Bradford District Care NHS Foundation Trust

Quality Report

New Mill,
Victoria Road,
Bradford
BD18 3LD
Tel: 01274 228300
Website: www.bdct.nhs.uk

Date of inspection visit: 11, 12 and 13 January 2016
Date of publication: 08/06/2016

Core services inspected	CQC registered location	CQC location ID
Acute wards for adults of working age and psychiatric intensive care units	Lynfield Mount Hospital and The Airedale Centre for Mental Health	TAD 17 TAD 54
Mental health crisis services and health-based places of safety	Lynfield Mount Hospital and The Airedale Centre for Mental Health	TAD 17 TAD 54
Trust Headquarters		TAD HQ

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 services at this Provider	Good
Are services safe?	Good
Are services responsive?	Good
Are services well-led?	

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

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

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

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

Summary of findings

Contents

Summary of findings

Overall summary

When aggregating ratings, our inspection teams follow a set of principles to ensure consistent decisions. The principles will normally apply but will be balanced by inspection teams using their discretion and professional judgement in the light of all of the available evidence.

The Care Qualty Commission conducted this announced focused inspection to review two requirement notices given at our last comprehensive inspection in June 2014. These related to breaches of Regualtion 9 Person-centred care and Regulation 15 Premises and equipment. The breach of Regulation 9 was found in the adult acute services and this related to people's needs not being met in a timely manner due to inconsistent medical care. The breach of Regulation 15 was in relation to the health based places of safety not meeting the Royal College of Psychiatrists guidance to assure against the risks of unsafe or unsuitable premises.

The methodology we use to inspect in June 2014 has changed and the core services were different. For example, psychiatric intensive care units (PICU) and health based places of safety (HBPoS) were inspected under the same core service. Health based places of safety are now inspected in the same core service as mental health crisis services. As the requirement notices did not relate to mental health crisis services, we did not visit any of them during this inspection.

Following the inspection in June 2014, the trust submitted action plans to us telling us how they would make improvements. This also covered areas where we had made recommendations.

We inspected the trust on 11, 12 and 13 January 2016. We visited five adult acute ward areas and two HBPoS. We spoke with staff of different grades, spoke with patients using the service and looked at care records.

We visited the following ward areas;

- Fern and Heather wards at The Airedale Centre for Mental Health
- Maplebeck, Ashbrook and Clover wards at Lynfield Mount Hospital
- We also visited two HBPoS which are based across both sites.

We found the trust had met the requirement notices. The HBPoS environments had been refurbished and now meet the Royal College of Psychiatrists guidance. The trust had made improvements relating to the availability of medical staff to review patients on the acute wards. We reviewed the actions plans submitted by the trust to meet recommendation made by us in June 2014 and found these had also been completed.

This meant we were able to re-rate the trust at this inspection as we found they had taken sufficient action to ensure all areas of concern had been addressed.

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?

Good

We rated safe as good because;

- The trust had refurbished the environments of the health based places of safety at both sites. This meant they were fit for purpose and met the current Royal College of Psychiatrists (RCP) guidance.
- There were sufficient staff to ensure that patients received appropriate support.
- There was adequate medical cover during the day and out of hours on call arrangements were in place in order to access senior medical staff over 24 hours in place for both teams.
- Staff we spoke with knew how to report incidents and were able to describe what should be reported.
- Staff we spoke with told us they had good working relationships with the police who always communicated with them by telephone prior to bringing in a patient under section 136.

Are services responsive to people's needs?

Good

We rated responsive as good because;

- Consultants had dedicated timeslots for when they attended the acute wards.
- Patients told us the availability of medical staff had improved.
- Staff told us the timetable in place meant they knew when consultants were available to review patients.
- Patients gave positive feedback about their care and treatment on the acute wards.
- Patients were supported by staff to make complaints. Information on how to complain was displayed on all of the wards.
- Evidence was available at ward level, which showed staff discussed discharge from the point of admission.
- There were systems in place to review patient's progression through their episode of care.

Are services well-led?

