CareQuality Commission

South West Yorkshire Partnership NHS Foundation Trust

Quality Report

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Date of inspection visit: 7 March -11 March 2016
Date of publication: 24/06/2016

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.

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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,

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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?

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.

Requires improvement ●

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?

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.

Requires improvement ●

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?   Requires improvement ●

We rated well-led as requires improvement because:

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- 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.

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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:

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- 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

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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.

South West Yorkshire Partnership NHS Foundation Trust

Detailed findings

Mental Health Act responsibilities

We do not rate responsibilities under the Mental Health Act 1983. We use our findings as a determiner in reaching an overall judgement about the Provider.

Mental Health Act (MHA) training was not mandatory for the staff of the trust and there was no overview of the quality, quantity, or the effectiveness of the training being delivered. There were plans to make the MHA training mandatory for staff in the trust.

Although the trust had a governance structure for monitoring the MHA, the senior management we spoke with did not have a good understanding of the operation of the MHA throughout the trust. The governance structure was not effective to oversee and monitor the implementation of the MHA.

We saw compliance with some aspects of the MHA code of practice; this was only in relation to the aspects of the code which had not changed since the introduction of the 2015 MHA code of practice. There was no consistent training in the trust which included the 2015 MHA code of practice and its implications for staff delivering care.

The trust did not have an overall implementation plan for the 2015 MHA code of practice.

The care records reviewed correctly detailed the patient's detention under the MHA. The MHA office filed original detention documentation and copies were held on the patient record.

Consent to treatment and capacity requirements of the MHA were adhered to and copies of certificates were held with medication cards.

Patients had been informed of their legal status and their rights under the MHA at the time of detention and this was revised by staff periodically.

The trust had a central MHA department which provided support and legal advice for staff on the MHA. Staff knew how to contact this department.

Independent mental health advocates (IMHA) were available for each ward across the trust services. There was information around the wards describing the IMHA services available.

Mental Capacity Act and Deprivation of Liberty Safeguards

Mental Capacity Act (MCA) training was not mandatory for the staff of the trust and there was no overview of the quality, quantity, or the effectiveness of the training being delivered. There were plans to make the MCA and DoLS training mandatory for staff in the trust.

Detailed findings

Staff generally had a good understanding of the MCA and how this related to their practice including application of the statutory principles. However, there were some areas of the trust where MCA was not consistently well understood.

The trust policy for the MCA had gone past its review date and did not include developments in practice around the MCA, its interface with the MHA or application of DoLS. There were up to date guidance documents for staff relating to developments in MCA and DoLS but these had no governance arrangements.

Generally, where necessary, mental capacity assessments had been carried out and recorded in the patient record. Some capacity assessments with regard to consent to treatment were missing from care plans and the best interest process was not always followed.

There was evidence and records of people being supported to make decisions where their mental capacity was an issue and best interests.

Advice and support regarding the MCA and DoLS was available from the central MHA office and staff knew how to contact this office for support.

Deprivation of liberty safeguards applications had been made when appropriate and staff described a good understanding of the interface between DoLS and MHA detention authority in some areas of the trust.

There was no clear mechanism for the trust to monitor its compliance with the MCA or the DoLS across the organisation.

Are services safe?

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

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

Summary of findings

The summary can be located on page 7.

Our findings

Safe and Clean environments

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.

In relation to cleanliness, nine locations of the trust scored 100% compared to the national average of 98%.

During the inspection, in general, wards and community team bases visited during the inspection were clean, tidy, and appropriate for the patients that they were supporting. The wards for patients with learning disabilities and autism, for example had an environment that was free from clutter, which was important in providing a low-arousal environment so that patients with autistic spectrum conditions were not distracted or over-aroused. The inpatient wards had access to outside space for patients.

Cleaning records were up to date and completed regularly. We observed Infection control principles adhered to throughout the inspection, for example hand-washing. Services carried out Infection control audits and where necessary, acted upon any issues found.

Almost all of the environments were well maintained. An exception to this was the Priestly Unit at Dewsbury District Hospital, the toilet in the male corridor had a small area of graffiti scratched into the wall and wood coming away from the door in another area. Staff told us these areas were on the redecoration schedule. In addition, the fire door had the bottom panel boarded up, which could compromise the safety of the door. Staff said a replacement had been ordered around a month previously. The premises were not owned by the trust and they were therefore reliant on the company who acted as the landlord.

A number of wards had blind spots that were mitigated using risk assessments, mirrors and observations. However, on the wards for older people with mental health problems, namely the Chantry unit and Ward 19, these areas where staff were unable observe patients had not been mitigated. Ward 19 had bedroom door handles both inside and out that were a ligature risk. This meant that patients who were at risk of self-harm would need to be nursed on close observations to mitigate this risk and this was not the least restrictive option for those patients.

Similarly, on the acute wards for adults of working age and psychiatric intensive care units, Ashdale, Elmdale, Priory 2 and Trinity 2 wards there were several blind spots without mirrors or any other way of ensuring staff would have a clear view of patients at all times. This meant that on these wards, patients could not be seen by staff if they were to fall, harm themselves, or be harmed by others.

On Beamshaw ward, in the patient lounge there was a television on a bracket and electrical cables were present. The bracket and cables had been identified as potential ligature risks. On the ward ligature risk assessment tool it stated that "risk migrated by external wall therefore viewable by staff at all times." However, throughout the course of our inspection, we saw patients watching television in the lounge and there were long periods where no staff were situated in an area where they would have been able to observe the lounge.

All the wards we visited that supported patients with mental health problems, complied with same sex accommodation guidance as defined in the Department of Health guidance for eliminating mixed sex accommodation.

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. There was sufficient room space to engage with patient, and patients and staff alarms as appropriate were installed in almost all services. However, in the long stay and rehabilitation units for patients with mental health problems, there was no nurse call or alarm

Are services safe?

systems in place in the patients' bedrooms for patients to alert staff if they needed them, and one patient reported at Enfield Down that they had fallen in recent weeks and had not been able to summon assistance.

Safe Staffing

The total number of substantive staff employed by the trust was 3881 at the time of the inspection. In the last 12 months 417 members of staff had left (11%). In the 12 months ending 31 October 2015 the overall trust sickness rate was 5.0% which is above the national average of 4.6% for all other mental health and learning disability trusts although there were variations between services. Older people's services - North Kirklees community mental health team had the highest sickness rate (where more than five people are employed) with 20%. Sickness rates in community inpatient, community adults and community end of life care services were at or below the trust target of 5%.

The trust vacancy rate was 4.1% and the overall trust turnover rate was 11%. Occupational therapy rotation staff had the highest staff turnover (where more than five people are employed) with 83%. The trust informed us that the occupational therapy rotation staff have a high turnover because of the nature of this service.

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.

At the time of the inspection, the trust whole time equivalent qualified nursing establishment was 1545. The whole time equivalent nursing assistant establishment was 727. There were 64 whole time equivalent nursing vacancies and 16 whole time equivalent nursing assistant vacancies.

In order to establish the number of staff required on each shift on the inpatient mental health wards, the trust had carried out a safer staffing review in 2015. This included a monthly report by wards on different issues that affected staffing including acuity, needs of the patient group and staff sickness. Following this review the trust had implemented minimum staffing levels of qualified and unqualified staff for each of the older adult wards across the trust. This information had also been used to inform skill mix.

However, the community mental health teams did not use a recognised tool to calculate their staffing requirement, except the attention deficit and hyperactivity disorder service and the Kirklees assertive outreach teams that had been developed in line with national policy implementation guidance. Staffing levels for the other community services were based on historic levels of need for staffing.

The staffing levels in the acute services for adults of working age, as well as the psychiatric intensive care unit and the forensic services did not always meet the trust safer staffing levels set by the trust. The trust monitored safe staffing levels by using safer staffing returns. These figures from June 2015 to January 2016 showed that the forensic wards, Priestley, Appleton, Chippendale, Bronte and Hepworth, were regularly under the target set by the trust for safe staffing levels. Newhaven and Hepworth wards had also been flagged as being under safe staffing levels for one month in this period of time. On the acute wards, Elmdale, Ashdale, Priory 2, Trinity 1, did not always meet the trust's monthly targets for safer staffing for the period November 2015 until February 2016. Both patients and staff on these wards commented adversely on the low staffing numbers, stating that activities were cancelled, and patients were unable to be escorted from the wards or on escorted leave. It was also not clear how, during these occasions where staffing numbers did not meet the trust safe staffing target, how staff would have been able to safely cope with any emergencies, incidents, or instances of restraint and seclusion that may occur.

There was high staff sickness on four of the acute wards for adults of working age with mental health problems, including Beamish, Trinity 2, Trinity 1 and Ashdale ward, as well as the psychiatric intensive care unit. Also on Beamish ward there were 4.5 whole time equivalent nursing vacancies and three whole time equivalent nursing vacancies. Vacancies on the forensic wards were at 2% overall but had six qualified nurse vacancies, plus and staff sickness at 5% overall.

On the wards for patients with learning disabilities or autism, staff continued to have regular one to one appointments with staff, and activities and leave continued to be facilitated, despite the high staff sickness on these wards.

The trust could not provide data on individual caseload size for all staff in the community mental health services.

Are services safe?

However, staff provided information on caseload numbers. The staff in the Barnsley assertive outreach team told us their average caseload was between 15 and 16. According to the Department of Health, Mental Health Policy Information Guide (2001) for early intervention and assertive outreach teams should carry a caseload of approximately 12 per care coordinator.

Department of Health policy information guide (2002) for community mental health teams recommend a maximum caseload of approximately 35. In the community mental health teams staff described high caseloads for adults of working age, in some instances were above this level. Staff within these teams expressed concern to us about their caseloads and capacity and how this could impact on the delivery of care. Staff in both the community specialist child and adolescent mental health services and the community services for patients with learning disabilities and autism told us that current staffing levels had an impact on their ability to provide a service and had led to increased waiting lists. Both services, particularly the child and adolescent mental health service had significant waits to access treatment. However, staff in the community services for older adults with mental health problems told us they had manageable caseloads.

The community inpatients services used a safer staffing acuity tool to ensure that nurse staffing levels were appropriate to meet patient needs. Vacancy rates in community inpatient, community adults and end of life care services were between 1 and 6%.

Caseloads for health visitors were below the maximum recommended levels. Sickness rates were below the trust target and staff vacancy rates were 8%. Staff vacancies in services for children and young people were not being filled because of uncertainty about the future of the service. The school nursing team told us that sometimes the volume of safeguarding concerns was not manageable safely because of a shortage of staff.

All the mental health inpatient wards told us that there was good access to medical cover at all times. All of the wards could access a doctor during core daytime hours, the majority of whom were based on ward or on site. Likewise, in the community mental health services, psychiatrists were part of the team establishment. Generally all staff, including the crisis teams and health based place of safety,

told us there was good access to psychiatrists including in emergencies. At times when medics were not on site, there were on call arrangements in place which managers and staff told us worked well.

The overall mandatory training compliance at the trust for the last 12 months was 86%. The trust target for mandatory training was 80%. Food safety level three had the lowest compliance rate at 35% followed by aggression management caring approaches to aroused situations training at 60%. The NHS Staff Survey 2015 reported that the quality of non-mandatory training, learning or development for staff was average in comparison with other mental health and learning disability trusts, and in the top 20% for staff resources and support.

There was a mandatory training programme in place. Staff told us training was delivered both face to face and by e-learning. Managers monitored compliance through supervision and were able to access individual training records through the intranet for their teams. We saw evidence of staff receiving email alerts when they were due to refresh a mandatory course.

At the time of the inspection, intermediate life support training, Mental Health Act (1983), MHA code of practice (2015), the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards was not mandatory. We were told that this would be mandatory from April 2016 and would become part of the rolling training programme introduced.

The inpatient forensic mental health wards all wards were above the trust target of 80% for staff completing their mandatory training.

On the acute wards for adults of working age with mental health problems and PICU, all but one of the wards were above the trust target of 80% for the staff having completed their mandatory training.

Despite the mandatory training in the community specialist children and adolescent mental health services being above the trust target for mandatory training, compliance was very low for basic life support. The compliance for this training in Barnsley was 12%, Calderdale and Kirklees was 31%, and Wakefield was 47%.

The average mandatory training rate for the community services for patients with learning disabilities and autism was 81%.

Are services safe?

The compliance rate for mandatory training was high for all community services for older people with mental health problems, the long stay and rehabilitation wards, wards for older people, and community services for adults of working age with mental health problems.

Assessing and managing risk to patients and staff

Risk assessment was generally good in all mental health community services, and on the mental health wards, and completed within trust guidelines, policies and procedures. The exception was ward 18 at the Priestly Unit (acute wards for adults of working age with mental health problems), the community specialist child and adolescent mental health services, and Enfield Down (a long stay rehabilitation service). Risk assessments were completed at initial assessment and following incidents in most services.

Most services used the Sainsbury's risk assessment tool: a recognised risk assessment tool. However, in the forensic services, the trust used a locally designed risk assessment tool, RAMP, and also undertook historical clinical risk management through a recognised tool HCR20 for all patients. Care records contained crisis and contingency plans in the community mental health services, including the crisis teams and health based places of safety.

There was a comprehensive range of risk assessments used across all acute wards and the psychiatric intensive care unit. On most wards, we found staff had completed risk assessments within trust guidelines and policies and procedures. However, staff on ward 18, the acute ward for adults of working age with mental health problems, at the Priestly Unit in North Kirklees, had not followed trust policies and procedures. We reviewed the care records of six patients and found staff had not fully completed five risk assessments within trust guidelines. There was no plan in place as to how any risks were to be managed by staff. Staff may be unaware of what actions to take to maintain patient safety when clear guidance is not in place.

We reviewed 24 clinical records, in the community specialist child and adolescent mental health services. All 24 of these records had incomplete risk assessments or risk assessments not using the trust's risk assessment tool. This meant that there was not a clear risk assessment and risk management plan in place in line with trust policy and procedure.

