

# Bradford District Care NHS Foundation Trust

## Inspection report

SBS New Mill  
Victoria Road, Saltaire  
Shipley  
West Yorkshire  
BD18 3LD  
Tel: 01274228300  
www.bdct.nhs.uk

Date of inspection visit: 28 Feb to 10 Apr 2019  
Date of publication: 11/06/2019

We plan our next inspections based on everything we know about services, including whether they appear to be getting better or worse. Each report explains the reason for the inspection.






This report describes our judgement of the quality of care provided by this trust. We based it on a combination of what we found when we inspected and other information available to us. It included information given to us from people who use the service, the public and other organisations.

This report is a summary of our inspection findings. You can find more detailed information about the service and what we found during our inspection in the related Evidence appendix.

## Ratings

### Overall rating for this trust

Requires improvement 

Are services safe?	Requires improvement 
Are services effective?	Requires improvement 
Are services caring?	Good 
Are services responsive?	Good 
Are services well-led?	Requires improvement 

We rated well-led (leadership) from our inspection of trust management, taking into account what we found about leadership in individual services. We rated other key questions by combining the service ratings and using our professional judgement.

# Summary of findings

## Background to the trust

Bradford District Care NHS Foundation Trust is an NHS provider of mental health, community health and specialist learning disability services. They support people of all ages who live in the Bradford, Airedale, Craven and Wakefield areas. They also work with people from other areas when needed.

The trust serves a population of over 580,000 people across Bradford and Airedale and over 335,000 people across Wakefield. The population is amongst the most diverse in the country with over 100 languages spoken.

The trust's catchment area includes areas of high deprivation and higher than expected demand for health services.

The trust was established in 2002. Community health services were transferred to the trust in 2011 from Bradford and Airedale Community Health Services which was the provider arm of the former primary care trust NHS Bradford and Airedale. The trust was authorised as a foundation trust in 2015.

The trust employs almost 3,000 staff covering clinical, corporate and clerical roles across the trust. In the financial year 2017/18, the trust's income was £142.6 million with an expenditure of £137.8 million.

The trust was first registered with the CQC on 17 June 2010 and has 14 active locations. These include:

- Airedale Centre for Mental Health
- Airedale General Hospital
- BDCT Headquarters, New Mill
- Barkerend Health Centre
- Bradford Royal Infirmary
- Holmewood Health Centre
- Horton Park Medical Centre
- Keighley Health Centre
- Kensington Street Health Centre
- Lynfield Mount Hospital
- Royds Healthy Living Centre
- Shipley Health Centre
- Waddiloves Health Centre
- Westbourne Green Community Health Care Centre

The trust has 54 different services across 50 sites covering mental health, community and learning disability services, including two mental health hospitals. It has 206 inpatient beds across 13 wards.

The trust provides the following mental health core services:

- Acute inpatient mental health wards for adults of working age and psychiatric intensive care unit
- Long stay/rehabilitation mental health wards for working age adults
- Forensic inpatient/secure wards

# Summary of findings

- Wards for older people with mental health problems
- Wards for people with a learning disability or autism
- Community-based mental health services for adults of working age
- Mental health crisis services and health-based places of safety
- Community mental health services for older people
- Specialist community-based mental health services for children and young people
- Community mental health services for people with a learning disability or autism

The trust provides the following community health services:

- Community health services for adults
- Community end of life care
- Community services for children, young people and families
- Community dental services

The trust has been inspected once previously using the current methodology, with the well led review for Bradford District Care NHS Foundation Trust completed between the 6 - 8 November 2017. As part of that well led review we inspected nine complete core services out of the 14 provided by the trust, including:

- Acute inpatient mental health wards for adults of working age and psychiatric intensive care unit
- Long stay/rehabilitation mental health wards for working age adults
- Wards for older people with mental health problems
- Wards for people with a learning disability or autism
- Community-based mental health services for adults of working age
- Mental health crisis services and health-based places of safety
- Community mental health services for people with a learning disability or autism
- Community health services for adults
- Community dental services

Following this inspection, we rated the trust as requires improvement overall with ratings of requires improvement in safe, effective and well-led; and ratings of good in caring and responsive.

At that inspection we issued eight requirement notices to the trust for breaches of regulation identified in seven core services and at a trust-wide well-led level.

The requirement notices issues related to the following Health and Social Care Act 2008 (Regulated Activities) Regulations 2014:

- Regulation 5: Fit and proper persons: directors
- Regulation 9: Person-centred care
- Regulation 10: Dignity and respect
- Regulation 12: Safe care and treatment

# Summary of findings

- Regulation 13: Safeguarding service users from abuse and improper treatment
- Regulation 17: Good governance
- Regulation 18: Staffing
- Regulation 20: Duty of candour

We told the trust that it must take the necessary actions regarding these eight breaches of regulation to comply with its legal obligations.

The trust provided us with an action plan demonstrating how it planned to meet these requirements. We have reviewed these actions through ongoing engagement with the trust, and during this recent inspection where this was appropriate.

Following the inspection in November 2017, we also suggested 43 actions, relating to eight of the core services inspected and trust-wide, the trust should take to prevent it failing to comply with legal requirements in the future, or to improve services. We reviewed a sample of these should-do actions at this recent inspection.

The trust had 11 Mental Health Act reviewer visits since the last inspection in November 2017. The most common concerns found at these visits across all the wards and sites included blanket restrictions, patients not having their section 132 rights explained to them, lack of assessments of capacity to consent to treatment, lack of risk assessments and discharge plans, and care plans not demonstrating patient involvement. We reviewed the application of the Mental Health Act in the mental health core services we inspected and senior leader oversight during this inspection.

## Overall summary

**Our rating of this trust stayed the same since our last inspection. We rated it as **Requires improvement****



## What this trust does

Bradford District Care NHS Foundation Trust is an NHS provider of mental health, community health and specialist learning disability services. It provides 54 different services across 50 sites, including two mental health hospitals, for people of all ages in the Bradford, Airedale, Craven and Wakefield areas.

## Key questions and ratings

We inspect and regulate healthcare service providers in England.

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs, and well-led?

Where we have a legal duty to do so, we rate the quality of services against each key question as outstanding, good, requires improvement or inadequate.

Where necessary, we take action against registered service providers and registered managers who fail to comply with legal requirements, and help them to improve their services.

## What we inspected and why

We plan our inspections based on everything we know about services, including whether they appear to be getting better or worse.

# Summary of findings

At this inspection, we inspected eight complete core services of the fourteen delivered by the trust between 28 February 2019 and 10 April 2019.

The core services inspected by unannounced inspection were:

- Acute wards for adults of working age and psychiatric intensive care units
- Forensic inpatient/secure wards
- Wards for older people with mental health problems.
- Wards for people with learning disability or autism
- Mental health crisis services and health-based places of safety.

The core services inspected by short notice announced inspection were:

- Community-based mental health services for older people
- Community end of life care
- Community health services for children, young people and families

We identified these core services for this inspection based on previous inspection ratings, information relating to risk received through engagement and our ongoing monitoring, and the length of time since the service was last inspected.

Our comprehensive inspections of NHS trusts have shown a strong link between the quality of overall management of a trust and the quality of its services. For that reason, all trust inspections now include inspection of the well-led key question at the trust level. Our findings are in the section headed “Is this organisation well-led?” and we use the well led framework to review the trust’s leadership and governance.

## What we found

### Overall trust

Our rating of the trust stayed the same. We rated it as requires improvement because:

- We rated the trust as requires improvement overall in safe, effective and well led. We rated caring and responsive as good. Our rating for the trust took into account the current ratings of the services not inspected this time.
- We rated well-led for the trust overall as requires improvement.
- Of the 14 core services, one is rated as inadequate and five as requires improvement, taking into account the current ratings of the services not inspected at this time. Of the eight core services inspected during this most recent inspection, one was rated as inadequate and three were rated as requires improvement.
- Overall ratings went down for the acute inpatient mental health services for adults of working age and the psychiatric intensive care unit to inadequate, and for the community health services for children and young people to requires improvement. The forensic low secure services were rated as requires improvement. The rating stayed requires improvement for the wards for older people with a mental health problem.
- Due to the concerns we found during our inspection of the trust’s acute inpatient mental health wards for adults of working age and psychiatric intensive care unit, we used our powers to take immediate enforcement action. We issued the trust with a Section 29A warning notice. This advised the trust that our findings indicated a need for significant improvement in the quality of healthcare. We will revisit these services to check that appropriate action has been taken and that quality of care has improved. However, by the time of the well-led review the trust had already taken significant action to address the issues identified in the warning notice.

# Summary of findings

- The trust was not providing consistently safe care, particularly on the inpatient mental health wards. Issues identified included ligature and environmental risks not being identified and managed, the maintenance of premises and equipment, medicines management, blanket restrictions that were not individually risk assessed, no alarms for patients to call staff in an emergency.
- The trust did not have effective systems in place to investigate incidents within appropriate timescales to identify learning from incidents and make improvements.
- The trust was not consistently providing effective care. The trust had failed to address concerns identified in the 2017 inspection in relation to staff supervision and audit of the Mental Capacity Act. Staff understanding and adherence to the Act was inconsistent.
- The arrangements for governance and performance management did not always operate effectively. Whilst there had been a recent review of governance arrangements the plans to change these were in the early stages and were not embedded at the time of the inspection.
- The trust did not always deal with risk issues and poor performance appropriately. Senior leaders were not aware of all the concerns found during the inspection. Areas for improvement identified at the last inspection in 2017 had not been addressed at the time of this inspection.

However:

- We rated community health services as outstanding overall for caring. We rated community end of life care services as outstanding overall. Three of the six mental health core services we inspected were rated as good. There were improvements in the overall ratings for the trust's wards for people with a learning disability or autism and mental health crisis services and health-based places of safety. The community mental health services for older people with a mental health problem were also rated as good.
- Two of the trust's services were rated as outstanding for caring, and 11 were rated as good. (This took into account the current ratings of the six services not inspected this time.)
- Staff interactions with patients we observed were kind, respectful and compassionate. Feedback from patients and those close to them was continually positive in almost all the services we inspected about the care provided. Feedback from patient and carer surveys was positive.
- Staff found innovative ways to enable people to manage their own health and care, particularly in those services rated as outstanding.
- Most of the trust's core services were providing care in a way that was responsive to patients' individual needs. The community end of life care services were rated as outstanding in the responsive key question.
- The directors of the trust had completed all the checks needed to work at that level. They all had disclosure and barring service certificates and met the fit and proper person requirements.
- The trust had implemented a new vision and strategy and had plans to improve services. Staff knew and understood the provider's vision and values.
- The trust actively engaged in collaborative work with regional and place-based external partners to agree joint health and care priorities to support the delivery of high-quality, sustainable care and treatment, and to meet the needs of the local population.

## Are services safe?

Our rating of safe stayed the same. We rated it as requires improvement because:

# Summary of findings

- We rated one of the trust's 14 core services as inadequate in safe, eight as requires improvement and five as good. In rating the trust, we took into account the current ratings of the six services not inspected this time.
- Staff were not assessing and managing the risks to patients. Ligature risk assessments in inpatient services were not fit for purpose and did not show how staff mitigated risk to patients who might try to harm themselves.
- Staff did not consistently achieve the right balance between maintaining safety and providing the least restrictive environment possible to support patients' recovery. Services had blanket restrictions in place that were not based on an individual assessment of risk and need.
- Staff in two of the four inpatient core services we inspected did not record restrictive interventions such as prone restraint, rapid tranquilisation, seclusion and long-term segregation appropriately. There was insufficient evidence that restrictive interventions were always appropriate, proportionate and the least restrictive response to an incident.
- Clinical premises and equipment were not maintained appropriately in four of the eight services we inspected. Emergency equipment and drugs were not checked regularly and missing items were not replaced. Medicines were not managed, stored or administered safely in two core services.
- Nurse call alarms were not in place in inpatient services for patients to use and there was no standard procedure for giving patients access to an alarm.
- Staff could not access all the necessary information in order to provide care and treatment; staff were using different versions of documents and were recording information in different places or recording on separate paper records, which meant information was not easy to locate.
- Effective systems were not in place to ensure that incidents were appropriately categorised and investigated within appropriate timescales to identify learning from incidents and make improvements. In some services, this meant that opportunities to prevent or minimise the risk of harm were missed.

However:

- All but two of the core services inspected had enough staff, who knew the patients and received basic training to keep them safe from avoidable harm.
- 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.
- When things went wrong, staff apologised and gave patients honest information and suitable support. Most staff had a good understanding of the Duty of Candour. The trust had effective systems in place to review and consider the requirements of the Duty of Candour following an incident.

## Are services effective?

Our rating of effective stayed the same. We rated it as requires improvement because:

- We rated four of the trust's 14 core services as requires improvement in effective and ten as good. In rating the trust, we took into account the current ratings of the six services not inspected this time.
- The trust had failed to address concerns identified in the 2017 inspection in relation to staff supervision. Staff were still not supported with supervision in line with the trust's policy. Systems to record and monitor staff supervision were still ineffective.
- The trust did not have in place effective systems to mitigate the negative consequences of deploying psychiatrists to work across both the acute mental health wards for working age adults and the community mental health services for



# Summary of findings

working age adults. There was a model of multi-disciplinary care in place offered to patients with the exception of the psychiatric intensive care unit. The consultant psychiatrists were not ward based, and worked from a continuing care model. Multi-disciplinary meetings were not always planned in advance which reduced the opportunity for the attendance of the patient, their carers and relatives, community mental health teams and advocates.

- In two core services staff understanding of the trust policy on the Mental Capacity Act was varied and we found assessment and recording of capacity and best interest decision making missing in some patients' records.
- The trust did not effectively audit the use of the Mental Capacity Act at the time of the inspection.

However:

- Staff in most services assessed the physical and mental health of all patients on admission. They developed individual care plans which were reviewed regularly through multidisciplinary discussion and updated as needed. Care plans reflected patients' assessed needs, and were personalised, holistic and recovery-oriented.
- Staff provided a range of treatment and care for patients based on national guidance and best practice. They ensured that patients had good access to physical healthcare and supported them to live healthier lives. Staff used recognised rating scales to assess and record severity and outcomes.
- Staff in most services understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice. Managers made sure that staff could explain patients' rights to them.
- Managers made sure that staff had the range of skills needed to provide high quality care. They supported staff with appraisals and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.

## Are services caring?

Our rating of caring stayed the same. We rated it as good because:

- We rated two of the trust's 14 core services as outstanding for caring; these were both community health services. Eleven of the core services were rated as good. We took into account the current ratings of the six services not inspected this time.
- Feedback from patients and those close to them was continually positive in almost all the services we inspected about the care provided; they thought staff went above and beyond their expectations in a number of these services. Feedback from patient and carer surveys was positive.
- Most patients described staff as professional, approachable, helpful, polite, discreet, approachable and understanding. Staff treated patients with compassion and kindness. They respected patients' privacy and dignity and understood the individual needs of patients and supported them to understand and manage their care, treatment or condition.
- In the community end of life service, people were truly respected and valued as individuals. They were empowered as a partner in their care practically and emotionally by an exceptional distinctive service.
- Staff informed and involved families and carers in assessments and in the design of treatment interventions. Carers were active partners in peoples' care in those community health services rated as outstanding, where staff were fully committed to working in partnership with people and making this a reality for each person.
- Staff understood and respected the personal, cultural, social and religious needs of patients and their families and took these into account in the way they delivered services.