Inspected but not rated;

Summary of findings

- The trust had taken action which ensured both requirement notices issued following the comprehensive inspection in June 2014 were met.
- The trust had refurbished two HBPoS suites at the Airedale Centre for Mental Health and Lynfield Mount Hospital to ensure they now met RCP guidance.
- The trust had impleted a timetable on the acute wards to ensure medical staff attendance was consistent throughout the week. This meant patients needs were now being met in a timely manner.
- The trust had developed and completed action plans to address areas where recommendations were made following the comprehensive inspection in June 2014.
- This included review of audits carried out within the child and adolescent mental health service to review existing policies and develop a forward plan of policy reviews. Also, audits of section 17 leave documentation to ensure risk assessments were being completed prior to leave being taken from the low secure wards.

Summary of findings

Our inspection team

The inspection team consisted of four Care Quality Commission inspectors, one assistant inspector and one CQC Mental Health Act reviewer.

Why we carried out this inspection

We carried out an announced focused inspection on 11, 12 and 13 January 2016 to review two requirement notices given at our last comprehensive inspection in June 2014. The trust had also submitted action plans to us telling us how they would make improvements in the areas where we had made recommendations.

How we carried out this inspection

We conducted this announced visit on 11, 12 and 13 January 2016. We talked to staff and senior management, visited ward areas, health based places of safety and reviewed care records.

We visited a number of areas including two male and two female acute wards, one psychiatric intensive care unit (PICU) and two health based places of safety (HBPoS),We spoke with 12 members of staff and 17 patients. We also reviewed the care records of 15 patients.

Information about the provider

Bradford District Care Foundation 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.

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 Hospital 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 services, CAMHS community teams, learning disability and community health teams.

What people who use the provider's services say

During our inspection, we spoke with 17 patients who were using the service. Most patients told us they felt safe. Patients also told us that staff were friendly and caring.

Most patients said they were happy with the cleanliness. However, one patient said they thought the ward furniture had not been changed for around 10 years. Patients told us they were able to personalise their bedrooms.

Patients we spoke with told us they thought the food was good, there was plenty of choice, and always something they liked. One patient told us 'snack boxes' were also available. Patients said they were able to make their own hot drinks.

Most patients said they thought staff were caring and that they, "do the best they can."

Summary of findings

Most patients spoke positively about their discharge and transition planning.

The health based places of safety were not in use during our visit so we were not able to speak to patients who were being assessed.

Bradford District Care NHS Foundation Trust

Detailed findings

Good

Are services safe?

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

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

Summary of findings

We rated safe as good because:

- The trust had refurbished the environments of the health based places of safety at both sites. This meant they were fit for purpose and met the current Royal College of Psychiatrists (RCP) guidance.
- There were sufficient staff to ensure that patients received appropriate support.
- There was adequate medical cover during the day and out of hours on call arrangements were in place for both teams in order to access senior medical staff over 24 hours.
- Staff we spoke with knew how to report incidents and were able to describe what should be reported.
- Staff we spoke with told us they had good working relationships with the police who always communicated with them by telephone prior to bringing in a patient under section 136.

Our findings

Safe and clean environment

All of the health-based places of safety (HBPoS) were commissioned for use 24 hours a day, seven days per week.

At Lynfield Mount Hospital and the Airedale Centre, the HBPoS environments met the current standards and regulations around the safety and suitability of premises and guidance on good practice published by the Royal College of Psychiatrists. The meant they were suitable to provide safe care and treatment for those detained under section 136 of the Mental Health Act 1983.

There were en-suite facilities within both HBPoS. The suites were connected to an alarm system with the rest of the hospital so staff could be called in an emergency. Patients had access to outside space for fresh air. There was direct access to the suite from outside so the police could bring someone to the HBPoS safely and discretely.

Detailed findings

The HBPoS were kept clean. The furniture within both suites was suitable for purpose. The chairs and sofa in place were sufficiently weighted and therefore could not be picked up or thrown to cause injury to others. There were curved mirrors in place where blind spots had been identified and there were no ligature risks. There were wall mounted TV's in place which were encased in secure cabinets.

Safe staffing

The HBPoS were staffed by the crisis team during working hours and the ward staff out of hours. The suites were managed by two experienced Band 6 nurses who would ensure that the HBPoS was staffed when it was being used during the day for a patient being assessed. The HBPoS were situated next to the acute wards at each of the two main hospital sites. This meant that staff from the wards were available to assist if required.

Staff we spoke with told us they had good working relationships with the police who always communicated with them by telephone prior to bringing in a patient under section 136. The staff also told us there were good communications in place relating to accessing approved doctors and approved mental health professionals.