At Enfield Down, one of the long stay and rehabilitation wards, 15 care records were examined. The risk assessments in these records were completed prior to admission by the care coordinator in the community. Staff explained that risk assessments were not managed by the ward staff and that they were managed by the care coordinator and updated at six monthly care programme approach (CPA) meetings. This meant risk assessments were not being reviewed regularly and were not updated following change in presentation and when risk changed. This placed patients at risk of harm from incorrect information being held about them, and their current risks not being managed effectively.

In the community learning disability and autism service, all the risk assessments and risk management plans were in place, including contingency plans. However, risk assessment tools varied across the teams and disciplines, different processes were used to record risks including the use of different templates, and some records incorporated risk management within care plans and others recorded changes to risk within daily progress notes. This meant staff could not easily access information around current risks and that information could be lost within progress notes.

Waiting lists in the community learning disabilities and autism services and the specialist community children and adolescent mental health services (CAMHS) were prioritised for allocation onto a care co-ordinator caseload based on patients' needs, level of risk and time on the waiting list. In the CAMHS, if a child presented with a learning disability, an eating disorder or was a looked after child, they would be fast tracked to that team.

Cases that required other interventions were placed upon the teams' waiting list. There was no proactive monitoring of people on the waiting list for treatment. There was no system in place to monitor changes to risk. Patients and families were provided with contact details explaining how to access help via a telephone number if more urgent assistance or advice was required.

In the community mental health services, there was a lone working policy in place. Each team and service were following local protocols. These included the use of a buddy system, phoning in to report to a duty worker, a log of planned visits, white boards, and an electronic diary. Staff showed a good understanding of lone working procedures and what action to take should they be

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concerned for their own safety or the safety of a colleague. They told us they felt safe at work. Staff said they were confident in the process, although they had rarely needed to action them.

We found little evidence of blanket restrictions on the mental health inpatient wards. We found that where wards were locked, there was clear signage for informal patients and visitors on how to leave the ward. The trust had an observation policy for observations of patients and staff were able to talk to us about this and the different levels of observations. There was a trust policy for searching patients and their belongings. Searching of patients was not routine, but where it was felt to be necessary due to risk to self or others, this was carried out in accordance with the trust policy. The policy complied with the MHA code of practice in relation to searches.

Staff managed risks on the acute wards for working age adults with mental health problems through individual risk assessment. However, none of the patients on Beamshaw and Clarke (acute wards for adults of working age) were allowed to take a bath without a member of staff present behind a shower curtain. This meant patient's individual risks had not been taken into account.

Restraint

The trust had a Management of Aggression and Violence: Personal Safety and Violence Reduction policy, procedures and guidance dated September 2015. The policy was due to be reviewed in September 2017. The trust was committed to reducing restrictive practices and this was identified within the policy. The trust had a mandatory training programme for staff across the trust for the management of aggression and violence. This was targeted at different groups of staff. Training ranged from personal safety and breakaway skills to specific physical restraint courses. Learning disability staff attended a specific training course about restraint.

Between 1 May 2015 and 31 January 2016, the trust reported that staff used physical restraint on 1,317 occasions and that on 253 occasions this was in the 'prone position (face down). The national institute for health and care excellence guidance NG10: Violence and aggression, recommends avoiding prone restraint, and only using it for the shortest possible time if needed. The Department of Health positive and proactive care guidance states there must be no planned or intentional restraint of a person in a prone/face down position on any surface, not just the floor.

It was not clear from the data for restraint or the staffs' description if prone restraint was used intentionally or unintentionally or how long people were held in the prone position.

Between 1 May 2015 and 31 January 2016, staff used prone restraint to administer rapid tranquilisation on 128 occasions. The trust told us that rapid tranquillisation is not recorded on Datix in these terms. What is recorded is if 'medication was given without agreement' under clinical actions (as a result of the incident). The trust provided this data for those incidents recorded as being prone restraint, as outlined above.

On inpatient wards for older people there were 301 incidents of use of restraint, 126 of which occurred on Ward 19. There were eleven incidents of prone restraint being used and this was highest on Ward 19 at seven episodes.

In forensic wards there were 201 incidents of use of restraint in the last nine months, there were 46 incidents of use prone restraint, 17 of which occurred on Bronte.

On wards for people with learning disabilities or autism there were 42 recorded restraint incidents. Staff told us they never used the prone restraint position. The ward was using mechanical restraints as part of the patient's care in seclusion. A mechanical restraint was a method of physical intervention which involved the use of authorised equipment, for example restraining belts. In line with good practice guidance the trust had commissioned an independent review to assess whether the use of mechanical restraints were the least restrictive option and whether there were any less restrictive alternatives which were appropriate and proportionate to the risks posed. The review also considered treatment, support given to ensure the patients' rights were respected and examined the welfare of the patient.

We saw a care plan in place for the use of mechanical restraints which had been agreed as part of the external review. Staff were skilled in de-escalating challenging situations. There were clear statements of restraint reduction.

The use of mechanical restraint for non-urgent, non-emergency reasons, which the ward was using for one particular patient, was felt to be innovative practice as the aim was to support the patient to be able to move away from seclusion.

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Seclusion and long-term segregation

The trust had a 'Seclusion and longer term segregation' policy dated August 2015 that was due for review in August 2016. In addition the trust had a document called Seclusion Quick Guide. This had been introduced so that all staff could see at a glance the changes to seclusion following the changes to the Mental Health Act Code of Practice in April 2015.

The trust had developed a 'seclusion and long term segregation policy' implementation plan. The trust had identified a number of risks following the changes to the code of practice and the ability to get the trust policy changed and staff trained. This identified that the new policy would be submitted for approval in October 2015 and implemented from November 2015. In addition there would be other communications and briefings to staff and changes in management of aggression and violence training would include a discussion on seclusion as well.

The trust reported that the number of incidents of use of seclusion between 1 August 2015 and 31 January 2016 was 301. They reported that the number of incidents of use of long-term segregation in the same six month period was 0.

In acute mental health wards for adults and PICU, Elmdale and Ashdale wards shared a seclusion room as did Beamshaw and Clarke wards. All seclusion rooms were appropriate and met national seclusion guidance. There were two way communication systems, individual temperature control, mirrors enabled full observations and patients were able to see a clock. There were no identified concerns with lack of medic availability following physical interventions and episodes of seclusion.

In forensic wards there were 46 incidents of use of seclusion. Johnson accounted for 17 (37%) of all seclusions. There was also a patient in long-term segregation in the forensic service which did not appear in the trust reported data.

In wards for people with a learning disability or autism the seclusion room was inspected and this had clear observation, there was a two way communication system, it was well ventilated and clean. Toilet and washing facilities were available and a clock was in the room. One patient was currently staying in that room due to complexities associated with autism and acute anxiety. We saw a report of an independent review of a patient in seclusion. No incidents of seclusion were provided for this

ward in data provided by the trust. At the time of our visit there was a patient in seclusion who had been in seclusion since March 2015. This was clearly recorded by the ward as seclusion. The patient's status was considered not to be segregation due to the fact that they had access to other facilities. There was a discrepancy in the data and understanding of seclusion between the ward and the trust.

In older people's inpatient wards there were no seclusion facilities on any of the wards we visited. On ward 19 there had been nine episodes of seclusion in the six months leading up to our inspection which related to two patients who were particularly unwell. As there were no seclusion facilities on the ward, the ward accessed the seclusion room on the adult acute ward across the corridor. We found that when this happened it was dealt with in a sensitive manner, ensuring that staff from ward 19 managed the patient and stayed with them throughout the seclusion period. Their privacy and dignity was maintained during the transfer with staff ensuring that other patients and visitors were asked to move to another area prior to moving the patient. When the seclusion facility had been used this was for appropriate reasons and was for very short periods of one to two hours. If a patient required a higher level of nursing they would have accessed one of the PICU beds within the trust.

In long stay and rehabilitation mental health wards there were no incidents of seclusion and there were no seclusion room facilities on the unit. If a patient became unwell they were transferred to one of the acute mental health wards within the trust or a psychiatric intensive care facility.

Medicines Management

A clinical pharmacy service was available throughout the trust from Monday to Friday, with a limited medicines supply service at weekends and a pharmacist on-call service for information and advice outside working hours. Ward staff told us that the pharmacist team were a good support if they had any medicines queries. Regular patient facing sessions were not held but, inpatients could meet with a specialist mental health pharmacist to discuss their medication on request. Pharmacists were involved in developing the trusts medicines related education programme to support safe medicines handling in both community and mental health services. Limited pharmacy capacity meant that regular support was not extended to the community based mental health teams. However,

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support with medicines reconciliation was provided to the home based treatment teams, to reduce the risk of errors and to support medicines optimisation. We also saw that pharmacist advice was sought 'ad hoc' to discuss individual patient issues.

A monthly medicines checklist was completed by wards and community teams to monitor the safe storage of medicines in accordance with trust policy. Inpatient wards also completed a quarterly medicines management assurance exercise to assess compliance with the key safety standards for medicines management. The outcome and any actions were shared with, and monitored by, the pharmacy team. Strategies were being developed to reduce incidents of missed doses across the trust, with the target reduction for the Commissioning for Quality and Innovation(CQUIN) being achieved for quarter three.

The trust had a suite of medicines related policies and procedures. However, as identified on the pharmacy risk register several of these documents were overdue for review, due to a "lack of pharmacy team capacity". A work plan had been put in place to try and address this by the end of 2015/16. The trusts Rapid Tranquillisation Policy had been updated in line with recent NICE guidance, (NICE NG10 2015: Violence and aggression: short-term management in mental health, health and community settings).

The trust had a nominated medicines safety officer and systems were in place for reporting and assessing medicines incidents and errors. The Drugs and Therapeutics committee also produced regular bulletins to share information about trust and national medicines safety updates. The trust was currently seeking feedback from, and looking at the effectiveness of the Business Development Units' Clinical Governance and Patient Safety Groups. There was a trust NICE steering and overview group who met three monthly to discuss NICE guidance that has been issued each month.

The trust did not have a defined strategy for the implementation of electronic prescribing and medicines administration. However, plans were in place to pilot electronic discharge with a small group of practices, to facilitate the rapid and secure transfer of information.

Medicines were generally well managed in the community health services. Medicines were stored securely and fridge temperature checks were complete and accurate. Missed dose audits took place in community inpatients services.

On the wards for patients with learning disabilities or autism, we reviewed all four medicines charts. We found a missing signature for an anti-epileptic drug in one record and a missing signature for an antifungal cream in another record. These errors had not been reported on the incident reporting system. Reporting missed doses of medications help reduce administration errors.

We saw no evidence that high dose monitoring was routinely carried out on the acute wards for adults of working age with mental health problems. Pharmacists had noted on charts that it should be done; however, we could not find evidence of the monitoring taking place. There were no completed monitoring forms and no information in patient records.

Safeguarding

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.

Minutes from the safeguarding strategic sub-group demonstrated that training, policies, and risks were regularly discussed. They also demonstrated that lessons learned from serious case reviews were shared and that information from business development units and local governance groups was reviewed, discussed and actions identified to be taken and by who.

The trust had a dedicated safeguarding team, which was led by one deputy director and two assistant directors. The service included two named nurses for children (one for mental health services and one for community health services) and a named nurse for adults. The named nurses were supported by a team of safeguarding advisors. The team was responsible for providing safeguarding training and advice to staff across the trust and for reviewing and investigating incidents involving safeguarding. The safeguarding children's team was well established. The team recognised that further work was needed to embed systems and processes in the safeguarding adults team.

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Safeguarding team meeting minutes in February 2016 showed that a safeguarding database was available for all staff and covered safeguarding adults and children. The minutes demonstrated that audits took place and that specialist supervision was in place for all team members.

There had been two safeguarding alerts and five safeguarding concerns raised for the trust between 1 January 2015 and 31 December 2016. The safeguarding alerts were raised for Fieldhead Hospital (21 October 2015) and The Dales (30 March 2015). Both alerts had been closed.

The trust had completed a review following the Saville report and had developed an action plan. The majority of the actions had been completed whilst some remained ongoing in line with the recommendations, for example to provide specialised workshops in response to local and national lessons learnt and guidance. An example of changes made included a new inpatient visitors policy that referred to the findings of the Saville enquiry. The policy was dated January 2016. It described what steps staff would need to take and what approval would be required for non-patient visitors including VIP's such as ministers and royalty, celebrities including television, radio and sports personalities.

There was a strategic plan for safeguarding children and adults which identified a number of key objectives for 2016 to 2017. The strategic safeguarding sub-group met quarterly and was responsible for implementing and monitoring the strategic plan.

Safeguarding was reported to the board by exception through leadership and performance reports and annually in a safeguarding report.

Safeguarding training rates were generally at or above the trust's target of 80% in community health services. Staff working with children, young people and families received formal safeguarding supervision every three months. This was in line with national service specifications and best practice.

Staff had completed the mandatory safeguarding adult and children training, with compliance being above the trust target of 80% in almost all services. However, the North community mental health team was 67% compliant with safeguarding adults training. Staff were being booked onto training to ensure full compliance.

However, in all the services we visited, staff were able to explain the potential identification of safeguarding concerns, their responsibilities, and local referral procedures. There were good links with the local safeguarding authority. Safeguarding was discussed within supervision and team meetings.

Care Quality Commission (CQC) Intelligent Monitoring identified that the trust was flagged as an elevated risk for whistleblowing alerts received by CQC.

The trust has confirmed that they have not had any regulation 28 reports issued in the past 12 months.

Track record on safety

We analysed data about safety incidents from three sources: incidents reported by the trust to the National Reporting and Learning system (NRLS) and to the Strategic Executive Information System (STEIS) and serious incidents reported by staff to the trust's own incident reporting system. These three sources are not directly comparable because they use different definitions of severity and type and not all incidents are reported to all sources. For example, the NRLS does not collect information about staff incidents, health and safety incidents or security incidents.

Providers are encouraged to report all patient safety incidents of any severity to the NRLS at least once a month. The average time taken for the trust to report incidents to NRLS was 21 days which means that it is considered to be a consistent reporter.

The trust reported a total 5,020 incidents to the NRLS between 1 January 2015 and 31 December 2015. When benchmarked the trust were at the lower end of the middle 50 percent of reporters. 75% of incidents reported to NRLS resulted in no harm, 21% in low harm, 2.5% in moderate harm, 0.4% in severe harm and 0.7% in death. The NRLS considers that trusts that report more incidents than average and have a higher proportion of reported incidents that are no or low harm have a maturing safety culture.

