Bradford District Care NHS Foundation Trust

Inspection report

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Ratings

Overall trust quality rating	Good
Are services safe?	**Requires Improvement**
Are services effective?	**Good**
Are services caring?	**Good**
Are services responsive?	**Good**
Are services well-led?	**Good**

Our findings

Our reports

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

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

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

We award the Use of Resources rating based on an assessment carried out by NHS Improvement. Our combined rating for Quality and Use of Resources summarises the performance of the trust taking into account the quality of services as well as the trust's productivity and sustainability. This rating combines our five trust-level quality ratings of safe, effective, caring, responsive and well-led with the Use of Resources rating.

Overall summary

What we found

Overall trust

We carried out short notice (24 hours) announced inspections of three of the community mental health services provided by this trust.

We inspected community mental health services for adults of working age because we rated them requires improvement at our last inspection. We inspected specialist community mental health services for children and young people because of the high-risk nature of this service, and because we have not inspected this service since 2014. We inspected crisis and health-based places of safety because of the high-risk nature of this service.

We also inspected the well-led key question for the trust overall because at our last inspection we rated the trust overall as requires improvement.

At this inspection community mental health services for adults of working age, and crisis and health-based places of safety were rated as good overall. In community adults of working age, the rating had improved from requires improvement. In crisis services the rating stayed the same with an increase in rating in the safe key question from requires improvement to good.

Specialist community mental health services for children and young people were given a rating of requires improvement overall, with a rating of good in the caring key question. The rating had gone down since our last inspection.

We did not inspect four services previously rated as requires improvement because we did not have intelligence which told us about risk in these services. We are continuing to monitor the progress of improvements to these services and will re-inspect them as appropriate.

Our findings

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

- We rated services as requires improvement in the safe key question, responsive and effective as good, and caring as good. We rated the trust as good in well-led.
- We rated six of the trust's ten mental health services, and three of the trust's community health services as good.
- The trust had made a number of improvements since the last inspection, the ratings of the trust overall, acute wards and psychiatric intensive care units, and community mental health services for adults of working age had improved, the rating of crisis services had stayed the same.
- There were several areas of concern at the last inspection which the trust had made improvements to. This included; governance processes, oversight and management of risk and performance, a reduction in the use of restrictive interventions, improvements to serious incident reporting and oversight and management of supervision, appraisal and mandatory training.
- The trust had taken action to improve the safety of services, rapid improvement processes had been used where concerns had been identified. Daily lean management processes meant that leaders were aware of risks and concerns in front line services.
- We observed and were told about staff who were kind, caring and compassionate. Staff had received several compliments about their work.
- The trust had a focus on the wellbeing of staff, offering incentives as well as practical and emotional support. Staff spoke of a positive culture of openness and transparency from senior leaders and were encouraged to develop both their professional skills and be innovative in the services in which they worked.
- The trust was responsive to the diverse needs of the population it served, had awareness of and was working to reduce health inequalities.
- The trust engaged with partner organisations to be an active part of the integrated care system. The trust saw staff, governors, patients and carers as partners in care and worked to ensure their voices were heard in the improvement of services.
- The trust had an experienced and skilled leadership team and a board of non-executives who were passionate and from a range of backgrounds bringing diverse experience to their roles.
- Governance processes were effective and embedded with a clear ward to board structure for reporting.
- There were some areas of outstanding practice which included the trust's work in the clinical incident stress debrief service.
- The trust had successfully embedded and managed a large vaccination programme for both adults and children.

However:

- The rating of the trust's specialist community mental health services for children and young people had reduced from good to requires improvement since the last inspection. The trust were aware of the risks and issues in this service and staff told us that they were starting to see improvements and revised governance structures were in place, but these were not embedded at the time of the inspection.
- We rated four of the trust's mental health services and one community health service as requires improvement. In rating the trust, we considered the current ratings of the eleven services we did not inspect this time.

Our findings

- There remained issues in the services we visited in relation to the quality of documentation. Information about patients and their care and risks was not always accessible. In community mental health services for adults and for children and young people, risk assessments and care plans were not stored consistently and often stored in progress notes. Consent to treatment was not always recorded and paperwork relating to community treatment orders was not in line with the Code of Practice.
- The management of policies and processes needed improvement. Some policies were not in line with statutory codes of practice and important information on timescales and processes were not always included, this was particularly in respect of human resources policies, and those relating to the Mental Health Act.
- The duty of candour regulation was not fully applied in the incidents we reviewed because an early apology was not always given in line with the legislation and was not part of the trust's processes. The trust did not have a specific duty of candour policy, although the process was outlined within other relevant policies.
- The trust had a focus on quality improvement and there were a number of initiatives in place. However, it was not always possible to track how outcomes and actions from some initiatives were monitored, such as actions from the board's 'go see' visits and feedback from staff network groups.
- Information collated from the staff survey and workforce race and disability equality standards evidenced that the trust had further work to do in order to tackle inequalities in the workplace.
- The trust had an estate at Lynfield Mount hospital and in some community services which was no longer fit for purpose.
- The trust had governance processes in place to monitor areas of risk and concern. However, in some risks in front line community services such as staffing, and caseload levels were not always prioritised by the board.
- Waiting times in some services were too long. This included waiting times for adult and children's neurological services and waiting times for dental treatment and therapies.
- The trust had begun to make improvements to their patient safety process including improvements in the investigation of serious incidents. However, incident investigations required further improvement on human and causative factors. Incidents were often found to be individual staff error and there were repeat themes in incidents where professional curiosity was lacking and risk thresholds were too high, and it was not possible to track how action had been taken to improve practice when these issues were managed at service level.

How we carried out the inspection

- worked with experts by experience who talked to patients and their carers about their experience of using trust services.
- visited both specialist community child and adolescent mental health services at Fieldhead in Bradford and Hillbrook in Keighley.
- Visited three community mental health teams for working age adults; the City team, North team and the Aire Wharfe team.
- visited community crisis services; the first response service, the intensive home treatment teams and the psychiatric liaison service at Airedale General Hospital.
- visited trust headquarters to speak with senior leaders.
- spoke with a variety of staff in face to face or virtual meetings including; health care assistants, nurses, doctors, allied health professionals, and managers.

Our findings

- Attended and observed several meetings and committees held by the trust.
- reviewed several records relating to the care and treatment of patients.
- reviewed a variety of documents relating to the management of the trust and the services it delivers.
- held four focus groups with; staff network groups, staff side and two open staff drop in calls.
- reviewed a variety of information we already held about the trust.
- sought feedback from several of the trust's stakeholders such as Healthwatch, the local authority, NHS England and Improvement and CCG's.

You can find further information about how we carry out our inspections on our website: www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

What people who use the service say

During our core service inspections, we spoke with 33 patients who had experience of using services who were either patients or carers. Feedback was mainly positive. We also gathered feedback from patients via Healthwatch colleagues.

Young people using child and adolescent mental health services spoke about feeling supported by professional and caring staff who were respectful, and managed confidentiality well. They said that staff listened and understand and were empathic to their needs and that teams were reliable and offered a variety of treatments.

Patients using crisis services described staff who were caring, understood their needs, responsive and who communicated with them well, they said that appointments were arranged quickly.

Patients using community mental health services for adults of working age had positive experiences. They described staff who provided emotional and practical support, said that they had access to doctors and had information about their medication. Some patients told us that the support they were offered had kept them out of hospital.

However,

Young people using child and adolescent mental health services told us that communication could be improved as there was not always a point of contact available. Young people and their families were frustrated by long waiting times.

Patients commented that continuity of care and changes of staff could improve in crisis services.

Patients using community mental health services for adults of working age told us that it could be difficult to access support from Somerset House at times.

Outstanding practice

We found the following outstanding practice:

Our findings

The trust had developed a critical incident stress debrief service, who delivered sessions focussing on the impact of events and offering 'psychological first aid' to staff affected. The purpose of this work was to enhance the trust's wellbeing and support offer to staff. The service had commenced in October 2020 and had offered 39 sessions in its first nine months.

Areas for improvement

Action the trust MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the trust MUST take to improve:

We told the trust that it must take action to bring services into line with three legal requirements. This action related to one service and the overall governance of the trust.

Trust wide

- The trust must ensure that all staff have a disclosure and barring check in line with trust policy, and that there is appropriate oversight of renewal dates and action taken when staff do not have a valid check in place. (Regulation 17)
- The trust must ensure that performance monitoring includes all risks to quality, safety and performance (Regulation 17)
- The trust must ensure that duty of candour notifications and policy and processes are in line with regulations and that the notification given includes an apology (Regulation 20)

In specialist community mental health services for children and young people

- The trust must ensure that all risks relating to the care of children and young people are documented in line with trust policy and alongside appropriate care plans to mitigate risks in relation to their physical and mental health. (Regulation 12)
- The trust must review the waiting time for the eating disorder and neurodevelopment teams to ensure that young people are being seen for assessment within the trust target time. (Regulation 9)

In community mental health services for adults of working age

- The Trust must ensure that all patients have an up to date care plan. (Regulation 12)

Action the trust SHOULD take to improve:

Trust wide

- The trust should review how grade four pressure ulcers are reported to external organisations.
- The trust should ensure that policies in relation to; human resources processes, complaints, disciplinaries and those associated with the Mental Health Act are reviewed to ensure they are accessible, contain accurate timescales and information and are in line with legislation.

Our findings

- The trust should ensure that where quality improvement programmes are undertaken there are clear governance processes to follow up actions for improvement including from serious incidents, complaints, staff network feedback and go see visits.
- The trust should continue to tackle inequalities in the workplace and that improvement is seen in the workforce race and disability equality standards.
- The trust should ensure that all staff, including those working in non-patient facing roles receive an annual appraisal.
- The trust should ensure that there is timely and equitable access to services.
- The trust should continue with the development of patient safety processes to ensure timely reporting, learning and clear actions to address individual staff practice, professional curiosity, risk thresholds.
- The trust should continue to ensure that all staff receive training in moving and handling and breakaway.
- The trust should continue to address the environmental estates issues at Lynfield Mount hospital.
- The trust should continue to address the inconsistencies in the rating of risks to ensure that significant risks to front line care are considered as key risks for the organisation.

In specialist community mental health services for children and young people

- The trust should ensure that the environment in the Keighley service is young person friendly.
- The trust should ensure that consent to treatment is recorded.
- The trust should continue to monitor the performance of the service via the development of audits and dashboards.
- The trust should continue to monitor and improve staffing.

In crisis and health based places of safety

- The trust should ensure risk assessments and environmental checks are always carried out on the arrival of patients to the health based places of safety.
- The trust should ensure that every patient had a copy of their care plan and that this is documented.
- The trust should ensure feedback about the service is obtained from patients and family members.
- The trust should ensure that performance data relating to the timely assessment of patients using the service is recorded for quality monitoring purposes.

In community mental health services for adults of working age

- The trust should ensure that all patients subject to a Community Treatment order have been offered access to an independent mental health advocate and have been read their rights in accordance with the Mental Health Act Code of Practice.
- The trust should ensure that all legal paperwork relating to Community Treatment Orders have been filled out correctly and that it is accessible.
- The trust should ensure that it continues to reduce waiting lists.
- The trust should ensure that equipment checks are carried out within Trust guidance.

Our findings

- The trust should ensure that all staff understand the process to follow in the event of someone tying a ligature and know the location of the ligature cutters.
- The trust should ensure that staff follow and understand the referral process.
- The trust should continue to monitor and manage staffing levels to ensure a safe level of staffing at the service.

Is this organisation well-led?

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

Leadership

Leaders had the skills, knowledge and experience to perform their roles. They had a good understanding of the portfolio they managed and were visible in services and approachable for patients and staff.

The trust had an experienced, skilled and knowledgeable board and leadership team. The Chief Executive was new to the trust within the 12 months prior to the inspection and had brought refreshed leadership and focus, with experience of working across the NHS in community, mental health acute and specialist services.

The chief executive led the executive management team which consisted of; the chief operating officer (also the deputy chief executive), the director of nursing, professions and care standards (also the director of infection prevention and control), the director of financing, contracting and estates, the medical director, the director of corporate affairs, the chief information officer and the director of human resources and organisational development.

The trust had an experienced board chair and one senior non-executive director and five non-executive directors. One of the non-executive directors was also the deputy chair of the trust. The non-executive directors brought a variety of experience from their relevant backgrounds, this included those working in private sector business, those with an academic background and a legal background.

The trust had a diverse board which reasonably reflected the diversity of the population served by the trust.

The non-executive directors chaired the sub committees of the board including the; quality and safety committee, audit committee, finance, business and investment committee, workforce and equality committee and the charitable funds committee and the leadership structure provided clear lines of accountability.

The medical director was supported by a chief pharmacist, a research and development director, a deputy medical director and director of medical education, and associate medical director and coaching lead and a clinical lead for dental services.

The trust split clinical services into two care groups;

- the mental health care group responsible for; acute mental health services, community mental health services, older people's mental health services, learning disability services, and psychological wellbeing services.
- the adult and children's physical health care group responsible for; dental services, 0-19 and specialist children's services, and community health services.

Our findings

The trust worked in a triumvirate model within services. The mental health care group had a clinical director for; patient safety, community mental health, acute services, child and adolescent mental health services, older people's mental health services and specialist services. Within the physical health care group there was a clinical lead for dental services. The clinical leads were line managed by the medical director and their deputies.

Members of the non-executive and executive management team had responsibilities for specialist areas including designated named nurses and doctors for safeguarding adults and children.

Succession planning was in place and where leaders had left the trust, early planning was put into place to ensure recruitment without delay. The trust had deputy directors in post who were skilled and experienced.

Vision and strategy

Leaders knew and understood the provider's vision and values and how they were applied to the work of their team. The trust had a clear strategy in place which they had refreshed, and which was underpinned by a variety of other strategies to support the provision of services which meet the needs of the population.

The trust had a 2019-2023 strategy in place 'better lives, together'. The trust had recognised the need to refresh and review their strategic plan for the final year of delivery following the impact of the Covid-19 pandemic and the appointment of a new chief executive.

The trust had a clear vision for the organisation to improve to good.

The trust's core purpose was; 'creating connected communities and helping people to feel as healthy as they can be at every point of their lives'.

The strategy was underpinned by the trust's vision to 'connect people to the best quality care, when and where they need it, and be a national role model as an employer', had core values and key goals which allowed focus on delivery of the trust strategy.

The trust had a range of other strategies to support the success of the overall strategy, examples included an allied health professional strategy, volunteer strategy, involvement strategy and people development strategy.

The strategies were responsive to risks faced by the trust. For example, the draft improving access to psychological therapy strategy was developed in response to the level of demand exceeding the capacity of the existing resource.

Strategies were also responsive to need highlighted by national research and guidance and according to the priorities of the integrated care system, for example with the trust's developing strategy on approaches to trauma informed care.

The trust were acutely aware of the impact of health inequalities on the population it served and tackling health inequalities was embedded throughout the trust's strategies and work programmes.

Culture

Staff feel respected, supported and valued.

Our findings

During the inspection we spoke with a range of staff in interviews and more than 40 staff via focus groups.

Staff described that they felt; supported, safe, positive and connected. They described leaders who were open, visible and approachable and listened to the problems occurring for front line staff. They told us that leaders acted on concerns and found solutions. They described an organisation which pulled together during Covid-19 with digital teams who supported staff to work flexibly as needed.

Staff told us about the weekly executive broadcast and how this ensured that particularly community staff felt supported and involved.

Staff told us that their professional growth and development was nurtured and that they were encouraged to generate ideas and be innovative in their practice. Staff described a trust which worked as part of the health and social care system and engaging with partners in the community.

Staff felt that the trust took a genuine interest in their wellbeing, that the trust had a people centred ethos, and they felt that they were cared for.

However, staff in some services reported feeling pressured and tired, they felt that levels of sickness and vacancies were increasing and increasing needs of patients was having an impact on their ability to do their jobs well.

Leaders were aware of the pressures felt by staff. One of the trust's key strategic goals was 'best place to work'. The trust recognised that a good organisational culture was key to the delivery of high-quality services and there were several strategies and work programmes in place to achieve this.

The trust had a 2019-2024 people strategy which focused on recruiting, retaining and developing high quality staff, optimising talent, developing an inclusive and diverse culture, building engagement and involvement strategies, and developing leadership and managerial capacity and capability.

The trust monitored the people strategy via several mechanisms.

The trust had taken part in the 2020 NHS staff survey. The overall response rate to the survey was 44%, this had reduced from 47% in the previous year. The lowest response rate was within mental health inpatients at 24% with the highest response rate at 52% in corporate services. There had been improvements on the previous year's score on most questions within the survey. There was a significant improvement in some key questions:

- 65% of staff would recommend the trust as a place to work. This was an increase of 6% on the previous year.
- 67% of staff would be happy with the standard of care provided by the trust to a relative should they need treatment. This was an increase of 7% on the previous year.
- 78% of staff felt that the care of patients was the organisations top priority. This was an increase of 5% on the previous year.
- 44% of staff felt that the organisation was taking positive action on health and wellbeing. This was an increase of 7% on the previous year.
- 40% of staff felt that the organisation had enough staff to enable them to do their job properly. This was an increase of 11% on the previous year.

Our findings

There remained some areas of concern for staff where scores were worse than the average benchmark. These were; feeling pressured to work when feeling unwell, and musculoskeletal problems. Staff experiencing musculoskeletal problems due to work in the last 12 months was 33.9% which was an increase on the previous year and in line with the worst across the NHS. The trust had actions plans in place to address these concerns.

There were significant variances in satisfaction across trust services and for staff who identified as having a protected characteristic. The trust had a trust wide action plan in place and had also broken down the top three concerns from each service type into locality action plans. In order to monitor progress, the deputy director of human resources had submitted a mid-year review report to the workforce committee in September 2021.

The trust had three staff networks;

- aspiring cultures (formerly known as the Black and Minority Ethnic staff network)
- beacon network (long term health condition, disability and carers)
- rainbow alliance (lesbian, gay, bisexual and transgender).

The aspiring cultures and rainbow networks were established within the trust, the beacon network had recently refreshed and relaunched. Staff network leads described a commitment from senior leaders to the groups and to equality, diversity and inclusion. Staff network leads met regularly to share experiences, ideas and issues. Staff told us that one of the non-executive directors attended network meetings and was open and supportive to listening to staff. However, it was difficult to ascertain how feedback from staff networks was actioned by leaders for learning and improvement.

Staff we spoke with during the inspection told us that they felt that the trust supported and embraced diversity in the workforce and the population served by the trust. Staff said that senior leaders had become curious in listening to the experiences of staff and were committed to tackling inequalities in the workplace, particularly noting the disparity of impact of Covid-19 on people with protected characteristics.

