Good

Bradford District Care Trust

Acute admission wards

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 Centre for Mental Health	TAD54	Fern Ward Heather Ward	BD20 6PD
Lynfield Mount Hospital	TAD17	Ashbrook Ward Maplebeck Ward Oakburn Ward	BD9 6DP

This report describes our judgement of the quality of care provided within this core service by Bradford District NHS Care 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 NHS Care Trust and these are brought together to inform our overall judgement of Bradford District NHS 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 acute admission wards	Good
Are acute admission wards safe?	Good
Are acute admission wards caring?	Good
Are acute admission wards effective?	Good
Are acute admission wards responsive?	Requires Improvement
Are acute admission wards 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

The acute admission wards are based on two hospital sites at Airedale Centre for Mental Health and Lynfield Mount Hospital. Airedale is a purpose built facility and provides two acute inpatient mental health wards for adults aged between 18 – 65. Referrals come from the Intensive Home Treatment Team or following a Mental Health Act assessment.

We found that there were clear procedures for reporting incidents and these were investigated and reviewed to prevent them from happening again. Learning from these incidents was shared with all staff.

There were also clear systems in place for reporting safeguarding concerns and staff understood what they had to do.

We found that at times systems for management of medicines led to delays in administration of medicines and staff did not always follow the trust procedures for reporting occasional gaps and omissions on medication charts.

There were procedures for identifying and managing risks to people's health and safety. Managers had clear strategies for responding to changes in people's mental state.

However, we found that there were health and safety issues in the 'activities of daily living' kitchen. For example, the temperatures of the fridges, where people's food was being kept, were not monitored, and the food itself was not properly stored and labelled after it had been opened.

Staffing levels were good and were flexible, for example should the patients require greater observation. Temporary staff were given an induction programme.

Risk and needs assessments were carried out when people were admitted and we found them to be comprehensive and followed by detailed care plans.

We saw that there were systems in place for people to give feedback to the service and this was acted on. We found that the team had systems in place to monitor the quality of the service and took necessary measures to improve their performance.

There were appropriate policies and procedures for people detained under the Mental Health Act. However, consent to treatment and rights under the Mental Health Act were not adhered to at all times.

We observed that staff were polite, kind and treated people with respect and dignity. People who used the service told us that they were pleased with the care they received. We found that people were involved in their care; however, there was a limited range of activities for people, and a lack of input from psychology services.

We found that medical staff were not always readily available to support the nursing team and people who used the service. We also saw that people's reviews were constantly cancelled and that consultants did not turn up for scheduled reviews.

However, the service took people's complaints seriously; investigating them, responding to them promptly and learning the lessons from them.

There were strong links with other internal and external agencies to help people move smoothly between services – from referral, admission and discharge.

We found there was a clear vision and strategy for the service and staff understood it well. Staff told us that they felt supported by their managers and were pleased to work for the trust

Summary of findings

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

Are services safe?

Good

Acute admission wards were effective in providing safe care and treatment. The staff knew about potential risks to people's health and safety, and how to respond to them and manage them. Incidents were reported and investigated and lessons were learnt and shared to prevent them happening again. However, sometimes there were delays in administration of medicines and staff did not always follow the trust procedures for reporting occasional medicines errors.

Are services effective?

Good

People's treatment was in line with current legislation, standards and national guidance. There were appropriate policies and procedures for people detained under the Mental Health Act. However, consent to treatment and rights under the Mental Health Act were not adhered to at all times. Staff worked well as a multidisciplinary team and took a 'person-centred' approach. There was a range of treatment approaches available to meet people's needs. Staff were well trained and had good access to training and development opportunities. A number of audits had been carried out to evaluate the service and monitor outcomes for people.

Are services caring?

Good

Acute admission wards were caring and people were really positive about the quality of the care and treatment they received and the attitude of the staff. Across all areas we observed that staff treated patients with dignity and respect. People told us they were involved in their care and given information they understood. However, the range of activities was limited and there was a lack of input from psychology services.

Are services responsive to people's needs?

Requires Improvement

Acute admission wards were not responsive to people's needs. We found that medical staff were not always readily available to support the nursing team and people who used the service. People's reviews were constantly cancelled and consultants did not turn up for scheduled reviews. Complaints were taken seriously; they were investigated, responded to promptly and lessons learnt from them.

Are services well-led?

Good

There was a clear vision and strategy for how Mental Health Services should develop in the future. Staff felt supported by their managers

and peers and considered that senior managers in the trust were accessible and open. Junior managers felt empowered to perform their roles effectively. There was a good governance system and staff used information from it to learn about risks within the trust.	

Summary of findings

Background to the service

The acute admission wards are based on two hospital sites at **Airedale Centre for Mental Health** and **Lynfield Mount Hospital**. Airedale is a purpose built facility and provides two acute inpatient mental health wards for adults aged between 18 – 65. Referrals come from the Intensive Home Treatment Team or following a Mental Health Act assessment.

