Good

Bradford District Care Trust

Quality Report

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Core services inspected	CQC registered location	CQC location ID
Adult admission wards	**Airedale Centre for Mental Health** **Lynfield Mount**	**TAD54** **TAD17**
Psychiatric Intensive Care Units and Health Based Places of Safety	**Airedale Centre for Mental Health** **Lynfield Mount**	**TAD54** **TAD17**
Services for Older People	**Airedale Centre for Mental Health** **Airedale General Hospital**	**TAD54** **TADY6**
Long stay/ Forensic/Secure services	**Lynfield Mount**	**TAD17**
Children and adolescent mental health services (CAMHS)	**BDCT Headquarters, New Mill**	**TADHQ**
Learning Disability Services	**Lynfield Mount** **Waddiloves Health Centre**	**TAD17** **TAD25**
Community based mental health crisis services	**BDCT Headquarters, New Mill**	**TADHQ**
Adult community mental health services	**BDCT Headquarters, New Mill**	**TADHQ**
Community health services for adults	**BDCT Headquarters, New Mill** **Wrose Health Centre** **Kensington Street Health Centre** **Barkerend Health Centre** **Holmewood Health Centre** **Horton Park Medical Centre** **Royds Healthy Living Centre** **Shipley Health Centre**	**TADHQ** **TADX9** **TADX8** **TADX7** **TADX5** **TADY4** **TADY5** **TADX4**

Summary of findings

	Westbourne Green Community Health Care Centre **Keighley Health Centre**	**TADX6** **TAD73**
Community health services for children, young people and families	**Barkerend Health Centre** **Holmewood Health Centre** **Keighley Health Centre** **Shipley Health Centre** **Westbourne Green Community Health Care Centre**	**TADX7** **TADX5** **TAD73** **TADX4** **TADX6**
End of life care	**Keighley Health Centre** **Airedale General Hospital**	**TAD73** **TADY6**

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

Summary of findings

Ratings

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

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

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

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

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

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

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Overall summary

We found that the trust was providing a good service to the population that it served. Within all the core services inspected we saw evidence of good practice. This was being delivered by caring and professional staff who were working collaboratively.

We saw that the trust was not always providing a safe service for people across some of the services it provided. This included the children and adolescent mental health service, the long stay/forensic/secure mental health service and the health based place of safety. We identified robust systems in place for managing risks within the trust. Clear protocols were established for the identification and investigation of safeguarding concerns. Staff were aware of their role in proactively identifying and reporting risks. However within the children's and young people's community service, staff we spoke with were concerned about the low number of new referrals accepted by the local authority, which they felt placed them at risk. The trust told us they will undertake a review of these concerns and talk with the local authority. We also found that in the children and adolescent mental health service and the long stay/forensic/secure services that risks were not always fully assessed or reviewed by staff. We have issued a compliance action in relation to the health based place of safety due to issues with ligature risks and received assurances that these risks would be addressed. We did not find wider organisational or systemic concerns about safety.

Overall, trust staff adhered to the requirements of the Mental Capacity Act 2005 to assess capacity to consent and work within best interest considerations where people lacked capacity; but in community health and learning disabilities services this could not always be evidenced. We visited most of the wards at each location where detained patients were being treated. In the majority of the care records we reviewed, which related to the detention, care and treatment of detained patients, the principles of the Mental Health Act (MHA) and the MHA Code of practice had been followed and adhered to.

We saw that the trust was providing evidence based treatments in line with best practice guidance. We saw that people were being supported to make choices and gave informed consent where possible. Evidence was seen of effective outcome measures being used throughout the trust in most of the services. The exceptions were within learning disability services where outcomes were unclear and assessments of capacity were not detailed and community health services where we found similar issues regarding capacity assessments and supervision of staff was not always occurring. The trust employed appropriately qualified and trained staff throughout their services. There were good systems to ensure adherence with the Mental Health Act 1983 when people were compulsorily detained.

We saw that overall the trust was providing a caring service for people across all core locations. Throughout the inspection we saw examples of staff treating people with kindness, dignity and compassion. The feedback received from people who used services and their visitors was generally positive about their experiences of the care and treatment provided by the trust.

We saw that the trust was not always responsive to people's needs across some of the services it provided but this appeared to be a transient problem due to the development of administrative hubs. Throughout the inspection we noted that the trust had organised services so that they met the needs of the local population based on the resources it had. We saw outstanding care for people receiving end of life care. Patients were highly complementary of the service and confirmed they had received a coordinated and seamless service with 24 hour access to 'The Gold Line' service. We found that mostly people's individual needs and wishes were met when the trust assessed, planned and delivered care and treatment to people. However recent changes to services including integrated care, single point of access and a move to administrative hubs meant that people had experienced (and still had to experience) longer than necessary delays in getting the care and treatment they required, particularly on the acute mental health wards and in community health services. Service users reported difficulty accessing crisis mental health services at night. The crisis team offered only telephone contact at night. Those who needed immediate assessment were directed to the emergency department at Bradford Royal Infirmary

Summary of findings

and Airedale General Hospital; where they might have to wait a long time to be assessed by the liaison psychiatry team because these services were not commissioned on a 24 hour basis.

We saw that overall the trust was well led with proactive and responsive trust wide leadership. There was a clear governance arrangements in place that supported the safe delivery of the service and to monitor and improve trust performance. Lines of communication from the board and senior managers to frontline services were mostly effective. Staff felt engaged with the trust and were well supported by local managers. We saw some recent good examples where board members spent time within services to understand the challenges faced and were actively engaging with front line staff including clinical buddying, walk abouts by the non executive directors and the culture conversations initiated recently by the chief executive officer. Staff felt well supported by their immediate line managers. However the organisations vision and values were not fully embedded across all community health teams. The recent scale and pace of change within the organisation was continuing to cause difficulties for the front line community mental health team staff. There had not been the appropriate level of engagement from leaders to ensure that this change was managed well. The scale and pace of change had also caused difficulties for service users in terms of accessing services and communicating with people within teams. We saw that there had been some recent improvements and a commitment to make these changes work including increasing trust board oversight and ownership of these issues.

Summary of findings

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

We always ask the following five questions of the services.

Are services safe?

Requires Improvement

There were systems in place to identify and investigate incidents within the inpatient and community settings. The trust was a high reporter of incidents which showed that they recognise when incidents occur and report them properly. We saw evidence that care staff learned from incidents and that this had resulted in changes to practice. There had been no 'never events'.

The trust had an identified safeguarding lead and well developed systems for ensuring that abuse was recognised, reported upon and investigated appropriately. Staff showed good awareness of safeguarding arrangements.

People received care in safe and suitable premises. The only exception was the care environment of the places of safety at Lynfield Mount and Airedale centre for Mental Health Hospitals which did not fully meet the current good practice guidance.

There was a trust-wide risk register and Board assurance framework, and the trust had structures in place to ensure that all risks were recorded and categorised. We found that there was a consistent approach across the trust to the use of risk assessments to keep people safe; however, risk assessments weren't always evident in the low secure service before people received leave.

Staffing levels were usually maintained at the level set by the trust. However there were times when staffing levels were stretched and people's needs were not always met on the low secure services. We saw, for example, that planned activities did not always take place and section 17 leave was cancelled when staffing levels were affected by short term absence on the low secure wards.

Staffing levels within the district nursing service were safe and, while there were vacancies in some community teams, there was ongoing monitoring to make sure that staffing levels were flexible and met the dependency needs of patients.

Are services effective?

Good

We saw that the trust was providing evidence based treatments in line with best practice guidance. We saw that people were being supported to make choices. Evidence was seen of outcome measures being used throughout the trust in most of the services. The exceptions were within learning disability and community health services where outcomes were unclear and assessments of capacity were not detailed.

Summary of findings

The trust employed appropriately qualified and trained staff throughout their services. There were good systems to ensure adherence with the Mental Health Act 1983 when people were compulsorily detained.

We found good evidence that in community services the children's and young family's service reviewed and implemented national good practice guidelines. The trust had also successfully implemented evidenced-based programmes such as the family nurse partnership programme.

We also found evidence that patients approaching the end of life were identified in the right way. Care, including effective pain relief, was delivered according to their personal care plans, which were regularly reviewed. Patients in the last days of life were identified quickly and appropriate action was taken.

We found within community adults and end of life services the majority of staff were up-to-date with mandatory training and there were systems in place to make sure that staff received regular appraisals. However, we found the clinical supervision of staff varied across the service and some staff did not have regular protected time to reflect on clinical practice.

Are services caring?

Good

Overall the trust was providing a caring service for people across all core locations. Throughout the inspection we saw examples of staff treating people with kindness, dignity and compassion.

We observed that staff were compassionate and caring towards people who used the service. The feedback received from people who used services and their visitors was generally positive about their experiences of the care and treatment provided by the trust. Where people could not speak with us, for example in learning disability and older people's services, we saw positive and warm interactions through using a formal framework – the Short Observational Framework for Inspection (SOFI) - for observing care when people cannot communicate their views.

Most people felt that they were involved in their care.

We saw that there was good handover of patient information from inpatient teams to community/crisis teams. Most staff were knowledgeable about people's needs. People had access to advocacy when they were in-patients, including specialist advocacy for people with learning disabilities to facilitate effective participation.

Summary of findings

Staff were also aware of the emotional aspects of caring for people and made sure that specialist support was provided for people where needed

We saw examples of outstanding involvement initiatives in some of the mental health services, including CAMHS services, early intervention service, and the employment of service user development workers. Involvement initiatives within community mental health services were more limited.

Are services responsive to people's needs?

Good

We saw outstanding care for people receiving end of life care. Patients were highly complementary of the service and confirmed they had received a coordinated and seamless service with 24 hour access to 'The Gold Line' service. The service understood the different needs of people it served and planned, designed and delivered services to meet those needs. There were systems in place to ensure patients were able to access the right care at the right time and services were flexible enough to fit in with patients and their family's lifestyles.

We found that mostly people's individual needs and wishes were met when the trust assessed, planned and delivered care and treatment to people. However recent changes to services including integrated care, single point of access and move to administrative hubs meant that some people had experienced (and still had to experience) longer than necessary delays in getting the care and treatment they required, particularly on the acute mental health wards and in community health services. We found there were delays in referrals from the administration hubs to community teams for adults and children and young people as a result people experienced delays to care and treatment.

The environments across the services afforded dignified care and promoted people's dignity including through the provision of individual en suite bedrooms in in-patient areas with the exception of the health based place of safety and the areas that the trust staff use within Bradford Royal Infirmary's A and E to assess people in crisis.

Service users reported difficulty accessing crisis mental health services at night. The crisis team offered only telephone contact at night. Those who needed immediate assessment were directed to the Emergency Department at Bradford Royal Infirmary and Airedale General Hospital; where they might have to wait a long time to be assessed by the liaison psychiatry team because these services were not commissioned on a 24 hour basis.

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Over half of complaints received and investigated in 2013-14 were upheld. Themes from complaints we reviewed during our inspection, included pressures on community mental health services and changes in the way of working which the trust was actively managing. People using the service knew how to raise complaints and concerns. Information on how to make a complaint was displayed in most areas. The trust ensured that learning from comments, complaints, compliments and concerns were embedded in their governance processes.