Trusts are required to report serious incidents to STEIS. These include 'never events' (serious patient safety incidents that are wholly preventable). NHS England have changed the way in which they report STEIS incidents and this is why we now have some incidents reported to STEIS 2 and others to STEIS 3. The trust reported 28 serious incidents to STEIS 2 between 1 January 2015 and 31 December 2015. None of these were never events, 36% were 'Suicide by Outpatient (in receipt of care)', 18% were

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incidents relating to 'Unexpected Death of Community Patient (in receipt of care)' and 11% were for both 'Suicide by Outpatient (not in receipt of care) ' and 'Pressure ulcer Grade 3'.

The trust reported 48 serious incidents to STEIS 3 between 1 January 2015 and 31December 2015. None of these were never events, 79% were 'Apparent/actual/suspected self-inflicted harm', 8% were 'Disruptive/ aggressive/ violent behaviour' and 4% were relating to 'Pressure ulcer', 'Slips, trips, falls' and 'Major incident/ emergency preparedness, resilience and response/ suspension of services '.

The trust submitted a list of 94 serious incidents that occurred between 30 July 2014 and 19 September 2015. Of these, 54 involved the death of a patient with a further three patients dying within four days of the incident occurring. The core service that reported the highest number of incidents was adults mental health community services. The commonest type of serious incidents were hanging, category 3 pressure ulcer, suspected/actual suicide and suspected/actual overdose.

CQC Intelligent Monitoring flagged the trust as a risk in relation to the number of deaths of patients detained under the Mental Health Act. The trust was also flagged as a risk for the number of suicides of patients detained under the Mental Health Act (all ages).

The results from the NHS Staff Survey 2014 showed that the trust was 'in the worst 20% of all mental health/learning disability trusts regarding staff reporting errors, near misses or incidents they had witnessed in the last month and for staff receiving health and safety training in the last 12 months.

The trust was 'in the best 20% of all mental health/learning disability trusts regarding staff feeling satisfied with the quality of work and patient care they are able to deliver, staff agreeing that their role makes a difference to patients, staff working extra hours, staff experiencing discrimination at work in the last 12 months and for work pressure felt by staff.

The NHS Safety Thermometer is a national improvement tool for local measuring, monitoring and analysis of patient harm and to assist in working to achieve harm free care. This focuses on four avoidable harms: - pressure ulcers; falls; urinary tract infections (UTI's) in patients with a catheter and blood clots (venous thromboembolism).

Barnsley business development unit (BDU) only completed the National Safety Thermometer. The rest of the trust uses the Mental Health Safety Thermometer. There were 50 new pressure ulcers recorded on the safety thermometer between December 2014 and December 2015. The most new pressure ulcers were recorded in January 2015 with seven. There were 24 falls with harm recorded on the safety thermometer between December 2014 and December 2015. The most falls with harm occurred in April 2015 with four. There were no falls with harm during January 2015 and September 2015.

There were 10 catheter and new UTI's recorded on the safety thermometer between December 2014 and December 2015. The most catheter and new UTI's occurred in January 2015 and May 2015 with two. There were no new UTI's recorded during February 2015, March 2015, June 2015, October 2015 and December 2015.

The Mental Health Safety Thermometer was designed to measure local improvement over time and should not be used to compare organisations, due to differences in patient mix and data collection methods. Safety Thermometer data should also not be used for attribution of causation as the tool is patient focussed.

'Harm free' care defined as patients that did not self-harm, do not feel unsafe, have not been a victim of violence or aggression and in inpatient settings have not been restrained. The proportion of patients with 'harm free care' between February 2015 and January 2016 was 90%. The percentage had increased in both December 2015 (91%) and January 2016 (93%). There was no data available for the proportion of patients in inpatient settings that had been restrained in the last 72 hours.

Between February 2015 and January 2016 the average proportion of patients that had self-harmed within the 72 hours was 3%.

In the same reporting period, the proportion of patients who had been the victim of violence/aggression in the last 72 hours was 1%. In January 2016 this was at its lowest point at 0.4%.

The proportion of patients that had an omission of medication in the last 24 hours between February 2015 and January 2016 was 12%.

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Reporting incidents and learning from when things go wrong

Our intelligence identified that the oldest serious incident on STEIS which is still ongoing was created on 12 February 2015. This incident relates to an 'Allegation Against HC Professional'.

All the staff we spoke to were clear about their role in completing incident reports using the Datix information system. The Datix incident report directed staff in completing the actions required using the information that was inputted by staff, for example a full investigation or implementing duty of candour. However, staff on the wards for patients with learning disabilities and autism did not always recognise and report medication incidents.

Five serious incident records were reviewed, including a three patient deaths, a grade three pressure ulcers, a patient fall. We observed the information gathered in preparation for the full investigations. We observed detailed investigations within time periods that were appropriate to the incident, including information from external agencies. We observed the root cause analysis for these incidents, with actions identified from the findings.

Team managers and the patient safety support team were able to generate reports to identify themes and trends that could be escalated to the board via the clinical governance and clinical safety committee meetings. They were cascaded to the services via the business delivery units. These reports, also known as risk scans, were also completed at the weekly executive board meeting, with themes and lessons learned disseminated through the wider executive management teams, and back down to the wards through the business delivery units. The serious risk incident owner, who is the deputy chief executive officer, was included in all incidents that were reportable to the information commissions office.

An incident reporting and management procedures policy (including serious incidents) was in place. This policy was supported by the trust's risk management policy and was overseen by the director of nursing, clinical governance and safety who is the accountable officer for ensuring that appropriate information reports, performance reports, and updates are available to appropriate individuals and groups to provide assurance in respect of the processes to the Trust Board.

Staff in the mental health services told us that following a serious incident, patients were given additional support where this was applicable, and staff would receive a de-brief. We were provided with examples, where staff had additional de-brief following a serious incident. Most staff we spoke to at both ward level and board level confirmed that staff received feedback and learning from incidents through monthly team meetings, supervision, learning events, via email from their team manager, on the intranet and in the quarterly communications newsletter.

We saw evidence of learning from incidents in community health services although the mechanisms for sharing learning were not always clear. Staff in community services for adults told us that feedback from incidents was not always provided and that it was sometimes inconsistent. In the community mental health services for older age adults there was little evidence of learning being shared following incidents with staff.

Using the Datix system, the patient safety unit sends quarterly reports to the commissioners on behalf of the business delivery units. This reflects the trust's openness and transparency with their stakeholders. Serious incidents are also reported in the trust's monitor report.

Duty of Candour

Staff training on duty of candour was trust wide, with the senior staff interviewed being aware of their responsibilities in relation to the duty of candour and the requirements of regulation 20 of the Health and Social Care Act 2008 (regulated activities) Regulations 2014. This regulation requires the trust to notify the relevant person of a suspected or actual reportable incident that resulted in moderate or severe harm as their statutory responsibility.

Staff from board level to ward level described behaviours and interactions with patients that reflected the trust core values of being open, honest and transparent with patients, relatives and carers. They told us that an appointment was made with patients, relatives and carers to discuss all incidents, and to go through the action taken by the trust and the reasons why, even in cases where the incident did not meet the threshold for duty of candour. Staff and directors told us that this reflected the culture of the organisation.

The trust policy "being open when things go wrong (duty of candour) "policy and guidance, as well as the "being open quick guide" were both available on the intranet to staff to

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encourage candour, openness and transparency. The being open quick guide was directive regarding reporting incidents, which incidents met the duty of candour, and what further action was required including a meeting with the patient, relatives and carers, and written follow up of the investigation and a written apology.

The Datix information management system supported the implementation of the duty of candour because it identified from the information that was inputted by staff whether duty of candour applied to the incident.

The same five serious incident records were reviewed during the inspection in relation to the trust's responsibilities in relation to the duty of candour and the requirements of regulation 20 of the Health and Social Care Act 2008 (regulated activities) Regulations 2014. This regulation requires the trust to notify the relevant person of a suspected or actual reportable incident that resulted in moderate or severe harm as their statutory responsibility.

Three of these incidents included evidence that the trust had met the requirements of the duty of candour statutory requirements under the Health and Social Care Act 2008 (regulated activities) Regulations 2014, regulation 20. The records demonstrated that there had been immediate contact with the patient, relative or carer, with an apology provided over the telephone. There was also evidence that a full investigation had taken place, and that the patient, relative or carer had been provided with written details of the investigation. A written apology was sent to the patient, carer or relative in each of these incidents. However, two of these incidents did not completely meet the requirements of the regulation as in one of the files details of the full investigation were not sent to the patient, relative or carer. Also, the patient letters sent in both these incidents did not have a clear message of apology contained in them.

Anticipation and planning of risk

The board had identified the strategic risks, which might affect business and had developed a board assurance framework. There were seven strategic risks highlighted in the Board Assurance Framework as amber or red. These were related to:

- Continued uncertainty of strategic partnership landscape, including commissioning, acute partners and local authorities linked to the Five-Year Forward View leading to unsustainable organisational form.
- Failure of transformation plans to realise appropriate quality improvement leading to development of a service offer that does not meet service user or carer needs and/or commissioning intentions.
- Changing service demands and external financial pressures in local health and social care economies have an adverse impact on ability to manage within available resources.Failure to deliver level of transformational change required impacting on ability to deliver resources to support delivery of the annual plan.
- Inadequate capture of data resulting in poor data quality impacting on ability to deliver against care pathways and packages and evidence delivery against performance targets and potential failure regarding Monitor Compliance Framework.
- Staff and other key stakeholders not fully engaged in process around redesign of service offer, leading to lack of engagement and benefits not being realised through delivery of revised models and ability to deliver best possible outcomes, through changing clinical practice.

Failure to develop required relationships or commissioner support to develop new services or expand existing services leading to contracts being awarded to other providers.The strategic risks were identified using a risk matrix assessment, in line with the trust risk policy and procedure. However the risk management procedure was not current as it had not been reviewed in 2014. Risk registers were held at trust board level, which included the strategic risks. Each business delivery unit held risk registers and in the trust action groups and these reported in to the trust risk register reviewed by the executive management team.

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

Summary of findings

The summary can be located on page 9.

Our findings

Assessment of needs and planning of care

Through the Care Quality Commission Intelligent Monitoring, the trust was flagged as an elevated risk for the proportion of patients who have been in hospital less than a year who received a physical health check on admission. Thirty-nine patients received a physical health check from a sample of 53 patient records. During our inspection we found evidence in care records across core services that people had received physical health check at admission.

Care and treatment was delivered in-line with current, evidence based guidance, standards and best practice in community health services. Patients' needs were assessed, risk assessments were conducted 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.

Mental Health Act reviewer visits to wards at South West Yorkshire Partnership NHS Foundation Trust between 6 January 2015 to 6 January 2016 highlighted six issues relating to a lack of patient involvement in care plan and three of the six issues where physical health checks were not routinely taken / part of care plan. During our inspection we saw evidence of patient involvement in care planning in the majority of the health records we looked at.

In community mental health services for adults of a working age we found two care plans that were out of date and had not been reviewed in line with the minimum 12 monthly requirement set by the trust.

In wards for people with learning disabilities or autism all patients had a completed 'hospital passport'. This is a document that assists people with learning disabilities to provide hospital staff with important information about them and their health when they are admitted to hospital. Patients had individualised behaviour support plans aimed at increasing quality of life and reducing the impact of behaviours that challenged. These plans provided staff with strategies to prevent or manage behaviours of concern safely. Staff could tell us how they applied these strategies and care records showed that behaviour was proactively being managed.

In community mental health services for people with learning disability or autism we saw evidence of staff developing care plans in different formats including easy read formats, based on the needs of the patient.

In November 2015 the trust had upgraded their electronic recording system (RIO) and this had caused some initial problems. This included some periods where the system was inaccessible for a few hours at a time. However, for inpatient areas the trust had contingency plans in place for this and the wards reverted to paper notes and scanned these in when the systems were not accessible. Staff on the inpatient wards did not report any major problems with the system other than it being slow at times. The issues with the RIO system were captured on the trust risk register and we informed that work was ongoing to improve this.

In community services staff experienced significant difficulties in accessing care records, this occurred where there were integrated teams and when staff were working away from base.

In specialist community mental health services for children not all information was available within the contemporaneous electronic records. Some assessments were held in paper records. This meant it was not always possible to have access to all clinical records when working away from the team base.

In community mental health services for older people there was a mixture of different systems and access arrangements across the service. This resulted in the staff

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not being able to access timely patient records when they were required. For example, one of the records we looked at on RIO had several pieces of information missing. However, when we asked to see the paper record we were told it was at a different location that did not have access to RIO.

In community mental health services for people with learning disability or autism staff told us the record system did not allow them to input all the assessments used by the various disciplines. Staff were unable to upload documents therefore not all assessments were stored on RIO. Staff had scanned these documents to a shared drive within a specific team's area of the network. This resulted in other teams or disciplines being unable to access the information directly.

Community mental health services for adults of a working age staff told us that they had experienced several problems with the system following the upgrade. This had meant that the most recent risk and care information had not always been available.

Best practice in treatment and care

We saw some outstanding practice in end of life care. The end of life care lead for the trust was also the end of life care lead for the locality. This meant that the trust was able to have a significant role in shaping end of life care services in the locality. The palliative care team were runners up in a national award for their oral hygiene steering group.

Care was not always delivered in line with evidence-based guidance and standards across the core services, including National Institute for Health and Care excellence (NICE) guidance and The Royal College of Psychiatrists. Core services used a range of tools to monitor clinical changes and effectiveness over time including; therapy outcome measure (TOMS); assessment of motor and process skills (AMPS); brief psychiatric rating scale (BPRS); recovery star; hospital anxiety and depression scale (HADS); clinical institute withdrawal assessment for alcohol (CIWA); and mini mental state examination (MMSE).

There was a range of therapeutic and evidence based approaches across the trust and these were delivered using a multi-disciplinary approach. Each core service had a referral pathway to psychology and this differed across the trust. Some teams had psychology as part of their team establishment and others referred to a team. This sometimes led to a difference of service provision.

