South West Yorkshire Partnership NHS Foundation Trust

Quality Report

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Core services inspected	CQC registered location	CQC location ID
Acute wards for adults of working age and psychiatric intensive care units	The Dales Priestley Unit Fieldhead Hospital Kendray Hospital	RXGCC RXGDD RXG10 RXG82
Wards for older people with mental health problems	The Dales Priestley Unit Fieldhead Hospital Kendray Hospital Poplars Community Unit for the Elderly	RXGCC RXGDD RXG10 RXG82 RXG31
Long stay/rehabilitation wards for working age adults	Enfield Down Lyndhurst	RXG36 RXG58
Forensic/Inpatient secure wards	Fieldhead Hospital	RXG10
Wards for people with learning disabilities or autism	Fieldhead Hospital	RXG10
Mental health crisis services and health based places of safety	Fieldhead Hospital The Dales Kendray Hospital	RXG10 RXGCC RXG82

Summary of findings

Community based mental health services for adults of working age	Fieldhead Hospital	RXG10
Community based mental health services for older people	Fieldhead Hospital	RXG10
Community mental health services for people with learning disabilities or autism	Fieldhead Hospital	RXG10
Specialist community mental health services for children and young people	Fieldhead Hospital Castleford and Normanton District Hospital	RXG10 RXG18
Community end of life care	Kendray Hospital Mount Vernon Hospital	RXG82 RXGX5
Community health services for children, young people and families	Fieldhead Hospital	RXG10
Community health inpatient services	Kendray Hospital Mount Vernon Hospital	RXG82 RXGX5
Community health services for adults	Fieldhead Hospital	RXG10

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

Summary of findings

Ratings

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

Overall rating for services at this Provider	Requires improvement 
Are Mental Health Services safe?	**Requires improvement** 
Are Mental Health Services effective?	**Requires improvement** 
Are Mental Health Services caring?	**Good** 
Are Mental Health Services responsive?	**Requires improvement** 
Are Mental Health Services well-led?	**Requires improvement** 

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

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

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

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

Summary of findings

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Overall summary

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

We found that the provider was performing at a level which led to a rating of requires improvement. We will be working with the trust to agree an action plan to assist them in improving the standards of care and treatment.

We rated the trust as requires improvement overall because:

- Staffing levels in some of the inpatient areas did not always meet the safer staffing levels set by the trust. This adversely impacted on activities, escorted leave and potentially patient and staff safety. We also found some patients were waiting a long time for a service, this was especially so in specialist community mental health services for children and young people and psychology therapy services. The waiting lists were also not being appropriately managed which could lead to escalation in patient risk not being recognised.
- Risk assessment and management were inconsistent across the trust. Staff did not always assess patient risk in line with the trust's policy. Staff did not always update the assessment in a timely manner when patient condition and presentation changed and risks were identified. Staff did not always share information regarding risk with other parts of the service. There were also environmental risks in some inpatient areas that had not been adequately managed by the trust.
- Physical health monitoring across the services was inconsistent. This was especially so where physical health monitoring was necessary in relation to specific medication and its use in long stay and rehabilitation and acute and psychiatric intensive care wards.
- Mental Health Act (MHA) and Mental Capacity Act (MCA) training was not mandatory for the trust staff and there was no overall board knowledge or overview of what training was being delivered or to which staff. Training was arranged and delivered locally and we found some areas where staff knowledge of the legislation in practice was very good. Unfortunately, we also found some areas where the staff knowledge of legislation in practice was very poor.
- Alongside the training for the MHA, we found that the trust had not implemented the changes to the 2015 MHA code of practice in the organisation. There were policies and procedures that had not been updated to meet the requirement of the 2015 code and the changes had not been actioned in practice. This meant that there was no assurance that patients and their carer's rights were protected.
- Whilst there was overview of staff appraisal in the trust there was no overview of managerial or clinical supervision for staff. We saw examples of supervision at a local level on an individual and group basis. However, this was not consistent across the trust and there were areas where supervision was not being held for a considerable period.
- The trust's electronic recording system, RIO, had been recently upgraded and different services across the trust were at various levels of implementation. Most services were finding it difficult to use the system effectively with areas needing to find their own solutions to the problems they were encountering. The difficulties were due to the system being slow to load and use information, a mixture of paper based and electronic records at various levels of development and different groups and disciplines or staff using different systems. Whilst some areas had developed their own solutions to problems with health records the inconsistency across the trust left risks to patient care and service delivery.
- There was a lack of assurance that the governance structures in place were effective across the organisation. Senior staff presented information to the board through governance meetings. We found that policies and procedures agreed at the board were not always consistent at a local level. Practice such as medication management, management of environmental risks across services and wards,

monitoring and management of waiting lists, data quality to inform performance and the use of electronic and paper based health records were all found to be inconsistent. Some of the practice we saw in these areas was effective and staff had worked hard to provide a good service. However, there was potential for the board not to be aware of the quality of practice delivered by frontline staff due to the governance structure. This was especially evident in Enfield Down, one of the long stay rehabilitation wards, where the governance system had not identified failings in the service.

- The board approved the fit and proper person's policy on 31 March 2015; this details the trust's responsibilities and states that the trust will ensure that it has procedures in place to assess an individual against the fit and proper person's requirements for all the new directors, prior to their appointment. Three of the new non-executive directors had not had Disclosure and Barring Service checks in line with the fit and proper person requirement, which came into force for NHS bodies on the 1 October 2014. This meant the trust was not complying with its policy or this requirement.

