

South West Yorkshire Partnership NHS Foundation Trust

Inspection report

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

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

This report is a summary of our inspection findings. You can find more detailed information about the service and what we found during our inspection in the related Evidence appendix.

Ratings

Overall rating for this trust

Good 

Are services safe?

Requires improvement 

Are services effective?

Good 

Are services caring?

Good 

Are services responsive?

Good 

Are services well-led?

Good 

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

Summary of findings

Background to the trust

South West Yorkshire Partnership NHS Foundation Trust formed in April 2002 and became a foundation trust in May 2009.

As a foundation trust the organisation is accountable to their members, who can have a say in how services are run and how they would like services to be developed. Approximately 14,300 local people including staff are members of the trust.

The trust is a provider of mental health, community health and learning disability services to a large geographical area covering Barnsley, Calderdale, Kirklees and Wakefield. The trust also provides some low and medium secure services to the whole of Yorkshire and Humber.

The trust had seven active locations at the time of inspection. These locations were spread across different hospital sites. They include, the Dales, Halifax, Priestley Unit, Dewsbury, Poplars Community Unit for the elderly, Pontefract, Enfield Down, Holmfirth, Fieldhead hospital, Wakefield, Kendray Hospital, Barnsley and Lyndhurst, Halifax. There were 471 inpatient beds across the trust over 30 wards.

The trust employs approximately 4,700 staff in both clinical and non-clinical support roles.

The trust is commissioned to provide services by a number of organisations: NHS England specialist commissioning, local commissioning groups, they work with local health and care partnerships which cover the Calderdale, Kirklees, Wakefield and Barnsley area and are part of the integrated care systems covering West Yorkshire and Harrogate.

We last inspected South West Yorkshire NHS Partnership Foundation Trust in April 2018. At that inspection we rated the trust requires improvement overall, with requires improvement for both the safe and responsive domain. The trust rated good overall for effective, caring and well led.

At that inspection we issued 14 requirement notices to the trust. That meant the trust had to send us an action plan saying what action it would take to meet the requirements.

Our action related to breaches of five legal requirements across the trust wide well led and four core services.

Regulation 9 - person centred care

Regulation 12 – safe care and treatment

Regulation 15 – premises and equipment

Regulation 17 – good governance

Regulation 18 – staffing

We told the trust that it must act to bring services in line with the 14 legal requirements. This related to four core services and the trust wide well led key lines of enquiry.

Trust wide

- The trust must ensure a trust wide approach to reducing restrictive practices across all inpatient wards

Specialist community mental health services for children and young people

- The trust must ensure that all community environments are assessed, reviewed and secured so that they provide the appropriate level of security for the service being delivered

Summary of findings

- The trust must ensure that staffing issues around the out of hours on call service are monitored, reviewed and resolved
- The trust must continue to take action to reduce waiting times and access to treatment times for the autism spectrum disorder specialist pathway.

Community-based mental health services for adults of working age

- The trust must ensure that staff suitably assesses and review, as required, all risks relating to clients' care and treatment. This must include assessment of management plans and crisis plans in order to mitigate risks
- The trust must ensure that staff within the service have access to, and keep up to date with their required mandatory training
- The trust must ensure that people are able to access support and treatment they need in a timely manner and take action to reduce excessive waiting times for treatment.

Wards for people with a learning disability or autism

- The trust must ensure that there are effective systems and processes in place to assess, monitor and review blanket restrictions
- The trust must ensure that there are effective systems and processes in place to assess, monitor, and improve the quality of patients and carers experience.

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

- The trust must ensure that staffing levels are sufficient to meet the needs of patients, provide therapeutic activity and enable staff to adhere to trust policies and procedures
- The trust must ensure that staff are compliant with mandatory training, including sufficient numbers of staff on all wards trained in cardiopulmonary resuscitation
- The trust must ensure that staff adhere to their policy and the Mental Health Act Code of Practice in the care and treatment of patients in seclusion
- The trust must ensure that staff undertake the required physical health monitoring following the administration of rapid tranquilisation and that all episodes of rapid tranquilisation are documented correctly
- The trust must ensure that staff adhere to their policies in the safe management of medicines and that medication administration records are signed when medication is being administered
- Staff must ensure they assess patients' risk at the intervals outlined in the trust policy and that this is reflected on the risk assessment tool. Staff must ensure they document their assessment of patient risk prior to them leaving the ward for Section 17 or informal leave
- The trust must ensure that staff complete Section 17 leave forms in full and this reflects that patients and their carers understand their responsibilities and the requirements of the leave
- The trust must ensure that restrictions placed on patients are based on an individual assessment of risk and need and that there is a formal process across the service to record and review these restrictions. The trust must ensure that informal patients are able to take their personal belongings when they leave the ward
- The trust must ensure that staff monitor and record clinic room temperatures, fridge temperatures and checks of emergency equipment in line with trust policy. The trust must ensure oxygen cylinders are in date and stored correctly

Summary of findings

- The trust must ensure that patients have easy access to summon assistance from their bedrooms across all wards
- The trust must ensure that the systems and process in place to monitor the performance of the ward are effective and are used to improve the care and treatment provided. This includes the accurate recording of staff supervision
- The trust must ensure that patients and their families and carers are involved in the planning of their care and treatment. The trust must ensure that care plans are personalised and reflect the patient's voice.

Forensic inpatient and secure wards

- The trust must ensure that patients have access to a nurse call system.

Overall summary

Our rating of this trust improved since our last inspection. We rated it as Good ● ↑

What this trust does

South West Yorkshire Partnership NHS Foundation Trust provides community, mental health and learning disability services to the people of Barnsley, Calderdale, Kirklees and Wakefield. They also provide some low and medium secure services to the whole of Yorkshire and the Humber.

Key questions and ratings

We inspect and regulate healthcare service providers in England.

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs, and well-led?

Where we have a legal duty to do so, we rate the quality of services against each key question as outstanding, good, requires improvement or inadequate.

Where necessary, we take action against service providers that break the regulations and help them to improve the quality of their services.

What we inspected and why

We plan our inspections based on everything we know about services, including whether they appear to be getting better or worse.

We inspected four complete core services.

- Acute wards for adults of working age and psychiatric intensive care units.
- Specialist community mental health services for children and young people.
- Wards for older people with mental health problems.
- Community based mental health services for adults of working age.

These were selected due to their previous inspection rating or our ongoing monitoring identified that an inspection at this time was appropriate to help us understand the quality of the service provided.

Summary of findings

Our comprehensive inspections of NHS trusts have shown a strong link between the quality of overall management of a trust and the quality of its services. For that reason, all trust inspections now include inspection of the well-led key question for the trust overall. What we found is summarised in the section headed *Is this organisation well-led?*

What we found

Overall trust

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

- We rated effective, caring, responsive and well-led as good, and safe as requires improvement. We rated 12 of the trust's 14 services as good and two as requires improvement. In rating the trust, we took into account the previous ratings of the 10 services not inspected this time.
- Although we still rated the acute wards for adults of working age and psychiatric intensive care units core service as requires improvement we could see areas of improvement. We improved the overall ratings for two of the four core services inspected. We rated the community-based mental health service for adults of working age as good for all five key questions.
- The trust board and senior leaders had the appropriate range of skills, knowledge and experience to perform their role. The trust had a clear vision and set of values which were embedded and respected across the organisation.
- Leadership development opportunities were available, including opportunities for staff below team manager level. The leadership and management development offer to staff took an inclusive approach, the pathway was open to both registered clinicians and non-registered support staff.
- The trust's target rate for appraisal compliance was 95%. At the time of inspection, the overall appraisal compliance rate was 97%. The appraisal process was aligned to the trust values and staff spoke positively regarding this process. On the whole staff felt respected, supported and valued within their teams.
- The trust had a policy on restrictive practices which had recently been introduced. Each ward now had a reducing restrictive practice log/risk assessment which recorded the local restrictions in place, and what the risk assessment was with and without each restriction in place, what the decision was, and the plan for review of any restrictive practice. This had helped services identify and reduce restrictive practices across the inpatient wards.
- On the whole, across the core services, we observed staff to be kind and caring towards patients. We observed positive relationships and could see staff knew the patients well.

However:

- We rated acute wards for adults of working age and psychiatric intensive care units as requires improvement overall. Although we could see areas of improvement since our last inspection the core service still rated requires improvement for the safe, effective, caring and well led key question.
- Children and young people were waiting over 18 weeks to receive treatment in some areas. Across the service four team's referral to treatment times exceeded 18 weeks. There were significant delays in accessing assessment for children and young people with autism spectrum disorder in all locations that offered this service.
- Although staff reported feeling respected, supported and valued amongst their local team and most by the senior managers. Two groups of staff felt they were not valued by senior leadership.