Heather is a 19-bed ward for women experiencing mental health problems that require inpatient care because they cannot be safely supported at home or in the community. The ward provides assessment, treatment and care to people who have been admitted informally or under the Mental Health Act 1983. The service offers 24-hour care from nursing staff, doctors and other professionals who will work together to help people recover.

Fern is a 15-bed ward for men experiencing mental health problems that require inpatient care because they cannot be safely supported at home or in the community. The ward provides assessment, treatment and care to people who have been admitted informally or under the Mental Health Act 1983. The service offers 24-hour care from nursing staff, doctors and other professionals who will work together to help people recover.

Lynfield Mount Hospital provides three acute inpatient mental health wards for adults aged between 18 – 65. Referrals come from the Intensive Home Treatment Team or following a Mental Health Act assessment.

Oakburn is a 21-bed ward for men experiencing mental health problems that require inpatient care because they cannot be safely supported at home or in the community. The ward provides assessment, treatment and care to people who have been admitted informally or under the Mental Health Act 1983. The service offers 24-hour care from nursing staff, doctors and other professionals who will work together to help people recover.

Ashbrook is a 25-bed ward for women experiencing mental health problems that require inpatient care because they cannot be safely supported at home or in the community. The ward provides assessment, treatment and care to people who have been admitted informally or under the Mental Health Act 1983. The service offers 24-hour care from nursing staff, doctors and other professionals who will work together to help people recover.

Maplebeck is a 21-bed ward for men experiencing mental health problems that require inpatient care because they cannot be safely supported at home or in the community. The ward provides assessment, treatment and care to people who have been admitted informally or under the Mental Health Act 1983. The service offers 24-hour care from nursing staff, doctors and other professionals who will work together to help people recover.

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

The team included CQC mental health inspectors, a Consultant Psychiatrist, a Mental Health Act Commissioner, Specialist Advisors in Mental Health Nursing, and Specialist Advisors in Occupational Therapy.

Summary of findings

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

Before visiting, we reviewed a range of information we hold about the core service and asked other organisations to share what they knew. We carried out an announced visit on 17, 18 and 19 June 2014. During the visit we held focus groups with a range of staff who worked within the service, such as nurses, doctors, therapists. We talked with people who use services. We observed how people were being cared for and talked with carers and/or family members and reviewed care or treatment records of people who use services. We met with people who use services and carers, who shared their views and experiences of the core service.

What people who use the provider's services say

Before our announced inspection, we spoke with people who used the service through focus groups. During our inspection, we spoke with people who used the service who were very positive about their experiences of care. We also saw that staff interacted with people politely and warmly. People told us that staff were very supportive, included them in their care planning and gave them information that helped them to make choices about their care. They also said that staff treated them with respect and dignity and listened to them.

Good practice

- There was a service development worker who focused on service user involvement.
- There were daily community meetings and people's views were taken into account and acted upon.

Areas for improvement

Action the provider MUST or SHOULD take to improve

- The trust must ensure that people receive the right care at the right time from the medical team.
- The trust should ensure that food is stored and monitored in line with food hygiene guidelines.
- The trust should ensure that people who use the services have access to psychological input.
- The trust should ensure that people who use services should have access to meaningful activities.
- The trust should ensure that consent to treatment and rights under the Mental Health Act are adhered to at all times.
- The trust should ensure that there are improvements to the management of medicines arrangements to ensure that people get timely treatment and to ensure that lessons are fully learnt from occasional medicines errors.

Bradford District Care Trust

Acute admission wards

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Fern Ward Heather Ward	Airedale Centre for Mental Health
Ashbrook Ward Maplebeck Ward Oakburn Ward	Lynfield Mount Hospital

Mental Health Act responsibilities

Detention papers and processes

Mostly we found compliance with the Mental Health Act (MHA). We found one example of non-compliance with the MHA regulations, which was an administrative issue rather than regulatory. Reports from the Approved Mental Health Professionals (AMHP) involved in assessment and detention were available; however there was no evidence of a system for routinely reminding AMHPs to complete these either on the ward, or by the MHA office.

Consent to treatment

Practice was variable. On some wards there were concerns but others had good practice. In some cases medication was being administered which was not authorised under section 58. On one ward there were out of date certificates stored with the drug chart which could lead to confusion. The evidence regarding assessments of capacity and consent to treatment was variable but largely good. On one ward assessments had been carried out for all people on the ward, regardless of whether they were subject to section 58. This was good practice. On other wards there were assessments completed, but not always by the responsible clinician.

Rights under the Mental Health Act

There was evidence of rights being presented to people appropriately, sometimes with a short delay. However the form that was used by the trust on first admission did not cover all the rights people were entitled to. There was no tool for staff to use on repeat readings, so managers were unable to confirm whether people had been informed of all of their rights. However there was evidence that people were having tribunals, receiving legal advice, and having access to advocacy.

