the multidisciplinary team.

A target of seven-day follow-up post-discharge by community staff was in place and mostly achieved. Discharge summaries were sent to people's GPs by the ward administrator to ensure they were kept informed of the person's progress and on-going needs, including medicines prescribed. There had been no recorded readmissions to the service within 90 days of discharge.

Ward staff reported that people's care co-ordinators were invited to care programme approach (CPA) meetings and usually attended.

Care pathway

There were clear care pathways in evidence. The clinical manager for the service reported that meetings had been held with commissioners and others to develop a smoother pathway and facilitate discharges for people with complex needs, particularly where funding of care needed to be agreed.

Care was delivered in the inpatient service by a multidisciplinary team. In addition, there was input from specialist teams, such as physical healthcare teams, when required.

People's diversity and human rights were respected. Attempts were made to meet people's individual needs including cultural, language and religious needs. Contact details for representatives from different faiths were provided and local faith representatives visited people on the ward.

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

Staff told us that very few people from black and ethnic minority groups were admitted to the ward. Some consideration of why this was the case had taken place. However, staff provided examples of how they had tried to meet the particular needs of people admitted. There was written information available on the ward in several local languages and interpreters were accessible when needed. This included information on recognising dementia in south Asian communities.

Are services responsive to people's needs?

Good 

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

Learning from concerns and complaints

There was a system in place to learn from complaints. We saw information on how to make a complaint was displayed in the ward. Information on the patient advice and liaison service (PALS) and mental health advocacy services for older people were also displayed. The carers' information pack also contained information on how to make a complaint or raise concerns about care. Staff provided examples of how changes had been implemented following complaints including the development of a protocol for admissions of people with functional health problems.

Staff told us they tried to address people's and carers' concerns informally as they arose. Most carers we spoke with told us they felt they would be able to raise a concern should they have one, and believed they would be listened to by staff. Trust data on complaints showed that there had been two formal complaints in relation to Ward 24 in the last 12 months both of which had been upheld.

Older people's community mental health teams

Planning and delivering services

The service provided support for older people with functional and organic conditions. A number of specialist services had been developed to meet the needs of these groups. These included the memory assessment and treatment service provided from a number of local clinics, the acute liaison teams and care home liaison teams.

The community teams provided care and treatment to people via an extended service operating over seven days. This reduced the need for older people to access crisis services and helped in preventing admission to hospital. The flexibility of the service allowed one person using the service to receive their medicine by injection on a Sunday as they preferred.

Community staff told us that if an inpatient bed was needed for a person using the service this was nearly always available. They told us that access to inpatient beds could be arranged for people in advance where there were concerns that they may not be able to maintain their safety at home. People were well supported in the community which reduced the need for inpatient beds. Staff described several examples of good preventative work with people that enabled them to remain at home and good contingency planning meant people rarely needed to use crisis services.

The trust had recently introduced an administration hub which meant that all calls to the community teams were routed via the hub, which then made contact with team members. Staff told us that this system was not working particularly well. People had complained about not being able to get through on the telephone. Some referrals were reported to have been misdirected to other teams. In addition the hub was a Monday- to-Friday service. At weekends, people could not access community mental health teams via the administration hub. Staff in the acute liaison team told us that referrals were generally faxed through to the team so the lack of administration hub at the weekend did not affect referrals coming through to the teams. Teams operated a duty system which meant people using the service and carers could contact teams directly and did not have to always go through the administration hub to contact staff.

Staff told us that the electronic records system was unreliable and often froze or was slow to open, which led to considerable time being wasted. One staff member described the system as "slow and ineffective." In rural areas staff told us that connectivity was inconsistent and this made communication via the telephone or intranet difficult at times.

We noted that access to psychology services was patchy across the community teams. Craven older people's community mental health team had a psychologist embedded in the team which staff told us was very helpful. Other teams told us there was often a long wait for people to see a psychologist.

Right care at the right time

Care and treatment was delivered by multidisciplinary teams. We observed a referrals meeting taking place and noted that people were allocated to staff according to their needs.