Are services safe?

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

Summary of findings

- Staff did not always complete and update risk assessments on acute wards for adults of working age and psychiatric intensive care services, wards for older people with mental health problems and specialist community mental health services for children and young people.
- Medicine management of as required medication was not always reviewed in line with good practice. Staff did not consistently undertake the required physical health monitoring following rapid tranquilisation.
- Not all patients had easy access to nurse call alarms. Where bedrooms did not have nurse call alarms, the trust had a protocol in place that sought to ensure patients had access to alarms, for example if they had limited mobility, were vulnerable to abuse, felt isolated, or had limited ability to communicate. However, this was not consistently implemented or interpreted across all the wards.

However:

- All clinical premises where people received care were safe, clean, well equipped, well furnished, well maintained.
- Staff understood how to protect patients from abuse and exploitation and services worked well with other agencies to do so. Staff had training on how to recognise and report abuse, and they knew how to apply it.
- Services managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with whole teams and the wider service. When things went wrong, staff apologised and met requirements of the duty of candour.

Are services effective?

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

- Staff provided a range of treatment and care for the patients based on national guidance and best practice. They ensured that patients had good access to physical healthcare and supported patients to live healthier lives.
- Most teams had access to the full range of specialists required to meet the needs of patients under their care. With the exception of the older adult wards where staff did not all have specialist dementia training, managers made sure that staff had a range of skills needed to provide high quality care. They supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.
- Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. The teams had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.
- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice.
- In specialist community mental health services for children and young people staff supported patients to make decisions on their care for themselves proportionate to their competence. They understood how the Mental Capacity Act 2005 applied to young people aged 16 and 17 and the principles of Gillick competence as they applied to people under 16. Staff assessed and recorded consent and capacity or competence clearly for children or young people who might have impaired mental capacity or competence.

However:

- On acute wards for adults of working age and psychiatric intensive care units care records did not consistently consider the full range of patients' needs and not all reflected the patient's voice. Care plans in the wards for older people with mental health problems were not always personalised.
- On wards for older people with mental health problems staff described the challenges of managing a ward with a mix of organic and functional patients. The quality of dementia care was inconsistent.

Summary of findings

Are services caring?

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

- Feedback from patients and carers was positive. In the patient friends and family test the trust had scored between 85 and 95 percent in the 12 months prior to inspection.
- Most staff treated patients with compassion and kindness, staff understood individual needs of patients and involved patients and those close to them in decisions about their care.
- In the specialist community mental health service for children and young people, patients and their families or carers had opportunities to be involved in decisions about the service.

However:

- On acute wards for adults of working age and psychiatric intensive care units, some staff did not always treat patients with compassion and kindness and could act in an abrupt way. Staff did not always respect patients' privacy as they did not always knock when entering bedrooms.

Are services responsive?

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

- Service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff.
- In community services, referral criteria did not exclude people who would have benefitted from care. On the wards for older people with mental health problems staff managed beds well and there was a clear admissions criteria and pathways.
- In the specialist community mental health service for children and young people, the service had identified issues with long waiting lists and delivered low level interventions to those waiting when appropriate. Staff recommended counselling and groups, both internal to the trust and provided by external partners, to support children and young people and their families or carers while waiting.
- On inpatient wards, patients had their own bedroom and were able to personalise them. There was access to quiet space.
- Services met the needs of all patients including those with a protected characteristic. Staff helped patients with communication, advocacy and cultural and spiritual support.

However:

- Children and young people were waiting over 18 weeks to receive treatment in some areas. Across the service four team's referral to treatment times exceeded 18 weeks. There were significant delays in accessing assessment for children and young people with autism spectrum disorder in all locations that offered this service. On acute wards for adults of working age and psychiatric intensive care units bed occupancy was high. This meant that a bed was not always available when needed. There were high numbers of patients readmitted after being discharged.
- On wards for older people with mental health problems access to garden space on Willows ward was restricted and signage on some wards was not dementia appropriate.

Are services well-led?

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

Summary of findings

- The Trust Board and leadership team had the appropriate range of skills, knowledge and experience. The Trust leadership and Board showed integrity on an ongoing basis. They had a comprehensive knowledge of current priorities and challenges and took action to address them. At the time of inspection, 19% of the board were from Black and minority ethnic backgrounds. The leadership structure had been reviewed since our last inspection and now included a director who had responsibility for operations and a director of provider development. The leadership for acute inpatient areas had also been reviewed to include matrons we could see how this had impacted positively in services.
- There was a robust and realistic strategy for achieving trust priorities and developing good quality, sustainable care. There were effective internal governance structures, systems and processes in place to support delivery of the strategy. Staff, patients, carers and external partners had the opportunity to contribute to discussions about the strategy and the trust were committed to place-based work which supported partnership working.
- Leadership development opportunities were available, including opportunities for staff below team manager level. Included in the offer the trust had several targeted programmes that met the identified needs of staff from under-represented groups, including moving forward which was specifically in place to support staff from minority communities. The offer took an inclusive approach that identified leadership was not role specific.
- The trust had a clear vision and set of values with quality and sustainability as the top priorities. Staff showed good knowledge and understanding of the trust vision and values and these were embedded across the organisation.
- The trust provided a range of wellbeing support for staff. The occupational health team had introduced a proactive process to support staff to manage distress caused by a work incident and the trust was promoting the #allofus campaign which promoted supporting the wellbeing of all.
- The trust had appointed a freedom to speak up guardian and provided them with sufficient resources and support to help staff to raise concerns. One freedom to speak up guardian had five hours dedicated time each week and there was a network of three additional guardians. Although the trust felt the dedicated time had an impact and enabled the freedom to speak up role and function to develop, a business case had been approved by senior leaders for a half time secondment to a freedom to speak up guardian lead post.
- The trust was actively engaged in collaborative work with external partners, such as involvement with sustainability and transformation plans. The trust had involvement in a number of partnership alliances across the different locations and had involvement with two integrated care systems. The trust chief executive officer was the lead executive for the West Yorkshire health and care partnership.
- The trust senior leadership team oversaw the equality, diversity and inclusion agenda within the trust. In April 2019 it made the equality, diversity and inclusion forum a sub-committee of the trust board. There was a strong governance structure around the agenda. The trust has developed an equality and diversity strategy and work programme and there was evidence of engagement across the trust involving staff and service users. However, some staff felt whilst there was strong leadership at board level, there were some areas of middle management which lacked awareness and understanding of Black minority ethnic and Workforce Race Equality Standard issues. The trust was undertaking a Building Leadership For Inclusion action research programme particularly focused at this management level.
- A clear framework set out the structure of the service team, division and senior trust meetings containing three lines of assurance. Leaders used meeting agendas to address quality and sustainability at all levels across the trust. The trust had recently completed the implementation of an electronic clinical record system. They were proud of the success of the delivery of this significant change management programme which had strong oversight from both the quality and audit committees, although they recognised there was more to do, embedding the system and maximising the benefit of its functionality.

Summary of findings

- The trust actively sought to participate in national improvement and innovation projects and was actively participating in clinical research studies. External agencies recognised the trust's improvement work. The trust was awarded NHS Standards of Procurement – Level 1 status and retained their Customer Service Excellence accreditation.

However:

- During core service inspections, we found breaches of regulation 12 relating to the completion of risk assessment documentation. We found concerns on the acute wards for adults of working age and psychiatric intensive care units, on wards for older people with mental health problems and at the specialist community mental health services for children and young people. We were concerned the trust did not have oversight of this risk and assurance that patients' risks were always been captured with risk management plans in place.
- Although the complaints system had space to record a communication plan, no information was recorded for any of the complaints we reviewed during inspection. Three of the six complaints we reviewed fell outside of the trust's 40-day response target.
- Achievement of the financial plan in the current year was predicated on the delivery of a large cost improvement programme of over £10m. This was not fully identified at the time of the inspection. The trust should address this to ensure delivery of the financial plan. The board had made a positive start in getting to grips with the challenge of financial sustainability, but this work needed to move at pace to deliver a credible plan moving forward.

Ratings tables

The ratings tables show the ratings overall and for each key question, for each service, hospital and service type, and for the whole trust. They also show the current ratings for services or parts of them not inspected this time. We took all ratings into account in deciding overall ratings. Our decisions on overall ratings also took into account factors including the relative size of services and we used our professional judgement to reach fair and balanced ratings.

Outstanding practice

We found an example of outstanding practice in the occupational health department, see the outstanding practice section in this report.

