Care Quality Commission

Good 🟢

Bradford District Care NHS Foundation Trust

Acute wards for adults of working age and psychiatric intensive care units

Quality Report

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Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/unit/team)	Postcode of service (ward/unit/team)
TAD17	Lynfield Mount Hospital	Acute wards for adults of working age and psychiatric intensive care units	BD9 6DP
TAD54	Airedale Centre for Mental Health	Acute wards for adults of working age and psychiatric intensive care units	BD20 6TA

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

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

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

Summary of findings

Ratings

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

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

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

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

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

Summary of findings

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Overall summary

Our overall rating of this service improved. We rated it as good because:

- The service provided safe care. The trust had taken significant action to improve the safety on the wards. The wards had enough nurses and doctors. Staff assessed and managed risk well. They minimised the use of restrictive practices, managed medicines safely and followed good practice with respect to safeguarding.
- Staff developed holistic, recovery-oriented care plans informed by a comprehensive assessment. Staff provided a range of treatments suitable to the needs of the patients and in line with national guidance about best practice. Staff engaged in clinical audit to evaluate the quality of care they provided.
- The ward teams included or had access to the full range of specialists required to meet the needs of patients on the wards. Managers supported staff with appraisals and opportunities to update and further develop their skills. Eighty seven per cent of staff

within the service had received regular supervision at the time of our inspection. However, on Fern ward this was lower with 59% of staff receiving regular supervision. The ward staff worked well together as a multidisciplinary team and with those outside the ward.

- Staff understood and discharged their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, and understood the individual needs of patients. They involved patients, families and carers in care decisions.
- The service managed beds well so that a bed was always available locally to a person who would benefit from admission and patients were discharged promptly once their condition warranted this.
- The service was well led, and the governance processes ensured that ward procedures ran smoothly.

Summary of findings

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

Are services safe?   **Good** ●

Our rating of safe improved. We rated it as good because:

- All wards were clean well equipped, well furnished, well maintained and fit for purpose, and significant action had been taken to improve the safety on the wards.
- The service had enough nursing and medical staff, who knew the patients and received basic training to keep patients safe from avoidable harm
- Staff assessed and managed risks to patients and themselves well and followed best practice in anticipating, de-escalating and managing challenging behaviour. Staff used restraint and seclusion only after attempts at de-escalation had failed.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.
- Staff generally had easy access to clinical information and there had been significant improvements in staff maintaining high quality clinical records.
- The service used systems and processes to safely prescribe, administer, record and store medicines. Staff regularly reviewed the effects of medicines on each patient's physical health.
- The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately.
- Managers investigated incidents and shared lessons learned with the whole team and the wider service.
- When things went wrong, staff apologised and gave patients honest information and suitable support.

However:

- Two ligature points on the wards had not been identified on the ligature risk assessment.
- On some occasions health and safety documentation was not completed consistently, accurately, or up to date. Maintenance work on the wards was not always being carried out or within the timescales agreed.
- There was an inconsistent approach to how observations were documented across the wards and the trust's observation and engagement policy could result in essential patient information not being recorded accurately or in a timely manner. Staff did not always undertake the necessary reviews in line with the Mental Health Act code of practice when patients were placed in seclusion.

Summary of findings

Are services effective?   **Good** ●

Our rating of effective improved. We rated it as good because:

- Staff assessed the physical and mental health of all patients on admission. They developed individual care plans, which they reviewed regularly through multidisciplinary discussion and updated as needed. Care plans reflected the assessed needs, were personalised and recovery-oriented.

- Staff provided a range of care and treatment interventions suitable for the patient group and consistent with national guidance on best practice. They ensured that patients had good access to physical healthcare and supported patients to live healthier lives.

- Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives.

- The ward teams included or had access to the full range of specialists required to meet the needs of patients on the wards. Managers made sure they had staff with a range of skills needed to provide high quality care.

- Managers provided an induction programme for new staff, supported staff with appraisals and opportunities to update and further develop their skills.

- Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. The ward teams had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.

- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and discharged these well. Managers made sure that staff could explain patients' rights to them.

- Staff supported patients to make decisions on their care for themselves. They understood the trust's policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly for patients who might have impaired mental capacity.

However:

- Whilst the majority of staff within the service received regular supervision, compliance with regular supervision was only 59% for staff on the Fern ward.

- The trust had reviewed its process for informal patients in respect of their right to leave wards of their own free will

Summary of findings

following serious incidents. However, the reviewed process and associated patient guidance was contradictory in places and made it unclear as to whether patients could leave the ward freely.

Are services caring?

Good ●

Our rating of caring improved. We rated it as good because:

- The majority of staff treated patients with compassion and kindness. They respected patients' privacy and dignity. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.
- Staff involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided. They ensured that patients had easy access to independent advocates.
- Staff informed and involved families and carers appropriately.

Are services responsive to people's needs?

Good ●

Our rating of responsive improved. We rated it as good because:

- Staff managed beds well. This meant that a bed was available when needed and that patients were not moved between wards unless this was for their benefit.
- The design, layout, and furnishings of the wards supported patients' treatment, privacy and dignity. Each patient had their own bedroom and bedrooms at the Airedale Centre for Mental Health were fitted with an en-suite bathroom. Patients could keep their personal belongings safe and there were quiet areas for privacy.
- The food was of a good quality and patients could make hot drinks and snacks at any time.
- The service met the needs of all patients who used the service – including those with a protected characteristic. Staff helped patients with communication, advocacy and cultural and spiritual support.
- The service treated concerns and complaints seriously; investigated them and learned lessons from the results and shared these with the whole team and the wider service.

However, we found the following issue that the provider needs to address:

- There was no shelter in the courtyard on the Heather ward and the date for this to be installed had passed.

Summary of findings

Are services well-led?   **Good** ●

Our rating of well-led improved. We rated it as good because:

- Leaders had the skills, knowledge and experience to perform their roles; had a good understanding of the services they managed and were visible in the service and approachable for patients and staff.
- Staff knew and understood the trust's vision and values and how they were applied in the work of their team.
- Staff felt respected, supported and valued. They reported that the trust promoted equality and diversity in its day-to-day work and in providing opportunities for career progression. They felt able to raise concerns without fear of retribution.
- Ward teams had access to the information they needed to provide safe and effective care and used that information to good effect.
- Staff engaged actively in local and national quality improvement activities.

Summary of findings

Information about the service

Bradford District Care NHS Foundation Trust provides six inpatient wards for adults of working age who require acute and psychiatric intensive care. The trust is registered to provide two regulated activities in relation to this service:

- Assessment or medical treatment for persons detained under the Mental Health Act 1983
- Treatment of disease, disorder or injury.

The trust provides the service from wards located at two sites; the Airedale Centre for Mental Health and Lynfield Mount Hospital.

The Airedale Centre for Mental Health provides two acute inpatient wards. These are:

- Heather ward, a 19 bed female acute admission ward
- Fern ward, a 15 bed male acute admission ward.

Lynfield Mount Hospital provides three acute inpatient wards, and one psychiatric intensive care unit. These are:

- Ashbrook ward, a 25 bed female acute admission ward with a one bed child and adolescent mental health service annex
- Oakburn ward, a 21 bed male acute admission ward with a one bed child and adolescent mental health service annex
- Maplebeck ward, a 21 bed male acute admission ward
- Clover ward, a 10 bed mixed gender psychiatric intensive care unit.

Patients using the acute wards may be detained under the Mental Health Act or admitted informally. All patients admitted to the psychiatric intensive care unit on Clover ward are detained under the Mental Health Act.

The acute wards for adults of working age and psychiatric intensive care unit were inspected between the 5 and the 7 March 2019 as part of the trust's last well led review. This core service was rated as inadequate overall; inadequate in safe and well led, and requires improvement in effective, caring and responsive. Due to the concerns we found during this inspection, we used our powers to take immediate enforcement action. We issued the trust with a section 29A warning notice in relation to this core service and we advised the trust that our findings indicated a need for significant improvement in the safety and quality of healthcare.

We revisited the acute wards for adults of working age and psychiatric intensive care unit in September 2019 to check that appropriate action had been taken to improve the safety and the governance of these services.