Waiting times for services were monitored. None of the older people's community mental health teams reported having a waiting list for services. The service was very responsive and able to provide timely assessments of people's needs. For example, the acute liaison team usually assessed people within 24 hours of receiving a referral. Acute liaison team staff were able to access people's acute care electronic records in order to monitor test results. This helped in the prioritisation of assessments as the information indicated the person's level of medical fitness.

Are services responsive to people's needs?

Good 

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

There was a waiting list of several weeks for the memory assessment and treatment service. A manager told us this was being addressed and the waiting time had been reduced substantially from six months.

The community teams followed-up people promptly after they were discharged from the in-patient mental health wards. They were good at meeting the target of follow-up within seven days and some teams told us they aimed to complete this within three days.

When we observed a community team allocations meeting we noted that care was patient centred and responsive to people's individual needs.

Care pathway

Clear care pathways were evident. The acute liaison team worked closely with staff in acute hospitals and intermediate care and responded quickly to referrals for the assessment of older people. We accompanied a member of the acute liaison team on a visit to an acute hospital ward to assess an older person's mental health needs. The referral had just been received by the team and given a high priority.

Systems in place to ensure the effective transfer of people from acute adult teams were good. Discussions took place between services to ensure the person was placed with the team that could best meet their needs. There was no strict age cut off for transition from one service to another. Decisions were based on the needs of the individual.

People's diversity and human rights were respected. Staff had undertaken training in equality and diversity although this was in need of updating.

We found examples of culturally sensitive services being provided to older people using the service, such as a multi-cultural day at the therapeutic day centre. This was provided by multi-lingual staff. The memory assessment and treatment service clinic we visited was provided in a way that focused on the needs of the local community. Staff were deliberately recruited who spoke local languages. Assessment tools had also been adapted to make them more effective with the population served. The psychologist at the clinic we spoke with was fluent in three local languages and conducted assessments in the person's preferred language where possible.

Community teams worked well with voluntary sector organisations supporting local black and minority ethnic communities. Voluntary organisations were seen as integral to people's care.

Teams were diverse and many staff had additional language skills which meant they could communicate directly with the diverse local population. Interpreting services were accessible when needed.

Learning from concerns and complaints

There was a system in place to learn from complaints. We saw information on how to make a complaint was displayed in community team offices, day centre and memory assessment and treatment service clinic. Information on the patient advice and liaison service (PALS) and independent mental health advocacy services for older people was also available. However, people who were seen by community staff at home were not routinely provided with information on how to make a complaint or contact the patient advice and liaison service (PALS).

Staff told us they tried to address people's and carers' concerns informally as they arose and provided examples of changes made to people's care as a result. Most people and carers we spoke with told us they felt they would be able to raise a concern should they have one, and believed they would be listened to by staff. Trust data on complaints showed that there had been three formal complaints in respect of the older people's community mental health teams in the last 12 months, one of which had been upheld.

Airedale Centre for Mental Health

Planning and delivering services

Information from the trust showed for 2013/14, the number of admissions was 74 and the number of discharges was 72. People who needed to be admitted to an inpatient bed could do so in a timely way. On the day of our visit to the ward we noted there were 10 people admitted to the 22-bed ward. There was a year to date median length of stay of 46.5 days from April 2013 to March 2014.

Male and female sleeping areas were separate on the ward with all rooms having ensuite facilities.

The ward had a business continuity plan to manage the ward in a number of emergency situations.

Are services responsive to people's needs?

Good 

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

We reviewed the medicine management policy and procedure; we found this provided detailed guidance on how to manage medicines, record administration of medication and manage controlled drugs.

People using the service on Bracken Ward did not have personal evacuation plans in place. This was discussed with the manager who confirmed this is a recommendation from the trust's fire officer and he will review the admission process to include this within the care planning documentation.

Right care at the right time

We reviewed the transfer and discharge policy and procedure; this was comprehensive guidance on how to discharge or transfer a patient between mental health services or to the acute hospital at Bradford Royal Infirmary. There was guidance on the minimum documentation which should be prepared and accompany the patient during these stages of their care. This included an emergency contact number should the family, patient or other professionals need further support. The discharge summary in place aimed to achieve a smooth and timely transfer of information to the patients GP; this was completed electronically on discharge from the ward.