Areas for improvement

We found areas for improvement including 14 breaches of legal requirements that the trust must put right. We found 39 things that the trust should improve to comply with a minor breach that did not justify regulatory action, to prevent breaching a legal requirement, or to improve service quality.

Action we have taken

We issued five requirement notices to the trust. Our action related to breaches of 14 legal requirements trust wide and in three core services. That meant the trust had to send us a report saying what action it would take to meet this requirement.

For more information on action we have taken, see the sections on Areas for improvement and Regulatory action.

What happens next

We will check that the trust takes the necessary action to improve its services. We will continue to monitor the safety and quality of services through our continuing relationship with the trust and our regular inspections.

Summary of findings

Outstanding practice

The occupational health team had introduced a proactive process to support staff to manage distress caused by a work incident. The process encouraged line managers to share the name and contact number of staff involved in serious incidents so they could contact the staff member by phone and ask if they needed someone to talk to. If they did, they would be offered a priority appointment with a counsellor for an initial 50-minute conversation, followed by more counselling sessions if needed. If a staff member involved in a serious incident did not wish to take up the offer of counselling, they would be called again a month later to check they were still doing ok. This demonstrated a proactive approach to staff support.

Areas for improvement

Action the trust **MUST** take is necessary to comply with its legal obligations. Action a trust **SHOULD** take is to comply with a minor breach that did not justify regulatory action, to prevent it failing to comply with legal requirements in future, or to improve services.

We told the trust that it must take action to bring services into line with four legal requirements. This action related to three core services.

Action the trust **MUST** take to improve:

Trust wide

- The trust must ensure that systems and processes are established and operated so they effectively ensure senior leaders have oversight of compliance with risk assessment documentation across services. Regulation 17.

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

- The trust must ensure that they effectively assess, monitor and mitigate risks relating to the safety of patients and staff and work to reduce the incidents of aggression and violence towards staff. Regulation 17.
- Staff must ensure they assess patients' risk at the intervals outlined in the trust policy and that this is reflected on the risk assessment tool. Regulation 12.
- The trust must ensure that staff assess and review 'as required' medication in line with guidance and that medicine with a short shelf life has a date of opening listed. The trust must ensure that staff undertake the required physical health monitoring following the administration of rapid tranquilisation and that all episodes of rapid tranquilisation are documented correctly. Regulation 12.
- The trust must ensure that staff monitor and record checks of emergency equipment in line with trust policy. Regulation 12.
- The trust must ensure that staff maintain an accurate, complete and contemporaneous care record in respect of each service user, including evidence of patient involvement and a holistic approach to their needs within their care plans. Regulation 17.
- The trust must ensure that patients are always treated with dignity and respect and staff are not abrupt in their approach. Regulation 10.
- The trust must ensure that patient documentation, including records relating to seclusion, restraint, Mental Health Act and Mental Capacity Act and physical health monitoring are completed and recorded consistently and accurately. Regulation 17.

Summary of findings

- The trust must ensure that the systems and processes including auditing procedures are robust and evidence improvements following action plans. Regulation 17.

Ward for older people with mental health problems

- The trust must ensure that risk assessments are comprehensive and reviewed in a timely manner. Regulation 12.

Specialist community mental health services for children and young people

- The trust must ensure that they assess the risks to the health and safety of service users receiving care and treatment and do all that is practicable to mitigate any such risks. All risks must be assessed, identified and documented in risk management plans including children and young people on the waiting list. Crisis plans must be individualised to the child or young person using the service. Regulation 12.
- The trust must continue to take action to reduce waiting times and access to treatment times for services that exceed 18 weeks. Regulation 9

Action the trust SHOULD take to improve:

Trust Wide:

- The trust should ensure all documentation relating to the accessible information standard is clearly completed when supporting the management of complaints.
- The trust should ensure complaints are managed in a timely way and meet their response target.
- The trust should ensure they address the gap in the cost improvement programme to ensure delivery of the financial plan.
- The trust should ensure they continue their work developing a financial sustainability plan to return the trust to financial balance at a timely pace to deliver a credible plan moving forward.
- The trust should consider reviewing the skill set of leaders within the business delivery units to embed the accountability framework ensuring they are empowered to progress service and productivity improvement.
- The trust should consider how it engages all teams within the organisation ensuring staff of all departments feel valued and respected.
- The trust should consider a review of their Mental Health Act policies to ensure required processes are included in all policy documents.
- The trust should consider adding review dates to the Major Critical Incident Response Plan July 2017 and the Business Continuity Management Procedure July 2017 to ensure they are current.

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

- The trust should ensure that wards are staffed to establishment level to meet the needs of patients.
- The trust should continue with their work on reducing restrictive practice in relation to blanket restrictions, restraint, rapid tranquilisation and seclusion.
- The trust should ensure that patients in seclusion are able to leave at the earliest opportunity and that this is reflected in the documentation.
- The trust should ensure that patients can see a clock from all of the seclusion rooms.

Summary of findings

- The trust should ensure that all patients have easy access to summon assistance across all wards.
- The trust should ensure appropriate cover is provided for allied health professionals when they are on extended periods of leave.
- The trust should ensure that patients have access to activities and therapies seven days a week.
- The trust should ensure that staff uphold patient confidentiality and not allow patients into staff offices where patient information is displayed.
- The trust should continue with work to improve upon bed management and ensure patient have access to a bed appropriate to their needs.
- The trust should continue to monitor CAMHS admissions on to the wards and ensure that staff caring for children under 18 on the acute wards have the skills, training and experience to do so.
- The trust should consider improving consistency across wards in staff engagement with supervision and the regularity of team meetings.
- The trust should continue with the matrons' plans to address some of the differences between locations and increase the learning and sharing good practice between them.
- The trust should consider ways to make the staff team feel more valued and respected.

Ward for older people with mental health problems

- The trust should ensure that the use of as required and covert medication is reviewed appropriately.
- The trust should ensure that staff are supported to manage the mix of organic and functional patients and that dementia care is appropriate.
- The trust should ensure that care plans are personalised and evidence patient involvement.
- The trust should ensure workforce planning considers the provision of psychology services to the wards
- The trust should ensure that environments and signage are appropriate for patients with dementia.
- The trust should ensure that work to complete the transfer to the new electronic patient record is completed.

Specialist community mental health services for children and young people

- The service should ensure that mechanisms are in place to review the effectiveness of services following changes to the delivery model and on-call arrangements.
- The trust should ensure that CQC ratings from inspections are displayed in all patient areas.
- The trust should ensure that all checks of clinical equipment are documented.
- The trust should ensure that people using the service can access all information relevant to care and treatment. This includes complaints, carers' assessments and LGBTI support.
- The trust should review how care plans are developed for children and young people following their initial assessment where there is a delay in accessing intensive treatment.
- The trust should review care plans so that consent is always recorded, and language reflects the child or young person in the service

Summary of findings

Community based mental health services for adults of working age

- The trust should ensure information relating to patients' risk assessments and care plans are easily available within the new electronic patient care records system.
- The trust should ensure medication is stored appropriately and is accessible to staff when required.
- The trust should continue to improve waiting times for access to psychological therapies
- The trust should consider implementing a system to record the management supervision of staff.

Is this organisation well-led?

Our comprehensive inspections of NHS trusts have shown a strong link between the quality of overall management of a trust and the quality of its services. For that reason, we look at the quality of leadership at every level. We also look at how well a trust manages the governance of its services – in other words, how well leaders continually improve the quality of services and safeguard high standards of care by creating an environment for excellence in clinical care to flourish.

We rated well led at the trust as good because:

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

- The Trust Board and leadership team had the appropriate range of skills, knowledge and experience. The Trust leadership and Board showed integrity on an ongoing basis. They had a comprehensive knowledge of current priorities and challenges and took action to address them. At the time of inspection, 19% of the board were from Black and minority ethnic backgrounds. The leadership structure had been reviewed since our last inspection and now included a director who had responsibility for operations and a director of provider development. The leadership for acute inpatient areas had also been reviewed to include matrons we could see how this had impacted positively in services.
- There was a robust and realistic strategy for achieving trust priorities and developing good quality, sustainable care. There were effective internal governance structures, systems and processes in place to support delivery of the strategy. Staff, patients, carers and external partners had the opportunity to contribute to discussions about the strategy and the trust were committed to place-based work which supported partnership working.
- Leadership development opportunities were available, including opportunities for staff below team manager level. Included in the offer the trust had several targeted programmes that met the identified needs of staff from under-represented groups, including moving forward which was specifically in place to support staff from minority communities. The offer took an inclusive approach that identified leadership was not role specific.
- The trust had a clear vision and set of values with quality and sustainability as the top priorities. Staff showed good knowledge and understanding of the trust vision and values and these were embedded across the organisation.
- The trust provided a range of wellbeing support for staff. The occupational health team had introduced a proactive process to support staff to manage distress caused by a work incident and the trust was promoting the #allofus campaign which promoted supporting the wellbeing of all.
- The trust had appointed a freedom to speak up guardian and provided them with sufficient resources and support to help staff to raise concerns. One freedom to speak up guardian had five hours dedicated time each week and there was a network of three additional guardians. Although the trust felt the dedicated time had an impact and enabled the freedom to speak up role and function to develop, a business case had been approved by senior leaders for a half time secondment to a freedom to speak up guardian lead post.