However:



# Summary of findings

- The trust's acute mental health wards for working age adults and psychiatric intensive care units did not consistently provide dignified care. Patients and their carers did not feel involved in care and treatment. Carers were critical of the service's communication.
- Patients were not routinely given a copy of their care plan.

## Are services responsive?

Our rating of responsive stayed the same. We rated it as good because:

- We rated one of the trust's 14 core services as outstanding, 11 as good and two as requires improvement. In rating the trust, we took into account the current ratings of the six services not inspected this time.
- Staff in most services planned and managed discharge well. They liaised well with services that would provide aftercare and were assertive in managing care pathways for patients who were making the transition to another inpatient service, community services or to prison. As a result, discharge was rarely delayed for other than clinical reasons.
- Services were easy to access. Referral criteria did not exclude patients who would have benefitted from care. Staff assessed and treated patients who required urgent care promptly and patients who did not require urgent care did not wait too long to start treatment. Staff followed up patients who missed appointments.
- The design, layout, and furnishings of most inpatient services and community services supported patients' treatment, privacy and dignity. Each patient had their own bedroom and 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.
- The trust met the needs of all patients, including those with protected characteristics. Staff helped patients with communication, advocacy and cultural and spiritual support. Staff had the skills, or access to people with the skills, to communicate in the way that suited patients.
- The trust treated concerns and complaints seriously and investigated them appropriately. There was an effective system in place to learn lessons from the results and monitor actions taken to prevent recurrence.

However:

- The trust's acute mental health wards for working age adults and psychiatric intensive care units were not responsive to patients' needs. The admission process was not led by ward teams. Bed occupancy rates and readmission rates were high. This meant that patients could not always return to the ward and the wards for older people were used to 'guest' patients. Staff did not find effective ways to communicate and care plan for patients with communication difficulties and did not have care plans in place to ensure they could communicate their wishes.
- Key performance indicators focussing on the responsiveness of the service, including data around waiting times for assessments and length of stay, were not regularly monitored in the trust's mental health crisis services and health-based places of safety.
- Access to specific assessments within the trust's community mental health services for older people with mental health problems was delayed in certain localities due to long waiting lists. The trust had plans in place to address this.

## Are services well-led?

Our rating of well-led stayed the same. We rated it as requires improvement because:

- We rated one of the trust's 14 core services as inadequate, three as requires improvement and ten as good. In rating the trust, we took into account the current ratings of the six services not inspected this time.

# Summary of findings

- The action taken by the trust to address many of the areas for improvement identified from the last inspection had not been effective in all areas. Whilst actions have been implemented they have not yet become embedded and their full impact has not been realised at this stage.
- The trust had still not put effective systems in place to ensure that serious incidents were reviewed and thoroughly investigated within appropriate timescales, and monitored to make sure that action was taken to remedy the situation, prevent further occurrences and make sure that improvements were made as a result. This was an area for improvement identified in the previous inspection in 2017.
- The trust had still not put effective governance processes in place to ensure that there was oversight of the use of restrictive interventions in inpatient services. This was an area for improvement identified in the previous inspection in 2017.
- The trust had introduced a system to monitor compliance rates for staff supervision, but this had not been effective. Effective oversight of supervision compliance was an area for improvement identified in the previous inspection in 2017.
- The trust had failed to update all active policies to reflect the changes to the Mental Health Act Code of Practice introduced in 2015. This was an area for improvement identified in the previous inspection in 2017.
- The trust did not have a clear and effective approach to local ward audits within services. There was limited evidence of audits being used effectively to improve quality or identify areas of poor performance within services. This was an area for improvement identified in the previous inspection in 2017.
- Internal governance processes had not identified most concerns found during the inspection of the trust's core services. The trust did not have systematic approach to continually improving the quality of its services and safeguarding high standards of care.
- The trust did not have effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected. The trust did not have a clear structure for overseeing performance, quality and risk, with board members represented across the divisions. Senior leaders did not have oversight of all issues facing services.

However:

- The newly developed trust strategy was directly linked to the vision and values of the trust. The trust involved clinicians, patients and groups from the local community in the development of the strategy.
- The trust had recently implemented a new management structure which included changes to the structure and composition of the board of executive and non-executive directors. The changes to the board of directors both strengthened and clarified the board level accountability for quality and operational management in the trust.
- Senior leaders made sure they visited all parts of the trust and fed back to the board to discuss challenges staff and the services faced. The trust's board of governors was proactive and provided constructive challenge to the trust's senior leadership team. The board of governors was moderately reflective of the local community.
- The trust welcomed and proactively sought external scrutiny of its services and its internal processes. The trust had commissioned an external provider review of the trust's leadership team and another to undertake thematic analysis of serious incidents involving the deaths of patients in both inpatient and community settings. The recommendations of these reviews were accepted by the trust board.

# Summary of findings

- Managers across the trust promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values. Staff knew and understood the provider's vision and values and how they applied to the work of their team. The trust had a number of effective processes in place for staff to raise concerns and staff told us that they felt able to raise concerns without fear of retribution.
- The trust engaged well with patients, staff, the public and local organisations to plan and manage appropriate services, and collaborated with partner organisations effectively.
- The trust had addressed areas for improvement from the 2017 inspection relation ensuring checks were completed for all its executive and non-executive directors, and that accurate records of these checks were maintained in line with the Fit and Proper Person Requirement regulation and the trust's policy. The trust had ensured that all staff were checked by the Disclosure and Barring Service in line with trust policy.

## Ratings tables

The ratings tables show the ratings overall and for each key question, for each service, hospital and service type, and for the whole trust. They also show the current ratings for services or parts of them not inspected this time. We took all ratings into account in deciding overall ratings. Our decisions on overall ratings also took into account factors including the relative size of services and we used our professional judgement to reach fair and balanced ratings.

## Outstanding practice

We found examples of outstanding practice in the trust's forensic / secure wards, mental health crisis services and health-based places of safety. For more information, see the outstanding practice section of this report.

## Areas for improvement

We found areas for improvement including 44 breaches of legal requirements that the trust must put right. We found 31 things that the trust should improve to comply with a minor breach that did not justify regulatory action, to prevent breaching a legal requirement, or to improve service quality.

For more information, see the Areas for improvement section of this report.

## Action we have taken

We issued one warning notice and seven requirement notices to the trust. Our action related to 44 breaches of legal requirements in five core services. That meant the trust had to send us a report saying what action it would take to meet this requirement.

For more information on action we have taken, see the sections on areas for improvement and regulatory action.

## What happens next

We will make sure that the trust takes the necessary action to improve its services. We will continue to monitor the safety and quality of services through our continuing relationship with the trust and our regular inspections.

## Outstanding practice

Forensic / Secure wards

# Summary of findings

- Staff on Thornton ward had taken part in the Foundation of Nursing Studies Inspire Improvement Programme – Creating Caring Cultures. They involved patients to develop a shared purpose which was to create a safe, supportive and respectful community within the ward. They called the project ‘#wearethornton’ and staff felt it had been successful in creating a positive culture on the ward so were planning to roll it out on the other two wards.
- The service had a transition team that was involved in the patient’s journey from pre-admission to post-discharge. The team identified a treatment pathway for each patient and ensured they had an allocated community care co-ordinator, occupational therapist and psychology assistant. They worked with the patients on building therapeutic relationships, supporting them to access recovery focused interventions whilst in hospital. They identified community support and ensured each patient who was moving towards discharge had a planned package of care with funding secured. The team remained involved following discharge for a short period of time to ensure an effective transition for the patients and reduce the risk of re-admission by increasing living and coping skills in the community. Previous patients were invited back to the wards to attend activities and act as mentors for current patients.
- The service held a patient led festival twice yearly, called ‘LYNFEST’ in the summer and ‘LYNFROST’ in the winter. This was a festival of music and arts for previous patients, current patients and their families which showcased live musical performances from patients, staff, local performers and community-based arts providers. The festival had run for three years and in 2017 received a national accolade for Breaking Down Barriers/Tackling Stigma. The festival won the National Service User award which recognises remarkable achievements and innovations led by service users in secure mental health services nationwide. LYNFEST had also been short-listed for one of the Care Trust’s You’re a Star Award’s in the Working Together category. The service had also won a trust innovation and quality award for ‘United Voice Players’ which involved current and previous patients who put on performances of acting, singing and dancing.

## Mental health crisis services and health-based places of safety

- Staff and managers were committed to improvements to the service. A dedicated member of staff had the role to lead on research and development. The service ensured that they collected evidence to show the impact of initiatives they were delivering.
- There was ongoing research to provide evidence of the effectiveness of the crisis intervention offered to people in Bradford. Research had highlighted the need for more support for families to reduce hospital admissions and managers were committed to finding funding to support this. A recent funding bid had been unsuccessful, but this had not deterred the team from continuing to source funding. A pilot was ongoing with the ambulance service to reduce the number of people requiring a visit to the emergency department. Data was collected to evidence the impact of this.

## Community End of Life Care

- We found all staff were dedicated and passionate about delivering the best service they could to patients and their families and they undertook their duties with absolute care and compassion.
- The service had a proactive approach to meeting the needs of the local population and engaged well with hard to reach groups and ethnic minorities. The service recognised changes in the local population and identified their unmet needs, raising this with those commissioning end of life services.
- The service lead in-reached into the dementia health assessment unit and accompanied psychiatrists on ward rounds to help with patients’ physical health needs. The palliative care support team had also visited patients on the ward to support staff caring for patients with dementia at their end of life.

# Summary of findings

## Areas for improvement

Action the trust **MUST** take is necessary to comply with its legal obligations. Action a trust **SHOULD** take is to comply with a minor breach that did not justify regulatory action, to prevent it failing to comply with legal requirements in future, or to improve services.

**We told the trust that it must take action to bring services into line with seven regulations in respect of 44 breaches of legal requirements. This action related to five core services.**

### Action the trust **MUST** take to improve:

#### Trust-wide

- The trust must ensure that effective governance systems are in place to assess, monitor and improve the quality and safety of the services. (Regulation 17)
- The trust must ensure that serious incidents are reviewed and thoroughly investigated within appropriate timescales and monitored to make sure that action is taken to remedy the situation, prevent further occurrences and make sure that improvements are made as a result. (Regulation 17)
- The trust must put an effective system in place to ensure that there is oversight of the use of restrictive interventions in inpatient services. (Regulation 17)
- The trust must ensure that restrictions are based on an individual assessment of risk and need. (Regulation 13)
- The trust must put an effective system in place to ensure that there is effective oversight of compliance rates for staff supervision. (Regulation 17)
- The trust must ensure that staff have access to accurate, complete and contemporaneous records in respect of each service user. (Regulation 17)
- The trust must update all active policies to reflect the changes to the Mental Health Act Code of Practice introduced in 2015. (Regulation 17)
- The trust must ensure that there is a clear and effective approach to audit within services. Audits must be used to improve quality within services. (Regulation 17)

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

- The trust must ensure that the care and treatment of service users is appropriate, meets their needs and reflects their preferences. Carrying out collaboratively with the relevant person, an assessment of needs and preferences for the care and treatment of the service user. Ensuring care and treatment is designed with a view to achieving service user's preferences and ensuring their needs are met. (Regulation 9)
- The trust must ensure they make reasonable adjustments to enable service users to receive care and treatment. (Regulation 9)
- The trust must ensure that readmission and bed occupancy rates are reviewed to ensure the care delivered is meeting the needs of patients. (Regulation 9)
- The trust must ensure service users are treated with dignity and respect. (Regulation 10)
- The trust must ensure that they assess the risks to the health and safety of service users receiving the care and treatment and do all that is practicable to mitigate any such risks. (Regulation 12)
- The trust must ensure the proper and safe management of medicines. (Regulation 12)

# Summary of findings

- The trust must ensure that the equipment used by the service provider for providing care and treatment is safe for such use. (Regulation 12)
- The trust must ensure that care or treatment for service users must not be provided in a way that – includes acts intended to control or restrain a service user that are not necessary to prevent, or not a proportionate response to risk of harm posed to the service user or another individual if the service user was not subject to control or restraint. (Regulation 13)
- The trust must ensure systems and processes are established and operated effectively to enable the registered person to assess, monitor and improve the quality and safety of the services. (Regulation 17)
- The trust must ensure it assesses, monitors, and mitigates the risks relating to the health, safety and welfare of service users. (Regulation 17)
- The trust must ensure there are sufficient skilled and competent staff to safely meet the needs of patients. (Regulation 18)

## Forensic / secure wards

- The trust must ensure that they assess the risks to the health and safety of service users receiving the care and treatment and do all that is practicable to mitigate any such risks. (Regulation 12)
- The trust must ensure that environmental assessments are reviewed as required and action is taken in response to issues when identified. (Regulation 12)
- The trust must ensure ligature assessments include all ligature risks in the environment and sufficient action is taken to mitigate those risks. (Regulation 12)
- The trust must ensure patients have access to nurse call alarms to be able to seek assistance in an emergency. (Regulation 12)
- The trust must ensure that care or treatment for service users must not be provided in a way that – includes acts intended to control or restrain a service user that are not necessary to prevent, or not a proportionate response to risk of harm posed to the service user or another individual if the service user was not subject to control or restraint. (Regulation 13)
- The trust must ensure staff do not withhold patients mail. (Regulation 13)
- The trust must ensure they adhere to the Mental Health Act Code of Practice when supporting patients in long term segregation. (Regulation 13)
- The trust must ensure that premises are suitable for the purpose for which they are being used. (Regulation 15)
- The trust must ensure that the seclusion room on Thornton ward complies with the requirements of the Mental Health Act Code of Practice and does not contain any safety hazards. (Regulation 15)
- The trust must ensure systems and processes are established and operated effectively to enable the registered person to assess, monitor and improve the quality and safety of the services. (Regulation 17)
- The trust must ensure it assesses, monitors, and mitigates the risks relating to the health, safety and welfare of service users. (Regulation 17)
- The trust must ensure they have a robust system in place to monitor patients in long term segregation. (Regulation 17)
- The trust must ensure that they have effective systems in place to monitor staff access to supervision. (Regulation 17)

# Summary of findings

- The trust must ensure that systems enable staff to accurately document episodes of seclusion and instances of rapid tranquilisation in line with the requirements of the Mental Health Act Code of Practice and best practice guidance. (Regulation 17)
- The trust must ensure their electronic system allows staff to easily locate Mental Health Act documentation and the most up to date copy of Section 17 leave forms. (Regulation 17)
- The trust must ensure staff adhere to the trust policy when searching patients. (Regulation 17)

## Wards for older people with mental health problems

- The trust must ensure staff understand the application of the Mental Capacity Act in relation to their role and patient groups and ensure deprivation of liberty safeguards applications are made and the progress of the applications to supervisory bodies monitored. (Regulation 11).
- The trust must ensure staff check and maintain the emergency equipment and drugs and replace items that are out of date or missing. (Regulation 12).
- The trust must ensure staff follow best practice when dispensing and recording medication to reduce the risk of error and patient harm. (Regulation 12).
- The trust must ensure patient and room searches are based on individual risk and do not form a blanket restriction. (Regulation 13).
- The trust must ensure that effective governance systems are in place to assess, monitor and improve the quality and safety of the services, including effective audit of the Mental Capacity Act. (Regulation 17).