Section 17 leave

Leave was authorised through a standardised system. Ward staff had a thorough process for ensuring leave was authorised before each person left the ward.

Detailed findings

Mental Capacity Act and Deprivation of Liberty Safeguards

We found that the acute admission staff had an extensive understanding of the Mental Capacity Act (MCA) and had attended training to ensure that they had the required knowledge. This training was completed as part of the mandatory trust training. The trust had a lead person in MCA and Deprivation of Liberty Safeguards (DoLS) that staff could contact for support.

Good

Are services safe?

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

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

Summary of findings

Acute admission wards were effective in providing safe care and treatment. The staff knew about potential risks to people's health and safety, and how to respond to them and manage them. Incidents were reported and investigated and lessons were learnt and shared to prevent them happening again. However, sometimes there were delays in administration of medicines and staff did not always follow the trust procedures for reporting gaps and omissions in medicines charts.

Our findings

Airedale Centre for Mental Health

Track record on safety

All staff spoken with demonstrated that they knew how to identify and report any abuse to ensure that people who used the service were safeguarded from harm. We saw training records indicating that all staff were trained in safeguarding vulnerable adults. All staff spoken with were able to name the designated lead for safeguarding, who was available to provide support and guidance. We saw that information was easily accessible to inform staff on how to report abuse.

Learning from incidents and improving safety standards

We saw that there was an effective system to record incidents and near misses. All the staff we spoke with clearly demonstrated how they would identify and report incidents. We saw that incidents were reported, investigated and analysed. Staff told us that they received feedback following incidents through meetings and information was circulated within the team.

We saw evidence that learning from incidents took place and that specific changes to practice was made as a result of incidents. This meant that the provider was able to identify, investigate and learn from incidents.

We looked at restraint records and saw that restraint was rarely used. The ward had employed strategies to reduce aggressive incidents that may lead to people being restrained. An example of this was through the training of staff in de-escalation skills. We saw that all staff had been trained in the physical intervention method used within the trust and all staff spoken with confirmed this. All staff told us that they received a debrief session following an incident and they could also access the trust's reflective group ran by psychologists.

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

We saw that the environment was clean and staff practiced good infection control procedures. The environment was purpose built and included anti-ligature fittings to ensure the safety of people who used the service. We saw that the security procedures were followed; however there was inconsistent recording of signing in and out of knife usage in the activities of daily living (ADL) kitchen. Most of the staff were aware of the lone working policy and told us that they followed it.

We saw that the trust rapid tranquillisation policy had been followed by staff who prescribed medicines to be given in an emergency. The trust process for regular ward based medicine management audits by pharmacists to confirm safe and secure storage was not fully operational although we were told that this would be resolved shortly following the appointment of additional pharmacy staff resource. On Heather and Fern Wards, we saw that some medication charts had been sent to the pharmacy to request supplies of medicines and remained off the ward for several hours. Nurses told us that this sometimes led to delays in the administration of medicines.

On Heather Ward we found that although medication charts were regularly checked by nurses to identify where occasional administration gaps or omissions were seen, staff did not follow the trust procedure for reporting, investigating and resolving these.

Staff told us and we saw that there was a safety alarm system in place to summon assistance from other staff on the wards and staff from other wards when needed. This helped to ensure the safety of people who used the service and that of staff.

Assessing and monitoring safety and risk

We saw that care plans and risk assessments clearly identified how staff were to support each person when they behaved in a way that could cause harm to them or to

Good

Are services safe?

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

others. We saw that people's needs were appropriately assessed and these clearly identified people's needs. We saw good examples of completed needs assessment, followed by detailed care plans and behavioural management plans.

We observed that all people had a contingency plan in place which had details on what actions to take and services to contact in case of an emergency.

We saw that fridge temperatures in the ADL kitchen were not monitored in Heather Ward and both wards did not follow appropriate food labelling and storage in line with food hygiene guidelines. Staff had not recorded what the minimum and maximum temperatures were and opened food was not dated, so it was not clear whether the food were stored at a safe level or were still in date for them to be safely consumed.

We saw that the staffing levels were appropriate with a good skill mix. We found that staffing arrangements ensured that people's needs could always be met safely with staffing levels consistently maintained on both wards. The managers told us that there was flexibility within staffing resources for additional staff to meet people's needs where this was assessed as required for one-to-one observations. We saw that both wards used a high number of bank and agency staff and that the trust had a structured induction process in place for all agency and bank staff. All agency staff spoken with told us that they had a formal induction when they started work.

Understanding and management of foreseeable risks

Staff told us that risks and near misses were recorded on the electronic system and the investigations outcomes were used to put in place management strategies for any risks identified.

The risks which could be anticipated from insufficient medical and nurses cover, and the impact of this on meeting patients' needs, had been considered.

We found that arrangements were in place to deal with foreseeable emergencies. All staff we spoke with told us that they had a contact telephone number in the office to get support in an emergency or at night, weekends or bank holidays. The manager confirmed that they would be an on call manager every time to provide support to staff when needed. This meant people could get the support they needed in an emergency.