Summary of findings

- The trust was actively engaged in collaborative work with external partners, such as involvement with sustainability and transformation plans. The trust had involvement in a number of partnership alliances across the different locations and had involvement with two integrated care systems. The trust chief executive officer was the lead executive for the West Yorkshire health and care partnership.
- The trust senior leadership team oversaw the equality, diversity and inclusion agenda within the trust. In April 2019 it made the equality, diversity and inclusion forum a sub-committee of the trust board. There was a strong governance structure around the agenda. The trust has developed an equality and diversity strategy and work programme and there was evidence of engagement across the trust involving staff and service users. However, some staff felt whilst there was strong leadership at board level, there were some areas of middle management which lacked awareness and understanding of Black minority ethnic and Workforce Race Equality Standard issues. The trust was undertaking a Building Leadership For Inclusion action research programme particularly focused at this management level.
- A clear framework set out the structure of the service team, division and senior trust meetings containing three lines of assurance. Leaders used meeting agendas to address quality and sustainability at all levels across the trust. The trust had recently completed the implementation of an electronic clinical record system. They were proud of the success of the delivery of this significant change management programme which had strong oversight from both the quality and audit committees, although they recognised there was more to do, embedding the system and maximising the benefit of its functionality.
- The trust actively sought to participate in national improvement and innovation projects and was actively participating in clinical research studies. External agencies recognised the trust's improvement work. The trust was awarded NHS Standards of Procurement – Level 1 status and retained their Customer Service Excellence accreditation

However:

- During our core service inspections, we found breaches of regulation 12 relating to the completion of risk assessment documentation. We found concerns on the acute wards for adults of working age and psychiatric intensive care units, on wards for older people with mental health problems and at the specialist community mental health services for children and young people. We were concerned the trust did not have oversight of this risk and assurance that patients' risks were always been captured with risk management plans in place.
- Although the complaints system had space to record a communication plan, no information was recorded for any of the complaints we reviewed during inspection. Three of the six complaints we reviewed fell outside of the trust's 40-day response target.
- Achievement of the financial plan in the current year is predicated on the delivery of a large cost improvement programme of over £10m. This was not fully identified at the time of the inspection, this needed to be addressed to ensure delivery of the financial plan. The board had made a positive start in getting to grips with the challenge of financial sustainability however this work needed to move at pace to deliver a credible plan moving forward.

Ratings tables

Key to tables					
Ratings	Not rated	Inadequate	Requires improvement	Good	Outstanding
Rating change since last inspection	Same	Up one rating	Up two ratings	Down one rating	Down two ratings
Symbol *	↔	↑	↑↑	↓	↓↓
Month Year = Date last rating published					

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

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

Ratings for the whole trust

Safe	Effective	Caring	Responsive	Well-led	Overall
Requires improvement ↔ Aug 2019	Good ↔ Aug 2019	Good ↔ Aug 2019	Good ↑ Aug 2019	Good ↔ Aug 2019	Good ↑ Aug 2019

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

Ratings for a combined trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community	Good Jun 2016	Good Jun 2016	Good Jun 2016	Good Jun 2016	Good Jun 2016	Good Jun 2016
Mental health	Requires improvement ↔ Aug 2019	Good ↔ Aug 2019	Good ↔ Aug 2019	Good ↑ Aug 2019	Good ↔ Aug 2019	Good ↑ Aug 2019

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

Ratings for community health services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community health services for adults	Good Jun 2016	Good Jun 2016	Good Jun 2016	Good Jun 2016	Good Jun 2016	Good Jun 2016
Community health services for children and young people	Good Jun 2016	Good Jun 2016	Outstanding Jun 2016	Good Jun 2016	Good Jun 2016	Good Jun 2016
Community health inpatient services	Good Jun 2016	Good Jun 2016	Good Jun 2016	Good Jun 2016	Good Jun 2016	Good Jun 2016
Community end of life care	Good Jun 2016	Outstanding Jun 2016	Good Jun 2016	Good Jun 2016	Good Jun 2016	Good Jun 2016
Overall*	Good Jun 2016	Good Jun 2016	Good Jun 2016	Good Jun 2016	Good Jun 2016	Good Jun 2016

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

Ratings for mental health services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Acute wards for adults of working age and psychiatric intensive care units	Requires improvement ↑ Aug 2019	Requires improvement ↔ Aug 2019	Requires improvement ↓ Aug 2019	Good ↑ Aug 2019	Requires improvement ↔ Aug 2019	Requires improvement ↔ Aug 2019
Long-stay or rehabilitation mental health wards for working age adults	Good Feb 2017					
Forensic inpatient or secure wards	Requires improvement Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018
Wards for older people with mental health problems	Requires improvement ↓ Aug 2019	Good ↔ Aug 2019	Good ↔ Aug 2019	Good ↔ Aug 2019	Good ↔ Aug 2019	Good ↔ Aug 2019
Wards for people with a learning disability or autism	Good Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018	Requires improvement Jul 2018	Good Jul 2018
Community-based mental health services for adults of working age	Good ↑ Aug 2019	Good ↔ Aug 2019	Good ↔ Aug 2019	Good ↑ Aug 2019	Good ↔ Aug 2019	Good ↑ Aug 2019
Mental health crisis services and health-based places of safety	Good Jun 2016					
Specialist community mental health services for children and young people	Requires improvement ↔ Aug 2019	Good ↔ Aug 2019	Good ↔ Aug 2019	Requires improvement ↔ Aug 2019	Good ↔ Aug 2019	Requires improvement ↔ Aug 2019
Community-based mental health services for older people	Good Feb 2017					
Community mental health services for people with a learning disability or autism	Good Jul 2018					
Overall	Requires improvement ↔ Aug 2019	Good ↔ Aug 2019	Good ↔ Aug 2019	Good ↑ Aug 2019	Good ↔ Aug 2019	Good ↑ Aug 2019

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

Wards for older people with mental health problems

Good   

Key facts and figures

South West Yorkshire NHS Partnership Foundation Trust provided inpatient care for older people with mental health problems. The trust provided five wards across five locations. These wards provided care for patients aged 65 and upwards who required hospital admission for their mental health. The wards also admitted people under the age of 65 who had a diagnosis of dementia. Wards were located at:

Beechdale ward – a 16 bed mixed sex ward for older people with functional or organic mental health problems. Beechdale ward was located at the Dales within Calderdale Royal Hospital.

Chantry unit – a 16 bed mixed sex ward for older people with functional or organic mental health problems. Chantry unit was located at Fieldhead Hospital, Wakefield

The Poplars – a 15 bed mixed sex ward that operated as a dementia assessment unit. Poplars was located within its own grounds in Pontefract

Ward 19 – ward 19 was split into two separate units. Ward 19M was a 15-bed male ward for older people with functional or organic mental health problems. Ward 19F was a 15-bed female ward for older people with functional or organic mental health problems. Ward 19 was located within the Priestley Unit at Dewsbury District Hospital.

Willows ward - a 10 bed mixed sex ward for older people with functional or organic mental health problems. Willows ward was located at Kendray Hospital, Barnsley.

The core service has been inspected twice. In March 2016 it was rated as good overall and in every domain except safe. The service was rated requires improvement in safe. The service was re-inspected in December 2016 and rated good overall and in every domain.

Our inspection was unannounced (staff did not know we were coming) to enable us to observe routine activity.

Before the inspection visit, we reviewed information that we held about the service and information requested from the trust.

During the inspection visit, the inspection team:

- visited all five wards, looked at the quality of ward environments and observed how staff were caring for patients
- spoke with 16 patients who were using the service
- spoke with 10 carers of people who were using the service
- spoke with the ward managers on each ward
- spoke with 28 other staff members including doctors, nurses, healthcare assistants, occupational therapists and matrons
- observed three multi-disciplinary patient meetings, one bed state meeting and one morning 'flash' meeting
- reviewed 18 patient records, including risk assessments, care plans and Mental Health Act and Mental Capacity Act documentation
- carried out a specific check of medication management on all wards, including reviewing prescription cards
- looked at a range of policies, procedures and governance documents relating to the running of the service.