We found that improvements had been made at the inspection in September 2019. However, there remained some areas that could be improved further and we identified regulatory breaches in relation to:

- staff not completing documentation fully when patients go on leave from the ward (Regulation 12 Safe care and treatment)
- the ward environment was not being reviewed regularly nor was action always taken in response to issues identified (Regulation 12 Safe care and treatment)
- ligature risk assessments did not reflect all ligature risks in the environment (Regulation 12 Safe care and treatment)
- patient risk management plans did not always address risks identified and were not always person-centred (Regulation 12 Safe care and treatment)
- systems and processes needed to be embedded to ensure that quality and safety was assessed, monitored and improved (Regulation 17 Good governance).

We completed this inspection to follow up on the breaches of regulation and areas identified as requiring improvement from the two previous inspections across all five key questions. Our findings are included within this report.

Summary of findings

Our inspection team

The team that inspected the service comprised two Care Quality Commission inspectors and two nurses acting as specialist professional advisors to the Care Quality Commission.

How we carried out this inspection

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

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

Before the inspection visit, we reviewed information that we held about the location.

During the inspection visit, the inspection team:

- visited all six wards that made up the service; looked at the quality of the ward environment and observed how staff were caring for patients
- spoke with 13 patients, six carers and reviewed 20 comments cards and three letters addressed to the CQC by patients currently using the service

- spoke with six ward managers and one deputy ward manager
- spoke with 18 other staff members; including nurses, healthcare support workers, occupational therapists, pharmacists, a doctor, an activities co-ordinator and an associate practitioner
- attended and observed a multidisciplinary team meeting, the purposeful inpatient admission process meeting and a daily call out meeting

- looked at 13 patients' care and treatment records
- carried out medicines management reviews for all six wards
- looked at the service's use of seclusion, restraint, patient observations and rapid tranquilisation
- looked at a range of other documentation relating to the running of the service.

Areas for improvement

Action the provider SHOULD take to improve

- The trust should ensure that all ligature anchor points, including those in communal areas or where staff are always present, are identified, clearly and explicitly recorded and mitigated across all the wards within the service.

- The trust should review its observation and engagement policy to ensure it is robust, used consistently across all wards within the service and ensures staff undertaking patient observations record all essential information accurately and in a timely manner.

- The trust should ensure that documentation in relation environmental risks, maintenance work and other health and safety considerations is consistent, accurate, signed, dated, and updated across all the wards within the service.

- The trust should ensure that there are regular reviews and checks to ensure all maintenance work identified is completed across the wards within the timescales agreed in order to provide a safe and comfortable environment for patients and staff.

- The trust should ensure that staff always carry out the necessary observations in relation to the seclusion of patients.

Summary of findings

- The trust should ensure that policies and procedures are clear and in line with the Mental Health Act and Mental Health Act Code of Practice for informal patients being able to leave the ward of their own free will.

- The trust should ensure that information about patients goals are recorded in their care records and that staff record information about discharge planning consistently and in a way that makes it easily accessible.

- The trust should ensure that all staff receive regular supervision.

- The trust should continue in its efforts to recruit additional permanent staff to vacant posts.

- The trust should ensure that all staff complete their mandatory and statutory training.

Are services safe?

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

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

Our findings

Safe and clean environment

All wards were clean well equipped, well furnished, well maintained and fit for purpose, and significant action had been taken to improve the safety on the wards.

Safety of the ward layout

Significant action had been taken by the trust to improve the safety on the wards, including in relation to the identification, assessment and mitigation of ligature risks. Current ligature risk assessments were in place for all wards and most wards used the summary report which contained all the information necessary in relation to the risks identified and how they were mitigated. However, Oakburn ward's summary report completed in April 2019 did not include all the dates the ligature risks had been reviewed. Ashbrook ward had a copy of all the documents relating to ligature risk available for staff, including the detailed assessments, summary reports and the ligature training completed.

However, the taps in the activity room on Ashbrook ward were not anti-ligature and had not been recorded in the ligature risk assessment. A privacy hood around a telephone on Heather ward had not been clearly recorded as a ligature risk with reference only to the phone and its features. However, as both of these ligature points were in the communal area of the wards, the risks were mitigated due to the fact that a staff member was always present.

The trust was in the process of installing new doors on the wards which had sensors that could detect when patients were using the doors to ligature and sounded an alarm. However, these doors had a thumb-slider to open the observation blinds built into them. The sliders were at approximately 1.5 metres height; made of metal and jutted out enough that a ligature could be put around it. The sliders had not been identified as a possible ligature risk by staff within the service. However, whilst this slider had not been specifically identified as a ligature point, at the time of the inspection the doors had not had their alarms activated and so the doors themselves remained on

ligature risk assessments and mitigation was in place. The trust did, however, confirm that even once activated, the doors themselves would remain on the ligature risk assessment.

There were blind spots on the ward which were mitigated via the use of mirrors and closed circuit television.

Staff did regular environmental risk assessments of the care environment. However, on some occasions health and safety documentation was not completed consistently, accurately, or up to date and there was an inconsistency in the level of information across the wards in relation to staff training in health and safety. On Ashbrook ward, a trip hazard in the communal area had been signed off as being addressed but was still present at the time of our inspection. We made the ward manager aware of this. Staff on Oakburn ward had not signed documentation relating to two daily environmental checks in March 2020 and on Fern ward environmental checks had not been completed for two days in March due to patient acuity. Also, on Fern ward, 32 minor findings identified in a fire risk assessment conducted in May 2019 had been completed and signed off centrally, but the ward's document had not been updated. Similarly, on Heather ward, which was the only ward to still use a paper-based log of maintenance work required, work had been completed with confirmation sent to the staff member who reported it, but the ward's log not updated.

We saw evidence that staff within the service created personal emergency evacuation plans for patients on the wards.

The ward complied with the Department of Health's guidance on eliminating mixed-sex accommodation.

Staff had easy access to alarms and patients had access to nurse call systems in their bedrooms and in the communal areas of the ward.

Maintenance, cleanliness and infection control

During our inspection, we found all ward areas to be clean, with good furnishings and saw evidence that staff adhered to infection control procedures such as handwashing.

At the time of our inspection, senior managers were holding meetings to discuss and formulate plans in mitigating the spread of the coronavirus.

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NHS trusts and other care trusts use surveys called patient led assessments of the care environment (PLACE) to enable patients to rate the quality of the environment at which their care and treatment is delivered. The PLACE scores for this service were:

Airedale Centre for Mental Health

- 99% for cleanliness
- 97% for condition, appearance and cleanliness

Lynfield Mount Hospital

- 98% for cleanliness
- 98% for condition, appearance and cleanliness

Seclusion room

Seclusion was only used on Clover ward, a psychiatric intensive care unit. The seclusion room on this ward allowed clear observation and two-way communication, had toilet facilities and a clock. The room allowed patients to have access to natural light, was well-ventilated and contained safe bedding. Patients also had access to mood-lighting to create a calming, therapeutic atmosphere.

Clinic room and equipment

Clinic rooms were fully equipped with accessible resuscitation equipment and emergency drugs that staff checked regularly. Staff maintained equipment well, kept it clean and 'clean' stickers were visible and in date.

Safe staffing
The service had enough nursing and medical staff, who knew the patients and received basic training to keep people safe from avoidable harm and deliver safe care and treatment.

Nursing staff

The staffing figures relating to this service are detailed below:

- Number of healthcare support workers – 69.44 WTE
- Number of healthcare support worker vacancies – 19.06 WTE
- Number of registered nurses – 90.04 WTE
- Number of registered nurse vacancies – 13.52 WTE
- Number of occupational therapists – 10.96 WTE
- Number of occupational therapist vacancies – 0.04 WTE
- Number of psychologists – 5 WTE
- Number of psychologist vacancies – none

On Fern ward, staffing levels was included on the trust's risk register. At the time of our inspection, three staff members were on maternity leave, one staff member was on a career break and there were two vacancies on the ward. In response to this:

- the ward manager had booked two agency members of staff until September 2020
- another agency member of staff was going through the process of becoming employed by the trust on a permanent basis
- staffing rotas were created eight weeks in advance so bank and agency staff could be booked to fill any gaps in staffing levels identified
- weekly health roster meetings took place with the other wards within the service to look at the rota for the coming weeks.

The trust was taking a proactive approach to addressing vacancies within the service. At the time of our inspection, 21 student nurses were going through the recruitment process for both sites and were due to take up permanent posts by September 2020. Further applications were also being processed with interviews scheduled to take place in April 2020 and there were plans to recruit further within this time.

Each of the wards had activity co-ordinators and access to doctors that were not counted in with the daily staffing figures.