The trust was therefore not always responsive to people's needs across some of the services it provided. Recent changes and improvements to the single point of access and administrative hubs should help to make the trust more responsive in the near future.

Are services well-led?

Good

The trust had a 'vision wheel' which had been developed three years ago which articulated a well-developed vision and values. At a recent Monitor governance review it was identified that it was unclear how vision, values and objectives were translated into specific, measurable and time-bound (SMART) goals. In response, the trust were developing a new quality strategy which was in draft form.

We saw that overall the trust was well led with proactive and responsive trust wide leadership. There was a clear governance arrangements in place that supported the safe delivery of the service and to monitor and improve trust performance. Lines of communication from the board and senior managers to frontline services were mostly effective. Managers and staff understood the roles and responsibilities of governance and quality performance. While most staff were aware of the trust's vision and strategy, not all staff knew about these. Staff felt engaged with the trust and were well supported by local managers. We found that staff understood leadership structures, particularly at local level.

We saw some recent good examples where board members spent time within services to understand the challenges faced and were actively engaging with front line staff including clinical buddying, walkabouts by the non executive directors and the culture conversations initiated recently by the chief executive officer. Staff felt well supported by their immediate line managers with the exception of the learning disability service teams. The recent scale and pace of change within the organisation was continuing to cause difficulties for the front line community and community mental health team staff. There had not been the appropriate level of engagement from leaders to ensure that this change was managed well. The scale and pace of change had also caused difficulties for

service users in terms of accessing services and communicating with people within teams. We saw that there had been some recent improvements and a commitment to make these changes work including increasing trust board oversight and ownership of these issues.

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Our inspection team

Our inspection team was led by:

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

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

The team included inspectors, inspection managers, Mental Health Act commissioners, a pharmacist inspector and an analyst. We also had a variety of specialist advisors which included consultant psychiatrists, junior doctors, consultant psychologists, senior nurses, student nurses, nursing assistants, advocates, social workers, senior managers, nurse consultants, advanced nurse practitioners, district nurses, health visitors, tissue viability nurses, dieticians and occupational therapists

The team also included four Experts by Experience who have personal experience of using or caring for someone who uses the type of services we were inspecting. Two of the experts were included in the inspections of the mental health services. Two experts were part of the teams inspecting the community health services.

Why we carried out this inspection

We inspected this core service as part of our comprehensive Wave 2 pilot mental health and community health inspection programme.

How we carried out this inspection

To get to the heart of people who use services' experience of care, we always ask the following five questions of every service and provider:

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

Before visiting, we reviewed a range of information we hold about the core services and asked other organisations to share what they knew. We held a public listening event, as well as listening events at each main hospital location for current in-patients including detained patients. We also arranged focus groups with a local black and minority ethnic (BME) mental health group and a local support group for transgender people prior to the inspection, facilitated by a voluntary organisation. We carried out announced visits to all core services on 17-19 June 2014.

During the visit we held focus groups with a range of staff who worked within the service, such as nurses, doctors, therapists and met with a range of community staff including district nurses and school nurses and health visitors. We met with representatives from other organisations including commissioners of health services, local authority personnel and local advocacy groups. We met with people who use services who shared their views and experiences of the core services we visited. We observed how people were being cared for and talked with carers and/or family members and reviewed care or treatment records of people who use services. We looked at a range of records including clinical and management records. We visited community mental health teams, health centres, community clinics and accompanied the provider's staff on home visits with patient consent.

We carried out a further announced visit on 3 July 2014 to Bracken Ward, the older people's ward at Airedale Centre as we were unable to visit it on the main inspection due to infection issues. We also carried out an unannounced visit to the A and E liaison service at Bradford Royal Infirmary on 1 July 2014.

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Information about the provider

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

The trust provides the following core services:-Mental Health

- Adult admission wards
- Psychiatric intensive care units and health based places of safety
- Services for older people
- Long stay services
- Forensic/secure services
- Children and adolescent mental health services
- Learning disability services
- Mental health community based crisis services
- Adult mental health community based services

Community Health Services

- Community health services for adults with long term conditions
- Community health services for children, young people and families
- End of life care

The trust also provides other specialist substance misuse community services that we did not inspect on this inspection. We are developing new methodology for inspecting substance misuse services and will pilot this within some nationally selected services from Autumn 2014. The trust also provides general dental treatment services and dental care in hospital under general anaesthetic. We did not inspect the trust's dental services on this occasion as we are also developing our new approach to regulating dental services. We are going to pilot and test this new methodology before we fully implement it in April 2015

Bradford District Care Trust integrated with community health services in April 2011. The trust serves a population of approximately 577,000 people. It has 209 mental health in-patient beds. There are over 3,000 staff working with at the trust.

Bradford District Care Trust was first registered with CQC on 17 June 2010 and has 15 active locations. These include trust headquarters. There are two main hospital locations; Lynfield Mount and the Airedale Centre for Mental Health, which both provide mental health services only. In addition the trust provides a range of community services and there are a number of bases from which the teams operate for mental health, CAMHS community teams, learning disability and community health teams.

Bradford District Care Trust has been inspected on thirteen occasions since registration. These inspections have occurred at four locations which are all currently active. Of these locations, Airedale Centre for Mental Health has been inspected five times, Holmewood Health Centre once, Horton Park Medical Centre once and Lynfield Mount Hospital six times. The reports of the inspections at these locations were published between December 2011 and January 2014.

In terms of previous issues with compliance with the regulations:

- Lynfield Mount Hospital in December 2012, a compliance action was issued regarding the management of medicines
- Lynfield Mount Hospital and Airedale Centre for Mental Health in January 2011, compliance actions were issued regarding records

The trust took steps to respond to these issues, with follow up visits demonstrating full compliance with regulations. All locations were currently compliant with the regulations of the Health and Social Care Act 2008.

What people who use the provider's services say

Listening events before the inspection

We held five listening events prior to the inspection. We held a public listening event at The Cellar Project in Shipley. We also worked with the SpeakOut Network, managed by the University of Central Lancashire, to engage with hard to reach community

groups. They helped us with two focus groups for harder to reach groups aimed at people from black and minority ethnic communities and people from transgender communities respectively.

We also ran two listening events for detained patients at the two hospital locations – Lynfield Mount and Airedale Centre for Mental Health.

Healthwatch also carried out their own events (including in conjunction with the local MIND association) and some service user led groups and they passed over their findings to us. Representation at these events from people who use services accessing community health services such as district nurses, school nurses and health visitors was limited.

There were lots of positive comments about activities in the community mental health services and the caring staff that work in the community mental health services. Some people were concerned about access to services, especially out of hours, crisis services and access to psychological therapies. Some negative comments were about staff seeming to be stretched and concern that staff did not fully consider cultural issues and treatment.

We also heard examples of people undergoing gender reassignment experiencing a lack of support for their psychological well-being during waits to undergo surgery and experiencing negative attitudes from NHS staff which included trust staff.

At these listening events, people told us that the staff were caring and respectful. Some people told us they know what their care plan is and that they were involved in their care.

People who had experience of both Lynfield Mount and Airedale Centre for Mental Health generally stated that, where they had a choice, they preferred to be admitted to Airedale because they felt that staff were often more caring and the environment was better. Some people also said there were few activities on the wards.

People on the older people ward commented favourably about how the move from Duchy Court to Bracken Suite was handled and were complementary about the care they received. However at the public engagement events people felt that the consultation around the significant changes to older people's services was not meaningful and service user involvement could be more fully embedded within the trust. Carers commented that they would like better information (subject to patient consent) and the variation in people being offered carer's assessments.

Community Mental Health survey

The Care Quality Commission Community Mental Health survey is sent to people who received community mental health services from the trust annually. This survey was conducted to find out about the experiences of people who receive care and treatment. Those who were eligible for the survey were people receiving specialist care or treatment for a mental health condition, aged 18 and above and had been seen by the trust between 1 July 2013 and 30 September 2013.

There were a total of 232 responses, which was a response rate of 28%. Overall, the trust is performing about the same as other trusts across most areas.

There were two questions within the Care Plan section where trust performance was significantly worse than other trusts. These concern whether or not respondents understood what was in their care plan and whether they had been given (or offered) a written or printed copy of their care plan. We discuss this in more detail in the caring domain section of the report.

Friends and Family Test

The trust launched the Friends and Family Test in May 2014. The Friends and Family Test seeks to find out whether people who have used the service would recommend their care to friends and family. The latest results show that 89% of respondents were likely or extremely likely to recommend the trust's service to friends and family if they needed similar care or treatment.

Comment Cards

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

There were a number of comment cards returned. Some comments contained both negative and positive elements.

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There were 58 positive comments which included caring staff and being cared for with dignity and respect.

There were 13 negative comments that included themes such as low staffing levels and occasional episodes of staff being unhelpful.

During the inspection

We spoke with a number of people during our inspection in hospital, across community mental health and community health sectors, including telephone interviews. We include their comments in the core service reports.

Good practice

Mental health services

Adult Admission wards

- We found good evidence that learning from incidents took place and that specific changes to practice were made as a result.
- There were a number of outcome measures to determine the effectiveness of the service provided.
- There was a service development worker who focused on service user involvement.

Psychiatric Intensive Care Units and Health Based Places of Safety

- There was good evidence that there was learning from incidents, and that changes to practice were made as a result of these incidents.
- There were a number of outcome measures to determine the effectiveness of the service provided.
- The trust's response time to health based places of safety was always met within six-hour target.

Long stay services and Forensic/Secure services

- The trust had a clear vision for the low secure and rehabilitation services, which involved increasing the community provision and working in the least restrictive way for people.
- Staff worked with people to promote independent living skills and social inclusion.

Mental health community based crisis services

- The trust provided ongoing training for staff in psychological therapy.
- There were non-medical prescribing leads for assessment and treatment.
- The lone worker policy was followed, which helped to keep staff safe when visiting in the community.

Adult mental health community based services

- There were non-medical prescribing leads for assessment and treatment.
- Safeguarding practices were safe and staff were knew how to make appropriate referrals.
- There were service user development workers employed by the trust.

Learning Disability Services

- We saw several examples of good practice in relation to health screening and facilitation at Waddiloves Health Centre. For example, we saw the use of a screening tool that had been developed specifically for people who had Down's syndrome.
- People referred to Waddiloves Health Centre also had their respiratory rate measured. This was then monitored during the time they received the service.
- The community teams worked well with hospitals to make sure that people had a better experience when admitted to hospital, and that their physical health needs were better met.

Services for Older People

- The design of Ward 24 was carefully considered. The team had worked hard to identify the best evidence in terms of designing a safe and therapeutic environment for older people with dementia.
- Some local integration meetings, which involved community psychiatric nurses, GPs, district nurses and others, were working particularly well. There was good communication and partnership working, which made sure that older people's needs were being met.
- There was a high level of investment in staff training and development across the service. This benefitted the service, people using the service and their carers.