Wards for older people with mental health problems

Summary of this service

Our rating of this service stayed the same. We rated it as good because:

- The service had enough nursing and medical staff to deliver care and keep people safe from avoidable harm. Staff assessed patient and environmental risks and responded to changes in that risk. Staff reported adverse incidents and learnt from when things went wrong.
- Staff assessed the physical and mental health needs of patients on admission and worked collaboratively to meet patient need. Patients had access to a range of professionals as part of their care. Staff were supported with regular supervision and annual appraisal.
- Staff treated patients and carers with kindness and respect. Patients and carers were able to give feedback on the care and treatment they received. Patients and carers we spoke with were positive about staff and the service.
- There were clear admission criteria and processes. Staff managed beds well. Patients had access to a range of facilities and information. Staff were responsive to patient needs, including those with a protected characteristic.
- Staff considered managers to be supportive and described an open and honest culture. Governance systems and processes allowed staff to assure the quality of care and generate improvements. Managers were aware of the challenges the service faced and had plans to address them. Staff had been involved in an ongoing service transformation project.

However:

- Staff described challenges in managing a mix of organic and functional patients and signage on some wards was not dementia appropriate.
- Staff did not always review the use of as required and covert medication.
- Risk assessments were not always comprehensive or completed in a timely manner. Care plans were not always personalised and did not always evidence patient involvement.
- Wards did not have access to dedicated psychology input.

Is the service safe?

Requires improvement  

Our rating of safe went down. We rated it as requires improvement because:

- Risk assessments were not always comprehensive or completed in a timely manner.
- Staff did not always review the use of as required medication and covert medication.

However:

- Wards were safe, clean, well equipped and well maintained.
- The service had enough nursing and medical staff, who knew the patients and received basic training to keep people safe from avoidable harm.
- The service provided mandatory training in key skills to all staff and monitored compliance.
- Staff completed observations as required and in line with trust policy.

Wards for older people with mental health problems

- The service managed patient safety incidents well. Adverse incidents were reported, reviewed and where appropriate subject to investigation. Learning was feedback to staff.

Is the service effective?

Good   

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

- Staff assessed the physical and mental health needs of all patients on admission.
- Staff from different disciplines worked together as a team to benefit patients.
- Staff had completed training around the assessment and management of dementia
- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and discharged these well.

However:

- Staff described the challenges of managing a ward with a mix of organic and functional patients. The quality of dementia care was inconsistent, for example, staff did not always use common tools, such as dementia care mapping and one-page profiles, to assess and monitor patient care.
- Care plans were not always personalised.
- Wards did not have access to dedicated psychology services. However, staff could refer to a centralised clinical psychology service.

Is the service caring?

Good   

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

- Staff treated patients, their families and carers with kindness, compassion and respect.
- Staff interactions with patients were positive. Staff engaged with patients in a caring and supportive manner.
- Staff orientated patients to the ward on admission. There were information packs for patients and carers.
- Staff sought feedback from patient and carers on the service they had received.

However:

- Patient involvement in decisions about care and treatment was not always captured in care records.

Is the service responsive?

Good   

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

Wards for older people with mental health problems

- Staff managed beds well. This meant that a bed was available when needed and that patients were not moved between wards unless this was for their benefit. There was a clear admission criteria and patient pathways.
- Each patient had their own bedroom and could keep their personal belongings safe. There were quiet areas for privacy and a range of facilities to support their care.
- Patients had access to a range of information which could be provided in different formats and languages.
- The wards met the needs of all people who use the service including those with a protected characteristic. Staff helped patients with communication, advocacy and cultural and spiritual support.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and wider service.

However:

- Access to garden space on Willows ward was restricted.
- Signage on some wards was not dementia appropriate.

Is the service well-led?

Good ● → ←

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

- Leaders had the skills, knowledge and experience to perform their roles. Managers were aware of the issues the service faced and had plans in place to address them.
- Staff knew and understood the trust's vision and values. They reflected these in the delivery of care.
- Staff felt respected, supported and valued. Teams worked collaboratively with each other and external stakeholders.
- Staff monitored the quality of the service and engaged in quality improvement activities.

However:

- We identified governance concerns within the service relating to medication management and the completion and updating of risk assessments.
- Staff on Poplars ward told us they felt isolated from the wider trust.

Areas for improvement

We found areas for improvement in this service. See the Areas for Improvement section above.

Community-based mental health services of adults of working age

Good  

See guidance note ICS 1 – then delete this text when you have finished with it.

Key facts and figures

South West Yorkshire Partnership NHS Foundation Trust provides community mental health services adults of working age across Barnsley, Wakefield and Calderdale and Kirklees. The service is split into three business delivery units which cover each of these localities (Calderdale and Kirklees classed as one locality).

The three sites we visited were based at:

- Batley (Kirklees): Becksid court
- Barnsley: Lundwood Health Centre
- Wakefield: Drury Lane Health and Wellbeing centre

Access to the service was via the trust's single point of access teams. Teams were aligned into two main pathways known as core and enhanced. The core team was intended for people with moderate to severe mental health conditions who required a less complex package of care. The enhanced team was intended for people with more complex mental health needs who required a more intensive level of support. The community mental health services for adults of working age also consisted of other teams which included the intensive home based treatment and early intervention in psychosis teams.

We last inspected community mental health services for adults of working age in March 2018. We rated the service as requires improvement overall. We rated the safe and responsive key questions as requires improvement, and gave a rating of good in the effective, caring and well led key questions. We issued the trust with two requirement notices because risk assessments and management plans were not regularly reviewed and updated and the excessive length of waiting times in some areas for access to psychological therapies. This was a breach of Regulation 9 and 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This inspection took place between 8 and 10 May 2019. Our inspection was announced 24 hours in advance to ensure that people would be available to speak with us. We inspected the service using all the key lines of enquiry in the five domains (safe, effective, caring, responsive and well-led).

Before the inspection visit, we reviewed information that we held about these services and requested information from the trust. During the inspection visit, the inspection team:

- visited three community bases where the services operated from
- spoke with 12 people, and five carers of people, who were using the service
- attended and observed five home visits and five clinic sessions
- spoke with five senior leaders
- spoke with 11 team managers from the core teams, enhanced teams, and single point of access teams
- spoke with 24 other staff members including doctors, nurses, social workers, psychologists, occupational therapists, support workers and administrative staff
- observed two multidisciplinary meetings, one neighbourhood meeting and one quality improvement workshop

Community-based mental health services of adults of working age

- looked at the care and treatment records of 13 patients
- looked at policies, procedures and other documents relating to the running of the service.

Summary of this service

Our rating of this service improved. We rated it as good because:

- The service had enough staff, who knew the patients and received basic training to keep patients safe from avoidable harm. The number of patients on the caseload of the teams, and of individual members of staff, was not too high to prevent staff from giving each patient the time they needed.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse, and they knew how to apply it.
- Staff provided a range of treatment and care for the patients based on national guidance and best practice. They ensured that patients had good access to physical healthcare and supported patients to live healthier lives.
- Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. The teams had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.
- Staff treated patients with compassion and kindness. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.
- The service was easy to access. Its referral criteria did not exclude patients who would have benefitted from care.
- The service had made significant progress towards reducing the waiting list times for access to psychological therapies. Although, continued to have some patients who had been waiting for an average of 174 weeks.
- Leaders had the skills, knowledge and experience to perform their roles, had a good understanding of the services they managed.
- Staff felt respected, supported and valued. They reported that the provider promoted equality and diversity in its day-to-day work and in providing opportunities for career progression. They felt able to raise concerns without fear of retribution.

However:

- Following the migration to the new electronic patient records system we found information relating to patients' risk assessment and care plans was not easily available and, in many cases, information had been transferred in to different areas of the new system.
- Resuscitation bags at Drury lane had not been checked for two weeks resulting in the airway aids been out of date.
- Staff in Barnsley and Kirklees told us they did not find senior managers to be visible within the service.

Is the service safe?

Good  

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

Community-based mental health services of adults of working age

- All clinical premises where patients received care were safe, clean, well equipped, well furnished, well maintained and fit for purpose.
- The service had enough staff, who knew the patients and received basic training to keep patients safe from avoidable harm. The number of patients on the caseload of the teams, and of individual members of staff, was not too high to prevent staff from giving each patient the time they needed.
- Staff assessed and managed risks to patients and themselves. They responded promptly to sudden deterioration in a patient's health. When necessary, staff worked with patients and their families and carers to develop crisis plans. Staff monitored patients on waiting lists to detect and respond to increases in level of risk. Staff followed good personal safety protocols.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse, and they knew how to apply it.
- The teams had a good track record on safety. The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

However:

- Following the migration to the new electronic patient records system we found information relating to patients' risk assessments and care plans was not easily available and, in many cases, information had been transferred in to different areas of the new system.
- Resuscitation bags at Drury lane had not been checked for two weeks resulting in the airway aids been out of date.
- Medication storage at Drury lane was disorganised with medication stored in carrier bags within the cabinet.