## Mental health crisis services and health-based places of safety

- The trust must ensure that all serious incidents are categorised correctly, fully investigated, and that staff are fully debriefed and learning is shared and communicated across teams. (Regulation 12)
- The trust must ensure that staff have the relevant training to carry out their roles. (Regulation 18)

## Community health services for children and young people

- The trust must improve children's and families access to the service and individual assessments. (Regulation 12)
- The trust must ensure that staffing levels across the service meet the relevant national guidance so that persons providing care or treatment to children and young people have the qualifications, competence, skills and experience to do so safely. (Regulation 18)

## Action the trust SHOULD take to improve:

### Trust-wide

- The trust should continue with implementing a systematic and standardised approach to quality improvement, and ensure staff are trained in the identified improvement methodology.
- The trust should review its approach to accreditation from national organisations.

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

- The trust should ensure that patients have the correct treatment authorisation certificates in place and stored with medication cards.
- The trust should consider that patients using the child and adolescent mental health suite at Lynfield Mount do not have access to outside space.



# Summary of findings

- The trust should ensure that maintenance is undertaken at Lynfield Mount.

## Forensic / secure wards

- The trust should ensure that staff complete seclusion care plans with all patients in seclusion.
- The trust should ensure that clinic room and fridge temperatures are recorded daily in line with trust policy.
- The trust should ensure that equipment needed in an emergency can be quickly located from each ward, in line with national guidance.
- The trust should ensure that staff sign every medication administration record to reflect whether a patient has received their medication.
- The trust should ensure that all unqualified staff are trained in the Mental Health Act and have a good understanding of their responsibilities under the Act.
- The trust should ensure that they have an effective system in place to enable staff to accurately document and monitor all areas of a patient's care and treatment. This includes physical health monitoring after rapid tranquilisation and all aspects of seclusion as outlined in the Mental Health Act Code of Practice.
- The trust should ensure that staff have undertaken an assessment of a patient's leave on their return, in line with trust policy.

## Wards for older people with mental health problems

- The trust should ensure a higher compliance of Mental Health Act and Mental Capacity Act training to ensure staff are able to understand the application of the Acts in relation to their role and patient group.
- The trust should ensure there is an overarching policy and risk assessment for the management of 'guest' patients.
- The trust should ensure local involvement and awareness of actions plans for environmental audits and risk assessments.
- The trust should consider providing personal safes for patients on Bracken Ward.

## Wards for people with a learning disability and/or autism

- The trust should ensure the systems and processes in place are effective for recording and monitoring supervision activity of staff.
- The trust should ensure it continues to reduce blanket restrictions in place on the ward, including the mandated blanket restriction regarding bathrooms and shower rooms.

## Mental health crisis services and health-based places of safety

- The trust should ensure that all patients accessing intensive home treatment are given a copy of their crisis management plan
- The trust should ensure that all care planning is documented on the standardised care plan and that patients receive a copy.
- The trust should ensure that waiting times for initial assessments are monitored.

## Community-based mental health services for older people

- The trust should ensure that staff are clear how and where to record all necessary information on the patient care record and that this is consistent across the service.

# Summary of findings

- The trust should ensure that patients are routinely offered a copy of their most up to date care plan and that this is documented clearly.
- The trust should ensure that all clinic areas and storage facilities are clutter free and tidy.
- The trust should continue to ensure that memory assessment waiting times are monitored and where waiting times are high, measures put in place to ensure that patients' needs are met and waiting times are reduced to below 18 weeks.

## Community end of life care

- The trust should ensure that staff complete a comfort and dignity care plans for all patients who are identified as entering their last days of life.
- The trust should ensure that all staff complete patients' records contemporaneously on the electronic records system where connectivity allows.
- The trust should ensure all staff are familiar with how to locate and complete an incident report on the electronic reporting system.

## Community health services for children and young people

- The trust should ensure that staff receive ongoing communications and clarity around the current change process.
- The trust should ensure that all staff have completed mandatory training in key-skills.
- The trust should resolve the information technology connectivity problems.

## Is this organisation well-led?

Our comprehensive inspections of NHS trusts have shown a strong link between the quality of overall management of a trust and the quality of its services. For that reason, we look at the quality of leadership at every level. We also look at how well a trust manages the governance of its services – in other words, how well leaders continually improve the quality of services and safeguard high standards of care by creating an environment for excellence in clinical care to flourish.

Our rating of well-led stayed the same. We rated it as requires improvement because:

- We rated one of the trust's 14 core services as inadequate, two as requires improvement and 11 as good. In rating the trust, we took into account the current ratings of the six services not inspected this time.
- The action taken by the trust to address many of the areas for improvement identified from the last inspection had not been effective in all areas. Whilst actions have been implemented they have not yet become embedded and their full impact has not been realised at this stage.
- The trust had still not put effective systems in place to ensure that serious incidents were reviewed and thoroughly investigated within appropriate timescales, and monitored to make sure that action was taken to remedy the situation, prevent further occurrences and make sure that improvements were made as a result. This was an area for improvement identified in the previous inspection in 2017.
- The trust had still not put effective governance processes in place to ensure that there was oversight of the use of restrictive interventions in inpatient services. This was an area for improvement identified in the previous inspection in 2017.

# Summary of findings

- The trust had introduced a system to monitor compliance rates for staff supervision, but this had not been effective. Effective oversight of supervision compliance was an area for improvement identified in the previous inspection in 2017.
- The trust had failed to update all active policies to reflect the changes to the Mental Health Act Code of Practice introduced in 2015. This was an area for improvement identified in the previous inspection in 2017.
- The trust did not have a clear and effective approach to local ward audit within services. There was limited evidence of audits being used effectively to improve quality or identify areas of poor performance within services. This was an area for improvement identified in the previous inspection in 2017.
- Internal governance processes had not identified most concerns found during the inspection of the trust's core services. The trust did not have systematic approach to continually improving the quality of its services and safeguarding high standards of care.
- The trust did not have effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected. The trust did not have a clear structure for overseeing performance, quality and risk, with board members represented across the divisions. Senior leaders did not have oversight of all issues facing services.

However:

- The newly developed trust strategy was directly linked to the vision and values of the trust. The trust involved clinicians, patients and groups from the local community in the development of the strategy.
- The trust had recently implemented a new management structure which included changes to the structure and composition of the board of executive and non-executive directors. The changes to the board of directors both strengthened and clarified the board level accountability for quality and operational management in the trust.
- Senior leaders made sure they visited all parts of the trust and fed back to the board to discuss challenges staff and the services faced. The trust's board of governors was proactive and provided constructive challenge to the trust's senior leadership team. The board of governors was moderately reflective of the local community.
- The trust welcomed and proactively sought external scrutiny of its services and its internal processes. The trust had commissioned an external provider review of the trust's leadership team and another to undertake thematic analysis of serious incidents involving the deaths of patients in both inpatient and community settings. The recommendations of these reviews were accepted by the trust board.
- Managers across the trust promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values. Staff knew and understood the provider's vision and values and how they applied to the work of their team. The trust had a number of effective processes in place for staff to raise concerns and staff told us that they felt able to raise concerns without fear of retribution.
- The trust engaged well with patients, staff, the public and local organisations to plan and manage appropriate services, and collaborated with partner organisations effectively.
- The trust had addressed areas for improvement from the 2017 inspection relation ensuring checks were completed for all its executive and non-executive directors, and that accurate records of these checks were maintained in line with the Fit and Proper Person Requirement regulation and the trust's policy. The trust had ensured that all staff were checked by the Disclosure and Barring Service in line with trust policy.

## Ratings tables

Key to tables					
Ratings	Not rated	Inadequate	Requires improvement	Good	Outstanding
Rating change since last inspection	Same	Up one rating	Up two ratings	Down one rating	Down two ratings
Symbol *	↔	↑	↑↑	↓	↓↓
Month Year = Date last rating published					

\* Where there is no symbol showing how a rating has changed, it means either that:

- we have not inspected this aspect of the service before or
- we have not inspected it this time or
- changes to how we inspect make comparisons with a previous inspection unreliable.

### Ratings for the whole trust

Safe	Effective	Caring	Responsive	Well-led	Overall
Requires improvement ↔ Jun 2019	Requires improvement ↔ Jun 2019	Good ↔ Jun 2019	Good ↔ Jun 2019	Requires improvement ↔ Jun 2019	Requires improvement ↔ Jun 2019

The rating for well-led is based on our inspection at trust level, taking into account what we found in individual services. Ratings for other key questions are from combining ratings for services and using our professional judgement.

### Ratings for a combined trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community	Good ↔ Jun 2019	Good ↔ Jun 2019	Outstanding ↑ Jun 2019	Good ↔ Jun 2019	Good ↔ Jun 2019	Good ↔ Jun 2019
Mental health	Requires improvement ↔ Jun 2019	Requires improvement ↔ Jun 2019	Good ↔ Jun 2019	Good ↔ Jun 2019	Requires improvement ↔ Jun 2019	Requires improvement ↔ Jun 2019

The rating for the well-led key question is based on our inspection at trust level, taking into account what we found in individual services. Ratings for other key questions take into account the ratings for different types of service. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

### Ratings for community health services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community health services for adults	Good Nov 2017	Good Nov 2017	Outstanding Nov 2017	Good Nov 2017	Good Nov 2017	Good Nov 2017
Community health services for children and young people	Requires improvement ↓ Jun 2019	Good ↔ Jun 2019	Good ↔ Jun 2019	Requires improvement ↔ Jun 2019	Good ↔ Jun 2019	Requires improvement ↓ Jun 2019
Community end of life care	Good ↔ Jun 2019	Good ↔ Jun 2019	Outstanding ↑ Jun 2019	Outstanding ↔ Jun 2019	Good ↔ Jun 2019	Outstanding ↑ Jun 2019
Community dental services	Good Nov 2017	Good Nov 2017	Good Nov 2017	Good Nov 2017	Good Nov 2017	Good Nov 2017
<b>Overall*</b>	Good ↔ Jun 2019	Good ↔ Jun 2019	Outstanding ↑ Jun 2019	Good ↔ Jun 2019	Good ↔ Jun 2019	Good ↔ Jun 2019

\*Overall ratings for community health services are from combining ratings for services. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

## Ratings for mental health services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Acute wards for adults of working age and psychiatric intensive care units	Inadequate ↓ Jun 2019	Requires improvement ↔ Jun 2019	Requires improvement ↓ Jun 2019	Requires improvement ↓ Jun 2019	Inadequate ↓ Jun 2019	Inadequate ↓ Jun 2019
Long-stay or rehabilitation mental health wards for working age adults	Requires improvement Nov 2017	Requires improvement Nov 2017	Good Nov 2017	Good Nov 2017	Good Nov 2017	Requires improvement Nov 2017
Forensic inpatient or secure wards	Requires improvement Jun 2019	Good Jun 2019	Good Jun 2019	Good Jun 2019	Requires improvement Jun 2019	Requires improvement Jun 2019
Wards for older people with mental health problems	Requires improvement ↔ Jun 2019	Requires improvement ↔ Jun 2019	Good ↔ Jun 2019	Good ↔ Jun 2019	Requires improvement ↔ Jun 2019	Requires improvement ↔ Jun 2019
Wards for people with a learning disability or autism	Good ↑ Jun 2019	Good ↑ Jun 2019	Good ↔ Jun 2019	Good ↔ Jun 2019	Good ↑ Jun 2019	Good ↑ Jun 2019
Community-based mental health services for adults of working age	Requires improvement Nov 2017	Requires improvement Nov 2017	Good Nov 2017	Good Nov 2017	Requires improvement Nov 2017	Requires improvement Nov 2017
Mental health crisis services and health-based places of safety	Requires improvement ↔ Jun 2019	Good ↔ Jun 2019	Good ↔ Jun 2019	Good ↔ Jun 2019	Good ↑ Jun 2019	Good ↑ Jun 2019
Specialist community mental health services for children and young people	Requires improvement Jun 2014	Good Jun 2014	Good Jun 2014	Good Jun 2014	Good Jun 2014	Good Jun 2014
Community-based mental health services for older people	Good Jun 2019	Good Jun 2019	Good Jun 2019	Good Jun 2019	Good Jun 2019	Good Jun 2019
Community mental health services for people with a learning disability or autism	Requires improvement Nov 2017	Good Nov 2017	Good Nov 2017	Good Nov 2017	Good Nov 2017	Good Nov 2017
<b>Overall</b>	Requires improvement ↔ Jun 2019	Requires improvement ↔ Jun 2019	Good ↔ Jun 2019	Good ↔ Jun 2019	Requires improvement ↔ Jun 2019	Requires improvement ↔ Jun 2019

Overall ratings for mental health services are from combining ratings for services. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

# Community health services

## Background to community health services

The trust provides the following community health services:

- Community health services for adults
- Community end of life care
- Community services for children, young people and families
- Community dental services

The core services inspected by short notice announced inspection were:

- Community end of life care
- Community health services for children, young people and families

## Summary of community health services

**Good** ● → ←

Our overall rating of these services stayed the same. We rated community health services as good.

We rated community health services as outstanding in caring and as good in the safe, effective, responsive and well-led key questions. This was the second inspection where community health services have been rated as good since November 2017. The rating in one community health service improved to outstanding. The rating in one community health service deteriorated to requires improvement.



# Community end of life care

**Outstanding** ☆ ↑

## Key facts and figures

The palliative care service provided care for patients with a life limiting condition that needed specialist input. The service comprised of three parts;

- The specialist palliative care team provided specialist advice and support for patients nearing the end of their life.
- The palliative care support teams (formally known as the hospice at home team) provided hands on care to patients at home in their last six to eight weeks of life and worked closely with the district nursing teams to provide patient care. One team covered the Bradford area and the other team covered the Airedale and Wharfedale area.
- The fast track team provided end of life care for patients in their own home and responded to referrals within 4 hours aiming to prevent unnecessary hospital admission and facilitate the timely discharge of patients from hospital to their preferred place of death.

The service received approximately 1,100 referrals in 2017 to 2018.

At this inspection we visited the teams at both Shipley Health Centre and Canalside Health Centre. We accompanied staff visiting patients in their homes and attended a multidisciplinary meeting at the local hospice.

We last inspected this service in 2014 and rated the service good overall and good in all domains except for responsive which we rated outstanding. No requirement notices were issued.