The trust had developed a critical incident stress debrief service, who delivered sessions facilitated by trained staff from a variety of disciplines focussing on the impact of events and offering ‘psychological first aid’ to people affected. The purpose of this work was to enhance the trust’s wellbeing and support offer to staff. The service had commenced in October 2020 and had offered 39 sessions in its first nine months.

Staff told us about the Black Lives Matter pledge made by the trust board and described how the trust had asked all teams to have conversations about racism and anti-racism. In response, in one of the mental health clinical teams, staff had developed a cultural curiosity group speaking about issues of race and access within practice.

Staff and the trust were aware that there was further work to do to progress this work further and improve outcomes for staff and patients using services.

The workforce race equality standard became compulsory for all NHS trusts in April 2015. Trusts must show progress against nine measures of equality in the workforce.

The trust last reported on the standards in September 2020, 21% of the trust’s workforce were from a black and minority ethnic background. There had been some positive improvements, for example; there had been an increase in the

number of staff from a black and minority ethnic background in senior roles within the trust. However, staff from a black and minority ethnic background remained three times more likely to enter the disciplinary process than their white colleagues, more likely to experience bullying, harassment and abuse from colleagues and members of the public, and 29% believed that there were not equal opportunities for career progression.

The Workforce Disability Equality Standard is comprised of a set of ten metrics. These aim to compare the experiences of Disabled and non-disabled staff in the NHS. The trust's data for 2021 showed that 6% of trust staff considered themselves to have a disability.

The metrics reflected positively on the trust's improvements, for example; 6% of staff in band eight roles and 3% of staff at very senior manager level had a disability. There were no disabled staff who had been involved in formal disciplinary or capability procedures. Disabled staff were only slightly (less than 1%) less likely to be appointed after shortlisting for roles. 84% of the Disabled staff responding to the survey felt that their employer had made reasonable adjustments that enabled them to carry out their work, this was above the national benchmark.

However, there remained some ongoing actions for the trust. Staff with a disability were more likely to experience abuse or harassment from the public, colleagues and managers, but were less likely to report this abuse and this had worsened since the previous year. There remained a 7% gap in those staff with a disability who believed they have equal career progression in comparison to their non-disabled colleagues. These staff were also 8% more likely to feel pressure to attend work when they were feeling unwell and felt 10% less valued in their work.

The trust also monitored the gender pay gap and the bonus gender pay gap. The trust workforce was 81% female and 19% male. The Trust level pay gap was 9% in favour of male employees. This was an increase on the previous 12 months. The bonus gender pay gap was -49% a reduction of 66% since 2020. The gap was now in favour of female staff. The trust were ninth of all NHS Foundation trusts in England for the gender pay gap.

The trust also used the NHS staff survey to complete a sexual orientation analysis report in 2020. The report analysed the difference in responses from selected staff survey questions, comparing the experiences of lesbian, gay and bisexual staff working for the trust to the experience of heterosexual staff. Lesbian, gay and bisexual staff accounted for 3% of the trust's workforce. Analysis showed that this staff group had a more negative experience in the workplace than their heterosexual colleagues.

The trust had action plans in place to address concerns for all staff groups which included; recruitment and retention, review of reasonable adjustments, actions on abuse, bullying and harassment and staff engagement. The trust had ensured that all staff with a protected characteristic who may be adversely affected by Covid-19 were supported with timely risk assessments to ensure they were enabled to continue to work safely throughout the pandemic.

The workforce and equality committee monitored compliance with the standards via dashboards and monitoring of action plans.

Staff told us that they were able to raise concerns without fear. However, some staff told us that the freedom to speak up process could be inconsistent, and that enough dedicated time had not previously been given to the role. Other staff told us that the likelihood of speaking up was dependent on the service they worked within because support from line managers was variable throughout the trust.

Our findings

The trust had an interim freedom to speak up guardian who managed the role two days per week. A new guardian was joining the trust in October 2021 and would be full time. The trust had plans to enhance the role by having freedom to speak up ambassadors based within services throughout the trust, there was not a timescale for this at the time of the inspection.

The freedom to speak up guardian told us that leaders were responsive to feedback from them and that the role and process was given importance within the trust's day to day working practices.

There were a variety of ways in which staff could contact the guardian. This included directly via telephone and email, and by raising anonymous questions for example during executive broadcasts. The trust had also advertised the availability of the guardian in staff wage slips, on the intranet and via posters for those who did not have access to email regularly.

The guardian also held drop-in sessions for staff. Executives attended these drop-in sessions to allow staff to ask questions with an open and transparent culture. Some staff valued this approach, we were concerned about the impartiality of these discussions and whether staff would feel confident to raise concerns.

Leaders were sighted on concerns being raised via this route. The guardian provided annual reports to the workforce and equality committee, the most recent report was provided in May 2021. This report showed that the trust had a freedom to speak up index score of 79% which was within the national average. The annual report contained several actions for the coming year to enhance the offer to staff. The plan included reaching out to recognised harder to reach groups of staff such as foundation doctors, staff network members and volunteers.

The guardian shared themes and overall learning from cases with the board, the workforce and equality committee, the patient safety and learning group and held a monthly meeting with the staff side chair, human resources leads, and the equality, diversity and inclusion lead.

The trust's quality dashboard included a quarterly update to the board on how many cases had been raised. In April to June 2021 there had been 20 staff who had chosen to speak up via the guardian, this was an increase of five staff on the previous quarter and the most reported theme was bullying and harassment. 13 staff who of these raised concerns asked not to be identified to the organisation and two were anonymous emails. Leaders were considering whether the increase in concerns raised was because of enhanced focus and communication about the guardian role, or whether this was a sign of cultural concerns.

There had been concerns relating to the culture within inpatient acute wards and forensic secure wards since the last inspection. Staff had not always treated patients with dignity and had not always acted in accordance with trust values. Where these incidents had occurred, the trust had taken appropriate action. However, there was not enough consideration and action planning within boards and committees of how the trust could be more proactive in identifying the risk of closed cultures developing within services. At a service level the trust had recently begun cultural conversations in inpatient services to ensure staff had protected time to discuss any concerns with managers.

The trust had dashboards and metrics in place to monitor staffing including sickness, vacancies and turnover. Dashboards were discussed in board meetings and sub-committees for oversight of risks. However, these focussed on inpatient services whereas most of the staffing risk was within community services.

Our findings

The trust had a sickness target of 4%. In July 2021 this was noted to be 7% which was an increase on the sickness rate of 5% reported in July 2020. Of the sickness absence, 5% were related to long term sickness, and 2% to short term sickness with anxiety, stress and depression remaining the main reason for long term staff sickness.

The trust had a vacancy rate target of 10% and were meeting this target at the time of the inspection with a trust wide vacancy rate of 10.5%.

Where there were gaps in staffing, the trust used agency and bank staff to ensure staffing levels were safe. The rates of use were increasing. As at July 2021, the trust had requested 11085 bank shifts and 2229 agency shifts. 15% of these shifts remained unfilled. The trust monitored the reasons that temporary staff were utilised and noted that these were the use of enhanced observations, vacancies and staff sickness absence.

The trust monitored compliance with safe staffing levels in the inpatient wards. In July 2021 staffing levels fell below 80% on five of the 13 inpatient wards.

Leaders were sighted on staffing risks and had a people development strategy in place (2019-2024) which outlined plans to mitigate risks from sickness, recruitment and retention. In the services we visited leaders had ensured that appropriate staff were deployed to provide care.

The trust did not have the same detailed staffing metrics in place to monitor staffing in community services for example to service and team level as they did with their inpatient services. Staffing concerns in community and district nursing are noted as a significant risk in the trust's organisational risk register and required an enhanced focus to allow oversight of impact on patients and staff. For example, the highest sickness levels recorded in July 2021 where across all community adult nursing services, dental services, and Bradford and Wakefield children's service areas.

Staff we spoke with during our inspections spoke of feeling pressured by staffing vacancies and sickness levels across the trust. Staffing was noted to be a challenge in 0-19 services, district and school nursing and child and adolescent mental health services.

Staff had the opportunity to discuss career development in annual appraisals which were aligned with the trust's values, strategy and quality improvement methodology. As at July 2021, the trust wide appraisal rate was 89%. However, compliance was worse in services with an administrative function with 63% completion in medical administration, 56% in digital services and 53% in trust management.

Staff had the opportunity to access clinical supervision, as at July 2021 compliance rates across the trust were 87%. The trust had been able to show a steady increase in compliance across all services which was an improvement since the time of the last inspection. Staff told us that they had access to good clinical supervision. Clinical supervisors had access to coaching skills sessions to enhance their skills.

The trust offered a variety of opportunities for career progression which included; trainee apprenticeships, nursing associate roles, the moving forward programme, leadership and management development passports. Staff told us that they were encouraged and supported to undertake training and continuous professional development.

The trust had a guardian of safe working hours who were experienced in their role. The trust had a mandatory target to reach zero working time directive breaches (over 60 hours per week) and zero shifts reported where doctors worked without an 11 hour rest break between shifts.

Our findings

In July 2021 there were no breaches of the 60 hour week but 43 occasions where doctors had worked without at least an 11 hour rest break between shifts. There were also 69 occasions where doctors worked more than 48 hours in a week, 49 occasions where Doctors worked more than 200 hours in a month and 160 occasions where Doctors were rostered to work more than four consecutive days or nights in a row.

The trust had plans in place to address these issues which included rostering rules to support the ongoing monitoring and reduction in occurrence. In addition, the trust had mechanisms for support to junior doctors which included virtual forums and monthly meetings with consultants. The guardian of safe working hours was able to give examples of how issues were resolved using these forums and of using exception reporting to make improvements.

The trust had a process in place to address poor performance which included a disciplinary policy. The trust identified the key messages from the policy as; 'supporting learning, investigating fully before taking action, ensuring staff have their say and know their rights and outlining the authority of managers in cases where disciplinary action is necessary'.

The trust had undertaken 19 disciplinary procedures with staff since 1 September 2020, of which four remained open at the time of inspection.

The trust's personal responsibility framework was aimed at supporting culture change, quality improvement and continuous improvement within the trust. The framework encouraged an environment which was supportive in changing behaviour, improving practice and supporting people to learn from mistakes. Cases where the personal responsibility framework was used as an alternative to formal disciplinary were monitored by human resources to collect and monitor equality and consistency data. Managers were responsible for ensuring the actions contained in improvement notices or development plans were delivered and monitored.

The trust disciplinary policy outlined timeframes for notifying staff of a hearing and timeframes for making an appeal. It did not stipulate timeframes to guide staff or investigators how long it should take for a disciplinary investigation to be completed. The trust told us that the target date for completion was 90 days and that there was a framework in place for monitoring against this key performance indicator. These timeframes were not included in the workforce dashboards and not readily available to members of the board.

There were delays in the processes. Of the 19 disciplinaries undertaken, fourteen had taken three months or more to complete, of the four that remained open, the longest had been open for seven months. In two other cases we reviewed, one had a delay of seven weeks between the date of a case conference and the outcome letter being sent to the staff member involved, the second case had an outstanding investigation report which had been in progress for three months. Staff also told us that there were delays and inconsistencies in these processes.

The trust had also begun embedding the NHS 'just culture' principles, beginning in August 2020 with a self-assessment framework including consultation with staff and staff side representatives leading into an action plan which was drafted in November 2020. The purpose of this work included the enhancement of reporting cultures across the organisation. This was not yet embedded at the time of the inspection.

The trust had a grievance policy and procedure which was in date and due for review in March 2023. The policy appropriately identified the use of the employee wellbeing and assistance services.

Our findings

The trust had managed 22 staff grievances since 1 September 2020. Five had been resolved informally, two had been partially upheld, one had been withdrawn and seven had not been upheld. At the time of inspection, seven were ongoing, the longest of which had been ongoing for eight months. They included concerns about recruitment processes, the behaviour of colleagues and allegations against managers.

We reviewed five grievances managed by the trust in the last 12 months, in two of the four cases investigated the timescales within the trust's policy had not been met.

The trust had disclosure and barring service procedure for staff to follow, which supported the Trust's employment policy. The procedure was due for review 31 October 2021.

Data provided by the trust evidenced that 139 of the trust's 3674 staff (4%) did not have a valid disclosure and barring check in place. The trust policy outlined that all staff had a check every three years or if they moved to a role which required a different level of disclosure.

We were concerned about the length of time some renewals had been overdue with no restrictions in place on staff working within services whilst they were completed.

The trust told us that these staff did have a valid disclosure and barring certificate in place but due to sickness absence or leave the data was not correct. The trust advised that they had started to work on this immediately after the inspection.

We were concerned that although performance data on compliance with disclosure and barring checks was provided via performance dashboards, they did not specify renewal dates which limited the oversight of the board.

The trust monitored the revalidation of staff who required a professional registration for their role and this data was reported to the quality and safety committee. The last data set was from April 2021 which showed that 95% of staff had been revalidated in date. Seven staff had not been revalidated within the required timescales.

The trust had a mandatory training programme in place for all staff which was thorough and appropriate to individual job roles. Staff could undertake additional training for specialist roles. In July 2021, overall trust compliance with mandatory training was 93%, this was an improvement since our last inspection. Performance dashboards reporting mandatory training compliance were broken down to service and team level to allow oversight and monitoring.

At the time of the inspection, compliance with training in moving and handling and breakaway were 71% and 61% respectively. However, this was due to the impact of Covid-19 on the ability to deliver face to face training. The trust had a plan in place for staff to be 80% compliant in line with trust target by January 2022.

Governance

Our findings from the other key questions demonstrated that governance processes were mostly operating effectively across the trust.

There had been improvements in governance systems since the last inspection particularly in supervision and mandatory training rates, oversight of restrictive interventions and investigation of serious incidents.

Our findings

The trust had structures, systems and processes in place to support the delivery of its strategy including sub-board committees and non-executive and executive directors were clear about their areas of responsibility.

We observed and reviewed papers from these sub-committees and the trust board. There were clear lines of responsibility for each sub-committee aligned with the board assurance framework. Risks were discussed and there was an appropriate flow of information between the board and the sub-committees. Committees met jointly where issues crossed between them, this evidenced the flexibility of governance processes in order to meet the needs of the trust. There was appropriate challenge and support from non-executive directors to the executive management team in holding leaders to account on areas for improvement.

There was effective flow of information throughout the trust. Daily lean management processes highlighted risks in front line services which were escalated as required to senior leaders. There was flow of information to the board and sub-committees via performance reporting and leaders provided reports and updates on work programmes. Additions to governance processes such as the patient safety and learning group and the compliance and risk group allowed enhanced oversight and action on high risk issues.

The trust had effective governance processes in place relating to the management of the Mental Health Act via the mental health legislation committee, chaired by a knowledgeable and experienced non-executive director. The committee had commissioned areas of work to address concerns such as a section 136 audit and had explored equality and diversity issues in reasons for detention to assess whether certain population groups were adversely affected.

The committee met bi-monthly, an involvement partner (a patient) was invited to contribute to the meeting. The meeting had a performance dashboard which was used to explore data on areas such as; the use of sections of the Mental Health Act and the number of care and treatment reviews carried out. The committee used CQC Mental Health Act review reports for feedback and action. The group provided an annual report on progress and actions.

The trust had a mental health legislation and care programme approach lead and a well-resourced mental health act administration team who all held a certificate in mental health law.

The committee reviewed data on restrictive interventions such as rapid tranquilisation, restraint, long term segregation and seclusion and blanket restrictions. This allowed the committee oversight of trends and concerns.

An area of good practice was the trust's approach to the use of restrictive interventions and commitment to their reduction.

The positive and proactive steering group met monthly and membership included senior leaders, staff and patients. The group reviewed monthly intervention reports of all restrictive interventions undertaken across the trust. Each inpatient ward was asked to return a monthly review document to explain where unusual, out of the ordinary patterns or successful actions in reducing restrictive practice have occurred related to; full physical intervention, rapid tranquilisation, long term segregation and new blanket restrictions.

A further working group had consulted another NHS provider to roll-out the concept of 'no force first'. A planned approach to the roll out was in place beginning with a review of management or violence and aggression training and moving to a pilot project within an inpatient ward environment.

Our findings

The trust had a range of policies and procedures in place in relation to the Mental Health Act. These included; the Mental Health Act, Mental Capacity Act and Deprivation of Liberty Safeguards, searching, seclusion, observation of patients, consent, and care programme approach. There were some areas of these policies which required review:

- the Mental Health Act policy cited an advocacy service no longer used by the trust.
- the seclusion policy was unclear on who the independent party should be in multidisciplinary review, as it referred to both the responsible clinician and the nurse in charge.
- the searching policy was not compliant with the Code of Practice regarding the searching of patients without consent. It stated that this was the decision of the nurse in charge whereas the Code of Practice states this is the responsible clinician's decision. The policy did not state that search should be completed where possible by a person of the same gender.
- the care programme approach policy was due for review in May 2022 however due to the revisions to this framework an early review would be good practice.
- the failure to attend policy referred to the 'Children's Mental Act' which is not accurate.

The trust had a patient advice and complaints department, a complaints policy and complaints handling procedure. However, it was not available on the trust website for use by people external to organisation.

The trust told us that they worked to a timescale of responding to all complaints within three working days and resolving all complaints within six months. This was not in line with the trust policy which stated that the response time was 30 working days for less complex cases and 60 working days for more complex cases. Performance data showed that in the last twelve months, 99% of complaints were responded to within six months.

All formal complaints were signed off by the chief executive to ensure oversight of risks and concerns raised by patients.

Between 1 September 2020 and 1 September 2021, the trust received 59 formal complaints and 532 informal complaints (concerns). Of these formal complaints nine were upheld, six were partially upheld, 23 were not upheld, two were inconclusive, one was withdrawn, one was closed and 17 were ongoing.

The team with the highest number of informal concerns raised was the first response service, services with the highest number of concerns raised were community mental health teams for adults of working age and community child and adolescent mental health services.

The top five reasons for complaints were; information, lack of support, attitude of staff, medication and waiting for appointments.

We reviewed five complaints during the inspection. We found that complaints investigations were thorough, and investigations took place involving relevant people, with follow up in writing. However, the trust's response to complainants did not always contain clear information for complainants regarding the timescales expected for them to receive an outcome.

The trust had undertaken an annual review of patient complaints and advice and this was shared at the quality and safety committee in May 2021.

Our findings

The trust gathered feedback from staff and complainants who had been involved in a complaint or made a complaint to improve and enhance experiences. There were specific examples of where the trust had used complaints as learning for example acute inpatient services had made amendments to the section 136 standard operating procedure to ensure responsibility and accountability was clear following a complaint.

Between 1 September 2020 and 1 September 2021, the trust had received 298 compliments. The main theme in compliments was that patients and carers commented on the support and professionalism provided by staff across the services.