However:

- Consistently across the service, we found good communication between staff and patients and staff treating patients with kindness, dignity, compassion and respect. This was supported by comments from patients who were positive about the care and treatment they received from services. There were also good examples of patient and carer involvement in their care.
- Staff uptake of mandatory training was above the trust standard of 80% in the majority of inpatient areas.
- We saw examples of good practice across the organisation and areas where staff had developed aspects of their service. There was proactive management across the trust, often in a challenging environment. We saw some areas of notable practice across areas of the trust, which are detailed within the report. These include; navigation / tele health service; adult epilepsy service; commitment to working collaboratively; ADHD service and prison in-reach; production of easy read cook books; community eating disorder pathway; falls audit and change to practice.
- The trust had a clear structure and governance in place for the reporting of safeguarding incidents from the ward to the board via a number of different groups. Staff followed the incident reporting, complaints and safeguarding procedures, across the services, including duty of candour. Staff described instances where they had received feedback following learning from incidents and we observed evidence of lessons learnt from board to ward in the almost all services. There were named safeguarding nurses and mandatory safeguarding training. Staff were able to explain their responsibilities and local referral procedures for safeguarding.
- The trust had a clear strategy, which established its long-term vision and strategic goals, underpinned by the values of the organisation. The trust had worked closely with its stakeholders to develop these values. The values were embedded in the business delivery units and reflected in the staff behaviours we observed during our inspection. The introduction of the trio of managers, comprising a general manager, a clinical lead and a practice governance coach, in the service lines in each business delivery unit had improved the service delivery, the staff understanding of the transformation programme, and staff morale.

Summary of findings

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

We always ask the following five questions of the services.

Are services safe?

Requires improvement

We rated safe as requires improvement because:

- Wards on both the inpatient wards for older people with mental health problems and the acute wards for adults of working age with mental health problems had areas where staff were unable to observe patients (blind spots), as well as ligature risks that were not identified on the ward ligature risk assessment.
- The staffing levels in the acute services for adults of working age, as well as the psychiatric intensive care unit, in the forensic services did not always meet the trust safer staffing levels set by the trust on all wards. This impacted adversely on activities, escorted leave, and potentially patient and staff safety.
- Risk assessments were not always completed in line with trust policies or procedures. In five of six records reviewed on ward 18 of the Priestly Unit, there were no plans in place to manage patient risk. In the community specialist child and adolescent mental health services, all patient records reviewed had incomplete risk assessments or risk assessments not using the risk assessment tool. There was no proactive monitoring of people on the waiting list for treatment or system to monitor changes to risk. At Enfield Down, one of the long stay and rehabilitation wards, the risk assessments were completed prior to admission by the care coordinator in the community. They reviewed and updated at six monthly care programme approach (CPA) meetings by the external care coordinator.
- The data collected by the trust regarding the use of restraint, including prone or face down restraint, seclusion and long-term segregation was not accurate, or recorded in sufficient detail to ensure patients were safeguarded.
- Medicines were not always well managed in the mental health services. On the wards for patients with learning disabilities or autism, missed doses of medication had not been reported on the incident reporting system. Medicine management in the Enfield Down service was not applied in line with the national institute of care and health excellence (medicine optimisation 2015, and psychosis and schizophrenia in adult 2014) and best practice guidance. On the acute wards for adults of working age with mental health problems, we saw no evidence that high dose monitoring was routinely carried out, despite pharmacists noting on charts that it should be done.

Summary of findings

- The written apology sent to patients, relatives and carers following serious incidents was not always clear. The trust did not always explicitly comply with the requirements of regulation 20 of the Health and Social Care Act 2008 (regulated activities) regulations 2014, duty of candour. The written details of the investigation into the incident, and the findings, were not always sent to the patients, relative or carer.

However:

- In the Patient Led Assessment of the Care Environment (PLACE) 2015 results, both the trust wide and location level scores were above the average for all NHS trusts with regards to cleanliness, food, privacy, dignity and wellbeing, condition appearance and maintenance and dementia.
- All the wards and community services we visited for patients with mental health problems had fully equipped clinic rooms with accessible resuscitation equipment and emergency drugs. All the inpatient complied with same sex accommodation guidance as defined in the Department of Health guidance for eliminating mixed sex accommodation.
- Mandatory training was above the Trusts target of 80%.
- The NHS Staff Survey 2015 reported that the percentage of staff suffering work-related stress in last 12 months at the trust was better than to the national average in comparison to other mental health and learning disability trusts.
- We found little evidence of blanket restrictions on the mental health inpatient wards. The trust was committed to reducing restrictive practices and this was identified within the policy.
- Medicines were generally well managed in the community health services.
- The trust had a clear structure in place for the reporting of safeguarding incidents from the ward to the board via a number of different groups. There were named safeguarding nurses and mandatory safeguarding training. Staff were able to explain their responsibilities and local referral procedures for safeguarding.
- Staff had a good understanding of the incident reporting procedure. The staff we spoke to at both ward level and board level confirmed that they received feedback and learning from incidents.

The board had identified the strategic risks, which might affect business and had developed a board assurance framework.

Summary of findings

Are services effective?