At this inspection we inspected all five domains.

Our inspection was a short-term announced which meant we announced the inspection 24-48 hours before we arrived.

Before this inspection we reviewed the information about this service and information requested from the trust.

During the inspection visit, the inspection team observed care and treatment in 13 patients' homes. We looked at 10 patient records and 10 prescription charts. We spoke with 20 patients and relatives and 18 members of staff including registered nurses, health care assistants, liaison workers, clinical nurse specialists in palliative care, palliative care consultants and service managers. We also interviewed the senior management team who were responsible for leadership and oversight of the service.

## Summary of this service

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

- The service used innovative approaches to provide integrated person-centred pathways of care that involved other service providers.
- The service was responsive to the needs of the local population and engaged well with hard to reach groups and ethnic minorities to provide individualised care. There was a proactive approach to understanding the needs and preferences of different groups of people.
- The service used technology innovatively to ensure people had timely access to treatment, support and care. The Gold Line gave round-the-clock telephone support to patients and carers who needed help, reassurance or advice.

# Community end of life care

- People were truly respected and valued as individuals. They were empowered as a partner in their care practically and emotionally by an exceptional distinctive service.
- Carers were seen as active partners in peoples' care. Staff were fully committed to working in partnership with people and making this a reality for each person.
- Staff found innovative ways to enable people to manage their own health and care and delivered holistic patient centred care.
- We found that without exception staff were passionate about the care they delivered and were determined to give the best care they could to patients and their relatives. Staff understood and respected the personal, cultural, social and religious needs of patients and their families and took these into account in the way they delivered services. We saw staff delivering holistic patient centred care.
- There was a positive culture with good relationships between staff who worked well together. They worked with partner organisations effectively to provide seamless patients care.
- The service was well led. Staff spoke highly of the clinical lead and their line managers and said they felt supported. Staff were proud to work for the service and were focused on the needs and experience of patients and families who used the service.
- We found the service was continually striving to improve. There was a positive culture of learning, continuous improvement and innovation.
- The service had enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment. The service made sure staff were competent for their roles and provided training and development to other staff providing care for patients at their end of life.
- 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 followed best practice when prescribing, giving, recording and storing medicines.

However:

- Although the service managed patient safety incidents well, not all staff were familiar with how to locate and complete an incident report.
- Staff did not complete the 'Comfort and Dignity Care Plan' for all patients who were identified as entering their last days of life.
- We had some concerns around staff who updated patients' records on return to the office. This meant the records were not completed contemporaneously and this may impact on the patients shared care. Staff confirmed there had been no incidents because of this.

## Is the service safe?

Good   

Our rating of safe stayed the same. We rated it as good because:

- The service provided mandatory training in key skills to all staff and made sure everyone completed it.
- 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.

# Community end of life care

- The service controlled infection risk well. We observed good infection, control and prevention practice. Staff used personal protective equipment such as gloves and aprons when providing patient care and we saw good handwashing and use of hand gel.
- Staff were aware of key risks such as falls and pressure care. We saw risk assessments were completed and action plans were in place to minimise risk to patients. Staff kept clear records and asked for support when necessary.
- The service had enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment.
- Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date and easily available to all staff providing care.
- The service followed best practice when prescribing, giving, recording and storing medicines.

However:

- Although the service managed patient safety incidents well, not all staff were familiar with how to locate and complete an incident report.
- Staff did not complete the 'Comfort and Dignity Care Plan' for all patients who were identified as entering their last days of life.
- We had some concerns around staff who updated patients' records on return to the office. This meant the records were not completed contemporaneously and this may impact on the patients shared care. Staff confirmed there had been no incidents because of this.

## Is the service effective?

**Good** ● → ←

Our rating of effective stayed the same. We rated it as good because:

- The service worked in accordance with national guidance and local guidelines and standards, to provide evidence-based care and treatment.
- The service took part in audit aimed to measure its effectiveness and used the findings to improve them.
- The service aimed to achieve positive outcomes for patients. Data provided by the service showed that between 1 October 2018 and 31 March 2019 the percentage of patients who died in their preferred place of death was 82%.
- Staff assessed and monitored patients regularly to see if they were in pain.
- Staff in the service worked well together and with other teams and professionals to provide good care for patients.
- The service made sure staff were competent for their roles and provided training and development to other staff providing care for patients at their end of life.
- Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. They followed the trust policy and procedures when a patient could not give consent.

## Is the service caring?

**Outstanding** ☆ ↑

# Community end of life care

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

- We found that without exception staff were passionate about the care they delivered and were determined to give the best care they could to patients and their relatives.
- People were truly respected and valued as individuals. They were empowered as a partner in their care practically and emotionally by an exceptional distinctive service.
- Carers were seen as active partners in peoples' care. Staff were fully committed to working in partnership with people and making this a reality for each person.
- Staff found innovative ways to enable people to manage their own health and care and delivered holistic patient centred care.
- Staff cared for patients with compassion and always considered their privacy and dignity.
- Staff understood and respected the personal, cultural, social and religious needs of patients and their families and took these into account in the way they delivered services. We saw staff delivering holistic patient centred care.
- Feedback from patients and those close to them was continually positive about the care staff provided and they thought staff went above and beyond their expectations.
- Staff provided emotional support to patients to minimise their distress and recognised the importance of patients emotional and social needs.
- Staff were fully committed to working in partnership with patients and those close to them, enabling them to be actively involved in decisions about their care and treatment.

## Is the service responsive?

**Outstanding** ☆ → ←

Our rating of responsive stayed the same. We rated it as outstanding because:

- The service used innovative approaches to providing integrated person-centred pathways of care that involved other service providers.
- The service planned and provided services in a way that met the needs of local people. The service worked closely with commissioners and the care network to plan and deliver end of life care to the local population.
- The service was responsive to the needs of the local population and engaged well with hard to reach groups and ethnic minorities to provide individualised care. There was a proactive approach to understanding the needs and preferences of different groups of people.
- People could access the service when they needed it. The service was delivered to ensure that patients received the right level of care at the right time.
- The service used technology innovatively to ensure people had timely access to treatment, support and care. The Gold Line gave round-the-clock telephone support to patients and carers who needed help, reassurance or advice.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff.

# Community end of life care

## Is the service well-led?

Good ● → ←

Our rating of well-led stayed the same. We rated it as good because:

- Managers had the right skills and abilities to run a service providing high-quality sustainable care. All staff spoke highly of their clinical lead and line managers. Staff felt well supported by their team leaders and managers at all levels.
- There was a positive culture with good relationships between staff who worked collaboratively. Staff were proud to work for the service and were focused on the needs and experience of patients and families who used the service.
- The service had a vision for what it wanted to achieve and workable plans to turn it into action developed with involvement from staff, patients, and key groups representing the local community.
- The service used a systematic approach to continually improve the quality of its services and safeguarding high standards of care by creating an environment in which excellence in clinical care would flourish.
- The trust had effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected.
- The service collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards.
- The service engaged well with patients, staff, the public and local organisations to plan and manage appropriate services and collaborated with partner organisations effectively.
- We found the service was continually striving to improve. There was a positive culture of learning, continuous improvement and innovation.

However:

- Care records were not effectively audited to identify where documentation was missing or incomplete.

## Outstanding practice

We found examples of outstanding practice in the trust's community end of life care services. For more information, see the outstanding practice section of this report.

## Areas for improvement

We found things that the trust should improve to comply with a minor breach that did not justify regulatory action, to prevent breaching a legal requirement, or to improve service quality.

For more information, see the Areas for improvement section of this report.

# Community health services for children and young people

Requires improvement  

## Key facts and figures

Our inspection was announced on 4 April 2019 to Bradford District Care NHS Foundation Trust (staff knew we were coming) to ensure that everyone we needed to talk to was available. The inspection took place between the 8 and 10 April 2019. Before visiting we reviewed a range of information we held about Bradford District Care NHS Foundation Trust and confirmed possible locations to visit with the provider.

The children's service was previously inspected in 2014. The outcome of the 2014 inspection identified the overall service rating as good, with responsive rated as requires improvement. Concerns about the ability of the service to respond to people's needs were identified.

At the inspection we visited eight locations throughout Wakefield, Bradford and Airedale where service teams were based and delivered services. These included: Tuscany Way, Wakefield, Family Nurse Partnership at Ashgrove Surgery, Wakefield, Coronation Hospital, Westbourne Green Community Health Centre, Queensbury Medical Centre, Shipley Health Centre and Canal Side Health Centre. Attendance at a baby clinic in Burley in Wharfedale.

During our visit we held focus groups and individual interviews with a range of staff which included health visitors, school nurses, special school nurses and managers. Overall, we spoke with 82 staff. We also spoke with 19 parents and eight children /young people and reviewed 21 children's/young people's records throughout the inspection.

## Summary of this service

Our rating of this service went down. We rated it as requires improvement because:

- The service did not have enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment. Best practice staffing guidance was not followed following a reduction in the children's community staffing budget as the service was in transition and part way through a service transformation process. The service had a number of vacancies due to the recent procurement of 0-19 services in Bradford and the transition of skill mix changes. The trust's skill mix information confirmed shortfalls in health visiting, school nursing and looked after children staffing groups.
- Caseloads for school nursing and health visiting nursing staff were high. Caseloads for looked after children were high and fell outside of recommended guidance of 100 children per whole time equivalent nurse.
- Staff said work related stress had increased and described poor technology connectivity and the increase in safeguarding work as having contributed to this stress.
- Performance against children's health needs assessments was poor.
- The service provided annual mandatory training in key skills to all staff which not all staff had completed. The trust did not meet fire safety year one, information governance attendance and Mental Capacity Act level 1 training sessions. Monthly reporting of compliance levels were reported at senior leadership meetings.
- The trust target of 80% attendance for Mental Capacity Act level one training was not achieved, figures submitted by the trust confirmed completion of 76% as of 30 November 2018.

However:

# Community health services for children and young people

- We spoke with 15 mothers, four fathers, one child and one young person. about their experiences. They said they were involved in their care and decision-making and were happy with the care and treatment received.
- 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.
- The service-controlled infection risk well. Staff kept themselves, equipment and the premises clean. They used control measures to prevent the spread of infection.
- The service had suitable premises and equipment and looked after them well.
- Staff completed detailed records of patients' care and treatment and updated risk assessments for each patient. Records were clear, up to-date and easily available to all staff providing care.
- The service managed patient safety incidents well. When things went wrong, staff apologised and gave patients honest information and suitable support.
- The service provided care and treatment based on national guidance and evidence of its effectiveness. The trust had made good progress in the implementation of the Healthy Child Programme and had evidenced based initiatives in place.
- The trust used a systematic approach to continually improve the quality of its services and safeguarding high standards of care.
- The trust had effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected.
- Managers at all levels in the trust had the right skills and abilities to run a service providing high-quality sustainable care.

## Is the service safe?

**Requires improvement** ● ↓

Our rating of safe went down. We rated it as requires improvement because:

- The service did not have enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment. Best practice staffing guidance was not followed following a reduction in the children's community staffing budget as the service was in transition and part way through a service transformation process. The service had a number of vacancies due to the recent procurement of 0-19 services in Bradford and the transition of skill mix changes. The trust's skill mix information confirmed shortfalls in health visiting, school nursing and looked after children staffing groups.
- Caseloads for school nursing and health visiting nursing staff were high. Caseloads for looked after children were high and fell outside of recommended guidance of 100 children per whole time equivalent nurse.
- Staff sickness rates fell outside of the trusts target of 4%; sickness on 8 April 2019 was 6.38%.
- Staff said work related stress had increased and described poor technology connectivity and the increase in safeguarding work as having contributed to this stress.
- The service provided mandatory training in key skills to all staff which not all staff had completed. The trust did not meet fire safety year one, information governance attendance and Mental Capacity Act level 1 training sessions. However, monthly reporting of compliance levels were reported at senior leadership meetings.



# Community health services for children and young people

- Health visitors prescribed in accordance with nonmedical prescribing legislation and guidance. Non-medical prescribing update training information provided to March 2019 showed training compliance in this area between 0 to 100%. Training statistics were not recorded for other school nursing teams. The trust did not identify whether this was an area of training required by school nurse teams. Non-medical prescribing updates were completed by health visiting teams and compliance ranged from 69% to 100%.
- Shortfalls in school nurse's attendance were recorded at the two-year medicines' management training by trust training statistics which confirmed attendance from zero to 75%.

However:

- 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.
- The service-controlled infection risk well. Staff kept themselves, equipment and the premises clean. They used control measures to prevent the spread of infection.
- The service had suitable premises and equipment and they were well maintained.
- Staff completed detailed records of patients' care and treatment and updated risk assessments for each patient. Records were clear, up to-date and easily available to all staff providing care.
- 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.

## Is the service effective?

Good ● → ←

Our rating of effective stayed the same. We rated it as good because:

- The service provided care and treatment based on national guidance and evidence of its effectiveness. Managers checked to make sure staff followed guidance. The trust had made good progress in the implementation of the Healthy Child Programme and had evidenced based initiatives in place.
- The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and monitor the effectiveness of the service.
- Staff of different kinds generally worked well together as a team to benefit patients. Doctors, nurses and other healthcare professionals supported each other to provide good care.
- Staff understood how and when to assess whether a patient had the capacity or competence to make decisions about their care. They followed the trust policy and procedures when a patient could not give consent.
- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. They knew how to support patients and families experiencing mental ill health and those who lacked the capacity to make decisions about their care.

However:

- The trust target of 80% attendance for Mental Capacity Act level one training was not achieved, figures submitted by the Trust confirmed completion of 76% as of 30 November 2018.

# Community health services for children and young people

- Performance against children's health needs assessments was poor, however, the Trust had implemented a new way of collecting this data and hoped to see an improvement by quarter four 2018/19.
- Teams and families experienced difficulties knowing which social worker was allocated to the child/young person which meant children's/young people's needs were not being met in a timely way.

## Is the service caring?

**Good** ● → ←

Our rating of caring stayed the same. We rated it as good because:

- Staff cared for patients with compassion. Feedback from parents and young people confirmed that staff treated them well and with kindness.
- We spoke with 15 mothers, four fathers, one child and one young person. about their experiences. They said they were involved in their care and decision-making and were happy with the care and treatment received.
- Staff provided emotional support to patients to minimise their distress. Support was available for bereaved parents through the bereavement link nurse and chaplaincy service who routinely offered their services to parents who lost a child.
- Support was provided by the multi-disciplinary team during the child's admission, stay and in preparation for their discharge home.