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- The service had successfully integrated the Chief Nursing Officer's 6Cs of nursing (care, compassion, competence, communication, courage and commitment) into the delivery of care.

Children and Adolescent Mental Health services

- There was an out-of-hours nursing service in place, which was provided by the speedit team (intensive home treatment and support) with management and consultant cover on-call. This service made sure that young people in crisis had urgent support. It also managed the need for inpatient admission or discharge to the community out-of-hours.
- A specialist 'post sixteen' pathway had been developed for young people aged 16 and above and the options available to them in CAMHS.
- As part of 'agile working', staff were provided with equipment such as tablets and video links. This enabled them to work from multiple locations and gave them better and more regular contact with young people and their families.
- Young people had the opportunity to be involved in the service through the collaborative work with Barnados. For example, young people told us that they had been involved in interviewing CAMHS staff and had input into the design of the waiting areas in CAMHS buildings.
- There were monthly consultations with a local children's care home to make sure that any mental health needs were met.
- Each school had a primary health worker, who carried out joint assessments with the CAMHS team and were the source of all non-urgent referrals to the service.

Community health services

Community health services for children, young people and families

- Health visitors and school nurses received regular safeguarding supervision, which was formally documented on the child's SystmOne electronic care record. Any lessons from the supervision session were shared within the multidisciplinary team who were caring for the child, and learning was shared with other local teams. Staff felt well supported by the trust's safeguarding team when they were handling complex safeguarding cases.
- The SystmOne safeguarding template included a multidisciplinary summary document. This ensured there was a clear and accurate record of events, as well as other safeguarding information.
- SystmOne records highlighted known risks relating to children and families, for example an abusive parent, so that staff were made aware and could take appropriate precautions before visiting the family's home.
- The family nurse partnership (FNP) team included several areas of good practice, some of which could be considered for development in other services provided by the trust.
- The looked after children's team continued to support children in full time education until 21 years old, rather than discharge them from the service at the usual age.
- The trust had positive examples of inter-agency working and developing services beyond national guidelines. For example, the Bradford families first (troubled families) pilot initiative, which is largely a social care and police-led initiative, included a dedicated health team who were based in the same location (Flockton House) as other families first teams. This meant troubled families received health support that they may not have received if the initiative had not included a directly-funded health component.

Long term conditions

- We found that the working women's service provided effective, multidisciplinary support for people who used the service.
- The podiatry team used real-time survey information to make improvements to the services.

End of life care

- The Bradford and Airedale Network for People with Learning Disabilities had a team of nurses, doctors, psychologists and social workers who supported people, their families and carers. The service had involved people in the production of easy-read guides and DVDs, which explained what happened at the end of life and how to plan for it.
- Patients on the Gold Standards Framework had access to The Gold Line. This was a dedicated service for patients and carers which could be accessed as an alternative to phoning 111, when the GP surgery was

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closed or if patients were finding it difficult to get help during the day and required advice. The Gold Line was manned by a senior nurse and the service was available 24-hours a day, seven days a week.
- End of life services had employed two palliative care liaison workers who accompanied patients from ethnic backgrounds and their carers through their end of life journey providing emotional support and identifying a holistic and culturally appropriate care package. A female, bilingual health support worker was also available for female patients to discuss personal health issues.

Areas for improvement

Action the provider MUST or SHOULD take to improve

Action the provider MUST take to improve

Mental Health Services

Adult Admission wards

- The trust must ensure that people receive the right care at the right time from the medical team.

Psychiatric Intensive Care Units and Health Based Places of Safety

- The trust must make sure that the health-based places of safety are safe and fit for purpose.

Action the provider SHOULD take to improve

Mental Health Services

Adult Admission wards

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

Psychiatric Intensive Care Units and Health Based Places of Safety

- The trust should make sure that close observations are maintained on people while in the shared communal areas.
- The trust should make sure that fridge temperatures are monitored, in line with food hygiene guidelines.
- The trust should make sure that people receive care from a full range of professionals in the multidisciplinary team.
- The trust should make sure that people's privacy and dignity is maintained while they are using the health-based place of safety.
- The trust should make sure that people using the service have access to a wide range of activities.

Long stay services and Forensic/Secure services

- The trust should ensure that relatives were given adequate information when escorting people during section 17 leave.
- The trust should ensure that risk assessments were completed before people went on section 17 leave.
- The trust should ensure that staffing issues do not impact on patient care.
- The trust should ensure that some staff receive specific training to give them better skills and knowledge to help them carry out their roles.
- The trust should ensure that Thornton Ward follows guidance on the use of CCTV in the visitors' room.

Mental health community based crisis services

- The trust should continue to work with commissioners of services to make sure appropriate services are available to people 24 hours a day.
- The trust should continue to liaise with managers of the acute hospitals to secure an appropriate environment for mental health assessments in each A&E department.
- The trust should continue to make sure that the impact of major service redesign, including the

development of the single point of access and administrative hubs, is properly monitored and managed to make sure that the service continues to deliver caring and responsive care.

Adult mental health community based services

- The trust should make sure that all community mental health teams adhere to safe working systems and the lone working policy.
- The trust should make sure that monitoring systems are in place for managing medicines.
- The trust should continue to make sure that the impact of major service redesign, including the development of a single point of access and administrative hubs, is properly monitored and managed. This is to make sure that care delivered continues to be responsive and caring.

Learning Disability Services

- The trust should make sure that all ligature risks identified in the assessment and treatment unit are reduced promptly.
- The trust should make sure that moving administration staff to hub offices does not place other staff in smaller community offices at risk of harm.
- The trust should make sure that information about people's care and treatment is provided in a format that each person who uses the service can understand.
- The trust should make sure that each person's mental capacity is assessed for every decision made about their care and treatment.
- The trust should make sure that there are effective repair and maintenance systems in place to promote the wellbeing of people who use the service.
- The trust should make sure that all staff are clear as to their objectives and how these are measured, to make sure that the service meets people's needs.
- The trust should make sure that the Intensive Support Team is developed so that it meets people's needs.
- The trust should make sure that staff have the appropriate training so that they can meet people's needs.

Services for Older People

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

Children and Adolescent Mental health Services

- The trust should ensure that risks relating to people using the service are fully documented in the electronic case note system (RIO) after each meeting, to make sure that all information about risk is captured and that this is communicated to all staff.
- The trust should ensure that the RIO system tick box system for recording risk triggers and safeguards, which lets staff know that young people using the service may be vulnerable, is used consistently and all staff should be made aware of this function.
- The trust should ensure that the lone working policy is made more accessible and clearly outline measures for staff safety when making community visits. This should be communicated to all staff and adhered to.
- The trust should ensure that an effective audit programme for CAMHS services is implemented and actions monitored record service improvements.
- The trust should ensure that policies and procedures should be brought up-to-date so that staff follow the trust's current guidelines.

Community health services

Community health services for children, young people and families

- The trust should ensure that staff report all delays in referrals from the administration hubs to community teams working with children, young people and families, monitor performance in regards to referral delays and take expedient action to address poor performance.

Summary of findings

- The trust should improve systems to ensure any risks associated with safeguarding referrals are identified, reported and monitored, both internally and externally through engagement with the local authority safeguarding teams.
- The trust should identify a non-executive board member with specific responsibility to champion the rights of children at board level discussions.
- The trust should ensure NHS complaints leaflets are available in all of the schools visited by school nurses employed by the trust.

Community health services for adults with long term conditions

- The trust should improve staff awareness of the Mental Capacity Act 2005 and how it is used to support people who use services.
- The trust should ensure that staff report all delays in referrals from the administration hubs to community teams working with adults with long term conditions, monitor performance in regards to referral delays and take expedient action to address poor performance.
- The trust should improve the effectiveness and analysis of the safety thermometer data and audits so that improvements in practice can be made as a result of the findings.

End of life care

- The trust should improve systems to make sure that all staff have access to regular protected time for facilitated, in depth clinical discussion.
- The trust should develop formal, documented competency assessments for healthcare support workers when double checking syringe drivers

Bradford District Care Trust

Detailed findings

Requires Improvement

Are services safe?

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

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

Summary of findings

There were systems in place to identify and investigate incidents within the inpatient and community settings. The trust was a high reporter of incidents which showed that they recognise when incidents occur and report them properly. We saw evidence that care staff learned from incidents and that this had resulted in changes to practice. There had been no 'never events'.

The trust had an identified safeguarding lead and well developed systems for ensuring that abuse was recognised, reported upon and investigated appropriately. Staff showed good awareness of safeguarding arrangements.

People received care in safe and suitable premises. The only exception was the care environment of the places of safety at Lynfield Mount and Airedale centre for Mental Health Hospitals which did not fully meet the current good practice guidance.

There was a trust-wide risk register and Board assurance framework, and the trust had structures in place to ensure that all risks were recorded and categorised. We found that there was a consistent approach across the trust to the use of risk assessments to keep people safe; however, risk assessments weren't always evident in the low secure service before people received leave.

Staffing levels were usually maintained at the level set by the trust. However there were times when staffing levels were stretched and people's needs were not always met on the low secure services. We saw, for example, that planned activities did not always take place and section 17 leave was cancelled when staffing levels were affected by short term absence on the low secure wards.

Staffing levels within the district nursing service were safe and, while there were vacancies in some community teams, there was on going monitoring to make sure that staffing levels were flexible and met the dependency needs of patients.

Our findings

Track record on safety

We looked at the incidents that had occurred recently at this trust. All trusts are required to submit notifications of

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

incidents to the National Reporting and Learning System. Serious incidents known as 'never events' are events that are classified as so serious they should never happen. In mental health services, the particular relevant never events are suicide of an in-patient from a fixed ligature point and absconsion from within medium and high secure services which the Trust does not provide. The trust had not reported any 'never events' since April 2011. The trust told us that there had been no never events since the requirement regarding never events came into force in 2009. We did not see or hear about any incidents that should have been classified as never events.

There were 276 incidents reported by the trust to the NRLS between April 2013 and March 2014; of which the Trust had reported 118 serious incidents between April 2013 and March 2014. Serious incidents are those that require an investigation. Of those serious incidents, incidents occurred most frequently in patients' homes and related to pressure sore management.

Comparisons with other similar trusts showed that that the proportions of reported incidents that are harmful in this trust were within the expected range.

Information on safety was collected from different sources and used to monitor performance. A range of performance indicators were monitored every month and reported centrally. Governance arrangements were in place to ensure there were appropriate reviews of all compliments, complaints, serious incidents and progress on action plans as well as risk registers.

Learning from incidents and Improving safety standards

The trust had systems in place to learn from incidents. When incidents occurred there were investigations and learning from those incidents, and the trust had a strong commitment to improving practice. Staff were able to tell us about recent incidents and the lessons that had been learnt. Lessons learned from incidents had been discussed within their specific team and disseminated through the trust through on line safety bulletins and email update alerts. This included updates and 'key messages' for staff. This showed that the Trust had embedded learning from incidents within the organisation.

Where a number of similar incidents had occurred there were investigations to analyse any common factors to improve patient safety, one example we saw related to falls within the older person's ward environment. These incidents were considered to look at whether any common factors increased or decreased the likelihood of falls.