In acute wards for adults of working age and PICU some wards were often unable to see a psychologist until after they were discharged from hospital. On Beamshaw and Clarke wards, patients could usually see a psychologist within five days. On Trinity 1 a psychologist visited the ward every Monday.

In community learning disability and autism teams, each psychology team had a waiting list that breached the services target of 18 weeks maximum wait. Staff told us historical restructures had reduced the size of the psychology teams and there were plans to increase these to meet the demand as part of the transformation programme.

The trust takes part in the National Audit of Schizophrenia audit. This audit relates to community patients with schizophrenia. :

- Performance in monitoring of physical health risk factors was a little above average for the trust. Even then, however, it is below the ideal target.
- Availability and uptake of CBT was below average and about average for family interventions. Thus, provision of psychological therapies was well below what should be provided.
- Many aspects of prescribing practice were about average for the trust. However, a rather high proportion of service users were receiving higher doses than normally expected.
- A higher than average proportion of service users in the trust on clozapine had received three or more antipsychotic medications before commencing clozapine.

A trust audit programme was in place to assess medicines handling in accordance with trust policy and national guidance. The trust subscribed to Prescribing Observatory for Mental Health (POMH UK) to enable audit of prescribing practice against national standards and to benchmark their performance against other similar trusts. We saw evidence of action being taken in response to audit findings. For example, The National Audit of Schizophrenia showed prescribing practice was largely in line with the average for all trusts. However, an inappropriately high proportion of service users on clozapine had received three or more antipsychotic medications before commencing clozapine. In response to this the trust was implementing a strategy to increase community access to Clozapine initiation.

Are services effective?

Similarly, work competed by the trust's Psychotropic Drugs requiring Special Monitoring group (September to November 2015) found "a discrepancy across the trust regarding the provision of resources for physical health monitoring. In some areas there is a well-resourced service, in other areas very little". As identified in the pharmacy risk register, the report also identified "clinical risks for service users prescribed lithium relating to missed monitoring and links with primary care". In response to these findings the trust was piloting a new community physical health monitoring model to improve the physical health care of people with mental illnesses across its secondary mental health care inpatient and community services.

Medicine management in the Enfield Down service was reviewed by pharmacists during the inspection and was found not to follow NICE guidelines (medicine optimisation 2015, and psychosis and schizophrenia in adult 2014) and best practice. Pro re nata (PRN) or medication when required had not been reviewed regularly and one patient had been prescribed an antibiotic which was contraindicated for use with their psychiatric medication. This placed the patient at risk of harm from physical health complications.

We saw evidence of audit at trust, business delivery units and local levels across the services in the trust. Staff said they were able to participate in audit directly and through supervision.

In specialist community mental health services for children audits were not regularly being undertaken to determine that new systems and processes were being embedded into practice. This was the case at each of the community bases.

The trust have participated in the following external audits:

- SWYP – 2014 Mental Health Inpatient Survey – Survey results manual.
- National Audit of Intermediate Care – Action Plan – Final Version.
- National Audit of Intermediate Care – 2014 Online Benchmarking Tool – Action Plan – Focus Areas / Barnsley BDU – March 2015.
- POMH Topic 4b Anti-dementia drugs prescribing trust repot – 7 April 2014.
- POMH UK Topic 10c: Prescribing antipsychotics for children and adolescents – summary results – Aug 2014.

- POMH UK Topic 10c: First supplementary audit report – Prescribing antipsychotics for children and adolescents – Aug 2014.
- POMH UK 14a – Prescribing in Substance Misuse: alcohol detoxification – 27 August 14.
- POMH UK 12b: Prescribing for people with a personality disorder.
- Sentinel Stroke National Audit Programme (SSNAP); Post-acute organisational audit – October 2015.

The trust has undertaken 18 local/clinical audits trust wide and intends to take various actions to improve the quality of healthcare provided. The 18 audits include:

- Medicine reconciliation audit – Psych report.
- Response Times for Intensive Home-based Treatment Team (IBHTT) Psychiatrist Reviews – July 2015.
- Patient Safety First Chart Checker – December 2014.
- Clozapine Monitoring in the Community (presentation).
- Audit on compliance with consent to treatment in community patients on CTO.
- Completed Audit Cycle – consent to treatment, Newton Lodge – 2003, Oct 2007, Dec 2012, and May 2015.
- Consent to Treatment – Audit and evaluation project outcomes monitoring form.
- Annual Health and Safety monitoring Audit report – 2014/15 (trust wide results).
- MHA Section 132 Audits – July 2015.
- Essential steps audit report (Enteral feed, catheter Insertion & Catheter Care) – Audit Rehabilitation Inpatient Areas; Barnsley – April 2015.
- Trust mental health services clinical record keeping audit – summary report – May 2015.
- Hand hygiene audit report (Kendray Hospital) – April 2015.
- Audit of compliance against the Health & Wellbeing of Looked after Children Quality Standard (QS31) – final – May 2015.
- Audit of Assessment and Recording of Capacity to consent to treatment by service users within the Wakefield, Working Age Adult Inpatient Units as highlighted by the CQC report Jan-Mar 2015.
- SWYPFT – Bed Management Report – March 2015.
- SWYPFT – Leadership Development Report – July 2015.
- SWYPFT – Performance Indicators Report – September 2015 (Draft).
- SWYPFT – Transformation Report – September 2015.

Are services effective?

The trust also had seven quality priorities which had key performance indicators within them to measure the trust outcomes: listening and acting on patient feedback, working across pathways, patient safety, access to services, improving care planning, improving recoding and evaluating care, and staff being fit professionally, mentally and physically to fulfil their role.

The trust have had good outcomes for their performance against the majority of the indicators. Overall, the trust achieved 63% of the key performance indicators they identified between 2014 and 2015, and in 20% of cases, they were within 10% of achieving their goal. The trust continues to have high performance in the area of listening and acting on patient feedback, working across care pathways and patient safety. There however have been some areas where there has been consistent underperformance against the 2014-15 targets.

The trust was not achieving the following targets:

- 90% target for face-to-face contact within 14 days of referral (with stretch) for people with non-acute mental health problems in Calderdale, Kirklees and Wakefield.
- 100% target of Barnsley child and adolescent mental health services patients seen within 5 weeks of referral.
- 90% target regarding adherence to cluster reviews in mental health.
- 90% mental health clustering assessments.
- 4% sickness target (however, the trust remains compliant with the national 5% target).
- The trust's internal goals for staff friends and family test.

The trust confirmed that concerns remained with the quality of clinical record keeping and data quality.

At the end of 2014/15 quarter four, the trust was achieving all of the performance indicators set by Monitor.

Skilled staff to deliver care

As at 17 February 2016, the percentage of non-medical staff that had had an appraisal in the last 12 months was 95%. Thirteen of the teams had an appraisal rate of 0%. This equated to 35 members of staff who have not had an appraisal in the last 12 months.

- As at 17 February 2016, there have been 113 (82.9%) doctors revalidated during the last 12 months across the trust.

- There were two questions in NHS Staff Survey 2015 which related to this trust in comparison to other Mental Health and Learning Disability trusts. This trust was in the top 20% of trusts relating to the percentage of staff feeling satisfied with the quality of work and patient care they are able to deliver. The trust was average in comparison to other trusts with regard to staff agreeing that their role make a difference to patients.

- There were no areas highlighted as better or worse than expected in the GMC Training Scheme Survey. General psychiatry and Old age psychiatry were 'within expectations' for all areas. Child and Adolescent Psychiatry, Forensic Psychiatry and General Practice where the majority of the results were not published. Clinical supervision & Regional Teaching for Child & Adolescent Psychiatry had no results as well as 'Handover' for Child and Adolescent Psychiatry and General Practice.

Most staff in community health services had an appraisal within the last 12 months.

Staff were required to receive managerial supervisions throughout the year, all mental health staff were required to receive 12 hours per year (pro rata) minimum clinical supervision. Staff told us that they received regular clinical supervision but the trust had no system in place to monitor that clinical supervision was taking place.

There was evidence of both clinical and managerial supervision in all core services with the exception of acute wards for adults of working age and psychiatric intensive care units. Staff across all the wards told us they had not received either clinical or managerial supervision for some considerable time, in some cases this was over 12 months. This was confirmed by ward managers and our review of staff files.

The core services had a range of disciplines appropriate to the needs of the patient group. Staff were appropriately qualified and had received both a trust and local induction. Staff also had access to mandatory training and specialist training for their personal and professional development and to enhance skills available in the team.

Most crisis teams had Approved Mental Health Practitioners (AMHP) within their teams which provided them with expertise in the Mental Health Act. An AMHP can carry out Mental Health Act assessments which determine whether a patient may need a hospital admission.

Are services effective?

Multi-disciplinary and inter-agency team work

All core services had regular multi-disciplinary team (MDT) meetings usually weekly or more often when the patient's need dictated this, with the exception of long stay and rehabilitation mental health wards. At Enfield Down patients did not have regular multidisciplinary meetings. We were informed by the staff that the service held Care Programme Review (CPA) meetings on a three to six monthly basis and this was when patients were fully reviewed. If patients wished to see the consultant between CPA's then they could request this. We reviewed 15 care records during our inspection and saw that three to six monthly CPA meetings were taking place. However, this meant that patients who didn't request to see the consultant could go up to six months without being seen and reviewed by the multidisciplinary team. We reviewed 26 care records sent by the trust, of these only seven records demonstrated regular and timely reviews taking place.

The multi-disciplinary team included a wide range of professionals, including dieticians, which helped to ensure that patients received joined up care.

A range of professionals from within and outside the trust attended multi-disciplinary meetings and there were good relationships with agencies outside of the trust.

In acute wards for adults of working age and PICU members of the community healthcare teams struggled to get to meetings at The Dales due to the distance they had to travel to attend and problems with parking on site. The patient was fully engaged in the process, discussions involved the patient and meetings were comprehensive. However, not all care records showed that decisions made during MDTs had informed the patients care planning.

In crisis teams as part of their duties under the crisis care concordat the teams had good working relationships with outside agencies, in particular emergency services. The Calderdale and Kirklees IHBT had police liaison officers who were clinical staff that worked with emergency services as part of a street triage. This enabled appropriate and timely assessment directly from the crisis team bridged a gap between mental health services and emergency services and enabled a more effective working relationship.

Wakefield and Barnsley IHBT were not commissioned to have police liaison officers and the team leaders felt if they had this service they would be more effective in supporting people in crisis.

Community mental health services for people with learning disability or autism teams were co-located in local authority teams and had valuable links with their colleagues in the wider MDT and local authority. However, they told us they did feel isolated from the trust at times.

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

South West Yorkshire Partnership NHS Foundation Trust does not routinely capture compliance information around Mental Health Act (MHA) training. The trust does not identify this as mandatory training. Staff training had been arranged locally in some areas but this differed across areas of the trust. The board did not have an understanding of the quantity or the quality and content of the training being delivered locally. Some staff had received training covering receipt and scrutiny of MHA documents and section 17 leave.

The trust had a Clinical Governance and Clinical safety Committee and a MHA Committee which provided assurance to trust board regarding the compliance with the MHA. Frontline services reported through the business development units into 'standing groups'. These were; quality improvement meeting; clinical governance group; trust-wide clinical policy and procedures advisory group; and the reducing restrictive physical interventions group. These groups did not report directly into committees but matters raised were taken to executive management team and committees by the lead director by exception. Senior management we spoke with did not have a good understanding of the operation of the MHA in the trust.

There was good compliance with most of the MHA code of practice across all services; however, this was only in relation to the aspects of the code that had not changed since the introduction of the 2015 Mental Health Act (MHA) code of practice. There was no consistent training in the trust which included the 2015 MHA code of practice and its implications for staff delivering care. Some staff we spoke to did not know there was an updated code of practice.

The trust did not have an overall implementation plan for the 2105 MHA code of practice. We saw a 'Mental Health Act Code of Practice Action Plan' which was developed

Are services effective?

February 2015 and had been reviewed September 2015, February 2016 and March 2016. This included a list of policies and procedures that needed to be updated and was based on the MHA code of practice Annex B; this showed a red, amber or green rating of progress. Only some of the policies and procedures had been updated. Several of these policies were indicated to have been updated and compliant with the code but when we looked at these on the trust intranet we found they were still not compliant with the code requirements. There was no detail of how the changes in the code and the trust policies or procedures would be implemented across the services.

The care records reviewed correctly detailed the patient's detention under the Mental Health Act. Original detention documentation was filed in the MHA office with copies held on the patient record.

Consent to treatment and capacity requirements of the MHA were adhered to and copies of certificates were held with medication cards. We saw the responsible clinician's discussions with the patient around capacity and a record of the capacity in the care records.

Patients had been informed of their legal status and their rights under the MHA at the time of detention and this was revisited by staff periodically.

The trust had a central MHA department which provided support and legal advice for staff on the MHA. Staff knew how to contact this department.

Independent mental health advocates (IMHA) were available for each ward across the trust services. There was information around the wards describing the IMHA services available. Wards used different advocacy services dependant on their location. Patients detained under the MHA were referred by staff or could self-refer. Older people's inpatient services operated an opt out referral service whereby patients who were detained were referred on admission to the IMHA and they could decide when they visited if they wanted to speak with them or not.

The trust had undertaken the following audits in relation to the MHA:

- Audit on compliance with consent to treatment in community patients on CTO.
- Completed Audit Cycle – consent to treatment, Newton Lodge – 2003, Oct 2007, Dec 2012, and May 2015.

- Consent to Treatment – Audit and evaluation project outcomes monitoring form.
- MHA Section 132 Audits – July 2015.
- Audit of Assessment and Recording of Capacity to consent to treatment by service users within the Wakefield, Working Age Adult Inpatient Units as highlighted by the CQC report Jan-Mar 2015.

