South West Yorkshire Partnership NHS Foundation Trust

Quality Report

Fieldhead Hospital
Ouchthorpe Lane
Wakefield
WF1 3SP
Tel: 01924 327000
Website: www.southwestyorkshire.nhs.uk

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Core services inspected	CQC registered location	CQC location ID
Community Based Mental Health Services For Older People	Fieldhead Hospital	RXG10
Wards for Older People With Mental Health Problems	Fieldhead Hospital Priestly Unit Poplars Community Unit for the Elderly The Dales Kendray Hospital	RXG10 RXGDD RXG31 RXGCC RXG82
Long Stay Rehabilitation Mental Health Wards for Working Age Adults	Enfield Down Lyndhurst	RXG36 RXG58
Community Mental Health Services for People with Learning Disabilities or Autism	Fieldhead Hospital	RXG10
Specialist Community Mental Health Services for Children and Young People	Fieldhead Hospital	RXG10
Acute Wards for Adults of Working Age and Psychiatric Intensive Care Units	Fieldhead Hospital The Dales Priestly Unit Kendray Hospital	RXG10 RXGCC RXGDD RXG82

Summary of findings

Forensic Inpatient/Secure Wards	Fieldhead Hospital	RXG10

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

Summary of findings

Ratings

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

Overall rating for services at this Provider	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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Overall summary

After the inspection in January 2017, we have changed the overall rating for the trust from requires improvement to good because:

- In March 2016, we rated 8 of the 14 mental health and community health core services as good. Since that inspection we have received no information that would cause us to re-inspect a core service or change the rating.
- In response to the inspection findings from the follow-up inspection visits, we have changed the ratings of four core services from requires improvement to good: community mental health services for older people, specialist community mental health services for young people, the forensic secure inpatient wards, and the long stay rehabilitation mental health wards for adults of working age.
- Also after the January 2017 inspection, we have changed ratings of the following key questions from requires improvement to good:

- responsive and well-led key for the acute inpatient mental health wards for adults of working age and psychiatric intensive care unit

- safe for wards for older people with mental health problems

- safe and well-led for the forensic inpatient secure wards

- safe, effective and well-led for the long stay rehabilitation mental health wards for adults of working age

- effective and responsive for the community mental health services for older people

- safe and well-led in the specialist community mental health services for young people

- well-led for the community mental health services for people with a learning disability and autism

- The trust had acted to meet the three trust-wide breaches of regulation identified at our inspection in March 2016. The trust had resolved almost all the technical issues with its electronic systems, and addressed staff performance issues on the system via staff training and revised user guidance. Mental Health Act and Mental Capacity Act training was mandatory. The trust was on a trajectory to meet the trust 80% compliance target by the end of March 2017 and training sessions had been planned for staff in to meet this trajectory within the timescale. They had an action plan to implement the revised code of practice across the trust, and almost all its policies, procedures and other documentation were in line with the revised Code of Practice. The trust ensured that all its executive directors and non-executive directors met the fit and proper person requirement and all personnel files had the relevant documentation to demonstrate the checks had been completed.
- Since the last inspection, the trust had appointed a new chief executive officer, which had a significant and positive impact on the organisation. The non-executive and executive directors described examples demonstrating an increased presence in the services across the organisation.The trio management structure, which included a general manager, a clinical lead and a practice governance coach, in the service lines in each business delivery unit was further embedded in the trust governance structures which had a positive influence on staff and service delivery. The trust had improved its approach to performance, governance and risk. Improvement had been made around communication and engagement with staff, and staff articulated a change in culture across the organisation and demonstrated a clear understanding of the organisation's vision and values, and the trust's direction of travel. The trust had revised and its governance structures to improve operational visibility at board level and improve communication vertically and horizontally board to wards and across business delivery units. The trust's business delivery units were responsible for delivering safe and effective services within geographical or specialist service areas,
- At these follow-up inspection visits between November 2016 and January 2017 the trust had taken action to meet 15 of the 17 requirement

notices issued at core service level following our previous inspection, in addition to the three trust-wide requirement notices. These included improvements in relation to ligature risks and blind spots, completion and review of risk assessments and risk management plans, access to electronic patient record systems and record keeping, wait times to access psychology, training in the Mental Health Act, application of the Mental Health Act, staffing levels on the ward to ensure safe treatment and care, physical health monitoring for high dose antipsychotic medication, regular multidisciplinary reviews, and performance indicators and audit.