Every six months, the Ministry of Justice publishes a summary of Schedule 5 recommendations which had been made by the local coroners with the intention of learning lessons from the cause of death and preventing deaths. There was one concern regarding the trust in one recent report (October 2012 – March 2013). It was recommended that guidelines be issued on situations when patients should remain under the care of the adult mental health teams and the need for a needs assessment prior to a patient's discharge. There was a good process in place for the prompt transfer of information to GPs about people's hospital assessment, treatment and care when they were discharged.

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

Across all the trust services, staff were trained in safeguarding vulnerable adults and children. Staff we spoke with were knowledgeable about their responsibilities in regards to the safeguarding process. They described the process for referring any identified potential or actual concerns to the relevant department. The trust policies and procedures were accessible on the trusts own intranet site. Health visitors we spoke to were concerned about number of new referrals the local authority accepted, which they felt placed them at risk. The trust said it will review these concerns and talk with the local authority.

We saw that staffing levels were safe. The exception was within some of the community teams where they were operating with high levels of staff sickness and within the low secure services where staffing levels were regularly operating below expected levels and this impacted on patient care. We saw, for example, that planned activities did not always take place and section 17 leave was cancelled when staffing levels were affected by short term absence on the low secure wards.

We saw there was a high use of bank and agency staff to cover sickness and to meet people's needs. Efforts were made to ensure continuity of care by using regular bank or

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

agency staff. Local managers were empowered to increase staffing levels on a temporary basis to ensure people were kept safe, for example when people were assessed as needing higher levels of observation.

We found that the medicine management team was effective and well led and was involved in all aspects of a person's medicine requirements. The Chief Pharmacist told us that safe medicines management was an integral part of the trusts strategy to improve the delivery of care to people using services.

The trust had taken steps to make sure that medicines were kept safely in response to some comments we raised following our previous inspection in July 2013. We saw that regular ward audit took place to support the safe storage and handling of medicines. There were clear and up to date procedures covering all aspects of medicines management and nurses told us that this was readily accessible along with regular access to pharmacist advice.

Arrangements were in place to ensure that medicine incidents were recorded and investigated. We found that there was an open culture of reporting medicine errors in order to change practices and to share lessons learned. One documented medication error had led to the preparation and distribution across the trust of clear guidance on the management of patients requiring insulin.

There were consistent arrangements in place for checking and recording the operational temperature of fridges used to store medicines in most areas with the exception of two community mental health teams.

On some acute wards appropriate food labelling and storage in line with food hygiene guidelines was not occurring within the ADL areas so it was not fully clear if food could be safely consumed.We saw that fridge temperatures in the activities of daily living (ADL) kitchen were not always monitored within the acute and PICU wards.

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

Assessing and monitoring safety and risk

The trust had a range of risk registers held at different levels of the organisation. The risk registers were comprehensive. Where we identified issues, we saw that the trust had already recorded the risk on the risk register and actions taken to mitigate the risk were in place.

The Corporate Risk Register provided an overview of the individual hazards / risks and the actions in place to mitigate them and progress being made with these actions.

Higher red risks were included on the register were

- persistently high average length of stay in adult inpatient services
- high number of service users on consultant caseloads in Community Mental Health teams
- lack of alignment between existing capacity and demand for service provision in the Community Mental Health Teams in Bradford (City, South and West, North) with high team caseloads.

In a presentation immediately prior to the inspection, the trust also highlighted the challenges and improvements the trust could make. Throughout our inspection, we identified similar corporate risks as identified by the trust. This meant that senior managers had good oversight of the overall risks and challenges they faced and how they would address these.

Premises run by the trust were noted to be clean and well maintained. There were procedures for the management, storage and disposal of clinical waste, environmental cleanliness and prevention of healthcare acquired infection guidance. During our inspection there was an outbreak of norovirus and all procedures were followed in relation to the outbreak and management of the virus to minimise the risks of further outbreaks.

Procedures were in place to ensure equipment was regularly maintained and fit for purpose. There were arrangements in place in patients' homes for the handling, storage and disposal of clinical waste, including sharps.

Staff received training in the management of violence and aggression. We found that restraint was used safely and only as a last resort. Staff across services employed strategies to reduce aggressive incidents that may lead to people being restrained.

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

Across mental health services, care plans and risk assessments clearly identified how staff were to support safely for example where people could cause harm to them or to others. People's needs and risks were appropriately assessed and reviewed.

Patients on the PICU were not fully kept safe from the risks posed from other patients due to staff not always maintaining observations levels.

Ligature risks were identified in in-patient areas and plans were in place to address or manage these. The exception was in the hospital based places of safety (HBPoS). We asked the trust to look at the safety of the HBPoS environment immediately following the inspection. They provided assurance of the plans and improvements they would make to ensure people could be cared for safely. People may be placed at risk because each HBPoS suite environment had ligature points and did not meet fundamental standards within the good practice guidance of the Royal College of Psychiatrists to assure against the risks of unsafe or unsuitable premises.

Understanding and management of foreseeable risks

We found that arrangements were in place to deal with foreseeable emergencies and appropriate contingency arrangements were in place to deal with foreseeable events in all the areas we visited.

Emergency equipment, including automated external defibrillators and oxygen, was in place in clinical areas and checked regularly to ensure it was fit for purpose and could be used effectively in an emergency. Medical devices were also checked regularly to ensure they were working correctly.

Systems were in place to maintain staff safety. The trust had good lone working policies and arrangements. However there was some variation in how robustly these policies were adhered to and monitored within some community mental health teams and CAMHs teams.

Good

Are services effective?

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

Summary of findings

We saw that the trust was providing evidence based treatments in line with best practice guidance. We saw that people were being supported to make choices. Evidence was seen of outcome measures being used throughout the trust in most of the services. The exceptions were within learning disability and community health services where outcomes were unclear and assessments of capacity were not detailed.

The trust employed appropriately qualified and trained staff throughout their services. There were good systems to ensure adherence with the Mental Health Act 1983 when people were compulsorily detained.

We found good evidence that in community services the children's and young family's service reviewed and implemented national good practice guidelines. The trust had also successfully implemented evidenced-based programmes such as the family nurse partnership programme.

We also found evidence that patients approaching the end of life were identified in the right way. Care, including effective pain relief, was delivered according to their personal care plans, which were regularly reviewed. Patients in the last days of life were identified quickly and appropriate action was taken.

We found within community adults and end of life services the majority of staff were up-to-date with mandatory training and there were systems in place to make sure that staff received regular appraisals. However, we found the clinical supervision of staff varied across the service and some staff did not have regular protected time to reflect on clinical practice.

Our findings

Assessment and delivery of care and treatment

Before we inspected, we looked at data we held about the trust. This included data from the Care Quality Commission Community Mental Health Survey 2013, the Department of Health Mental health Minimum Data Set and the information Centre for Health and Social Care. These did not highlight any areas of elevated risk.

In most of the services we found that the care and treatment provided was effective. This was because people's needs were discussed at the time of referral and decisions were made among professionals following a review. We saw that individuals and their carers were involved in the planning and the review of their care packages. The trust has a high proportion of patients on Care Programme Approach (CPA) who have had a formal review within 12 months in 2013/14.

In the services we inspected, most teams were using evidence based models of treatment and references to NICE guidelines. Staff provided care to people based on national guidance, such as National Institute for Health and Care Excellence (NICE) guidelines and were aware of recent changes in guidance. We saw evidence of discussion on NICE guidelines in people's health care notes. Ward staff carried out regular audits as a way of ensuring high quality care was provided to people. For example, we saw audits of people's care plans had been undertaken and detailed feedback provided to enable improvements

Community mental health teams offered a good range of evidence based psychological therapies. However patients and staff told us that there were long waiting lists to access psychological therapies.

The A&E psychiatric liaison team was based in Airedale General and Bradford district hospitals. This was not a 24 hour service. We saw that people were assessed as quickly as possible and the team endeavoured to see people within the four hour casualty waiting time within the resources of the commissioned service of a single worker on duty.

Across services, people's needs were assessed and care was delivered in line with their individual care plans. Assessments included a review of the person's physical

health with specific assessments of risks such as physical health and self harm risks, infection risks, skin integrity, risk of falls and nutritional risks which were more relevant in older people's services.

When falls had occurred particularly in older people's in-patient services, we saw that this was recorded in people's care records; there was a falls protocol in place and evidence of medical assessment following falls.

Care pathways for end of life services demonstrated the trust had full regard to the Gold Standards Framework (GSF) to ensure patients were appropriately assessed and supported with their end of life needs. The service had responded appropriately to changes in the use of the Liverpool Care Pathway (LCP) through an audit of patients who were on the pathway; reassessment on a regular basis and following interim guidelines. This showed the service had responded to concerns regarding implementation of the LCP and ensured a safe approach.

The trust was successful in gaining a licence to provide the evidenced based "Family Nurse Partnership" programme within certain localities of the Bradford and Airedale. The programme provided intensive support to certain families who meet set criteria with the aim of improving pregnancy outcomes, child health development and parents' economic self-sufficiency. We found the team was providing excellent care to the families currently on the programme.

The bed occupancy rate was high in the adult acute services of the trust. This was being monitored on a regular basis and efforts were being made to reduce bed occupancy levels in the short and long term. When people were assessed by the intensive home treatment team patients were graded on a red, amber, green basis to ensure the most acutely unwell patients received care in the service best able to meet their needs. We saw that there was good collaborative working between the in-patient and community teams.

The Trust were working in partnership with a research organisation to look at the future demand for services based on demographics and how the Trust can meet this demand, including demand for in-patient services.

Outcomes for people using services

The trust has accreditation for it electroconvulsive therapy service to assure and improve the quality of the administration of electroconvulsive therapy. The CAMHS team were members of the Quality Network For Community CAMHS (QNCC), a quality network run by the Royal College of Psychiatrists. The trust has not sought accreditation with the Royal College of Psychiatrists for its in-patient mental health services. The trust has a Research Development Unit and benefits from commissioning bespoke research and learning from research projects.

The trust used the NHS Safety Thermometer which is a national improvement tool for measuring, monitoring and analysing patient harms and 'harm free care'. The data for palliative care services showed 100% harm free care was being achieved. Within community adult services we were shown the system and process for inputting the safety thermometer data and we saw the team leaders were entering the data monthly. However, there was no evidence available to demonstrate the effectiveness and analysis of the safety thermometer data reaching frontline community health staff. Senior staff confirmed the trust did not provide the individual community teams with any analysis and outcomes from the data supplied. This meant that all staff were not always aware how community health services routinely analysed the information to identify themes, trends or areas for improvement.