The trust reported that the average staff turnover within the service in the 12 months prior to our inspection was 16%. This figure included staff movement between wards and promotions. The average staff sickness rate in the last 12 months was 7%. The trust reported that it had reviewed its approach to monitoring and managing staff sickness and this had led to a 13% reduction in the level of long-term staff sickness levels.

Managers had calculated the number and grades of nurses and healthcare assistants required to deliver safe care and treatment using the NHS safer staffing model. This model set the minimum numbers of nurses and healthcare support workers to deliver safe care and treatment on the wards. Senior managers had identified that additional staff above these numbers were often required on the wards and an understanding of this was gathered through the clinical teams looking at reasons for booking additional staff such as patient acuity. A model roster was developed

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which allowed teams to more proactively book additional staff when required. This was also being supported by the roll out of a safe care acuity tool and monitored through daily lean management processes, quality and operational meetings and safer staffing structures.

An experienced registered nurse was present in the communal areas of the ward at all times. In the main, staffing levels on the ward allowed patients to have regular one-to-one time with their named nurse, which was corroborated by most of the patients we spoke with. Two of the thirteen patients we spoke with said staff were too busy for there to be one-to-one time and they didn't see their named nurse as often as they would like.

Staff shortages rarely resulted in staff cancelling escorted leave or ward activities. Activities could sometimes be delayed but when this happened, they went ahead later than planned on the same day. There were enough staff to carry out physical interventions such as observations, restraint and seclusion safely and staff had been trained in the use of these interventions.

Medical staff

There was adequate medical cover day and night. There were onsite doctors during the day and out of hours doctors for both sites who could attend the wards quickly if there was a medical emergency.

Mandatory training

Staff received and were up to date with most of the modules of their mandatory and statutory training. The overall staff compliance for mandatory and statutory training within the service was 90%.

- ligature risk training 94% compliance
- basic life support 89% compliance
- intermediate life support 93% compliance
- care programme approach care planning 90% compliance
- care programme approach clinical risk 88% compliance
- equality and diversity 99% compliance
- fire 96% compliance
- food hygiene 91% compliance
- health and safety awareness 91% compliance
- infection prevention and control level 1 100% compliance
- infection prevention and control level 2 94% compliance
- information governance 97% compliance

- managing aggression and violence breakaway 80% compliance
- managing aggression and violence physical interventions 94% compliance
- medicines management 92% compliance
- moving and handling people (minimum assistance) 89% compliance
- moving and handling level 1 87% compliance
- NHS conflict resolution 99% compliance
- prevent 96% compliance
- rapid tranquilisation 93% compliance
- risk management 99% compliance
- safeguarding adults level 2 83% compliance
- safeguarding children level 3 90% compliance
- safeguarding children level 2 98% compliance
- safeguarding children level 1 100% compliance

Staff compliance in relation to the care programme approach roles and responsibilities module was 60%. However, the remaining staff were due to complete this training by April 2020. For level 2 food safety catering, only 53% of staff had completed this training. However, the trust told us that some staff eligible for this training worked on a rotation basis for the trust, as well as the acute trusts, which impacted on them being able to access this. This meant that some staff may have had training that was up to date, but which was not reflected in these figures. Managers were reviewing this and in discussions to resolve the issue Managers were reviewing this and in discussions to resolve the issue.

Assessing and managing risk to patients and staff
Staff assessed and managed risks to patients and themselves well and followed best practice in anticipating, de-escalating and managing challenging behaviour. **Staff used restraint and seclusion only after attempts at de-escalation had failed. The ward staff participated in the trust's restrictive interventions reduction programme.**

Assessment of patient risk

The service used a process called the SBAR (situation, background, assessment and recommendation) for patients due to be admitted to the ward. This process required referring parties to provide the service with information about the patient's background, the reasons

for the admission and the risks they presented to themselves and others. This process ensured that staff had the information necessary prior to a patient being admitted.

We looked at 13 patients' care and treatment records during our inspection. All 13 records contained clear and appropriate risk assessments for each patient which were regularly updated. Risk was discussed routinely as part of the service's newly implemented the purposeful inpatient admission process. This process also enabled managers to have oversight of how often staff were updating risk assessments. Nurses within the service also used checklists to review the number of days since each patients' risk assessment and crisis plan had been updated to support patient safety.

Staff used a variety of risk assessment tools that were built into the trust's care records system and other electronic systems. These included clinical risk, crisis and contingency plans, fire risk assessments and a tool based on the recognised Functional Analysis of Care Environments risk tool.

Management of patient risk

Staff were aware of and dealt with any specific issues such as diabetes, physical injuries and other physical and mental health issues.

Staff identified and responded to changing risks to or posed by patients. Examples included reviewing Section 17 leave when illicit drugs were found in a patient's e-cigarette, changes in the level of patient observations and reviews and updates of patients' risk management plans.

Staff were able to identify and respond quickly and appropriately to signs that a patient's health had suddenly deteriorated. Staff gave examples of possible signs of deterioration which included behaving out of character, fixed stares, agitation and distress.

Staff used patient observations to manage and mitigate risk and to keep patients safe on the wards. These observation levels were individually risk assessed and regularly reviewed through the purposeful inpatient admission and multidisciplinary team processes. Records reviewed demonstrated that observations were being completed. However, there was an inconsistent approach

to how observations were documented across the wards and we had concerns about the trust's policy on the use of patient observations and inconsistencies in its use. The policy indicated that:

- a member of staff should undertake the observations of the patient
- sign a form to say the observation time had been completed
- pass information about presentation, risk and engagement to a second staff member
- the second staff member should document this in the patient's records.

This meant there was the potential for time delays in the information being handed over and recorded and that information may not be entirely accurate given it was a second-hand account, especially if the ward was busy or a patient was on an increased level of observations. However, on Ashbrook ward staff used an observations template for patients with high levels of risk, which contained a column for the staff member undertaking observations to record information in writing for the second staff to document. On Clover ward, the observing member of staff was always responsible for documenting observation information.

Staff applied blanket restrictions on patients' freedom only when justified. The wards had a list of restricted items such as sharp or flammable items which were appropriate for the patient group. All patients were in possession of a fob device which they used to gain access to their bedroom at any time of day.

Staff adhered to best practice in implementing a smoke-free policy. During our last inspection, patients were being assigned Section 17 leave for smoke breaks which was not in line with the Mental Health Act. However, during this latest inspection, this matter had been addressed and staff were providing nicotine replacement patches and inhalators to help patients cease or reduce their smoking habits.

Use of restrictive interventions

Staff used restraint only after de-escalation had failed and used the correct techniques. The ward staff participated in the trust's restrictive interventions reduction programme. We reviewed four incidents of restraint and nine incident

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report forms and saw evidence that staff had used verbal de-escalation techniques in order to avoid the use of restraint. We also saw evidence that staff debriefed patients and gave them assurance following the use of restraint.

Staff understood and worked within the Mental Capacity Act definition of restraint. They were aware that restraint under the Act did not solely refer to physical restraint but any restrictions on a patient's liberty and that when doing so, the least restrictive option should be used. Staff on the wards were also using guidance and techniques in line with the NHS Safewards initiative. Safewards is designed to reduce the need for restrictive interventions through a variety of methods such as the use of soft and positive words, clear mutual expectations, reassurance, mutual help discussions and calm down methods.

Staff followed the National Institute for Health and Care Excellence guidance when using rapid tranquilisation. We reviewed four records of rapid tranquilisation and saw evidence that staff undertook the necessary observations and checks following its use in line with this guidance. A clinical audit of the use of rapid tranquilisation had identified that there was low assurance around staff compliance with the trust's rapid tranquilisation policy and procedure and this was included on the service's risk register. In response to this:

- a rolling programme of clinical audits in relation to the use of rapid tranquilisation had been put in place
- additional training had been delivered to staff in relation to rapid tranquilisation
- all incidences of rapid tranquilisation used on the wards needed to be discussed in the purposeful inpatient admission process meetings and formulation discussions to ensure the trust's policy and procedure was being adhered to.

Staff used seclusion appropriately. We looked at three records of seclusion and found that there were justifiable reasons recorded for placing each patient in seclusion. In all three records, we identified that staff were not always undertaking the necessary observations such as two-hourly nursing reviews, four-hourly reviews by a doctor and 15-minute reviews by other staff. However, this was on one 15 minute staff observation in one seclusion record and one medical review in another record and incident reports had been made in relation to these missed observations. The third record had five missed staff observations spread across the episode of seclusion.

