

Good



South West Yorkshire Partnership NHS Foundation  
Trust

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

## Quality Report

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## 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	North Community Mental Health Team	S71 5RG
RXG10	Fieldhead Hospital	Barnsley Assertive Outreach Team	S70 3RD
RXG10	Fieldhead Hospital	Wakefield Community Mental Health Team 1 (The Dancer)	WF1 4EB
RXG10	Fieldhead Hospital	Wakefield Single Point of Access	WF1 3SP
RXG10	Fieldhead Hospital	South Kirklees Assertive Outreach Team	HD1 3LT

# Summary of findings

RXG10

Fieldhead Hospital

Wakefield ADHD and Autism  
service

WF1 5PN

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

Good 

Are services safe?

Good 

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

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# Summary of findings

## Overall summary

We rated community-based mental health services for adults of working age as GOOD because:

- patients had risk assessments in place which were reviewed regularly. Risk management was practised in daily and weekly multi-disciplinary meetings
- there were good safeguarding practices in place. Staff knew how to identify abuse and raise concerns
- there were lone worker protocols in place that staff understood and adhered to
- services were engaged in clinical audit. Systems were in place to monitor adherence to National Institute for Health and Care Excellence (NICE) guidance. Action plans were in place to achieve compliance where required
- patients were involved in decisions about their care. Care plans were personalised, holistic and recovery focused
- feedback from patients was positive. We observed patients being treated in a respectful manner and with a caring and empathic approach
- there were processes in place to prioritise referrals and respond to urgent referrals. Teams were able to engage with individuals who found it difficult or were reluctant to engage with services

- there was strong leadership at team and business delivery unit levels.

However;

- there were long waiting times for access to psychological therapies in parts of the service. In Barnsley North community mental health team this was an average of 54 weeks. Provision of psychological therapies to the South Kirklees assertive outreach team was also insufficient
- the ADHD and autism team had a referral to first contact time of 44 weeks. The time from first contact to second contact was 14 weeks. Commissioners were introducing increased funding for the service to help address this
- training on the Mental Health Act and Mental Capacity Act was not mandatory training and not all staff had received training
- electronic systems used to store patient records were unreliable. Contingency plans to use paper records were in place. The issue of electronic records systems was on the trust risk register
- staff expressed concerns about caseload and capacity. They were concerned that teams were reaching, or at their maximum workloads and this would limit the amount of time they could spend with each person who used the service.

# Summary of findings

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

### Are services safe?

**We rated community-based mental health services for adults of working age as Good for safe because:**

- every patient had a risk assessment in place. These were comprehensive and updated regularly
- staff were knowledgeable around safeguarding and understood trust policies and processes in this regard. There were strong links with local authority safeguarding structures
- compliance with mandatory training was high
- there was a policy in place to support lone working. Staff understood the policy and were using it in practice
- there was a clear process in place for reporting adverse incidents. This was understood by staff. There was evidence of learning from adverse incidents.

However;

- staff expressed concerns about caseload and capacity. They were concerned that teams were reaching, or at their maximum workloads and this would limit the amount of time they could spend with each person who used the service.

Good



### Are services effective?

**We rated community-based mental health services for adults of working age as GOOD for effective because:**

- care plans were personalised, holistic and recovery focused
- systems were in place to monitor adherence to National Institute for Health and Care Excellence guidance. Action plans were in place to achieve compliance where required
- teams included a range of mental health disciplines and there was effective multidisciplinary working embedded in practice
- staff received supervision and appraisal. There was access to specialised training
- practice was compliant with the Mental Health Act(MHA) and the Mental Capacity Act (MCA).

However:

- access to psychological therapies was not consistent across the trust.
- staff expressed concern over the reliability of the trust's electronic systems used to store patient records. The issue was on the trust risk register. Contingency plans to use paper records were in place
- not all staff had received training on the MHA and MCA.

Good



# Summary of findings

## Are services caring?

**We rated community-based mental health services for adults of working age as GOOD for caring because:**

- the feedback we received from patients was positive
- we observed positive, empathetic relationships between staff and patients
- staff treated patients with kindness, dignity, respect and compassion
- patients were involved in decision making about their treatment and in the development of care plans.

Good



## Are services responsive to people's needs?

**We rated community-based mental health services for adults of working age as REQUIRES IMPROVEMENT for responsive because:**

- there were long waiting times for access to psychological therapies in parts of the service. In Barnsley North community mental health team this was an average of 54 weeks. Provision of psychological therapies to the South Kirklees assertive outreach team was also insufficient
- the ADHD and autism team had a referral to first contact time of 44 weeks. The time from first contact to second contact was 14 weeks. Commissioners were introducing increased funding for the service to help address this.

However

- teams had targets in place for time from referral to triage and assessment. Five of the six teams we visited were meeting these targets
- there were processes in place to prioritise referrals and respond to urgent referrals
- there were teams and process in place to engage with individuals who found it difficult or were reluctant to engage with services
- there was access to translation services including at short notice for urgent referrals
- there was a process in place to manage complaints.

Requires improvement



## Are services well-led?

**We rated community-based mental health services for adults of working age as GOOD for well-led because:**

- the trust's vision and values were displayed in all sites. The majority of staff we spoke to were aware of these. There was a values based induction to help embed these

Good



# Summary of findings

- there was strong local leadership of teams
- team managers felt supported by TRIOs within their business divisional unit.
- staff were aware of the providers whistle blowing and duty of candour policies
- there was strong team working and mutual support between staff
- managers had opportunities for leadership development
- the ADHD and autism service was involved in a range of innovative developments. For example they had helped develop the ADHD star and created guidance and a checklist for premises that house autism services.