Good practice in applying the Mental Capacity Act

South West Yorkshire Partnership NHS Foundation Trust does not routinely capture compliance information around Mental Capacity Act (MCA) training. The trust does not identify this as mandatory training. We found that staff training had been arranged locally in some areas but this differed across areas of the trust. The board did not have an understanding of the quantity or the quality and content of the training being delivered. Staff generally had a good understanding of the Mental Capacity Act and how this related to their practice. However, there were some areas of the trust, such as acute mental health inpatients, where MCA was not consistently well understood.

There was a policy for the MCA on the trust intranet which staff could access. The policy had gone past its review date and did not include developments practice around the MCA, its interface with the Mental Health Act or application of Deprivation of Liberty Safeguards (DoLS). There were guidance documents for staff relating to developments in DoLS case law and the MCA but these had no author, publication date, version control or document status attached and as such had no governance arrangements.

Generally where necessary mental capacity assessments had been carried out and recorded in the patient record. Assessment were both time and decision specific and we saw evidence of both simple capacity assessments for day to day decisions and more complex assessments. However, in acute wards for adults of working age and psychiatric intensive care units capacity assessments with regard to consent to treatment were missing from care plans and the best interest process was not always followed.

There was evidence of people being supported to make decisions where their mental capacity was an issue. Any decisions made on behalf of an incapacitated person were taken in their best interests and recorded in their care record.

Although the MCA does not apply to young people under 16 the Gillick competence framework was used to

Are services effective?

determine a young person's ability to make decisions. Where the MCA did apply to young people over the age of 16 staff demonstrated an understanding of the core principles underpinning the MCA.

Advice and support regarding the MCA and DoLS was available from the central MHA office. Staff knew how to contact this office for support.

We saw evidence of the deprivation of liberty safeguards applications being made when appropriate and staff described a good understanding of the interface between DoLS and MHA detention authority in some areas of the trust. Between 1 November 2015 and 31 January 2016, 27 Deprivation of Liberty Standards (DoLS) applications were made. Of these 27, 15 were granted, five patients were discharged prior to the outcome, four were not granted, one withdrawn, one not assessed and one was awaiting outcome.

There was no clear mechanism for the trust to monitor its compliance with the MCA or the DoLS across the organisation.

Minutes from the safeguarding strategic sub group in May 2015 identified that a decision had been taken that training in the Mental Capacity Act should be made mandatory and that a paper was being developed for the executive management team. We saw a paper called 'Review of Mental Capacity and Mental Health Act training' that was produced by the trust MHA/MCA lead. This paper described how legislation training was required and recommended making this mandatory with regular refresher training and to include MHA code of practice changes and developments brought about by the Supreme Court decision in relation to DoLS. The paper had no publication date and we could not find details of whether the paper had been approved or not. Senior managers of the trust were also not aware if this paper had been approved of not.

Are services caring?

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

Summary of findings

The summary can be located on page 10.

Our findings

Kindness, dignity, respect and support

The trust's overall score for privacy, dignity and wellbeing in the Patient Led Assessment of the Care Environment (PLACE) 2015 was 95% which was above the average of 87% for all other NHS trusts. The score for Enfield Down, The Poplars and Castle Lodge were the lowest scores for privacy, dignity and wellbeing, with Fieldhead Hospital, Kendray Hospital and Dewsbury District Hospital scoring 96%. Scores for all sites were above national average. This meant patients thought that the trust treated them with dignity and respect, and that the patients described their well-being as excellent throughout the trust.

During our inspection, interactions were observed between staff and patients in all the services we visited. All staff were caring and compassionate towards patients. They treated them with dignity and respect.

However, 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.

For example, a member of staff was observed supporting a person at lunch time on the wards for people with learning disabilities and autism; the interaction was sensitive and non-intrusive, enabling the person to eat his meal in a calm environment. The staff member gave prompts to regulate the quantity of food the person was eating and this was done discreetly and respectfully.

We saw evidence that staff were able to build a good rapport with patients, even in services where they had known the patient for a short time. It was clear that staff were knowledgeable about the patients they were supporting. They were able to tell inspectors about the

patients that were receiving care and treatment in the services that they worked in, including information about the patients' histories, their likes and dislikes, and their hobbies and interests.

Patients and relatives told us that staff were professional and approachable. They felt that staff listened to them. However, two out of the 31 patients in the community mental health service for adults of working age told us that they did not have a good relationship with their care co-ordinator, and one of these patients said they did not feel that they were being listened to. Eight issues had been raised with the CQC via Share Your Experience between 1 January 2015 and 22 January 2016. Of these, seven were negative and one was positive. Themes were around use of medication, staff not listening to patient or carers concerns, use of agency staff, staff attitude and lack of physical healthcare checks.

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. For example, some of the patients we observed on the wards for older adults with mental health problems had severe levels of cognitive impairment and became agitated or aggressive at times. When this happened, we saw staff respond to patients in a calm and reassuring manner and allow patients time to calm down using de-escalation techniques. The percentage of staff feeling satisfied with the quality of work and patient care they deliver from the NHS Staff survey 2014 was in the best 20% of mental health/learning disability trusts.

There were several examples of outstanding care in services for children and young people. During an immunisation clinic we saw staff providing t-shirts to maintain the modesty of girls who were wearing long sleeves that they were unable to roll up. We also observed the school nursing team rapidly putting in place support for a vulnerable child.

Are services caring?

Across community health services, we saw patients and their relatives being treated with kindness, dignity and respect, and saw compassionate care being delivered. Patients and carers were mostly positive about the care and treatment they received from these services.

The involvement of people in the care they receive

The mental health wards and community services we visited used a variety of methods to orientate the patients to the service, for example showing the patient around the ward, pre-admission visits, offering them leaflets about the service, and having photos of the ward staff in the patient areas.

For example on the wards for patients with learning disabilities and autism, prior to admission to the ward the staff team met with patients and their families to go through what to expect on the ward prior to admission. Pre-admission visits for patients and families were also offered. On the ward patients were shown around. A file was available with photographs of the different therapy staff.

Almost all patients, relatives and carers we spoke with told us that they were involved in planning their treatment and care. On almost all wards, the majority of the care plans we saw were holistic and individually tailored to the patient. They demonstrated that patients had been involved in co-producing their care plans. Patients were offered copies of their care plans, though not all the patients we spoke to confirmed this.

In the acute mental health services for working age adults "my physical health" and "my mental health" booklets were implemented to encourage patients to discuss and for staff to capture the information. A staff member on Trinity 1 had introduced the booklet with input from pharmacist. These had been rolled out to other wards.

Patients in the long stay and rehabilitation wards had 'patient own' files, which they were able to keep these files in their room. These contained information on the unit, copies of care plans, and activity plans.

The community service for patients with learning disabilities and autism had developed care plans which had been developed in an easy read format to meet the patients' needs.

However, on the forensic mental health wards, we examined 24 care planning records and found that 44% did not contain evidence of patient involvement. Although, we observed 14 patient reviews which all demonstrated good patient participation in the care planning and risk assessment process. Patients were actively encouraged to maintain independence by staff. Patients we spoke to said they felt involved in their care. Patients had folders which contained care planning information.

Also, the Mental Health Act reviewer visits to wards at South West Yorkshire Partnership NHS Foundation Trust between 6 January 2015 and 6 January 2016 highlighted six issues relating to a lack of patient involvement in care plan and three of the six issues where physical health checks were not routinely taken or part of care plan.

Families and carers were encouraged to become involved in the patient's care. We observed family members at their relative's appointments. Families and carers told us they were encouraged to become involved in the patient's treatment, including meetings with the patient and other professionals to discuss the patient's care and treatment, for example care plan meeting and multi-disciplinary meetings. All the carers we spoke with in the community mental health service for older people told us staff helped them, providing emotional support and signposted them to people who could assist with more practical support like benefits entitlement.

In all areas, information on how to access advocacy services was available and advocates regularly attended patient meetings.

Community meetings were held on the acute wards weekly. Minutes of the meetings varied across wards. On some wards, we saw evidence that changes were made to the service because of the feedback given by patients at these meetings, but on others patients' views were not clear and it was not evident whether any further actions were required in response to patient's comments and queries.

In the specialist community mental health services for children and adolescents, young people had been involved in interviews for new staff. They had also made decisions regarding decorations and colour schemes at the team bases.

Patients were able to provide feedback on the service they received through the use of the friends and family cards, or through the trust website.

Are services caring?

Sixty nine per cent of respondents in the staff Friends and Family Test data were either 'likely' or 'extremely likely' to recommend the trust as a place to receive care which was below the England average of 79%.

Seventy seven per cent of respondents in the mental health patient Friends and Family Test data were either 'likely' or 'extremely likely' to recommend the trust as a place to receive care which was below the England average of 87%. Ninety eight per cent of respondents in the community patient Friends and Family Test data were either 'likely' or 'extremely likely' to recommend the trust as a place to receive care which was above the England average of 95%.

In the CQC Community Mental Health Patient Experience Survey 2015, the trust performed better than other trusts for questions related to 'How well does this person organise the care and services you need?' and 'Overall in the last 12 months, did you feel that you were treated with respect and dignity by NHS mental health services?'

In addition, in the waiting areas of the specialist community mental health services for children and adolescents, we saw eye catching feedback forms that had been designed in consultation with the local patient participation group. There were computer terminals with the same questionnaire available for people to complete.

Are services responsive to people's needs?

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

Summary of findings

The summary can be located on page 11.

Our findings

Service Planning

The trust had the equality delivery system 2 (EDS2) framework which supports NHS commissioners and providers to deliver better outcomes for patients and communities and better working environments for staff, which are personal, fair and diverse. The EDS2 is a tool for health service organisations engaging with service users, carers, staff, the public and other key stakeholders – to use, to review, their equality performance and to identify future priorities and actions. It includes local and national reporting and accountability mechanisms.

At the heart of the EDS2 was a set of 18 outcomes grouped into four goals. These outcomes focussed on the issues of most concern to patients, carers, communities, NHS Staff and Boards. It was against these outcomes that performance was analysed and graded, and equality objectives and associated actions determined. The four goals were:

- Better health outcomes.
- Improved patient access and experience.
- A representative and supported workforce.
- Inclusive leadership.

The trust were working to:

- Involve local interests with the NHS in a sustained, informed and meaningful way.
- Present information in accessible language and accessible formats.
- Focus on people and outcomes rather than processes.
- Ensure that the opportunity is taken to make real improvements.

Stakeholders were involved in a programme of engagement for large scale transformations about the future of the services, as part of the 2014 t0 2019 strategy. This was in a range of locally based activities delivered by the business delivery unit for that geographical area or specialist service area.

The trust's quality priorities, including the trust's quality plan for 2014 to 2017, were determined by the patient experience feedback, the trust's Commissioning for Quality Improvement Scheme (2015-16), the trust's annual governance report, and from the trust's consultation with their stakeholders about their priorities for the coming year through the Quality Account Survey.

The vision for community health services was integrated into the wider vision for the Barnsley area, as the trust had a place-based model of service delivery. Senior staff acknowledged that there was more work to be done to integrate community health services with mental health services although this was established in some areas, for example between community and adolescent mental health services and community services for children and young people. Community health services were engaged on a transformation programme which included a new service specification for district nursing and transformation of intermediate care. There was considerable uncertainty around the future of the community services for children and young people, following the failed procurement of this service. There was evidence that the trust was working with commissioners to try to reach a solution.

Access and discharge

The trust proportion of admissions to acute wards kept by the crisis resolution home treatment team have been above the England average for six of the seven quarters reported, although they exceeded the national 95% target in all quarters.

Between 1 August 2015 and 31 January 2016, the average bed occupancy rate was 88% including leave and 83% excluding leave. Twenty five of the 37 wards were above the 85% bed occupancy benchmark. Beechdale, Ashdale (formerly Ward 3 & Beaumont), Willow Ward 6, Trinity 2, Chantry, Ward 18 (Priestly Unit), Elmdale and Priory 2 wards had a bed occupancy rate over 100%. Elmdale Ward had the highest with 108.9%. It should be noted that Castle Lodge, Fox View, Ward SMU and Savile Park View are now

Are services responsive to people's needs?

closed. Research undertaken by the Royal College of Psychiatrists indicated that where wards were running at over 85% bed occupancy, this could have a negative impact on patient care.

On the acute wards for adults of working age with mental health problems, a problem with bed availability was identified, particularly when patients leave broke down and they needed to return to the ward earlier than planned. This on occasions meant patients could not return to the ward and needed to go to a hospital out of their area. Ward managers told us of times where 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 last 6 months. Nine of the 44 placements were where patients needed a gender specific psychiatric intensive care unit bed (PICU). For the acute mental health wards alone, there were 37 out of area placements in the last six months. Nine of the 37 placements were where patients needed a gender specific PICU bed. These beds are not commissioned by the trust but they do class these as out of area for financial purposes.

These people have been placed with other providers in long term placements following the closure of Savile Park at Castleford. The trust record these as out of area for financial monitoring but they are not out of area in the sense that they are not waiting to return to a trust bed, they are likely to be in those placements for the rest of their lives.

There were 257 readmissions within 90 days reported by the trust between 1 August 2015 and 31 January 2016. The wards with the highest number of readmissions within 90 days were Ashdale (formerly ward 3 & Beaumont – the Dales) with 45, Ward 18 (priestly unit) with 38, Elmdale (The Dales) with 27, Priory 2 (Fieldhead) with 22 and Trinity 2 (Fieldhead) with 21.

Average length of stay for patients discharged in the last 12 months trust wide (1 February 2015 to 31 January 2016) was 69 days excluding leave. The average length of stay for current patients up to 31 January 2016 was 329 days without leave and 331 days including leave.

Between November 2014 and November 2015, the trust performed below the England average for delayed transfers of care in 11 of the 13 months reported. Between 1 August 2015 and 31 January 2016 there were 59 delayed discharges from inpatient facilities. The majority of these delays occurred within wards for older people with mental health problems and acute wards for adults of working age and psychiatric intensive care units.

In the last six months, the wards for older people with mental health problems reported the highest number of delays. There were 26 delayed discharges for this service in total, and ward 19 had the highest number of delayed discharges for all wards with ten. The care records reviewed demonstrated that the delay was mainly due to patients awaiting an appropriate placement for patients with higher levels of need.