Lynfield Mount Hospital

Track record on safety

All staff spoken with demonstrated that they knew how to identify and report any abuse to ensure that people who used the service were safeguarded from harm. We saw training records that indicated that all staff were trained in safeguarding vulnerable adults. All staff spoken with were able to name the designated lead for safeguarding who was available to provide support and guidance. We saw that information was easily accessible to inform staff on how to report abuse.

Learning from incidents and improving safety standards

We saw that incidents were reported and investigated. Staff told us that they received feedback following incidents through meetings and information was circulated within the team.

We saw evidence that learning from incidents took place and that specific changes to practice was made as a result of incidents.

We looked at restraint records and saw that it was rarely used. The ward had employed strategies to reduce aggressive incidents that may lead to people being restrained. An example of this was through the training of staff in de-escalation skills. We saw that all staff had been trained in the physical intervention method used within the trust and all staff spoken with confirmed this. All staff told us that they received a debrief session following an incident and they could also access the trust's reflective group ran by psychologists.

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

We saw that the environment was clean and staff practiced good infection control procedures. We saw that the security procedures were followed, however on Oakburn and Maplebeck Wards there was inconsistent recording of signing in and out of knife usage in the activities of daily living (ADL) kitchen. Most of the staff were aware of the lone working policy and told us that they followed it.

We saw that the trust rapid tranquillisation policy had been followed by staff who prescribed medicines to be given in an emergency.

Good

Are services safe?

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

Staff told us, and we saw, that there was a safety alarm system in place to summon assistance from other staff on the wards and staff from other wards when needed. This helped to ensure the safety of people who used the service and that of staff.

Assessing and monitoring safety and risk

We saw that care plans and risk assessments clearly identified how staff were to support each person when they behaved in a way that could cause harm to them or to others. We saw that people's needs were appropriately assessed and these clearly identified people's needs. We saw good examples of completed needs assessments, followed by detailed care plans and behavioural management plans.

We observed that all people had a contingency plan in place which had details on what actions to take and services to contact in case of an emergency.

We saw that fridge temperatures in the ADL kitchen were not monitored in Oakburn and Maplebeck Wards and all wards did not follow appropriate food labelling and storage in line with food hygiene guidelines. Staff had not recorded what the minimum and maximum temperatures were and opened food was not dated, so it was not clear whether the food were stored at a safe level or were still in date for them to be safely consumed.

We saw that the staffing levels were appropriate with a good skill mix. We found that staffing arrangements ensured that people's needs could always be met safely with staffing levels consistently maintained on both wards.

Managers told us that there was flexibility within staffing resources for additional staff to meet people's needs, where this was assessed as required for one-to-one observations. We saw that all wards used a high number of bank and agency staff, particularly Oakburn, and we saw that the trust had a structured induction process in place for all agency and bank staff. All agency staff spoken with told us that they had a formal induction when they started work. The wards were supported by consultants and junior doctors who also worked with other people who used community services. We saw that psychological input was very limited.

Understanding and management of foreseeable risks

Staff told us that risks and near misses were recorded on the electronic system and any investigation outcomes were used to put in place management strategies for any risks identified.

The risks which could be anticipated from insufficient medical and nurses cover and the impact of this on meeting patients' needs had been considered.

We found that arrangements were in place to deal with foreseeable emergencies. All staff we spoke with told us that they had a contact telephone number in the office to get support in an emergency or at night, weekends or bank holidays. The manager confirmed that there would be a duty/on call manager each time to provide support to staff when needed. This meant people could get the support they needed in an emergency.

Good

Are services effective?

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

Summary of findings

People's treatment was in line with current legislation, standards and national guidance. There were appropriate policies and procedures for people detained under the Mental Health Act. However, consent to treatment and rights under the Mental Health Act were not adhered to at all times. Staff worked well as a multidisciplinary team and took a 'person-centred' approach. There was a range of treatment approaches available to meet people's needs. Staff were well trained and had good access to training and development opportunities. A number of audits had been carried out to evaluate the service and monitor outcomes for people.

Our findings

Airedale Centre for Mental Health

Assessment and delivery of care and treatment

We saw that both wards applied some clinical guidelines, which were evidence based from NICE guidelines, to support their practice. Records sampled showed that comprehensive assessments had been completed of the person's needs and risks We saw that care plans were comprehensive, personalised and regularly reviewed. They showed that people and their families, where appropriate, had been involved in developing the care plans.

People's capacity to consent to their care and treatment was assessed. We saw that where people were able to they had consented. People were informed of their right to access an Independent Mental Health Advocate (IMHA) if they were detained there under the Mental Health Act 1983.

Outcomes for people using services

We saw that the provider carried out an outcomes satisfaction survey where people gave a summary of the care and treatment they received. The results showed that most of the people were happy with the care they received.