## Is the service responsive?

**Requires improvement** ● → ←

Our rating of responsive stayed the same. We rated it as requires improvement because:

- People could not always access specific services and assessments when needed.
- Staff said the increase in looked after children across the area had impacted on leaving care and youth offending teams. To-date, there had been no incidents due to the increase in looked after children. However, short- and long-term risks related to staff non-attendance at multi-agency meetings where health and agency information was shared which kept the child/young person safe. Another impact related to health reviews of young people entering the care system not being completed. Looked after children were identified as a risk on the risk register.
- Staff said looked after children initial health assessments were delayed due to the large numbers of looked after children entering the service.
- Children and adolescent mental health patients had experienced delays of eight to 10 months following their initial assessment before further support was provided through the Children and adolescent mental health service team.
- Key performance indicators for health visiting and school nursing were not achieved in all areas.
- Two-year waits existed for children's autism assessments through the local Acute NHS trust.

However:

- Good progress had been made by the trust in planning and providing services that met most of the needs of local people.

# Community health services for children and young people

- Close working with other providers, tertiary centres, commissioners, parents and young people resulted in improvements and support for the service.
- The service took account of patients' individual needs and met most people's needs in vulnerable circumstances
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff.

## Is the service well-led?

Good ● → ←

Our rating of well-led stayed the same. We rated it as good because:

- The trust had a vision for what it wanted to achieve and workable plans to turn it into action developed with involvement from staff, patients, and key groups representing the local community.
- Managers across the trust promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values. Staff described senior managers as visible and approachable.
- The trust used a systematic approach to continually improve the quality of its services and safeguarding high standards of care.
- The trust had effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected.
- The trust collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards.
- The trust engaged well with patients, staff, the public and local organisations to plan and manage appropriate services and collaborated with partner organisations effectively.
- The trust was committed to improving services by learning from when things went well and when they went wrong, promoting training, research and innovation.

However:

- Staff had raised concerns about the current change process, job security and high levels of anxiety were identified. Staff morale was low in the Bradford teams.
- Staff experienced ongoing problems with technology connectivity which had led to low morale. Staff said this had impacted on them doing their job and the team were not as agile due to these problems.
- During the inspection we found that the service was under considerable pressure from several factors including those outside of the service's control. Managers were aware and were trying to address this.

## Areas for improvement

We found areas for improvement that the trust must put right. We also found things that the trust should improve to comply with a minor breach that did not justify regulatory action, to prevent breaching a legal requirement, or to improve service quality.

For more information, see the Areas for improvement section of this report.

# Mental health services

## Background to mental health services

The trust provides the following mental health core services:

- Acute inpatient mental health wards for adults of working age and psychiatric intensive care unit
- Long stay/rehabilitation mental health wards for working age adults
- Forensic inpatient/secure wards
- Wards for older people with mental health problems
- Wards for people with a learning disability or autism
- Community-based mental health services for adults of working age
- Mental health crisis services and health-based places of safety
- Community mental health services for older people
- Specialist community-based mental health services for children and young people
- Community mental health services for people with a learning disability or autism

The core services inspected by unannounced inspection were:

- Acute inpatient mental health wards for adults of working age and psychiatric intensive care unit
- Forensic inpatient/secure wards
- Wards for older people with mental health problems
- Wards for people with a learning disability or autism

The core services inspected by short notice announced inspection were:

- Community-based mental health services for older people
- Mental health crisis services and health-based places of safety

## Summary of mental health services

**Requires improvement**   

Our overall rating of these services stayed the same. We rated mental health services as requires improvement.

## Summary of findings

We rated mental health services as requires improvement in safe, effective and well-led, and good in the caring and responsive key question. This was the second inspection since 2017 where mental health services have been rated as requires improvement. The rating in one of the mental health services deteriorated to inadequate. Two of the six mental health services we inspected improved their overall rating to good.

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

Inadequate ● ↓

## Key facts and figures

Bradford District Care NHS Foundation Trust provides six inpatient wards for adults of working age who require acute and psychiatric intensive care.

The wards are located at two sites.

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.

- Ashbrook ward, a 26 bed female acute admission ward
- Oakburn ward, a 22 bed male acute admission ward
- 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 inspection was undertaken between 5 March 2019 and 7 March 2019. The inspection was unannounced. We visited all six wards during this inspection as part of our planned inspection programme. We inspected the following key questions; safe, effective, caring, responsive and well led.

Our Mental Health Act Reviewers visited each ward between December 2017 and January 2019. During these visits they found concerns relating to; blanket restrictions, patients not having their rights explained to them, the availability of information in relation to contacting CQC and independent mental health advocacy services, assessments of capacity, and a lack of detail in risk assessments. They also had concerns that patients' care plans did not evidence person centered care, patient involvement and discharge planning.

Following these visits, the trust provided action statements telling us how they would make improvements to the service's adherence to the Mental Health Act and associated Code of Practice. We reviewed these concerns at this inspection.

We previously inspected this service in October 2017. We rated the service as requires improvement overall, with ratings of requires improvement in the safe, effective and well-led key questions, and ratings of good in the caring and responsive key questions. We found the trust to be in breach of the following regulations within the Health and Social Care Act (Regulated Activities) Regulations 2014:

- Regulation 9; person centered care. This related to the trust ensuring that patient care plans were reviewed and personalised.
- Regulation 12; Safe Care and Treatment. This related to environmental safety, risk assessments, the reporting of safeguarding, monitoring of patients following the use of restrictive interventions and mandatory training.
- Regulation 13; Safeguarding service users from abuse and improper treatment. This related to blanket restrictions.

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

- Regulation 17; Good governance. This related to the trust ensuring that the systems in place operated effectively to keep patients safe.
- Regulation 18; Staffing. This related to the trust ensuring there were sufficient staff numbers to consistently provide all aspects of patient care.

We reviewed each of these breaches of regulation as part of this inspection.

Prior to the inspection, we reviewed all of the information we held about the services, and requested additional information from the trust. We also held a range of focus groups with staff and patients in the six months prior to the inspection.

During the inspection visit, the inspection team;

- visited all six wards, looked at the quality of the environments and observed how staff were caring for patients
- spoke with 14 patients using the service, and reviewed their comments on 17 feedback cards
- spoke with five carers or relatives of people using the service
- spoke with ten leaders of the service including the interim deputy director, interim head of service, service manager, clinical manager, and all six ward managers
- spoke with 20 other staff including doctors, nurses, healthcare assistants, occupational therapists, psychologist, activity coordinators, assistant practitioners and advanced nurse prescribers
- looked at the care and treatment records of 15 patients
- reviewed the medication administration records of 91 patients
- attended and observed meeting such as safety huddles, daily walk about meetings and a mutual help meeting
- reviewed a range of policies and procedures and other documents relating to the running of the service.

## Summary of this service

**Due to the concerns we found during this inspection, we used our powers to take immediate enforcement action. We issued Bradford District Care NHS Foundation Trust with a section 29A warning notice. This advised the trust that our findings indicated a need for significant improvement in the quality of healthcare. We will revisit these services to check that appropriate action has been taken and that quality of care has improved.**

Our rating of this service went down. We rated it as inadequate because:

- The provider was not delivering safe care. People were not safe and at high risk of avoidable harm. Staff had not undertaken risk assessments of the care environment and mitigated those risks. Where patients demonstrated higher levels of risk staff did not follow processes and procedures to mitigate these via appropriate monitoring and recording. The service used restrictive interventions and the quality, purpose and proportionality of these was not reviewed and appropriately recorded. Audits were not effective. We had concerns about the management, storage and administration of medications. Staff did not ensure all clinical equipment was present and fit for purpose. Compliance with mandatory training was low. Staff did not always ensure that incidents were correctly categorised to ensure opportunities for investigation and learning could take place.
- The care provided was not always dignified. Patients were caused distress when their beds were allocated to other patients whilst they were on leave.



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

- The provider was not delivering effective care. Not all patients had care plans which were personalised, and none of the patient care plans we reviewed contained a detailed, goal orientated discharge plan. The service did not work from a multi-disciplinary approach. Staff were not appropriately supervised according to the trust's own policy.
- The service was not always responsive to the needs of individual patients. The admission process was not led by ward teams. Bed occupancy rates and readmission rates were high. Staff did not find effective ways to communicate and care plan for patients with communication difficulties and did not have care plans in place to ensure they could communicate their wishes. The trust did not have a robust and clear procedure in place to support the dignified conveyance of patients between wards.
- The service was not well led. The trust systems and processes did not ensure the effective identification of risks. When risks were highlighted to the service via external bodies and following incidents, the trust did not act in a timely manner to make the required improvements. Processes and practices were not always taking place according to trust policies. Ward level audits were either not effective at identifying these issues or action did not take place to address the issues identified at all, or in a timely way.

However:

- The wards were clean and well furnished. The reporting of safeguarding was of good quality, staff knew how to spot signs of abuse and how to report incidents. The trust had recently changed the staffing model and staff and patients told us there were enough staff to meet the needs of patients.
- Staff supported patients' physical health needs and provided therapies and activities to meet the needs of patients as per best practice guidance.
- Staff were caring, compassionate and professional in their interactions with patients.
- Staff supported patients cultural and spiritual needs. Staff understood the complaints process and complaints were managed according to the trust's own policy. Staff supported patients to access their local community and maintain relationships which were important to them.
- Staff told us that leaders were supportive and approachable.

## Is the service safe?

**Inadequate** ● ↓

Our rating of safe went down. We rated it as inadequate because:

- Care premises, equipment and facilities were unsafe. Staff could not clearly see all areas of the ward, the ligature risk assessments in place were not fit for purpose and did not mitigate risk to patients who might try to harm themselves. Patients had come to harm due to the ward environment on Oakburn ward. The trust had undertaken fire risk assessments and actions had not been taken to address the risks identified. Not all equipment was present in the emergency grab bags. Equipment in clinic rooms was not calibrated and staff did not record that they had taken action when temperatures were not within the correct range. Patients did not have access to alarms to summon help from staff. The wards at Lynfield Mount were not well maintained, we observed blocked drains and peeling plaster.
- There was routine disregard of standard operating and safety procedures. Staff had not completed risk assessments for all patients, and updated these following an incident. Staff did not protect patients from harm by following the trust processes for the management of leave from the ward. The trust had put procedures in place to improve the monitoring of patient leave, but these were not yet embedded and patients had come to harm during episodes of leave. Staff did not always accurately record that they had completed observations of patients.

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

- The service provided mandatory and required training to staff in key skills but did not make sure everyone had completed it. Not all staff were trained in areas such as moving and handling, the Mental Capacity Act, safeguarding adults and children and the care programme approach.
- Staff did not follow best practice and the guidance in the Mental Health Act because they applied blanket restrictions which were not audited and reviewed and did not follow the trust's own policy regarding the searching of patients.
- The use of restrictive practices such as prone restraint, rapid tranquilisation and seclusion did not follow best practice guidance. Staff did not record these interventions as per the trust's own policy. The recording of restrictive interventions did not evidence that they were always proportionate and least restrictive.
- The paper records held for the monitoring of seclusion episodes were not always accessible or updated on the electronic record in a timely way.
- People were at risk because medication was not managed, audited and stored securely. We found out of date and unlabelled medications during our inspection. Audits of controlled drugs did not always take place.
- People were at risk because staff did not always follow best practice guidance when managing medicines. Staff did not always review the side effects of anti-psychotic medications with patients. The recording of the administration of medication was poor and we found omissions in several patient medication records.
- There were unacceptable levels of serious incidents, including patient deaths. The trust had not taken timely and immediate action to learn from these incidents and prevent reoccurrence. This was in relation to ligature risk assessments and the management of patient leave. Opportunities to prevent or minimise harm were missed.
- There was not a robust procedure in place for the management of the conveyance of patients across the site with clear guidance for staff.

However:

- All wards were clean and well furnished.
- The wards had enough nursing and medical staff, who knew the patients well.
- Staff understood how to protect patients from abuse and worked with colleagues and other agencies in order to do so. Staff knew how to recognise and report abuse.

## Is the service effective?

**Requires improvement** ● → ←

Our rating of effective stayed the same. We rated it as requires improvement because:

- Staff were not supported with supervision in line with the trust's policy.
- Care plans were not always personalised. Some care plans contained incorrect names, and there was not always evidence of patient involvement.
- The trust did not have in place effective systems to mitigate the negative consequences of deploying psychiatrists to work across both the acute mental health wards for working age adults and the community mental health services for working age adults. There was a model of multi-disciplinary care in place offered to patients with the exception of the psychiatric intensive care unit. The consultant psychiatrists were not ward based, and worked from a continuing care model. Multi-disciplinary meetings were not always planned in advance which reduced the opportunity for the attendance of the patient, their carers and relatives, community mental health teams and advocates.

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

- Not all patients had the correct medication authorisation (T2 and T3) certificates located with their medication cards.
- The trust had not ensured that they completed actions relating to the recommendations following visits from our Mental Health Act Reviewers.
- One patient had a restrictive care plan in place and there was no recording that staff had undertaken a capacity assessment or held a best interest discussion.

However:

- Staff assessed the physical and mental health of all patients on admission.
- Staff provided a range of treatment and care for patients based on national guidance and best practice. This included activities, occupational therapy and psychology input.
- Staff were skilled in supporting patients with their physical health needs and this was embedded throughout the service.
- Staff understood their roles and responsibilities under the Mental Health Act 1983. Managers made sure that staff could explain patients' rights to them.
- Staff supported patients to make decisions on their care for themselves.

## Is the service caring?

**Requires improvement** ● ↓

Our rating of caring went down. We rated it as requires improvement because:

- The trust did not always provide dignified care, including the allocation of beds to patients which belonged to patients who were on leave and escorting patients across the car park in restraint.
- Carers reported that they and their relatives had received care and treatment which was not always kind, dignified and respectful.
- Patients and their carers did not feel involved in care and treatment, carers told us about difficulties in communicating with staff.
- Patients told us that they had not been involved in their care plan and had not seen a copy.

However:

- Most patients described staff as professional, approachable, helpful, polite, discreet, approachable and understanding.
- Staff treated patient information confidentially and sought consent to share their information with others.
- The trust used the triangle of care as a model to ensure involvement of carers in the care and treatment of patient. The trust had a carers hub to support carers and relatives.
- We saw evidence of some staff undertaking carers assessments.

## Is the service responsive?

**Requires improvement** ● ↓

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

Our rating of responsive went down. We rated it as requires improvement because:

- The trust bed management process did not allow ward level involvement in the decisions for admission. Ward staff did not always have information regarding patients before they arrived for admission.
- The bed occupancy rate was higher than 100% and during our inspection we saw that there were more patients than beds available. Staff told us, and we saw evidence in incident forms, that this meant that the decision to discharge patients, 'guest' them on other wards, or allow them overnight leave from the wards, was being made and patients were not able to return to the same room or the same ward in some cases.
- There was a higher number of readmissions to the service within 28 days compared to the last inspection.
- None of the patients had discharge plans in place to ensure they could access a goal orientated recovery. Patient discharge was not planned from the time of admission.
- The service did not ensure that patients with additional needs such as; visual impairments, mobility issues or where English was not their first language had accessible and clear care and communication plans in place. The lengthy sounding of alarms at Lynfield Mount during fire tests caused distress to patients with autistic spectrum disorder.