The trust reported that in the 12 months prior to our inspection there had been:

- 278 incidences of the use of rapid tranquilisation
- 1190 incidences of the use of restraint, none of which were in the prone position
- no incidences of long-term segregation
- 41 incidents of the use of seclusion.

The highest number of restraint were 308 on Ashbrook ward and 283 on Maplebeck ward. This was comparable to our previous inspection in September 2019 when the trust reported that there had been 554 incidences of restraint over six months (April to September 2019). There was a similar picture for the use of rapid tranquilisation as the trust had reported for the April to September six-month period that there had been 107 incidences of its use and this latest 12 month period was just over double that figure. When comparing the two time periods in relation to the use of seclusion, the comparison showed a slight rise in the regularity of its use since the last inspection. However, we were assured through discussions with staff that restraint and seclusion was only ever used as a last resort after de-escalation techniques had failed.

Safeguarding
Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Staff were trained in adult and child safeguarding, knew how to make a safeguarding referral and did so when appropriate. There was a named safeguarding nurse and the trust's safeguarding team provided staff with additional advice and support, including in the safety huddles and walkabouts on the ward.

We asked the trust for the total number of safeguarding referrals made by staff within the service in the 12 months prior to our inspection. They were unable to currently provide the number of safeguarding adult concerns raised to the local authority from 1 February 2020 onwards due to a change in the systems within the local authority. This issue was recorded on the trust's risk register and had been raised and documented at a recent safeguarding adults board meeting. However, the trust sent us figures for the

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February 2019 to January 2020 period which showed 10 safeguarding referrals had been sent to the local authority by staff within the service. The trust did not report any numbers for safeguarding referrals in relation to children.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act 2010. These included use of the trust's equality and diversity policies, non-discriminatory practices and the appointment of LGBT+ champions within the service.

Staff knew how to identify adults and children at risk of or suffering significant harm and worked in partnership with other agencies to protect them.

Staff followed safe procedures for children visiting the wards. Child visits were planned in advance and children were always seen off the ward.

Staff access to essential information
Staff generally had easy access to clinical information and there had been significant improvements in staff maintaining high quality clinical records.

The trust's care records system was electronic and staff who spoke with us found the system easy to use. However, six staff members said the system could be very slow in starting up which they found frustrating as it sometimes caused delays in accessing patient information.

We reviewed 13 patients' care records and found that there had been significant improvements in staff maintaining high quality clinical records, with sufficient information to deliver safe care and treatment. However, goal setting and consistent documentation of discharge plans could be improved further to make it quicker to access this information.

Medicines management
The service used systems and processes to safely prescribe, administer, record and store medicines. Staff regularly reviewed the effects of medications on each patient's mental and physical health.

Staff followed good practice and National Institute of Health and Care Excellence guidance in relation to the transport, storage, administration and dispensing of medicines on the wards. Each ward has an allocated pharmacist and pharmacy technician who were based on the wards for part of each day and attending purposeful

inpatient admission and multi-disciplinary team meetings. Pharmacists provided advice and guidance to staff and also undertook checks of the medicines management arrangements and ensured patients' behaviour was not being controlled by excessive use of medicines.

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Checks were in place for patients who had been prescribed high-dose antipsychotic medicine. Staff completed high-dose antipsychotic therapy monitoring forms and these were attached to patients' prescription forms.

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Staff ensured patients were made aware of the effects and rationale for their prescribed medicines. We observed a pharmacist talking with a patient about changes to their medicine during our inspection.

The service had a controlled drugs accountable officer and medicines safety officer who worked in the pharmacy directorate.

Track record on safety

There had been five serious incidents within the service in the 12 months prior to our inspection. These included one suspected suicide, a suspected attempted suicide, an admission of a patient under 16 years of age to the children and adolescent mental health annex within Ashbrook ward, and two allegations of abuse against patients. The trust investigated these incidents and immediate action was taken where appropriate.

Adverse events within the service included medicine errors and we saw evidence that these had been reported using the trust's incident reporting system.

Reporting incidents and learning from when things go wrong
The service managed patient safety incidents well. Staff recognised incidents and reported them

Are services safe?

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appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

Staff knew what incidents to report and how to report them. Examples of incidents that were routinely reported on the ward included unauthorised absences from the wards, violence and aggression, self-harm and attempted suicide.

Staff understood what their responsibilities were under the duty of candour. The duty of candour legally requires all healthcare staff to be open and honest when things go wrong, offer an apology and full explanation and find ways to put the matter right.

Staff received feedback and lessons learned from investigations into incidents, both within and outside of the service via team meetings, emails, during safety meetings and during supervision. Staff were debriefed and supported following a serious incident.

The trust had recently reviewed the process for informal patients to leave wards freely, making the risk assessment process more robust. This was in response to serious incidents that had happened involving informal patients who had left the ward.

Another improvement was the introduction of the purposeful inpatient admission process which ensured that risk assessments, risk management plans and all essential patient information was discussed and reviewed.

Are services effective?

Good ●

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

Our findings

Safe and clean environment
All wards were clean well equipped, well furnished, well maintained and fit for purpose, and significant action had been taken to improve the safety on the wards.

Safety of the ward layout

Significant action had been taken by the trust to improve the safety on the wards, including in relation to the identification, assessment and mitigation of ligature risks. Current ligature risk assessments were in place for all wards and most wards used the summary report which contained all the information necessary in relation to the risks identified and how they were mitigated. However, Oakburn ward's summary report completed in April 2019 did not include all the dates the ligature risks had been reviewed. Ashbrook ward had a copy of all the documents relating to ligature risk available for staff, including the detailed assessments, summary reports and the ligature training completed.

However, the taps in the activity room on Ashbrook ward were not anti-ligature and had not been recorded in the ligature risk assessment. A privacy hood around a telephone on Heather ward had not been clearly recorded as a ligature risk with reference only to the phone and its features. However, as both of these ligature points were in the communal area of the wards, the risks were mitigated due to the fact that a staff member was always present.

The trust was in the process of installing new doors on the wards which had sensors that could detect when patients were using the doors to ligature and sounded an alarm. However, these doors had a thumb-slider to open the observation blinds built into them. The sliders were at approximately 1.5 metres height; made of metal and jutted out enough that a ligature could be put around it. The sliders had not been identified as a possible ligature risk by staff within the service. However, whilst this slider had not been specifically identified as a ligature point, at the time of the inspection the doors had not had their alarms activated and so the doors themselves remained on ligature risk assessments and mitigation was in place. The trust did, however, confirm that even once activated, the doors themselves would remain on the ligature risk assessment.

There were blind spots on the ward which were mitigated via the use of mirrors and closed circuit television.

Staff did regular environmental risk assessments of the care environment. However, on some occasions health and safety documentation was not completed consistently, accurately, or up to date and there was an inconsistency in the level of information across the wards in relation to staff training in health and safety. On Ashbrook ward, a trip hazard in the communal area had been signed off as being addressed but was still present at the time of our inspection. We made the ward manager aware of this. Staff on Oakburn ward had not signed documentation relating to two daily environmental checks in March 2020 and on Fern ward environmental checks had not been completed for two days in March due to patient acuity. Also, on Fern ward, 32 minor findings identified in a fire risk assessment conducted in May 2019 had been completed and signed off centrally, but the ward's document had not been updated. Similarly, on Heather ward, which was the only ward to still use a paper-based log of maintenance work required, work had been completed with confirmation sent to the staff member who reported it, but the ward's log not updated.

We saw evidence that staff within the service created personal emergency evacuation plans for patients on the wards.

The ward complied with the Department of Health's guidance on eliminating mixed-sex accommodation.

Staff had easy access to alarms and patients had access to nurse call systems in their bedrooms and in the communal areas of the ward.

Maintenance, cleanliness and infection control
During our inspection, we found all ward areas to be clean, with good furnishings and saw evidence that staff adhered to infection control procedures such as handwashing.

At the time of our inspection, senior managers were holding meetings to discuss and formulate plans in mitigating the spread of the coronavirus.