The provider used audits to evaluate the service provided in order to monitor outcomes for people. There were a number of audits which were carried out in order to ensure that service needs were identified and could be used to improve the effectiveness of service delivery. This meant that the service could identify areas of strong and weak practice in order to improve the service provided.

The provider used some outcome measures to determine the effectiveness of the service which they provided. We saw that the team used Health of the Nation Outcome Scales-Care Pathways and Packages Project (HoNOS-CPPP), which is an outcome measure which decided the progress of therapeutic interventions.

Staff, equipment and facilities

We saw that staff received the training they needed and where updates were required, this was monitored through a system that highlighted it. All staff spoken with told us that they received regular supervision and had an annual appraisal.

Staff told us that they received further training in different areas of their specialities that benefited and addressed the needs of people who used the service. The team had nurses specialising in areas such as nurse prescriber, Dialectical Behavioural Therapy (DBT), mindfulness and solution focused therapy. This meant staff were appropriately qualified and competent in their job role.

We saw that the wards had state of the art equipment in their bathrooms that could be used for people with physical disabilities. We found that there were two bedrooms specifically adapted to meet the needs of people with physical disabilities. There were a number of therapy rooms that had equipment and material used for therapies such as, art, relaxation and sports. The wards had a well-equipped physical examination room.

Multidisciplinary working

In records we sampled there was evidence that the multidisciplinary team worked together. We saw some well collaborated evidence of working as a team following the Care Programme Approach (CPA) frame work. The team consisted of nurses, consultants, junior doctors, psychologists, occupational therapists (OT) and social workers. People told us and we saw that they attended their review meetings.

We saw evidence of working with others including internal and external partnership working, such as multidisciplinary working with GPs, intensive home treatment team (IHTT), community mental health team, independent sector and local authority. Staff explained to us the advantages of the

Good

Are services effective?

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

electronic system which easily linked different teams to access people's records when needed. Staff told us that they worked closely with the IHTT to coordinate care to support with discharges.

Mental Health Act (MHA)

We reviewed the records of some people currently detained under a section of the Mental Health Act (1983). Mostly we found compliance with the Mental Health Act. In Fern ward we saw that there were out of date certificates stored with the drug chart which could lead to confusion. One assessment of capacity and consent to treatment was not available and a case of medication was being administered without being authorised under section 58. In Heather one report from the AMHP involved in assessment was not available but written in clinical notes.

Section 17 leave was authorised through a standardised system. Ward staff had a thorough process for ensuring leave was authorised before each person left the ward.

Lynfield Mount Hospital

Assessment and delivery of care and treatment

We saw that all wards applied some clinical guidelines, which were evidence based from NICE guidelines, to support their practice. Records sampled showed that comprehensive assessments had been completed of the person's needs and risks. We saw that care plans were detailed, person-centred and regularly reviewed. They showed that people and their families, where appropriate, had been involved in developing the care plans.

People's capacity to consent to their care and treatment was assessed routinely. We saw that where people were able to they had consented. People were informed of their right to access an Independent Mental Health Advocate (IMHA) if they were detained there under the Mental Health Act 1983.

Outcomes for people using services

We saw that the provider carried out an outcomes satisfaction survey where people gave feedback about the care and treatment they had received. The results showed that most of the people were happy with the care they received. We saw that people had access to Patient Advice and Liaison Service (PALS).

The provider used audits to evaluate the service provided in order to monitor outcomes for people. There were a number of audits which were carried out particularly in Ashbrook in order to ensure that service needs were identified and could be used to improve the effectiveness of service delivery. This meant that the service could identify areas of strong and weak practice in order to improve the service provided.

The provider used a number of outcome measures to determine the effectiveness of the service which they provided. We saw that the team used Health of the Nation Outcome Scales-Care Pathways and Packages Project (HoNOS-CPPP), which is an outcome measure which decided the progress of therapeutic interventions.

Staff, equipment and facilities

We saw that staff received the training they needed and most of them were up to date. All staff spoken with told us that they received regular supervision and had an annual appraisal.

We saw that all staff we spoke with were appropriately qualified and competent in their job role.

There were activity and recreation rooms on all wards however the activity room in Oakburn was bare, lacked equipment and disorganised. The recreation room had a pool, table tennis and badminton but looked sparse with no comfortable seats for people. The wards had a well-equipped physical examination room.

Multidisciplinary working

In records we sampled there was evidence that the multidisciplinary team worked together. We saw some well collaborated evidence of working as a team following the Care Programme Approach (CPA) frame work. The team consisted of nurses, consultants, junior doctors, occupational therapists and social workers. Staff told us that input from psychology services was very limited. People told us, and we saw, that they attended their review meetings.