# Summary of findings

## Information about the service

South West Yorkshire NHS Foundation Trust (SWYPT) provided community adult mental health services across Barnsley, Wakefield and Calderdale and Kirklees. The service was split into three business delivery units (BDUs) which cover each of these localities. The BDUs were led by a three person management team known as a TRIO. The TRIO consisted of a clinical lead, operational manager and practice governance coach.

The trust provided a range of services including assertive outreach teams, community mental health teams, single point of access teams, community therapy teams and psychological therapy services.

The trust was in the process of redesigning services in line with its mental health acute and community transformation programme. The trust had begun to implement the new model within South Kirklees and the AOT and community teams were merging. This included the development of core and enhanced care pathways. The core pathway was provided for individuals with moderate to severe illness who could be predominantly managed by a single practitioner. The enhanced pathway

was provided to individuals with a severe illness who required a multidisciplinary approach. The pathway also captured patients who could be difficult to engage and required more assertive engagement. The enhanced pathway utilised a flexible assertive community treatment (FACT) model. FACT provided an equivalent to assertive outreach for individuals who required it. The FACT model was based on using the resources of the whole team to provide a flexible period of intensive contact. A daily FACT meeting was held to identify individuals who required the service and to plan the delivery and allocation of resources.

The attention deficit hyperactivity disorder service was based in Wakefield but served the wider geography. The service worked with young people moving from children to adult services and adults seeking assessment, referral and community based treatment. The service was not part of the transformation programme.

The Care Quality Commission has not previously inspected these locations.

## Our inspection team

The team was led by:

Chair: Peter Jarrett, Retired Medical Director

Head of Inspection: Jenny Wilkes, CQC

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

Berry Rose, Inspection Manager, community health services, CQC

The team that inspected this core service comprised: a CQC inspector and three specialist advisors. The three specialist advisors were a consultant psychiatrist, mental health nurse and a social worker.

## Why we carried out this inspection

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

## How we carried out this inspection

To 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?

# Summary of findings

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

On this inspection we visited six community mental health services provided by the trust. They were:

- North community mental health team (CMHT) in Barnsley
- Barnsley assertive outreach team (AOT)
- Wakefield CMHT 1
- Wakefield single point of access (SPA)
- South Kirklees AOT
- ADHD and autism service

Before the inspection visit, we reviewed information that we held about these services, asked a range of other organisations for information and sought feedback from people who used services at focus groups.

During the inspection visit, the inspection team:

- toured each team premise
- spoke with the manager of each team

- spoke with 49 other staff members including administrative staff, consultant psychiatrists, nurses, occupational therapists, psychologists, social workers and support workers
- spoke with 31 patients who used the service and two carers
- reviewed four comment cards received from individuals who used the service
- attended and observed six home visits
- attended and observed five clinical appointments including screening appointments and care programme approach (CPA) reviews
- attended and observed three multi-disciplinary meetings
- attended and observed one group supervision session
- attended and observed one clozapine clinic
- looked at 29 care records of patients
- 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

During the inspection we spoke with 31 patients. We also observed 11 clinical engagements including six home visits.

The majority of feedback from patients who used services was positive. People told us that they found staff to be caring and supportive. Patients were involved in decisions about their care and treatment. Our

observations of staff interaction with patients were good. Staff engaged with individuals in a respectful manner and provided space for them to express their opinions. The two carers we spoke to were also positive about the service their loved one was receiving.

We collected four comment cards from patients. All four were positive about the service they had received.

## Good practice

The ADHD and autism service had been involved in several innovations. The team had been involved in the development of the ADHD star. The ADHD star was an assessment and care planning tool for individuals with ADHD. The service had also developed a checklist to ensure environments were appropriate for individuals with autism.

The team had worked with prison and probation services to improve the screening of ADHD for individuals within those environments.

# Summary of findings

## Areas for improvement

### Action the provider **MUST** take to improve

#### Action the provider **MUST** take to improve

- The provider must ensure equitable and timely access to psychological therapies

### Action the provider **SHOULD** take to improve

#### Action the provider **SHOULD** take to improve

- The provider should ensure the RIO electronic care records system is robust and reduce susceptibility to down time
- The provider should ensure that they continue to work with commissioning bodies to reduce waiting times to the ADHD and autism service

- The provider should ensure that staff are provided with appropriate training to manage clients with comorbidities such as learning disabilities.
- The provider should ensure staff in the Barnsley AOT, Wakefield SPA, Kirklees AOT and ADHD and autism service receive training on the Mental Health Act and Mental Capacity Act.
- The provider should ensure that there is effective communication and consultation with staff around the transformation programme

## South West Yorkshire Partnership NHS Foundation Trust

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

### Detailed findings

#### Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
North Community Mental Health Team	Fieldhead Hospital
Barnsley Assertive Outreach Team	Fieldhead Hospital
Wakefield Community Mental Health Team 1 (The Dancer)	Fieldhead Hospital
Wakefield Single Point of Access	Fieldhead Hospital
South Kirklees Assertive Outreach Team	Fieldhead Hospital
Wakefield ADHD and Autism service	Fieldhead Hospital

#### Mental Health Act responsibilities

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

Training in the Mental Health Act (MHA) was not recorded as mandatory training by the trust. Staff within teams had

received various levels of training. On average 60% of staff across the six teams we visited had received recent training in the MHA. Despite this, staff we spoke to demonstrated a good understanding of the MHA and how to apply it.