There was adequate medical cover during the day and out of hours on call arrangements were in place in order to access senior medical staff over 24 hours in place for both teams.

Assessing and managing risk to patients and staff

There was CCTV coverage in HBPoS at both sites, which meant that the safety and security of patients and staff could be monitored at all times. At Lynfield Mount site there was no signage up to inform patients of this. However, the manager told us this would be in place by the end of the day. Staff told us that they carried a personal alarm and radio although the HBPoS always had two staff in attendance. In the event of an alarm being raised, staff from acute wards would also attend.

Staff told us the police agreed to stay in the HBPoS if there were risks of patients being violent or aggressive and staff felt that this arrangement worked well. Training in prevention and management of violence and aggression (PMVA) had been completed by all staff. This meant that staff had the appropriate training to deal with episodes of violence or aggression.

Track record on safety

There had not been any serious or untoward incidents relating to the HBPoS in the previous 12 months. There was an incident reporting system in place. Staff understood their responsibilities in relation to reporting incidents. Managers told us they analysed incidents to identify any trends and would take appropriate action in response.

Reporting incidents and learning from when things go wrong

Staff we spoke with knew how to report incidents and were able to describe what should be reported. Managers had access to monthly reports which included information from incident recording and achievements against key performance targets per team. Incident data was reviewed in senior management meetings, team meetings and individual supervision.

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 rated responsive good because:

- Consultants had dedicated timeslots for when they attended the acute wards.
- Patients told us the availability of medical staff was good.
- Staff told us the timetable in place meant they knew when consultants were available to review patients.
- Patients gave positive feedback about their care and treatment on the acute wards.
- Patients were supported by staff to make complaints. Information on how to complain was displayed on all of the wards.
- Staff discussed discharge from the point of admission.
- There were systems in place to review patient's progression throughout their episode of care.

Our findings

Access and discharge

The trust told us they had reduced the use of out of area beds to zero in the last 12 months. This meant patients received the care they need nearer to their home. We found evidence within the electronic care records that discharge was discussed and planned for from admission and at the first ward round by the patient's clinical team. We were told that 'dashboards' were in place which were 'RAG rated' to show where a patient was in terms of their treatment. The RAG system is a management method of rating for issues. We saw the system was reviewed on a daily basis by the nursing team.

We found that the trust had implemented systems to ensure that on each of the acute wards, consultants had dedicated weekly time slots for when they were available to attend the wards. In addition to this, the acute wards each had dedicated junior doctors and advanced nurse practitioners who were available around these times to assist with all aspects of patient care.

The facilities promote recovery, comfort, dignity and confidentiality

The ward environments were spacious, nicely decorated with a range with rooms available for therapy and activities. The wards had communal lounge and dining areas, quiet areas and offices. All wards offered patients access to outside space. Patients had their own bedrooms with en-suite facilities. They were able to accress their rooms at any time. We saw patients were able to personalise their rooms.

All the wards we visited had a programme of activities available to patients. Some activities were specifically recovery focused and were part of patient's individual therapy. Patient records contained personal activity plans that were discussed and agreed by both patients and staff.

Staff told us when patients were admitted to the wards they spent time with a member of staff who would become their named nurse. This person was responsible for ensuring the patient was settled in, oriented and had been given information about their admission.

The food menu was of good quality with healthy options available. Comments we received from patients about the food was, "good", "there is plenty of choice" and "it is really nice and of good quality." Menus were displayed on all ward areas. There were fixed mealtimes in place and snacks were available at all other times. Patients said they were able to make their own hot drinks.

All wards had locks on the main entrances with entry and exit controlled by staff. Signs were displayed on ward doors providing informal patients information about their rights to leave the ward with the exception of the Clover ward (PICU). All ward managers confirmed that patients were informed of their right to leave the ward. Patients we spoke with confirmed this.

Meeting the needs of all people who use the service

On all of the wards, information was displayed on notice boards to inform patients about the wards. This included the names of the staff on duty and how to make a complaint. Staff on the wards also wore uniforms, which made them identifiable to patients.

Good

Are services responsive to people's needs?

Managers told us interpreter services were available and these had been used to assist in assessing patients' needs and reading their rights under the Mental Health Act. The hospital had a multi-faith room and rooms where patients could meet their visitors.

Staff working in the trust were aware of patient's individual needs and tried to ensure these were met. This included cultural, religious and language differences with translation services available, leaflets printed in different languages and access to members of religious groups.