In the last six months, there had been 16 delayed discharges for acute services and the psychiatric intensive care unit. The highest numbers of delayed discharges were from Ward 18 (Priestly Unit) ward. The wards at Fieldhead Hospital had implemented patient flow process monitoring, involving social care and community teams. Any patients in hospital for more than 40 days were automatically added to this. The trust had instigated this to manage the pathway of the individual patient rather than managing the 'bed'.

There were six delayed discharges in the same time period last six months. These were all attributed to Enfield Down service in Huddersfield. Staff told us delayed discharges occurred as a result of funding for appropriate placements.

The trust failed to meet two of the 10 targets regarding the number of days from initial referral to initial assessment during 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 four weeks. The trust were completing this in an average (mean) of 41 days.

Following the patient assessment, 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 Barnsley but staff told us the majority of young people in Barnsley had waited 18 months for treatment and a parent

Are services responsive to people's needs?

told us their child had waited 18 – 24 months. Patients referred to the care pathways for eating disorder, crisis, looked after children and learning disability were seen significantly quicker than the figures above.

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.

Data provided for the ADHD and autism service showed that the wait from referral to first contact was 309 days. The wait from first contact to second contact was 102 days. National institute for health and care excellence (NICE) quality standard (QS51) calls for waiting times between referral and assessment to be no longer than three months. However this is recognised as a national concern. The trust and commissioners had discussed ways to reduce this time. Commissioners had agreed to additional funding on both a short and long term basis to support this.

The community mental health services all reported long waits for patients in some parts of the trust to access psychological therapies.

Between 1 March 2015 to 29 February 2016, the average wait from assessment to treatment for psychological therapies recorded in the North Kirklees CMHT was the highest of the four services we visited as part of our inspection, with an 80 days wait for patients to start treatment. Although we did not visit the Priestly Older Peoples Service Treatment Team we felt it important to include these figures as the waiting time of 683 days to access psychological therapies exceeds the 18 week assessment to treatment time expected within the NHS. However, there were only two referrals to the Priestly team during the period mentioned.

The waits to access psychological services reported by the community mental health services for patients with learning disabilities or autism breached the 18 week waiting list target set by the service. Staff told us some patients had been waiting as long as 13 months for assessments. Information received from the trust, indicated the Wakefield psychology team had the largest waiting list of 73 patients.

The figures provided by the trust for the community mental health teams for adults of working age, showed that within

North CMHT the average waiting time from the date of referral to the date of the first therapy was 54 weeks. The maximum wait was 76 weeks. This was confirmed by staff who told us waiting lists had been as high as two years.

Staff and patients confirmed there was long waits to access psychological therapies in the focus groups we facilitated as part of our inspection programme.

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%. The teams told us that they met this target through strong interagency working and the ability to work cohesively as a team.

The trust has performed below the England average for the proportion of patients on a care programme approach pathway followed up with seven days of being discharged from a psychiatric inpatient unit for four of the seven quarters between January 2014 and December 2014. The last three quarters have seen an improvement with a rise in follow up rates to above the England average levels from January 2015, achieving 98.6% for April to June 2015; 1.6% higher than the England average for the same period.

In community services for adults referral to treatment times consistently exceeded the national target for 95% of patients to be seen within 18 weeks of referral. Out of hours care was provided by a rapid response team. We found that the health integration team, which provided services for refugees and asylum seekers, was very proactive in raising awareness of the service. The team held health promotion events at local schools and business to raise awareness of the role of the health integration team and of how services could be accessed. However, in community inpatient services, the Sentinel Stroke National Audit Programme reported that discharge processes for patients who had a stroke were level E (lowest / worst level achievable). Overall, the stroke service was ranked third nationally for stroke outcomes.

The facilities promote recovery, comfort, dignity and confidentiality

Are services responsive to people's needs?

There was a full range of rooms and equipment on the wards and in the community services to support treatment and care. The rooms and facilities could adequately meet patients' needs, with spaces for clinical activities, therapies and activities.

On the inpatient wards for patients with learning disabilities and autism, there were quiet spaces within the setting, including a sensory area where people could relax if they wanted to. However, staff in the crisis teams told us that the smaller rooms available when the larger rooms were in use were not adequate to offer patients one to one support.

Most of the community teams told us that bases were bright, well-maintained with appropriate furniture. Staff said that the rooms available for individual consultations were adequately sound proofed to maintain people's privacy.

The community team in Wakefield that supported for people with learning disabilities had a spa bath and a sensory room at the horizon centre which patients or carers could arrange to use to promote relaxation.

However, the staff in the community that supported older age adults with mental health problems in Barnsley 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.

Also, the Kirklees Outreach Team was difficult to locate as the building was part of a site which also housed a bingo hall. There was no signage to direct people from the car park to the building.

On all the inpatient wards, patients could access an outside area. However, on some of the acute inpatient wards for adults of working age with mental health problems, patients would have to leave the ward to access it. This meant those without section 17 leave were unable to access this space.

During our inspection, on all the wards where patients stayed for longer periods of time, we observed that patient were encouraged to personalise their bedrooms and saw examples of this. Some patients had pictures of their family or pets, or cuddly toys, and others had artwork they had done during arts and crafts groups on the wards.

The patients we spoke to on these wards told us that the food was of good quality and there was plenty of choice. Patients had access to drinks and snacks twenty-four hours a day. Where patients needed support to make drinks, to make snacks, or with eating, we observed staff supporting patients in a calm and respectful way.

On most of the inpatients wards, there was a wide range of activities available seven days a week during the day and evenings. On some wards, activity facilitators carried out activities, along with, occupational therapists and ward staff. Patients were also involved in the decisions about the activities they wanted to participate in on the wards.

However, on the acute ward for adults of working age with mental health problems, the provision of activities was at weekend was variable. Only Ward 18, the Priestly Unit at Dewsbury District Hospital and Trinity 2, the Fieldhead Hospital in Wakefield, had pre planned activities advertised at the weekend. In other acute wards, we saw posters on display that stated that activities at the weekend were dependent upon staffing levels. Community meeting minutes demonstrated that patients on these wards wanted more activities available. Similarly, on the forensic wards, activities were limited at weekends. We spoke to 31 patients and 16 complained that activities were frequently cancelled due to a lack of staff. National Institute of Health Care and Excellence guidance for 'service user experience in adult mental health services' states that service providers should ensure systems are in place for patients in hospital to access meaningful and culturally appropriate activities seven days a week.

In community end of life care 84% of patients achieved their preferred place of care at the end of their life. When the preferred place of care was not achieved, the service explored the reasons for this and lessons were learnt.

In community inpatient services there was a link nurse within local accident and emergency departments who flagged patients with rehabilitation needs. This meant that patients could access specialist rehabilitation quickly.

There was a Dementia Matron based within the trust who provided support for people living with cognitive impairment or dementia.

Meeting the needs of all people who use the service

All inpatient wards had good access for people with physical disabilities. There were bathroom and shower

Are services responsive to people's needs?

facilities for people with limited mobility and those who used a wheelchair. All the community services were also able to meet the needs of those who required disabled access. Where teams were located above ground floor level lifts were in place and ground floor consultation rooms were available. These services also supported people in their own home, as well as other alternative accessible venues, like GP surgeries.

On the inpatient wards for older people with mental health problems, where there were patients with a diagnosis of dementia, there was dementia friendly signage which incorporated words and pictures at a visible height so that patients could find their way around more easily. On 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. However, environments in the community services for older adults with mental health problems were not dementia friendly.

In all the services we inspected, information was available on the treatment and care provided in the service. In the community services there was also information on other services that could offer the patient support. Independent mental health advocacy leaflets were available on the inpatient wards. Whilst information leaflets in other formats, such as large print or other languages, were not displayed in services, all staff told us that this could be accessed when required by a patient, carer or relative. Staff in all services confirmed that they had access to interpreters and translation services where this was required.

During the inspection staff told us they could accommodate different cultural, spiritual and religious needs in both the inpatient and community settings. Staff told us that patients were encouraged to continue to attend their own religious meetings as much as possible. Staff said there was a diversity team at the trust whom they could seek advice from.

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 were encouraged to visit their usual chosen place of faith. Also, the trust were able to provide a choice of food in order to meet the dietary requirements of different religious and health needs, for example, vegan, vegetarian and coeliac diets as well as kosher or halal meat if required.

Listening to and learning from concerns and complaints

The customer services team was responsible for managing compliments, comments, concerns and complaints. This included feedback from the patient advice and liaison services. The manager of the customer service team reported to the company secretary, who reported to the Board via the medical director and director of nursing, clinical governance and safety. The customer service team supported service users and others raising issues, regardless of whether feedback is handled as a complaint, concern, comment or compliment. The business delivery units (BDUs) ensured that the insight gained from the feedback was acted upon to improve, plan, develop and evaluate service delivery. This was supported by the current Customer Services Policy: supporting the management of complaints, concerns, comments and compliments. This was reviewed by the trust board annually. All complaints were inputted onto the Datix information management system. This enabled weekly complaints reports to be sent to the business delivery units and the trust board. Annual complaints audits were completed by the customer service accreditation and an external company. The trust had key performance indicators for its timescales in responding to and resolving complaints. There was a monthly customer service group which facilitated staff in sharing their learning.

The trust received 707 compliments between 1 February 2015 and 31 January 2016), with the Health Trainers Team in Wakefield based at Castleford, Normanton & District Hospital receiving the most with 123. Two hundred and sixty five complaints were received between 2014 and 2015, compared to 338 received in 2013-14. Three hundred and six complaints were received between 1 February 2015 and 31 January 2016 and of these; six complaints were referred to the ombudsmen. The highest number of complaints received for both 2013 to 2014, and 2014 to 2105, were categorized as 'all aspects of clinical treatment' and 'communication and information to patients (written and oral).

Five complaints records were reviewed. All five records demonstrated that people were supported to complain. The records demonstrated that the complaints were handled appropriately, with people being supported with compassion. There was evidence for all but one complaint where the staff were unable to contact the complainant,

Are services responsive to people's needs?

that there were full thorough investigations, excellent records keeping, with details of the root causes of the complaint, the evidence gathered, the recommendations and the suggested mechanisms for sharing the learning. For example, we saw evidence that paperwork had been updated as a result of a patient complaint. We observed that complaints had been reviewed by the executive board and the non-executive directors. We saw evidence that the trust was good at keeping the complainant updated on the progress of the complaint. However, the records were not clear that these complaints had been appropriately risk assessed by an appropriate individual, for example by a medical director or the director of nursing, where a patient was involved.

Patient in all the services we inspected confirmed they knew how to raise concerns or complaints. Most wards or services gave patients information to complain on admission or entry into the service. We observed posters and leaflets in all the patient areas in both community services and the inpatient wards within the clinical waiting areas that we visited, except for the psychiatric intensive care unit, Trinity One in Wakefield. Information on this ward

about how to complain was not displayed on the ward which meant patients may not be fully aware of how to make complaints. The family and carers we spoke to also demonstrated they would know how to make a complaint.

However, in one of the patient focus groups we attended, the service users stated that they had made complaints about the trust decision regarding psychological therapies but the customer service team had addresses their complaints as concerns. They had since addresses this with the trust to request they were readdressed as complaints.

On the inpatient wards for people with mental health problems, for example the wards for older people, the acute wards and long stay rehabilitation wards, patients were able to alert staff to their concerns and complaints, for example about food and activities, which they were provided with feedback on.

All the staff we spoke to understood how to respond to complaints in line with the trust policy. Attempts would always be made to resolve the complaint informally in the first instance. Learning from complaints was shared in the team meetings and in full service meetings.

Are services well-led?

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

Summary of findings

Our findings

Vision, values and strategy

The trust had a strategy for 2014-2019, which established its long-term vision and strategic goals, and the outcomes framework to measure its progress. An operational plan for 2014 to 2016 set out the trust wide priorities for these two years, including the challenges at service level and board level, as well as improvement and development objectives. Fundamental to this strategy and operational plan was the trust's commitment to their programme of 'transformation': transforming their services to ensure that they continue to meet people's needs, offer the best care and improved outcomes, and also offer the best value for money. The trust grouped their transformation plans into four key areas: forensics, general community, learning disabilities and mental health.

The trust worked closely with key stakeholders, including staff, patients and governors, in 2013 to 2014 to co-create its mission, vision and values, fundamental to its programme of transformation. In the following year, 2014 to 2015, the trusts revised vision and values were embedded across the organisation in an overarching development approach, known as the 'year of values,' with plans to staff in these value-based behaviours. The trust have continued to build on this work and annually review these values to ensure these are still fit for purpose.

The trust's vision was 'Enabling people to reach their potential and live well in their community'. The trust's six values were as follows:

• Honest, open and transparent.
• Respectful.
• Person first and in the centre.
• Improve and be outstanding.
• Relevant today, ready for tomorrow.

• Families and carers matter.

The trust values were embedded in the business delivery units and reflected in the staff behaviours we observed during our inspection. Most staff were able to tell us what these were and how they were used during their supervision and appraisal process in order to reflect on their practice. The trust's mission and values were displayed in the all the inpatient wards we visited. The trust completed values based recruitment.

The executive board members and non-executive board members confirmed that they completed both announced and unannounced visits to the services. The non-executive board members gave us examples of when they had visited the wards in order to gain further assurance about the information they received. Most staff were aware of their local management structures up to the trio of managers responsible for their business delivery unit. They also knew who the chief executive was. However, staff were less familiar in recognising the senior management levels in-between and the non-executive directors.

There was a lack of awareness of Board level representation among staff in community services for children and young people.

Good governance

The trust board of directors were accountable for the running of the trust. They were responsible for setting the strategic direction and associated priorities for the trust, for ensuring that there was effective governance for all services, and for providing a focal point for public accountability. The executive management team provided executive oversight and decision making at an operational level. The executive team ensured that resources were deployed to support the delivery of the trust's plan, that performance was scrutinised and challenged by the business delivery units, and that the work of the executive management team was aligned with the trust board.

The executive management team had four organisational development structures within it: transformation, strategy and risk, delivery, and extended executive management team. The extended executive management team structure

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engaged first line reporting staff in the service transformation and delivery. The organisational requirement group which focussed on the delivery of the operational plan 2014 to 2016 and supported the work of the executive management team. The organisational development group was the forum for each lead director to report on the delivery of the key initiatives that they were responsible for and aligning these to the organisational development. Both were chaired by the chief executive.