However:

- Patients had their own rooms where they could keep personal belongings safely.
- Staff supported patients to access the local community and encouraged them to maintain relationships which were important to them.
- Staff supported patients to access advocacy and met their cultural needs.
- The service treated concerns and complaints seriously, reviewed them monthly at service level and acted on the feedback. They shared learning and outcomes with staff and patients.

## Is the service well-led?

**Inadequate** ● ↓

Our rating of well-led went down. We rated it as inadequate because:

- The service had systems and processes in place to monitor and assess risk. However, there was little understanding or management of risks and issues and significant failures in audit systems and processes. Ward level audits were either not effective at identifying these issues or action did not take place to address the issues identified at all, or in a timely way. This included the issues we identified on this inspection.
- The trust had not taken action in a timely manner in response to risk or when improvements were needed, including in response to the findings at our last inspection.
- Mental Health Act review reports have not been acted upon and utilised as part of Mental Health Act monitoring at the trust.
- Leaders were out of touch with the issues affecting front line staff and had not identified and understood the risks and issues described by staff during the inspection.
- Staff did not always evidence they worked in line with the values of the trust.
- There was minimal evidence of learning and reflective practice taking place following serious incidents and patient deaths. Incidents of harm were repeated before the trust had taken action.

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

However:

- Managers running the service had the right skills and abilities. Most staff spoke highly of leaders and the support they received from them.
- The trust had a vision for what it wanted to achieve and workable plans to turn it into action developed with involvement from staff, patients, and key groups representing the local community.
- Managers across the trust promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values. Ward staff were supportive of their colleagues and worked together to achieve outcomes for patients. Staff enjoyed their jobs.

## Areas for improvement

We found areas for improvement that the trust must put right. We also found things that the trust should improve to comply with a minor breach that did not justify regulatory action, to prevent breaching a legal requirement, or to improve service quality.

For more information, see the Areas for improvement section of this report.

# Forensic inpatient or secure wards

Requires improvement  

## Key facts and figures

Bradford District Care Foundation Trust provides inpatient forensic services at Moorlands View within Lynfield Mount Hospital. Moorlands View is a purpose-built 33 bed unit for men with mental health problems who require management under conditions of low security.

At the time of inspection, the service comprised of three wards:

- Thornton ward – a 12 bed admissions ward
- Baildon ward – a 10 bed treatment ward
- Ilkley ward – an 11 bed rehabilitation ward

Patients on these wards were detained under the Mental Health Act and some had Ministry of Justice restrictions placed on them.

The inspection took place on 5 and 6 March 2019. The inspection was unannounced and was part of our planned inspection programme. We inspected against all our key questions; safe, effective, caring, responsive and well led.

Our Mental Health Act Reviewers visited each ward between June 2017 and February 2019. They assessed the adherence of the service to the Mental Health Act and Code of Practice. During these visits they found concerns relating to; blanket restrictions, care planning, the seclusion environment and documentation, access to Section 17 leave, assessment of capacity, risk assessments and physical health assessments. The trust submitted action statements following these visits telling us how they would make improvements and we reviewed these as part of this inspection.

We previously inspected this service in June 2014. We rated the service as good overall with safe as requires improvement. There were no breaches of regulation. The wards were inspected as part of long stay/forensic/rehabilitation core service previously, therefore these three forensic wards have not previously been inspected under our current methodology as a single core service.

Prior to the inspection, we reviewed all of the information we held about the service. We also held a range of focus groups with staff and patients in the six months prior to the inspection.

During the inspection visit, the inspection team;

- visited all three wards, looked at the quality of the environments and observed how staff were caring for patients
- spoke with 9 patients using the service and three carers or relatives
- spoke with six managers of the service; the interim deputy director, service manager, clinical manager, two ward managers and one assistant ward manager
- spoke with 20 other staff including; doctors, nurses, advanced nurse practitioners, healthcare assistants, occupational therapists, assistant psychologists, social workers, domestic staff and the advocate for the wards
- looked at the care and treatment records of nine patients, the rapid tranquilisation records of three patients, the seclusion records of three patients, and reviewed the medication administration records of 12 patients
- attended and observed the safety huddle, a music therapy session and the walking group

# Forensic inpatient or secure wards

- reviewed a range of policies, procedures and other documents relating to the running of the service.

## Summary of this service

Our rating of this service went down. We rated it as requires improvement because:

- The service did not always deliver safe care. Risk assessments of the environment did not include all potential risks, had not been reviewed as required and the trust had not taken action to mitigate all those risks. There were no nurse call alarms on any of the wards for patients to use and no standard procedure for giving patients access to an alarm. The service had blanket restrictions in place that were not based on an individual assessment of risk and need. Staff did not adhere to trust policy in searching patients and monitoring their mail. Staff did not clearly evidence that they had used long term segregation appropriately or that they had followed best practice and trust policy in doing so. The seclusion room contained a safety hazard.
- The service was not always well led. Senior managers did not have sufficient oversight of the issues in their service and ensure staff were adhering to trust policy in relation to searching, mail monitoring and long-term segregation. Systems and processes in place to enable good governance of the wards were not always effective. The trust did not have robust systems in place to monitor and safeguard patients in long term segregation. Staff supervision was not effectively monitored and the electronic record system did not enable staff to effectively document seclusion episodes or the monitoring of rapid tranquilisation.

However:

- There were sufficient staff to meet the care and treatment needs of patients. Staff and patients reported they felt safe on the ward. The wards were clean and the environment was well maintained.
- Staff undertook comprehensive assessments of patients' physical and mental health needs and used these to develop care plans in collaboration with patients. Staff provided a range of treatment interventions suitable for the patient group and used recognised rating scales to monitor outcomes. Staff across all disciplines worked well together and teams had effective working relationships with external agencies.
- Staff treated patients with kindness and respect. Staff understood the individual needs of patients and supported them to manage their condition and treatment. Staff involved patients in their care and treatment and won awards for their innovative practice in patient care. The service provided carers with the opportunity to be involved in their relative's treatment and to provide feedback on the care they were receiving.
- The service was responsive to patients' needs. Staff planned for discharge from admission and discharge only occurred when a patient was ready to move on. A transition team supported patients from pre-admission to post-discharge. Patients had access to facilities to meet their needs and reported the food was of good quality. The trust ensured patients had access to spiritual support and interpreters where required. Patients knew how to complain and staff handled complaints appropriately.
- Staff spoke positively about managers within the service and most staff felt respected and supported. Staff reported morale was generally good and that all members of the multi-disciplinary team felt their voice was heard and opinion respected. Staff were not afraid to speak up and felt able to raise concerns if needed.

## Is the service safe?

**Requires improvement** ● ↓



# Forensic inpatient or secure wards

Our rating of safe stayed the same. We rated it as requires improvement because:

- The trust had not identified all ligature risks in the environment or taken sufficient action to mitigate these risks. Ligature risk assessments did not contain every room or every risk within them.
- There were no nurse call alarms on any of the wards for patients to use, no standard procedure for giving patients access to an alarm or any identified mitigation to the risk of not having nurse call alarm systems in place. This meant that patients could not easily seek assistance from staff in an emergency.
- Environmental risk assessments were not always reviewed as required and some had actions outstanding for almost twelve months.
- Blanket restrictions were in place across the service without an individual assessment of patients' risk and needs. These restricted patients' access to outside space, hot drinks and mobile phones. Staff did not risk assess how patients' Section 17 leave had gone on their return, in line with trust policy.
- Staff did not adhere to trust policy in searching patients. Patients were searched as routine procedure rather than when there was a reason.
- Staff monitored patients' mail as a blanket restriction, which was not in line with trust policy or the Mental Health Act.
- Staff did not clearly evidence that they had used long term segregation appropriately or that they had followed best practice and trust policy in doing so.
- The seclusion room had a raised floor which was a safety hazard and was therefore not in line with the requirements of the Mental Health Act Code of Practice.

However:

- The wards were clean and the environment was well maintained. Clinic rooms were fully equipped and equipment was checked in line with manufacturer's guidance.
- Staff and patients reported they felt safe on the ward. Staff were trained in relational security. Staff continually reviewed patients' risk and developed plans with patients to manage that risk.
- There were sufficient staff to meet the care and treatment needs of patients. Overall staff compliance with mandatory training was above 75%. Staff and patients reported staffing levels were ok and they could seek assistance when needed.
- All staff knew how to report incidents and staff and lessons learned were shared across the service. Staff and patients were offered a debrief and support following an incident.

## Is the service effective?

Good   

Our rating of effective stayed the same. We rated it as good because:

- Staff completed a comprehensive assessment of each patient's mental health and physical health needs on admission to the ward. Staff used these assessments to develop personalised and holistic care plans. Staff developed care plans in collaboration with patients.
- Staff provided a range of treatment interventions suitable for the patient group and used recognised rating scales to monitor outcomes. Patients had good access to physical healthcare and medication was prescribed in line with national guidance.

# Forensic inpatient or secure wards

- Staff were experienced and qualified. Staff across all disciplines worked well together and teams had effective working relationships with external agencies.
- Qualified staff understood their responsibilities under the Mental Health Act. Patients understood their rights and had access to an advocate.
- Staff understood the Mental Capacity Act and completed capacity assessments for patients when a need was identified. The trust had a policy on the Act and staff could seek support from the Mental Capacity Act lead.

However:

- The service had a vacancy for a psychologist in the months leading up to inspection. As a result, certain aspects of treatment had been limited, such as formulations and psychological therapies.
- Unqualified staff had a limited understanding of the Mental Health Act. Mental Health Act paperwork was not always easily located on the electronic system.

## Is the service caring?

Good ● → ←

Our rating of caring stayed the same. We rated it as good because:

- Staff treated patients with kindness and respect. Patients said staff treated them fairly and listened to them. We observed positive interactions between staff and patients on the ward and during activity sessions
- Staff understood the individual needs of patients and supported them to manage their condition and treatment. Staff assisted patients to access support in the community that met their cultural, social and religious needs.
- Staff involved patients in their care and treatment. Patients' review plans and risk assessments showed evidence of a collaborative approach. Patients we spoke with felt involved in their care and understood their treatment plan.
- Staff won awards for their innovative practice in patient care. They held a patient led festival and developed an amateur dramatics patient led group. Patients were encouraged to return after discharge to participate in ward activities and act as role models for current patients.
- The majority of carers we spoke with felt involved in their relative's care. The trust had a patient and carer involvement strategy titled 'You and Your Care' which was overseen by a strategic reference group. The trust had a carers' forum, a carers' hub and a patient and carer panel.

However:

- Staff placed restrictions on patients that did not always ensure their privacy and dignity was maintained.

## Is the service responsive?

Good ● → ←

Our rating of responsive stayed the same. We rated it as good because:

- The service provided an effective transition for patients at the point of admission and discharge. Staff from the service were involved in pre-admission assessments and continued time limited work after discharge to ensure a successful transition into the community.

# Forensic inpatient or secure wards

- The transition team developed discharge plans with the patients from admission and kept oversight of how patients were moving along their pathway to achieve their goals and progress towards discharge.
- Patients had access to facilities that met their needs and enabled them to take part in activities. Patients reported the food was good and they had access to food that met their dietary and cultural requirements, such as halal and gluten free meals. Patients had access to spiritual support and interpreters where required.
- Staff ensured patients had access to education and learning opportunities through Moorlands View Recovery College. Staff supported patients to maintain relationships with those important to them and held meetings over skype with community teams to enable their continued involvement in the patients' care.
- Patients knew how to complain and the wards displayed information on this. Staff knew how to manage complaints and reported they received feedback on the outcome of complaints.

## Is the service well-led?

**Requires improvement** ● ↓

Our rating of well-led went down. We rated it as requires improvement because:

- Senior managers did not have sufficient oversight of the issues in their service and did not ensure staff adhered to trust policies in relation to searching, mail monitoring and long-term segregation.
- Systems and processes in place to enable good governance of the wards were not always effective. The ligature audits were not sufficiently detailed and environmental audits were out of date with outstanding actions. The business continuity plan and evacuation plan were overdue for review.
- Some systems and processes were missing or were not fit for purpose. The trust did not have a robust system for monitoring long term segregation or staff supervision. The electronic record system did not enable staff to effectively document seclusion episodes or the monitoring of rapid tranquilisation.

However:

- Staff spoke positively about managers within the service. Ward managers had a good understanding of the issues on their wards and had access to leadership programmes.
- Senior managers held open door sessions and were visible on the wards.
- Staff felt respected and supported. Staff reported morale was generally good and that all members of the multi-disciplinary team felt their voice was heard and opinion respected.
- Staff were not afraid to speak up and felt able to raise concerns if needed.

## Outstanding practice

We found examples of outstanding practice in the trust's forensic / secure services. For more information, see the outstanding practice section of this report.

## Areas for improvement

We found areas for improvement that the trust must put right. We also found things that the trust should improve to comply with a minor breach that did not justify regulatory action, to prevent breaching a legal requirement, or to improve service quality.

# Forensic inpatient or secure wards

For more information, see the Areas for improvement section of this report.

# Community-based mental health services for older people

Good 

## Key facts and figures

Bradford District Care NHS Foundation Trust provides community mental health interventions to older patients across several different locations. They provide specialist assessment and support for older patients with complex and enduring mental health problems. The service receives referrals from a variety of sources including self-referral, GP referrals and referrals from inpatient wards.

Staff see patients in the community, either in local GP surgeries, community centres or in patients' homes.

The older people's community mental health services were inspected together with the inpatient wards for older people with a mental health problem in June 2014. Therefore the community-based mental health services for older people have not been inspected as an individual core service before this inspection.

We completed this inspection of the community mental health services for older people on the 26 – 28 February 2019. Our inspection was short notice announced; we informed the trust on 25 February 2019 to give the service the opportunity to plan and agree with patients to observe their appointments.

Before the inspection visit, we reviewed information we held about the services and sought feedback from patients and staff via focus groups.

During the inspection visit, the team;

- visited three main sites, completed environment checks and met with staff
- spoke with three patients that were using the service
- spoke with six carers of patients who were using the service
- reviewed the care and treatment records of 11 patients
- reviewed one mental capacity assessment
- spoke with managers at two sites
- spoke with the service manager
- spoke to 25 other staff including doctors, nurses, healthcare support staff, administration support and occupational therapists
- carried out specific checks on medication management arrangements
- observed one multidisciplinary team meeting
- observed six patient appointments.

## Summary of this service

We have not rated this service before. We rated it as good because:

- The service provided safe and effective care, there were sufficient numbers of staff who were adequately supported through supervision and appraisal and staff were very knowledgeable about their areas of work.

# Community-based mental health services for older people

- Managers provided extensive support to staff and were approachable, visible and always helpful. Staff and managers clearly had a lot of respect for each other and worked well together.
- Staff used best practice in treatment and care offered.
- Staff treated patients with compassion and kindness. They showed a good understanding of patients' needs and they made efforts to involve families and carers wherever they could.
- The service worked closely with the community to ensure they were able to reach individuals that might need the service. They offered a wide range of appropriate interventions and activities which met the needs of patients.
- The service had implemented an effective incident reporting system and they ensured that they shared information gathered using this process. They used lessons learnt from incidents and complaints and patient and carer feedback to make changes to services where appropriate.