# Detailed findings

The MHA was being followed in practice. There was an understanding of consent to treatment, community treatment orders and requirements to read patients their rights. Consent to treatment forms were attached to medication cards.

Advice and support was available from a central MHA team. The trust MHA team also carried out audits and monitored practice. Independent Mental Health Advocates services were in place across the service.

## Mental Capacity Act and Deprivation of Liberty Safeguards

Training in the Mental Capacity Act (MCA) was not recorded as mandatory training by the trust. Staff within teams had received variable levels of training. The average training rate across the six teams we visited was 60%.

Overall staff we spoke to demonstrated a good understanding of the MCA and the five statutory principles. The community mental health teams and assertive

outreach teams had approved mental health professionals and best interests assessors (BIA) within the staffing establishment. Advice and support was available from colleagues and a central team.

Capacity assessments had taken place and there was evidence of BIA involvement where appropriate.

# 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

### Safe and clean environment

The buildings we visited were clean and well maintained. Furniture and décor was of a good standard. Interview rooms were equipped with alarms and staff were aware of how to use and respond to them. General equipment was well maintained. Portable appliance testing (PAT) had been carried out on all relevant equipment

Clinic and treatment rooms we visited were equipped with the necessary equipment to carry out examinations as required. Equipment was well maintained and emergency response equipment such as defibrillators were checked regularly. Fridges used to store medication were in working order and temperatures were checked and recorded.

Staff showed an awareness of infection control. There were appropriate infection prevention measures in place, including the provision of hand gels. Posters advising on proper hand washing technique were on display in toilets. Staff received infection control training as part of their mandatory training. Four of the teams were 100% compliant with this training. In Wakefield CMHT the compliance rate was 83%. In the Wakefield SPA compliance was 75%.

Buildings had secure entry and exit procedures. Reception staff managed a signing in and out system for visitors and staff. Fire safety measures were in place and equipment had been tested. Environmental risk assessments were in place and up to date.

Staff in the ADHD and autism service had developed a checklist to ensure that environments were appropriate for individuals with autism. The document had been placed on the trust intranet for other services to access if they wished.

### Safe staffing

The trust provided the following details about staffing levels in the six teams for the last 12 months:

North community mental health team (CMHT)

Qualified nurses (wte): 7.4

Nursing assistants (wte):

Number of vacancies for qualified nurses (wte):

Number of vacancies for nursing assistants (wte):

Staff sickness rate (%) in 12 month period: 0.5

Staff turnover rate (%) in 12 month period: 9.2

Barnsley Assertive Outreach Team (AOT)

Qualified nurses (wte): 5.6

Nursing assistants (wte): 6

Number of vacancies for qualified nurses (wte): 2.0

Number of vacancies for nursing assistants (wte):

Staff sickness rate (%) in 12 month period: 1.9

Staff turnover rate (%) in 12 month period: 0

Wakefield CMHT

Qualified nurses (wte): 3.1

Nursing assistants (wte):

Number of vacancies for qualified nurses (wte):

Number of vacancies for nursing assistants (wte):

Staff sickness rate (%) in 12 month period:

Staff turnover rate (%) in 12 month period: 0.7

Wakefield Single point of access (SPA)

Qualified nurses (wte): 2.7

Nursing assistants (wte):

Number of vacancies for qualified nurses (wte):

Number of vacancies for nursing assistants (wte):

Staff sickness rate (%) in 12 month period: 10.8

Staff turnover rate (%) in 12 month period: 0

South Kirklees AOT

Qualified nurses (wte): 4.0

Nursing assistants (wte):

Number of vacancies for qualified nurses (wte): 1.0

Number of vacancies for nursing assistants (wte):

# Are services safe?

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

Staff sickness rate (%) in 12 month period: 7

Staff turnover rate (%) in 12 month period: 0

ADHD and autism service

Qualified nurses (wte): 2.36

Nursing assistants (wte):

Number of vacancies for qualified nurses (wte): 1.0

Number of vacancies for nursing assistants (wte):

Staff sickness rate (%) in 12 month period: 2.3

Staff turnover rate (%) in 12 month period: 20.3

Not all of the teams had used a recognised tool to estimate the number of staff required. The manager of the ADHD and autism service told us staffing had been developed in line with Policy Implementation Guidance (PIG). The staffing establishment for the South Kirklees AOT had originally been developed in line with PIG. However the service was merging with other South Kirklees community teams under the flexible assertive community treatment model (FACT) and this was no longer relevant. There was no tool used in the remaining teams. However staffing reviews had taken place. For example this led to a new occupational therapy post in the North CMHT. A staffing tool was incorporated in the new structures.

We requested from the trust individual caseload numbers for each of the teams which we visited. The trust informed us they were unable to provide individual caseload numbers. This meant it was not possible to determine the caseloads of individual members of staff. However when we spoke to staff in Barnsley AOT they told us they had an average caseload of between 15 and 16. According to the Department of Health, Mental Health Policy Information Guide (PIG) 2001 early intervention and AOTs should carry a caseload of approximately 12 per care coordinator.