NHS trusts and other care trusts use surveys called patient led assessments of the care environment (PLACE) to enable patients to rate the quality of the environment at which their care and treatment is delivered. The PLACE scores for this service were:

Airedale Centre for Mental Health

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- 99% for cleanliness
- 97% for condition, appearance and cleanliness

Lynfield Mount Hospital

- 98% for cleanliness
- 98% for condition, appearance and cleanliness

Seclusion room

Seclusion was only used on Clover ward, a psychiatric intensive care unit. The seclusion room on this ward allowed clear observation and two-way communication, had toilet facilities and a clock. The room allowed patients to have access to natural light, was well-ventilated and contained safe bedding. Patients also had access to mood-lighting to create a calming, therapeutic atmosphere.

Clinic room and equipment

Clinic rooms were fully equipped with accessible resuscitation equipment and emergency drugs that staff checked regularly. Staff maintained equipment well, kept it clean and 'clean' stickers were visible and in date.

Safe staffing

The service had enough nursing and medical staff, who knew the patients and received basic training to keep people safe from avoidable harm and deliver safe care and treatment.

Nursing staff

The staffing figures relating to this service are detailed below:

- Number of healthcare support workers – 69.44 WTE
- Number of healthcare support worker vacancies – 19.06 WTE
- Number of registered nurses – 90.04 WTE
- Number of registered nurse vacancies – 13.52 WTE
- Number of occupational therapists – 10.96 WTE
- Number of occupational therapist vacancies – 0.04 WTE
- Number of psychologists – 5 WTE
- Number of psychologist vacancies – none

On Fern ward, staffing levels was included on the trust's risk register. At the time of our inspection, three staff members were on maternity leave, one staff member was on a career break and there were two vacancies on the ward. In response to this:

- the ward manager had booked two agency members of staff until September 2020

- another agency member of staff was going through the process of becoming employed by the trust on a permanent basis
- staffing rotas were created eight weeks in advance so bank and agency staff could be booked to fill any gaps in staffing levels identified
- weekly health roster meetings took place with the other wards within the service to look at the rota for the coming weeks.

The trust was taking a proactive approach to addressing vacancies within the service. At the time of our inspection, 21 student nurses were going through the recruitment process for both sites and were due to take up permanent posts by September 2020. Further applications were also being processed with interviews scheduled to take place in April 2020 and there were plans to recruit further within this time.

Each of the wards had activity co-ordinators and access to doctors that were not counted in with the daily staffing figures.

The trust reported that the average staff turnover within the service in the 12 months prior to our inspection was 16%. This figure included staff movement between wards and promotions. The average staff sickness rate in the last 12 months was 7%. The trust reported that it had reviewed its approach to monitoring and managing staff sickness and this had led to a 13% reduction in the level of long-term staff sickness levels.

Managers had calculated the number and grades of nurses and healthcare assistants required to deliver safe care and treatment using the NHS safer staffing model. This model set the minimum numbers of nurses and healthcare support workers to deliver safe care and treatment on the wards. Senior managers had identified that additional staff above these numbers were often required on the wards and an understanding of this was gathered through the clinical teams looking at reasons for booking additional staff such as patient acuity. A model roster was developed which allowed teams to more proactively book additional staff when required. This was also being supported by the roll out of a safe care acuity tool and monitored through daily lean management processes, quality and operational meetings and safer staffing structures.

An experienced registered nurse was present in the communal areas of the ward at all times. In the main,

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staffing levels on the ward allowed patients to have regular one-to-one time with their named nurse, which was corroborated by most of the patients we spoke with. Two of the thirteen patients we spoke with said staff were too busy for there to be one-to-one time and they didn't see their named nurse as often as they would like.

Staff shortages rarely resulted in staff cancelling escorted leave or ward activities. Activities could sometimes be delayed but when this happened, they went ahead later than planned on the same day. There were enough staff to carry out physical interventions such as observations, restraint and seclusion safely and staff had been trained in the use of these interventions.

Medical staff

There was adequate medical cover day and night. There were onsite doctors during the day and out of hours doctors for both sites who could attend the wards quickly if there was a medical emergency.

Mandatory training

Staff received and were up to date with most of the modules of their mandatory and statutory training. The overall staff compliance for mandatory and statutory training within the service was 90%.

- ligature risk training 94% compliance
- basic life support 89% compliance
- intermediate life support 93% compliance
- care programme approach care planning 90% compliance
- care programme approach clinical risk 88% compliance
- equality and diversity 99% compliance
- fire 96% compliance
- food hygiene 91% compliance
- health and safety awareness 91% compliance
- infection prevention and control level 1 100% compliance
- infection prevention and control level 2 94% compliance
- information governance 97% compliance
- managing aggression and violence breakaway 80% compliance
- managing aggression and violence physical interventions 94% compliance
- medicines management 92% compliance
- moving and handling people (minimum assistance) 89% compliance
- moving and handling level 1 87% compliance

- NHS conflict resolution 99% compliance
- prevent 96% compliance
- rapid tranquilisation 93% compliance
- risk management 99% compliance
- safeguarding adults level 2 83% compliance
- safeguarding children level 3 90% compliance
- safeguarding children level 2 98% compliance
- safeguarding children level 1 100% compliance

Staff compliance in relation to the care programme approach roles and responsibilities module was 60%. However, the remaining staff were due to complete this training by April 2020. For level 2 food safety catering, only 53% of staff had completed this training. However, the trust told us that some staff eligible for this training worked on a rotation basis for the trust, as well as the acute trusts, which impacted on them being able to access this. This meant that some staff may have had training that was up to date, but which was not reflected in these figures. Managers were reviewing this and in discussions to resolve the issue Managers were reviewing this and in discussions to resolve the issue.

Assessing and managing risk to patients and staff

Staff assessed and managed risks to patients and themselves well and followed best practice in anticipating, de-escalating and managing challenging behaviour. **Staff used restraint and seclusion only after attempts at de-escalation had failed. The ward staff participated in the trust's restrictive interventions reduction programme.**

Assessment of patient risk

The service used a process called the SBAR (situation, background, assessment and recommendation) for patients due to be admitted to the ward. This process required referring parties to provide the service with information about the patient's background, the reasons for the admission and the risks they presented to themselves and others. This process ensured that staff had the information necessary prior to a patient being admitted.

We looked at 13 patients' care and treatment records during our inspection. All 13 records contained clear and appropriate risk assessments for each patient which were regularly updated. Risk was discussed routinely as part of the service's newly implemented the purposeful inpatient admission process. This process also enabled managers to

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have oversight of how often staff were updating risk assessments. Nurses within the service also used checklists to review the number of days since each patients' risk assessment and crisis plan had been updated to support patient safety.

Staff used a variety of risk assessment tools that were built into the trust's care records system and other electronic systems. These included clinical risk, crisis and contingency plans, fire risk assessments and a tool based on the recognised Functional Analysis of Care Environments risk tool.

Management of patient risk

Staff were aware of and dealt with any specific issues such as diabetes, physical injuries and other physical and mental health issues.

Staff identified and responded to changing risks to or posed by patients. Examples included reviewing Section 17 leave when illicit drugs were found in a patient's e-cigarette, changes in the level of patient observations and reviews and updates of patients' risk management plans.

Staff were able to identify and respond quickly and appropriately to signs that a patient's health had suddenly deteriorated. Staff gave examples of possible signs of deterioration which included behaving out of character, fixed stares, agitation and distress.

Staff used patient observations to manage and mitigate risk and to keep patients safe on the wards. These observation levels were individually risk assessed and regularly reviewed through the purposeful inpatient admission and multidisciplinary team processes. Records reviewed demonstrated that observations were being completed. However, there was an inconsistent approach to how observations were documented across the wards and we had concerns about the trust's policy on the use of patient observations and inconsistencies in its use. The policy indicated that:

- a member of staff should undertake the observations of the patient
- sign a form to say the observation time had been completed
- pass information about presentation, risk and engagement to a second staff member
- the second staff member should document this in the patient's records.

This meant there was the potential for time delays in the information being handed over and recorded and that information may not be entirely accurate given it was a second-hand account, especially if the ward was busy or a patient was on an increased level of observations. However, on Ashbrook ward staff used an observations template for patients with high levels of risk, which contained a column for the staff member undertaking observations to record information in writing for the second staff to document. On Clover ward, the observing member of staff was always responsible for documenting observation information.

Staff applied blanket restrictions on patients' freedom only when justified. The wards had a list of restricted items such as sharp or flammable items which were appropriate for the patient group. All patients were in possession of a fob device which they used to gain access to their bedroom at any time of day.