Management of risk, issues and performance

Leaders used performance systems to identify, understand, monitor and reduce or eliminate risks.

NHS Improvement supported that the trust recognised its financial challenges, worked collaboratively and consistently delivered financial stability and planning. The trust had not reported any regulatory issues or adverse external audit reports and NHSE&I has not had any reason to need to test financial governance due to the trust's current financial position.

The finance, business and investment committee met bi-monthly and had oversight of financial risks to the organisation. The non-executive director who chaired the committee had a private sector business background and brought experience to the role.

The trust reported in July 2021 a high rate of confidence in hitting controls in half one of the year, forecasting a break-even position. They continued to plan for efficiencies with a cost improvement plan in place. The trust had sought external support from an external consultancy to consider cost improvements.

Risks to the trust financial position continued to be the financial impact of; agency staff use, staff sickness, the use of enhanced observations, enhanced infection, prevention and control, and out of area placements.

The trust's deputy director of patient safety, compliance and risk was the lead for the trust's sustainability transformation programme; together we improve, create and sustain (TWICS). This programme was sponsored by the Chief Executive who is responsible for reporting progress to the finance, business and investment committee and trust Board.

The trust continued to have estates challenges in their inpatient services at Lynfield Mount Hospital. The estate was no longer fit for purpose for example it included shared patient bathrooms in some areas. The trust had expressed an interest in capital funding from the new hospitals programme. The trust had worked with the integrated care system and providers at place to support the prioritising of funding for the estate.

The trust had an estates and facilities team who were aware of issues faced by front line staff and had addressed some areas of concern such as providing lone working devices to staff and addressing lighting and security issues at Lynfield Mount Hospital.

The trust had an infection prevention and control team, and effective systems and processes in place to manage infection prevention and control and we were assured by their board assurance framework during Covid-19.

The trust had systems effective systems in place to identify risks including incidents and safeguarding.

Our findings

Staff used an electronic system to report incidents and the trust had an incident reporting policy in place. The number of incidents reported in July 2021 was 934 incidents, this was in line with the trust average. The trust had incident dashboards in place which reported numbers of incidents, the number of incidents of violence and aggression, medication incidents and near miss incidents.

In the twelve months prior to the inspection we had raised concerns with the trust in relation to risks of staff not always reporting all incidents. In response to this the trust were developing the 'just culture' principle.

Between 1 September 2020 and 31 August 2021, the trust had reported 31 serious incidents. Of these incidents 18 related to the suicide of patients using adult or children and young people's community mental health services. Other incidents included admissions of children, staff behaviour, medication and information governance. The trust had a governance process in place to investigate patient safety incidents. All incidents reported via the electronic system were screened by the serious incident team.

Serious incidents were overseen on a weekly basis by the serious incident panel, (chaired by the director of nursing, professions and care standards and medical director), and outcomes of serious incident investigations were reported on a monthly basis into the patient safety and learning group and to the board.

We reviewed four serious incidents during the inspection. The trust had made progress in the quality of serious incident investigations since the time of the last inspection. The trust was aware that further improvements to serious incident reporting were required. We found that serious incidents remained more of a review of care and compliance with policy and process rather than a thematic analysis.

In the incidents we reviewed, there was limited analysis of clinical decisions, risk appetite was often a causative factor, and, in some cases, we found that the staff involved had lacked professional curiosity.

In order to address the issues with serious incident investigation, the trust was using refresher training in the use of the 'five whys' approach to prepare for the launch of the NHS patient safety incident response framework and were considering the use of subject matter experts in serious incident investigations.

The trust had agreed key performance indicators in place to enable effective monitoring of their patient safety process, the target for each was 100%.

- patient safety investigations allocated an investigator within 24 hours. As at 1 September 2021, the trust were 97% compliant with this target with one incident not allocated within 24 hours.
- initial patient safety review completed within two weeks following the incident. As at 1 September 2021, the trust were 86% compliant with this target.
- patient safety investigation approved within timescale of 12 weeks. As at 1 September 2021 the trust were 63% compliant with this target.

The trust told us that the reasons for delays was due to availability of key people within the investigation process both internally and externally to the organisation.

Our findings

The trust continued to monitor the occurrence of pressure ulcers in patients accessing community nursing services. A pressure ulcer strategy was in place which included; monitoring pressure ulcer incidence, sharing themes trends and learning across the localities and developing training to meet the needs identified. The pressure ulcer training programme was comprehensive and included delivery to care and nursing homes.

There had been an overall decrease in the number of pressure ulcers occurring, and the number occurring where there had been an omission in care. In April 2020 386 pressure ulcers were reported with a decrease to 87 in May 2021. Omissions in care either at home or within a care home setting were reported to be 72 in April 2020 and 13 in May 2021.

However, there had been an increase in the occurrence of grade four pressure ulcers, with 12 confirmed incidents reported between January and April 2021. Two of these incidents had prompted the use of the duty of candour and omissions in care were found. The serious incident investigation process had not been followed and the incidents had not been reported through the strategic executive information system. This meant that although learning was shared internally from these incidents, information was not shared with commissioners, NHSE and CQC.

The trust had investigated these incidents from a thematic perspective and had developed a strategy to manage and mitigate the risks identified which included enhanced training on reporting, and the development of a pressure ulcer dashboard for additional oversight.

There was evidence that the trust had processes to ensure learning occurred following serious incidents. For example, prior to the inspection, leaders were aware of an increase number of patient suicides in the community. The themes from the serious incident investigations identified that many of the patients involved did not have up to date care plans and risk assessments. The trust implemented a rapid improvement week in 2020 with the chief operating officer as the executive sponsor to resolve this issue. There had been effective improvements in compliance as an outcome of this work.

The trust had other mechanisms for learning which included communication with staff and learning events.

The trust had a ‘patient safety and learning group’ which met monthly. Staff from partner organisations had been invited to attend. Outcomes of complaints, audits and regulatory visits were discussed. An action log was in place to monitor the progress of the group.

In order to additionally monitor quality, the trust had developed quality and safety visits. A quality assessment tool was used, which was based on CQC’s key lines of enquiry and on-site visits were undertaken to assess quality against standards. The outcomes were monitored via the patient safety and learning group with reports on outcomes of the visits shared with service managers for action.

The duty of candour was referenced in the serious incident policy, and the incident reporting and management policy. However, there was not a specific policy in relation to the duty of candour.

The trust had demonstrated good awareness of some parts of their statutory duty of candour. Since 1 September 2020 the trust used the Duty of Candour process on 50 occasions for notifiable safety incidents, 33 of these were within serious incident investigations.

Our findings

We reviewed three of these incidents and found that the trust had informed the affected patients of the incident and offered reasonable support. However, the trust had not demonstrated full adherence to the principles of the duty of candour because an apology was not evident in any of the three incidents we reviewed. In addition, the need to make an apology was not present in the trust's process.

The trust had good systems in place to identify and manage safeguarding concerns in relation to adults and children. There was a designated named nurse and doctor in place for safeguarding.

The trust had a safeguarding adults and safeguarding children policy which were in date contained relevant information and guidance on key subject areas.

The adult safeguarding policy required a review to bring it into line with trust processes. It stated that the process for referral to the local authority was first via a line manager or safeguarding manager within the trust for advice prior to referral to the local authority. We were concerned that this meant that information may be diluted in communication and delayed. We discussed this with the trust who provided assurance that this was a wording error and that the policy would be amended and reissued for clarity and that this was not the process in practice.

The trust had a clear mandatory safeguarding training programme in line with inter collegiate guidance. Compliance with safeguarding training was 85% and above across the trust.

There were other learning opportunities available for staff which included seven-minute briefing sessions and an online site to access safeguarding information. The safeguarding team produced quarterly safeguarding newsletters which included lessons learned from case studies or serious case reviews, and changes to policy or procedure.

During the inspection we reviewed 12 safeguarding referral forms for adults and children. We found them to be of good quality. Referrals evidenced that staff had a good understanding of safeguarding and referred risks when appropriate to access multi-agency support.

The trust had several reporting metrics in place to monitor safeguarding concerns contained in a safeguarding dashboard which was discussed at board and committees, the dashboards tracked the number of referrals completed and the number of duty calls received for support.

In addition to reporting via dashboards, the trust head of safeguarding produced an annual safeguarding report and a monthly safeguarding assurance report to the Care Group Quality and Operations meetings.

The trust had been involved in one child safeguarding practice review published in February 2021. The review evidenced that several actions had been put into place to make improvements since the time of the incident.

In July 2021 the trust (along with partners across the city) were involved in a 'Thematic Child Sexual Exploitation Child Practice Safeguarding Review' and the trust were working with partner organisations to set an action plan.

The trust had a mortality review process. All deaths of patients using trust services were reviewed in the weekly mortality and duty of candour meeting, chaired by the medical director and director of nursing, professions and care standards.

Our findings

Between 1 September 2020 and 1 September 2021, the trust reviewed the deaths of 329 patients receiving services. At each meeting the group discussed each death and the circumstances deciding whether further investigation was required. The group reported learning identified through reviews into the appropriate governance processes.

We reviewed three structured judgement reviews during the inspection, they were thorough and clear and appropriately identified areas of learning to improve future practice.

The Chief Coroner's Office publishes the local coroners Reports to Prevent Future Deaths which all contain 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. The trust had not been in receipt of any Regulation 28 reports in the twelve months prior to the inspection.

The chief pharmacist led the medicines department. Medicine optimisation and safety was integrated into the governance structure of the trust.

The chief pharmacist and medical director collaborated on the development of the medicine optimisation strategy. Progress with the strategy had been slowed due to the impact of the Covid-19 pandemic and the involvement of the medicines team in the vaccination programme.

The medicine optimisation strategy was linked to the trust strategy and targeted specific areas and a medicine safety officer had been appointed to improve oversight of medicine optimisation within the trust. One strategy area was seamless access, which translated into improving the working relationships across the various partners. This included improving the visibility and availability of pharmacists within the community mental health teams and liaison within the acute trust.

The medicine optimisation department was targeting de-prescribing and inappropriate prescribing in the inpatient wards. This was planned to be extended to the community mental health teams. Areas that were being addressed as part of the strategy included checks on the physical health monitoring and actions taken as a result of abnormal results.

Pharmacy staff had regular dispensary and clinical pharmacy team meetings, regular one to one's and annual appraisals, including the chief pharmacist by the medical director.

The trust board had previously received, regular updates on medicines optimisation from the Chief Pharmacist's report. This had been stood down in 2020 as part of a streamlined approach to governance during the pandemic. The trust told us that the oversight report, through the quality and safety committee would be resumed from October 2021.

The medicines management safety group reported to the quality and safety committee, and reviewed themes and discussed potential for harm from reported incidents and near misses on a quarterly basis.

The chief pharmacist used a pharmacy specific risk register which reflected current risks within services. Mitigation of the risks included recruitment to a new consultant pharmacist post and obtaining additional funding for pharmacist resources.

The trust had been allocated funding for electronic prescribing and the department had recruited pharmacy staff to lead on this within the department.

Our findings

The Chief pharmacist worked with other pharmacy teams in adjacent trusts and local clinical commissioning groups through networking groups.

The trust had recently revised their risk management strategy which included a refreshed approach to the organisational risk register and board assurance framework, this remained in development at the time of the inspection.

The trust managed the risks to the trust's strategy via the board assurance framework. Each sub-committee was responsible for the monitoring and oversight of risks aligned to them on the board assurance framework and this was reviewed in each meeting. In the committee meetings we attended we saw how discussions and actions were linked to the board assurance framework.

The board assurance framework highlighted six key risks to the trust's four strategic priorities. Each risk had an initial, current and target risk score and each risk was aligned to the responsibility of the relevant sub committee with an executive director lead. Risks relating to the effective use of resources were deemed to be the most significant.

Each risk was broken down to allow exploration of any gaps in controls or assurance with an outline of actions and progress. Links to operational risks were also included.

The trust had clear processes for the oversight of operational risk, however the use of these could be inconsistent.

The organisational risk register included 21 key risks with themes concerning; workforce and wellbeing, Covid-19 impact, financial sustainability and estates. Risks control measures and actions were clear.

A risk assessment matrix to score risks against their impact and likelihood, and associated guidance were in place to support staff in identifying and escalating risks to risk registers.

A key organisational risk register was created from all risks with the highest rating (a rating of 15 or more) and this was reviewed by the board. Each care group also had a risk register which fed into the overall risk register.

The trust were aware that the use of risk scoring was inconsistent, and that this had led to risks with less significance to front line care being included as high risks which meant that the oversight of these could be prioritised over risks in front line services.

In order to mitigate this, the trust had risk guardians in place and organisational risks were reviewed by the compliance and risk group which was chaired by the chief executive.

In addition to risk registers, we saw that risks to the delivery of care were discussed in board and at committee meetings. Advise, alert, assure reports were used by sub committees to highlight risks in front line services to ensure oversight from senior leaders.

A risk to the delivery of care were the current waiting lists in community services. The trust had received significantly higher numbers of referrals since 1 September 2020. There were 4,411 referrals to child and adolescent mental health services and 4749 referrals to adult community mental health services in the last 12 months.

Our findings

The trust had processes in place for the management of waiting lists which included review of risks to each person waiting for services. There were action and improvement plans in place to reduce waiting lists. However, waiting times for dental services, community mental health teams, community child and adolescent mental health services, psychology and improving access to psychological therapy were significant.

In child and adolescent mental health services longest waits were for eating disorder services and neurodevelopmental services where the longest wait for treatment was 714 days. In community mental health services for working age adults, there were 185 patients waiting for an initial assessment appointment. The trust was not able to confirm how long the waiting list to be allocated an assessment was. There were significant wait times in the adult mental health psychology service. Patients were waiting for an assessment for up to 59 weeks and for therapy for up to 89 weeks. The longest wait was more than two years for dialectical behaviour therapies and psychotherapy in Bradford. The trust provided community dental services and had significant waiting lists for consultant led treatment. This had been impacted by Covid-19 and the suspension of hospital operating lists. In July 2021, 123 patients were waiting for treatment, and the longest wait was 87 weeks, ten patients had been waiting for more than 52 weeks.

We were concerned that because services were geographically based this meant that those living in less populated areas of the trust catchment area were more likely to receive care first. This adversely effected patients living in Bradford to those living in Keighley or Craven. Detailed waiting time data was not included in the trust dashboards for oversight by committees and the board other than those services which were part of NHS Oversight framework such as dental services, first episode psychosis and improving access to psychology therapy.

The use of out of area placements for inpatient mental health beds was a risk to the trust's financial stability, and to the wellbeing of patients spending time away from their families. In July 2021 the trust had used out of area placements for 30 adult acute patients and eight psychiatric intensive care unit patients, this accounted for 609 bed days. This had increased from 476 in July 2020. The trust advised that the reduction of bed numbers by ten in the inpatient wards to allow for the safe care of Covid-19 patients and increasing acuity of need had impacted on this. The trust had worked with an independent provider to procure beds and had service level agreements and processes in place to monitor the safety and effectiveness of these placements.

The trust also monitored risk in services via a programme of 'go see' visits. The trust's framework described the process as; 'a vehicle for the trust to 'know its business, run its business and improve its business' at both an operational and a strategic level. The framework included templates for feedback to services and into the governance structures. Between 1 April 2021 and 15 September 2021, 42 visits had taken place, 21 visits were in person and 21 took place virtually. Visits had been undertaken by the chief executive, the trust chair, directors and non-executive directors and covered a range of inpatient and community teams. Governors had also been supported to attend services. Following the visits, a report was shared with the quality and safety committee to discuss themes and trends. However, we could not see how actions were formed and undertaken to make improvements as outcomes of these visits.

Information management

The trust had effective processes in place for information management.

The trust had a designated Caldicott guardian who was the medical director and a senior information risk owner, and a chief digital information officer. There was a governance structure in place to support the delivery of information management which included oversight by the audit committee.

Our findings

The trust evidenced the importance of a digitally enabled trust, the chief information officer was part of the trust's board.

The trust had a clinical chief information officer, who worked alongside the chief information officer. They were experienced and qualified in the role, undertaking a digital academy leadership programme. The bringing together of a clinician to the digital focus of the trust ensured the user voice was strong and that issues facing front line staff were clear and could be actioned and improved.

An external audit into data security and protection toolkit had been conducted. The objective of the toolkit is to enable organisations to measure their performance against the national data guardian's ten data security standards. The audit report showed confidence in the trust's interim self-assessment.

There had been no significant data or security breaches at the trust over the last 12 months.

The trust were in the process of refreshing their digital strategy at the time of the inspection. The draft strategy focused on how the trust would continue to work in partnership with colleagues at place and across the integrated care system.

The trust had an established information technology infrastructure, investment in which had enabled the digital teams to support the workforce to mobilise flexible working during the Covid-19 pandemic.

There was a dedicated team in place at the trust who focused on cyber security, the trust was one of the first to receive 'cyber essentials plus'. This is a government information assurance scheme that is operated by the National Cyber Security Centre and includes an assurance framework and a simple set of security controls to protect information from threats coming from the internet.

The trust continued to use data to enable oversight of risk and performance via integrated performance reports which were available to the board and sub-committees. In some areas, these reports required further development.

Engagement

The trust was outward facing and were an active partner and leader within local health and social care providers to ensure that an integrated health and care system was commissioned and provided to meet the needs of the local population.

The trust had developed close working relationships with other NHS providers, the local authority and voluntary sector providers both at place and across the West Yorkshire and Harrogate integrated care system. These networks had been strengthened during the Covid-19 pandemic. The trust's recently refreshed strategy aligned with the agenda of the integrated care system.

The trust were an integrated partner within the Bradford District and Craven place. The place based health and care partnership 'Act as One' had seven priority programmes based around communities being 'Healthy and Happy at Home'. One area of work the partnership had recently created was the 'one workforce hub' a website to support staff across health and social care in the district and jointly manage healthcare opportunities.

As part of the national transforming care programme within the West Yorkshire and Harrogate integrated care system, the trust had engaged with partner organisations to reconfigure their assessment and treatment unit for people with learning disabilities. This was based on the need to reduce bed numbers in assessment and treatment units across the

integrated care system from 22 to 15 beds in order to prevent escalation to hospital admission and provide treatment as locally as possible to patients with learning disabilities and autism. A multidisciplinary redesign steering group was developed which included partner organisations, staff and patient representatives. The implementation plan was to begin in December 2021 and would provide two units across Bradford and Wakefield managed as a single system across providers underpinned by a co-produced single integrated quality framework.

NHS England and Improvement commented that the trust worked collaboratively, with NHS partners, local authorities and the voluntary sector. They stated that the trust had been successful at securing and retaining services through tender processes. They described that the trust actively sought opportunities to work with NHSI collaborative programmes to improve services, examples including the moving to good programme, getting it right first time, and workforce initiatives.