Requires improvement 

We rated effective as requires improvement because:

- There were issues in all the community mental health services for staff with regard to recording keeping and using the RIO electronic recording system. Staff were unable to upload and save information in some services, and were unable to access the system and retrieve this information when required. Some services did not have the necessary templates for their treatment on the system.
- Staff on the acute wards for adults of working age, and the psychiatric intensive care unit, had not received either clinical or managerial supervision for some considerable time, in some cases this was over 12 months. The trust had no system in place to monitor clinical supervision meetings.
- At the long stay and rehabilitation service, Enfield Down, patients did not have regular multidisciplinary meetings.
- Mental Health Act training, including the 2015 code of practice and it implications for staff delivering care, was not mandatory across the trust. The trust did not have an overall implementation plan for the 2015 MHA code of practice.
- Mental Capacity Act (2005) training was not mandatory across the trust. Policies had not been reviewed and guidance documents had details missing, including author, version and date of publication. There was no clear mechanism for the trust to monitor its compliance with the Mental Capacity Act or the Deprivation of Liberty Safeguards across the organisation. The Mental Capacity Act was not consistently understood on the acute wards for working age adults and psychiatric intensive care units. On these wards, capacity assessments with regard to consent to treatment were missing from care plans and the best interest process was not always followed.

However:

- Care and treatment was delivered in-line with current, evidence based guidance, standards and best practice in community health services. Patients' needs were assessed and appropriate care plans were developed.
- Patient outcomes were monitored through participation in local and national audits.
- There was good evidence of communication between the professionals involved in providing care and treatment to patients through structured handovers and multi-disciplinary meetings to plan patient care.

Summary of findings

- The core services had a range of disciplines appropriate to the needs of the patient group. Staff had access to mandatory training and specialist training for their personal and professional development and to enhance skills available in the team.
- Independent mental health advocates were available for each ward across the trust services.

Are services caring?

Good 

We rated caring as good because:

- In services across the trust, we observed patients and their relatives being treated with kindness, dignity, compassions and respect.
- We observed examples of good communication between staff and patients in all the services, both when they were supporting patients, and when they were avoiding or de-escalating challenging situations.
- The mental health wards and community services we visited used a variety of person-centred methods to orientate the patients to the service.
- Most of the patients, carers and parents we spoke to made positive comments about the care and treatment they received from services. They told us they were involved in planning their treatment and care.
- On almost all wards, the majority of the care plans were holistic and individually tailored to the patient. They demonstrated that patients had been involved in co-producing their care plans.

However:

- On the forensic mental health inpatient wards, 44% of the care planning records observed did not contain evidence of patient involvement.

Are services responsive to people's needs?

Requires improvement 

We rated responsive as requires improvement because:

- Some of the mental health wards had very high levels of bed occupancy. In some cases, this had an adverse impact on the quality of care. On the acute wards for adults of working age with mental health problems, a bed was not always available for patients when they returned from leave. This meant that patients could be transferred to a hospital out of area, or patients would return to the ward and have to sleep in rooms

other than bedrooms, for example, visitor rooms or interview rooms where beds had been provided. Ward managers told us this was in line with the trust's policy to keep patients safe. There were 44 out of area placements in the 6 months before this inspection. For the acute mental health wards alone, there were 37 out of area placements in the last six months.

- Patients had to wait a long time to be assessed or treated by some of the trust's community –based services. The trust failed to meet two of the 10 targets regarding the number of days from initial referral to initial assessment in the last 12 months. One of these missed targets was in the Calderdale and Kirklees children and adolescent mental health community team. The national target from referral to initial assessment is 28 days. The trust was completing this in an average (mean) of 41 days. Waiting times for treatment following assessment were long with the average wait being 147 days and the longest wait 913 days. This meant in Calderdale and Kirklees young people were waiting on average four and a half months for treatment and in Wakefield six months. Figures were not available for the Barnsley specialist child and adolescent mental health service. The wait times from referral to assessment for community mental health services for older adults, showed that three of the four locations we visited as part of our inspection were not meeting national targets. The longest wait of 78 days was recorded at North Kirklees Community Mental Health Team. The community mental health services all reported long waits for patients in some parts of the trust to access psychological therapies.
- Not all of the trust's facilities promoted recovery, comfort and dignity. The Kirklees outreach team was difficult to locate, as the building was part of a site that also housed a bingo hall. There was no signage to direct people from the car park to the building. However, people would normally be provided with a map to assist them with locating the service. Environments in the community services for older adults with mental health problems were not dementia friendly. In the Barnsley team, staff reported the building to have a leaking roof, and the building was old and in need of decoration. This had been reported but repairs had not been carried out at the time of our inspection. These problems did not impact on patient care.
- In two of the bases for the specialist community mental health services for children and adolescents, the weighing scales were in a public area not a private clinical room. This did not promote privacy and dignity for the young person. On the acute wards for adults of working age with mental health problems,

the provision of activities at weekends was variable, with only two out of the nine wards having pre-planned activities advertised at the weekend. Similarly, on the forensic services, activities were limited at weekends. Patients on both the acute and forensic wards complained that there were insufficient activities and that they wanted more.