The trust participated in the national audits of Schizophrenia, Psychological Therapies, lithium monitoring, prescribing for ADHD, prescribing anti-dementia drugs and prescribing antipsychotics for children and adolescents. These audits showed that in many areas the trust were providing clinically effective services and performing the same or better than most similar trusts with some outlier indicators. The trust had a system for local clinical and non-financial audits to ensure people received good outcomes in relation to their care and treatment. We saw a number of audits including audits in relation to involvement of fathers in cases referred to Child and Adolescent Mental Health Services (CAMHS), CQUIN (Commissioning for Quality and Innovation) targets on dementia, best practice in Mental Health Act Managers' Hearings, section 17 leave recording , Care Programme Approach (CPA) arrangements and Physical Health Audit Report. The audits were robust and benchmarked clinical services against best practice. Results in the majority of areas showed positive progress and demonstrate improving practice.

Across the older people's service the trust was introducing PROMs (Patient Reported Outcome Measures). This

Good

Are services effective?

involved collecting survey data from people who use the service in order to measure and understand the quality of the services that were being delivered and whether people were achieving positive outcomes.

We found that the learning disability Intensive Support Team needed to be developed to ensure it was effective in meeting the needs of people who used the service. We found that outcomes were measured for people who used learning disability service were unclear and assessments of capacity were not all detailed.

The medicines management team were pro-active in monitoring the use of medicines to make sure that prescribing was safe, and followed best practice, professional guidance and legislation

Staff, equipment and facilities

We saw that most trust staff were able to access regular supervision and appraisal within mental health teams. Clinical or reflective supervision was variable across community nursing teams. This meant some community staff did not have dedicated time to reflect on their practice and identify any learning points from clinical issues which arose.

The take up of mandatory training was also good; on line training enabled staff to undertake this training at times convenient to them. Staff told us they had undertaken training pertinent to their role including in safeguarding vulnerable adults, fire safety and life support techniques. Records showed that most staff were up to date with statutory and mandatory training requirements and the training matrix was on display near the entrance to the wards in some in-patient areas. Data showed staff compliance with mandatory training across various staff groups as at March 2014. These were:

- Information Governance – 89% compliance across staff groups
- Fire Safety – 83% compliance across staff groups
- Infection prevention – 82% compliance across staff groups
- Moving and handling – 79% compliance across staff groups
- All training – 83% compliance across staff groups.

The trust developed an action plan where there was lower compliance. The plan, as at 30 April 2014, provided information on the staff groups with the lowest and highest compliance with training and what actions were to be taken to increase compliance levels.

Most staff had undertaken specialist training in specific areas for example dementia care and use of syringe drivers in end of life care. The trust told us that they did not provide a specific service for people who have autistic spectrum conditions and recognised this as a gap in service provision. Staff in learning disability services had received training in autism awareness and some staff had received further training to develop their skills and knowledge. However, due to the needs of the current people admitted to the unit it was not possible to provide this further training to all staff.

There were limited activities on some of the in-patient areas, for example staff in the learning disability services we spoke with were frustrated that they were not able to provide regular activities due to the needs of the people placed there.

Focus groups were held with all grades of staff. Clinical staff told us they were able to discuss and raise issues about clinical quality and felt confident that their immediate line managers would listen to and take action as required. Some of the community health teams raised concerns that their caseloads had exceeded manageable limits. High caseloads of community care co-ordinators were monitored and managed including through monthly supervision with performance issues and caseload capacity embedded in this process. Specialist supervision was available for Approved Mental Health Professionals (AMHP) and non medical prescribers.

We were told that the trust had identified the need for an increased staffing level across community mental health teams and that recruitment was underway but not completed this meant there were areas where there was a high use of bank and agency staff, for example the South and West Community Mental Health Team. This risk was also on the corporate risk register which was regularly reviewed.

Consultant psychiatrists case loads had been reduced considerably and many patients had been discharged back

to their GP. This meant that people who had been assessed as being well for significant period were passed to their GP for ongoing monitoring. We heard at the listening events that this transition caused anxiety for some people.

The Early Intervention service employed two recovery support workers which helped people access other services such as employment and education.

Equipment in clinical areas was checked regularly and monitored to ensure it was fit for purpose. Equipment was cleaned between uses, and labelled to show when it had last been cleaned. Service checks of equipment were carried out. The national staff survey indicated that the availability of hand washing materials was better than the England average for mental health trusts which helped to control infections.

There was timely provision of equipment particularly beds, mattresses and syringe drivers to patients receiving end of life care. Staff were trained in the use of relevant equipment, for example there was a programme in place for syringe driver training.

The acute wards at the Airedale Centre for Mental Health had state of the art bathroom equipment for people with physical disabilities and two bedrooms specifically adapted to meet the needs of people with physical disabilities. This meant that people with physical disabilities could be cared for in an appropriate setting and did not have to be cared for out of their home area.

Multi-disciplinary working

We saw examples of good multidisciplinary and collaborative team working. We found examples of in-patient services working alongside the intensive home treatment teams to provide person centered care and treatment to people. People using the service told how they were involved in the planning and review of their care.

We saw that there were multidisciplinary team meetings held on a weekly basis in the in-patient areas. These meetings included the person using the service. The exception was Clover Ward (PICU) where there was no evidenced input from other health professionals as there was no occupational therapist or psychology in post. This meant that people were not receiving care from a full multi-disciplinary team.

The trust had arrangements to ensure that physical health issues were properly assessed and treated. The trust had a range of policies to ensure that physical health issues were considered. Physical health leads were within each location to champion the importance of ensuring people's physical health needs were considered.

We saw that the trust worked collaboratively and in partnership with a number of other providers within their specialist in-patient services. Health visitors told us they usually had positive integrated working with midwives based at the acute hospital and in the community, school nursing teams, other health visiting teams and mental health services.

We saw a good example of multi-disciplinary working with external healthcare professionals to deliver effective pain management in the in-patient areas.

We saw that there was good handover of patient information from in-patient teams to community mental health and crisis teams. Staff that we spoke with were knowledgeable about the needs of the people.

Community mental health teams for older people demonstrated good inter-agency working with other organisations. For example, the Alzheimer's society undertook some joint sessions with the teams at the day hospitals. Joint visits were undertaken with district nurses when relevant to the person's care. The long term goal of the Trust was to have fully integrated teams with mental health and community team professionals working in a fully integrated way.

We saw several examples of effective working and communicating between teams. These included internally between in-patient and community services and between the in-patient service and local acute services. Some of the community mental health services attended regularly to work with the ward teams. The trust had recently changed the model of care in its mental health services so that people saw the same consultant psychiatrist in the community and hospital. This helped promote continuity of care. There were also liaison psychiatry teams in both local acute hospitals

Mental Health Act (MHA)

We found that where the Mental Health Act 1983 was used, people were detained with a full set of corresponding legal paperwork. People were treated in least restrictive ways and the staff were working within the Code of Practice.

Good

Are services effective?

We visited all of the wards at each location where detained patients were being treated. We saw that there were a relatively high proportion of patients who were (or who had recently been) detained under the Mental Health Act 1983 on each ward. We saw that where people in the community were subject to a Community Treatment Order (CTO) the proper processes had been followed.

In the majority of care records reviewed, relating to the detention, care and treatment of detained patients, the principles of the Act had been followed and the Code of Practice adhered to. There were occasional minor lapses in adherence to the MHA Code of Practice on individual files. We saw that attempts were made to inform people of their rights on admission and when they were placed on a CTO. Staff were proactive to help patients to understand their rights for example by referring people to specialist advocates.

We saw that the trust had good systems in place for meeting its responsibilities under the Mental Health Act. There was a good system of oversight of the MHA monitoring function by a sub committee of the Board which monitored a number of factors including MHA activity and outcomes for people. The trust had very good systems to audit the use of the Mental Health Act and we saw recent audits on section 17 leave, restraint and Community Treatment Orders which were comprehensive. The audits would have been improved further if they had ensured that the service user was placed at the heart of the audit process for example capturing the views of patients as a routine part of the audit.

Good

Are services caring?

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

Summary of findings

Overall the trust was providing a caring service for people across all core locations. Throughout the inspection we saw examples of staff treating people with kindness, dignity and compassion.

We observed that staff were compassionate and caring towards people who used the service. The feedback received from people who used services and their visitors was generally positive about their experiences of the care and treatment provided by the trust. Where people could not speak with us, for example in learning disability and older people's services, we saw positive and warm interactions through using a formal framework – the Short Observational Framework for Inspection (SOFI) - for observing care when people cannot communicate their views.

Most people felt that they were involved in their care.

We saw that there was good handover of patient information from inpatient teams to community/crisis teams. Most staff were knowledgeable about people's needs. People had access to advocacy when they were in-patients, including specialist advocacy for people with learning disabilities to facilitate effective participation.

Staff were also aware of the emotional aspects of caring for people and made sure that specialist support was provided for people where needed

We saw examples of outstanding involvement initiatives in some of the mental health services, including CAMHS services, early intervention service, and the employment of service user development workers. Involvement initiatives within community mental health services were more limited.

Our findings

Kindness, dignity and respect

We observed positive interactions between staff and patients in a number of different care settings across the range of community health services. Patients were treated with compassion and empathy. We observed staff speaking with patients and provided care and support in a kind, calm, friendly and patient manner. We talked with many parents who accessed health visiting services during our inspection and received a number of CQC comment cards. We received very positive comments about the quality of service and care received from all these parents. We did not receive any negative comments about staff attitude during our inspection.

The patients we spoke with were complimentary about staff attitude and engagement. On the wards, we saw staff interacted with people and engaged positively with the people. The trust had a range of meetings in the inpatient services to ensure patients had an opportunity to explore issues and make decisions about the ward.

We observed that staff were compassionate and caring towards people who used the service including in learning disability and older people's services. This was further confirmed when we formally observed care through using a specific tool which is called Short Observational Framework for Inspection (SOFI) which is a formal framework for observing care where people cannot communicate their views.

We observed staff in all of the hospital locations helping patients to understand information in a way that reflected the patients' specific level of understanding.

Concerns were raised about the single point of access from community mental health team patients with comments about staff not always being caring and that people had to speak to different people when they contacted this service. People said they had experience of being put on hold then speaking to a different person and having to share their information again.

The in-patient services scored well in recent Patient-Led Assessments of the Care Environment (PLACE) annual

assessment. These self-assessments are undertaken by teams of NHS and independent heath care providers and patient assessors (members of the public must make up at least 50% of the team). The trust scored highest for privacy, dignity and wellbeing. When compared with other organisations, this puts the trust in the top 25% of organisations that had PLACE assessments.

Since June 2013 the trust has reported Grade 3 or 4 pressure ulcers developed on the caseload of its nursing services (which includes those developed in the residential care homes) as Grade 1 Serious Incidents. The pressure ulcer coordinator has provided over 32 training sessions to residential care home staff in over 21 residential care to help improve pressure wound care.

The environments across the services afforded dignified care and promoted people's dignity including through the provision of individual en suite bedrooms. There were two exceptions in relation to the environment:-

- people's dignity was compromised when people in the health based place of safety Lynfield Mount and Airedale need to access the toilet. They had to cross a public corridor to visit the toilet and due to the significant ligature risks in the identified toilet area would have to be supervised while in the toilet.
- the environment of the bay designated for mental health assessment at Bradford Royal Infirmary offered little privacy and dignity as it was curtained on one side with bays either side. It was inappropriate to carry out MHA assessments which occur on a relatively regular basis. The trust are reliant on the acute hospital for the availability of premises and rooms within the A and E department and we asked they work with the acute hospitals to improve this situation.