The trust had a council of governors which included publicly elected governors, elected staff governors and governors appointed from key stakeholders working with the trust such as the local authority.

The trust chair ensured governors were a key part of the trust's governance structures and understood their important role in providing the voices of staff, patients and carers to the leadership team. Governors were given a range of opportunities including monthly updates from the chair and open house sessions to ask informal questions. They told us that they were encouraged to provide feedback and challenge to the chair, the non-executive directors and the leadership team.

During the inspection, we spoke with a range of governors. Governors told us that the trust chair was open and welcoming of their feedback. They said that during the Covid-19 pandemic the trust had shown continued commitment to ensuring their involvement. They felt listened too and felt that leaders had a real drive and commitment to striving for improvement and getting it right for patients. Governors said that they felt part of the team and gave an example of raising a concern about a service and being supported to attend an onsite visit to understand the service and speak with staff. Governors told us that information was provided to them in a format which was understandable and encouraged them to seek assurance and ask questions. They told us that they felt comfortable to approach the non-executive directors and were given opportunities to visit services and shadow sub-committees of the board.

Governors were sighted on the risks and challenges faced by the trust and those matched with the concerns of the trust

Third sector partners told us that strong collaborative culture of engagement with partnership organisations.

The trust's patient involvement strategy was launched in 2019 'Your Voice Matters'. The trust stated that two drivers core to implementing and achieving the objectives had been defined as 'Reaching In' to services and 'Reaching Out' to connect, build relationships and work with communities wherever there is experience, expertise and insight to draw on. A work plan was in place monitored by the trust's patient experience and involvement lead to ensure evidence of progress and outcomes.

The trust encouraged patients and carers to get involved in consultations on improvements and revised strategies in services. Patients were involved with board sub-committees.

The trust was a member of the triangle of care. The triangle of care accreditation sets out six standards on how 'carers, patients and professionals should work together to promote safety and recovery and to sustain wellbeing in mental health by including and supporting carers'. It has six standards which the trust used as standards in all services. In addition, the trust had a carers hub, a carers action group and carer champions.

Our findings

Staff told us that patient and carer involvement was high on the agenda. Staff told us that there was a commitment in the trust to hearing the voice of patients and carers. One example of this involvement was where a patient's direct experience of seclusion was shared in the quality and safety committee in May 2021. The experience of this patient sparked a review of the trust's seclusion policy by the involvement partner and suggestions on improvements and comparisons to other organisations' policy were made.

The trust used the friends and family test to understand the experiences of patients using services. In July 2021 the trust received 412 responses. The positive experience scores were variable with a 95% score for the trust overall, 93% for the mental health care group, 90% in children's services and 97% in adult services.

The trust's patient experience and involvement lead reported regularly into the quality and safety committee providing reports on progress and actions.

Learning, continuous improvement and innovation

The trust had made improvements since the time of our last inspection, many of these improvements were done in line with the 'Care Trust Way' the trust's quality improvement methodology. The methodology was embedded at levels throughout the trust.

NHS Improvement stated that; 'the trust has a comprehensive strategy for continuous improvement – 'the Care Trust Way. This is a board-to-ward framework. All staff are trained in the common tools and methodology and it has led to demonstrable improvements.

Staff we spoke with were able to describe the different ways in which they had been involved in innovation, they told us how they were encouraged to share ideas for development of services. Many of the staff we spoke with were able to describe the 'Care Trust way' quality improvement methodology and described working for a trust who always strived to improve and had a 'can do attitude'.

The trust continued to progress with becoming a learning organisation. Changes to the organisational risk registers, board assurance framework and serious incident processes were supporting the trust's journey. We found that where serious incidents had occurred the trust had worked with partner organisations to make improvements and share learning. For example, the medical director was working with NHS England raising learning from when young people were admitted to the trust's adult inpatient wards.

The trust had recognised areas of concern in services and had undertaken rapid improvement work. These had occurred in mental health inpatient wards and in community mental health services and included staff, patients and carers with an executive sponsor. Rapid improvement weeks had brought about change and review processes were in place to ensure change was sustainable.

The trust recognised where services would benefit from improvement. In September 2021 the trust held a showcase event describing the improvement journey of their dementia assessment unit. The journey evidenced how using a refreshed staffing structure, enhanced shadowing, learning and development, additional support, and new ideas and people, several improvements were achieved. These improvements included;

- a reduction in the length of stay from 622 days in 2018-2019 to 120 days in 2020-2021
- a reduction in requests for bank and agency staff from 73,127 hours in 2018-2019 to 7220 in 2021.

- a reduction in incident reports from 1329 in 2018-2019 to 416 in 2020-2021.

The trust had an annual audit plan, participating in local and national audits to enhance the quality of care. An electronic auditing system had been in place since July 2021.

Trust wide internal audits which had been undertaken included; Covid-19 expenditure costs, data security and protection toolkit, the board assurance framework, cost improvement programme, patient money and property, administration of the Mental Health Act, freedom to speak up, infection control. Further audits were planned which included; clinical supervision, medicines management, mental capacity act, and health inequalities.

At the time of inspection, there were 15 overdue recommendations from audits which the audit committee were monitoring.

The trust participated in research, a research strategy was in place and the trust had an embedded research team. The trust had successfully trailed work with the 'born in Bradford' research study.

The trust had implemented improved practice.

- in 2021, the trust launched a revised volunteering strategy. The volunteer service's vision was to 'increase new and existing volunteering opportunities across the trust, aiming to help individual volunteers and the organisation to realise the full positive impact of volunteering'.
- the trust had also launched its 'green plan' for 2021-2026, setting out the trust's aims to achieve environmental improvements.
- the trust had developed an 'app' to monitor fixed ligature point risks in their inpatient estate.
- the trust had relaunched their 'better lives' charity for which they acted as corporate trustee.

The trust worked flexibly and creatively throughout the Covid-19 pandemic and subsequent national lockdowns. Some examples of good practice were;

- the production of infant massaging videos by the perinatal mental health team to support new mothers.
- the revised offer of support by specialist school nurses to ensure families could be supported at home when schools were closed.

The trust were delivering the vaccination programme across Bradford and had successfully managed two large vaccination hubs. The programme had included reaching out to hard to reach communities and more recently the vaccination of 12-15-year olds.

The trust celebrated continuous improvement and innovation. The trust held annual 'you're a star' awards to celebrate success. The awards included 'living our values' where staff are celebrated for embodying the trust's values of 'we care, we listen, we deliver'.

Trust teams and staff had received the following awards and accreditations;

- Health and Safety Team Secured a sixth successive Royal Society for the Prevention of Accidents Gold Award.
- British Society of Paediatric Dentistry's 2020 Outstanding Innovation Award.

Our findings

- Clinical Teaching Excellence Awards Individual Award, Leeds Institute of Medical Education.
- Cyber Security and informatics Team Cyber Essentials and Cyber Essentials Plus accreditation award from the National Cyber Security Centre.
- Telegraph and Argus Community Stars Award for Fundraiser of the Year.

Trust teams and staff had been shortlisted for several awards;

- HSJ Patient Safety Awards 2020, Mental Health Initiative of the Year for creating and embedding a systematic approach to side effect monitoring of patients prescribed Clozapine.
- School Nursing Special Needs Team RCNi Nurse Awards 2020, Child Health category.
- iCare Innovation Stories Nursing Times Workforce Awards.
- The Care Trust Way Team HSJ Awards 2020, Staff Engagement Award.
- Community Organisation Award for Disability category in the ITV National Diversity Awards.
- Covid -19 Community Nursing Home Visiting team Nursing Times Awards 2020, Infection Prevention and Control category.

Key to tables

Ratings	Not rated	Inadequate	Requires improvement	Good	Outstanding
Rating change since last inspection	Same	Up one rating	Up two ratings	Down one rating	Down two ratings
Symbol *	➔➔	↑	↑↑	↓	↓↓

Month Year = Date last rating published

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

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

Ratings for the whole trust

Safe	Effective	Caring	Responsive	Well-led	Overall
Requires Improvement ➔➔ Dec 2021	Good ↑ Dec 2021	Good ➔➔ Dec 2021	Good ➔➔ Dec 2021	Good ↑ Dec 2021	Good ↑ Dec 2021

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

Ratings for a combined trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Acute locations	Not rated	Not rated	Not rated	Not rated	Not rated	Not rated
Ambulance	Not rated	Not rated	Not rated	Not rated	Not rated	Not rated
Adult social	Not rated	Not rated	Not rated	Not rated	Not rated	Not rated
Mental health	Requires Improvement	Good	Good	Good	Good	Good
Community	Good	Good	Outstanding	Good	Good	Good
Primary medical	Not rated	Not rated	Not rated	Not rated	Not rated	Not rated
Overall trust	Requires Improvement ➔➔ Dec 2021	Good ↑ Dec 2021	Good ➔➔ Dec 2021	Good ➔➔ Dec 2021	Good ↑ Dec 2021	Good ↑ Dec 2021

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

Rating for acute services/acute trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Royds Healthy Living Centre	Good Sep 2016	Good Sep 2016	Good Sep 2016	Good Sep 2016	Good Sep 2016	Good Sep 2016
Overall trust	Requires Improvement ➔➔ Dec 2021	Good ↑ Dec 2021	Good ➔➔ Dec 2021	Good ➔➔ Dec 2021	Good ↑ Dec 2021	Good ↑ Dec 2021

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

Rating for Royds Healthy Living Centre

	Safe	Effective	Caring	Responsive	Well-led	Overall
People with long term conditions	Not rated	Not rated	Not rated	Not rated	Not rated	Good Sep 2016
Families, children and young people	Not rated	Not rated	Not rated	Not rated	Not rated	Good Sep 2016
Older people	Not rated	Not rated	Not rated	Not rated	Not rated	Good Sep 2016
Working age people (including those recently retired and students)	Not rated	Not rated	Not rated	Not rated	Not rated	Good Sep 2016
People experiencing poor mental health (including people with dementia)	Not rated	Not rated	Not rated	Not rated	Not rated	Good Sep 2016
People whose circumstances may make them vulnerable	Not rated	Not rated	Not rated	Not rated	Not rated	Good Sep 2016
Overall	Good Sep 2016	Good Sep 2016	Good Sep 2016	Good Sep 2016	Good Sep 2016	Good Sep 2016

Rating for mental health services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Acute wards for adults of working age and psychiatric intensive care units	Good May 2020	Good May 2020	Good May 2020	Good May 2020	Good May 2020	Good May 2020
Mental health crisis services and health-based places of safety	Good ↑ Dec 2021	Good →← Dec 2021	Good →← Dec 2021	Good →← Dec 2021	Good →← Dec 2021	Good →← Dec 2021
Wards for older people with mental health problems	Requires improvement Jun 2019	Requires improvement Jun 2019	Good Jun 2019	Good Jun 2019	Requires improvement Jun 2019	Requires improvement Jun 2019
Community-based mental health services of adults of working age	Good ↑ Dec 2021	Requires Improvement →← Dec 2021	Good →← Dec 2021	Good →← Dec 2021	Good ↑ Dec 2021	Good ↑ Dec 2021
Community mental health services for people with a learning disability or autism	Requires improvement Feb 2018	Good Feb 2018	Good Feb 2018	Good Feb 2018	Good Feb 2018	Good Feb 2018
Wards for people with a learning disability or autism	Good Jun 2019	Good Jun 2019	Good Jun 2019	Good Jun 2019	Good Jun 2019	Good Jun 2019
Forensic inpatient or secure wards	Requires improvement Jun 2019	Good Jun 2019	Good Jun 2019	Good Jun 2019	Requires improvement Jun 2019	Requires improvement Jun 2019
Community-based mental health services for older people	Good Jun 2019	Good Jun 2019	Good Jun 2019	Good Jun 2019	Good Jun 2019	Good Jun 2019
Specialist community mental health services for children and young people	Requires Improvement Dec 2021	Good Dec 2021	Good Dec 2021	Requires Improvement Dec 2021	Good Dec 2021	Requires Improvement Dec 2021
Overall	Requires Improvement	Good	Good	Good	Good	Good

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

Rating for community health services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community health services for adults	Good Feb 2018	Good Feb 2018	Outstanding Feb 2018	Good Feb 2018	Good Feb 2018	Good Feb 2018
Community end of life care	Good Jun 2019	Good Jun 2019	Outstanding Jun 2019	Outstanding Jun 2019	Good Jun 2019	Outstanding Jun 2019
Community health services for children and young people	Requires improvement Jun 2019	Good Jun 2019	Good Jun 2019	Requires improvement Jun 2019	Good Jun 2019	Requires improvement Jun 2019
Overall	Good	Good	Outstanding	Good	Good	Good

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

Specialist community mental health services for children and young people

Requires Improvement

Is the service safe?

Requires Improvement

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

Safe and clean environments

All clinical premises where children and young people received care were safe, clean, well equipped, well furnished, well maintained and fit for purpose.

Staff completed and regularly updated thorough risk assessments of all areas and removed or reduced any risks they identified.

All interview rooms had alarms and staff available to respond.

All clinic rooms had the necessary equipment for children and young people to have thorough physical examinations.

Most areas were clean, well maintained, well-furnished and fit for purpose. The building at Keighley was a listed building and so was a little dated in relation to decoration.

Staff made sure cleaning records were up-to-date and the premises were clean. We observed the buildings to be clean and tidy.

Staff always followed infection control guidelines, including handwashing. Staff in the buildings continued to wear face masks and hand gel was available throughout the buildings. Posters were displayed highlighting the importance of infection control and preventing the spread of coronavirus.

Staff made sure equipment was well maintained, clean and in working order.

Safe staffing

The service did not always have enough staff, who knew the children and young people and received basic training to keep them safe from avoidable harm. The number of children and young people on the caseload of core team, and of individual members of staff, was high which meant that staff did not always have capacity to give each child and young person the time they needed. There were high rates of staff turnover.

Nursing staff

The service did not always have enough nursing and support staff to keep children and young people safe. The core team had the highest vacancy rate with five vacant care coordinator posts. Several staff had left the service or had recently retired.

Specialist community mental health services for children and young people

The service had difficulty recruiting to nursing posts and had tried to be flexible with recruitment and had recently recruited newly qualified social workers as an alternative. Several posts had been filled and were going through the trust processes. The service had recognised that more work needed to be done to increase staffing levels and funding had been identified to create a high intensity team which could work with the more complex young people. Managers were aware that recruitment would be a challenge.

Managers limited their use of bank and agency staff and requested staff familiar with the service.

Managers made sure all bank and agency staff had a full induction and understood the service before starting their shift.

The service had a high turnover rate of staff at 18.36%. Several experienced staff had recently retired or left the service. This had put further pressure on the existing staff as caseload sizes had increased with average caseload sizes of between 40-60 young people.

Managers supported staff who needed time off for ill health.

Levels of sickness were 5.8%. However, staff said that some staff were feeling burnt out and had experienced periods of sickness which put extra pressure on the team.

Managers used a recognised tool to calculate safe staffing levels and work had been completed to identify staffing gaps. The trust had committed to providing a considerable amount of funding to increase posts. Managers were aware of that they would need to be creative in recruitment of the posts. The service knew what ideal staffing levels would be but expressed frustrations at not being able to recruit staff.

Medical staff

The service had enough medical staff working across the teams. The service had 12 doctors which included six consultants. Junior doctors managed the out of hours rota and dealt with emergencies.

Managers could use locums when they needed additional support or to cover staff sickness or absence.

Managers made sure all locum staff had a full induction and understood the service.

The service could get support from a psychiatrist quickly when they needed to. Staff reported good relationships with the medical staff who supported the team and young people.

Mandatory training

Staff had completed and kept up to date with their mandatory training. There were some face-to-face sessions which had been cancelled due to coronavirus restrictions, but plans were in place to ensure that staff were up to date. The overall rate for mandatory training was 67% due to low compliance with level two food safety (50%) and breakaway training (44%). Most other courses had over 90% compliance rate.

The mandatory training programme was comprehensive and met the needs of children and young people and staff.

Managers monitored mandatory training and alerted staff when they needed to update their training.

Specialist community mental health services for children and young people

Assessing and managing risk to children and young people and staff

Staff usually assessed and managed risks to children and young people and themselves. They responded promptly to sudden deterioration in a child and young person's health. When necessary, staff working in the community children and young person's team worked with young people and their families and carers to develop crisis plans. Staff followed good personal safety protocols.

Assessment of child and young person risk

Staff were not consistently completing and updating risk assessments on a standard format. During the inspection we reviewed seven records where risk assessments should be contained within trust records, and were unable to locate risk assessments for these seven young people. Three of the records had not been updated after significant incidents. We met with managers who had been able to locate the information. However, we were concerned that staff were not following the trust process and that important information could not be located in an emergency or if a member of staff went off sick. Risks and other information were often contained within progress notes.

Staff used a recognised risk assessment tool. An initial risk assessment was completed by the duty team and a more comprehensive assessment was done at initial assessment. Staff were updating risk assessments at least yearly in line with trust policy.

Staff could recognise when to develop and use crisis plans and advanced decisions according to child and young person need. Young people were given details of who they could contact in a crisis.

Management of child and young person risk

Staff responded promptly to any sudden deterioration in a child or young person's health. Staff worked closely with the local hospitals and other services to identify anyone whose risks had increased. Daily communication was taking place with services and families could ring the service if they were worried about a young person.

Staff continually monitored children and young people on waiting lists for changes in their level of risk and responded when risk increased. There was currently a waiting list for allocation of key worker within the core team. All referrals received triage within one working day of referral. The referral was then rated based on triage and clinical presentation as per the duty and filtering system. This was a new system which had been in place for six months.

All urgent cases were triaged and seen by duty or crisis workers and all other routine cases were placed on a waiting list for assessment.

Staff followed clear personal safety protocols, including for lone working. Most appointments were now done remotely or in the office base. Where staff were seeing young people for home visits or in the community, they followed the lone working procedure.

Safeguarding

Staff understood how to protect children and young people from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it. The provider had a named nurse and doctor for child safeguarding and the teams had a safeguarding lead.

Staff received training on how to recognise and report abuse, appropriate for their role.

Specialist community mental health services for children and young people

Staff kept up to date with their safeguarding training. Safeguarding adults and children training was delivered separately with levels one to three being mandatory for staff. The completion rates were above 80% for all courses with level three safeguarding children training at 77%.

Staff could give clear examples of how to protect children and young people from harassment and discrimination, including those with protected characteristics under the Equality Act.

Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them. Staff worked closely with the local authority to jointly work with anyone who was at risk in the family home. Discussions were taking place almost daily with safeguarding colleagues in the local authority. Staff were invited to and attended strategy meetings where concerns had been raised.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. The trust had safeguarding leads who could be contacted for advice and links were in place with the local authority.