Staff adhered to best practice in implementing a smoke-free policy. During our last inspection, patients were being assigned Section 17 leave for smoke breaks which was not in line with the Mental Health Act. However, during this latest inspection, this matter had been addressed and staff were providing nicotine replacement patches and inhalators to help patients cease or reduce their smoking habits.

Use of restrictive interventions

Staff used restraint only after de-escalation had failed and used the correct techniques. The ward staff participated in the trust's restrictive interventions reduction programme. We reviewed four incidents of restraint and nine incident report forms and saw evidence that staff had used verbal de-escalation techniques in order to avoid the use of restraint. We also saw evidence that staff debriefed patients and gave them assurance following the use of restraint.

Staff understood and worked within the Mental Capacity Act definition of restraint. They were aware that restraint under the Act did not solely refer to physical restraint but any restrictions on a patient's liberty and that when doing so, the least restrictive option should be used. Staff on the wards were also using guidance and techniques in line with the NHS Safewards initiative. Safewards is designed to

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reduce the need for restrictive interventions through a variety of methods such as the use of soft and positive words, clear mutual expectations, reassurance, mutual help discussions and calm down methods.

Staff followed the National Institute for Health and Care Excellence guidance when using rapid tranquilisation. We reviewed four records of rapid tranquilisation and saw evidence that staff undertook the necessary observations and checks following its use in line with this guidance. A clinical audit of the use of rapid tranquilisation had identified that there was low assurance around staff compliance with the trust's rapid tranquilisation policy and procedure and this was included on the service's risk register. In response to this:

- a rolling programme of clinical audits in relation to the use of rapid tranquilisation had been put in place
- additional training had been delivered to staff in relation to rapid tranquilisation
- all incidences of rapid tranquilisation used on the wards needed to be discussed in the purposeful inpatient admission process meetings and formulation discussions to ensure the trust's policy and procedure was being adhered to.

Staff used seclusion appropriately. We looked at three records of seclusion and found that there were justifiable reasons recorded for placing each patient in seclusion. In all three records, we identified that staff were not always undertaking the necessary observations such as two-hourly nursing reviews, four-hourly reviews by a doctor and 15-minute reviews by other staff. However, this was on one 15 minute staff observation in one seclusion record and one medical review in another record and incident reports had been made in relation to these missed observations. The third record had five missed staff observations spread across the episode of seclusion.

The trust reported that in the 12 months prior to our inspection there had been:

- 278 incidences of the use of rapid tranquilisation
- 1190 incidences of the use of restraint, none of which were in the prone position
- no incidences of long-term segregation
- 41 incidents of the use of seclusion.

The highest number of restraint were 308 on Ashbrook ward and 283 on Maplebeck ward. This was comparable to our previous inspection in September 2019 when the trust

reported that there had been 554 incidences of restraint over six months (April to September 2019). There was a similar picture for the use of rapid tranquilisation as the trust had reported for the April to September six-month period that there had been 107 incidences of its use and this latest 12 month period was just over double that figure. When comparing the two time periods in relation to the use of seclusion, the comparison showed a slight rise in the regularity of its use since the last inspection. However, we were assured through discussions with staff that restraint and seclusion was only ever used as a last resort after de-escalation techniques had failed.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Staff were trained in adult and child safeguarding, knew how to make a safeguarding referral and did so when appropriate. There was a named safeguarding nurse and the trust's safeguarding team provided staff with additional advice and support, including in the safety huddles and walkabouts on the ward.

We asked the trust for the total number of safeguarding referrals made by staff within the service in the 12 months prior to our inspection. They were unable to currently provide the number of safeguarding adult concerns raised to the local authority from 1 February 2020 onwards due to a change in the systems within the local authority. This issue was recorded on the trust's risk register and had been raised and documented at a recent safeguarding adults board meeting. However, the trust sent us figures for the February 2019 to January 2020 period which showed 10 safeguarding referrals had been sent to the local authority by staff within the service. The trust did not report any numbers for safeguarding referrals in relation to children.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act 2010. These included use of the trust's equality and diversity policies, non-discriminatory practices and the appointment of LGBT+ champions within the service.

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Another improvement was the introduction of the purposeful inpatient admission process which ensured that risk assessments, risk management plans and all essential patient information was discussed and reviewed.

Are services caring?

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

Good 🟢

Our findings

Kindness, privacy, dignity, respect, compassion and support

Staff treated patients with compassion and kindness. They respected patients' privacy and dignity. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.

During our inspection, we observed staff interacting with patients in a friendly, supportive and caring manner. Staff supported patients to understand and manage their care, treatment and condition.

Staff directed patients to other services when appropriate and supported them to access those services. We saw evidence in patients' care records that staff had supported and directed patients to acute hospitals and physiotherapy for physical healthcare issues, directed a patient to voluntary groups to help with their condition and arranged for support for a patient to manage their addictions and use of steroids.

In the main, the feedback about how well staff treated patients was positive. However, we received some negative feedback including comments on staff attitudes being variable on Heather and Clover wards and staff being too busy to be able to speak with patients and carers on Ashbrook and Clover wards.

Staff who spoke with us felt if they had any concerns about disrespectful, discriminatory or abusive behaviour towards patients, they would be able to report these concerns without fear of reprisals.

Staff maintained the confidentiality of information about patients. The service had confidentiality policies in place that were understood and adhered to by staff. All staff within the service had received information governance training which included the need to maintain client confidentiality in accordance with the Data Protection Act.

NHS trusts and other care trusts use surveys called patient led assessments of the care environment (PLACE) to enable patients to rate the quality of the care and treatment delivered. The PLACE scores for this service were:

Airedale Centre for Mental Health

- 100% for privacy

- 92% for disability
- 92% for dementia

Lynfield Mount Hospital

- 100% for privacy
- 85% for disability
- 86% for dementia

Involvement in care

Staff involved patients and carers in care planning and risk assessment and actively sought their feedback on the quality of care provided.

Involvement of patients

Staff used the admission process to inform and orient patients to the ward and the service. Patients were greeted by a member of staff, introduced to their named nurse, shown around the ward, shown their bedroom and were given a welcome pack which contained information about the service, treatments, how to make a complaint and their rights.

We saw evidence in care records that staff routinely involved patients in discussions and decisions about their care and treatment and offered patients a copy of their care plan. We also observed a pharmacist discussing the changes to a patient's medicine prescription with them.

Staff communicated with patients so that they understood their care and treatment. Staff used a variety of methods to communicate with patients such as flash cards, online translation services, signers, access to information in braille and other languages and easy-read for patients with a learning disability.

Staff involved patients when appropriate in decisions about the service. For example, the ward manager on the Heather ward told us that a patient had been part of the recruitment panel that interviewed her for her role.

Patients and carers had opportunities to give feedback on the service. These included friends and families tests, service user rights forums (SURF), 'patients say so' groups, complaints and comments cards, meetings between staff and patients on wards. Patients were also asked to complete occupational therapy and activities feedback forms. Staff used the feedback received to improve life for individuals and the service overall. For example, during an occupational therapy week event in November, a patient completed a survey and said that an occupational

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Good ●

therapist had referred them to a local arts and crafts group at an external mental health service as they had flagged they were feeling isolated. This opportunity enabled the patient to re-engage in arts and crafts and meet new people. Patients were also asked to complete occupation therapy and activities feedback forms. These forms allowed patients to tell staff what they liked about occupational therapy group activities and asked for their suggestions as to how they could be improved for the future.

Staff also ensured that patients could access advocacy when required.

Involvement of families and carers

Carers had opportunities to give feedback on the service. These included friends and families tests, complaints and comments cards, meetings with staff and through carers' hubs. Staff used the feedback received to improve life for individuals and the service overall.

Staff informed and involved families and carers appropriately.

Staff supported, informed and involved families or carers. We saw evidence in patients' care records that families and carers attended multidisciplinary meetings and ward rounds and that staff maintained contact with them via phone and email. Care records also evidenced that families and carers had been involved in creating care plans for their loved one's care and treatment.

Staff helped families to give feedback on the service via friends and families tests, complaints and comments cards and by speaking to staff on the wards.

Staff gave carers information on how to find the carer's assessment.

Are services responsive to people's needs?

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

Our findings

Access and discharge

Staff managed beds well. A bed was available when needed and that patients were not moved between wards unless this was for their benefit. Discharge was rarely delayed for other than clinical reasons.

Bed Management

The average bed occupancy within the service within the last 12 months was 96%. High bed occupancy rates across the service was included on the service's risk register and daily reviews of occupancy were being undertaken by staff on the wards.