Staff in the South Kirklees AOT who were operating to the FACT model told us caseloads ranged from 16 to 24. This was within the proposed caseload size for the enhanced pathway which was 20 to 25. Under the FACT model staff carried a mixed caseload of individuals some of whom required an assertive outreach approach and more frequent contact. Staff expressed concern over caseload

size and felt that the new model diluted the assertive outreach component of care. However due to the model being in the early stages of implementation it was not possible to determine any impact.

Department of Health PIG (2002) for CMHTs recommends a maximum caseload of approximately 35. In CMHTs staff described high caseloads that in some instances were above this level.

Staff within these teams expressed concern to us about their caseloads and capacity and how this could impact on the delivery of care. We discussed with staff how these caseloads were managed. Staff described a team approach in which colleagues supported each other. Caseload management was discussed within supervision and at team meetings. Staff felt they were working close to full capacity but were managing within their teams.

Staff in the SPA did not carry caseloads. Staff in the ADHD and autism team told us they operated manageable caseloads.

Psychiatrists were part of the establishment within the CMHTs and the ADHD and autism service. Psychiatrists were built into the establishment of the FACT model in South Kirklees. Staff had rapid access to psychiatrists when required. Staff in the SPA was able to access a consultant psychiatrist for advice when required. They were also able to refer to the crisis team.

There was a mandatory training programme in place for staff. Staff told us mandatory training was delivered in both e-learning and face to face formats. Attendance and required training was monitored through supervision. Staff compliance with mandatory training was high across five of the teams. Wakefield SPA was the only team below the trust target of 80% compliance. This was due to the low number of staff employed by the service (less than three) and staff sickness.

North CMHT: 95.3%

Barnsley AOT: 100%

Wakefield CMHT 1: 89.4%

Wakefield SPA: 76.5%

South Kirklees AOT: 91.9%

ADHD and autism service: 100%



# Are services safe?

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

Within Wakefield SPA there were four elements of training below the 80% trust target. These were the management of aggression (33%), fire safety (60%), infection control (75%) and information governance (75%).

The average mandatory training rate across adult mental health services was 89%.

## Assessing and managing risk to patients and staff

The service used the Sainsbury mental health risk assessment tool. Initial assessment was carried out by the SPA using a level one risk assessment. The level one risk assessment was used as a triage assessment tool. CMHT and AOT completed a level two assessment for individuals placed on the care programme approach (CPA). The level two assessment provided a more in depth and comprehensive assessment. The ADHD and autism team completed a level one risk assessment. There was a trust policy in place to support risk management and the use of the tools.

Risk assessments were updated in response to a patient's presentation, or every 12 months as part of a review. We reviewed 29 care records and all had a risk assessment in place. However four had not been updated in line with the minimum requirement set by the trust. Assessments were of a good standard and comprehensive in nature. Risk information was also contained within progress notes on the care record.

Risk was discussed in daily meetings with teams and at weekly multi-disciplinary meetings. We observed two daily meetings and one flexible assertive community treatment (FACT) meeting in which patients who were using the service, or had been referred into it were reviewed. Individuals who were waiting for the service were also monitored. There was an effective discussion of risk in all three meetings. The need to prioritise individuals based on risk was considered. CMHTs used a red, amber and green (RAG) rated system. A RAG system is used to categorise a patient's level of risk. A low level of risk is classed as green. A moderate level of risk is described as amber. A high level of risk is classed as red.

In the South Kirklees AOT the meeting was held in line with the FACT model. Individuals were risk rated based on a red or green system. Individuals assessed as red were placed on the enhanced pathway. Individuals assessed as green were placed on the core pathway. The Standard operating procedure for the new FACT model states that teams will

use a RAG system. It was not clear why this had not yet been implemented. However the new model was in the early stages of implementation and work to deliver it was on-going. Staff expressed concern that the new FACT model simplified risk management. They felt that coupled with an increased caseload risk management and individual knowledge was not as comprehensive. However due to the model being in the early stages of implementation it was not possible to determine any impact.

Crisis plans were in place for individuals and we observed these in care notes. In the SPA these were called relapse plans and were in place for individuals who had been referred on to other community services but had not yet been seen. Information on crisis services had been provided. We observed a crisis plan being reviewed with an individual who used the service during a home visit. Time was taken to ensure the individual understood the contents.

Safeguarding training was mandatory for staff. This included both safeguarding adults and children. AOTs, the ADHD and autism service and Wakefield SPA were fully compliant with both sets of training. The South Kirklees AOT was fully compliant with safeguarding adults training and 80% compliant with safeguarding children training. North CMHT was 66.7% compliant with safeguarding adults training and 83.3% compliant with safeguarding children training. Staff were being booked onto training to ensure full compliance.

Teams had good links with local safeguarding authorities. They were able to explain the potential identification of safeguarding concerns and referral procedures. Safeguarding was discussed within supervision and team meetings. The service had incorporated vulnerable adult risk management (VARM) into its practice. VARM is a multi-agency risk management process to support vulnerable adults who have mental capacity but who make decisions that place them at risk.

There was a lone working policy in place and each team were following local protocols. These included the use of a buddy system, phoning in to report to a duty worker and a log of planned visits. Lone worker devices were available in North CMHT, Barnsley AOT and South Kirklees AOT. Wakefield CMHT, Wakefield SPA and the ADHA and autism



# Are services safe?

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

service were due to receive devices. Lone working devices are worn by staff and provide a means of identifying their location. Staff showed a good understanding of lone working procedures.