Is the service effective?

Good   

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

- Staff provided a range of treatment and care for the patients based on national guidance and best practice. They ensured that patients had good access to physical healthcare and supported patients to live healthier lives.
- The teams included or had access to the full range of specialists required to meet the needs of patients under their care. Managers made sure that staff had a range of skills needed to provide high quality care. They supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.
- Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. The teams had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.
- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice.
- Staff supported patients to make decisions on their care for themselves. They understood the provider's policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly for patients who might have impaired mental capacity.

Community-based mental health services of adults of working age

However:

- The trust did not have a system in place to routinely record and monitor management supervision.

Is the service caring?

Good ● → ←

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

- Staff treated patients with compassion and kindness. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.
- Staff involved patients in care planning and risk assessment and ensured that patients had easy access to advocates when needed.
- Staff informed and involved families and carers appropriately.

Is the service responsive?

Good ● ↑

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

- The service was easy to access. Its referral criteria did not exclude patients who would have benefitted from care.
- The service met the needs of all patients including those with a protected characteristic. Staff helped patients with communication, advocacy and cultural and spiritual support.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff.
- The service had made significant progress towards reducing the waiting list times for access to psychological therapies. Although, continued to have some patients who had been waiting for an average of 174 weeks.

Is the service well-led?

Good ● → ←

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

- Leaders had the skills, knowledge and experience to perform their roles, had a good understanding of the services they managed.
- Staff knew and understood the provider's vision and values and how they were applied in the work of their team.
- Staff felt respected, supported and valued. They reported that the provider promoted equality and diversity in its day-to-day work and in providing opportunities for career progression. They felt able to raise concerns without fear of retribution.
- Teams had access to the information they needed to provide safe and effective care and used that information to good effect.

Community-based mental health services of adults of working age

However:

- Staff in Barnsley and Kirklees told us they did not find senior managers to be visible within the service.
- Information relating to patients' risk assessment and care plans was not easily available following the migration to the new electronic patient records system and, In many cases, information had been transferred in to different areas of the new system.

Areas for improvement

We found areas for improvement in this service. See the Areas for Improvement section above.

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

Requires improvement   

Key facts and figures

South West Yorkshire Partnership Foundation NHS Trust provides seven acute mental health inpatient wards for adults of working age and two psychiatric intensive care units across four locations as follows:

Priestley Unit, Halifax Road Dewsbury WF13 4HS

- Ward 18 - 23 bed mixed sex ward

The Dales Calderdale Royal Hospital, Salterhebble Halifax HX3 0PW

- Ashdale Ward - 24 bed male ward
- Elmdale Ward - 24 bed female ward

Fieldhead Hospital, Fieldhead, Ouchthorpe Lane, Wakefield, West Yorkshire, WF1 3SP

- Stanley Ward - 22 bed male ward
- Nostell Ward - 22 bed female ward
- Walton psychiatric intensive care unit - 14 bed mixed sex ward

Kendray Hospital, Doncaster Road Barnsley South Yorkshire S70 3RD

- Beamshaw Ward - 14 bed male ward
- Clarke Ward - 14 bed female ward
- Melton Suite psychiatric intensive care unit - 6 bed mixed sex ward

The wards can provide care and treatment for up to 163 patients. Patients can be detained under the Mental Health Act 1983 or informal.

We have carried out six Mental Health Act monitoring visits across the service between September 2018 and February 2019. Following these visits, the trust provided an action statement telling us how they would improve the service and improve adherence to the Mental Health Act and Mental Health Act Code of Practice.

We previously inspected the acute and psychiatric intensive care unit services between 6 March 2018 and 11 April 2018. The inspection report was published 3 July 2018 and we found some areas for improvement. We rated the service as inadequate in safe, requires improvement in effective, responsive and well led, and good in caring. The service was rated as requires improvement overall.

During this inspection, we inspected the whole core service and all of the key questions of safe, effective, caring, responsive and well led. Our inspection was unannounced (staff did not know we were coming) to enable us to observe routine activity.

During our inspection we:

- toured all of the ward environments and observed how staff were caring for patients
- reviewed five seclusion rooms

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

- reviewed 26 patient care records, three restraint records, 10 rapid tranquilisation records and nine seclusion records
- attended seven multi-disciplinary team reviews
- interviewed 17 patients and six carers
- reviewed feedback from 20 comment cards
- interviewed seven senior managers responsible for the services
- interviewed 50 other staff including: ward managers, doctors, nurses, occupational therapists, psychologists, pharmacists, therapy staff, healthcare assistants, bank and agency staff and domestic staff
- completed a review of medicines management on each ward
- reviewed a range of other documents, policies and procedures.

Summary of this service

Our rating of this service stayed the same. We rated it as requires improvement because:

- The assessment of and management of patient risk was not consistent. The ward acuity was high and there was high rates of staff assaults. There were omissions in medicine management surrounding the review of 'as required' medication and physical health monitoring after rapid tranquilisation. Short shelf life medicine did not have a date of opening. Monitoring of emergency equipment was not consistently completed. Not all patients were able to summon assistance using a nurse call alarm if they needed to.
- Care assessments did not always consider the full range of patients' diverse needs or evidence patient involvement.
- There were times when people did not feel well-supported or cared for. Nine patients we spoke to described staff as sometimes "rude" or "abrupt". Staff did not consistently knock before entering patient bedrooms and patient confidentiality was not maintained on some wards.
- Bed occupancy was high and staff reported a pressure to admit patients despite voicing concerns about clinical risk. Patients were occasionally placed on an unsuitable ward or an air bed. Not all wards provided activities seven days a week.
- Clinical and internal audit processes were inconsistent in their impact and errors had been found in documentation of important clinical documents such as seclusion and Mental Capacity Act. Staff morale was mixed. Staff did not always raise concerns or suggestions as they did not feel they would be heard or that any action would come from it.

However:

- The environment was clean and well maintained. Some wards had implemented measures to reduce restrictive practice and staff used restraint and seclusion appropriately. Safeguarding was given sufficient priority and staff adhered to the duty of candour. There was evidence of investigations following serious events, lessons learnt were shared and duty of candour was well embedded. Staffing levels had been increased following work with NHSI. Staff could access specialist training to reflect the needs of the client group.

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

- Patients had a prompt physical health assessment on admission and monitoring though admission. The ward teams had access to the full range of specialists required to meet the needs of patients on the wards. Managers ensured that these staff received training, supervision and appraisal. The ward staff worked well together as a multidisciplinary team and with those outside the ward who would have a role in providing aftercare. Some wards had AIMS accreditation. Staff had good understanding of their responsibilities under the Mental Health Act 1983.
- Interactions we observed were largely positive. Staff demonstrated a good knowledge of each patient. All carers we spoke with were involved in patient care. Patients and carers were able to feed back about the ward and have a say about their treatment options.
- The facilities allowed for a diverse activity programme, including tai chi and hydrotherapy. Patients enjoyed the food and accommodation. Patients had access to advocates, interpreters and pastoral care. Complaints and concerns were investigated and findings shared.
- Ward managers were knowledgeable and capable, committed to improve the quality of care for patients and involved in research projects. The modern matron post was giving wards the authority to implement change. There was good learning and support across and within the business delivery units. Staff had opportunities for development and career progression.

Is the service safe?

Requires improvement ● ↑

Our rating of safe improved. We rated it as requires improvement because:

- Staff did not always assess and manage risks to patients and themselves well. Risk assessments were not always updated following incidents and there was limited evidence of risk management plans.
- Staff reported a high number of staff assaults.
- Staff did not always follow the trust nurse call alarm protocol to ensure all patients had access to a call bell or means of summoning assistance on all the wards.
- Staff did not have easy access to relevant clinical information due to the newly implemented electronic record keeping system.
- The service did not always store medicines safely. Medicines with a short shelf life did not have a date of opening and not all wards showed us their T28 waste exemption certificate.
- Staff did not always review patients' use of 'as required' medication. Staff did not consistently undertake the required physical health monitoring following rapid tranquilisation.
- There were some gaps in checks of emergency equipment.