There were six non-executive directors and a chair that made up part of the board. All the non-executive directors spoke positively about their role in the trust and the trust itself. They confirmed that they received an induction and an annual appraisal to support them in their role. They gave examples of the how the trust demonstrated a commitment to its values and confirmed that patients had been encouraged to share their experience directly with the Board, either at board meetings or via a non-executive director who met with the patient prior to the meeting. The non-executive directors told us that the information was reported by exception but they maintained that they felt they received sufficient assurance from the trust, and where they required further information, they felt confident in asking for this, and the additional information would be provided. The non-executive directors also told us that they received further assurance from planned and unplanned patient safety walks and visits to the services in the trust.

A members' council of governors provided a link between the local communities and the board of directors. The members' council was responsible for contributing to the development strategy, holding the board to account for its decisions, ensuring effective appointments of the Trust Chair and non-executive directors, and the appointment of external auditors. The trust identified finding a cross section of council members to reflect the demographics of the population as a challenge. Staff, service users and carers, and local partnerships were represented by the council members. The governors elected to the council attend the trust board meeting held eight times per year. They told us that they received the meeting agenda and papers well in advance of the meetings to help them prepare. They were also offered a training session to support them in their role. Like the non-executive directors, they also told us they received additional assurance form visiting the wards and community services. A formal process had been established for raising questions to the board and receiving a response in a timely manner.

The trust had four committees, which reported directly to the board: the clinical governance and clinical safety committee, the remuneration and terms of services committee, the Mental Health Act committee, and the audit committee.

There were also three time-limited committees that reported to the board: the equality and inclusion forum, the estates forum, and the information management and technology committee.

Feeding into these committees were a number of sub committees, action groups and sub groups which formed the transformation programme work streams.

Representatives on these transformation programme work-streams included district directors for the trust business delivery units. These business delivery units were the delivery mechanisms for the trust within geographical or specialist service areas. There were five business delivery units: specialist services, Calderdale and Kirklees, Forensic mental health services and child and adolescent mental health services, Wakefield and Barnsley. Each business had the delegated authority to ensure the effective delivery of the trust plan within an effective performance framework for that business delivery unit.

Each service line within the business delivery unit had management and leadership arrangements through a 'trio.' The trios included a general manager, a clinical lead, and a practice governance coach. All staff confirmed that since the introduction of these trios between 2014 and 2015, there had been an improvement in service delivery and in the understanding of the transformation programme.

We found that staff awareness of senior leaders within community health services was variable and staff reported that they did not feel that community health services were visible in the wider trust.

The trust risk register was in place as required by the trust risk policy and procedure. However the risk management procedure was not current as it had not been reviewed in 2014. Risk registers were held at trust board level and by each business delivery unit The risk registers held by the business delivery units were reviewed and any risks which could have an impact across the trust were reported to the executive management team. These risks were recorded on the trust risk register. Risk registers were also held in the trust action groups responsible for the trust programmes

Are services well-led?

and projects. A risk matrix as used to assess risk levels. All the staff we spoke to confirmed that they were able to feed into the trust risk register via their local risk register and their team manager.

There were eleven risks recorded on the trust corporate risk register.

There was one severe risk (20 plus rating on the matrix) for the child and adolescent mental health services. This related to the risk in 2016 to 2017 that the trust would be unable to secure sufficient funding to support a sustainable child and adolescent mental health service. The remaining 10 risks were categorised as trust-wide risks, and all were logged as severe. They included the:

- Capture of clinical information on RIO will be insufficient to meet future compliance and operational requirements to support service line reporting and the implementation of the mental health currency leading to reputational and financial risk in negotiation of contracts with commissioners.

- Implementation of new currency models for mental health and community services will move the current funding arrangements from block contracts to activity-based contracts. This could present clinical, operational and financial risk if cost and pricing mechanisms are not fully understood at local, regional and national level.

- Risk linked to local authority as providers. Continued reduction in Local Authority funding and changes in benefits system will result in increased demand of health and social care services which would impact on capacity and resources in integrated teams where local authorities are providers. Reduced funding in provision by local authorities would reduce the service capacity within integrated teams and pathways which would create potential service and clinical risks, including impact on waiting times, assessment and management of risk.

- Risk that the planning and implementation of transformational change through the transformation programme would increase clinical and reputational risk in in-year delivery by imbalance of staff skills and capacity between the 'day job' and the 'change job'.

- Bed occupancy was above that expected due to an increase in acuity and admissions, which was causing pressures across all bed-based mental health areas across the Trust.

- Risk of adverse impact on clinical, operational and financial risk if the Trust was unable to manage the transition in year three of the five-year plan, as the plan states that the Trust would be operationally, clinically and financially unsustainable by the end of 2016 to 2017 in its current configuration.

- Risk that the trust's financial and service viability will be adversely impacted as a result of local commissioning intentions from Clinical Commissioning Groups and local authorities which require either cash reduction in contract as a response to austerity with requirement for different models of care across different geographies which reduce the opportunity for generating service synergies and economies of scale across pathways.

- Risk that trust's clinical operational and financial sustainability will be adversely impacted on in 2016/17 by impact of local commissioning intentions from CCGs and local authorities which include reductions in national funding due to impact of changes in national allocation, level and pace of requirement by CCGs for QIPP savings, and level of priority for spending on mental health and community services versus other system pressures.

- Risk related to local authority as commissioner. Impact of continued reduction in Local Authority budgets may have negative impact on level of financial resources available to commission services from NHS providers which represents a clinical, operational and financial risk, in particular for services commissioned by public health, which includes 0-19 services, health and wellbeing and drugs misuse.

- Reputational risk and financial risk due to increase in reported information governance incidents to Information Commissioner.

Risk management systems were scrutinised by the Audit Committee, supported by internal audit and external audit, and the overall management of risk was monitored by the Trust Board, through the Board Assurance Framework and risk register.

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The role of internal audit was to provide an independent and objective opinion to the Chief Executive and Trust Board on the system of control. The work of internal audit was undertaken in compliance with the NHS Internal Audit Standards. The audit programme was based on a risk assessment of the Trust, using the Assurance Framework and the Trust's risk register. Action plans were agreed to address any identified weaknesses. The Audit Committee relied on internal audit to provide assurance to the Board on the effectiveness of these action plans.

All eleven risks on the trust risk register we observed had appropriate action plans in place.

Internal audit is required to identify any areas to the Audit Committee where it is felt that insufficient action is being taken to address risks. External audit also plays a key part in identifying key risks to the organisation in relation to its work and in the monitoring and review of the trust's systems and processes, particularly in relation to financial probity and value for money.

Whilst the governance structures were in place and the board told us they felt assured by the information they received, we observed some areas where they could not be assured in relation to the information they were receiving.

There was no consistent training in the trust which included the 2015 MHA code of practice and its implications for staff delivering care. The Mental Health Act and the code of practice training, and the Mental Capacity Act and Deprivation of liberty safeguards training, was not mandatory. We found that staff training had been arranged locally in some areas but this differed across areas of the trust. There was no clear mechanism for the trust to monitor its compliance with the MCA or the DoLS across the organisation, or the MHA code of practice (2015). The board did not have an understanding of the quantity or the quality and content of the training being delivered.

The trust was rated as 'Satisfactory' in the 2014/15 Information Governance Toolkit.

However, the trust information systems did not allow the easy reporting of accurate data and information on the performance of services. Reports requested from the trust contained conflicting or inaccurate information regarding the services provided.

Staff confirmed during focus groups that there were issues across services with the RIO information system used by

the trust with regard to the data being recorded and the reports generated. In the focus groups, staff in some services reported that they had internal systems in place to manage the issues with the system, for example being unable to log onto the system, the system not saving entries, and not all the forms working on the system. Therefore the reports being generated were inaccurate as data was not being inputted. For example, the report on patient contacts were inaccurate, because they were unable to input into the system to record the information required for the report. The trust had consulted legal advice in response to the system and this was on their risk register. There was no consistency to the contingency plans implemented in services, and some managed this better than other services.

There was inconsistency in the use of the electronic systems and paper records in some community services and wards across the trust. The learning disability and autism service used different electronic recording systems based on their location within the service and geographic area. These systems did not communicate and there were no process in place to ensure information was shared across teams effectively. In the community mental health services for adults of working age, there were periods of time where the RIO electronic care records system was not accessible due to issues with the system itself, and there were insufficient systems in place to manage this. In addition, patient information was not easily accessible on the wards for patients with learning disabilities and autism.

The trust could not provide accurate data relating to waiting times in the specialist community child and adolescent mental health services. They had been working on data quality and were confident that recent data was accurate and consistently recorded. Unfortunately the trust was not confident that data input in to the system prior to April 2015 was accurate. This affected the data available for Barnsley in particular. The trust were not able to provide combined data for how many cases individual clinical staff were working with or how many patients were waiting for therapy. It was therefore not possible to determine how effectively and efficiently the trust were managing capacity and demand within the service. It was not possible to identify potential bottlenecks within the workflow.

Recruitment of staff was a significant issue for the trust. The trust described the challenges, and its proactive approach in recruitment and staff development schemes. The trust

Are services well-led?

had carried out a safer staffing review in 2015. This included a monthly report by wards on different issues that affected staffing including acuity, needs of the patient group and staff sickness. Following this review the trust had implemented minimum staffing levels of qualified and unqualified staff for each of the older adult wards across the trust. This information had also been used to inform skill mix. During our inspection we saw managers on the wards for older age adult with mental health problems, working with this to ensure that wards were staffed to the minimum staffing levels set by the trust. Although the wards for patients with learning disabilities or autism had experienced high levels of sickness, they ensured enough staff were on duty to meet the needs of the patients.

However, on the inpatient acute wards for adults with mental health problems and the acute wards, there were insufficient staff to enable patients to take leave and for activities.

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. Regular review of policies and procedures is necessary to ensure that they reflect current good practice or changes in legislation. The trust had a suite of medicines related policies and procedures. However, as identified on the pharmacy risk register several of these documents were overdue for review, due to a "lack of pharmacy team capacity." A work plan had been put in place to try and address this by the end of 2015/16.

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. Mandatory training was 86% across the trust, which was above the trust's target of 80%. Supervision and appraisal rates were high, except on the acute wards for patients with mental health problems, where there was insufficient supervision on some of the wards. Most of the community services and inpatient wards completed clinical audits. However, the community services for people with learning disabilities or autism reported little engagement in clinical audits within the service apart from the clinical records audit.

The trust used key performance indicators to measure performance. Team managers had access to an electronic dashboard called the work performance wall. These

provided team mangers with up to date and accurate data and supported managers to monitor compliance with supervision, sickness management and training needs of the staff team. The system provided a red, amber, and green rating system to enable managers to quickly identify staff who required sickness absence meetings, return to work reviews, or were becoming out of date for mandatory training. The use of key performance indicators to gauge team performance was inconsistent at service level, and within services. Some team managers reported that there were systems in place to manage performance and that they received feedback when performance needed to be improved, for example, the long stay rehabilitation service were supported to improve their mandatory training performance levels.

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.

However, in the community learning disability services, teams who were co-located within local authority teams did not report their performance formally to the trust. There were teams which did not have a team leader in post placing greater responsibility on other members of the team. The systems and processes to monitor the quality and safety of services integrated with local authority services were not in place for the community learning disability or autism service.

The trust had long waits in some areas to access the community child and adolescent mental health services. There was also long waits experienced by the community services to access psychological therapies. Access to this service and psychological therapies was being addressed by the transformation programme. However, current systems and processes were not adequate to manage these waiting lists or the risks for the patients whilst on these waiting lists.

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.

Are services well-led?

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. On the acute inpatients mental health wards, we saw no evidence that high dose monitoring was routinely carried out. Pharmacists had noted on charts that it should be done; however, we could not find evidence of the monitoring taking place. There were no completed monitoring forms and no information in patient records. On the long-stay and rehabilitation wards, patients who were prescribed high dose antipsychotic medication did not have physical health monitoring including electrocardiograms in line with national guidance.

Finally, in the long stay and rehabilitation service, the governance structures in place to monitor and improve services were insufficient. Patient risk assessments were not completed on admission and updated at regular intervals, following incidents and changes in presentation. Patients did not have regular multidisciplinary review meetings to ensure timely and appropriate review of care and treatment. In this service the clinical governance coach post for the trio for that service had been vacant for 12 months.

Fit and Proper Person's test

The trust policy for the trust board declaration and register of fit and proper persons, independence, interests, gifts and hospitality was approved by the trust board on the 31 March 2015, following the requirement to ensure that its executive directors and non-executive directors meet the Fit and Proper Persons Requirement (FPPR), (Regulation 5 of the Health and Social Care Act (Regulated Activities) Regulations2014).This regulation ensures that directors of NHS providers are fit and proper to carry out this important role. This was reflected in the minutes from the trust board meeting of the 31 March 2015.

The trust policy details the chair's responsibility to declare to the Care Quality Commission (CQC) that the fitness of the directors has been assessed in line with the this regulation, and that they are satisfied that the individual is fit and proper to be able to fulfil their role and do not meet any of the unfitness criteria specified in Schedule 4, Part 1 of the Health and Social Care Act 2008 (Regulated

Activities) Regulations 2014. The trust submitted its most recent declarations to the (CQC) on the 2 February 2016 to confirm there were two new directors and these relevant checks had been completed.

The trust policy approved by the board on 31 March details the trust's responsibilities 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. It also states that the Company Secretary is responsible for ensuring that these procedures are in place for non-executive directors and other director appointments.

We reviewed the personnel files of six executive directors on the board, and six non-executive directors, which included the Chair.

All six executive directors had job descriptions, application forms, evidence that references were sought and provided, copies of relevant professional certificates. Two of the six files contained the self-declaration forms to indicate that the human resources department at the trust had checked the directors against insolvency, director disqualification, bankruptcy and debt relief, and with Companies House.