Care pathway

Care was delivered in the inpatient service by a multidisciplinary team. In addition, there was input from specialist teams, such as physical healthcare teams and when required diabetic and dietetic services from the Bradford Royal Infirmary were accessed.

People's diversity and human rights were respected. Attempts were made to meet people's individual needs including cultural, language and religious needs. We saw that patient information leaflets on the Mental Health Act were available in 26 different languages.

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

Listening and learning from complaints

We reviewed the complaints policy and procedure and could see evident that there was a system in place to manage and learn from complaints. We saw information leaflets on how to make a complaint was in the family room for access for visitors. Information on the patient advice and liaison service (PALS) and mental health advocacy services for older people were also displayed.

For the period April 2013 to March 2014 the ward had not received any formal complaints and there had been no serious incidents.

Are services well-led?

Good 

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

Summary of findings

The trust's vision and direction was communicated effectively to staff. The governance structure in place also supported the delivery of the service. Services for older people were joined-up and well-led, and managers were visible and accessible to people who use the service, carers and staff. The trust encouraged development of the service and also involved people who use the service and their carers.

Our findings

Airedale General Hospital

Vision and strategy

The trust's vision and strategies for the service were evident and on display in the ward. Staff told us they understood the vision and direction of the trust and felt connected to senior management and the trust board. Staff felt that dementia care services were an increasingly high priority for the trust. Trust messages were cascaded via a regular newsletter and in team meetings.

Responsible governance

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

The ward manager had regular contact with the clinical manager and felt well supported. The clinical manager received a copy of all incidents reported on the ward and checked that any resulting actions were followed through. They visited the ward daily and maintained oversight of the quality of care provided. The trust's medical director had visited Ward 24 recently and assisted with the provision of meals to people using the service. Senior managers were said to be very responsive when approached.

Staff understood the management structure and where to seek additional support. For example, when we spoke with staff about safeguarding processes, they all told us they would seek advice from the ward manager or in their absence the safeguarding team for the trust if they needed to.

Data on performance was collected regularly. Information on monthly performance was on display near the entrance to the ward where people who use the service, visitors and staff could see it. Performance against these targets was monitored by senior managers to ensure any shortfalls were addressed.

Leadership and culture

We found Ward 24 was well-led and there was evidence of clear leadership at a local level. The ward manager was visible on the ward during the day-to-day provision of care and treatment to people, was accessible to staff and proactive in providing support to people. The culture on the ward was open and encouraged staff to bring forward ideas for improvements in care. Staff told us they felt valued and empowered to develop and improve the service.

The service was proactive and anticipated and planned for change.

Staff we spoke with were enthusiastic and engaged with ward developments, including plans to move the ward to another site in 2015. The ward manager had undertaken considerable research in respect of appropriate environments for people with dementia and had contributed to the design of the new facility. Estates and facilities staff had been engaged in the process and had accompanied the ward manager on a visit to another service for people with dementia which had a reputation for excellence in design.

Staff told us they felt able to report incidents, raise concerns and make suggestions for improvements and were confident they would be listened to by senior managers. Ward staff praised their manager. Performance indicators were displayed near the ward entrance which meant information on ward performance was available to people who use the service and visitors. This reflected the open ward culture.

Engagement

Care was person-centred. Ward staff encouraged the engagement and involvement of people on a day to day basis.

A local carers' action group was active in raising concerns about the planned move of Ward 24 in 2015. The trust was

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aware of concerns related to increased travel time and costs for carers and visitors to the proposed new ward and had agreed to finance increased transport costs for a fixed time period in response to these concerns.

The service user and carer involvement group met regularly. Representatives from the group were involved in interview panels for the recruitment of new staff and in designing and reviewing written information prepared by the trust to ensure it met people's needs in terms of clarity and appropriateness.

Letters were sent to people recently discharged from the ward and their carers requesting feedback about the care and treatment provided. The ward manager reported a response rate of 70% and said that most of the feedback was positive. Improvements had been made in response to feedback received from people and carers. For example, improved signage had been introduced.