However:

- The ward environments were clean, well equipped, well furnished, well maintained and fit for purpose. Staff assessed and managed environmental risk and had taken measures to mitigate blind spots.
- The service provided mandatory training in key skills to all staff. Staff had access to specialist training to reflect the change in client group, such as personality disorder and substance misuse training.

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

- Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.
- The service had recently worked with NHS Improvement Mental Health Safety Improvement Programme to review the establishment levels resulting in an increase in staffing levels.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse, and they knew how to apply it.
- Staff used restraint and seclusion only after attempts at de-escalation had failed. The ward staff participated in the provider's restrictive interventions reduction programme. This core service was participating in the Mental Health Safety Improvement Programme and Nostell ward was a pilot site for the reducing restrictive practice programme.

Is the service effective?

Requires improvement ● → ←

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

- Care records did not consistently consider the full range of patients' needs and not all reflected the patients' voice. Staff did not always develop care plans that met the needs identified during assessment. For example, we reviewed records where patients did not have a care plan for epilepsy, falls or substance misuse despite these needs being identified through assessment.

However:

- Staff assessed the physical and mental health of all patients on admission.
- Staff provided a range of care and treatment interventions suitable for the patient group and consistent with national guidance on best practice. They ensured that patients had good access to physical healthcare and supported patients to live healthier lives.
- The ward teams included, or had access to, the full range of specialists required to meet the needs of patients on the wards. Managers made sure they had staff with a range of skills need to provide high quality care. They supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.
- Staff from different disciplines worked together as a team to benefit patients. The ward teams had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.
- Staff understood their roles and responsibilities under the Mental Health Act 1983. Managers made sure that staff could explain patients' rights to them.

Is the service caring?

Requires improvement ● ↓

Our rating of caring went down. We rated it as requires improvement because:

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

- Some staff did not always treat patients with compassion and kindness and could act in an abrupt way. During inspection we observed two occasions when staff responded abruptly to patients or were indiscrete whilst discussing a patient in a communal area.
- Staff did not always respect patients' privacy as they did not always knock when entering bedrooms and not all patients had access to a private space to make calls.
- Patient confidentiality was not fully upheld on some of the wards. We observed patients walking into a ward office where patient information was displayed and visible on boards, and staff were engaged in conversations about other patients, for example by telephone to care coordinators.

However:

- Most staff treated patients with compassion and kindness and took account of their individual needs.
- There had been improvements in patient involvement in care planning. Staff understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition. Staff sought patient feedback on the quality of care provided and ensured that patients had easy access to independent advocates.
- Staff informed and involved families and carers appropriately.

Is the service responsive?

Good ● ↑

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

- The service treated concerns and complaints responsively, investigated them and learned lessons from the results, and shared these with the whole team and the wider service.
- The design, layout, and furnishings of the wards supported patients' treatment, privacy and dignity. Each patient had their own bedroom with an en-suite bathroom and could keep their personal belongings safe. There were quiet areas for privacy.
- The food was of a good quality and patients could make hot drinks at any time.
- The service met the needs of patients who used the service – including those with a protected characteristic. Staff helped patients with communication, advocacy and cultural and spiritual support.

However:

- Bed occupancy was high. This meant that a bed was not always available when needed and that patients were moved to wards not reflective of their needs for example, on nine occasions, patients who should have received care on an adult admission ward had been admitted to a psychiatric intensive care unit or an older adults ward. On other occasions, patients had slept on an air bed because no proper bed was available.
- There were high numbers of patients readmitted after being discharged.
- Not all wards provided therapies or activities seven days a week due to the working hours of activity co-ordinators.

Is the service well-led?

Requires improvement ● → ←

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

Our rating of well-led stayed the same. We rated it as requires improvement because:

- Governance processes did not always operate effectively at ward level and auditing processes were not seen to be effective in implementing change. There were numerous errors and omissions found in documentation, including medicines, restraint, seclusion, Mental Health Act and Mental Capacity Act documentation, despite auditing processes being in place.
- Not all staff felt respected, supported and valued or felt that their concerns would be acted upon.

However:

- The trust implemented a new auditing process to mitigate the documentation errors found on inspection.
- The trust had introduced training and new roles to assist staff to access opportunities for career progression.
- Leaders at team level had a good understanding of the services they managed and were visible in the service and approachable for patients and staff. The trust had recently changed the management structure of this core service and introduced new modern matron roles. These roles were having a positive impact on the wards.
- Staff knew and understood the provider's vision and values and how they were applied in the work of their team.
- Staff reported that the provider promoted equality and diversity in its day-to-day work and in providing opportunities for career progression. They felt able to raise concerns without fear of retribution.
- Staff engaged actively in local and national quality improvement activities. Wards were involved in research programmes.

Areas for improvement

We found areas for improvement in this service. See the Areas for Improvement section above.

Specialist community mental health services for children and young people

Requires improvement   

Key facts and figures

South West Yorkshire Partnership NHS Foundation Trust's specialist community mental health services for children and young people has eight community child and adolescent mental health teams across six locations in Barnsley, Calderdale and Kirklees, and Wakefield.

The trust provides tier 2 services in Wakefield and Barnsley. Tier 2 provision at Calderdale and Kirklees is provided by a separate service external to the trust. Tier 2 services consist of specialist teams who work in community and primary care settings and offer consultation to families and other practitioners. They identify people with severe or complex needs requiring more specialist intervention and/or, assessment. Once assessed and if appropriate, children and young people are allocated to a specialist care tier 3 pathway within each locality.

The trust provides tier 3 mental health services to children and young people up to the age of 18. Tier 3 services are multidisciplinary teams or services working in a community mental health setting or a child and adolescent psychiatry outpatient service. They provide a service for children and young people with more severe, complex and persistent disorders. Each of the teams had multiple specialist pathways where a child or young person could be allocated to for treatment.

At the last core service inspection on 3 July 2018, the service had two key questions (safe and responsive) rated requires improvement. The service was rated as good for caring, effective and well led.

Our inspection was announced the day prior to the inspection (staff knew we were coming) to ensure that everyone we needed to talk to was available. We visited the Barnsley and Wakefield East sites.

Before the inspection visit, we reviewed information that we held about these services and information requested from the trust.

During the inspection visit, the inspection team:

- visited two of the office bases where specialist child and adolescent mental health community services were provided. (Barnsley and Wakefield East)
- spoke with three children or young people and 12 families and carers that were using the service
- spoke with three managers of the services
- spoke with ten other staff members; including doctors, nurses, support workers, administrative staff, therapists, psychologists and mental health practitioners with a variety of professional backgrounds
- observed two multidisciplinary meetings and one team meeting
- attended one schools visit, attended three outpatient appointments and observed staff interaction with children, young people and their families or carers in the waiting areas.
- received 11 comment cards from people that used the service
- reviewed ten records including children and young people's risk assessments and care plans
- spoke with eight senior leaders for the service via teleconference following the inspection. This included general managers, clinical leads, the deputy director for the service and practice governance coaches.

Specialist community mental health services for children and young people

Summary of this service

Our rating of this service stayed the same. We rated it as requires improvement because:

- Staff did not always assess or manage risk well. Staff did not follow up on all identified risks, create management plans or appropriate crisis plans. The service did not actively monitor children and young people on waiting lists to detect and respond to increases in level of risk.
- Children and young people were waiting over 18 weeks to receive treatment in some areas. Across the service four team's referral to treatment times exceeded 18 weeks. There were significant delays in accessing assessment for children and young people with autism spectrum disorder in all locations that offer this service. Children and young people on waitlists did not have a formal care plan until they received intensive treatment. For those admitted into the service care plan entries were written from a clinical perspective, more so than for the individual receiving treatment.
- Staff did not always record consent clearly for children or young people in their care records.
- Staff did not ensure that children and young people and their families and carers had access to all the information they should. This included information on complaints, carers assessments and LGBTI support.
- Issues relating to on-call provision were not yet fully resolved. There were staffing gaps in the rotas as there were not enough staff to cover all responsibilities.
- Staff did not always follow systems and processes for cleaning and checks of clinical equipment. The Barnsley service did not have CQC ratings from the previous inspection displayed in patient areas.

