Requires improvement

South West Yorkshire Partnership NHS Foundation Trust

Community mental health services for people with learning disabilities or autism

Quality Report

South West Yorkshire Partnership NHS Foundation
Trust
Fieldhead
Ouchthorpe Lane
Wakefield
WF1 3SP
Tel: 01924 327000
Website: www.southwestyorkshire.nhs.uk

Date of inspection visit: 5 December 2016
Date of publication: 24/03/2017

Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RXG10	Fieldhead Hospital	Kirklees community learning disability service Kirklees intensive support team	WF13 4AD
RXG10	Fieldhead Hospital	Wakefield community learning disability service Wakefield intensive support team	WF1 2TF

Summary of findings

This report describes our judgement of the quality of care provided within this core service by South West Yorkshire Partnership NHS Foundation Trust. Where relevant we provide detail of each location or area of service visited.

Our judgement is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from people who use services, the public and other organisations.

Where applicable, we have reported on each core service provided by South West Yorkshire Partnership NHS Foundation Trust and these are brought together to inform our overall judgement of South West Yorkshire Partnership NHS Foundation Trust.

Summary of findings

Ratings

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

Overall rating for the service	Requires improvement 
Are services safe?	**Requires improvement** 
Are services effective?	**Good** 
Are services caring?	**Good** 
Are services responsive?	**Requires improvement** 
Are services well-led?	**Good** 

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

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

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

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

Summary of findings

Contents

Summary of findings

Overall summary

We rated community-based mental health services for people with learning disabilities or autism as requires improvement overall because:

- Staff could not quickly access risk assessments in 17 of the 26 care records we reviewed. They were either stored in different formats and/or different locations, or had not migrated to the new electronic system.
- Waiting times to see members of the multidisciplinary team and for specialist clinics were long in Barnsley and Kirklees. Therefore, the community-based mental health services for people with a learning disability or autism were still not meeting Regulation 9 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

However:

- The community based mental health services for people with a learning disability or autism had improved speed of access to psychology, meaning that nobody was waiting for longer than 18 weeks for psychological assessment or therapy.
- The trust had ensured systems and processes were in place to monitor the quality and safety of services integrated with local authority services. The trust had worked with commissioners to develop key performance indicators that were meaningful to staff and people who used the service. They had restructured their learning disability teams and all staff were now accountable to trust managers. The community based mental health services for people with learning disabilities or autism were now meeting Regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014. Therefore we found at this inspection that the services had addressed the issues that had caused us to rate the well-led domain as requires improvement following the inspection in March 2016.
- The trust had also completed actions in response to recommendations CQC stated they should take following the inspection in March 2016. At this inspection, almost all care records documented consideration of consent and capacity, and some included detailed accounts of decision-making when people lacked capacity to decide for themselves. Also, all staff could access the trust electronic care record system to access and input information about people who were using the service. There was a policy in place governing information sharing with other organisations, including the local authority.
- Following our inspection in March 2016, we rated the services as good for effective and caring. Since that inspection we have received no information that would cause us to re-inspect these key questions or change the ratings.

Summary of findings

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

Are services safe?

Requires improvement

We rated safe as requires improvement because:

- At the last inspection in March 2016 we rated the safe domain as good. However, we made recommendations that the trust should ensure their risk assessment tool is used consistently across the service. At this inspection in December 2016, staff could not quickly access risk assessments in 17 of the 26 care records we reviewed. They were either stored in different formats and/or different locations, or had not migrated to the new electronic system.

However:

- The trust standard risk assessment tool was available for staff to complete in people's electronic care records.
- Most records in Kirklees included an individual risk assessment in one of a number of formats.

Are services effective?

Good

At the last inspection in March 2016 we rated effective as good. Since that inspection we have received no information that would cause us to re-inspect this key question or change the rating.

- Also, at this inspection we looked at whether the trust was consistently recording details of decisions within capacity assessments, as we had previously identified this as something the provider should improve.

Are services caring?

Good

At the last inspection in March 2016, we rated caring as good. Since that inspection we have received no information that would cause us to re-inspect this key question or change the rating.

Are services responsive to people's needs?

Requires improvement

We rated responsive as requires improvement because:

- Waiting times to see members of the multidisciplinary team and for a range of specialist assessments were long in Barnsley and Kirklees.

However:

- The service had addressed the waiting times to access psychology which had caused us to rate the responsive domain as requires improvement at the inspection in March 2016. Nobody was waiting longer than 18 weeks for psychology.