People using services involvement

Patients within community services told us community nurses, therapists and matrons visiting them actively promoted their independence and provided meaningful information about self-care. Parents using the health visiting and school nurse services commented positively about the amount of involvement, support and information they had received from members of staff including written information to make informed decisions.

The majority of people we spoke with before and during the inspection told us they felt involved in their care and treatment. They told us that staff treated them as individuals and encouraged them to recover. Carers we spoke with at listening events were positive about the care provided by the trust, others felt that their involvement could be improved and they were not always consulted appropriately especially during service redesigns. Many carers commented that they were not always given an assessment of their needs as carers.

The Community Mental Health Patient Experience Survey 2013 was conducted to find out about the experiences of people who received care and treatment. Those who were eligible for the survey were receiving specialist care or treatment for a mental health condition, aged 18 and above and had been seen by the trust between 1 July 2013 and 30 September 2013

Analysis of data showed that the trust was performing 'about the same' as other trusts in all of the major areas, including whether people in the community felt well supported by mental health staff. There are two questions within the care plan section where the trust performance was significantly worse than other trusts. These concern whether or not respondents understood what was in their care plan and whether they had been given (or offered) a written or printed copy of their care plan. This risk could be highlighting potential communication issues between staff and patients. We asked people about this, most people using services said they had been given a copy of their care plan.

The care plan documents across the trust were found in the electronic patient notes (EPN) system and from reviewing this is was sometimes difficult to see how the involvement of the individual was recorded. People using the service and carers told us that care was planned and reviewed with them however in some cases this was not evidenced in the EPN. For example we reviewed the records of six people who used the older people's service and found that the 'service user view' section of the care plan was blank in three of them despite there being evidence of involvement in other ways.

Patients and carers can access information, via the trust website, about medicines used in mental health settings and services available to help them make informed decisions about medication and the services they could receive. We found that some of the written information was not always written in versions specific to groups of patients to aid their understanding, for example people with learning disabilities and children

Good

Are services caring?

People had access to advocacy when they were in-patients, including specialist advocacy for people with learning disabilities to enable their ability to participate effectively. However the community advocacy provision for people in contact with community mental health teams was described as patchy by staff witin the community mental health teams.

The majority of people we spoke with before and during the inspection told us they felt involved in reviewing their needs. They told us that staff listened to them and encouraged them to recover.

In the older peoples service it was evident that patients were actively involved in decisions about their care and treatment where they had capacity to do so. Where people lacked capacity we spoke to family carers who told us that they were fully involved in these discussions. Where people could not communicate their needs, it wasn't always clear what efforts had been made to engage and seek better engagement of people that use the service particularly where they had cognitive impairment.

We saw examples of outstanding involvement initiatives in some of the mental health services. In the CAMHS services people were fully and meaningfully involved in commenting on and engaging with service design and service delivery issues through an innovative partnership with the charity Barnardos. In the early intervention service, former service users had been recruited into a variety of roles. This enabled these workers to use their own experience of recovery to help engage with people that used the service and to act as recovery role models. On some of the wards there was a service user development worker who supported people to engage and be involved in the services provided to them.

The trust has raised awareness about the use of the Mental Capacity Act. We saw examples of the appropriate use of capacity assessments and best interest meetings with a record of decisions, with an exception within the learning disability in-patient services. The trust was working with the local authority to further develop staff learning. The trust has made no applications in the last eighteen months for an authorization of a Deprivation of Liberty Safeguard. We did not find any restrictive practices that may have amounted to a deprivation. Following a recent court judgement, people had been reviewed to consider the restrictions placed upon people.

Community health staff were less clear about the Mental Capacity Act and DoLS - this meant that there was a risk that district nurses may not be fully aware of their responsibilities when visiting people in care homes of any legal framework or restrictions people were subject to. Within adult community teams we also found staff were not always aware of their responsibilities regarding mental capacity and consent. We spoke with staff who understood the need to gain consent, and about mental capacity. However, staff told us that they would refer to mental health clinical staff or GP if they were in doubt about a patient's understanding or cooperation with treatment plans. We also saw no information within care records that highlighted information on the person's ability to make decisions.

In the community end of life service, Advance Decision to Refuse Treatment (ADRT) were clearly documented and staff were aware and complied with national and specialist guidance for the management of patients with an existing ADRT.

Emotional support for care and treatment

During our visits to health centres where clinics were being held we saw members of staff who provided good emotional support to families and children. For example, during our visit to a well-child clinic we observed an health visitor nursery nurse provide excellent emotional support to three young children who were due to have immunisations with the practice nurse. Patients and relatives receiving end of life care told us they were well supported when they were first informed of their terminal illness difficult diagnosis. We observed that staff used a holistic approach encompassing physical, social and spiritual well-being and this was incorporated into care planning. Access was available to a psychologist and social worker who provided pre and post bereavement support.

We held engagement events before the inspection including with people who used the community mental health services. These people told us of mixed experiences of care. Some people stated they had received the support that they needed whilst others had less positive experiences frequently mentioned was the difficulty for out patients in accessing key people when required or receiving limited support.

We saw that people admitted as in-patients to mental health units were supported to maintain contact with their family and continue links with their local community

Good

Are services caring?

through appropriate and flexible visiting arrangements. People's cultural needs were discussed and staff considered cultural or personal preferences as part of the assessment and provision of care. Staff reflected the ethnic diversity in the area they worked.

Despite being subject to detention on the Mental Health Act and subject to restrictions, patients within the low secure and rehabilitation wards were complimentary about the care they received. We saw that staff on the PICU demonstrated a high level of emotional support to people on the unit at an individual level and took time to explain and support them in a sensitive manner. Patients in the low secure services completed 25 hours of meaningful activity each week and staff worked with people to identify what activities they would like to engage with. The availability of appropriate activities on the PICU and most of the acute wards were more limited.

Staff in the older people's services responded to people in distress in a calm, gentle and respectful manner whilst ensuring they anticipated patients needs. It was evident that staff in older people's services had adopted the Chief Nursing Officer's "6 C's of nursing" and implemented these good practice guidelines in their practice to ensure they provided compassionate care.

Good

Are services responsive to people's needs?

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

Summary of findings

We saw outstanding care for people receiving end of life care. Patients were highly complementary of the service and confirmed they had received a coordinated and seamless service with 24 hour access to 'The Gold Line' service. The service understood the different needs of people it served and planned, designed and delivered services to meet those needs. There were systems in place to ensure patients were able to access the right care at the right time and services were flexible enough to fit in with patients and their family's lifestyles.

We found that mostly people's individual needs and wishes were met when the trust assessed, planned and delivered care and treatment to people. However recent changes to services including integrated care, single point of access and move to administrative hubs meant that some people had experienced (and still had to experience) longer than necessary delays in getting the care and treatment they required, particularly on the acute mental health wards and in community health services. We found there were delays in referrals from the administration hubs to community teams for adults and children and young people as a result people experienced delays to care and treatment.

The environments across the services afforded dignified care and promoted people's dignity including through the provision of individual en suite bedrooms in in-patient areas with the exception of the health based place of safety and the areas that the trust staff use within Bradford Royal Infirmary's A and E to assess people in crisis.

Service users reported difficulty accessing crisis mental health services at night. The crisis team offered only telephone contact at night. Those who needed immediate assessment were directed to the Emergency Department at Bradford Royal Infirmary and Airedale General Hospital; where they might have to wait a long time to be assessed by the liaison psychiatry team because these services were not commissioned on a 24 hour basis.

Over half of complaints received and investigated in 2013-14 were upheld. Themes from complaints we reviewed during our inspection, included pressures on community mental health services and changes in the way of working which the trust was actively managing. People using the service knew how to raise complaints and concerns. Information on how to make a complaint was displayed in most areas. The trust ensured that learning from comments, complaints, compliments and concerns were embedded in their governance processes.

The trust was therefore not always responsive to people's needs across some of the services it provided. Recent changes and improvements to the single point of access and administrative hubs should help to make the trust more responsive in the near future.

Our findings

Planning and delivering services

Teams worked hard to ensure individualised and person centred care tailored to best meet the needs of patients, families and carers. Some people could access services, including acute admission wards and community teams, at the right time and without significant levels of delay.

The trust provided care which was largely responsive to people's needs. The service had an understanding of specific needs of the people it served.

We saw that staff on the inpatient wards worked with community teams to plan for people's discharge and community nurses attended ward review meetings prior to their discharge.

We saw that the physical health needs of people were routinely assessed and monitored and the team worked in collaboration to ensure that the identified needs were met. Specific care plans for people's physical health needs had been developed where appropriate.

The trust had recently introduced a single point of access (SPA) and administration hub which meant that all calls to the community teams were routed via the hub, which then

Good

Are services responsive to people's needs?

made contact with team members. Staff told us that this system did not work well initially. People had complained about not being able to get through on the telephone. Some referrals were reported to have been misdirected to other teams. We saw that efforts were made to improve the functioning of the SPA and administrative hubs. However the responsiveness of the SPA was still problematic in community services. Community nursing teams continued to identify the SPA service as a risk which affected the flexibility of community services.

Some patients we spoke with found it difficult to contact district nurses through the SPA. Parents we talked with or who had completed our comment cards referred to the hub phone line negatively because they had to wait for the health visitor to ring them back. There were delays in ordering specialist equipment for patients, such as specialist drains of up to eight weeks to be available because they were ordered through the SPA. One health visitor gave an example where it took four days to try and get hold of a speech and language therapist because they had to contact via a single point of contact number rather than ringing the clinic directly. Other health visitors explained they did not always get a message from the admin hub informing them a family was awaiting contact. There were recent incidents relating to the responsiveness of the SPA including incidents of formation about patient visits had not been passed onto community nurses and another incident where a patient had been left sitting on a toilet for over 2 hours before staff were contacted.

We received information from the trust in relation to the measures they had taken and planned to take to reduce the risks identified and concerns from staff, for example improvements and checks on the workflow management to ensure patients weren't missed. However community staff we spoke with were not aware of the changes made by the trust and therefore these changes had not been embedded in practice.

We found a number of issues in regard to consistently high levels of bed occupancy rates especially on the acute wards. Between January and March 2014, the trust's total bed occupancy was 99% compared to the England average of 87%. It is generally accepted that, when occupancy rates rise above 85%, it can start to adversely affect the quality of care provided to patients. The average mean bed occupancy for all of the acute wards across the Trust was over 100% when use of leave was included. We saw evidence that people had to be transferred across wards throughout the Trust as well as using out of area beds to manage demand. Close links were maintained to bring people back within area as soon as possible to ensure people received care closer to home. We saw initiatives to reduce bed occupancy levels including looking over the longer term which we report on in the effective domain. The lack of alternatives to hospital such as crisis house services or local authority led provision would mean any further reductions may impact further on stretched services.