There had been 22 patients placed in an out of area psychiatric intensive care unit in the 12 months prior to our inspection. The main reasons for these out of area placements was because there were no psychiatric intensive care unit beds available within the trust or the patient required seclusion at a time when the trust's own seclusion room was in use.

Beds were now available for patients on their return from leave in the six months prior to our inspection. Bed availability for patients returning from leave had previously been an issue within the service so the trust had been successful in its steps to address this.

Patients were rarely moved between wards during an admission episode. In the six months prior to our inspection, no patients had been moved during an admission episode.

Beds were not always in a psychiatric intensive care unit close to patients' homes and loved ones. However, ward managers said that out of area placements were rare. Staff from Clover ward, which was the trust's psychiatric intensive care unit, provided advice and guidance to their colleagues on the acute wards for adults of working age at both Airedale and Lynfield Mount in relation to changes in medicines, de-escalation techniques, occupational therapy activities and other options to help alleviate and address patients' heightened behaviours, which often helped them in supporting patients so it negated the need for them to be moved to a psychiatric intensive care unit.

Discharge and transfers of care

In the six months prior to our inspection, there had been only one delayed discharge within the service which related to the Fern ward that had not been for clinical reasons. The delay was due to there being no suitable accommodation to meet the patient's physical health needs.

Staff planned for patients' discharge in partnership and liaison with other teams, organisations, care managers and care coordinators. There was evidence of discharge planning with patients within patients' care records and discharge planning was discussed during a daily call out meeting we observed.

We saw evidence in patients' care records that staff supported patients during referrals and transfers between services.

The service complied with the transfer of care standards by ensuring transfer and referral forms and letters contained clinical headings so that all essential information about care, treatment and the patient's progress were included.

The facilities promote recovery, comfort, dignity and confidentiality

The design, layout, and furnishings of the ward supported patients' treatment, privacy and dignity. Each patient had their own bedroom and bedrooms at the Airedale Centre for Mental Health were fitted with an en-suite bathroom. Patients could keep their personal belongings safe. There were quiet areas for privacy. The food was of good quality and patients could make hot drinks and snacks at any time.

Patients had their own bedrooms on the ward which they were able to personalise.

Patients had somewhere secure to store their possessions. Some items could be stored in lockable cupboards in patients' bedrooms but restricted items such as sharp or flammable items were stored in locked cupboards that only staff had the keys to for safety reasons.

Staff and patients had access to a range of rooms and equipment to support care and treatment such as clinic rooms, quiet rooms, occupational therapy kitchens and arts and crafts rooms. However, the ward manager on the Heather ward did not have their own office and had to look for an available suitable room if they needed to hold confidential conversations, including the examination room when it was not in use. The temperature in this

Are services responsive to people's needs?

Good ●

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examination room on this ward was high. The ward had underfloor heating and solar panels had recently been fitted to the building roof which had resulted in the increase in temperature.

Patients could make a phone call in private. Patients had access to their own phones following an individual risk assessment and there were phone booths in the ward areas they could use.

Patients had access to outside space. Each ward had its own courtyard and garden area which patients could access freely. These areas were pleasant, well-maintained and had seating areas. However, the courtyard on the Heather ward had no shelter for patients to protect them in poor weather conditions or from sunburn and the date for one to be installed had passed.

Patients who spoke with us said that the food was of a good quality. Patients had access to hot drinks and snacks all day. NHS trusts and other care trusts use surveys called patient led assessments of the care environment (PLACE) to enable patients to rate the quality of the environment at which their care and treatment is delivered, including the quality of food provided. The PLACE score for food for the wards at the Airedale Centre for Mental Health was 98%. There was no score available for the wards based at Lynfield Mount Hospital.

Patients' engagement with the wider community
Staff supported patients with activities outside the service, such as work, education and family relationships.

Staff ensured patients had access to education and employment opportunities when this was appropriate. For example, on Heather ward, one of the nurses was a former employment specialist and they still had contacts and links with services who could offer work experience and other opportunities for employment to patients. Staff within the service had effective links with organisations that could offer training to enhance skills and experience needed for employment and staff supported patients to attend job interviews.

Staff encouraged patients to maintain contact with the people who mattered to them and who could support them with their care and treatment such as friends, family members and carers. Staff highlighted to patients the benefits of involving loved ones in decisions about their care.

Meeting the needs of all people who use the service
The service met the needs of all patients – including those with a protected characteristic. Staff helped patients with communication, advocacy and cultural and spiritual support.

The service made adjustments to meet the needs of disabled patients or patients with mobility issues. When the wards were unable to meet the specific needs of patients, ward managers were able to refuse admissions and alternative arrangements were made.

The service met the needs of patients with specific communication needs. Staff could arrange for information to be provided in an easy-read format for patients with a learning disability and information could be provided in other languages or in braille for people with a visual impairment.

Patients and staff on the wards had easy access to interpreters and signers when they were required who could normally attend the wards within a day. Staff also used online translation services to communicate with people for whom English was not a first language.

Patients had a choice of food to meet their dietary requirements. These included healthy options for patients with weight issues or diabetes, gluten-free options, halal and kosher meats and vegetarian and vegan options.

Staff ensured that patients had access to appropriate spiritual support. Each ward had its own multifaith room and staff could arrange for a priest, vicar, imam or rabbi to visit the wards if a patient requested to speak with one.

Listening to and learning from concerns and complaints
The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and wider service.

In the 12 months prior to our inspection there were 158 concerns and 14 formal complaints raised across the service. Out of these complaints and concerns, 56 were upheld and 32 were partially upheld. One complaint was referred to the Parliamentary and Health Service Ombudsman and this was not upheld.

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Patients knew how to make a complaint or raise concerns. There were posters on all the wards which told patients how to complain and on admission, patients were given welcome packs which included information about how to make a complaint. The patients we spoke with knew how to make a complaint, both internally and externally.

In the main, staff provided patients with feedback following a complaint either on 'you said, we did' boards or on an individual basis. Only one patient told us that they had complained and had not received feedback.

Staff protected patients who raised concerns or complaints from discrimination and harassment. Staff members against whom complaints had been made could be moved to other wards and sites whilst the complaint was being investigated and complaints could be dealt with independently by the trust's patient advice and liaison service. When a complaint was made against another patient, staff could increase levels of patient observations and risk assessments and management plans were updated for both parties. The trust also had equality and diversity policies and procedures in place to protect patients from discrimination and harassment.

Staff knew how to handle complaints appropriately and received feedback and lessons learned on the outcome of investigations into complaints via team meetings, emails and during supervision sessions. For example, patients on Maplebeck ward had complained there were not enough activities to do because the activities coordinator had been on long-term sickness absence. In response to this, the ward was given access to two occupational therapists and a healthcare support worker who ensured patients always had sufficient numbers of various activities on the ward to keep them occupied.

Are services well-led?

Good 🟢

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Our findings

Leadership

Leaders had the integrity, skills and abilities to run the service. They understood the issues, priorities and challenges the service faced and managed them. They were visible in the service and supported staff to develop their skills and take on more senior roles.

Leaders had the skills, knowledge and experience to perform their roles. Leaders had a good knowledge of the systems used within the service, had worked in the mental health sector for a long time, had skills in coaching and engagement, had worked as healthcare support workers and nursing associates, received awards in diversity and nursing, and worked in training roles.

Leaders had a good understanding of the services they managed and could explain how the team was providing high quality care. Examples included the improvements made to the service via the use of the purposeful inpatient admission process such as improved quality of care records and safety processes and audits carried out within the service. The wards held daily meetings called daily call outs. Each ward manager met with the clinical lead to discuss bed occupancy, Section 17 leave, discharges, staffing, incidents that had happened in the last 24 hours, care plans, medicines, use of rapid tranquilisation and seclusion, security, length of stay, any escalation in patients' risks or behaviours, risk management plans and staff compliance with their mandatory and statutory training.

Leaders were visible within the service and were approachable for patients and staff.

There were leadership development opportunities available for all staff, not just those currently in people management roles.

Vision and strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. Managers made sure staff understood and knew how to apply them.

The trust's vision and values were 'we care, we listen, we deliver' which staff knew and understood how they applied to their work. The trust's senior leadership team successfully communicated the trust's vision and values to frontline staff within the service. During our inspection, we saw staff working with patients and their commitment, caring manner and professionalism were in line with these values.