However:

- We had some concerns about the way information was recorded and stored on the new electronic patients recording system and it was not clear if patients were routinely offered a copy of their care plan.
- Whilst the sites that we visited were clean and well maintained, some clinics and storage areas were cluttered and untidy.
- Waiting time for a memory assessment in some areas were high.

## Is the service safe?

**Good** ●

We have not rated safe before. We rated it as good because:

- The service had enough staff and they all received basic training to ensure people were kept safe from avoidable harm.
- Staff worked well with each other and other agencies to ensure the safety of patients.
- Staff had a good understanding of patient risk, they knew their patients well and put measures in place to manage risks where they were identified.
- Teams worked flexibly to be able to prioritise patients where heightened risk was identified.
- The service had a good track record on safety and they had an effective incident reporting process in place which enabled them to learn and share lessons easily.

However:

- Whilst the sites that we visited were clean and well maintained, some clinics and storage areas were cluttered and untidy.
- Information relating to patients' care and treatment was not always easy to find on the new electronic patient recording system. Staff did not consistently record information on the same document and store it in the same place in the electronic record. This could cause some confusion for staff who were not familiar with the services or take longer for staff to find the information they needed.

# Community-based mental health services for older people

## Is the service effective?

**Good** ●

We have not rated effective before. We rated it as good because:

- All patients had a comprehensive mental health assessment in place and it was clear that mental health and physical health needs were being met.
- Staff had the right training, qualifications and experience to enable them to do their jobs effectively.
- Staff and teams came together from different professions to provide an effective multi-disciplinary approach to their work, both internally and with external teams and organisations.
- Staff had a good understanding of the Mental Health Act and Code of Practice and Mental Capacity Act.
- The service offered a wide range of appropriate interventions to meet the needs of all patients.

## Is the service caring?

**Good** ●

We have not rated caring before. We rated it as good because:

- Staff were extremely caring, compassionate and supportive towards their patients. They had a good understanding of their needs and supported patients to be as involved in their care as possible.
- Staff made themselves available if patients, families or carers needed them. It was clear that staff put their patients first.
- Staff involved families and carers whenever it was appropriate.

However:

- We found that staff were not routinely recording that they had offered patients a copy of their care plan.

## Is the service responsive?

**Good** ●

We have not rated responsive before. We rated it as good because:

- Patients accessing community mental health services for older people could do so quickly. The service operated a duty system which gave immediate access to assessment and treatment.
- Staff, including doctors, could see patients urgently on the same day where it was assessed as necessary.
- Staff were undertaking effective community engagement work to enable them to meet the needs of the diverse local communities.
- Staff offered a flexible approach to appointments and locations which enabled patients and carers with mobility problems the chance to engage fully in services.



# Community-based mental health services for older people

- The service worked closely with other local service providers which enabled them to offer a seamless service where patients care overlapped.

However:

- Access to a memory assessment in Bradford and South and West was sometimes delayed due to long waiting lists. A small number of patients waited between 24 and 28 weeks in South and West but if a patient's condition deteriorated they could be prioritised and seen sooner. Commissioning of these services was different across the trust areas and there is already a plan in place to bring these into line with each other, and effectively manage the waiting times.

## Is the service well-led?

**Good** ●

We have not rated well-led before. We rated it as good because:

- Team leaders were well thought of and clearly offered teams a lot of support and encouragement. They had knowledge and experience and had a good understanding of the services they managed.
- Staff said they felt respected supported and valued and managers spoke highly of staff.
- Staff told us that immediate line managers were always visible and approachable, and they told us that they knew how to contact a senior leader who would respond if they needed support.
- The trust and the service had implemented systems to ensure good governance was possible and we saw evidence of these systems being utilised.
- Team leaders and managers were aware of the concerns we raised and were implementing plans to make improvements.
- Staff and teams were working with the local university to research and improve practice in their area of work.

## Areas for improvement

We found things that the trust should improve to comply with a minor breach that did not justify regulatory action, to prevent breaching a legal requirement, or to improve service quality.

For more information, see the Areas for improvement section of this report.

# Wards for people with a learning disability or autism

Good  

## Key facts and figures

Bradford District Care NHS Foundation Trust provide one inpatient ward for people with a learning disability or autism. The ward is located at Lynfield Mount hospital in Bradford.

Lynfield Mount hospital has been registered with the Care Quality Commission since 2010 to carry out the following regulated activities:

- assessment and treatment for persons detained under the Mental Health Act 1983
- treatment of disease, disorder or injury
- accommodation for persons who require treatment for substance misuse
- accommodation for persons who require nursing and personal care
- diagnostic and screening procedures.

The Highfields assessment and treatment ward is a purpose built inpatient service, which is able to provide care to a maximum of six male or female patients.

The ward was able to admit patients who were detained for treatment under the Mental Health Act (1983), or those with deprivation of liberty safeguards in place. There were no informal patients admitted to the ward at the time our inspection, all patients were detained under the Mental Health Act.

We carried out a Mental Health Act monitoring visit at the Highfields assessment and treatment ward in February 2018. Following this visit, the trust provided an action statement telling us how they would improve the service and improve adherence to the Mental Health Act and Mental Health Act Code of Practice.

We last inspected the inpatient wards for people with a learning disability or autism in November 2017. We rated this service as 'requires improvement' overall with ratings of 'good' in the caring and responsive key questions, and requires improvement in safe, effective and well-led.

This inspection was completed on 12 March 2019. It was an unannounced inspection and we inspected all key lines of enquiry in the five domains (safe, effective, caring, responsive and well-led).

Before the inspection visit, we reviewed information that we held about these services and requested information from the trust.

During the inspection visit, the inspection team;

- visited the ward, looked at the quality of the environments and observed how staff were caring for patients
- spoke with four patients who were using the service, and reviewed their comments on two feedback cards
- spoke with six carers of patients who were using the service
- spoke with senior service managers, and the clinical manager, ward manager and responsible clinician
- spoke with eight other staff members including nurses, healthcare support workers, an occupational therapist, a psychologist and occupational therapy assistants
- looked at the care and treatment records of two patients

# Wards for people with a learning disability or autism

- reviewed medication management including the medication administration records of all six patients
- attended and observed one ward handover meeting
- looked at policies, procedures and other documents relating to the running of the service.

## Summary of this service

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

- The service provided safe care. The ward environments were safe and clean. The wards had enough nurses and doctors. Staff assessed and managed risk well, managed medicines safely, followed good practice with respect to safeguarding and minimised the use of restrictive practices. Staff had the skills required to develop and implement good positive behaviour support plans to enable them to work with patients who displayed behaviour that staff found challenging.
- Staff developed holistic, recovery-oriented care plans informed by a comprehensive assessment. They provided a range of treatments suitable to the needs of the patients cared for in a ward for people with a learning disability (and/or autism) 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 ensured that these staff received training and appraisal. The ward staff worked well together as a multi-disciplinary team and with those outside the ward who would have a role in providing aftercare.
- 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 actively involved patients and families and carers in care decisions.
- Staff planned and managed discharge well and liaised well with services that would provide aftercare. As a result, discharge was rarely delayed for other than a clinical reason.
- The service worked to a recognised model of mental health rehabilitation. It was well led and the governance processes ensured that ward procedures ran smoothly.

However:

- Staff did not review the blanket restriction mandated by the trust in relation to bathrooms and shower rooms.
- The trust did not have an effective system to record and monitor supervision. The service did not have local arrangements to support that staff received regular supervision in line with trust policy.

## Is the service safe?

Good  

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

- The ward was safe, clean, well equipped, well furnished, well maintained and fit for purpose.

# Wards for people with a learning disability or autism

- The service had enough nursing and medical staff, who knew the patients and received basic training to keep people safe from avoidable harm.
- Staff assessed and managed risks to patients and themselves well.
- Staff had the skills required to develop and implement good positive behaviour support plans and followed best practice in anticipating, de-escalating and managing challenging behaviour.
- Staff understood how to protect patients from abuse and/or exploitation and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and/or exploitation and they knew how to apply it.
- Staff had easy access to clinical information and it was easy for them to maintain high quality clinical records – whether paper-based or electronic.
- Staff followed best practice when storing, dispensing, and recording the use of medicines. Staff regularly reviewed the effects of medications on each patient’s physical health. They were aware of, and worked towards achieving the aims of, the STOMP programme (stop over-medicating people with a learning disability).
- The wards had a good track record on safety. 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.

However:

- Staff did not review the blanket restriction mandated by the trust in relation to bathrooms and shower rooms.

## Is the service 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 were reviewed regularly through multidisciplinary discussion and updated as needed. Care plans reflected the assessed needs, were personalised, holistic 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. This included access to psychological therapies to support for self-care and the development of everyday living skills and to meaningful occupation. Staff 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. Staff participated in clinical audit.
- The ward team included or had access to the full range of specialists required to meet the needs of patients on the ward. Managers made sure they had staff with a range of skills needed to provide high quality care. They supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.
- 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 team had effective working relationships with staff from services that would provide aftercare following the patient’s discharge and engaged with them early on in the patient’s admission to plan discharge.

# Wards for people with a learning disability or autism

- 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 provider's policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly for patients who might have impaired mental capacity.

However:

- Staff told us that they received regular supervision however the trust did not have in place an effective system to record and monitor supervision.

## Is the service caring?

**Good** ● → ←

Our rating of caring stayed the same. We rated it as good because:

- 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.

## Is the service responsive?

**Good** ● → ←

Our rating of responsive stayed the same. We rated it as good because:

- Staff planned and managed discharge well. They liaised well with services that would provide aftercare and were assertive in managing the discharge care pathway. Patients did not have excessive lengths of stay.
- The design, layout, and furnishings of the ward/service supported patients' treatment, privacy and dignity. Each patient had their own bedroom and could keep their personal belongings safe. There were quiet areas for privacy.
- The food was of a good quality and patients could access hot drinks and snacks at any time.
- The wards met the needs of all people who use the service – including those with a protected characteristic. Staff helped patients with communication, advocacy and cultural and spiritual support.

## Is the service well-led?

**Good** ● ↑

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

# Wards for people with a learning disability or autism

- Leaders had a good understanding of the service they managed and how it supported the aims of the transforming care programme. Leaders had the skills, knowledge and experience to perform their roles, were visible in the service and approachable for patients and staff.
- Staff knew and understood the provider'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 provider 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.
- Our findings from the other key questions demonstrated that most governance processes operated effectively at ward level and that performance and risk were managed well.
- Ward teams had access to the information they needed to provide safe and effective care and used that information to good effect.

However:

- There was insufficient oversight of staff supervision and systems in place were not effective to monitor the uptake of supervision by staff. Ward staff did not record on the trust's central database when they had undertaken supervision.

## Areas for improvement

We found things that the trust should improve to comply with a minor breach that did not justify regulatory action, to prevent breaching a legal requirement, or to improve service quality.

For more information, see the Areas for improvement section of this report.

# Mental health crisis services and health-based places of safety

Good  

## Key facts and figures

The crisis service delivered by Bradford District Care NHS Trust was made up of two intensive home treatment teams, two health based place of safety suites and a 'First Response' team that spanned the whole service. Staff were also based in the two hospitals to deliver the psychiatric liaison service.

Bradford District Care NHS Foundation Trust Crisis Service mental health crisis services and health-based places of safety are based across two sites, one at Lynfield Mount hospital in Bradford and the other at the Airedale Centre for Mental Health in Keighley.

Lynfield Mount Hospital and the Airedale Centre for Mental Health have been registered with the Care Quality Commission since 2010 to carry out the following regulated activities:

- assessment and treatment for persons detained under the Mental Health Act 1983
- treatment of disease, disorder or injury
- diagnostic and screening procedures
- accommodation for persons who require treatment for substance misuse
- accommodation for persons who require nursing and personal care.

We last inspected the service in October 2017. We rated the service as requires improvement in the safe and well led key question, and rated the service as good in effective, caring, and responsive key questions.

Our inspection was announced the day before we arrived on site (staff knew we were coming) to ensure that everyone we needed to talk to was available and the service could arrange for us to observe staff and patient interactions.

This inspection was completed on the 5 – 7 March 2019. We inspected all key lines of enquiry in the five domains (safe, effective, caring, responsive and well-led).

Before the inspection visit, we reviewed information that we held about these services and requested information from the trust.

During the inspection visit, the inspection team:

- looked at the quality of the environments
- observed how staff were caring for patients
- spoke with five patients who were using the service
- spoke with three service managers
- spoke with 16 other staff members including nurses, healthcare support workers, a social worker employed by the local authority, tele coaches and triage staff
- looked at the care and treatment records of 17 patients
- reviewed 20 section 136 records
- reviewed medication management



# Mental health crisis services and health-based places of safety

- attended and observed a handover meeting
- looked at policies, procedures, team meeting minutes and other documents relating to the running of the service
- pathway tracked three patients in depth
- attended four home visits.

## Summary of this service

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

- People in the area were receiving an effective 24/7 crisis response. Those in immediate risk could be seen and responded to immediately. Peoples' risks were consistently managed and any changing risks were considered and addressed through effective handover meetings.
- People had access to a full pathway of care from the first call or referral, including identification of risks, completion of a comprehensive assessment and interventions delivered all in a timely manner.
- Staff were skilled and able to deliver best practice interventions to people accessing the service. Staff were using innovative approaches of working with patients using technology. The needs of the families were consistently considered and the teams were looking at ways in which family members could be further supported.
- Patients were supported to access resources in the community and to look at ways in which they could keep themselves well. The service worked well with other teams within the trust and with external partners such as the police, local authority and the ambulance service to ensure that new ways of helping people were always being explored.
- All teams had effective leadership who understood the needs of staff and patients. Staff felt supported and staffing levels were managed. Systems and processes were generally well established and operated effectively to assess and manage risk and improve the quality of the service.

However:

- Staff were not up to date with ten of the role specific training courses, which included safeguarding children, basic life support and immediate life support.
- Staff did not feel informed about several serious incidents which had occurred in the previous 12 months. Investigations from serious incidents were not effectively communicated to staff and staff were unclear as to the actions and learning from these incidents. Incidents were not always categorised by staff appropriately which meant they were not investigated as they should have been in line with the trust's policy.
- The trust was not collecting data to monitor the effectiveness of the service. The local managers understood the running of the service on a day to day basis, but this did not form any key performance indicator monitoring.
- There were some issues with the patient record system which meant that information was not always stored in the correct place. The trust was aware of the issues and were working on ways to improve this for staff and patients.

## Is the service safe?

**Requires improvement**   

# Mental health crisis services and health-based places of safety

Our rating of safe stayed the same. We rated it as requires improvement because:

- The trust did not ensure that incidents were categorised, reviewed and investigated appropriately. The trust did not ensure that staff learned from incidents including the 11 serious incidents which had taken place in this service.
- The service was not compliant with ten of the role specific training courses. This included basic life support, immediate life support and safeguarding children.