We saw evidence of working with others including internal and external partnership working, such as multidisciplinary working with GPs, intensive home treatment team (IHTT), community mental health team, independent sector and local authority. Staff told us that they worked closely with the IHTT for smooth transition in and out of the wards

Mental Health Act (MHA)

We reviewed the records of some people currently detained under a section of the Mental Health Act (1983) and in the main found compliance with the MHA. In Oakburn we saw that one person had no capacity assessment to consent to

Good

Are services effective?

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

treatment. Another person had no evidence that rights were explained to them and that it was further tried again. In Maplebeck we found that one patient had no AMHP report available and Second Opinion Appointed Doctor (SOAD) consultees did not record their interviews. We saw that staff had systems in place to check that leave was authorised before people could go out. We saw very good practice in Ashbrook where all section 58 consent to treatment was recorded and rights under section 132 was very good.

We observed that there was evidence that people were having tribunals, received legal advice, and had access to advocacy.

Good

Are services caring?

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

Summary of findings

Acute admission wards were caring and people were really positive about the quality of the care and treatment they received and the attitude of the staff. Across all areas we observed that staff treated patients with dignity and respect. People told us they were involved in their care and given information they understood. However, the range of activities was limited and there was a lack of input from psychology services.

Our findings

Airedale Centre for Mental Health

Kindness, dignity and respect

All the people we spoke with who used the service were very positive about the care they received and were complimentary about the support they received from the whole team. They also felt they could get the help they needed anytime. People told us that they had been treated with respect and dignity and commented that staff were polite, friendly and willing to help.

We saw that people had access to fruit, hot and cold drinks when needed. People had a variety of menu choices for their meals. Where people had dietary needs this was clearly documented and monitored. All people spoken with told us that they were happy with the food and they were able to choose what they wanted.

People using services involvement

The wards provided people with information leaflets which were specific to the services which they provided. This meant that people who used the service had important information and any useful additional information was available to them.

The service had systems in place to collect feedback from people who used the service. Questionnaires on what people felt about the care provided were readily available for people who used the service and their families to complete. We saw that community meetings were held each morning and people's views were taken into account and acted upon. This meant that people were involved in how the services were run. The staff told us that they had an open culture for people to feedback how they felt about the service provided.

People spoken with told us that they were involved in their care reviews and were free to air their views. Records we sampled showed that people and family members' views were taken into account and were supported to make informed choices.

People had access to an independent advocate, IMCA and citizens advice bureau who visited twice a week. There was information available on how to access this service. There was a service development worker who focused on service user involvement.

Emotional support for care and treatment

Staff were responsive to the individual needs of people who used the service. We found that staff had a very good understanding of people's particular needs.

People were provided with psychological input to relaxation groups, mindfulness and solution focused therapy. We saw that people had access to talking therapies, one-to-one, to support them with their emotional well-being. We saw that staff facilitated some social interventions such as activities in the community in a structured manner to ensure that social needs were met. OT supported staff with people's activities of their choice; however the range of activities were limited. People were given enough information to ensure that they got support from the services if needed.

Lynfield Mount Hospital

Kindness, dignity and respect

All the staff we spoke with demonstrated a clear understanding of how to treat people with respect and dignity. The staff were polite, compassionate and respectful in their interactions with people. People we spoke with told us that staff treated them with respect and dignity and were positive about the care they received.

We saw that people had access to hot and cold drinks when needed. People had a variety of menu choices for their meals. All people spoken with told us that they were happy with the food and they were able to choose what they wanted.

People using services involvement

People told us that community meetings were held each morning on the ward where they could talk about the positive and negative things which helped to make things better. The service had a process to gather feedback from people who used the service with forms to complete by

Good

Are services caring?

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

people who used the service. The managers told us that they also encouraged informal verbal feedback from people who used the service and acted upon their requests immediately.

The provider produced information leaflets which were specific to the services they provided. This meant that people who used the service had relevant information and had to access to further information which was useful to them.

People had a variety of care plans which were individualised and showed evidence of risk assessments. The review meetings were used to involve people and their views within the care planning process. We found some evidence of people's views being included within the care planning and process. All people we spoke with told us that they were involved in their care and some of them had copies of their care plans.

People had access to an independent advocate and IMCA. There was information available on how to access this service. There was a service development worker who focused on service user involvement.

Emotional support for care and treatment

Staff we spoke with had an understanding of the particular needs which related to people who used the acute mental health services. Family members were provided with written information about the service which we saw. In discussion with staff, we observed in all wards that information about their journey through mental health services was displayed on the walls and they were given choices. People were offered robust support through their involvement by staff.

We saw that people had access to talking therapies on a one-to-one basis with their named nurse, which was consistent with Maplebeck and Ashbrooke. We observed an excellent activity programme in Ashbrooke and people were engaged in activities, however, activities were very limited in Maplebeck and Oakburn. People in Ashbrooke told us that they were fully involved in the choice of activities and that they took place regularly. Some people in Maplebeck and Oakburn told us that there was nothing to do most of the time and they got bored. We saw that psychological input was very limited in all wards. The managers told us that they had to refer people to psychology if assessed as high needs for psychological input.