Managers took part in serious case reviews and made changes based on the outcomes.

Staff access to essential information

Staff working for the specialised community mental health team for children and young kept detailed records of children and young people' care and treatment. However, records were not always clear, and easily available to all staff providing care.

Child and young person progress notes were comprehensive; however, staff could not always easily locate specific documents such as risk assessments and care plans. The service used an electronic record system and staff and managers were aware of the limitations of this system and described difficulties that staff had daily.

When children and young people transferred to a new team, there were no delays in staff accessing their records.

Records were stored securely.

Medicines management

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

Staff followed systems and processes when safely prescribing, administering and recording medicines. The service did not store or administer medication at either site.

Staff reviewed children and young people' medicines regularly and provided specific advice to children and young people and carers about their medicines.

Staff followed current national practice to check children and young people had the correct medicines.

The service had systems to ensure staff knew about safety alerts and incidents, so children and young people received their medicines safely.

Decision making processes were in place to ensure people's behaviour was not controlled by excessive and inappropriate use of medicines.

Specialist community mental health services for children and young people

Staff reviewed the effects of each child and young person's medication on their physical health according to national guidance.

Track record on safety

The service had a good track record on safety.

Reporting incidents and learning from when things go wrong

The service managed child and young person safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave children and young people honest information and suitable support.

Staff knew what incidents to report and how to report them. We reviewed six incidents and found that staff had clearly documented what had happened. The incidents we reviewed included staffing concerns and communication. We saw that immediate actions had been taken.

Staff raised concerns and reported incidents and near misses in line with trust policy.

Staff reported serious incidents clearly and in line with trust policy. There had been two recent serious incidents relating to the suicide of young people. The trust had carried out comprehensive reviews of both incidents and identified learning. Themes included better communication and support for young people who were on the waiting list for specialist services. This included gender identity services and the trust were implementing training for staff to better support young people.

Staff understood the duty of candour. They were open and transparent and gave children and young people and families a full explanation when things went wrong.

Managers debriefed and supported staff after any serious incident. Staff reported feeling supported after incidents and generally through what had been a difficult year. Staff felt able to discuss concerns they had about young people and were able to use daily huddles for support.

Managers investigated incidents thoroughly. Children and young people and their families were involved in these investigations.

Staff received feedback from investigation of incidents, both internal and external to the service.

Staff met to discuss the feedback and look at improvements to child and young person care.

There was evidence that changes had been made as a result of feedback. Managers had responded to concerns that had been raised around communication and cancelling of appointments. An admin team had been brought into the service to assist staff with all administrative tasks and improve community with young people and their families. Managers responded quickly to feedback during the inspection.

Specialist community mental health services for children and young people

Is the service effective?

Good

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

Assessment of needs and planning of care

Staff assessed the mental health needs of all children and young people. They worked with children and young people and families and carers to develop individual care plans however these were not always on a standard format and were not always updated. Care plans were often basic and lacked detail.

Staff completed a comprehensive mental health assessment of each child and young person. The service usually had weekly assessment slots available for new referrals throughout the week. Staff supported the assessment slots by completing two assessments each per week. The assessment was done over a few appointments to allow the workers to get to know the young person and fully understand their needs. Psychology staff usually completed formulation but due to the increase in referrals and pressure on the service they were delivering training to all key workers in place of formulation.

Staff did not always ensure that they recorded how children and young people had a full physical health assessment and knew about any physical health problems. Physical health assessments were completed by a separate team that came into the service weekly. Managers had identified that this was a gap in the service and were looking to recruit physical health workers into the service. Evidence of physical health checks could not be found in records. A separate team completed the health checks for young people and attended the service weekly to do sessions. However, we were unable to find evidence of this within care records. For a child and young person with an eating disorder, we were unable to find that a risk assessment and any physical health checks had been completed when they entered the service.

Staff did not always develop care plans for each child and young person which met their mental and physical health needs.

Care plans were difficult to locate and were not consistent in where they are documented on the system. We reviewed seven young people's records and could not see if the care plans had been shared with the young person and parents although some young people said they did have a care plan.

Care plans were not always personalised, holistic and recovery orientated. The care plans we reviewed were basic and lacked detail in some areas. Staff were not always storing information in the correct place on the system. Work was ongoing with staff around the recording of information so that it was easy to obtain.

Best practice in treatment and care

Staff provided a range of treatment and care for children and young people based on national guidance and best practice. They ensured that children and young people had good access to physical healthcare and supported them to live healthier lives. Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives.

Specialist community mental health services for children and young people

Staff provided a range of care and treatment suitable for the children and young people in the service. Treatment options included individual counselling, family therapy, group therapy, group work, play therapy, art therapy, psychotherapy, deep relaxation, cognitive behavioural therapy, anxiety management, parental counselling or medication and practical support.

Staff delivered care in line with best practice and national guidance.

Staff were not directly supporting young people for their physical health needs. There was no dedicated staff working within the team and staff from the central trust delivered this.

Staff supported children and young people to live healthier lives by supporting them to take part in programmes or giving advice. People we spoke to said that there was great support regarding healthy eating, access to a dietician, staff encouraging participation in physical exercise.

Staff used recognised rating scales to assess and record the severity of child and young person conditions and care and treatment outcomes.

Staff used technology to support children and young people. Appointments had moved online with staff using technology to see young people remotely.

Staff did not always take part in clinical audits, benchmarking and quality improvement initiatives. The service did not have an audit schedule in place. An audit of care records had taken place, but evidence was limited of what changes had been made as a result of the issues identified.

Skilled staff to deliver care

The teams included or had access to the full range of specialists required to meet the needs of children and young people under their care. Managers made sure that staff had the range of skills needed to provide high quality care. They supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.

The service had a full range of specialists to meet the needs of the children and young people. The service was made up of a core team of care coordinators who were nurses or social workers. The service also had support staff, therapy staff and access to dieticians. The service was supported by several other smaller teams. These were primary care mental health workers who worked into schools and a team working with young people up to the age of two. The service was supported by a full team of medical staff and admin staff.

Managers ensured staff had the right skills, qualifications and experience to meet the needs of the children and young people in their care, including bank and agency staff.

Managers gave each new member of staff a full induction to the service before they started work.

Managers supported staff through regular, constructive appraisals of their work. Staff were receiving managerial supervision at 94% and clinical supervision rates were 86%.

Managers made sure staff attended regular team meetings or gave information from those they could not attend. We observed team meetings take place online and saw staff being supported and updated on changes within the service. Lessons learnt were shared with staff through emails and meetings.

Specialist community mental health services for children and young people

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Staff were being supported to deliver psychosocial interventions or to identify where they were delivering this.

Managers made sure staff received any specialist training for their role.

Managers recognised poor performance, could identify the reasons and dealt with these.

Multi-disciplinary and interagency teamwork

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

Daily huddles were taking place where staff could discuss any young people that they had concerns about. Staff discussed changes in risk in relation to young people and could agree actions to address identified issues and risks.

Daily conversations took place between staff either in the office or online and staff were supported by medical staff and managers.

Weekly meetings also took place for the teams in the service, and we observed good links with the local authority, schools and primary care.

Staff held regular multidisciplinary meetings to discuss children and young people and improve their care.

Staff made sure they shared clear information about children and young people and any changes in their care, including during transfer of care.

Staff had effective working relationships with other teams in the organisation.

Staff had effective working relationships with external teams and organisations.

Adherence to the Mental Health Act and the Mental Health Act Code of Practice

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice.

Staff received and kept up to date with training on the Mental Health Act and the Mental Health Act Code of Practice and could describe the Code of Practice guiding principles.

Staff had access to support and advice on implementing the Mental Health Act and its Code of Practice.

Staff knew who their Mental Health Act administrators were and when to ask them for support.

The service had clear, accessible, relevant and up-to-date policies and procedures that reflected all relevant legislation and the Mental Health Act Code of Practice.

Specialist community mental health services for children and young people

Children and young people had easy access to information about independent mental health advocacy.

Good practice in applying the Mental Capacity Act

Staff supported children and young people to make decisions on their care for themselves. They understood the trust policy on the Mental Capacity Act 2005 applied to young people aged 16 and 17 and the principles of Gillick competence as they applied to people under 16. Staff assessed and recorded consent and capacity or competence clearly for children and young people who might have impaired mental capacity or competence.

Staff received and kept up to date with training in the Mental Capacity Act and had a good understanding of at least the five principles.

There was a clear policy on the Mental Capacity Act, which staff could describe and knew how to access.

Staff knew where to get accurate advice on Mental Capacity Act.

Staff gave children and young people all possible support to make specific decisions for themselves before deciding a child and young person did not have the capacity to do so. Staff assumed that young people had capacity and checked this at each appointment.

Staff assessed capacity to consent clearly each time a child and young person needed to make an important decision. However, evidence of consent to treatment could not be found on the young people's record.

When staff assessed children and young people as not having capacity, they made decisions in the best interest of children and young people and considered the child and young person's wishes, feelings, culture and history.

Staff understood how to support children under 16 wishing to make their own decisions and applied the Gillick competency principles when necessary.

Staff knew how to apply the Mental Capacity Act to children and young people aged between 16 to 18 and where to get information and support on this.

Is the service caring?

Good

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

Kindness, privacy, dignity, respect, compassion and support

Staff treated children and young people with compassion and kindness. They understood the individual needs of children and young people and supported children and young people to understand and manage their care, treatment or condition.

Staff were discreet, respectful, and responsive when caring for young people. We observed caring interactions in the appointments we observed.

Specialist community mental health services for children and young people

Staff gave children and young people help, emotional support and advice when they needed it. The young people and their families we spoke to felt able to contact workers when they needed support.

Staff supported children and young people to understand and manage their own care treatment or condition.

Staff directed children and young people to other services and supported them to access those services if they needed help. Staff had access to a wide range of community resources.

Children and young people said staff treated them well and behaved kindly. We spoke to 10 people who use the service and nine people out of the 10 said that the service is good. People felt that the approach of staff was positive. They all spoke about the way they feel emotionally supported with a high level of trust. Consultants and medical staff are professional, caring, and always open to discuss any concern. Confidentiality is managed well on both sides and with great respect.

Staff understood and respected the individual needs of each child and young person.

Staff felt that they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards children and young people.

Staff followed policy to keep child and young person information confidential.

Involvement in care

Staff involved children and young people in care planning and risk assessment and actively sought their feedback on the quality of care provided. They ensured that children and young people had easy access to independent advocates. Staff informed and involved families and carers appropriately.

Involvement of children and young people

Staff involved children and young people who reported that they knew what their care and treatment involved. Young people felt that they knew what was in their care plan. The people we spoke to said that they felt fully involved in the planning of care and that each approach is person centred. People also said that treatment of care was reviewed regularly through a shared decision-making process.

Staff made sure children and young people understood their care and treatment (and found ways to communicate with children and young people who had communication difficulties). The service had developed four videos which young people and their families could access to give them information on the service. Initial feedback had been positive.

Staff involved children and young people in decisions about the service, when appropriate.

Children and young people could give feedback on the service and their treatment and staff supported them to do this.

Staff supported children and young people to make advanced decisions on their care.

Staff made sure children and young people could access advocacy services.

Specialist community mental health services for children and young people

Involvement of families and carers

Staff supported, informed and involved families or carers. Families were encouraged to attend assessments and appointments where this was deemed appropriate. We saw evidence of families being involved in appointments and the families we spoke to felt involved. The service had a family approach which meant that families were at the centre of treatment. The families we spoke to said they felt informed, involved and updated.

Staff helped families to give feedback on the service.

Staff gave carers information on how to find the carer's assessment. Assessments were done through social workers at the local authority. Staff had links with the connect to support service at the district council.

Is the service responsive?

Requires Improvement

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

Access and waiting times

The service was struggling to meet the increasing demand of referrals and acuity in young people. Staff were finding it hard to manage the expectations on completing assessment requirements against having existing high caseloads. The service had a referral criteria which did not exclude children and young people who would have benefitted from care.

Staff assessed and treated young people who required urgent care promptly through the duty system. Young people who did not require urgent care were sometimes waiting slightly longer than the trust target of 11 weeks for routine assessments. The national target is 18 weeks for routine referrals to Child and Adolescent Mental Health Services.

The service had a process in place for monitoring the wellbeing of young people waiting for a service. All referrals received triage within one working day of referral. The referral was red, amber, green rated based on triage and clinical presentation. All urgent cases were triaged and seen by duty or crisis and all cases waiting were identified as routine waits and were then overseen utilising a standard process. Daily huddles took place which included discussions around changes in risk and agreement on actions to address this. Managers could escalate waiting times and young people awaiting allocation to senior managers. Discussions at a senior level were taking place around appropriate action and support to mitigate, manage and reduce the identified risks.

Staff followed up children and young people who missed appointments

The waiting list had emerged due to the pressures on the team and increasing referrals and level of need . Managers had made the decision to temporarily suspend initial assessments for all new routine referrals for one month. Those who were deemed high risk through triage were assessed. This was in response to staffing pressures and to allow staff some time to review young people on their caseloads. At the time of the inspection the core team had 19 cases awaiting first appointment. All the young people on this list were non urgent referrals and had been risk assessed accordingly. There were a further 65 young people awaiting a second appointment who were also assessed as non-urgent referrals.

The service submitted data to show the average waiting times for the service at August 2021 were:

- first appointment average wait was 16 days
- second appointment average wait was 45 days, the longest wait for an appointment was 92 days.

The teams outside the core team had their own waiting lists and the number of young people awaiting non urgent allocation were as follows;

- primary mental health team**;** 50 young people
- eating disorder team; nine young people routine and non-urgent young people. The longest wait was 78 days.
- neurodevelopment team; 49 young people waiting for a first appointment and 97 young people waiting for a second appointment. The longest wait for an appointment was 714 days.

Staff tried to engage with people who found it difficult, or were reluctant, to seek support from mental health services.

Staff tried to contact people who did not attend appointments and offer support.

Children and young people had some flexibility and choice in the appointment times available.

Staff worked hard to avoid cancelling appointments. However due to staffing pressures and emergencies appointments were sometimes cancelled at short notice. Staff tried to give a clear explanation and offered new appointments as soon as possible. Young people said that they had a direct line with the clinical staff, and that this made things much better and quicker if you need to handle an emergency. Appointments ran on time and staff informed children and young people when they did not.

The service ensured that children and young people, who would benefit from care from another agency, made a smooth transition. This included ensuring that transitions to adult mental health services took place without any disruption to the child and young person's care.

Staff supported children and young people when they were referred, transferred between services, or needed physical health care.

The service followed national standards for transfer.

Facilities that promote comfort, dignity and privacy

The design, layout, and furnishings of treatment rooms supported children and young people' treatment, privacy and dignity.

The service had a full range of rooms and equipment to support treatment and care. Staff worked across two sites which both had a variety of interview rooms. Staff were increasingly using technology to see young people.

Interview rooms in the service had sound proofing to protect privacy and confidentiality.

Meeting the needs of all people who use the service

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

The service could support and adjust for disabled people and those with communication needs or other specific needs.

Specialist community mental health services for children and young people

Staff made sure children and young people could access information on treatment, local services, their rights and how to complain. Booklets were provided to young people when they entered treatment and the service had recently developed some short videos which could be accessed by young people and their families. This provided a more interactive way of informing people about the service.

The service provided information in a variety of accessible formats so the children and young people could understand more easily.

The service had information leaflets available in languages spoken by the children and young people and local community.

Managers made sure staff and children and young people could get hold of interpreters or signers when needed.

Listening to and learning from concerns and complaints

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

Children and young people, relatives and carers knew how to complain or raise concerns. Information booklets were provided to young people and their families when they entered the service. Complaints could be raised with staff and managers. The children and young people advisory service was also available to people, who had concerns they didn't want to raise with the local teams.

Staff understood the policy on complaints and knew how to handle them. The people we spoke to said that concerns had been raised directly with the service or worker and most of them were resolved quickly. None of the people we spoke to had raised an official complaint

Community child and adolescent mental health services accounted for 12 formal complaints and 39 informal complaints between 1 September 2020 and 1 September 2021. The top five reasons for complaints across the trust were; information, lack of support, attitude of staff, medication and waiting for appointments.

Managers investigated complaints and identified themes. Managers had started to look at the concerns being raised around communication. Administrators had recently been brought into the team as a central resource to provide extra support to the team.

Staff protected children and young people who raised concerns or complaints from discrimination and harassment.

Staff knew how to acknowledge complaints and children and young people received feedback from managers after the investigation into their complaint.

Managers shared feedback from complaints with staff and learning was used to improve the service. We fed back some concerns during the inspection that some young people felt that appointments were sometimes cancelled last minute, and communication could be improved. Managers acted on this feedback at the time of the inspection.

The service used compliments to learn, celebrate success and improve the quality of care. Between 1 September 2020 and 1 September 2021, the service had received 68 compliments. Themes from compliments were; the positive impact of support groups and the support and guidance offered to parents.

Specialist community mental health services for children and young people

Is the service well-led?

Good

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

Leadership

Leaders had the skills, knowledge and experience to perform their roles. They had a good understanding of the services they managed and were visible in the service and approachable for children and young people and staff.

Staff said that managers were supportive and understood the needs of the service. The service had an operations manager and a clinical manager who were relatively new to the team. There had been a considerable amount of work completed to ensure that staff felt supported and knew what improvements needed to be made. Managers understood the direction of the service and had listened to staff when they said that the changes needed to be managed in line with the increasing workload. The managers within the team had defined roles to ensure that staff knew who was leading on the operations side of the service and who would be driving forward clinical improvements.

Vision and strategy

Staff knew and understood the provider's vision and values and how they (were) applied to the work of their team.

Managers were aware that the specification of the service needed reviewing and were working with local commissioners to ensure that this reflected what was required. The service knew where they needed to be and were working hard to implement the vision of the service. Staff felt that the vision and strategy of the trust was in line with what was required.

Culture

Staff felt respected, supported and valued. They said the trust promoted equality and diversity in daily work and provided opportunities for development and career progression. They could raise any concerns without fear.

Staff felt that the culture of the service had improved recently, and staff were working well together. The last year had seen a considerable increase in referrals and several staff had left the team. Some staff reported feeling stressed and that there was a lot of pressure on the staff working within the core team. During the inspection a staff development day was being held for the core team. This team had the most vacancies and the highest caseloads and so carried the most day to day risk. We observed the development session to be well structured and gave staff a chance to talk through concerns and solutions.

Governance

Our findings from the other key questions demonstrated that governance processes were being developed at the service. However, these were not fully embedded at the time of the inspection.