However:

- Staffing levels and skill mix were planned, implemented and reviewed to keep people safe. Any staff shortages were responded to quickly and adequately.
- Safeguarding vulnerable adults, children and young people was given sufficient priority. Staff took a proactive approach to safeguarding and focused on early identification. There was active and appropriate engagement in local safeguarding procedures and effective work with other relevant organisations.
- Risks to people who used the services were assessed, monitored and managed on a day-to-day basis. These included signs of deterioration in a patient's mental health which meant they needed to be seen sooner or more often. People were involved in managing risks and risk assessments were person-centred, proportionate and reviewed regularly.

## Is the service effective?

**Good** ● → ←

Our rating of effective stayed the same. We rated it as good because:

- People had a comprehensive assessment of their needs, which included consideration of clinical needs, mental health, physical health and wellbeing. The expected outcomes were identified and care and treatment was regularly reviewed and updated.
- Staff were qualified and had the skills they needed to carry out their roles effectively and in line with best practice. Staff received regular supervision and appraisals in line with the trust policy and were supported to maintain and further develop their professional skills and experience.
- There were effective handovers and shift changes, to ensure that staff managed risks to people who use services. When people received care from a range of different staff, teams or services, this was coordinated. Staff worked collaboratively to understand and meet the range and complexity of people's needs.

However:

- Care planning was not contained in a standard format in the new electronic record system and did not demonstrate that patients had a copy despite them being involved in developing the care plan. The service was addressing this with key personnel from the trust.

## Is the service caring?

**Good** ● → ←

Our rating of caring stayed the same. We rated it as good because:

- Feedback from people who used the service was positive and patients felt supported by staff.

# Mental health crisis services and health-based places of safety

- People were treated with dignity, respect and kindness during all interactions with staff and relationships with staff were positive. People felt supported and said staff cared about them.
- Staff helped people and those close to them to cope emotionally with their care and treatment. People's social needs were understood. People were supported to maintain and develop their relationships with those close to them, their social networks and community. They were encouraged to manage their own health and care when they could.

## Is the service responsive?

Good ● → ←

Our rating of responsive stayed the same. We rated it as good because:

- People could access the right care at the right time. Access to care was managed to take account of people's needs, including those with urgent needs. The appointments system was easy to use and supported people to access support quickly. People were kept informed of any disruption to their care or treatment.
- The involvement of other organisations and the local community was integral to how services were planned and delivered. There were innovative approaches to providing integrated person-centred pathways of care that involved other service providers, particularly for people with multiple and complex needs.
- There was active review of complaints which were effectively managed and responded to, and improvements were made as a result across the services.

However:

- Data around waiting times for initial assessments was not monitored by the trust.

## Is the service well-led?

Good ● ↑

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

- The leadership team for the local services were knowledgeable about quality issues and priorities. Managers understood what the challenges were for the team were and acting to address them.
- Local leaders prioritised safe, high quality, compassionate care and promoted equality and diversity. Leaders modelled and encouraged cooperative, supportive relationships among staff so that they felt respected, valued and supported.
- There was a strong focus on innovation within all teams with staff being supported to improve the service.
- Managers of the local services used performance information to monitor the effectiveness of the service.

However:

- Managers had not ensured that all staff completed mandatory training.
- The trust did not have an effective system to learn from serious incidents which impacted on this core service.

# Mental health crisis services and health-based places of safety

## Outstanding practice

We found examples of outstanding practice in the trust's mental health crisis services and health-based places of safety. For more information, see the outstanding practice section of this report.

## Areas for improvement

We found areas for improvement that the trust must put right. We also found things that the trust should improve to comply with a minor breach that did not justify regulatory action, to prevent breaching a legal requirement, or to improve service quality.

For more information, see the Areas for improvement section of this report.

# Wards for older people with mental health problems

Requires improvement   

## Key facts and figures

Bradford District Care NHS Foundation Trust provides inpatient care for older people across two wards. The Dementia Assessment Unit at Lynfield Mount Hospital and Bracken Ward at the Airedale Centre for Mental Health.

Lynfield Mount hospital and the Airedale Centre for Mental Health have been registered with the Care Quality Commission (CQC) since 2010 to carry out the following regulated activities:

- assessment and treatment for persons detained under the Mental Health Act 1983
- treatment of disease, disorder or injury
- accommodation for persons who require treatment for substance misuse
- accommodation for persons who require nursing and personal care
- diagnostic and screening procedures

The Dementia Assessment unit provides 24-hour care to support people presenting with behavioural and psychological symptoms associated with dementia. Assessment and treatment is provided by a multidisciplinary team which includes consultant psychiatrists, nurses, physiotherapists and occupational therapists.

The Dementia Assessment Unit is located at Lynfield Mount Hospital.

Bracken Ward provides 24-hour inpatient care for anyone over the age of 65 who is experiencing acute mental health issues. Assessment and treatment are provided to support older people with the symptoms associated with acute mental health. The multi-disciplinary team includes registered mental health nurses, healthcare support workers and occupational therapists supporting with personal care and structuring the day to support with recovery.

Bracken ward is based at the Airedale Centre for Mental Health which is located on the Airedale General Hospital site.

Both wards have 22 beds for males and females.

Our Mental Health Act reviewers visited Bracken Ward in December 2017 and the Dementia Assessment Unit in January 2019. They assessed the adherence of the service to the Mental Health Act and Code of Practice. During the visit in January 2019 they found concerns relating to; the reading of patients' rights, information regarding advocacy, blanket restrictions, detention records and capacity to consent to treatment, involvement with relatives and carers and discharge planning. The trust had not yet submitted their action statement following the visit in January 2019 which tells us how they would make improvements.

We last inspected the inpatient wards for older people in November 2017. We rated this service as 'requires improvement' overall with ratings of 'good' in the caring and responsive key questions, and 'requires improvement' in safe, effective and well-led.

This inspection was completed on 12 and 13 March 2019. Our inspection was unannounced and we inspected all key lines of enquiry in the five domains (safe, effective, caring, responsive and well-led).

Before the inspection visit, we reviewed information that we held about these services and requested information from the trust.

During the inspection visit, the inspection team;

# Wards for older people with mental health problems

- visited both wards, completed a tour of the environment and observed how staff were caring for patients
- spoke with two ward managers
- spoke with 11 other staff including a consultant psychiatrist, junior doctor, pharmacist, occupational therapists, activity co-ordinator, registered nurses and healthcare support workers
- spoke with five patients
- spoke with six carers or relatives of patients using the service and reviewed four comment cards
- looked at the care and treatment records of eight patients
- looked at medication management and medication administration records
- observed one ward round
- observed two safety huddles
- observed mealtimes on both wards and a range of activities including music therapy and a meditation group
- looked at a range of policies, procedures and other documents relating to the running of the service.

## Summary of this service

Our rating of this service stayed the same. We rated it as requires improvement because:

- Staff did not always follow their processes for maintaining and checking emergency equipment and drugs. Also, staff did not always follow best practice when dispensing and recording medication to reduce the risk of error and patient harm.
- Staff had implemented blanket restrictions on both wards including the use of plastic cups, locked bedroom doors and outdoor spaces on the Dementia Assessment Unit and daily room searches on Bracken Ward with no audit or review.
- Not all staff understood the Mental Capacity Act. Staff did not record capacity and best interest decisions in some patients' records. Staff did not make deprivation of liberty safeguards applications when needed. Staff did not monitor the progress of applications to supervisory bodies.
- Staff reported issues with the entering and accessing of information on the new electronic patient record system.
- Trust governance processes were not always effective in ensuring staff applied policy and practice consistently across the services. There was lack of evidence of mental capacity compliance audits and there was no overarching policy for the management of 'guest' patients on Bracken Ward.

However:

- Patients assessments were comprehensive, evidence based and contained detailed physical health assessments. Care plans and risk assessments were holistic and reflected individual patient need.
- Ward environments were accessible to all patients including patients who had difficulties with mobility or a disability. There was a range of facilities available to patients and a range of inclusive activities.
- Both wards were clean, well equipped, well furnished, well maintained and fit for purpose.

# Wards for older people with mental health problems

- Staff involved patients and their carers and families in all aspects of their care. Patients and carers told us they were treated with kindness, dignity and respect and staff demonstrated a knowledge and awareness of the individual needs of patients.
- Managers made sure staff teams incorporated a range of skills needed to provide high quality care. Staff were supported with regular appraisals, supervision, team meetings and opportunities to develop and innovate.
- Concerns and complaints were taken seriously. Staff had a good understanding of the duty of candour. Complaints would be investigated, lessons learnt and shared.
- Managers had processes and procedures in place to monitor and meet key performance indicators in relation to training, supervision, appraisals and bed management.

## Is the service safe?

**Requires improvement** ● → ←

Our rating of safe stayed the same. We rated it as requires improvement because:

- Staff did not always maintain equipment well or keep it clean. We found gaps in the weekly checking of emergency equipment and drugs and staff had failed to replace items that were out of date or missing.
- Staff did not always follow best practice when dispensing, and recording medication.
- Staff applied some blanket restrictions on both wards.
- Staff kept detailed records of patients' care and treatment but due to a recent change with the trust's electronic patient record system records were not always in the correct place and not easily available to all staff giving care.

However:

- Staff completed and updated risk assessments for each patient and used a range of recognised risk assessment tools to assess and manage risk.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so.
- The wards managed patient safety incidents well and staff understood the duty of candour.
- Both wards were clean, well equipped, well furnished, well maintained and fit for purpose.

## Is the service effective?

**Requires improvement** ● → ←

Our rating of effective stayed the same. We rated it as requires improvement because:

- Staff understanding of the trust policy on the Mental Capacity Act was varied and we found assessment and recording of capacity and best interest decision making missing in some patients' records.
- Staff did not always make deprivation of liberty safeguards applications when needed and did not always monitor the progress of applications to supervisory bodies.
- The trust's quarterly Care Programme Approach audit was not effective in ensuring that the Mental Capacity Act was being applied correctly.

# Wards for older people with mental health problems

However:

- Staff assessed the physical and mental health of all patients on admission. The plans were personalised, holistic and recovery-oriented.
- Staff provided a range of treatment and care for patients based on national guidance and best practice.
- Managers made sure they had staff with a range of skills needed to provide high quality care. They supported staff with appraisals, supervision, as well as opportunities to update and further develop their skills.
- Staff from different disciplines worked together as a team to benefit patients.
- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice. Managers made sure that staff could explain patients' rights to them.

## Is the service caring?

**Good** ● → ←

Our rating of caring stayed the same. We rated it as good because:

- The staff treated patients with compassion and kindness and respected patients' privacy and dignity, and supported their individual needs.
- Staff involved patients and those close to them in decisions about their care, treatment and changes to the service.
- Feedback from the patient and carer surveys was almost entirely positive.

## Is the service responsive?

**Good** ● → ←

Our rating of responsive stayed the same. We rated it as good because:

- A discharge co-ordinator role complemented the team on the Dementia Assessment Unit to support the discharge pathway.
- Staff and patients had access to the full range of rooms and equipment to support treatment and care including activity space, occupational kitchens and outdoor space.
- The service was accessible to all who needed it and took account of patients' individual needs.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff.

However:

- The trust used Bracken Ward to 'guest' patients from the acute wards for adults of working age. There was a local working procedure but no overarching policy.

## Is the service well-led?

**Requires improvement** ● → ←



# Wards for older people with mental health problems

Our rating of well-led stayed the same. We rated it as requires improvement because:

- The service did not have effective systems to ensure that equipment and medication were suitably maintained.
- Not all staff understood the Mental Capacity Act. The service did not have effective systems to monitor adherence to the Mental Capacity Act. We did not find evidence that staff undertook or took part in local compliance audits in relation to the Mental Capacity Act.
- Despite Bracken Ward establishing local procedures regarding the management of 'guest' patients the trust did not have an overarching policy.
- The introduction of a new electronic patient record system had caused issues with the entering and accessing of information.
- The certificate for the Stirling Centre Accreditation for Dementia Friendly Design had expired and the Dementia Assessment Unit had not completed the re-auditing process.

However

- Senior managers promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.
- Ward managers had processes and procedures in place to monitor and meet key performance indicators and held regular safety huddles and staff meetings.
- The trust engaged staff, patients and carers and had good systems in place to support volunteers in services.
- Staff could discuss opportunities for improvement, training and innovation and were supported to develop these.

## Areas for improvement

We found areas for improvement that the trust must put right. We also found things that the trust should improve to comply with a minor breach that did not justify regulatory action, to prevent breaching a legal requirement, or to improve service quality.

For more information, see the Areas for improvement section of this report.

This section is primarily information for the provider

## Requirement notices

### Action we have told the provider to take

The table below shows the legal requirements that the service provider was not meeting. The provider must send CQC a report that says what action it is going to take to meet these requirements.

For more information on things the provider must improve, see the Areas for improvement section above.

**Please note:** Regulatory action relating to primary medical services and adult social care services we inspected appears in the separate reports on individual services (available on our website [www.cqc.org.uk](http://www.cqc.org.uk))

**This guidance** (see [goo.gl/Y1dLhz](http://goo.gl/Y1dLhz)) describes how providers and managers can meet the regulations. These include the fundamental standards – the standards below which care must never fall.

#### Regulated activity

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Treatment of disease, disorder or injury

#### Regulation

Regulation 9 HSCA (RA) Regulations 2014 Person-centred care

#### Regulated activity

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Treatment of disease, disorder or injury

#### Regulation

Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect

#### Regulated activity

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Treatment of disease, disorder or injury

#### Regulation

Regulation 11 HSCA (RA) Regulations 2014 Need for consent

#### Regulated activity

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Treatment of disease, disorder or injury

#### Regulation

Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

#### Regulated activity

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Treatment of disease, disorder or injury

#### Regulation

Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment

This section is primarily information for the provider

## Requirement notices

### Regulated activity

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Treatment of disease, disorder or injury

### Regulation

Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment

### Regulated activity

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Treatment of disease, disorder or injury

### Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance

### Regulated activity

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Treatment of disease, disorder or injury

### Regulation

Regulation 18 HSCA (RA) Regulations 2014 Staffing

This section is primarily information for the provider

## Enforcement actions

We took enforcement action because the quality of healthcare required significant improvement.

### Regulated activity

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Treatment of disease, disorder or injury

### Regulation

Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

### Regulated activity

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Treatment of disease, disorder or injury

### Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance

# Our inspection team

Jenny Wilkes, Head of Hospital Inspection, led this inspection. Two executive reviewers and a specialist advisor supported our inspection of well-led for the trust overall.

The inspection team included one inspection manager, 13 inspectors, one pharmacist specialist, one Mental Health Act reviewer, three assistant inspectors, one analyst, one inspection planner, two executive reviewers, 18 specialist advisers, and one expert by experience.

Executive reviewers are senior healthcare managers who support our inspection of the leadership of trusts. Specialist advisers are experts in their field who we do not directly employ. Experts by experience are people who have personal experience of using or caring for people who use health and social care services.