## Track record on safety

Between June 2014 and September 2015 the community mental health services reported 35 serious incidents. There were four serious incidents reported by the teams we visited. These were:

- a suspected / actual overdose in North CMHT
- a suspected / actual overdose in CMHT 1 Wakefield
- a suspected / actual suicide in CMHT 1 Wakefield
- a suspected / actual suicide in CMHT 1 Wakefield

Incidents were investigated using root cause analysis (RCA).

## Reporting incidents and learning from when things go wrong

Staff reported incidents using Datix. Datix was a web based risk management system. Staff understood the reporting process and were aware of what to report. In the last 12 months teams we visited had reported 114 adverse incidents. The highest reporting team was the South Kirklees AOT who reported 32 incidents. The lowest reporting team was the ADHD and autism service who reported 5 incidents.

Datix forms were reviewed by local team managers and senior managers within the business delivery unit (BDU). Incidents rated as amber or red required a 48 hour response from the team manager including a 48 hour safety check.

A structure was in place to facilitate formal investigation of serious adverse incidents. This involved a root cause analysis (RCA) approach. We reviewed the RCA for the four serious incidents reported by the teams we visited. They were comprehensive and included a detailed chronology of events. Contributory factors and root causes were assessed. Where applicable lessons learnt and recommendations were captured. The process to share and disseminate learning was also recorded. This included holding learning events and discussing the findings through the governance structure of the relevant BDU.

Adverse incidents and trends were an agenda item on team meetings and BDU business and governance meetings. Staff received feedback on adverse incidents through team meetings and supervision. Learning events had also been held in response to serious incidents.

Staff had a good understanding of duty of candour. There was a module on the Datix system to identify incidents where duty of candour was appropriate.

# 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

### Assessment of needs and planning of care

We looked at 29 care records across the service. Each record had an assessment in place which had been completed in a timely manner. Assessments were comprehensive and captured areas such as mental and physical health, substance misuse and social issues such as housing and employment. Care plans evidenced multi-disciplinary input.

Twenty three of the care plans we reviewed were personalised, holistic and recovery orientated. We found two care plans that were out of date and had not been reviewed in line with the minimum 12 monthly requirement set by the trust.

Records were stored in both paper and electronic form. Electronic records were stored on the RIO system. The RIO system was upgraded to RIO 7 in November 2015 and staff told us that they had experienced several problems with the system following the upgrade. This had meant that the most recent risk and care information had not always been available. Staff told us that the system had improved but was still prone to going slow or going off line.

Issues with RIO were reported through Datix. In the six months prior to our inspection staff across adult community mental health services had reported 25 incidents related to RIO. Records showed that the teams we visited had reported six incidents during this period. Each team had contingency plans in place in the event of a system failure. This involved the use of paper records which were inputted once the system was restored. The issues with the RIO system were captured on the trust risk register risk register and work was ongoing to improve its resilience.

### Best practice in treatment and care

National Institute for Health and Care Excellence (NICE) guidance was available on the intranet and also cascaded through BDUs by the management TRIO. Clinicians demonstrated a good knowledge of NICE guidance. This was also supported and monitored by the trust pharmacy service. We spoke to a pharmacist attending the Wakefield AOT. They attended three times a week and part of their role was to carry out audits of prescriptions. We saw a care record of an individual who was being prescribed above the British national formulary guidance. The care record provided a rationale and a timescale to review prescribing

levels. The trust participated in the prescribing observatory for mental health UK (POMH) to benchmark practice against guidance and other comparable trusts. This included the prescribing and use of Depakote for ADHD in children, adolescents and adults.

Patients were able to access psychological therapies across the services. This included cognitive behavioural therapy provided in individual and group sessions. However access and provision was inequitable. In some services, such as Barnsley CMHT and AOT and the ADHD and autism service psychologists and therapists were part of the establishment. However in other teams such as Wakefield CMHT patients were referred into the trust adult psychological therapies service (APTS). Waiting times to access therapies in each locality varied.

Individuals who used the service were offered support around social needs including employment, housing and benefits. Assessments included recording employment and accommodation status. We saw evidence in care plans of individuals being referred to support agencies to help meet their needs.

The physical health of individuals using the services was considered on initial assessment and managed in collaboration with GP surgeries. Shared care protocols were in place to support this. We reviewed 29 care records and found that a physical health assessment had been carried out in all but three. There was evidence of ongoing monitoring of physical care. We observed one clozapine clinic during the inspection. The clinic was well run and appropriate physical health monitoring took place.

Services used mental health cluster type to measure outcomes. Mental health clusters group patients together based on their diagnosis and severity. Patients can move between clusters as their condition improves or worsens. The recovery star, brief psychiatric rating scale (BPRS) and health of the nation outcome scales were also used within different teams. The ADHD and autism service utilised the ADHD star and the spectrum star which was used with individuals diagnosed with autism.

Audits were carried out across the services we visited. There was a programme of trust audit supplemented by local audits at BDU and team level. Trust audits that had been undertaken included an audit on compliance with consent to treatment for community patients on a

# 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.

community treatment order and a clinical record audit. BDUs also carried out audits and fed back learning through the BDU governance structure and team meetings. Staff also undertook their own case note audits within teams.

## Skilled staff to deliver care

Teams were multidisciplinary in nature. Staffing establishments varied according to service but included nursing, occupational therapy, psychologists, psychiatrists and social workers.