People in acute care did not got a fully responsive service due to recent changes in the arrangements in medical care. The trust had changed to an integrated model of care so that consultants psychiatrists worked both in the community and were responsible for their inpatient people when admitted to provide continuity of care. Consultant psychiatrists were not able to be fully responsive due to competing demands. This impacted on in-patient care with reviews and appointments delayed or cancelled, people having to wait longer to see their doctors, medicine and Mental Health Act decisions (such as the approval of section 17 leave) not being made in a timely manner. The majority of people on the acute wards we spoke with told us that they were not able to see their doctors when they wanted to.

Most of the wards visited were delivered as same sex services and this meant that people were receiving the care they required and their privacy and dignity was maintained. The exception was the PICU that had good gender separation but observation levels were not always maintained to ensure people's dignity was maintained at all times.

There was no low secure service at the trust for females; patients who required this support have to be transferred to services out of area or into beds within the independent sector.

Right care at the right time

There were appropriate systems to share information with other services to ensure people received the right care at the right time. Community mental health staff were able to provide telephone support and home visits; if a person was assessed in a crisis staff would alert the intensive home treatment team, single point of access duty officer or make arrangements for a Mental Health Act assessment. People received timely input from the early intervention in

Good

Are services responsive to people's needs?

psychosis team who supported people when first diagnosed with experiencing psychotic episodes. Research shows that timely and responsive support at this stage of people's illness helps alleviate many of the negative effects of severe and enduring mental health problems later in life.

Where people were found in the community in crisis, there were good working relationships to ensure people were assessed in a timely way in the hospital based place of safety (HBPoS). There was effective inter-agency working including intensive home treatment team, crisis team, approved mental health professionals, assessing doctors, and the police service. This ensured that people were receiving the care they would need at the right time. Response times were short and good and people were kept in the HBPoS for only as long as necessary.

People across Bradford who were experiencing a mental health crisis told us about their problems in accessing support out of hours. We found that after a certain time the intensive home treatment teams hand over to a sole practitioner and to the A and E liaison service which was not commissioned on a 24 hour basis except on a temporary basis at Airedale General Hospital. People were not able to access the intensive home treatments out of hours except via telephone support. People were seen if they were assessed as needing a Mental Health Act Assessment but otherwise people were referred to access services within office hours or encouraged to go to A and E. This resulted in people going to busy acute hospital emergency departments when they were in mental distress and there may be delays in being seen by a mental health professional due to limitations on the service.

Before being admitted to the PICU comprehensive pre-admission information was obtained from the other wards, GPs or community teams, in advance of an admission to ensure staff knew of the risks and how they could best support people during their stay within PICU services.

Most people were discharged from in-patient care in a timely manner. Staff told us that discharge from the ward was sometimes delayed while a package of care for the person was agreed or due to people's social circumstances, e .g. homelessness or immigration status. People within learning disability services experienced delays being discharged from the assessment and treatment unit due to issues with delays in the allocation of social workers from the local authority. Efforts were made to progress delays for these reasons. Occupational therapists carried out home assessments and were able to ensure necessary arrangements were in place before older people were discharged. The data we received from the trust showed that there had been a relatively small number of delayed discharges in older people's services in the last six months. Most patients were followed up within seven days of discharge from inpatient care in line with national guidance. The trust had a local higher target of people being followed up within 3 days which was being met for over 75% of patients.

Specialist dental and chiropody services were provided at Waddiloves Health Centre for people in community learning disability services who were unable to access local community services

We saw outstanding care for people receiving end of life care. People were highly complimentary of the service and confirmed they had received a coordinated and seamless service. People in the end stages had access to 'The Gold Line' service which was available 24 hours a day seven days a week as an alternative to other health services such as phoning 111 including when having difficulty accessing their GP. Data for four months up to March 2014 showed 35 patients using the Gold Line had avoided unnecessary admission into hospital. There was evidence of proactive outreach programmes and service adaptations to meet the needs of people in vulnerable circumstances. For example, there was evidence of collaborative working to ensure palliative care needs for people with learning disabilities were met.

Waiting times for services were monitored across services for example in A and E liaison and in community services None of the older people's community mental health teams reported having a waiting list for services. However there was a waiting list of several weeks for the memory assessment and treatment service but the waiting time had been reduced substantially from six months.

Care Pathway

There were clear care pathways in evidence across in-patient, community mental health and community health teams.

The trust has commenced an innovative project to assess care pathways which was at pilot stage, identifying points where things are most likely to 'go wrong' within a certain pathway.

Good

Are services responsive to people's needs?

The aim was to identify and mitigate against risks thus improving the patient's experience and safety. Allied Health Professions (AHPs) and the Dental Service were testing the feasibility of this approach.

AHPs have identified the lack of specialist therapists on mental health wards for service users with specific physical health needs (e.g. a service user who had recently suffered a stroke and still required rehabilitation physiotherapy was unable to access it easily). AHPs have also identified limited dietician resource on wards as a risk.

People's diversity and human rights were respected. Attempts were made to meet people's individual needs including cultural, language and religious needs. Contact details for representatives from different faiths were provided and local faith representatives visited people on the wards. We found examples of culturally sensitive services being provided to older people using the service and in end of life care through palliative care liaison workers and female bilingual health support worker to discuss personal health issues. The trust staff reflected the diverse population of the local communities which meant that care could often be given in the person's preferred language where possible. We were told that translation and interpretation service were available although we heard of possible planned reductions in the service provided in-house.

A choice of meals was available with significant effort made to ensure a varied range of cultural needs were met representing the multi-cultural nature of the communities the Trust serves .

There was a good process in place for the prompt transfer of information to GPs about people's hospital assessment, treatment and care when they were discharged.

Learning from concerns and complaints

Our analysis of data from our intelligence monitoring before the visit showed that the trust received 94 formal complaints between period April 2013 to March 2014; a very slight increase from the previous year. Complaints therefore represented a very small number of incidents compared to the overall extent of daily interactions between the staff of the trust and people using the service throughout its services. Over half of complaints received and investigated in 2013-14 were upheld with 17 to be concluded. Two thirds of complaints reported came from the mental health services, with the other third coming from community health services. One complaint was under investigation by the Parliamentary and Health Service Ombudsman (PHSO).

Complaints were received for 45 different wards or teams. There were five or more complaints for three service areas:

- South and West Community Mental Health Team (10 complaints, four upheld, four to be concluded)
- North Community Mental Health Team (six complaints, two upheld, two to be concluded)
- Airewharfe Community Mental Health Team (five complaints, two upheld)

Common themes among the formal complaints included:

- staff – attitude, lack of support for patients, poor communication
- care planning
- record keeping
- wait for appointments.

These complaints may corroborate some of the pressures on community mental health services and changes in the way of working for example through the admin hub and move to single point of access which the trust was actively managing.

A recent review of the complaints function had led to changes of responsibility within the complaints department, the transfer of Patient Advice Liaison Service (PALS) to streamline the complaints and concerns process and the workshops which are taking place over the summer period to review the complaints procedure.

The complaints database showed that complaints were actively managed and progressed to ensure people received a speedy response. We saw evidence that attempts were made to resolve people's complaints and an apology given where necessary. We saw that learning had been drawn from complaints; for example one complaint highlighted that there were unclear transfer arrangements following the retirement of a community consultant psychiatrist and action drawn up to prevent this reoccurring; another complaint led to the development of an improved protocol for admissions of older people with functional health problems.

People using the service knew how to raise complaints and concerns. Information on how to make a complaint was displayed in most areas. Information on the patient advice

Good

Are services responsive to people's needs?

and liaison service (PALS) and mental health advocacy services were also displayed. Complaints were discussed in various meetings including service and locality clinical governance meetings and team meetings. This meant that the service ensured that learning from comments, complaints, compliments and concerns were embedded in their governance processes.

Good

Are services well-led?

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

Summary of findings

The trust had a 'vision wheel' which had been developed three years ago which articulated a well-developed vision and values. At a recent Monitor governance review it was identified that it was unclear how vision, values and objectives were translated into specific, measurable and time-bound (SMART) goals. In response, the trust were developing a new quality strategy which was in draft form.

We saw that overall the trust was well led with proactive and responsive trust wide leadership. There was a clear governance arrangements in place that supported the safe delivery of the service and to monitor and improve trust performance. Lines of communication from the board and senior managers to frontline services were mostly effective. Managers and staff understood the roles and responsibilities of governance and quality performance. While most staff were aware of the trust's vision and strategy, not all staff knew about these. Staff felt engaged with the trust and were well supported by local managers. We found that staff understood leadership structures, particularly at local level.

We saw some recent good examples where board members spent time within services to understand the challenges faced and were actively engaging with front line staff including clinical buddying, walk-abouts by the non executive directors and the culture conversations initiated recently by the chief executive officer. Staff felt well supported by their immediate line managers with the exception of the learning disability service teams. The recent scale and pace of change within the organisation was continuing to cause difficulties for the front line community and community mental health team staff. There had not been the appropriate level of engagement from leaders to ensure that this change was managed well. The scale and pace of change had also caused difficulties for service users in terms of accessing services and communicating with people within teams. We saw that there had been some recent improvements and a commitment to make these changes work including increasing trust board oversight and ownership of these issues.

Our findings

Vision and strategy

The trust had a 'vision wheel' which had been developed three years ago which articulated a well-developed vision and values. We were told that staff, people who use services and carers were integral to its development and it was developed in partnership. Senior managers acknowledged that the vision wheel may not be owned by community healthcare staff as they were not part of the trust when it was developed.

The trust was progressing an application to become a foundation trust with Monitor. Monitor requires that the Trust Board has appropriate quality governance arrangements in place. To be authorised, applicants must demonstrate a quality governance score of less than 4, with none of the four categories in the Quality Governance Framework (Strategy, Capabilities and culture, Structures and processes, and Measurement) can be entirely Amber-Red rated.

Monitor's pilot review process concluded that the Trust has a quality governance score of 4.0. Monitor found that the Trust had a vision, high level aims and strategic objectives which were quality focused, however succinct quality goals were difficult to establish from the strategy and other documents; it was unclear how objectives were translated into specific, measurable and time-bound (SMART) goals with the need for clearer milestones and outcomes. In response to the Monitor governance review, the trust were developing a new quality strategy which is currently in draft form.

Most staff across mental health in-patient services told us they understood the vision and direction of the trust and felt connected to senior management and the trust board. Trust messages on the vision and strategy were cascaded

via regular newsletters and in team meetings. Staff in older peoples services felt that dementia care services were an increasingly high priority for the trust. There were ongoing plans in place to develop children and families services to ensure the local population's needs were met within the health visitor implementation plan. The end of life service had a clear local vision to improve and develop high-quality end of life care with a move to a seven seven-day service supported this vision. Most community staff were aware of the trust's vision and strategy, however this was not fully embedded amongst all staff.

The Board Assurance Framework captures the key potential risks to the trust's strategy. These are assessed against the trust's strategic aims and business strategy. In common with all NHS providers, the trust has to make substantial cost efficiencies. We found some examples of where current resource limitations and the changes made to reduce spend may result in adverse consequences for patient care, for example the gap between demand for services and capacity, availability of out of hours provsions across the health and social care economy and pressure on in-patient beds. The Board Assurance Framework recognised the risks in this context.