Summary of findings

- Most of the people on the waiting list for psychology, specialist assessments, or to see other members of the multidisciplinary team, were also getting support from another member of the team.
- Staff prioritised people on the waiting list according to risk.

Are services well-led?

Good

We rated well-led as good because:

- The service had addressed the issues that had caused us to rate well-led as requires improvement following the March 2016 inspection.
- At the inspection in March 2016, staff employed by the trust were not based in the local authority teams. Also, teams integrated with local authority services were not governed by key performance indicators and did not provide performance data to enable the trust to monitor the quality and safety of service provision. In addition, not all staff based within local authority community learning disability services could update the trust's clinical care records.
- At this inspection in December 2016, we found that the trust had restructured their learning disability teams and all staff were now accountable to trust managers. All staff could access the trust electronic care record system to access and input information about people who were using the service. There was a policy in place governing information sharing with other organisations, including the local authority.
- Senior managers had worked with commissioners to develop key performance indicators that were meaningful to staff and people who used the service.

However:

- Three of the four services had not yet reported on the key performance indicators.

Summary of findings

Information about the service

South West Yorkshire Partnership NHS Foundation Trust provides community services for people with a learning disability across Barnsley, Calderdale, Kirklees and Wakefield. The services have been restructured since our previous inspection. None of the services are now integrated with the local authority. Each locality has a community learning disability team and an intensive support team. The teams are commissioned by their local clinical commissioning groups.

The community learning disability teams work with people and their carers to assess individual skills and needs, plan support and care, and support physical and mental health needs. The intensive support teams are able to respond more quickly to people who need urgent care, for example if placements are at risk of breaking down.

When the CQC inspected the trust in March 2016, we found that the trust had breached regulations. We issued the trust with two requirement notices for community based mental health services for people with learning disabilities or autism. These related to the following regulations under the Health and Social Care Act (Regulated Activities) Regulations 2014:

- Regulation 9 HSCA (RA) Regulations 2014 Person centred care
- Regulation 17 HSCA (RA) Regulations 2014 Good governance.

Our inspection team

Our inspection team was led by:

Team Leader: Kate Gorse-Brightmore, inspection manager (mental health), Care Quality Commission.

The team inspecting this core service comprised a CQC inspection manager and a CQC inspector.

Why we carried out this inspection

We undertook this inspection to find out whether South West Yorkshire Partnership NHS Foundation Trust had made improvements to their community mental health services for people with learning disabilities or autism since our last comprehensive inspection of the trust in March 2016.

When we last inspected the trust in March 2016, we rated community mental health services for people with learning disabilities or autism as **requires improvement** overall. We rated the core service as good for safe, good for effective, good for caring, requires improvement for responsive and requires improvement for well-led.

Following this March 2016 inspection we told the trust that it must take the following actions to improve community mental health services for people with learning disabilities or autism:

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

These related to the following regulations under the Health and Social Care Act 2008 (Regulated Activities) regulations 2014:

- Regulation 9: Person centred care.
- Regulation 17: Good governance.

We also told the trust that it should take the following actions to improve:

- The trust should ensure their risk assessment tool is used consistently across the service.

Summary of findings

- The trust should ensure staff consistently record details of decisions within capacity assessments.
- The trust should ensure there is a process for all staff to access information held in clients' electronic records.

How we carried out this inspection

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

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

Before the inspection, we reviewed information that we held about community-based mental health services for people with learning disabilities or autism, and requested information from the trust. This suggested that the ratings of good for safe, effective and caring, that we made following our March 2016 inspection, were still valid. Therefore, during this inspection, we focused on issues that had caused us to rate the service as requires improvement for responsive and well-led. We also made three recommendations at the inspection in March 2016 that the trust should take that we followed up at this inspection. We announced this inspection two days before the site visit.

During the inspection visit, the inspection team:

- visited two of the four localities (community learning disability teams and intensive support teams at Kirklees and Wakefield)
- spoke with three of the managers who had responsibility for these services
- spoke with 10 other staff members, including nurses, clinical psychologists, speech and language therapists, a physiotherapist and a healthcare assistant
- looked at 26 treatment records of people who were using the service.

After the inspection visit, the inspection team:

- spoke with the managers of the other two localities (Barnsley and Calderdale)
- spoke with one person who was using the service and five carers
- looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the provider's services say

We spoke with one person who was using the service, and five carers. We spoke with at least one person from each of the four localities.

All of the people we spoke with had positive things to say about the service. They described staff as friendly, willing to help, understanding, compassionate and caring. Three carers told us that the service had really helped them and the people they cared for.