Staff were appropriately skilled for their role. However in North CMHT staff told us that they had some individuals on their caseload with additional learning disabilities. Staff did not feel fully equipped to deal with these individuals. Staff told us they had contacted learning disability services for advice and support but did not feel this had been sufficient. However learning disability awareness training was part of core training for staff in the service. Additional training had also been procured including training around Aspergers syndrome.

Staff we spoke to had received both a trust and local induction. Staff told us they received regular supervision and had access to team meetings. We observed one group supervision session for staff within Barnsley AOT. The session was well structured and effective. Staff were given space to discuss issues in a supportive environment.

Staff had access to specialist training. We saw evidence of two nurses who had been supported to undertake masters degrees. Within Wakefield CMHT there were three staff undertaking quality of care training and one staff member who had been identified for additional safeguarding training. Within the ADHD and autism service staff had undertaken training on the autism diagnostic observation schedule as well as training on the assessment of dyspraxia and sensory integration training.

The percentage of non-medical staff that had been appraised in the last 12 months was 98%. We spoke to two administrators during our inspection. They had both received an annual appraisal and supervision. 83% of doctors had been revalidated during the last 12 months.

Team managers had access to policies and human resources support to address poor staff performance and attendance. We spoke to one administrator who described changes that had been made to her equipment in response to an illness.

## Multi-disciplinary and inter-agency team work

The teams operated within a multidisciplinary team (MDT) framework and we observed a collaborative approach to care and treatment. Regular and effective MDT meetings took place. We observed three meetings. The meetings were planned and well structured. Discussion was effective and comprehensive covering areas such as risk, changes in presentation and safeguarding concerns. Peer support and advice was offered within the meetings. Urgent referrals were identified and allocated.

There were good links with other teams and services within the trust. These included links with crisis services, bed management and inpatient wards. Staff in CMHTs told us they were invited to attend ward rounds for individuals under their care coordination.

All teams had good links with primary care, social services and other external organisations. These included care homes, private providers, GP surgeries and voluntary sector organisations. The Wakefield SPA was working with GP surgeries to expand their liaison and advisory role.

Teams had social workers and approved mental health practitioners within their teams. These staff were employed by local authorities but formed part of the community teams.

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

Training in the Mental Health Act (MHA) was not recorded as mandatory training by the trust. Staff within teams told us they had received training on the MHA. However this training varied in nature and was inconsistent across teams. Teams kept records of training but acknowledged these did not capture all events. For example Barnsley AOT told us they held a MHA awareness session 12 months ago but an attendance register was not taken. Figures were provided for staff who had attended MHA training. Figures provided were:

North CMHT – 87.5% (seven staff out of eight)

Barnsley AOT – 54.5% (six staff out of 11)

Wakefield CMHT 1 – 100% (five staff out of five)

Wakefield SPA – 50% (two staff out of four)

South Kirklees AOT – 33.3% (one staff out of three)

ADHD service – 58.3% (seven staff out of 12)

# 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.

Staff told us they were aware of training sessions that were scheduled and were seeking to book themselves on.

Staff we spoke to demonstrated a good understanding of the MHA and how to apply it. There was an understanding of consent to treatment, community treatment orders (CTO) and requirements to read individuals their rights. Staff were able to access MHA policies on the trust intranet. Advice and support was available from colleagues and a central MHA team. The trust MHA team also carried out audits and monitored practice.

MHA documentation was stored in paper form. Risk assessments and care plans were in place to support CTOs. Evidence of individuals on CTOs being given their rights was captured within progress notes. We saw consent to treatment forms attached to medication and depot cards.

Independent Mental Health Advocates (IMHA) services were in place across the service. Staff and individuals who used the service that we spoke to were aware of the IMHAs and how to access them.

## **Good practice in applying the Mental Capacity Act**

Training in the Mental Capacity Act (MCA) was not recorded as mandatory training by the trust. Staff within teams told us they had received training on the MCA. However this training varied in nature and was inconsistent across teams. Figures were provided for staff who had attended MHA or MCA training. Figures provided were:

North CMHT – 87.5% (seven staff out of eight)

Barnsley AOT – 54.5% (six staff out of 11)

Wakefield CMHT 1 – 100% (five staff out of five)

Wakefield SPA – 50% (two staff out of four)

South Kirklees AOT – 33.3% (one staff out of three)

ADHD service – 58.3% (seven staff out of 12)

Staff told us they were aware of training sessions that were scheduled and were seeking to book themselves on.

Overall staff we spoke to demonstrated a good understanding of the MCA and the five statutory principles. We saw capacity assessments that had taken place including around financial management. We saw evidence that individuals had been supported to make decisions and the involvement of best interest assessors (BIA) where required.

The CMHTs and AOTs had approved mental health professionals and BIAs within the staffing establishment. Advice and support was available from colleagues and a central team. Audits around the MCA were undertaken at both trust and local levels.

# Are services caring?

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

## Our findings

### Kindness, dignity, respect and support

We observed five consultations and six home visits during the inspection. Patients were treated with compassion and understanding. Staff engaged with individuals in a respectful and dignified manner. Staff displayed good listening skills and discussed care and treatment options in a clear manner. Interactions were positive and recovery focused. Staff showed a good understanding of individual need and were person centred in their approach.

We spoke to 31 individuals who used the service. Overall people told us they were happy with the service they received. Staff were considered to be caring and responsive. However two individuals told us that they did not get on with their care coordinator and one felt that they were not being listened too. One individual felt they were not getting the right service but planned to discuss this with their care coordinator at their next appointment. People accessing the ADHD and autism service were particularly praising of the service they received.