Specialist community mental health services for children and young people

The service had a new operations manager who was ensuring that governance systems were in place. At the time of the inspection not all processes had been fully embedded.

The managers had oversight of the service issues around increasing demand on the teams, high acuity and staffing pressures. They met daily in management huddles to discuss urgent concerns which could then be escalated to senior managers. Staff had risk rated the issues presented by young people to ensure they could access support in a timely manner.

A performance dashboard had recently been introduced to the service. The dashboard was in early development and gave managers oversight of any young people who were due a risk assessment or care plan review. During the inspection we found a risk assessment that was out of date and we were unable to find this young person on the dashboard. This meant that the out of date risk assessment had not been flagged on this system. This was raised with managers on the day of the inspection who were investigating the issue.

Systems were in place to monitor staff vacancies, sickness and mandatory training and to escalate these issues to senior managers. Staff were receiving both managerial and clinical supervision and systems were in place to monitor this. Any issues which needed escalating were fed to senior managers who had good oversight around waiting times.

Management of risk, issues and performance

Teams had access to the information they needed to provide safe and effective care and used that information to good effect. Managers were aware of the risks within the service and actively working to manage and mitigate them.

Leaders had oversight of the risks associated with the service including concerns about staffing, waiting lists, information management and increasing referrals.

The service had an improvement plan in place which included actions to ensure staff had the skills to deal with increasing acuity, review of waiting times and caseloads. The plan had been put in place by the operations manager as part of the new role to drive improvements in the service. The plan was monitored locally and was overseen through the Care Group Quality and Operations meeting. Issues could be escalated to the business plan performance senior leadership team meeting as required. Significant escalations were made to the Quality and Safety Committee as part of the care group presentation to committee.

The issues described by staff and managers matched what was on the risk register. Managers were aware the recruitment of staff was a risk to the delivery of safe care and treatment. The well being of staff in the team had also been identified as a risk due to the increase in referrals and staffing pressures.

Information management

Staff collected analysed data about outcomes and performance and engaged actively in local and national quality improvement activities.

Specialist community mental health services for children and young people

The child and young person information system was not easy to use, and staff reported that documents were not always easy to find and stored in the same place by all staff. Staff had raised the issues around the system with senior managers. This meant that all documentation to provide care could not be located. During the inspection we found it difficult to locate care plans, risk assessments and physical health assessments for young people. Staff stored these in progress notes.

The system was a secure electronic record system and all staff could access the system. This system was used throughout the trust which helped teams to effectively communicate and manage a child and young person's treatment journey.

Staff had access to the equipment and information technology needed to do their work. Staff working in the community had access to a laptop or a mobile device where it was needed. Staff had been supported to improve access to online facilities for child and young person contact and to keep in touch with team members. Staff had welcomed these changes.

Staff were required to undertake information governance training as part of their mandatory training, 93% of staff had undertaken this training.

Engagement

Managers engaged actively other local health and social care providers to ensure that an integrated health and care system was commissioned and provided to meet the needs of the local population. Managers from the service participated actively in the work of the local transforming care partnership.

Managers worked closely with other local healthcare services and organisations (schools, public health, local authority, voluntary and independent sector) to ensure that there was an integrated local system that met the needs of children and young people living in the area. The area had a wide range of community services which staff were aware of and knew how to access. We saw information displayed on staff boards and desks about what services were available to young people and their families in the local area.

There were local protocols for joint working between agencies involved in the care of children and young people.

Learning, continuous improvement and innovation

The service had submitted funding for eight psychoeducational videos for young people experiencing emotional dysregulation leading onto substance misuse, self-harm and eating difficulties. They aim was to educate young people regarding mental health, understanding emotions, effects of trauma and traumatic relationships. The videos would provide a toolkit of mindfulness and distress tolerance techniques in a practical sense, promoting empowerment and interpersonal effectiveness. Participants would also receive a personal 30-minute weekly call with a mental health practitioner to discuss each video. Any risk concerns will be escalated via the usual processes**.**

Mental health crisis services and health-based places of safety

Good

Is the service safe?

Good

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

Safe and clean environments

All clinical premises where patients received care were safe, clean, well equipped, well furnished, well maintained and fit for purpose. The physical environment of the health-based places of safety met the requirements of the Mental Health Act Code of Practice.

Staff completed and regularly updated thorough risk assessments of all areas and removed or reduced any risks they identified. A Mental Health Act (MHA) reviewer visited both health-based places of safety sites on 10 December 2020. Appropriate procedures were in place and followed at both sites to reduce the risk of harm to patients and staff. However, there had been occasions where incidents of harm had occurred to patients because the environment was not always safe with searching and risk assessments for patients were not always carried out safely on arrival.

All interview rooms had alarms and staff available to respond. All areas were clean, well maintained, well-furnished and fit for purpose. Rooms used by patients contained furniture, fittings and equipment that were unlikely to be used to cause harm or injury to the patient or staff member. Call alarms were accessible to patients and staff.

Both health-based places of safety sites met the environmental requirements of the Mental Health Act Code of Practice. There were dedicated entrances for the police to bring patients into the suites which provided privacy during admissions. Both sites had a lounge with seating and a television, a separate sleeping area and a toilet and shower area. Both sites had a clock visible to the patient so that they could orientate themselves in time.

Staff made sure cleaning records were up-to-date and the premises were clean. Staff followed infection control guidelines, including handwashing. Staff followed Covid-19 guidelines to maintain a safe working environment. The premises were clean and hand sanitisers were mounted on walls throughout the premises. Face masks were available for staff and visitors at reception. Staff maintained social distancing within the open plan office.

Safe staffing

The service had enough staff, who received basic training to keep people safe from avoidable harm. The number of patients on the caseload of the mental health crisis teams, and of individual members of staff, was not too high to prevent staff from giving each patient the time they needed.

Nursing staff

The service had enough nursing and support staff to keep patients safe. Staffing levels were monitored daily and any concerns were escalated to the trust quality and safety workforce committee. Staff spoke positively about staffing levels. One staff member told us staffing levels were the best they had ever been.

Mental health crisis services and health-based places of safety

The health-based places of safety were staffed by nurses from the adjoining acute admission wards. There was a separate rota, which provided the health-based places of safety with dedicated staff. When they were not in use, the dedicated staff worked on the wards.

The service had high turnover rates however there were low vacancy rates. This was for the trust adult mental health community services as a whole. Within the crisis service, team leaders and staff told us turnover within their specific teams was low, so shortage of staff had not been a problem. The service had a high number of experienced staff with long service.

Managers limited their use of bank and agency staff and requested staff familiar with the service. Managers made sure all bank and agency staff had a full induction and understood the service before starting their shift. Bank staff from within the trust were used to cover any staff absences. Agency staff were rarely used.

Levels of sickness were higher than the target for the trust adult mental health community services as a whole.

Medical staff

The service had enough medical staff.

The service could get support from a psychiatrist quickly when they needed to. A full-time psychiatrist was employed at Lynfield Mount Hospital. Staff at Airedale Hospital had access to a psychiatrist via the duty rota. Staff told us the duty psychiatrist always responded quickly.

Mandatory training

Staff had completed and kept up to date with their mandatory training. We reviewed the trust dashboard and managers' local dashboards and spoke with staff. Despite Covid-19 restrictions, most training targets were being met or exceeded. An exception was the breakaway skills training that had been impacted by the pandemic. A training plan was in place and on trajectory for staff to complete this training.

The mandatory training programme was comprehensive and met the needs of patients and staff.

Managers monitored mandatory training and alerted staff when they needed to update their training. However, staff took responsibility to ensure their own training was kept up to date.

Assessing and managing risk to patients and staff

Staff assessed and managed risks to patients and themselves. They responded promptly to sudden deterioration in a patient's health. When necessary, staff working in the mental health crisis teams worked with patients and their families and carers to develop crisis plans. Staff followed good personal safety protocols.

Assessment of patient risk

Mental health crisis services and health-based places of safety

Staff completed risk assessments for each patient on admission, using a recognised tool, and reviewed this regularly, including after any incident. Risk assessments completed by the crisis teams were comprehensive and detailed regarding potential harm. Risks were reviewed at every visit and any change in risk was discussed within the team. Risk assessments completed by the psychiatric liaison nurses were detailed and included the '5 P's of formulation' cognitive-behavioural risk reduction model.

Staff could recognise when to develop and use crisis plans and advanced decisions according to patient need. Crisis plans were developed with the patient at the initial appointment or when the patient was ready to discuss and go through their crisis plan with staff.

Management of patient risk

Staff responded promptly to any sudden deterioration in a patient's health. Staff continually monitored patients for changes in their level of risk and responded when risk increased. A Red/Amber/Green (RAG) rating system was in place to indicate a patient's progress from admission to discharge to identify the degree of risk present and determine when they would next be seen.

Staff followed clear personal safety protocols, including for lone working. There was a buddy system in place where buddies contacted each other at the start and end of each shift, and on entering and leaving a lone visit. Staff carried a personal safety device whilst carrying out visits. Staff felt safe and told us the personal safety device provided them with reassurance.

Safeguarding

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

Staff received training on how to recognise and report abuse, appropriate for their role. Staff kept up to date with their safeguarding training for adults and children.

Staff could give clear examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them. Risk assessments identified any potential risks of harm to self, to others and from others.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff knew who the trust safeguarding lead was and could contact them for advice. All staff had access to the trust safeguarding policy and a safeguarding concerns prompt sheet. The prompt sheet included step by step instructions on raising a concern and contact details for advice and support.

Staff access to essential information

Staff working for the mental health crisis teams kept detailed records of patients' care and treatment. Records were clear, up-to-date and easily available to all staff providing care.

Patient notes were comprehensive and all staff could access them easily. Records were stored securely. Patient records were securely stored on an electronic recording system, which was accessible for all staff. Records were comprehensive. All staff could access records easily and without delay.

Medicines management

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

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines. Staff were aware of the Intensive Home Treatment Team (IHTT) and First Response Service (FRS) medicines policy and procedure. This was a sub-procedure of the trust's main medicines policy. The policy covered the safe and secure handling of medicines, specifically within IHTT and FRS.

Staff reviewed patients' medicines regularly and provided specific advice to patients and carers about their medicines. Patients and family members told us medicines were regularly reviewed and they were involved in the process.

The pharmacy risk register had identified a risk with pharmacy staffing due to Covid-19 vaccination clinics and current vacancies in the pharmacy team. This was identified as a high risk. Risks included reduced capacity to answer queries about medicines in a timely manner and less opportunities for patients to discuss their medicines with an expert. An action plan was in place to reduce the risk.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely.

Track record on safety

The service had a good track record on safety.

Reporting incidents and learning from when things go wrong

The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

Staff knew what incidents to report and how to report them. Staff were aware of how to report incidents and felt comfortable in doing so. They described the process for completing an incident report on the electronic incident reporting system.

Staff reported serious incidents clearly and in line with trust policy. Nine serious incidents were recorded for the crisis service during the previous 12 months. All of the incidents were suspected suicide. Three of these investigations were completed and six were ongoing. Serious incidents were overseen on a weekly basis by the serious incident panel. The panel reviewed the progress of the investigations and approved the final report. Outcomes of serious incidents were reported on a monthly basis into the patient safety and learning group and discussed at the monthly Care Group Quality and Operations meeting.

Mental health crisis services and health-based places of safety

Managers investigated incidents thoroughly. Managers debriefed and supported staff after any serious incident. Staff provided examples of serious incidents that had been reviewed, discussed and debriefed by managers. Forums were used to share incidents and lessons learned. These were discussed in team meetings and supervisions. Staff were aware of a 'lessons learned dashboard' on the trust website and monthly reports were provided for all incidents submitted to look at any trends or themes.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong. Patients and family members were fully involved in any investigation.

There was evidence that changes had been made as a result of feedback. Staff provided examples of how lessons had been learned from incidents and changes made. Staff described how learning lessons were mainly about the process they followed and whether they could have done anything better.

Is the service effective?

Good 

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

Assessment of needs and planning of care

Staff assessed the mental health needs of all patients. Staff working for the mental health crisis teams worked with patients and families and carers to develop individual care plans and updated them when needed. Care plans reflected the assessed needs, were personalised, holistic and recovery-oriented.

Staff completed a comprehensive mental health assessment of each patient. This included an account of the events leading to the referral, what their current issues were, any safeguarding concerns and an assessment of risk.

Staff made sure that patients had a full physical health assessment and knew about any physical health problems. Care records contained details of physical health checks and regular physical health monitoring. The service employed a physical health lead and feedback within the teams was very positive about this role.

Staff developed a comprehensive care plan for each patient that met their mental and physical health needs. Care plans were developed with patients and described interventions and treatment. Care plans described what was important to the patient, what recovery looked like to them, goals the patient wanted to achieve and what their expectations were. The care plans were lengthy and the sections relevant to the crisis teams were completed in all the care plans we viewed. These included a comprehensive crisis care plan. Care plans evidenced that the care provided was recovery focused and holistic.

Staff regularly reviewed and updated care plans when patients' needs changed. Care plans were personalised, holistic and recovery-orientated. In response to feedback and learning from incidents, staff had completed updated care planning training in December 2020. This training focused on how to make care planning a more collaborative process.

Best practice in treatment and care

Mental health crisis services and health-based places of safety

Staff working for the mental health crisis teams used recognised rating scales to assess and record severity and outcomes. Staff working for the crisis teams and in the health-based places of safety participated in clinical audit, benchmarking and quality improvement initiatives.

Staff provided a range of care and treatment suitable for the patients in the service. Staff delivered care in line with best practice and national guidance from relevant bodies including The National Institute for Health and Care Excellence (NICE) and Department of Health and Social Care.

Staff supported patients to live healthier lives by supporting them to take part in programmes or giving advice. Patients provided examples of the support they had received from staff. For example, with healthy eating and support with managing their medicines.

Staff used recognised rating scales to assess and record the severity of patient conditions and care and treatment outcomes.

Staff used technology to support patients. All staff had their own laptop and smart phone. They had access to a SharePoint site where important information and guidance was stored. Appointments were booked via a calendar system that all staff had access to.

Staff took part in clinical audits, benchmarking and quality improvement initiatives. Managers used results from audits to make improvements.

Skilled staff to deliver care

The mental health crisis teams included or had access to the full range of specialists required to meet the needs of patients under their care. Managers made sure that staff had the range of skills needed to provide high quality care. They supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.

The service had a full range of specialists to meet the needs of the patients. These included; a psychiatrist, psychological therapist, psychiatric liaison nurse, advanced nurse practitioners, occupational therapists, nursing staff and social workers.

Managers made sure staff had the right skills, qualifications and experience to meet the needs of the patients in their care, including bank and agency staff. Managers gave each new member of staff a full induction to the service before they started work. Staff described a thorough induction process that provided the training and knowledge required for the role. The trust induction included mandatory training. A local induction covered topics such as health and safety and personal safety. New staff spent several days shadowing experienced staff and had regular one to one meetings to assess how they were progressing.

Managers supported staff through regular, constructive appraisals of their work. All staff received an annual appraisal.

Managers supported medical and non-medical staff through regular, constructive clinical supervision of their work. Staff received a monthly management / caseload supervision, which focused on improving standards of care and support for staff members. Staff took part in group supervisions sessions, which were used for specialist and inhouse training. For example, the psychological therapist used group supervisions sessions for specialist and inhouse training including crisis survival skills for patients.

Mental health crisis services and health-based places of safety

Managers made sure staff attended regular team meetings. Team meetings were booked electronically and accessible to all staff on the shared calendar, so anyone in the team could add to the agenda. People were able to dial in to team meetings from home via a video link.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Time was allocated within working hours for training. Staff told us there were plenty of opportunities for professional development and it was encouraged.

Managers made sure staff received any specialist training for their role. For example, trauma informed training, perinatal training, autism, bi-polar awareness and Maastricht interview training.

Multi-disciplinary and interagency teamwork

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

Staff held regular multidisciplinary meetings to discuss patients and improve their care. Multi-disciplinary team (MDT) meetings took place every morning and ensured arrangements were in place for every patient being seen that day. The meetings included a review of all patients currently being cared for who required a visit that day and a review of all patients who had been reviewed but had not yet been discussed in a daily team review meeting. Discussions took place about any complex cases and the action to be taken. Those patients rated as 'amber' were reviewed weekly.

Staff made sure they shared clear information about patients and any changes in their care, including during transfer of care. When patients received care from different staff, teams or services, this was coordinated. Handover records were detailed and up to date.

Staff had effective working relationships with other teams in the organisation and with external teams and organisations. For example, the police, local authority, GPs, accident and emergency staff, local charities and the voluntary care sector. Patients were referred to the MyWellbeing College, which offers guidance on things such as low mood, anxiety, sleep problems and stress. The college is run by the trust and other local partners and charities. Trust and external staff were complimentary about the joined up working between the teams.

Adherence to the Mental Health Act and the Mental Health Act Code of Practice

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice.

Staff received and kept up to date with training on the Mental Health Act and the Mental Health Act Code of Practice and could described the Code of Practice guiding principles. Training compliance exceeded the trust target. 96.89% of staff had completed Mental Health Act training and 100% had completed Mental Health Act training for healthcare support workers. These figures were for the trust adult mental health community services as a whole.

Staff had access to support and advice on implementing the Mental Health Act and its Code of Practice. They knew who their Mental Health Act administrators were and when to ask them for support.

Mental health crisis services and health-based places of safety

The service had clear, accessible, relevant and up-to-date policies and procedures that reflected all relevant legislation and the Mental Health Act Code of Practice.

Patients had easy access to information about independent mental health advocacy. This was provided during appointments.

Staff explained to each patient their rights under the Mental Health Act in a way that they could understand, repeated as necessary and recorded it clearly in the patient's notes each time. This included the rights of those patients brought into the health-based place of safety under section 136. Two section 136 admissions were case tracked by a MHA reviewer during their visits to the health-based places of safety. Records were detailed and each person's individual journey was recorded electronically.

Good practice in applying the Mental Capacity Act

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

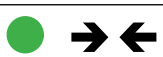
Staff received and kept up to date with training in the Mental Capacity Act and had a good understanding of at least the five principles. Staff knew where to get accurate advice on the Mental Capacity Act. Training compliance exceeded the trust target. 97.89% of staff had completed Mental Capacity Act training. This figure was for the trust adult mental health community services as a whole.

There was a clear policy on the Mental Capacity Act, which staff could describe and knew how to access.

Staff gave patients all possible support to make specific decisions for themselves before deciding a patient did not have the capacity to do so. Staff assessed and recorded capacity to consent clearly each time a patient needed to make an important decision. This was clearly documented in care records. Patients were consulted about whether they wanted their friends and family involved in their care. The service followed the guidance in the consensus statement. The consensus statement sets out how and when clinicians should share information about patients within the legal framework, where this may help prevent suicide.