Two carers told us that they had had to wait for between six and nine months for an appointment for a specialist assessment or to see a particular clinician. They felt that this delay had a negative impact on the person they cared for. One of the carers had complained and was satisfied that the person they cared for had now been seen.

Summary of findings

Areas for improvement

Action the provider MUST take to improve

- The trust must ensure timely access to specialist assessment and interventions within community learning disability teams.
- The trust must ensure that clinical risk assessments are completed and accessible within the electronic care record system.

Action the provider SHOULD take to improve

- The trust should ensure they report on the key performance indicators for each service to ensure the ongoing monitoring of quality and safety in the community mental health services for people with learning disabilities and autism.

South West Yorkshire Partnership NHS Foundation Trust

Community mental health services for people with learning disabilities or autism

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Kirklees community learning disability service Kirklees intensive support team	Fieldhead Hospital
Wakefield community learning disability service Wakefield intensive support team	Fieldhead Hospital

Mental Capacity Act and Deprivation of Liberty Safeguards

Following our last inspection in March 2016, we recommended that the trust should ensure that staff consistently record details of decisions within capacity assessments. At this inspection, almost all care records documented consideration of consent and capacity, and some included detailed accounts of decision-making when people lacked capacity to decide for themselves.

Requires improvement

Are services safe?

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

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

Our findings

Assessing and managing risk to patients and staff

Following our previous inspection in March 2016, we advised that the trust should ensure their risk assessment tool was used consistently across the service. On this inspection we reviewed 26 care records; 12 in Kirklees and 14 in Wakefield. We found that the trust standard Sainsbury risk assessment tool was available in all people's electronic care records, and that it was completed for people who had been referred into the service within the past two months. However, only nine of all records reviewed included the Sainsbury risk assessment (five in Kirklees and four in Wakefield).

In Kirklees, staff could not find risk assessments for nine people during our visit. This was because information on risk was stored in other formats either within the new electronic system, on the shared computer drive or on a previous electronic system. Not all staff could access the previous electronic system. Managers later provided assurance that six people did have some form of risk assessment on their care record. Three did not have any risk assessment.

In Wakefield, staff told us that risk assessments were completed for ten people but had not migrated to the new electronic system and were therefore not visible. Managers told us that they would immediately take action to resolve this. Migration is when information from a previous system is brought over to a new system; this had happened in Wakefield the week before our inspection.

On the day of inspection staff could not quickly access a summary and formulation of risk from 17 of the 26 records we reviewed. This meant that if staff did not know the person well they would not be able to give urgent, appropriate advice and support to help keep the person safe.

Are services effective?

Good

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

Our findings

Good practice in applying the Mental Capacity Act

Following our last inspection in March 2016, we recommended that the trust should ensure that staff consistently record details of decisions within capacity assessments.

We reviewed 26 care records at this inspection. At both Kirklees and Wakefield, we saw evidence of staff considering consent and capacity routinely in their work. It was not always easy to locate information about capacity in people's care records. In three care records in Kirklees, we could not find any reference to capacity, consent or best interests.

In Wakefield we saw three examples and in Kirklees we saw one example of detailed accounts of best interest decision-making when people lacked capacity to decide for themselves. Individual staff had created their own way of recording the process. This was in line with the trust's Mental Capacity Act policy.

Good

Are services caring?

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

Our findings

At the last inspection in March 2016, we rated caring as good. Since that inspection we have received no information that would cause us to re-inspect this key question or change the rating.

Are services responsive to people's needs?

Requires improvement

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

Our findings

Access and discharge

At the inspection in March 2016, waits to access psychological therapies were high and in excess of 18 weeks.

At this inspection, wait times for psychological therapies had improved significantly. There was nobody on the current psychology waiting list who had been waiting for longer than 18 weeks. Clinical psychologists had achieved this by reviewing the people on the waiting list, recruiting an assistant psychologist and moving to a more 'clinic-based' way of working. Clinical psychologists were also supporting generic improving access to psychological therapy teams to build up skills to work with people with a learning disability. The requirement notice relating to waiting times for psychology had therefore been met.

However at this inspection in December 2016, waiting times to see members of the multidisciplinary team and for specialist assessments were high in Barnsley and Kirklees. There were 18 people waiting over six weeks for an assessment for dysphagia (a problem with eating, drinking or swallowing with potentially serious health consequences).