The six non-executive directors' personnel files contained a trust profile with photographs. There was evidence in these files that new non-executive directors had been inducted and those that had been there over a year had an appraisal, which included feedback from the members council. However, the files did not contain all the evidence that the relevant checks had been completed under the fit and proper person requirement, for example there was no evidence that the human resources department had made the relevant checks with regard to bankruptcy, director disqualification or insolvency. Only the Chair's personnel file had then original application form contained in the file, though this contained one of two suggested references.

The fit and proper person declaration that was required to be completed by the chair and the directors of the trust required them to agree for checks to be made on the individual against the children's barred list or the adults' barred list maintained under section 2 of the Safeguarding Vulnerable Groups Act 2006, or in any corresponding list maintained under an equivalent enactment in force in Scotland or Northern Ireland. Only one of the personnel files reviewed for the non-executive directors contained a current disclosure and barring certificate to confirm these

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checks had been made. Without a check with the disclosure and barring service, the trust did not fully comply with Schedule 4 part 2 of the Regulation to ensure appointees are of good character.

Interviews with both the Director of HR and workforce development and the Trust Board Secretary confirmed that three of the new non-exec directors had not had checks with the disclosure and barring service despite being recruited since March 2015 when this Declaration of Interests Policy for Directors of the Trust Board, including Fit and Proper Person Requirement, was reviewed and agreed at the Board on the 31 March 2015, ready for the fit and proper person requirement, which came into force on the 1 April 2015 and earlier for NHS bodies on the 1 October 2014.

The non-executive directors we spoke to confirmed that as part of their role they came into contact with patients as they gained further assurance from completing ward tours and speaking to patients. However, the trust confirmed that they never went on the wards unescorted.

Leadership and culture

The NHS Staff Survey 2015 showed that the trust performed better than the national average for all mental health and learning disability trusts for the percentage of their staff having to work extra hours, the percentage their staff suffering from work related stress in the last 12 months and the percentage of their staff experiencing harassment, bullying or abuse from other staff in the last 12 months. It performed in the highest 20% of trusts with regard to their staff satisfaction with the quality of work and patient care they were able to deliver, their staff satisfaction with resourcing and support, and the percentage of staff believing the organisation provides equal opportunities for career progression and promotion.

The trust performed the same or similar to other mental health and learning disability trusts relating to:

- Staff recommending the organisation as a place to work or receive treatment.
- The percentage of staff agreeing that their role makes a difference to service users.
- Staff recognition and value by managers and the organisation.
- Staff satisfaction with their level of responsibility and involvement.
- Effective team working.

- Support from immediate managers.
- The percentage of staff appraised in the last 12 months.
- The quality of the appraisals.
- The quality of non-mandatory training, learning or development.
- The percentage of staff satisfied with the opportunities for flexible working patterns.
- The organisations and managements interest in and action on health and wellbeing.
- The percentage of staff experiencing discrimination at work in last 12months.
- The percentage of staff witnessing potentially harmful errors, near misses or incidents in last month.
- The percentage of reporting errors, near misses or incidents witnessed in the last month.

However, the trust performed worse than the national average of all mental health and learning disability trusts for questions related to:

- Staff feeling motivated at work.
- The percentage of staff feeling under pressure in the last months to attend work when feeling unwell.
- The percentage of staff experiencing physical violence from patients, relatives or the public in the last 12 months.
- The percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months.
- The percentage of staff reporting most recent experiences of violence.
- The percentage of staff reporting most recent experiences of harassment, bullying or abuse.
- Percentage of staff reporting good communication between senior management and staff.
- Percentage of staff able to contribute towards improvements at work.
- The fairness and effectiveness of procedures for reporting errors, near misses and incidents.
- The staff confidence and security in reporting unsafe clinical practice.
- The effective use of service user feedback.

In addition, 54% of respondents in the staff Friends and Family Test were either 'likely' or 'extremely likely' to recommend the Trust as a place to work which was slightly lower than the England average of 62% in the most recent quarter which was Quarter 2 2015/2016 (1 July 2015 to 30 September 2015).

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There were three whistleblowing concerns raised with the CQC relating to the trust between 1 January 2015 and 31 December 2015. Two were raised against Fieldhead Hospital and one against Enfield Down. Two further whistleblowing concerns were raised during the inspection against the trust. All staff we spoke to confirmed that they were aware of the trust's whistleblowing policy and reported that they felt able to raise concerns without fear of victimisation or reprisal.

During the inspection, we held a number of focus groups with staff in a range of roles, and from different services across the trust localities. All the staff we spoke to spoke positively about their work. The majority of staff felt supported in their roles, though there was a difference of opinions about the communication around the transformation programme, including the new community hubs, the twelve hour working patterns, and the computer system, which all contributed to some dissatisfaction for some staff.

All staff reported that morale was good, or improving. The delays and communication around the transformation programme was reported as a challenge to staff morale, particularly in the community mental health services, including those for learning disabilities services. Insufficient staffing was reported as a concern for staff morale in the acute and forensic mental health services. This was supported by the information we received from staff side, the staff union representatives.

All the staff we spoke to told us that they had good, supportive relationships with their team, and that local managers were supportive and approachable. Staff felt supported by the trio that managed their service line, including the clinical lead, the general manager and the practice governance coach. The introduction of a 'trio' for each location was seen to be positive by all staff.

Engagement with the public and with people who use services

The trust's first quality priority was to continue to listen and act on patient feedback to continually improve the patient experience of their services. The trust was high performing on this priority, achieving over 75% of the target they set themselves. The quality improvement and assurance team were responsible for supporting local and national patient experience initiatives. The quality improvement groups and customer service group were led by the director of nursing,

clinical governance and patient safety and the company secretary respectively. In this way, patient experience and engagement information, including concerns, complaints, compliments, and comments, information travelled between the board, the committees, and the business delivery unit by the lead directors. The trust had an equality and diversity report called 'equality first' and an 'equality analysis' that supported the plan for patient engagement and involvement.

Engagement with the service users included the friends and family test, the trust wide experience survey focussing on how much people felt involved in their care, and the annual service user information project, which involved service users and staff reviewing the trust's information to ensure that it is relevant, up-to-date and in line with national standards.

Service users were involved in a programme of engagement for large scale transformations about the future of the services, as part of the 2014 t0 2019 strategy. This was in a range of locally based activities delivered by the business delivery unit for that geographical area or specialist service area.

Building on the listening events as part of the transformation programme held in 2013, to keep local people involved and engaged in the transformation of their adult community mental health services, people were invited to events in 2015 in their localities to hear the service changes proposed and to have an opportunity to feedback. More than 300 people attended these 'Next Steps' events, including service users, carers, staff and members of the public. The trust presented proposals for intensive home-based treatment teams, single point of access, and community mental health services.

The trust had published a 'what matters: listening to and acting on service user feedback' publication, which included feedback from the trust's engagement activities.

There was a mixed response from staff and patients in the focus groups that were held as part of the inspection. Some staff, particularly those on the mental health inpatient wards, told us that there had been lots of patient engagement, including in the transformation plans. However, other staff told us that patients had not had a chance to be involved in any consultation, more so those patients in the community mental health services and those receiving support from the psychological services.

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The executive directors told us that the trust's goal was to move from engagement and involvement to co-production through service users attending the local 'recovery colleges' and completing courses to support them in moving through their recovery, along with peer volunteers and staff. They also told us that service users had been involved in recruitment, which was confirmed by other staff levels.

The members council included a service user and carer representative.

Quality improvement, innovation and sustainability

The trust's strategic plan for 2014 to 2019, confirmed the financial, operational and clinical sustainability for the trust. The trust were committed to a programme of 'transformation,' including the creative minds initiative that the trust has invested in that uses creative approaches and activities in healthcare supports this transformation work. The Creative Minds initiative had won the Health Service Journal Award for Compassionate Patient Care. The strategic plan 2014 to 2019, which identified the opportunities and challenges for the business delivery units and the service transformation, was being delivered through the operational plan 2014 to 2016.

The emphasis for sustainability for year three onwards of the strategic, five year plan was through continue the journey towards enabling recovery and promoting care through initiatives like Creative Minds, trust growth through partnerships at different levels, for example regional partnerships for urgent and emergency care as part of vanguards, and district based services integrated with locality partnership services. The trust were also committed to successful national procurement of specialised services.

The trust had the following seven quality priorities for 2015 to 2016:

- Service users are central to what we do.
- Timely access to services.
- Improve care and care planning.
- Improve recording keeping and data quality.
- Improve transfers of care by working in partnership across the care pathway.
- Ensure that our staff are professionally, physically and mentally fit to undertake their duties.
- Improve the safety of our service users, carers, staff and visitors.

These priorities, including the trust's quality plan for 2014 to 2017, were determined by the patient experience feedback, the trust's Commissioning for Quality Improvement Scheme (2015-16), the trust's annual governance report, and from the trust's consultation with their stakeholders about their priorities for the coming year through the Quality Account Survey.

The trust had challenging performance indicators against each of the seven quality priorities. The trust maintained a good standard of performance against the majority of these indicators, with continued high performance in the areas of listening and acting on patient feedback, working across care pathways and patient safety.

A quality improvement group was set up with cross-organisational multi-professional quality leader representation, overseen by the Director of Nursing, Clinical Governance and Patient Safety. This group was responsible for implementation and ongoing monitoring of the trust's quality improvement plan. The measures identified within the quality priorities 2015 to 2016 within the quality account were measured through monthly quality and performance reports were produced for the executive management team performance meetings, which included staffing, incident management, revalidation and clinical risks, a bi-monthly quality account report produced for the clinical governance and safety committee, and through the Clinical Commissioning Groups via the Quality Board meetings.

Improving the quality of data remained one of the trusts key strategic priorities. There was continued focus in 2014-15 on improving the quality of clinical record keeping. This underpinned the delivery of safe effective care and assured the executive management team and the trust board that data taken from the clinical record and used for activity and performance monitoring and improvement is robust.

The trust had developed a quality impact tool to help them identify any risks around cost improvement programmes, service changes and transformation plans. It linked with the trust's seven quality priorities and covered three aspects of quality: person-centred, safe, and efficient and effective. During the inspection, we observed comprehensive data dashboards available to the managers from the board to the business delivery units, which monitored the effectiveness of the business delivery units annually against the seven quality priorities.

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The trust used its annual clinical audit programme to make sure improvements were implemented and sustained. The clinical audit and practice evaluation strategic overview was part of the trust's broader organisational quality framework. Local and national audit, as well as service evaluation were supported by the trust quality improvement and assurance team.

This team were responsible for assessing the trust against national guidance and regulatory bodies. In 2015 to 2016, they completed 39 quality visits to eight inpatient units and 24 community services. After each visits reports were produced and circulated to the relevant business delivery units to facilitate learning in the appropriate service lines. In addition, the team was responsible for local and national patient initiatives.

The trust recognised that the non-clinical support teams like human resources, finance and corporate development were integral to supporting the front-line clinical services in delivering quality interventions and services. This group of services were known as the quality academy.

The trust participates in the following national/ service accreditation & peer review schemes:

- Baby Friendly HV re assessment report 2015-14.
- Barnsley joint re assessment report letter 2015-05.
- Barnsley joint re assessment report letter 2015-05-20.
- Stroke Services Peer Review Jan 2014.
- AIMS PICU Draft report – Draft Peer Review Report – Melton Suite PICU – 25 March 2015.
- AIMS PICU final report – Trinity 1 – 24 June 2015.
- ECTAS Calderdale ECT Clinic- Peer Review Report Cycle 3 – 23 June 2010.
- ECTAS Fieldhead ECT Clinic – Peer-Review Report Cycle 2 – 17 June 2010.
- MSNAP – Barnsley MSNAP standards consultation document.
- MSNAP Calderdale Older People's Memory Service – 1 June 2015.
- MSNAP Wakefield Memory Service Final report (Accredited 28 April 2015 to 28 April 2017.
- QNCC New Street Health Centre – 2013 Final Report – Feb 2014.

- Quality Network for Forensic Mental Health Services. Last peer review in December 2015. Review Summary Low Secure Services – Bretton Centre and Newhaven Unit – December 2014. Review Summary – Medium Secure Services – Newton Lodge – December 2014.

The trust have not and or do not participate in the following national accreditation/peer review schemes:

- The Community of Communities Scheme.
- The Home Treatment Accreditation Scheme (HTAS).
- The Quality Network for Inpatient Learning Disability Services (QNLD)
- The Psychiatric Liaison Accreditation Network (PLAN).
- The Quality Network for Perinatal Mental Health Services. (However, the trust does participate in the Y&H perinatal MH Network).

There were some examples of good practice throughout the trust in relation to innovation and service improvements, in addition to the transformation agenda.

All inpatient wards for patients with mental health problems had been involved in a project to reduce length of stay. This was done by an outside agency, which looked at barriers and how to reduce length of stay.

The trust had four 'recovery colleges' in its local districts. The courses delivered at the recovery colleges had been developed and delivered by people who had experience of health problems. They offered different learning opportunities to support patients in their recovery.

The older adult wards were just beginning the process of rolling out the safe-wards model of care. This was about reducing restrictive practices in mental health and learning disability settings by using positive language to reduce conflict in mental health settings, in particular the use of restrictive practices such as restraint.

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.

This section is primarily information for the provider
Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 5 HSCA (RA) Regulations 2014 Fit and proper persons: directors How the regulation was not being met: 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 is a breach of regulation 5 (3) (a)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing How the regulation was not being met: Mental Health Act and Mental Capacity Act training was not mandatory for any staff and was not monitored for effectiveness by senior management of the trust. This is a breach of regulation 18 (2)(a)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983	Regulation 17 HSCA (RA) Regulations 2014 Good governance How the regulation was not being met: The 2015 MHA code of practice had not been implemented across all services of the trust. This is a breach of regulation 17(2)(a)

Regulated activity	Regulation

This section is primarily information for the provider
Requirement notices

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

Diagnostic and screening procedures

Treatment of disease, disorder or injury

Regulation 17 HSCA (RA) Regulations 2014 Good governance

How the regulation was not being met:

Care records were both electronic and paper based and staff did not have access to contemporary, accurate and comprehensive patients records.

This is a breach of Regulation 17(2)(c)