When staff assessed patients as not having capacity, they made decisions in the best interest of patients and considered the patient's wishes, feelings, culture and history. If a patient required rapid tranquilisation in the health-based places of safety, this was authorised under the Mental Capacity Act. Appropriate documentation was completed when rapid tranquilisation was used.

Is the service caring?

Good 

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

Kindness, privacy, dignity, respect, compassion and support

Mental health crisis services and health-based places of safety

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

Staff were discreet, respectful, and responsive when caring for patients. Feedback from patients and family members was very positive about the caring nature of staff. Patients said they felt supported and staff cared about them

Staff gave patients help, emotional support and advice when they needed it. Interactions with patients were observed to be friendly and clear. Staff spoke to patients with empathy and compassion.

Staff supported patients to understand and manage their own care treatment or condition. This was evidenced from conversations with patients. One patient told us, "They [staff] really encouraged and supported me through my anxiety and depression."

Staff directed patients to other services and supported them to access those services if they needed help. Staff signposted patients to services they worked alongside and information leaflets were handed out. One patient described how staff had gone the extra mile to get the help they needed with a food parcel.

Patients said staff treated them well and behaved kindly. One patient told us, "Staff on the whole have been really caring, responsive and good communicators."

Staff understood and respected the individual needs of each patient and followed policy to keep patient information confidential. Staff were very knowledgeable about the patients they supported.

Involvement in care

Staff in the mental health crisis teams involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided. They ensured that patients had easy access to advocates when needed.

Staff informed and involved families and carers appropriately.

Involvement of patients

Staff involved patients and gave them access to their care plans. Care plans were completed with the patient and they were provided with a copy at the second visit. It was not always recorded in the care plan whether the patient had been given a copy. However, a new performance measure had recently been implemented to monitor compliance. This was being audited and monitored by the trust quality and safety committee.

Patients could give feedback on the service and their treatment and staff supported them to do this. However, not all patients and family members said they had been provided with the opportunity to feedback.

Staff made sure patients could access advocacy services. Information about advocacy services was provided to patients if requested or required.

Involvement of families and carers

Mental health crisis services and health-based places of safety

Staff supported, informed and involved families or carers. Care plans included the views of families and carers.

Is the service responsive?

Good 

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

Access and discharge

The mental health crisis service was available 24-hours a day and was easy to access – including through a dedicated crisis telephone line. The referral criteria for the mental health crisis teams did not exclude patients who would have benefitted from care. Staff assessed and treated people promptly. Staff followed up people who missed appointments.

The service had clear criteria to describe which patients they would offer services to and responded quickly when patients called.

The trust set and the service broadly met the target times for seeing patients from referral to assessment and assessment to treatment. All patients in the health-based places of safety between 1 January and 31 July 2021 were assessed within the 24 hours target time. For the psychiatric liaison team, the clinical manager's dashboard showed 50% of patients between 1 January and 31 August 2021 were seen within one hour. Most of the remainder were seen within four hours and all were seen within 24 hours.

The Intensive Home Treatment Team (IHTT) had a target of first contact with all patients within 24 hours. However, there was no evidence this was monitored or recorded. Frequency of contact following the initial assessment was based on clinical need.

The First Response Service aimed to see patients within one to four hours. Most delays occured due to poor patient engagement so when patients could not be seen within one to four hours, the service followed the 72-hour pathway to see all patients within this time. 39% of patients between 1 January and 31 August 2021 had been seen within one hour, 67% within five hours and 99.5% had been seen within 72 hours. Managers monitored this information locally.

The crisis team had skilled staff available to assess patients immediately, 24 hours a day seven days a week. Psychiatric liaison nurses worked between 8am and 9pm. The night shift was covered by a member of the IHTT.

The team tried to engage with people who found it difficult, or were reluctant, to seek support from mental health services. IHTT staff followed the 72-hour non-engagement pathway. This was rated and the rating depended on whether the person had been contacted and declined to work with staff, or whether the person could not be contacted.

The team tried to contact people who did not attend appointments and offer support. Staff followed the trust failure to attend procedure. This involved attempting to make contact with the patient by various methods and two attempts to visit the patient at home. If no contact was made, the patient was reviewed by the MDT and the outcome clearly documented and shared with other services and professionals involved.

Mental health crisis services and health-based places of safety

Staff worked hard to avoid cancelling appointments and when they had to, they gave patients clear explanations and offered new appointments as soon as possible. Staff told us appointments predominantly ran on time and they informed patients when they did not.

Facilities that promote comfort, dignity and privacy

The design, layout, and furnishings of treatment rooms supported patients' treatment, privacy and dignity.

The service had a full range of rooms and equipment to support treatment and care and protect privacy and confidentiality.

Patients' engagement with the wider community

Staff supported patients with activities outside the service, such as work, education and family relationships.

Patients were provided with information on services that offered opportunities for education and work.

Staff helped patients to stay in contact with families and carers.

Meeting the needs of all people who use the service

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

The service could support and make adjustments for people with disabilities, communication needs or other specific needs. Any language or communication difficulties were identified at the initial assessment. The service supported people from different backgrounds and cultures. People's ethnicity was recorded and monitored during the Covid-19 pandemic to identify people who may be at higher risk from coronavirus.

The psychological therapist had developed grab bags with self-soothe items for patients. The service contacted and worked with one of the local mosques. They provided funding to adapt the grab bags to make them more culturally appropriate.

Staff made sure patients could access information on treatment, local services, their rights and how to complain. The service provided information in a variety of accessible formats so the patients could understand more easily. The service had information leaflets available in various languages spoken by patients within the local community. Information leaflets included an easy read crisis survival skills guide and contact information for useful organisations.

Some staff spoke different languages and managers made sure staff and patients could access interpreters when required. To assist with communication, a member of staff had enrolled on British Sign Language training.

Listening to and learning from concerns and complaints

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

Mental health crisis services and health-based places of safety

Patients, relatives and carers knew how to complain or raise concerns. Written information was provided on how to make a complaint, including the contact details for the trust's advice and complaints department.

Staff understood the policy on complaints and knew how to handle them. Between 1 September 2020 and 1 September 2021, the service had received 53 complaints, four of these were formal complaints. The majority of complaints were raised regarding the first response service which had received 39 informal complaints. The top five reasons for complaints were; information, lack of support, attitude of staff, medication and waiting for appointments.

In the same time period, the service had received 28 compliments. Themes from the compliments received were in relation to the care, advice and support offered to people using the service and their families or carers.

Staff were aware of how complaints were managed and lessons were learned to reduce the risk of a complaint or incident re-occurring. An example of an improvement made from listening to complaints was the introduction of a free phone number so patients did not have to worry about how long they were on the phone to staff.

Managers investigated complaints and identified themes. Managers shared feedback from complaints with staff and learning was used to improve the service. Learning was disseminated in monthly Care Group Quality and Operations meetings and shared and discussed with staff in supervision and team meetings.

Is the service well-led?

Good 

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

Leadership

Leaders had the skills, knowledge and experience to perform their roles. They had a good understanding of the services they managed and were visible in the service and approachable for patients and staff.

Local managers and team leaders were open and transparent throughout the inspection visit. They had a good knowledge of the service and how the teams worked together.

Staff told us managers and team leaders were visible and approachable and had an open-door policy. Staff told us managers and team leaders were supportive and understanding, and keen to help out and support the teams. One staff member told us, “It's a small trust so it's very informal, everybody knows everybody.”

Vision and strategy

Staff knew and understood the provider’s vision and values and how they (were) applied to the work of their team.

Staff were aware of the trust’s vision and values. They told us there were weekly updates and invites to join in with executive broadcasts. Staff told us conversations took place in team meetings and morning handovers about the latest changes and they felt involved. They told us there were plenty of opportunities to feedback on any proposed changes.

Mental health crisis services and health-based places of safety

Staff knew how they and their teams fitted into the trust's vision and values. One staff member told us how their team ensured their values were in line with the trust values.

Culture

Staff felt respected, supported and valued. They said the trust promoted equality and diversity in daily work and provided opportunities for development and career progression. They could raise any concerns without fear.

Staff knew how to escalate concerns and were aware of the whistle-blowing process. New training on freedom to speak up was being provided. Effective speaking up arrangements help to protect patients and improve the experience of staff.

Staff told us there were plenty of opportunities for personal and professional development, and this was encouraged and supported.

There was a positive staff culture. Staff respected each other and worked together as a team. One staff member told us, "You have to work together in this team because of the nature of the work. It isn't a team who are afraid to have a difference of opinion. People can say what they think and are respected for it." Another staff member told us, "We are a considerate team, we share the workload out."

Governance

Our findings from the other key questions demonstrated that governance processes operated effectively at team level and that performance and risk were managed well.

Systems and processes were in place to assess and monitor the quality of the service. A monthly quality and safety data pack was produced that included metrics monitored by various committees. Metrics included workforce, safeguarding, serious incidents, all incidents, staff and patient feedback and quality of care.

Care Group Quality and Operations meetings took place monthly, supplemented by weekly managers' calls.

The clinical manager and team leaders monitored their own teams' performance, including caseloads and referrals. Target times for seeing patients from referral to assessment were being monitored however data was not provided to us for the Intensive Home Treatment Team.

The trust had a mental health legislation committee. The role of this committee was to provide evidence of assurance on the effectiveness of the trust's mental health legislative systems and processes, and the quality of the services provided. We reviewed the annual report from April 2020 to March 2021, which included updates and assurances on a number of areas including compliance with mental health legislation, section 117 aftercare audit, the timeliness of reports to managers and Mental Capacity Act progress updates.

Management of risk, issues and performance

Teams had access to the information they needed to provide safe and effective care and used that information to good effect.

Mental health crisis services and health-based places of safety

Risk to patients, staff and others was well managed within the teams. A risk register was in place and was used to record and monitor any identified risks. There was only one identified risk on the crisis service register at the time of the inspection. This was to ensure three day follow up appointments for Intensive Home Treatment Teams were taking place and being accurately recorded.

Information management

Staff collected analysed data about outcomes and performance and engaged actively in local and national quality improvement activities.

Patient information was stored on a secure electronic record system, which all staff could access. This system was used throughout the trust which helped teams to effectively communicate and manage a patient's care and treatment journey.

Information governance and data security was included in staff mandatory training. Staff in the crisis teams were exceeding the Trust target for completion of this training.

Engagement

Managers engaged actively with other local health and social care providers to ensure that an integrated health and care system was commissioned and provided to meet the needs of the local population. Managers from the service participated actively in the work of the local transforming care partnership.

There were effective, multi-agency arrangements to agree and monitor the governance of the mental health crisis service and the health-based places of safety. Managers of the service worked actively with partner agencies (including the police, ambulance service, primary care and local acute medical services) to ensure that people in the area received help when they experienced a mental health crisis; regardless of the setting.

Teams engaged well with other healthcare professionals and partner agencies. For example, psychiatric liaison staff working with staff from the local acute trust in A&E and on the hospital wards.

There was a joint working standard operating procedure in place between the service and West Yorkshire Police for the street triage service. This involved a nurse and a police officer working together in a police vehicle and attending incidents where a person was mentally unwell. This approach meant that persons could be directed and signposted to other mental health support services rather than a section 136 suite when it was considered appropriate.

Learning, continuous improvement and innovation

The service was in the process of implementing the Core 24 model. The NHS Mental Health Implementation Plan for mental health crisis care and liaison outlines the national ambition for all general hospitals to have mental health liaison services, with 70% meeting the Core 24 standard for adults and older adults. Core 24 will primarily improve the response in psychiatric liaison but will have a positive impact on other areas of the service. The implementation of the new Core 24 model will increase the number of psychiatric liaison nurses and ensure this service is staffed 24 hours per day. Staff told us they had been involved in the Core 24 consultation process. Implementation was being monitored by the Care Group Quality and Operations meeting.

Mental health crisis services and health-based places of safety

The service was working with the local authority to develop a crisis respite option. The aim of this is to provide a place to deliver intensive home treatment safely when the home is not viable and avoid inpatient admission. This is in response to the impact of bed shortages on the acute community mental health services and to reduce the risk of that impact.

A staff member told us, “We are looking at better ways we can measure the patient's experience. We have contacted other trusts to see what they've developed and use. It feels exciting, there's a lot to come.”

Community-based mental health services of adults of working age

Good ↑

Is the service safe?

Good ↑

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

Safe and clean environment

All clinical premises where patients received care were safe, clean, well equipped, well furnished, well maintained and fit for purpose.

Staff completed and regularly updated thorough risk assessments of all areas and removed or reduced any risks they identified. All buildings had up to date fire risk assessments.

The Trust had taken a decision to remove ligature audits within community settings. This was replaced with a standard operating procedure. The procedure focussed on mitigating risks in high risk areas where patients were unaccompanied such as toilets. Staff had access to ligature cutters, however not all staff were aware that the service had ligature cutters or knew where the ligature cutters were stored, which meant they would not have been able to access them in an emergency.

Following our visit, the service took action to remind staff where the ligature cutters were stored including producing a poster and adding the standard operating procedure and location of the cutters to the daily huddle agenda for discussion within the team.

All interview rooms had alarms and staff available to respond.

All clinic rooms had the necessary equipment for patients to have thorough physical examinations.

All areas were clean, well maintained, well-furnished and fit for purpose. Staff followed infection control guidelines, including handwashing. The services had a Covid-19 policy in place and masks and hand gel were available throughout the buildings. Social distancing protocols were in operation.

Staff made sure most equipment was well maintained, clean and in working order. Most equipment was well maintained and had stickers with the dates of safety checks, however we found the safety check for a set of scales at Meridian House was out of date. We also found the temperature checks for the medication fridge at Meridian House had not always been recorded daily. Four checks had been missed in the previous month.

Safe staffing

The service had enough staff, who knew the patients and received basic training to keep them safe from avoidable harm. The number of patients on the caseload of the teams, and of individual members of staff, was not too high to prevent staff from giving each patient the time they needed.

Community-based mental health services of adults of working age

Nursing staff

The service had enough qualified and support staff to keep patients safe. The vacancy rate across the service was 7.23%. This varied between different teams with one team having no vacancies. Managers monitored staffing levels and could use agency staff if required.

Caseload numbers varied across teams and managers took complexity into account when allocating services users onto caseloads. Average caseloads in the Airedale and City teams were between 30-35, but higher in the North team at 40. Staff told us their caseloads were manageable and new staff were given smaller caseloads. Managers monitored caseloads through caseload management, and staff told us that recent recruitment had helped reduce caseload numbers.

The service had reducing vacancy rates. Managers had been actively recruiting new staff and this had reduced vacancy rates.

Managers made arrangements to cover staff sickness and absence. Sickness rates across community services were 5.8% Sickness rates varied between teams and sickness rate in the City CMHT was at 10.5%. This had been put on the risk register to be monitored. Sickness and absence were monitored and managed at the staff huddles and initially covered by the team. Longer term absence or absence the team were unable to cover was escalated and managers used bank and agency staff where required.

Managers made sure all bank and agency staff had a full induction and understood the service before starting their shift. Bank and agency staff received a full local induction to the service and ongoing support.

The service had high turnover rates. Turnover rates were at 19.26% across services. Managers were actively recruiting staff.

Managers used a recognised tool to calculate safe staffing levels.

Medical staff

The service had enough medical staff. Each team had access to psychiatrists and junior doctors. The service could get support from a psychiatrist quickly when they needed to. Most patients told us that they were able to access a psychiatrist easily, however some patients accessing the North Team at Somerset House told us it could be difficult to access a psychiatrist.

Mandatory training

Staff had mainly completed and kept up-to-date with their mandatory training. Compliance with mandatory training was an average of 90%. Compliance with face to face training was lower in relation to immediate life support at 69%, managing aggression and violence breakaway training at 68% and Moving and Handling People at 60%. We were told this was due to challenges with carrying out face to face training during the pandemic. Face to face training had been re-established and managers had put plans in place to ensure staff received these training courses.

The mandatory training programme was comprehensive and met the needs of patients and staff.

Managers monitored mandatory training and alerted staff when they needed to update their training.

Community-based mental health services of adults of working age

Assessing and managing risk to patients and staff

Staff assessed and managed risks to patients and themselves well. They responded promptly to sudden deterioration in a patient's health. When necessary, staff worked with patients and their families and carers to develop crisis plans. Staff monitored patients on waiting lists to detect and respond to increases in level of risk. Staff followed good personal safety protocols.

Assessment of patient risk

Staff completed risk assessments for each patient on arrival, using a recognised tool, and reviewed this regularly, including after any incident. We looked at 14 records. 13 had up to date risk assessments that were reviewed regularly.

We found 84% of risk assessments had been updated in a 12-month period in the North team, 95% in AireWharfe and 90% in the City team.

The service was changing the way risk was monitored. Staff were in the process of transferring to the new document called 'my care and safety plan' and were increasing the frequency of risk assessment monitoring to every 30 days. This was in response to learning from serious incidents.

Staff could recognise when to develop and use crisis plans and advanced decisions according to patient need.

Management of patient risk

Staff responded promptly to any sudden deterioration in a patient's health.

Staff continually monitored patients on waiting lists for changes in their level of risk and responded when risk increased. Waiting lists varied between services. Waiting lists had reduced in most teams. Managers monitored waiting lists on a weekly basis. The service also had links with a voluntary sector provider that offered support for patients whilst they were on the waiting list. Patients were encouraged to use this service.

Staff followed clear personal safety protocols, including for lone working. There was a lone worker policy and services had local lone working protocols to manage staff safety.

Safeguarding

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

Staff received training on how to recognise and report abuse, appropriate for their role. Most staff had completed training in safeguarding adults and children to an appropriate level.

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

Community-based mental health services of adults of working age

Staff knew how to make a safeguarding referral and who to inform if they had concerns. The teams contained social workers who took a lead on safeguarding concerns. The social work manager was the safeguarding lead for the team and monitored safeguarding alerts. Staff could also access the Trust's safeguarding team for support.

Managers took part in serious case reviews and made changes based on the outcomes.

Staff access to essential information

Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date and easily available to all staff providing care.

Patient notes were comprehensive and all staff could access them easily. We looked at 14 sets of records. Patient notes were clear and up to date.

When patients transferred to a new team, there were no delays in staff accessing their records.

Records were stored securely. All notes were electronically stored. All staff had their own laptops which were password protected and could access the records system from these.

Medicines management

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

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines. We checked 15 prescription charts. All charts were reviewed within the required time and were within the British National Formulary limits. Managers allocated nurses to audit medication on a weekly basis. Medication was ordered by nurses within the team.

Staff reviewed patients' medicines regularly and provided specific advice to patients and carers about their medicines. Prescribers explained the purpose and any side effects of medication prescribed. Patients told us their medication was reviewed regularly and that they received information and advice about their medication.