However, there were 332 people on the waiting list across the four locations to see other members of the multi-disciplinary team, or for specialist clinics. There was also evidence of people waiting long periods to access these disciplines/clinics, with 67 people (20% of those on the waiting list) waiting longer than 18 weeks.

In Barnsley, 18 people were waiting longer than 18 weeks to see other members of the multi-disciplinary team or to access specialist clinics, including five people waiting for physiotherapy, five people waiting or occupational therapy, and eight people waiting for speech and language therapy. The longest wait was 77 weeks. However, 14 of the 18 people who had been waiting longer than 18 weeks were getting support from other members of the multidisciplinary team.

In Calderdale, nobody was waiting longer than 18 weeks to see a member of the multidisciplinary team or to access specialist clinics.

In Kirklees, 48 people were waiting longer than 18 weeks to see a member of the multi-disciplinary team or to access specialist clinics, including three people waiting for physiotherapy, 13 people waiting for occupational therapy, nine people waiting for an assessment for autism spectrum disorder, 15 people waiting for nursing, and eight waiting for speech and language therapy. The longest wait was 81 weeks for an assessment for autism spectrum disorder. Thirty of the 48 people on the waiting list for longer than 18 weeks were getting support from other members of the multidisciplinary team.

In Wakefield, one person had been waiting longer than 18 weeks for speech and language therapy. They had been waiting 26 weeks and were getting support from another member of the multidisciplinary team.

In Barnsley and Kirklees therefore there were significant problems with waiting lists. Sixty-six people had been waiting longer than 18 weeks to see a specialist clinician and 22 of these were not getting any support from another member of the team during their wait. A minority (eight in total) had been waiting more than a year to see a specialist, and two of these were not getting any support from another member of the team.

Eighteen people in total were waiting longer than the trust target of six weeks for a dysphagia assessment from a speech and language therapist. Eight of these 18 people had been waiting longer than 18 weeks. Dysphagia is a difficulty eating, drinking or swallowing. It affects around 10% of people with a learning disability. It can lead to people getting food or drink in their lungs and other health problems that can be very serious.

There were processes in place to reduce the risk to people on the waiting list. Staff triaged each person at referral stage, and graded their urgency using the initial risk screening tool. There was a specific tool for dysphagia, with a low threshold for urgent appointments. Staff told us that all people on the waiting list had been assessed as low risk. Waiting lists were reviewed every four to six weeks, and people and carers were informed of how to contact the service if their situation changed. Most people on the waiting list were also open to another member of the community learning disability team, who could help to monitor their wellbeing. However, the two carers we spoke with who had experience of waiting for between six and nine months for a specialist appointment told us that the wait had had a negative impact on the person they cared for.

Are services well-led?

Good

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

Our findings

Good governance

At the inspection in March 2016, staff employed by the trust were not based in the local authority teams. Also, teams integrated with local authority services were not governed by key performance indicators and did not provide performance data to enable the trust to monitor the quality and safety of service provision. In addition, not all staff based within local authority community learning disability services could update the trust's clinical care records.

At this inspection in December 2016, the trust teams had been restructured, with a single base for community learning disability and intensive support teams in each locality: Barnsley, Calderdale, Kirklees and Wakefield. All staff employed by the trust were line managed by trust managers, and all used the trust electronic care record system to access and input information about people who were using the service. There was a policy in place governing information sharing with other organisations, including the local authority.

Service managers had been working with commissioners to develop 17 key performance indicators that were meaningful to staff and people using the service. These included operational standards around numbers of referrals logged within 24 hours, percentage of people using the service who have a health action plan and hospital passport, and percentage of care plans developed with a person-centred approach. Some of these standards were linked to national targets around transforming care for people with a learning disability. All standards had a clear 'method of measurement' identified.

Key performance indicators had been reported on in one location, Calderdale. The other locations had not yet started measuring their performance, but anticipated producing quarterly reports by the end of March 2017. The staff we spoke with in Kirklees and Wakefield were only aware of two of the key performance indicators (targets for seeing new referrals and targets for clinical time).

Overall, the trust had met the requirement notice relating to systems and processes to monitor the quality and safety of services. The fact that the services were no longer integrated with the local authority meant that part of the requirement notice was not relevant.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care How the regulation was not met: We found long waiting times for members of the multidisciplinary team or specialist clinics in Barnsley and Kirklees. This had the potential to impact negatively on service users' wellbeing. This is a breach of Regulation 9(3)(b)

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment How the regulation was not met: Staff could not quickly access risk assessments in 17 of 26 care records reviewed. This is a breach of Regulation 12(2)(b)