However:

- The target set for trusts is that 90% of patients in crisis must be assessed within four hours after a referral has been made. All four teams achieved higher than the national average. Calderdale, Kirklees and Wakefield met this target in 93% of cases during January to December 2015. In the same period Barnsley achieved 98%.
- Most of the environments were spacious, pleasantly decorated and calming in the majority of services.
- Services were accessible for people with disabilities and offered an environment conducive for mental health recovery. These environments were adapted to appropriate mental health conditions. For example low stimulus rooms and sensory areas for patients with learning disabilities or autism. There was also dementia friendly signage which incorporated words and pictures at a visible height so that patients could find their way around more easily on the inpatient wards for older age adults with mental health problems. On one of these wards, Willow Ward, there were signs in braille on all the doors so that patients who were visually impaired could find their way round the ward.
- Patients' cultural, spiritual and faith needs were met in all the services across the trust. On the inpatient wards, the trust had access to religious leaders of different denominations through the chaplaincy service who were able to attend the ward to see patients. Informal patients or those with section 17 leave on inpatient wards and patients in community services were encouraged to visit their usual chosen place of faith.
- Patients we spoke to knew how to make a complaint about the services they received. Staff were able to describe how complaints were dealt with, including their responsibilities under duty of candour.

Are services well-led?

We rated well-led as requires improvement because:

Requires improvement

Summary of findings

- Whilst the governance structures were in place, there was a lack of assurance regarding the information being presented to the board by the senior management team through governance meetings. Systems and processes agreed between the board and the senior management team were not always consistent at a local level. In the long stay and rehabilitation service, the governance structures in place to monitor and improve services were insufficient.
- The systems to monitor the implementation and compliance of the Mental Health Act (2015) code of practice and the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards were insufficient. The board did not understand the quantity, or the quality and content, of the training being delivered.
- The implementation of the action plan regarding the use of the RIO information system was inconsistent across some wards and community services, with some services using paper records along with the electronic system. Staff could not always access the patient information and the systems in place to manage this were not consistent across the trust.
- The trust could not provide accurate data relating to waiting times in the specialist community child and adolescent mental health services, wait times to access psychology from this service and caseloads. They could not be confident that data input in to the system prior to April 2015 was accurate. This affected the data available for Barnsley in particular. The current systems and processes were not adequate to manage the waiting list for patients to access the child and adolescent mental health services, or the waiting lists for patients in the community mental health services to access psychological therapies, as well as the risks for the patients whilst on these waiting lists.
- A number of trust policies and procedures exceeded their stated review dates and revised policies were not available, for example the risk management procedure and policies related to the revised code of practice.
- The trust were unable to monitor the outcomes for patients in the community learning disability and autism services. These teams who were co-located within local authority teams did not report their performance formally to the trust.
- The systems to manage medication across the trust were not applied consistently. In the acute inpatient wards for working

age adults with mental health problems and in the long stay and rehabilitation inpatient wards for people with mental health problems, the systems were not effective for monitoring medication

- There were inconsistencies in the systems for managing the environmental risks across services and wards, including the blind spots and ligature risks identified on the wards for older adults with mental health problems and the acute wards for adults of working age with mental health problems.
- The trust did not meet the fit and proper persons' requirements for their directors and non-executive directors.
- Staff were not familiar with the senior managers in-between the trio of managers responsible for their service line and the chief executive, as well the non-executive directors.
- There was a lack of awareness of board level representation among staff in community services for children and young people.

However:

- The trust had a clear strategy, which established its long term vision and strategic goals, underpinned by the values of the organisation. The trust had worked closely with its stakeholders to develop these values and they were embedded in the business delivery units and reflected in the staff behaviours we observed during our inspection.
- The introduction of the trio of managers, including a general manager, a clinical lead and a practice governance coach, in the service lines in each business delivery unit between had improved the service delivery, the staff understanding of the transformation programme, and staff morale.
- Staff followed the incident reporting, complaints and safeguarding procedures, across the services, including duty of candour. We observed evidence of lessons learnt from board to ward in the almost all services.
- The trust key performance indicators were used to measure performance in all but the community learning disability and autism service, including the use of clinical audits. Team managers had access to an electronic dashboard called the work performance wall.

Summary of findings

- In the child and adolescent community mental health service, the senior management team worked closely with the local authority and clinical commissioning groups within their areas. Performance and service developments were reviewed, and actions agreed in regular monthly forums.
- The trust was high performing on its quality priority to listen and act on patient feedback to continually improve the patient experience of their services, achieving over 75% of the target they set themselves.

Summary of findings

Our inspection team

Our inspection team was led by:

Chair: Peter Jarrett, Retired Medical Director

Head of Hospital Inspection: Jenny Wilkes, CQC

Team Leaders: Chris Watson, Inspection Manager, mental health services, CQC

Berry Rose, Inspection Manager, community health services, CQC

The team included CQC inspectors and a variety of specialists: experts by experience who had personal experience of using or caring for someone who uses the type of services we were inspecting, consultant psychiatrists, health visitors, Mental Health Act reviewers, social workers, pharmacists, registered nurses (general, mental health and learning disability nurses), a psychologist, occupational therapists and senior managers.

Why we carried out this inspection

We inspected this core service as part of our ongoing comprehensive mental health inspection programme.

How we carried out this inspection

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

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

Before the inspection visit the inspection team:

- Requested information from the trust and reviewed the information we received.
- Asked a range of other organisations for information including Monitor, NHS England, clinical commissioning groups, Healthwatch, Health Education England, Royal College of Psychiatrists, other professional bodies and user and carer groups.
- Sought feedback from patients and carers through attending more than10 detained patient and carer groups and meetings.
- Received information from patients, carers and other groups through our website.