### The involvement of people in the care that they receive

Patients told us they were involved in decisions about their care. The care records we reviewed demonstrated this. We reviewed 29 care records. We found that 23 were personalised, holistic and recovery orientated. Two were out of date. People we spoke with were aware of the content of their care and crisis plans.

Families and carers were involved in care with the consent of the individual using the service. In three of the consultations we observed family members were present. They were able to contribute to the discussion and their views were considered. Staff were able to carry out carers assessments and develop care plans where required. Carers could also be referred to support services for assessment or support. We spoke to two carers during the inspection. They stated they felt involved in care and were involved in decisions around treatment as appropriate. One of the individuals had a carers assessment and care plan in place.

Advocacy services were available in all of the teams that we visited. Staff were aware of how to access these services and promotional material was on display in buildings. Individuals we spoke to were aware of advocacy services and felt comfortable asking their care coordinators for more information or support to help access them.

Individuals we spoke to had been invited to attend consultation events around the transformation of services. We spoke to individuals who had also been asked about joining service user forums within their service. Staff in the Barnsley AOT, Wakefield CMHT 1 and ADHD and autism service told us they had sat on interview panels with individuals who used the service.

# 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

Referrals into community mental health teams (CMHT) and assertive outreach teams (AOT) were managed through a single point of access service (SPA). The SPA triaged referrals and escalated urgent referrals into crisis services. The SPA had procedures in place to ensure that urgent referrals were seen within either four or 24 hours depending on the urgency. Non urgent referrals were assessed for their need and referred into the appropriate service. There was a 14 day target for non-urgent referrals. CMHTs and AOTs had a 14 day target from referral to first appointment. Referrals to the ADHD and autism service were managed by that service. Referrals could be prioritised based on assessment.

The trust provided data regarding the length of time patients were waiting to start treatment after being assessed. The data was split into two localities; Calderdale, Kirkless and Wakefield and Barnsley.

In Calderdale, Kirkless and Wakefield 87% of patients were given an initial assessment within 14 days of referral. This national target was 80%. The national target from initial assessment to onset of treatment within six weeks was 95%. Calderdale, Kirkless and Wakefield achieved 98%. In Barnsley 96% of patients were given an initial assessment within 14 days of referral and 99% commenced treatment within six weeks.

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

Patients in some parts of the trust faced long waits to access psychological therapies. Wakefield CMHT 1 referred into the Wakefield adult psychological therapies service (APTS).

Figures provided by the trust showed that waiting times to access this service were on average 52 days. The ADHD and autism service had psychology built into their establishment and were able to offer access to individual and group therapies.

However figures provided by the trust showed that within North CMHT the average waiting time from the date of referral to the date of the first therapy was 54 weeks. The maximum wait was 76 weeks. This was confirmed by staff who told us waiting lists had been as high as two years. The average waiting time to access psychological therapy had been increasing over the last two years. This was the result of an increase in demand and a temporary reduction in psychology provision within the BDU in 2014. There were 10.4 whole time equivalent (wte) staff in 2013. This was reduced to 8.1 wte in 2014. The current staffing level was 10.5 wte and had been increased in response to demand.

The trust had carried out a comparison of workforce across the BDUs and identified that Barnsley psychological services were working with a smaller workforce per head of population than the other localities. The local transformation strategy included plans to increase the psychological therapy workforce within the BDU by 3.5 wte. The BDU had begun to pilot a choose and book system in two CMHTs and an opt-in system in two different CMHTs to reduce the number of appointments not attended at the assessment stage. Staff told us the pilots would be evaluated and the most successful rolled out across all CMHTs.

The waiting list for psychological services within North CMHT was regularly reviewed. A referrer could request that a new referral was prioritised for clinical reasons. Such referrals would be discussed within the team at an allocation meeting and a decision to prioritise made on clinical need and risk. Psychology services were expanding group interventions to help manage and reduce the waiting list. These included the introduction of a dialectical behaviour therapy skills group and a mindfulness based cognitive therapy group. Plans were in place to continue to expand these activities.

South Kirkless AOT were able to access psychological therapies through the Kirkless psychology service. However this access was limited and staff told us they were unable to access psychological therapies for individuals with a diagnosis of psychosis which is not in line with NICE best practice guidance. The Kirkless psychology service had a



# Are services responsive to people's needs?

Requires improvement 

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

0.5 wte clinical psychologist working across the Kirklees care management pathway. In addition there were sessions from a family and systemic psychotherapist but staff told us this did not meet demand. Staff also received case supervision from the clinical psychologist in a group format.

We raised the provision of psychological therapies within the South Kirklees team with the trust. The trust acknowledged that access was not as comprehensive as it should be. The community transformation process was aiming to increase psychological provision and create better access.

Individuals who used the service that we spoke to did not specifically raise the provision of psychological therapies as an issue. However individuals who attended a focus group during the inspection raised concern over the possible closure of the art psychotherapy group in Wakefield and the impact this would have on their recovery.

The SPA had procedures in place to ensure that urgent referrals were seen within either four or 24 hours depending on the urgency. There was a 14 day target for non-urgent referrals. CMHTs and AOTs had a 14 day target from referral to first appointment.

Teams were proactive in re-engaging with individuals who did not attend appointments. Follow up calls and letters were utilised to maintain contact and book a new appointment date. Assertive outreach services and approaches were in place for individuals who found it difficult or were reluctant to engage with services.