Patients were given a choice about the meals they ate and we were told that meals took account of people's cultural, physical and personal needs. For example, meals were available for patients who required halal meat, diabetics and vegetarians.

Listening to and learning from concerns and complaints

Patients told us they knew how to make a complaint and felt assured that any complaints made would be dealt with appropriately. Where one patient had complained about not having an aspect of their care discussed with them, we saw action was taken in response to this.

Staff told us they were aware of the complaints policy and described how they would respond

to a complaint from a patient. They also described additional support available for patients such as advocacy services.

We interviewed the ward managers on all the wards we inspected and asked them about how they would deal with complaints or concerns. We were told there was a complaints policy in place in the trust and any complaints would be investigated and responded to in line with this policy. However, we found some informal complaints were not being logged with the complaints department. In addition, the resolutions had not being logged. We discussed this with the operational service manager who told us this issue would be addressed immediately. We also received further assurance form the director of nursing around how the trust was improving their approach to dealing with complaints.

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

Inspected but not rated

- The trust had taken action which ensured both requirement notices issued following the comprehensive inspection in June 2014 were met.
- The trust had refurbished two HBPoS suites at the Airedale Centre for Mental Health and Lynfield Mount Hospital to ensure they now met RCP guidance.
- The trust had implemented a timetable on the acute wards to ensure medical staff attendance was consistent throughout the week. This meant patients needs were now being met in a timely manner.
- The trust had developed and completed action plans to address areas where recommendations were made following the comprehensive inspection in June 2014.
- This included review of audits carried out within the child and adolescent mental health service to review existing policies and develop a forward plan of policy reviews. Also, audits of section 17 leave documentation to ensure risk assessments were being completed prior to leave being taken from the low secure wards.

Our findings

Vision and values

The trust had a 'vision wheel' which articulated well developed vision and values. We were told it was developed with staff, service users and carers and it is about the culture of the organisation and everyone striving to improve, and also about responding to commissioners and working in partnership with our local partners and local authority.

Good governance

In relation to meeting the requirement notices and other areas of improvement recommended by CQC the trust have ensured that actions plans have been reviewed on a regular basis. This was evident in all areas looked at during the inspection. The HBPoS's at both sites have been refurbished to ensure current RCP guidance is now being met. The availability of medical staff on the acute wards has been timetabled to ensure weekly sessions are planned for and attended. Patients and staff reported to us that this system works well for them.

As part of this inspection, action plans relating to recommendations made at the last inspection in June 2014 were reviewed. This involved the inspection team reviewing a number of documents in relation to actions met. For example, review of audits carried out within the child and adolescent mental health service to review existing policies and develop a forward plan of policy reviews. Also, audits of section 17 leave documentation to ensure risk assessments were being completed prior to leave being taken from the low secure wards. The action plan for the HBPoS was completed in December 2014 and signed off by the Board in January 2015. The action plan relating to the Continuous Care Medical Model was signed off as complete at the May 2015 Board meeting.

Commitment to quality improvement and innovation

The trust described a number of methods they had engaged to drive improvement within services. For example, a piece of work has been carried out around complaints by the trust with the University of Central Lancashire in order to improve the handling of complaints within the trust. A team of peripatetic nursing staff have been set up within the trust to ensure services can be responsive and cover shortfalls.

Leadership, morale and staff engagement

The trust told us they have invested in a number of internal leadership programmes. 'Engaging leaders', is for every member of staff from band 7 and above all the way to executive level. It is a well designed programme with six modules which takes about six month with some high profile speakers. 130 staff have completed the first programme. There will be around 600 staff completed when the current programme has finished. The trust have also implemented a bespoke programme called 'Moving

Are services well-led?

forwards', which is addressing an issue of black and ethnic minority staff not progressing. Two members of staff have already achieved promotion and everyone is sponsored by a senior member of the team. The trust reported encouraging staff to take advantage of the external programmes, such as the NHS leadership academy. One of the key themes of the whole programme is wherever staff are in the organisation, they are a leader, it is a practical programme that encourages staff to take back to their teams.

The trust told us they were pleased with the results of their latest staff survey. Improvements had been made from the previous year in the responses from staff in felt raising concerns. Good responses had also been received on feeling supported, making a difference and having the opportunity to be appraised.