During the announced inspection visit from the 7 March to 11 March 2016 the inspection team:

- Visited 70 wards, teams and clinics.
- Spoke with over 225 patients and 49 relatives and carers who were using the service.
- Collected feedback from 676 patients, carers and staff using comment cards.
- Joined more than 15 service user meetings.
- Spoke with more than 50 ward and team managers and 485 staff members.
- Attended more than 45 focus groups attended by staff.
- Interviewed over 55 senior staff and board members.
- Attended and observed 24 hand-over meetings and multi-disciplinary meetings.
- Joined care professionals for 34 home visits and clinic appointments.
- Looked at over 326 treatment records of patients.
- Carried out a specific check of the medication management across a sample of wards and teams.
- Looked at a range of policies, procedures and other documents relating to the running of the service.
- Requested and analysed further information from the trust to clarify what was found during the site visits.

Observed a board development meeting.

Summary of findings

Information about the provider

South West Yorkshire Partnership NHS Foundation Trust provides services across Barnsley, Calderdale, Kirklees and Wakefield to a population of more than one million people. The trust provides inpatient, community and day clinics as well as specialist services within West Yorkshire, and also to a wider geographical area in some of their specialist services.

The trust provide the following core services:

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

South West Yorkshire Partnership NHS Foundation Trust has 11 registered locations serving mental health and learning disability needs, including four hospitals sites: Castleford Normanton and District Hospital, Fieldhead Hospital, Kendray Hospital and Mount Vernon Hospital. It also provides community health services at 38 locations. The trust advised that 8 Fox View, Saville Close and Castle Lodge were temporarily (long term) closed to admissions and would remain so for the foreseeable future.

The trust was formed in 2002 and employs more than 4,700 staff, in both clinical and non-clinical support services. In the last financial year 2014/15, the trust's income was £237.7 million with an expenditure of £231.9 million.

South West Yorkshire Partnership NHS Foundation Trust has been inspected 15 times since registration with five locations inspected.

We have previously issued nine compliance actions against two locations with an additional 12 improvement actions. At the time of our inspection, Fieldhead Hospital was non-compliant in relation to regulation 11 - safeguarding people who use services from abuse and regulation 15 - safety and suitability of premises. During this inspection, we found that the trust had met the outstanding compliance actions.

South West Yorkshire Partnership NHS Foundation Trust has had 17 Mental Health Act reviewer visits between 06 January 2015 and 06 January 2016. The main issue highlighted was that capacity and consent were not always considered or documented. This was found on 14 occasions. Six of these instances occurred at Fieldhead Hospital. The next most common issue was that patients were not always advised or aware of their legal rights. This was found on nine occasions.

What people who use the provider's services say

We received 676 comment cards from people who use the services. Of these comment cards the majority (65%) contained positive comments regarding the service. The remaining cards were mixed in their comments (8%) or contained negative comments regarding the service provided (14%). Some comments were left blank or were unclear.

We received most comments from mental health forensic inpatient/secure wards (25%) and acute wards and psychiatric intensive care units (22%). The lowest number of comment cards was from crisis and health based place of safety (0.5%).

Themes from positive comment cards and the phrases used:

Summary of findings

- Staff attitude – caring, respectful, friendly, and supportive.
- Environment – clean, safe, very good, stress free.
- Service – effective, great, caring, helpful.
- Treatment - treated with dignity and care, great, good information provided.

Negative comments included:

- Certain nurses don't listen.
- Access for disabled sometimes difficult.
- Not enough staff.
- Patients should be allowed to smoke.
- Food could be improved.

In community health services almost all patient and carers we spoke to were positive about the service they received. Patients and carers told us that staff were professional, respectful and supportive of their needs. Feedback from patients and carers was particularly positive in services for children and young people.

We met with patients who were detained under the Mental Health Act (1983) and their carers individually and in groups. Feedback from these patients and carers was mainly positive regarding the care they received and the environment they were in. They felt involved in care planning, decisions and listened to. However, some patients commented that there were not enough activities on the ward due to staffing and sometimes rights were not explained to patients.

During the inspection we spoke with patients and their carers about the care they received most feedback was positive and staff were described as caring, supportive, and willing to listen. They felt staff made time for patients and were involved in care decisions. Patients generally said they felt safe but that there were occasions where when they felt threatened by other patients. We also received some negative feedback regarding some services. This included:

- There were a lot of agency nurses on the wards.
- Staff did not always respond to people's concerns quickly enough.
- Waiting times for some therapies and treatment was sometimes long.

The friends and family test for South West Yorkshire Partnership Foundation Trust showed that 79% of people who used the services were likely or extremely likely to recommend the service. 6% said they were unlikely or extremely unlikely to recommend the service.

Good practice

Community-based mental health services for adults of working age.

- The attention deficit hyperactivity disorder (ADHD) and autism service had been involved in several innovations. The team had been involved in the development of the ADHD star. The ADHD star was an assessment and care planning tool for individuals with ADHD. The service had also developed a checklist to ensure environments were appropriate for individuals with autism.
- The team had worked with prison and probation services to improve the screening of ADHD for individuals within those environments.