Teams responded promptly when patients phoned in. Eight of the individuals who used the service that we spoke to made reference to being able to contact staff easily via telephone. They told us staff were responsive and returned calls if they were not available. Duty workers were also available to speak to.

Services were flexible in the times and location of appointments. We saw one example of an individual in North CMHT who had a regular appointment at 18:15pm due to work commitments.

## **The facilities promote recovery, comfort, dignity and confidentiality**

Buildings that patients visited were well maintained, clean and had appropriate furniture. Rooms were available for individual consultations. Interview rooms were adequately sound proofed to maintain people's privacy.

There was a range of information available in reception areas and throughout the buildings. This included information on services and treatments, local advocacy services and participation groups, general health care and patient rights.

## **Meeting the needs of all people who use the service**

The service was able to meet the needs of those who required disabled access. Where teams were located above ground floor level lifts were in place and ground floor consultation rooms were available. Staff also carried out home visits or used alternative trust locations to aid access for individuals using the service. However, we spoke to one individual who used the Wakefield CMHT service. They stated that the disabled parking spaces were often blocked by non-disabled drivers. There was no evidence of this on our visit.

Teams had access to translation services. This included face to face and telephone translation. Staff told us translation services were responsive and of a good quality. Information leaflets were not routinely displayed in other languages. However staff were able to access services to have documents translated where required. Language needs were identified through referral and assessment information.

## **Listening to and learning from concerns and complaints**

Trust data showed that across AOTs, CMHTs, SPA and the ADHD service over the last 12 months 94 complaints had been received. Sixty one of these complaints were upheld. None of the complaints had been referred to the Parliamentary Ombudsmen.

We spoke to four individuals who used the service who had complained in the past. Three felt that their complaint was taken seriously. However, one individual felt their complaint wasn't dealt with to their satisfaction although they had not followed this up. Individuals who used the

# Are services responsive to people's needs?

Requires improvement 

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

service that we spoke to stated they would be comfortable raising complaints. Not all individuals were immediately aware of how to do so but told us they would approach staff or take an information leaflet.

Staff we spoke to were aware of the complaints process and how to escalate a formal complaint. Learning from complaints was disseminated through team meetings and supervision.



# 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

### Vision and values

The majority of staff that we spoke to were aware of the trust's vision and values. Copies of these were displayed in buildings we visited. Staff undertook a values based induction to help integrate these into care.

Staff we spoke to were aware of senior managers within their business delivery unit (BDU). Members of the TRIO had attended services. Some staff had met senior trust management at trust events. Staff acknowledged they received regular emails from the chief executive and communications department but some felt there was a disconnect between local teams and senior managers.

### Good governance

Services monitored performance through commissioner targets, commissioning for quality and innovation targets and key performance indicators. There were regular business meetings at team and BDU level where performance was discussed. In South Kirklees we saw a performance board that was on the intranet and accessible to managers.

Team managers felt supported in their role by the TRIOs within their BDU and felt the system worked well. Managers were able to escalate risks through line managers for inclusion on either the BDU or trust risk register. Staff were aware of how to report adverse incidents and there was evidence of learning as a result. For example following a serious incident in Wakefield CMHT actions were put in place to improve crisis and contingency plans. An audit was carried out to ensure improvements had been made.

Clinical audit was taking place within teams. Learning was shared within BDUs through the governance structure and team meetings.

Staff received supervision and appraisals in line with trust policy. Compliance with mandatory training was good. However Mental Health Act and Mental Capacity Act training was not recorded by the trust as mandatory. Compliance with safeguarding training was good.

### Leadership, morale and staff engagement

Within the six teams that we visited sickness and absence rates averaged 4.6%. There were no bullying or harassment cases open in the teams we visited.

Staff told us that local managers were supportive and approachable. Staff and team managers felt supported by the TRIOs that worked above them.

There was strong evidence of teams working well together. Staff told us colleagues were supportive. Morale was generally good. However, there was concern relating to the ongoing transformation programme and redesign of community services. The transformation programme had been delayed and this caused additional anxiety. Staff were anxious about how new models would work and what it would mean for both themselves and patients. The trust had held consultation events and we spoke to staff who attended these. Some staff we spoke to felt informed about the process but others did not.

Staff reported they were able to raise concerns without fear of victimisation. Staff were aware of the trust whistleblowing process and duty of candour requirements. Managers were considered approachable.

The trust had a 'middle ground' training programme designed to help band six staff (usually senior nurses) develop into band seven, (management) roles. We spoke to two staff members who had completed the training. They told us they found it to be a useful programme.

### Commitment to quality improvement and innovation

The ADHD and autism service had been involved in several innovations. The team had been involved in the development of the ADHD star. The ADHD star was an assessment and care planning tool for individuals with ADHD. The service had also developed a checklist to ensure environments were appropriate for individuals with autism.

The team had also worked with prison and probation services to improve the screening of ADHD for individuals within those environments.

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

Treatment of disease, disorder or injury

#### Regulation

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

The provider did not ensure there was equitable access to psychological therapies across localities or that this was provided in a timely manner.

Waiting times to access psychological therapies was high. Within the Barnsley business delivery unit the average wait was 54 weeks. Psychological provision to the South Kirklees assertive outreach team was also insufficient. This had the potential to impact upon individual's recovery.

This is a breach of Regulation 9 (3) (b)