Responsible governance

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

Data on performance was collected regularly and analysed by both the performance and governance departments. Performance against targets were monitored by senior managers to ensure any shortfalls were addressed. Information on monthly performance was on display in some services where people who use the service, visitors and staff could see it. The trust's risk management team analysed the risks within the organisation and this information was shared with all staff to reduce risks to safety. For example, the trust had provided data regarding the number of grade 3/4 pressure ulcers identified in the community. Significant learning had occurred and there had been improvements in the management of pressure ulcers as a result.

There was a lack of governance initiatives locally within the CAMHs service so it was not always clear how the service was aiming for continuous improvement.

As part of the inspection we asked for a number of trust policies to understand the frameworks in which staff should be working. A number of policies had passed their review date without being reviewed or revised. This meant that it was not fully clear whether policies were updated against current guidance to inform best clinical practice.

There were a range of risk registers across the trust from ward, service, directorate and corporate risk registers. Where we identified risks through the engagement events and at the inspection, we saw that these identified risks were already included within the risk register and plans in place to mitigate the risk. In common with all providers, the trust has to make substantial cost efficiencies which meant that some risks could not be fully mitigated because resources were not available, for example bed occupancy levels.

We saw that there was good oversight of responsibilities under the Mental Health Act responsibilities through the Mental Health Legislation Committee which included local authority representation.

Leadership and culture

We have seen some recent good examples where board members were actively engaging with front line staff, these include clinical buddying, walkabouts by the non executive directors and the culture conversations initiated recently by the chief executive officer. Since January 2014, in response to the Francis report, the Chief Executive was hosting culture conversations across the trust to help him understand from staff what it is like to work at the trust and whether there is a learning culture which was patient centred, open and transparent. Actions were then put in place to respond to feedback from staff during these conversations.

Senior managers had spent time within services to understand the challenges that frontline staff face,for example, the trust's medical director had visited Ward 24 recently and assisted with the provision of meals to people using the service and the director of nursing had spent time with the assessment and treatment centre.

We found that across services staff felt well supported by their immediate line managers. The exception within the learning disability service teams where there was a lack of

visible leadership. This meant that people who used the service did not always benefit from a service that was effective in meeting their needs and the team were unclear of their objectives.

The scale and pace of change in the organisation was reported as continuing to cause difficulties for the front line community mental health team staff and managers and was recognised by the executive team.

At the listening events and speaking with service users we also heard that the scale and pace of change had also caused difficulties for service users in terms of accessing the service and communicating with people within teams. We saw that there had been some recent improvements and a commitment to make these changes work including increasing trust board oversight and ownership of these issues.

Some staff said they had not been fully listened to as part of the consultation regarding these changes to anticipate problems, for example, in the development of the single point of access, administrative hubs and the move of the older people's wards from Duchy Court to Bracken Ward. People told us that the impact on staff and relatives in regards to increased travel was not fully appreciated in the planning or implementation of the ward move.

The trust had a range of programmes which had been or were being implemented as part of Leadership, Talent Development and succession planning.

Engagement

There was evidence of good engagement of people within mental health services including some outstanding examples such as the partnership with Barnardos within CAMHs services, service users being utilised within EIS services and service user development workers within some in-patient areas.

In relation to trust wide initiatives there was a range of involvement opportunities including

- a trust service user and carer involvement group which met regularly. Notwithstanding some positive outputs from this group comments from the engagement event reported that the group could be more effective and integrated more fully into clinical governance arrangements here were:
- 15 Steps Quality Challenge, a tool kit and a way of evaluating a service by having a multi-disciplinary challenge team looking at whether the service is welcoming; safe; caring and involving; calm and well organised and dignified and respectful which included service users within the evaluation.
- Patient feedback mechanisms through NHS Choices; Patient Opinion, satisfaction questionnaires, leaflets and by a facility called e-feedback in some clinical areas; this was an electronic feedback system where patients and their families could enter their answers to a series of questions
- Service User involvement in for example, interviews and events

A local carers' action group was active in raising concerns about the planned move of Ward 24 in 2015. People at the engagement events felt that the consultation on changes to older people's services were not meaningful and decisions were already made before consultation began. The trust was aware of concerns related to increased travel time and costs for carers and visitors to the proposed new ward and had agreed to finance increased transport costs for a fixed time period in response to these concerns.

Engagement with service users was less developed across community health services and related principally to feedback and limited involvement in governance groups. In addition, we did not see service user engagement integrated fully across clinical governance arrangements for mental health and community, for example clinical audits did not evidence involvement by service users in the design of audits and nor was there routine expectations that clinical auditing methods would ensure that the patients' voice was heard. A recent audit on restraint did not ask for patients' views on recent restraint episodes and whether patients were offered a debrief in line with the MHA Code of Practice.

The trust had responded to the small number of comments about its services made on websites such as Patient Opinion and NHS Choices website, where appropriate.

As a result of the NHS staff survey results 2012 a number of key areas were identified to explore further with staff and to enable regular 'temperature checks' to take place throughout the year. The key areas identified were:

- workplace stress and wellbeing
- line manager support.

The trust is in the best 20% nationally for eight of the 28 key findings, which includes percentage of staff witnessing and

reporting errors, near misses and incidents from the 2013 NHS Staff Survey and performs better than average for a further four key findings. The trust scored within the worst 20% of mental health trusts in two areas regarding staff feeling pressure to work when feeling unwell and the percentage of staff having equality and diversity training.

Following the release of the NHS staff survey results services developed action plans in response to the staff survey results for their local service areas.

The trust also survey staff on an on going basis, launched the staff 'Friends and Family' Test and carried out a number of health visiting teams workshops in March 2014. The purpose of the workshops were for staff to be provided with an update about the Integrated Care Pathway and for staff to input into this work going forward. Their views on this new way of working were collated and how staff were feeling at the current time was discussed.

Since January 2012 the trust's sickness rates have been consistently higher than the average when compared to mental health and community provider trusts. However, the trust has seen a slight decrease from 2012/11 to 2012/13 The trust has introduced new protocols to manage longer term sickness and reduce sickness levels overall. From the data submitted by the trust in April 2014, the percentage of permanent staff leavers in the last 12 months was 9%. There has been a steady increase from just over 7% in May 2013 although the 2013/14 remained below the 10% target. The trust reports that the main reasons for staff leaving in March 2014 were retirements, promotions and relocation.

We heard messages from community health and adult and older people's community mental health teams that staff felt disconnected from the wider organisation. At focus groups we organised, a number of community staff in community health, community mental health and older people's community services expressed feeling disconnected from the senior management within the trust.

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

Performance Improvement

The trust's programme for quality improvement 'Taking Quality Forward Programme' originally commenced in 2011 as an initial response the Francis Report. We saw examples of achievements / outcomes from Taking Quality Forward including:

- Serious incident management – improved approach to investigating serious incidents.
- Clinical risk management – clinical risk is more effectively addressed.
- Board walkabouts – programme of visits by Board members where issues are identified and acted upon.
- Clinical buddying – Non Executive Directors link with clinicians enabling learning and understanding.

Taking Quality Forward has been updated with new quality initiatives

Examples of quality initiatives in the refreshed Taking Quality Forward include:

- Patient stories – a range of patient stories have been used at Trust Board meetings for learning and sharing purposes.
- 'Talk to us, we're listening': enabling staff to ask questions and get a response.
- Medical staffing review: a full review of the medical staffing arrangements has been undertaken and actions implemented. Three new consultants, in adult mental health, had been recruited and this will lead to a reduction of locum usage.
- Family & Friends test has been implemented before being made mandatory. The latest results show that 89% of respondents were likely or extremely likely to recommend the trust's service to friends and family if they needed similar care or treatment.
- Care pathway assessment: Allied Health Professions (AHPs) and the Dental Service are testing the feasibility of a pilot to assess care pathways, identifying points where things are most likely to 'go wrong' within the pathway.
- Service user and carer quality event: the trust facilitated an event to capture service users' and carers' views.

These initiatives formed part of the new comprehensive quality strategy which is currently in draft form.

Data on performance was collected monthly throughout the integrated directorates of the trust. Performance measures included completion of staff training and

Good

Are services well-led?

appraisal and clinical measures such as the number of incidents and complaints reported. Performance against these targets was monitored by senior managers to ensure any shortfalls were addressed using a red, amber, green (RAG) system which helped to see at a glance the grading of risks and changes in the rating of risks.

We saw that learning had been drawn from incident and complaints for service improvement; However in a small number of cases it was unclear why the systems within the trust were not in place to ensure incidents did not occur such as proper transfer of caseloads following a member of staff leaving the trust and significant delays in ordering essential medical equipment.

We saw that there were a number of audits which were carried out which were able to measure standards in terms of development and improvement within the service. These audits included care planning and CPA, records keeping, hand hygiene, medication and health and safety. This meant that performance of services were monitored in order to drive improvement. Where performance did not meet the expected standard, action plans were put in place and implemented to improve performance.

The trust reported that it has performed well against nearly all principal indicators in 2013/14 including national indicators, quality indicators, contractual requirements, and finance and service transformation. A recent external audit on key performance indicators provided assurance to the trust that the data reported against four key performance indicators was accurate and represented a true level of performance at the trust.

The trust uses the Electronic Staff Record (ESR) system as its primary means of recording and monitoring Human Resource activities. Staff can also have access to their Employee Record to make requests and update details. A recent external audit on key risks was identified with this system and the objectives of the review were to provide assurance that the risks identified were being managed. This report provided overall significant assurance. An action plan was drawn up and implemented around the four recommendations made.

Some of the trust's services had received local or national recognition for providing quality and innovative services. For example, the palliative liaison service work with ethnic minorities had won a Department of Health and Social Care award under the category 'Improving Lives for People with Cancer' and was awarded with a commendation.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	People who use services and others having access to premises must be protected against risks associated with unsafe or unsuitable premises, by means of suitable design and layout and appropriate measures in relation to the security of the premises. Regulation 15. (1) (a) (b). How the regulation was not being met People who used the service and others may be placed at risk because each HBPoS suite environment had ligature points and did not meet fundamental standards within the good practice guidance of the RCP to assure against the risks of unsafe or unsuitable premises. There were ligature points in the toilets used which meant potential self-harm and ligature risks to people who used the service. Toilets were located in the corridors that were used by visitors which meant people were escorted to toilets through the corridors and could put other people at risk. Furniture was not fixed to the floor and that could potentially be used as weapons

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	People must be protected against the risks of receiving care and treatment that is inappropriate or unsafe by means of planning and delivery of care and treatment in such a way that meet people's individual needs. Regulation 9 (1) (b) (i). How the regulation was not being met People's needs were not met in a timely manner due to inconsistent medical care. Consultants and junior doctors were not able to turn up for reviews as scheduled and appointments with people were cancelled resulting in people having to wait longer to see their doctors. People were not consistently reviewed on

This section is primarily information for the provider

Compliance actions

time and this had impacted on people's care.People were not able to see their doctors when they wanted to. Doctors were not readily available to respond to urgent needs or emergencies when needed.