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

- A member of staff from Trinity 1 psychiatric intensive care unit (PICU) had introduced 'my mental health' and 'my physical health' booklets. Patients were able to go through these booklets with staff and give their views and input in relation to what support they needed with their physical and mental health. These booklets had then been shared with the other acute and PICU wards.
- Patients were able to attend 'recovery college', which works in partnership with volunteers and other supporting organisations to run a range of workshops and courses which promote well-being and good mental health.
- The trust had implemented Creative Minds, which is a strategy that develops community partnerships and co-funds creative projects across South West Yorkshire Partnership NHS Foundation Trust's localities in Barnsley, Calderdale, Kirklees, and Wakefield. It utilises

creative activities such as arts, sports, recreation and leisure, delivered in partnership with local community organisations to increase the confidence, develop the social skills, and improve the lives of people.

Wards for older people with mental health problems.

- On Willows Ward a falls audit was undertaken by the ward manager. This identified that higher levels of falls happened in patient bed areas and bathrooms. It was also identified that nearly all patients who had fallen were found by staff and not by use of nurse call buttons. Following this audit nurse call strips were installed in each bedroom and bathroom at floor level so patients could alert staff if they had fallen without having to attempt to stand with a potential injury.
- Staff at The Poplars had developed an easy read rights leaflet for dementia patients which was simplified using short direct sentences with the addition of pictures to clarify key points.
- On all wards there were dementia friendly improvements that had been made. This included dementia friendly signage and use of colours identified as easy to see for people with cognitive impairment. On Beechdale ward the trust had secured funding from the Kings Fund to significantly improve the environment for people with dementia. This included a "rempod" which is a pop up reminiscence room that works by turning any care space into a therapeutic & calming environment.

Specialist community mental health services for children and young people.

- People who used the service with a serious eating disorder, who ordinarily would have been admitted to inpatient care, were receiving home support during breakfast and evening meal times. This was from the staff providing the crisis response within the service.
- Each of the teams provided crisis support at home for children and young people when required.

Community mental health services for people with learning disabilities or autism.

- We spoke to one member of staff who told us of their journey from receiving support from the service, through to gaining employment and their discharge from the service. They told us this would not have been possible without the support the service had provided.
- We were shown a range of 'cook and eat' easy read cook books. A member of staff had co-produced the books with a group of patient consultants. The cook books were designed to help people with a learning disability cook independently and were used within therapy sessions to support people develop confidence and independence.

Community end of life care.

- The palliative care team were runners up in the 2015 International Journal of Palliative Nursing Multidisciplinary Teamwork Award for their oral hygiene steering group.
- The continuing development of staff skills, competence and knowledge was seen as a priority and the service had developed a range of comprehensive training courses for staff at all levels.
- Staff we spoke with in the community and on the wards of the community hospitals demonstrated a consistently high knowledge of end of life care issues.
- The palliative care team was multi-disciplinary with medical, nursing, social work, occupational therapy, physiotherapy and dietetic membership. Staff, teams and services were committed to working collaboratively and found innovative and efficient ways to deliver more joined up care to people who use the service.
- The end of life care lead for the trust was also the end of life care lead for the Barnsley locality. This meant that the trust had a significant role in contributing to the shaping of end of life care services. We saw evidence of this in representative membership on locality groups including co-chair for the end of life care steering group.
- The supportive care at home service which was managed by the trust recorded the preferred place of care on the end of life care plan and 84% of patients known to the Specialist Palliative Care Team achieved their preferred place of care at the end of life. Where preferred place of care was not achieved the reasons for this were explored and lessons were learnt.

Summary of findings

- The end of life/specialist palliative care team had worked with learning disability services to develop a more creative approach to communication with patients around advance care planning at the end of life.
- A volunteer service had been developed and based with the team to support the community palliative care service to obtain independent service user feedback in the form of telephone surveys.

Community health services for adults.

- The service had developed a drop-in mobility clinic for patients with mobility and falls issues. The clinic had been extended to cope with increased demand. Patients attending were screened for falls and follow up assessments were arranged if required.
- The care navigation / tele health service linked with other community services in promoting patient self-management of long term conditions. The care navigation service provided signposting, referral, advice and support for patients following a crisis. The service provided ongoing coaching and support to promote self-management for patients with long term conditions. Health coaching was linked, for example, to weight management. The service could demonstrate its effectiveness in preventing hospital admissions.
- The stop smoking service offered access via both telephone and instant messaging support. It had also developed an online portal where patients could register and undertake their own stop smoking journey.
- The tissue viability service managed the incidence of pressure ulcers proactively and it had developed an action plan for 2016/2017 in response to the incidence of pressure ulcers. The action plan included identifying care homes with an increased risk of pressure sores and delivering training to identified care homes as a pilot of the “react to red” skin initiative. The tissue viability service used a wound care formulary and followed agreed protocols.
- The adult epilepsy service had well developed links with the emergency department of the local hospital and held a weekly referral meeting to review emergency admissions. The service maintained similar links with the ambulance service to review patients with an established diagnosis of epilepsy. The adult epilepsy service provided a series of two to three education and guidance sessions to inform patients and their carers in residential care homes.

Community health services for children, young people and families.