Staff stored and managed medicines and prescribing documents in line with the provider's policy.

Staff reviewed the effects of each patient's medication on their physical health according to NICE guidance. Staff ran clinics to monitor the health of patients who were taking medication with known side effects.

Track record on safety

The service did not have a good track record on safety.

There were eleven serious incidents relating to the Community Mental Health Team over the last 12 months.

Community-based mental health services of adults of working age

Serious incidents mainly related to the suicide of patients. A review of the serious incidents highlighted several themes. These were poor record keeping, specifically care plans not always being updated regularly and a lack of compliance with the missed appointment policy and referrals getting lost. Staff did not always follow up patients who missed appointments as required in the policy. This meant that patients would not always been seen regularly and there were sometimes long periods of time where patients were not seen.

Team leaders could tell us about the learning from incidents and changes that had been made following investigations. Patient safety reviews were completed when there were safety concerns.

Reporting incidents and learning from when things go wrong

The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

Staff knew what incidents to report and how to report them. All incidents were reported via an electronic reporting system.

Staff raised concerns and reported incidents and near misses in line with trust/provider policy.

The service had no never events.

Staff understood the duty of candour. They were open and transparent, and gave patients and families a full explanation if and when things went wrong.

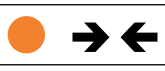
Managers debriefed and supported staff after any serious incident

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations. There was evidence that changes had been made as a result of investigations into incidents. For example, the North team had changed the process around reminders for administering depot medication following a medication error.

Staff received feedback from investigation of incidents, both internal and external to the service. Learning from incidents were discussed at team meetings. The Trust had a 'lessons learned' newsletter for sharing learning from incidents, however staff did not appear to be aware of this.

Staff met to discuss the feedback and look at improvements to patient care.

Is the service effective?

Requires Improvement 

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

Assessment of needs and planning of care

Community-based mental health services of adults of working age

Staff assessed the mental health needs of all patients. They worked with patients and families and carers to develop individual care plans and updated them as needed. Care plans reflected the assessed needs, were personalised, holistic and recovery-oriented.

Staff completed a comprehensive mental health assessment of each patient. Patients received a comprehensive assessment with the assessment team. Patients were offered an initial assessment, following allocation, within four weeks. Patients then stayed with the assessment team for up to 12 weeks prior to being transferred to one of the other teams.

Staff made sure that patients had a full physical health assessment and knew about any physical health problems.

Staff developed a comprehensive care plan for each patient that met their mental and physical health needs

Staff did not always review and update care plans when patients' needs changed.

We looked at 14 records, 12 had up to date care plans. One patient was being seen by the medic and did not require a care plan; one patient did not have an up to date care plan.

We reviewed the manager's dashboards which provided information on how many care plans were in date. These varied between teams. We found 73% of care plans had been updated in a 12-month period in the North team, 92% in AireWharfe and 79% in the City team.

We reviewed this further and found that some of the information on the dashboard was inaccurate, for example one of the patients did not have a care plan because they were no longer in the service.

Services had undertaken a five-day rapid improvement week considering how care plans were used collaboratively and strengthening the importance of them, this project included patients. This has resulted in a new care plan being created and an increase in the frequency of renewing care plans. The service was in the process of changing to the new 'my care and safety plan' but had not completed this process.

Care plans were personalised, holistic and recovery-orientated. Most care plans showed evidence of patient involvement and were based around patient goals. The new 'my care and safety plan' had been produced with patients and included sections on goal setting, staying well, preventing relapse and crisis.

Best practice in treatment and care

Staff provided a range of treatment and care for patients based on national guidance and best practice. They ensured that patients had good access to physical healthcare and supported them to live healthier lives. Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives.

Staff provided a range of care and treatment suitable for the patients in the service.

Staff delivered care in line with best practice and national guidance from relevant bodies such as the National institute of Health and Care Excellence (NICE). Treatment was offered based on clinical need. A range of psychological therapies recommended by the NICE were offered to patients. These included cognitive behavioural therapy, psychotherapy, trauma focused work and eye movement desensitisation and reprocessing therapy.

Community-based mental health services of adults of working age

The Trust had a new trauma informed personality pathway. This pathway supported frequent attenders and people with personality disorders. Patients on this pathway had a consultation which led to a formulation and a multi-agency care plan.

However, there was a waiting list for psychological therapies. The trust target was 18 weeks, and this was being exceeded in some of the teams. The longest waiting times occurred in the North team and the City team with the longest wait in the city team being one year and 37 weeks.

Managers had put plans in place to mitigate the risk of these waiting times. These included calls to patients, liaising with local voluntary services to offer extra support to patients, active recruitment and reviewing current provision with a view to increasing effectiveness of provision.

Staff made sure patients had support for their physical health needs, either from their GP or community services. Staff carried out physical health monitoring when required. Services had associate practitioners who provided the physical health clinics and took a lead in monitoring patients physical health needs.

Staff supported patients to live healthier lives by supporting them to take part in programmes or giving advice. Most teams had social prescribers who supported patients to connect into community services. Staff also provided support with smoking cessation

Staff used recognised rating scales to assess and record the severity of patient conditions and care and treatment outcomes.

Managers used results from audits to make improvements. Team managers carried out weekly audits of five to six sets of documentation. Action plans were created from these audits and feedback was given to staff where actions were required.

Skilled staff to deliver care

The teams included or had access to the full range of specialists required to meet the needs of patients under their care. Managers made sure that staff had the range of skills needed to provide high quality care. They supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.

The service had (access to) a full range of specialists to meet the needs of each patient. The teams contained psychiatrists and doctors, physical health and mental health nurses, occupational therapists, social workers. In addition to this there was a psychology team who specialised in a range of therapeutic approaches.

Managers made sure staff had the right skills, qualifications and experience to meet the needs of the patients in their care, including bank and agency staff. In addition to mandatory training specialised courses were available for staff to increase their knowledge and skills. For example, staff told us they were studying for approved mental health professional and social work qualifications.

Managers gave each new member of staff a full induction to the service before they started work.

Community-based mental health services of adults of working age

Managers supported staff through regular, constructive appraisals of their work. All staff told us they had received supervision and appraisals. Staff received yearly appraisals and supervision every six to eight weeks. Supervision structures included case management supervision, clinical supervision, peer supervision and opportunities to discuss complex cases.

Managers made sure staff attended regular team meetings and gave information to those who could not attend. Team meetings took place every month, minutes were recorded, and learning was shared within team meetings.

Managers recognised poor performance, could identify the reasons and dealt with these.

Multidisciplinary and interagency team work

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

Staff held regular multidisciplinary meetings to discuss patients and improve their care. Multidisciplinary staff attended weekly complex case discussions, formulation meetings and referral meetings.

Staff made sure they shared clear information about patients and any changes in their care, including during transfer of care. Staff attended huddles every morning to discuss patient care. The structure of these meetings varied between teams with some teams having a structured purpose for huddles on different days of the week.

Managers told us that referrals were managed through the online system. We saw that referrals had been made under the referrals tab on the system. Referrals were discussed at referral meetings. However, we were told by some staff that referrals were still made by email.

Staff had effective working relationships with other teams in the organisation.

Staff had effective working relationships with external teams and organisations.

Adherence to the Mental Health Act and the Mental Health Act Code of Practice

Staff did not always understand their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice.

Staff received and kept up-to-date with training on the Mental Health Act and the Mental Health Act Code of Practice and could describe the Code of Practice guiding principles.

Staff had access to support and advice on implementing the Mental Health Act and its Code of Practice. Staff told us they could access advice from the Mental Health Act Office. Teams also contained Approved Mental Health Professionals who could provide advice and support.

Staff followed clear, accessible, relevant and up-to-date policies and procedures that reflected all relevant legislation and the Mental Health Act Code of Practice.

Community-based mental health services of adults of working age

Not all patients had easy access to information about independent mental health advocacy. We found that patients who were under Community Treatment Orders were not always referred to independent mental health advocacy. This does not comply with the Trust policy which required everyone detained under the Mental Health Act to have an automatic referral to an Independent Mental Health Advocate. When we raised this with the Trust, they told us that all patients were sent a letter which included a link to the Independent Mental Health Advocacy service. It is a requirement of the code of practice to provide information about this verbally.

Staff did not always explain to each patient their rights under the Mental Health Act in a way that they could understand, repeated as necessary and recorded it clearly in the patient's notes each time. We found one record which showed that a patient subject to a Community Treatment Order had not been read their rights.

For patients subject to a Community Treatment Order, staff did not always complete all statutory records correctly.

We found one record where there had a delay in authorising medication appropriately. This had been covered by a temporary authorisation which related to urgent treatment, but this issue had not been identified for three months.

Care plans clearly identified patients subject to the Mental Health Act and identified the Section 117 aftercare services they needed.

Good practice in applying the Mental Capacity Act

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

Staff received and kept up-to-date with training in the Mental Capacity Act and had a good understanding of at least the five principles.

There was a clear policy on the Mental Capacity Act.

Staff knew where to get accurate advice on Mental Capacity Act.

Staff gave patients all possible support to make specific decisions for themselves before deciding a patient did not have the capacity to do so. Records showed that staff had considered mental capacity and that there was evidence of informed consent. We saw examples of staff giving information and treatment options to patient and supporting them to make informed choices.

Staff assessed and recorded capacity to consent clearly each time a patient needed to make an important decision.

The service monitored how well it followed the Mental Capacity Act and made changes to practice when necessary.

Staff audited how they applied the Mental Capacity Act and identified and acted when they needed to make changes to improve.

Community-based mental health services of adults of working age

Is the service caring?

Good 

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

Kindness, privacy, dignity, respect, compassion and support

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

Staff gave patients help, emotional support and advice when they needed it. We spoke to ten patients and seven carers. Feedback from patients and carers was mostly positive. Patients told us they had positive relationships with staff and gave us examples of receiving support that met their needs when they needed it. However, we received some feedback from patients accessing the North team at Somerset House who told us it was difficult to contact staff when they needed support.

Staff supported patients to understand and manage their own care treatment or condition.

Staff directed patients to other services and supported them to access those services if they needed help. Records showed that staff provided information and referrals to services to support patients with health and social issues. Patients told us that staff supported them to access community services.

Patients said staff treated them well and behaved kindly.

Staff understood and respected the individual needs of each patient.

Staff felt that they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients and staff.

Staff followed policy to keep patient information confidential.

Involvement in care

Staff involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided. They ensured that patients had easy access to independent advocates.

Involvement of patients

Staff involved patients and gave them access to their care plans. Patients told us that they completed care plans together and that they had been given copies of their care plans.

Staff made sure patients understood their care and treatment (and found ways to communicate with patients who had communication difficulties).

Community-based mental health services of adults of working age

Staff involved patients in decisions about the service, when appropriate.

Patients could give feedback on the service and their treatment and staff supported them to do this.

Staff supported patients to make advanced decisions on their care.

Staff made sure patients could access advocacy services. The service had links with an advocacy service and supported patients to access this.

Staff informed and involved families and carers appropriately.

Involvement of families and carers

Staff supported, informed and involved families or carers. Carers we spoke to felt involved in their loved one's care and told us staff gave them information about diagnosis and treatment. Carers were involved in care plans where appropriate and given the opportunity to ask questions.

Staff helped families to give feedback on the service.

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

Is the service responsive?

Good

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

Access and waiting times

The service was easy to access. Its referral criteria did not exclude patients who would have benefitted from care. Staff assessed and treated patients who required urgent care promptly and patients who did not require urgent care did not wait too long to start treatment. Staff followed up patients who missed appointments.

The service had clear criteria to describe which patients they would offer services to and offered patients a place on waiting lists. Patients were placed on a waiting list when there was no capacity in team. Staff prioritised patients based on risk and could refer into other teams if they had concerns about the patient having a high level of risk. The team's duty worker contacts at least three people each day, from the un-allocated or absent care coordinator waiting list. The worker updates the system following the telephone review.

The service did not meet trust target times for seeing patients from referral to assessment but did meet targets for assessment to treatment. There was a 5- 7 working day delay in referral to allocation timescales. Following on from this 95 % of patients were offered an appointment within 4 weeks. There were 27 people on the waiting list for the City CMHT team, nine people on the waiting list for the Airedale CMHT team and 26 people in the North team. Specialist services varied for example there were 0 people on the waiting list for the SMABS team.

Community-based mental health services of adults of working age

Staff saw urgent referrals quickly and non-urgent referrals within the trust target time.

Staff tried to engage with people who found it difficult, or were reluctant, to seek support from mental health services. Staff considered barriers to engagement, including carrying out more frequent visits to build relationships and considering and offering solutions to cultural and language barriers.

Staff tried to contact people who did not attend appointments and offer support. The Trust had a 'Failure to Attend Appointments' policy which provided guidance about what staff should do if a patient did not attend an appointment. These included telephone calls, home visits and contacting relatives and other agencies.

Patients had some flexibility and choice in the appointment times available. However, the services primarily operated on a 9-5 Monday to Friday basis. Patients were signposted other services if they needed support out of hours.

Staff worked hard to avoid cancelling appointments and when they had to, they gave patients clear explanations and offered new appointments as soon as possible. Services used duty cover or would pick up appointments within the teams in order to minimise cancelling appointments.

Appointments ran on time and staff informed patients when they did not.

The service used systems to help them monitor waiting lists/support patients. Patients on the waiting list are reviewed weekly and any concerns are reviewed. The Trust have also linked in with a voluntary service project to provide informal support for patients on the waiting list.

Staff supported patients when they were referred, transferred between services, or needed physical health care.

The service followed national standards for transfer.

The facilities promote comfort, dignity and privacy

The design, layout, and furnishings of treatment rooms supported patients' treatment, privacy and dignity.

The service had a full range of rooms and equipment to support treatment and care.

Interview rooms in the service had sound proofing to protect privacy and confidentiality. We were told that Meridian House had been renovated and that the rooms were now soundproof.

Meeting the needs of all people who use the service

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

The service could support and make adjustments for people with disabilities, communication needs or other specific needs. Premises were accessible and staff could access sign language interpreters if required.

Staff made sure patients could access information on treatment, local services, their rights and how to complain.

Community-based mental health services of adults of working age

The service provided information in a variety of accessible formats so the patients could understand more easily.

The service had information leaflets available in languages spoken by the patients and local community. Managers were aware of the local population needs and information could be made available in different languages.

Managers made sure staff and patients could get hold of interpreters or signers when needed.

Listening to and learning from concerns and complaints

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

Patients, relatives and carers knew how to complain or raise concerns. Patients and carers told us they felt able to complain if they needed to.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint.

The community mental health teams were the service with the highest number of concerns raised across the trust. Between 1 September 2020 and 1 September 2021, the service received 14 formal complaints and 105 informal complaints. Managers investigated complaints and identified themes. The top five reasons for complaints were; information, lack of support, attitude of staff, medication and waiting for appointments. We reviewed three complaints. Managers followed the complaints procedure to resolve both informal and formal complaints.

Patients received feedback from managers after the investigation into their complaint.

Managers shared feedback from complaints with staff and learning was used to improve the service.

The service used compliments to learn, celebrate success and improve the quality of care. In the same time period, the service had received 34 compliments. Themes from compliments were in relation to; advocating, listening and providing support through people's recovery.

Is the service well-led?

Good ↑

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

Leadership

Leaders had the skills, knowledge and experience to perform their roles. They had a good understanding of the services they managed and were visible in the service and approachable for patients and staff.

Community-based mental health services of adults of working age

Managers were visible in the service and senior managers visited the service regularly to provide support. Managers understood the services they managed and had the skills and training required to carry out their roles. Managers were given the opportunity to develop and were offered leadership courses to improve their skills.

Vision and strategy

Not all staff were not aware of the provider's vision and values and how they (were) applied to the work of their team.

Most staff were unclear of the providers vision and values. Teams did not have specific objectives or plans based on the organisations vision and values. Managers told us they based staff appraisals on the organisation's values.

Culture

Staff felt respected, supported and valued. They said the trust promoted equality and diversity in daily work and provided opportunities for development and career progression. They could raise any concerns without fear.

Staff we spoke to felt supported and told us there was a positive culture in the team. They told us they could raise any concerns they had. Staff received regular supervision and support and managers had developed a variety of opportunities for sharing knowledge and learning. Staff were aware of the whistleblowing policy and knew they could speak to a freedom to speak up guardian if needed.

Governance

Our findings from the other key questions demonstrated that governance processes operated effectively at team level and that performance and risk were managed well.

The service had regular team meetings which were used to discuss the service and provide information to staff. Feedback from team meetings went to the managers Care Group Quality and Operations (QUOPs) meetings and information from these meetings was fed back to staff within team meetings. Managers also had weekly managers calls.

Teams had key performance indicator targets and managers monitored these at weekly performance meetings. Managers were able to view compliance with key performance indicators on the team dashboards. These included information on compliance with care plan and risk assessment updates and staff training.

Managers provided regular caseload management supervision for staff and this had helped reduce waiting lists. Managers had also implemented 'stop the clock' days which meant time was put aside to enable staff to focus on ensuring records were up to date.

We found that some of the information about care plan and risk assessment updates did not accurately reflect the levels of compliance.

Management of risk, issues and performance

Teams had access to the information they needed to provide safe and effective care and used that information to good effect.

Community-based mental health services of adults of working age

Teams had systems in place for reviewing information about risk within daily huddles and putting plans in place to manage concerns.

Teams had access to a risk register, and staff could submit items for the risk register. This would usually be done through discussion at team meetings. Key risks for the teams related to waiting lists. This was reflected on the Trust's risk register.

Managers had systems in place to identify poor performance. These included auditing and case management systems. Managers undertook performance management with staff when required.

Information management

Staff collected analysed data about outcomes and performance and engaged actively in local and national quality improvement activities.

Staff had the equipment they needed to carry out their roles including laptops and phones. Staff told us that internet access was sometimes unreliable, this was being investigated by the Trust.

Managers had access to dashboards and systems which enabled them to monitor performance.

Engagement

Managers engaged actively other local health and social care providers to ensure that an integrated health and care system was commissioned and provided to meet the needs of the local population. Managers from the service participated actively in the work of the local transforming care partnership.

Managers collaborated with other providers and community groups to increase patient support. Managers used third sector providers to extend and complement service provision, for example to provide extra support for patients outside of office hours.

Managers and staff were aware of local needs and engaged with local cultural centres and community centres to expand support for patients.

Managers engaged with patients on specific projects such as the work on the 'my care and safety plan.'

Learning, continuous improvement and innovation

There was a culture of continuous learning within teams. Teams had allocated time for reflective practice and peer supervision. Managers identified training needs in staff appraisals and there were opportunities for staff to undertake further training to develop skills within the teams.