We spoke with staff at different levels on the ward. All staff reported feeling very supported by their manager. Staff were kept up-to-date about developments in the trust through regular newsletters and emails. Staff on the ward had the opportunity to meet weekly with the ward manager to discuss the planned move of the service in 2015 and were positive about this approach.

Performance improvement

The ward manager told us they had access to ongoing leadership training and development, which had been very beneficial in terms of increasing skills and confidence.

Data on performance was collected monthly. Performance measures included completion of staff training and appraisal and clinical measures such as the number of incidents and complaints reported. Performance against these targets was monitored by senior managers to ensure any shortfalls were addressed. Where performance did not meet the expected standard, action plans were put in place and implemented to improve performance.

Older people's community mental health teams

Vision and strategy

Staff told us they understood the vision and direction of the trust and most felt connected to senior management and the trust board. Trust messages were cascaded via a

regular newsletter and in team meetings. A consultant psychiatrist told us they considered the trust board was driven by the "right values" and was easy to contact and speak to.

Responsible governance

There was a clear governance structure in place that supported the safe and effective delivery of the service. Lines of communication from the board and senior managers to the frontline services were mostly effective, and staff were aware of key messages, initiatives and the priorities of the trust. Staff understood the management structure and where to seek additional support.

Leadership and culture

We found the community mental health teams for older people were well-led and there was evidence of clear leadership at a local level. Team managers were accessible to staff. The culture of teams was open and staff were encouraged to bring forward ideas for improvements in care. Most staff told us they felt valued and empowered to develop and improve the service.

Engagement

There was a service user and care involvement group that met monthly. Representatives from the group were involved in interview panels for the recruitment of new staff and in designing and reviewing written information prepared by the trust to ensure it met people's needs in terms of clarity and appropriateness, such as the memory assessment and treatment service leaflet. However, we found limited evidence of attempts to gather feedback from people using the service, about the service they received, particularly people with cognitive impairment.

We spoke with staff at different levels in the community mental health teams for older people. All staff reported feeling supported by their manager, with one manager being described as "inspiring". Staff were kept up-to-date about developments in the trust through regular newsletters and emails. The views of staff were collected through supervision sessions and at team meetings. Most staff told us they felt confident in being able to raise concerns. Teams had put in place action plans to address staff concerns identified through the annual staff survey.

At focus groups we organised, a number of community staff expressed feeling disconnected from the senior

Are services well-led?

Good 

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management within the trust. Although they said they had been consulted on changes taking place they felt that their views had not been listened to or taken on board by senior management.

Performance improvement

Community staff told us they had access to ongoing leadership training and development which had been very beneficial in terms of increasing skills and confidence in managing teams and engaging with trust managers.

Data on performance was collected monthly. Performance measures included completion of staff training and appraisal and clinical measures such as the number of incidents and complaints reported. Performance against these targets was monitored by senior managers to ensure any shortfalls were addressed. Where performance did not meet the expected standard action plans were put in place and implemented to improve performance.

Airedale Centre for Mental Health

Vision and strategy

Staff were able to talk us through the vision and strategy for the service and information about the future direction of the trust was on display on the ward. Staff reported that they felt very well engaged with their manager and that they had been supported well through the recent transition to a new location. However, some staff said they had not been listened to as part of the consultation regarding the move. As a consequence a number of experienced staff were finding it difficult to get to the new geographical location or had left their post due to struggling with new travel arrangements. The staff we spoke with were of the opinion that the impact on staff in regards to travel was not fully appreciated in the planning or implementation.

Responsible governance

There was limited performance data available which is not currently reviewed by the ward manager to identify risks and drive performance.

There was a clear governance structure in place that supported the safe delivery of the service. There were appropriate lines of communication from the board and senior managers to frontline services.

The ward manager attended a ward manager's meeting, meeting notes for this were reviewed; we could see from the minutes that items discussed were around staff sickness, appraisals, training, safeguarding, recruitment,

transformation projects, complaints and care pathways. Information was disseminated from the ward managers meeting to the ward staff by the manager in the form of team meetings.

The clinical manager received a copy of all incidents reported on the ward and checked that any resulting actions were followed through. They visited the ward daily and maintained oversight of the quality of care provided.