- We reviewed evidence within the 0-19 service which showed outstanding support processes for women and children at risk of female genital mutilation. We also observed exceptional support and recognition for a young carer.
- We observed the school nursing service provide exceptional support for young girls during a vaccination clinic by providing alternative clothing to protect their privacy and dignity if they were unable to roll up their sleeves so that staff could administer the vaccination.
- The work the paediatric epilepsy team were undertaking to develop the epilepsy passport and sudden unexpected death in epilepsy work. We observed excellent support for children and young people during our inspection and this was corroborated by other teams we spoke with.
- The Theratots programme which was developed by the children’s therapy team. This programme included links with portage services and supported parents with children with complex learning needs.
- We received consistent positive feedback from parents regarding the care they have received during our inspection; this was further corroborated when reviewing the friends and family data.
- We observed exceptional resilience of staff in the 0-19 service and family nurse partnership during our inspection. All staff were positive about the service they provided, which was commendable in light of the uncertainty about the future of the 0-19 service.

Summary of findings

Areas for improvement

Action the provider MUST take to improve

Trust-wide

- The trust must ensure that non-executive directors have checks with the disclosure and barring service in line with the fit and proper person requirement, which came into force for NHS bodies on the 1 October 2014.
- The trust must ensure that Mental Health Act and Mental Capacity Act training is mandatory for specified members of staff and that this is monitored for effectiveness by senior management of the trust.
- The trust must ensure the 2015 MHA code of practice is implemented across all services of the trust.
- The trust must ensure care records are up to date and accessible in order to deliver people's care and treatment in a way that meets their needs and keeps them safe.

Community mental health services for adults of a working age

- The trust must ensure equitable and timely access to psychological therapies.

Community mental health services for people with learning disabilities or autism

- The provider must ensure timely access to psychological therapies.
- The trust must ensure systems and processes are in place to monitor the quality and safety of services integrated with local authority services.

Wards for older people with mental health problems

- The trust must ensure that there are clear lines of sight on The Poplars, ward 19 and Chantry Unit.
- The trust must review the door handles on ward 19 to ensure that the premises suit the need of patients.

Long stay/rehabilitation mental health wards for working age adults

- The trust must ensure that risk assessments are completed on admission and updated at regular intervals in addition to being updated following incidents and changes in presentation.
- The trust must ensure that patients who are prescribed high dose antipsychotic medication are subject to physical health monitoring including electrocardiograms in line with national guidance.
- The trust must ensure that patients have regular multidisciplinary review meetings to ensure timely and appropriate review of care and treatment.
- The trust must ensure that appropriate leadership is in place to ensure that governance structures in place to monitor and improve the service.
- The trust must ensure that request for second opinion doctors are made in a timely manner.
- The trust must ensure T2 and T3 certificates are completed accurately and reviewed for errors.
- The trust must ensure all staff receive training in the MHA and MCA.

Community-based mental health services for older people

- The trust must ensure they reduce the waiting times for psychological therapies.

Specialist community MH services for children

- The trust must take action to improve the overall waiting time for young people accessing treatment.
- The trust must devise a proactive system for monitoring risks of young people waiting to be seen.
- The trust must ensure audits are undertaken to ensure that new systems and ways of working become embedded in practice and that quality standards are being followed.
- The trust must devise a system for monitoring total number of open cases, total number of patients on a waiting list, individual staff caseload sizes.

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

- The trust must ensure that there are clear lines of sight on Trinity 2, Ashdale, Elmdale and Priory 2.
- The trust must ensure that staffing levels, skill mix and how staff are deployed is appropriate on all wards.
- The trust must ensure that staff receive appropriate supervision on all wards.

Summary of findings

- The trust must ensure that consent to treatment and where appropriate, capacity assessments are completed and recorded appropriately.
- The trust must ensure high doses of medication are monitored.

Forensic inpatient & secure wards

- The trust must ensure that staffing levels are appropriate to meet the needs of the patients.
- The trust must ensure that the clinic room temperature is safe for the storage of medicines.
- The trust must ensure that positive behaviour support plans are implemented for all patients with learning disability or autism.
- The trust must ensure that there are effective systems in place to record levels of staff training and supervision.
- The trust must continue with plans to improve the consistency of Mental Health Act, Mental Capacity Act and immediate life support training.

Action the provider SHOULD take to improve

Trust-wide

- The trust should ensure that all the non-executive directors and the executive directors have accessible evidence that the individuals have been checked against insolvency, director disqualification, bankruptcy and debt relief, and with Companies House, in with the fit and proper person requirement, which came into force for NHS bodies on the 1October 2014.
- The trust should ensure that they comply with the requirements of regulation 20 of the Health and Social Care Act 2008 (regulated activities) regulations 2014, duty of candour. They should ensure that there is a clear written apology sent to patients, relatives in carers and details. They should also ensure that written details of the investigation into the incident, and the findings, are sent to the patients, relative or carer.
- The trust should ensure data collected regarding the use of restraint, seclusion and long-term segregation is accurate.

Community health inpatient services:

- The trust should consider recording patients' goals and discharge plans to ensure that patients are able to review the details.
- The trust should ensure that early warning scores are recorded consistently across all community inpatient wards.
- The trust should ensure that on ward 4 early warning scores are recorded on the EWS chart rather than retrospectively on the care plan.
- The trust should review the availability of therapies and activities in the afternoon to ensure that patients have a sufficient range of activities.
- The trust should take action to reduce the length of stay.
- The trust should review the roles of healthcare assistants in community inpatients services to ensure that there is consistency across the wards.
- The trust should consider improving the environment for dementia patients in community in patient services.