However;

- Clinical premises where children and young people were seen were safe and clean. The number of children and young people on the caseload of the teams, and of individual members of staff, was not too high to prevent staff from giving people using the service the time they needed. Staff ensured that children and young people who required urgent care were seen promptly.
- The service had identified issues with long waiting lists for intensive treatment and gaps in commissioning and were working to resolve these. When appropriate, they provided low level interventions to those waiting for intensive treatment. They were implementing new service models to better meet the needs of people using the service and were working with commissioners to get additional funding and a clear service specification.
- Staff developed holistic, recovery-oriented care plans informed by a comprehensive assessment and in collaboration with families and carers. They provided a range of treatments that were informed by best-practice guidance and suitable to the needs of children and young people. Staff engaged in clinical audit to evaluate the quality of care they provided.
- The teams included or had access to the full range of specialists required to meet the needs of those using the service. Managers ensured that these staff received training, supervision and appraisal. Staff worked well together as a multidisciplinary team and with relevant services outside the organisation.
- Staff understood the principles underpinning capacity and competence in line with the Mental Capacity Act and Gillick competence.
- Staff treated children and young people with compassion and kindness, respected their privacy and dignity, and understood their individual needs. They actively involved children, young people and their families and carers in care decisions.

Specialist community mental health services for children and young people

- The service was easy to access in terms of referrals and initial assessment. Staff assessed and were able to expedite treatment for children and young people who required urgent care promptly. The criteria for referral to the service did not exclude children and young people who would have benefitted from care.
- The service was well led, and the governance processes ensured that procedures relating to the work of the service ran smoothly.

Is the service safe?

Requires improvement ● → ←

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

- Staff did not assess and manage all risks to children and young people using the service. They did not identify all risks that were visible in referrals or appointments on the risk assessment tool. This could mean that risks might not be apparent to other workers who might provide care to that young person in the future. Some children and young people did not have risk management plans in place. People that used the service were not fully supported to keep themselves safe.
- Staff did not monitor children and young people on waiting lists to detect and respond to increases in level of risk. Children and young people, families and their carers were advised to contact the service if risks increased. Crisis plans did not always offer individualised support to the children or young people when in crisis.
- All recommendations from a safeguarding action plan and reviews following recent serious incidents were not completed in accordance with dates specified in the corresponding action plans.
- Staff did not always record cleaning and equipment checks on all clinical equipment used on children and young people in the service.
- Issues identified at our last inspection relating to out of hours, on-call medical arrangements was not yet fully resolved, though were improving. There were staffing gaps in the rotas due to limited medical staff availability.
- During the inspection the Barnsley service did not have CQC ratings from the previous inspection displayed in patient areas.

However;

- When informed, staff responded promptly to sudden deterioration in a child or young person's health. Staff followed good personal safety protocols.
- All clinical premises where children and young people received care were clean, well equipped and well furnished.
- The service had enough staff, who knew the people using the service. Sickness and vacancy rates had improved in the service. Staff received basic training to keep children and young people safe from avoidable harm. The numbers of children and young people on the caseload of the teams, and of individual members of staff, was not too high to prevent staff from giving each person the time they needed.
- Staff understood how to protect children and young people from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse, and they knew how to apply it. The provider had child safeguarding lead.
- Staff kept detailed records of children and young people's care and treatment. Records were up to date and easily available to all staff providing care.

Specialist community mental health services for children and young people

- Staff reviewed the effects of medications on each child or young person's physical and mental health.
- The service managed safety incidents well. Staff mostly recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave people that used the service honest information and suitable support.

Is the service effective?

Good   

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

- Staff assessed the mental health needs of all children and young people. They worked with children and young people and their families or carers to develop individual care plans once receiving treatment. They updated them when needed. Care plans reflected the assessed needs, were personalised, holistic and recovery-oriented.
- Staff provided a range of treatment and care for children and young people based on national guidance and best practice. They engaged with physical healthcare providers and supported people that used the service to live healthier lives.
- Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives.
- The teams included or had access to the full range of specialists required to meet the needs of children and young people under their care. Managers made sure that staff had a range of skills needed to provide high quality care. They supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.
- Staff from different disciplines worked together as a team to benefit people using the service. They supported each other to make sure children and young people had no gaps in their care. The teams had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.
- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice.
- Staff supported children and young people to make decisions on their care for themselves proportionate to their competence. They understood how the Mental Capacity Act 2005 applied to young people aged 16 and 17 and the principles of Gillick competence as they applied to people under 16. Staff assessed and recorded consent and capacity or competence clearly for children or young people who might have impaired mental capacity or competence.

However;

- Care plans were completed at the first date of treatment, not following initial assessment. This meant children and young people using the service did not always have a clear plan in place. This was in accordance with the provider's policy. Language in some care plans read more as a clinical document for staff, rather than for the individual receiving treatment.

Is the service caring?

Good   

Specialist community mental health services for children and young people

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

- Staff treated people that used the service with compassion and kindness. They understood their individual needs and supported children and young people to understand and manage their care, treatment or condition.
- Staff involved children, young people and their families or carers in care planning and risk assessment.
- Children, young people and their families or carers had opportunities to be involved in decisions about the service and had access to advocacy services.

However;

- Staff did not provide carers with information about how to access a carer's assessment.

Is the service responsive?

Requires improvement ● → ←

Our rating of responsive stayed the same. We rated it as requires improvement because:

- Children and young people were waiting over 18 weeks to receive treatment in some areas. Across the service, four team's referral to treatment times exceeded 18 weeks. There were significant delays in accessing assessment for children and young people with autism spectrum disorder in all locations that offered this service.
- The service did not make all information required available to patients. This included information on how to complain and information leaflets relating to LGBTI support.

However;

- The service's referral criteria did not exclude children or young people who would have benefitted from care. Staff assessed and treated those who required urgent care promptly. Staff followed up on children and young people who missed appointments.
- The service had identified issues with long waiting lists and delivered low level interventions to those waiting when appropriate. Staff recommended counselling and groups, both internal to the trust and provided by external partners, to support children and young people and their families or carers while waiting. The service was implementing new service models to better meet the needs of people using the service.
- The service ensured that children and young people, who would benefit from care from another agency, made a smooth transition. This included ensuring that transitions to adult mental health services took place without any disruption to their care.
- Services identified gaps in commissioning arrangements and were working to resolve these. They sought additional funding and were working with commissioners to identify a clear service specification.
- The service investigated and responded to complaints. Lessons learnt from the recommendations were shared with all staff.

Is the service well-led?

Good ● → ←

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

Specialist community mental health services for children and young people

- Leaders had the skills, knowledge and experience to perform their roles, had a good understanding of the services they managed, and were visible in the service and approachable for staff and people using the service.
- Staff knew and understood the provider's vision and values and how they were applied in the work of their team.
- Staff felt respected, supported and valued. Staff had access to support for their own physical and emotional health needs. They felt able to raise concerns without fear of retribution.
- Teams had access to the information they needed to provide safe and effective care and used that information to good effect.
- Our findings from the other key questions demonstrated that governance processes operated effectively at team level and that performance was reviewed.
- Staff collected and analysed data about outcomes and performance. They engaged actively in local and national quality improvement activities and clinical research.
- Managers worked closely with other local healthcare services and organisations (schools, public health, local authority, voluntary and independent sector) to ensure that there was an integrated local system that met the needs of children and young people living in the area. There were local protocols for joint working between agencies involved in the care of children and young people.

However;

- Recommendations from one internal review were not completed in line with original timeframes identified on the corresponding action plan.

Areas for improvement

We found areas for improvement in this service. See the Areas for Improvement section above.

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 the service provider was not meeting. The provider must send CQC a report that says what action it is going to take to meet these requirements.

For more information on things the provider must improve, see the Areas for improvement section above.

Please note: Regulatory action relating to primary medical services and adult social care services we inspected appears in the separate reports on individual services (available on our website www.cqc.org.uk)

This guidance (see goo.gl/Y1dLhz) describes how providers and managers can meet the regulations. These include the fundamental standards – the standards below which care must never fall.

Regulated activity

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

Treatment of disease, disorder or injury

Regulation

Regulation 9 HSCA (RA) Regulations 2014 Person-centred care

Regulated activity

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

Treatment of disease, disorder or injury

Regulation

Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect

Regulated activity

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

Treatment of disease, disorder or injury

Regulation

Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

Regulated activity

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

Treatment of disease, disorder or injury

Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance

Our inspection team

Jenny Wilkes, Head of Hospitals Inspection led this inspection. We had access to one executive reviewer on this inspection who was a Chief Executive Officer. We also used a specialist advisor who had previous experience as a board level director. NHS Improvement also supported our inspection of well-led for the trust overall.

The team included two further specialist advisors who had expertise in safeguarding and equality and diversity.

The inspection team covered four core services and included 11 inspectors, one inspection manager, one Mental Health Act reviewer, three assistant inspectors, a pharmacist specialist, one expert by experience and specialist advisors.

Executive reviewers are senior healthcare managers who support our inspections of the leadership of trusts. Specialist advisers are experts in their field who we do not directly employ. Experts by experience are people who have personal experience of using or caring for people who use health and social care services.