Requires improvement

Are services responsive to people's needs?

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

Summary of findings

Acute admission wards were not responsive to people's needs. We found that medical staff were not always readily available to support the nursing team and people who used the service. People's reviews were constantly cancelled and consultants did not turn up for scheduled reviews. Complaints were taken seriously; they were investigated, responded to promptly and lessons learnt from them.

Our findings

Airedale Centre for Mental Health

Planning and delivering services

The trust provided care which was largely responsive to people's needs. The service had an understanding of specific needs of the people it served. The trust operated a single point of access referral system and IHTT which assessed people for admission. There was a consultant on-call out of hours who could attend to any urgent issues. We saw that staff worked with community teams to plan for people's discharge and community nurses attended ward review meetings prior to their discharge. Staff told us that most people were discharged within the expected time since they had started working closely with the IHTT relieving pressure on bed blockages. Staff told us that some people were placed out of area due to shortage of beds. They said that they maintained close links with the bed management team for moving people around services.

We saw that in assessments, the physical health needs of people were routinely assessed and monitored and the team worked closely with the duty doctor and secondary health care services to ensure that the identified needs were met. Specific care plans for people's physical health needs had been developed where appropriate. People were assessed for their health needs within six hours of admission by the duty doctor.

Right care at the right time

We found that people's needs were not met in a timely manner due to inconsistent medical care. Consultants and junior doctors worked both in the community and were responsible for their inpatient people when admitted to provide continuity of care. None of them were ward based. We saw that consultants were not able to turn up for reviews as scheduled and appointments with people so there were cancelled resulting in people having to wait longer to see their doctors. Staff told us that at times they had six consultants turning up at the same time to see people and due to a number of nurses on the ward it was not possible to facilitate all reviews. The majority of people we spoke with told us that they were not able to see their doctors when they wanted to.

Staff told us that doctors were not readily available to respond to urgent needs and did not consistently come for their reviews on time and this had impacted on people's care. For example, at times section 17 leave forms were not renewed on time and people's medication not reviewed on time. There were times when advocates and family members turned up for reviews and had to return without the meeting taking place due to the consultant not turning up. We spoke with one consultant who told us that this system was new and they were learning from it. Junior doctors told us that it was difficult for them to balance times between community and inpatient services.

Care pathway

The wards worked closely with the IHTT to ensure that people who had been admitted to hospital as inpatients were identified and helped through their discharge. For example, nurses from IHTT and social workers would attend discharge planning meetings on the ward and a joint visit would be carried out by both teams for home assessment and follow up visits, where appropriate.

Staff told us that sometimes there could be a delay in discharging people due to the lack of suitable placements to adequately meet people's needs in the community. This was referred to the bed management team as this led to delays in accepting new admissions.

We saw that a multi-faith room was available for people to use and that spiritual care and chaplaincy was provided when requested. We saw that there was a range of choices provided in the menu that catered for people's dietary, religious and cultural needs.

Interpreting services were available within the service to meet the needs of people who did not speak English well enough to communicate when receiving care and treatment.

Learning from concerns and complaints

All people spoken with told us that they could raise complaints when they wanted to and they were listened to

Are services responsive to people's needs?

Requires improvement

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and given feedback from these. The ward manager in Heather told us that there had been a few informal complaints in the ward and logged them as 'minor complaints'. This included issues raised where people did not wish to address formally through PALS or the trust's complaints policy. We looked at this log and saw it evidenced that the issues raised were addressed and what the outcomes and learning were. We saw that information on how to make a complaint was easily accessible and in a user friendly format. All staff spoken with knew how to support people who used the service and their relatives to make a complaint.

Lynfield Mount Hospital

Planning and delivering services

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Staff told us that doctors were not readily available to respond to urgent needs and did not consistently come for their reviews on time which had impacted on people's care. For example, during our inspection in Oakburn we observed one person who became upset when the consultant was scheduled to come in the morning and had not turned up by mid-afternoon. Staff told us that this was an on-going problem with consultants and junior doctors. Other external professionals and family members would turn up for reviews and the meeting would not take place. We spoke with one consultant who told us that it was difficult to maintain appointments as urgent issues would arise in the community such as urgent assessment under MHA.

Care pathway

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Staff told us that sometimes there could be a delay in discharging people due to the lack of suitable placements to adequately meet people's needs in the community. This was referred to the bed management team as this led to delays in accepting new admissions.

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Interpreting services were available within the service to meet the needs of people who did not speak English well enough to communicate when receiving care and treatment.

Requires improvement

Are services responsive to people's needs?