Community health services for children and young people:

- The trust should ensure that all staff adhere to infection protection and control guidelines, in particular bare below elbows, in community clinics.
- The trust should risk assess school nurse staffing vacancies to ensure that there is sufficient capacity to safely manage safeguarding concerns.
- The trust should work to reduce the waiting times for children's therapy services from the current position of 18-20 weeks.
- The trust should work to provide assurance to staff that services for children and young people are part of the wider trust and have strong representation from floor to board level.

Community end of life care services:

- The trust should ensure that measurable improvements are demonstrated in relation to improving specialist support for patients with long term conditions at the end of life.

Community health services for adults.

- The trust should ensure that lines of accountability to the senior management team are clear to staff in front line community services

Summary of findings

- The trust should ensure that community services staff are fully engaged and consulted as to the transformation of community services.
- The trust should ensure that community clinics provided by the district nursing service are reviewed in liaison with practice nursing provided by primary care to ensure community nursing consistently prioritises housebound patients.
- The trust should ensure that the podiatry service is staffed to planned establishment levels.
- The trust should ensure the staff intranet and trust internet reflect the full range of community services available for patients.
- The trust should ensure that patient group directions used in community services are up to date.
- The trust should ensure that the policy for lone working in up to date.
- The trust should ensure arrangements to record clinical supervision are in place.

Community mental health services for adults of a working age:

- The trust should ensure the RIO electronic care records system is robust and reduce susceptibility to down time.
- The trust should ensure that they continue to work with commissioning bodies to reduce waiting times to the attention deficit and hyperactivity disorder and autism service.
- The trust should ensure that staff are provided with appropriate training to manage clients with comorbidities such as learning disabilities.
- The trust should ensure staff in the Barnsley assertive outreach team Wakefield single point if access, Kirklees assertive outreach team and attention deficit and hyperactivity disorder and autism service receive training on the Mental Health Act and Mental Capacity Act.
- The trust should ensure that there is effective communication and consultation with staff around the transformation programme.

Wards for people with learning disabilities or autism:

- The trust should ensure its planned improvement to provide more accessible patient information is fully actioned.
- The trust should ensure data collected regarding the use of restraint and seclusion is accurate.
- The trust should improve its process for recording non-mandatory training such as MHA and MCA.
- The trust should consider the benefits of providing mandatory MHA and MCA training to staff.
- The trust should ensure that missed medication doses are reported on the incident reporting system.
- The trust should ensure accurate recording of checking of emergency equipment.

Community mental health services for people with learning disabilities or autism:

- The trust should ensure their risk assessment tool is used consistently across the service.
- The trust should ensure staff consistently record details of decisions within capacity assessments.
- The trust should ensure there is a process for all staff to access information held in client's electronic records.

Long stay/rehabilitation mental health wards for working age adults:

- The trust should ensure there is adequate space in the clinic room to carry out physical health examinations and care.
- The trust should ensure that there are systems in place for patients to summon assistance.

Community-based mental health services for older people:

- The trust should ensure they involve staff in learning from incidents.
- The trust should consider how staff throughout the trust are made aware of lessons learnt following an incident.

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

- The trust should ensure risk assessments are reviewed in a timely manner.
- The trust should have processes in place that enables all teams to monitor training around the Mental Health Act and Mental Capacity Act.
- The trust should ensure that appraisals are completed equally across the teams.

Summary of findings

- The trust should provide easy read leaflets about its services in ways that meets the needs of different people, i.e. a different language.

Specialist community mental health services for children and adolescents:

- The trust should continue to implement their own identified recovery plans in relation to waiting list management.
- The trust should review and continue to improve access to contemporaneous clinical records.
- The trust should closely monitor the action plan in place to reduce information governance breaches and undertake regular audit to seek assurances that safeguards are being maintained.
- The trust should ensure staff are up to date with basic life support training.
- The trust should ensure that environmental risk assessments have been completed for each of the community bases.
- The trust should ensure team managers undertake an audit of compliance with the lone worker policy and review the policy in line with appropriate staff feedback.
- The trust should ensure regular audits of clinical records are undertaken to monitor compliance with trust policy.
- The trust should ensure regular audits of FP10 prescription use are carried out to ensure safe and appropriate issuing and storage.
- The trust should consider moving the weighing scales in the team bases into more private areas.

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

- The trust should ensure that ligature risks are mitigated on all wards where possible.
- The trust must ensure that shower facilities are appropriate on Melton suite, Clarke and Beamish ward.
- The trust should ensure patients are able, with appropriate risk assessments, to have a bath without supervision on Beamshaw and Clarke ward.
- The trust should ensure the complaints policy is on display on all wards.
- The trust should ensure where possible that a bed is available for patients when they return from leave.
- The trust should ensure that activities are available seven days a week and on Beamish and Clarke ward patients should be able to use the gym at weekends.
- The trust should have systems in place to ensure staff, where necessary, are aware of and working in accordance with current guidance in relation to the Mental Health Act and the Mental Capacity Act.

Forensic inpatient & secure wards:

- The trust should ensure that the care and treatment of individuals in long-term segregation complies with Mental Health Act (MHA) code of practice.
- The trust should ensure that the food provision is of good quality.
- The trust should ensure that staff inform patients of their rights and record this in patient notes at regular intervals as set out in the MHA code of practice.
- The trust should ensure that consent and capacity to consent should be assessed and recorded in patient notes in accordance with the MHA code of practice.

The trust should ensure that access to patient records is available for all relevant staff in order for staff to provide safe patient care.