Staff understood the management structure and where to seek additional support. For example, when we spoke with staff about safeguarding processes, they all told us they would seek advice from the ward manager or in their absence the safeguarding team for the trust if they needed to.

We also reviewed the safeguarding policy and procedure which provided clear guidance on what the differing types of abuse maybe, the signs to be aware of and how to report any concerns or alerts. A flow chart was in place to support the understanding of the procedure.

Data on performance was collected via the RIO patient administration system and used to contribute toward the Mental Health Minimum Dataset. Information on monthly performance was not displayed near the entrance to the ward where people who use the service, visitors and staff could see it. We discussed this with the clinical service manager and the ward manager who agreed now the move had been completed it was something they would address.

Leadership and culture

We found Bracken ward was well-led and there was evidence of clear leadership at a local level. The ward manager was visible on the ward during the day-to-day provision of care and treatment to people, was accessible to staff and proactive in providing support to people. The culture on the ward was open and encouraged staff to bring forward ideas for improvements in care.

Staff we spoke with were enthusiastic and engaged with ward developments, including plans to move the ward to this site which had been completed approximately seven weeks ago.

Estates and facilities staff had been engaged in the process and had undertaken a Health and Safety assessment on 1 July 2014. This outlined areas of work still to be completed following the move to the Airedale site.

Are services well-led?

Good 

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

Staff told us they felt able to report incidents, raise concerns and make suggestions for improvements and were confident they would be listened to by senior managers. Ward staff praised their manager.

Engagement

The PALS team also visited the ward every fortnight to ask patients for their input and feedback into the care and support they received while on the ward. Any items raised to the PALS team are emailed to the ward manager for action.

There was a facility called e-feedback on the ward; this was an electronic feedback system where patients and their families can enter their answers to a series of questions. Based on data entered from November 2013 to April 2014 a selection of responses were, 100% answered the question how well did staff treat you with dignity and respect; 92% answered the question how well do you feel staff members have explained your treatment to you; 83% answered the question how well did the different people caring for you work together to give you the best possible care (for example community staff, medical staff and nurses).

We spoke with staff at different levels on the ward. All staff reported feeling very supported by their manager. Staff were kept up-to-date about developments in the trust through regular team meetings and emails.

At the engagement events we held and events facilitated by HealthWatch before the inspection, carers also reflected that they felt that they had not been listened to fully as part of the consultation regarding the move of Bracken ward. Some carers reported difficulty to get to the new geographical location.

Performance improvement

The ward manager told us they had access to ongoing leadership training and development, which had been very beneficial in terms of increasing skills and confidence.

The Electronic Staff Record (ESR) is a staff database which allows the management of staff training and appraisals. The ward manager also held his own training matrix

(training record) for the staff on the ward; this showed the mandatory training required, dates completed or dates due for renewal. This assisted with the prompt booking of training as renewals became due. For the year ending March 2014, the ward achieved 95.4% for their mandatory training completeness.

The manager records in the ESR system the date that a staff member's appraisal has taken place; this is then held on their personal record as an audit trail for monitoring purposes. On the day of the inspection we were unable to review a completed appraisal form for a staff member.

Infection prevention and control was one of the mandatory training requirements. We reviewed the policy and procedure in place and found it to be detailed guidance for staff to be able to follow. The trust has 24-hour contact number for an infection control nurse should any member of staff have an emergency situation they needed guidance and advice. Recently the ward had a norovirus and all procedures were followed in relation to the outbreak and management of the virus to minimise the risks of spreading further.

As part of the trust's monitoring of infection control an annual cleanliness audit is completed this was last undertaken in May 2014, where an overall score of 97.63% had been achieved.

Data on performance was collected monthly. Performance measures included completion of staff training and appraisal and clinical measures such as the number of incidents and complaints reported. Performance against these targets was monitored by senior managers to ensure any shortfalls were addressed. For the period April 2013 to March 2014, the data showed that the ward had reported 3 incidents; they had used an average of 11.3 whole time equivalent per week of NHSP bookings (bank staff); 90% of staff had completed the information governance training and 100% had completed the fire training. Where performance did not meet the expected standard, action plans were put in place and implemented to improve performance.