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

Learning from concerns and complaints

All people spoken with told us that they could raise complaints when they wanted to and they were listened to and given feedback from these. The trust had a complaints procedure and there was information displayed on the wards which informed people and family members how to make complaints. We saw a log of complaints from all acute wards which people raised through PALS or the trust's complaints policy. We looked at this log and saw it evidenced that the issues were investigated and what the outcomes and learning were. Any learning was shared amongst all acute wards and how and when change should be implemented. We saw that some practice had changed as a result of concerns which had been raised. Complaints were discussed in the service's clinical governance meeting which took place regularly and they were also raised in team meetings. This meant that the service ensured that learning from comments, complaints, compliments and concerns were embedded in their governance processes.

Good

Are services well-led?

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

Summary of findings

There was a clear vision and strategy for how Mental Health Services should develop in the future. Staff felt supported by their managers and peers and considered that senior managers in the trust were accessible and open. Junior managers felt empowered to perform their roles effectively. There was a good system of governance in place, which cascaded learning from incidents and information about risks to staff.

Our findings

Airedale Centre for Mental Health

Vision and strategy

Most of the staff we spoke with told us that they were pleased to work for the trust. All the staff we spoke with told us that they felt supported by their line managers and worked as an integrated team. The majority of staff told us that they were frustrated by inaccessibility and lack of support from the medical team. All staff spoken with showed a good understanding of the values, vision and objectives of their team and the trust.

Responsible governance

Most of the staff spoken with told us that the trust clinical governance team analysed the risks within the organisation and this information was shared with all staff to reduce risks to safety. All new policies were identified and communicated to staff through staff meetings, reflective groups and emails. All the staff we spoke with confirmed to us that they received regular communication from the board and their managers. This meant that staff were kept up to date with changes within the trust.

The service carried out a variety of audits, which were monitored regularly and actions taken to improve quality.

Leadership and culture

Staff told us, and we saw, that they received regular newsletters from the senior management. Staff told us that they felt well supported by their managers and peers. Most of the staff told us that senior managers were accessible, approachable and encouraged openness. Regular team meetings were held with minutes recorded.

Engagement

We saw that people's views were gathered through feedback from questionnaires. People and their families were routinely given questionnaires about services provided. We saw that these results were analysed to provide an overview of the service provided and necessary changes made to improve the service. This meant people were able to provide feedback about the service and their views were taken into account.

Staff were aware of the whistleblowing policy and that they would feel confident to report and refer concerns if it was needed. The whistleblowing policy was available on the trust's intranet site for staff to refer to.

Performance Improvement

All staff received annual appraisals and their personal and professional development goals were set. We saw that there were a number of audits which were carried out which were able to measure standards in terms of development and improvement within the service. These audits included records keeping, hand hygiene, medication and health and safety. This meant that performance of the service was monitored in order to drive improvement.

We found that there was a robust system to monitor performance. We saw that a detailed analysis of all wards was produced in the Integrated Performance Inpatient Services Report which was made available to people who used the service, their families and staff.

Lynfield Mount Hospital

Vision and strategy

All staff spoken with showed a good understanding of the values, vision and objectives of the service. Staff told us that the aim of the service was to support people to deliver safe, high quality care and to keep them in hospital for the shortest possible time. Staff told us that the team had a focus on person-centred care and would always try to improve the way they worked.

Responsible governance

Team meetings were held to discuss audit, complaints and incidents. Staff told us team meetings were good for feedback and sharing learning in regard to audits undertaken within, and outside of, the wards. Feedback about performance was shared with managers. Staff confirmed that they understood they role of clinical governance within the trust. Senior managers raised any issues that needed inclusion in the trust wide risk register

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and the manager told us that this was generally an effective tool for capturing ongoing concerns. The team told us that a debriefing would occur after any major incident with time and space set aside for this. Debriefing could be as a team or individually, depending on what was required. It would be run either by the psychology team as a 'reflective group', or by the manager if appropriate. This meant that mechanisms were in place to support staff and to promote their positive well-being.

Staff told us that they were aware of the trust's whistleblowing policy and that they felt able to report incidents and raise concerns and that they would be listened to. Staff confirmed that their manager was supportive and acted upon any concerns raised.

Leadership and culture

Staff we spoke with told us they were well supported by their managers. We saw, and staff confirmed, that the team was cohesive with high staff morale. They all spoke positively about their role and demonstrated their dedication to providing quality patient care.

Engagement

The team were proactive in its approach to seek a range of feedback from people using the service. People were engaged using questionnaires and comment. Staff told us senior managers engaged with them, provided information and regularly consulted with them in a variety of ways.

Performance improvement

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Compliance actions

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures	People must be protected against the risks of receiving care and treatment that is inappropriate or unsafe by means of planning and delivery of care and treatment in such a way that meet people's individual needs. Regulation 9 (1) (b) (i). People's needs were not met in a timely manner due to inconsistent medical care. Consultants and junior doctors were not able to turn up for reviews as scheduled and appointments with people were cancelled resulting in people having to wait longer to see their doctors. People were not consistently reviewed on time and this had impacted on people's care. People were not able to see their doctors when they wanted to. Doctors were not readily available to respond to urgent needs or emergencies when needed.