Staff had opportunities to contribute to discussions about the strategy of the service in team meetings, away days and during supervision and appraisal sessions.

Staff could explain how they were working to deliver high quality care within the budgets available. Examples included the improvements made to the service via the use of the purposeful inpatient admission process such as improved quality of care records and safety processes.

Culture

Staff felt respected, supported and valued. They felt the service promoted equality and diversity and provided opportunities for career development. They could raise concerns without fear.

Staff felt respected, supported and valued within the service and within the wider organisation. They felt positive and proud about working for the trust and within their team. Staff told us that managers dealt with any difficulties within their teams appropriately and in a timely manner.

Staff felt confident in raising concerns without fear of reprisals and there was an open and transparent culture within the service that encouraged speaking out. Staff had access to the trust's whistleblowing policy via the trust's intranet. Staff knew what the role of the trust's freedom to speak up guardian was and how to contact them if they needed their support.

Managers dealt with poor performance promptly and effectively. The trust had a performance management system in place which included a process for addressing staff performance issues.

Staff appraisals included conversations about career development and how it could be supported.

The trust promoted equality and diversity into its day to day work and provided opportunities for career progression. The trust had equality and diversity policies, staff were trained in equality and diversity and there were LGBT+ champions within the service.

Staff had access to support for their own physical and emotional health needs via occupational health and an employee assistance programme.

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The trust recognised staff success within the service. The trust held annual star awards that staff could be nominated for and some ward managers sent messages to staff to thank them for their hard work and achievements.

Governance

Leaders ensured there were structures, processes and systems of accountability for the performance of the service. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

Governance systems and structures within the service were effective and had improved since our last inspection.

We found the wards were clean and tidy, and that staff adhered to infection prevention procedures. There were enough skilled and experienced staff to provide safe care and treatments to patients. Most staff received regular supervision and were appraised. Risk assessments, management plans and crisis plans, and care plans were completed, with record keeping generally of a good standard. Staff adhered to the Mental Health Act and Mental Capacity Act and knew how to deal with complaints, report incidents and make safeguarding referrals. Staff within the service engaged in clinical audits and used the findings to improve the service. The medicines management and bed management arrangements within the service were effective.

There was a clear framework of what must be discussed at a ward, team or directorate level in team meetings to ensure that essential information was shared. We looked at minutes of team meetings and agenda items included risk, safeguarding, areas for improvement and learning from incidents and complaints.

Staff implemented recommendations from the reviews of deaths, incidents, complaints and safeguarding incidents.

Staff understood the arrangements for working with other teams, both within the organisation and with external teams, to meet the needs of patients.

Management of risk, issues and performance

Leaders managed performance using systems to identify, understand, monitor, and reduce or eliminate risks. They ensured risks were dealt with at the appropriate level. Clinical staff contributed to decision-making on service changes to help avoid financial pressures compromising the quality of care.

Staff maintained and had access to the risk register at ward or trust level and could submit items to be included on it. For example, staffing on Fern ward had been raised as an issue and this was included on the risk register.

The service had a business continuity plan in place that included contingencies for emergencies which could affect the running of the service such as floods, loss of premises, loss of information technology systems and adverse weather conditions.

The service was in the process of making cost improvements, but these were not compromising patient care. Cost improvements included the need for managers to be mindful of the use bank and agency staff to be justified and proportionate, make efforts to reduce the need for paper within the service and to avoid the unnecessary use of printing documentation in colour.

Information management

The service collected reliable information and analysed it to understand performance and to enable staff to make decisions and improvements. The information systems were integrated and secure.

The service used systems to collect data that were not overburdensome for frontline staff.

Staff had access to the equipment and information technology needed to do their work. The information technology infrastructure, including the telephone system was adequate.

Staff who we spoke with found the trust's care records system easy to use. Overall, we found the care records system was effective and contained sufficient information needed to deliver safe care and treatment. However, there was some issues with recording goals in the care plans and the consistency of recording discharge planning. Six staff members who spoke with us said the system was very slow to start up, which could cause delays in accessing information quickly.

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Staff within the service had received information governance training which highlighted the need to maintain client confidentiality in accordance with the Data Protection Act.

Managers had access to information to support them with their management role. The information was in an accessible format, timely, accurate and identified areas for improvement, and available on the wards. However, health and safety actions were not always completed, recorded consistently or accurately.

Staff made notifications to external bodies when required such as the Care Quality Commission, commissioners and local authority safeguarding teams.

Engagement

The service engaged well with patients, staff, equality groups, the public and local organisations to plan and manage appropriate services. It collaborated with partner organisations to help improve services for patients.

Staff, patients and carers had access to up-to-date information about the work of the trust via bulletins and emails.

Patients and carers had opportunities to give feedback on the service via friends and families tests, service user rights forums (SURF), 'patients say so' groups, complaints and comments cards, meetings between staff and patients on wards and carers' hubs. Patients were also asked to complete occupation therapy and activities feedback forms. Staff used feedback received to improve life for individuals and the service overall.

Between February 2019 and February 2020, 205 people who used the service completed friends and families tests. The data showed that 84% of people would recommend the service to friends and families and six percent wouldn't. The data sent by the trust indicated that no friends and families tests were completed during this period in relation to the Maplebeck ward.

Managers had access to feedback from people who used the service and involved them in decision-making about making changes and improvements to the service.There were board quality and safety visits which took into account the views of staff and people who used the service and allowed for the escalation of issues to the senior leadership team for consideration and resolution. A rapid improvement week took place at the beginning of April

2019 following the trust being issued with a 29a warning notice due to the need to significantly improve the quality of healthcare in the service. The rapid improvement week allowed senior managers to engage with commissioners, regulators, inpatient staff and people who used the service. There were also weekly meetings between team leaders and ward managers up to the end of December to support the delivery of local improvement plans.

Senior managers within the service engaged with the people who used the service, staff and external stakeholders. In May 2019, a future of mental health inpatients engagement event with the Bradford and Airedale mental health programme board was held to review the future direction of inpatient mental health services. In June 2019 a clinical summit was held with patients, commissioners and inpatient staff which included looking at enhanced therapeutic environments and patient safety. The results of this session informed a business case and board decision to introduce new doors on the wards which sounded alarms when patients used them to ligature.

Learning, continuous improvement and innovation

All staff were committed to continually improving services and had a good understanding of quality improvement methods. Leaders encouraged innovation and participation in research. Innovations on the ward included:

- the use of an audit tool at the end of each episode of seclusion on Clover ward to identify good practice and areas for improvement
- introduction of the purposeful inpatient admission process which enabled managers and staff to monitor patient safety and care planning on the wards and,
- the use of the SBAR process (situation, background, assessment and recommendation) for patients due to be admitted to the ward which ensured referring parties provided the service with information about the patient's background, the reasons for the admission and the risks they presented to themselves and others prior to admission.

Staff within the service were given time and support to consider any opportunities for improvements and innovation during meetings, supervision and appraisal sessions. An example of innovation included the creation of

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a hydration station on Heather ward. Healthcare support workers had converted a trolley and made it into a hydration station that included a variety of teas and cordials to ensure patients were well hydrated.

Staff used quality improvement methods and knew how to apply them. These included the use of clinical audits, the purposeful inpatient admission process and daily call-out processes which allowed staff and managers within the service to monitor and improve the delivery of care and treatment and safety processes on the wards. Staff on the wards were also using guidance and techniques in line with the Safewards initiative. Safewards is an NHS initiative designed to reduce the need for restrictive interventions through a variety of methods such as the use of soft and positive words, clear mutual expectations, reassurance, mutual help discussions and calm down methods.

Staff within the service participated in research including:

- NHS staff views on mandatory sexuality monitoring information

- suicide in middle-aged men and
- the national confidential inquiry into suicide and homicide by people with mental Illness.

Clover ward participated in the National Association of Psychiatric Intensive Care Units accreditation scheme. Heather ward participated in collaboration with NHS Improvement and the Royal College of Psychiatry in relation to sexual safety.

Other accreditation schemes that the acute wards participated in included:

- ISO 9001:2015 Quality Management Certification for Estates and Facilities
- British Approvals for Fire Equipment: fire safety,
- Royal Society for the Prevention of Accidents gold award
- Contractors Health and Safety Assessment Scheme
- Commission for Quality and Innovation healthy food standards
- Qualsafe accreditation of the trust in relation to it being a trust of in-house first aid training.