However:

- We have again rated the acute wards for adults of working age and psychiatric units and the community mental health services for people with a learning disability or autism as requires improvement overall . We rated the acute inpatient mental health services as rated requires improvement in the safe and effective domains due to staff training compliance for immediate life support, staff supervision, and the understanding and application of the Mental Capacity Act. The community mental health services for people with a learning disability or autism was rated requires improvement for safe and responsive due to risk assessments and risk management plans not being accessible at the time of the inspection and wait times to access specialist services and other professionals.
- The forensic secure inpatient wards remained rated as requires improvement in the effective domain due to staff's lack of understanding and application of the Mental Capacity Act and the specialist community mental health services for young people remained rated as requires improvement in the responsive key question due to waiting times to access treatment.
- Whilst the trust had completed work in relation to its strategic aims for pharmacy and medicines optimisation, due to the size of this large-scale project some of these actions were behind target. Three policies were not compliant with the revised Mental Health Act Code of Practice (2015), one policy was yet to be implemented, and four policies had their review dates extended. Supervision systems, the trust's work on equality and diversity and inclusion for service users and staff, the development of the freedom to speak up guardian role, and the systems to identify and review incidents of mortality, were all still in their infancy and required further embedding across the trust.
- Following the March 2016 inspection, we rated community based mental health services for adults of working age as requires improvement in the responsive domain due to waiting time for access to psychological therapies. The trust has provided clear action plans explaining the changes taking place over a longer timescale due for completion in March 2017. The Care Quality Commission will return at a later date to re-inspect this service.

The full report of the inspection carried out in March 2016 can be found here at http://www.cqc.org.uk/provider/RXG.

Summary of findings

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

We always ask the following five questions of the services.

Are services safe?

Good

We rated safe as good because:

- In March 2016, we rated five of the 14 core services as requires improvement for safe. This led us to rate the trust as requires improvement overall for this key question.
- Between November 2016 and January 2017, we inspected all five of the core services rated as requires improvement for safe. We changed the rating for the safe key question from requires improvement to good in four of the five core services we inspected, including the wards for older people with mental health problems, the specialist community mental health services for young people, the forensic secure inpatient wards, and the long stay rehabilitation wards for adults of working age.
- In March 2016, we found that risk assessments were not completed on admission or reviewed at regular intervals. Staff were not safely monitoring the effects of high dose medication at Enfield Down, a long stay rehabilitation mental health ward. The specialist community mental health services for young people did not have a proactive system for monitoring risk for young people whilst they were on the waiting list. Some ligature risks had not been identified and blind spots had not been mitigated on some of the wards for older adults with a mental health problem. Staffing levels on the forensic secure inpatient wards were not always appropriate to meet patients' needs, clinic room temperatures were not safe for the storage of medicines, and positive behaviour support plans are implemented for all patients with learning disability or autism.
- At the inspection visits between November 2016 to January 2017, we found the trust had addressed all these issues. Risks arising from blind spots were mitigated by the use of mirrors, risk assessments and observations on the wards for older people with a mental health problem.Ligature audits were in place for each ward and were reviewed on an annual basis or as any risks changed. In the specialist community mental health services for young people, staff had devised a new process to review risks relating to young people on the waiting list and to respond to any changes in risk. Care records for patients on the long stay rehabilitation mental health wards contained up to date risk assessments and there was evidence that these were reviewed and updated within multidisciplinary meetings at least once a month. On this ward, the service had implemented

Summary of findings

a new audit process to monitor high-dose medication to ensure that patients were having the appropriate physical health checks. Staffing levels were sufficient in the forensic services to ensure that patients were able to take Section 17 leave, have one to one meetings and ward activities. On the forensic secure wards, positive behaviour support plans were in place for all patients with learning disability or autism. Clinic temperatures were managed to ensure that medication was stored at the correct temperature so it remained effective.

However:

- We did not change the rating for the acute inpatient mental health wards for adults of working age and psychiatric unit. The trust had taken action to address the breaches of regulation identified in March 2016, including the safe management of poor lines of sight on the wards, the identification, mitigation and elimination of ligature risks, audits to safely monitor the effects of high dose medication, staffing levels in the wards, and risk assessments and risk management plans were in place and reviewed. However, average compliance with mandatory training was below 75% and cardiopulmonary resuscitation training was 64% on these wards. This meant that not all staff were trained in how to respond to patients in an emergency. However, the trust were on course to reach its trajectory of 80% compliance by the 31st March 2017 for this training.
- We changed the rating of safe from good to requires improvement for community mental health services for people with a learning disability or autism because at the last inspection in March 2016 we recommended that the trust should ensure their risk assessment tool is used consistently across the service. At this inspection staff could not quickly access risk assessments in two thirds of the care records we reviewed. They were either stored in different formats and/or different locations, or had not migrated to the new electronic system.

Are services effective?

Good

We rated effective as good because:

- In March 2016, we rated four of the 14 core services as requires improvement for effective and we identified three trust-wide breaches of regulation in this domain. This led us to rate the trust as requires improvement overall for this key question.
- Between November 2016 and January 2017, we inspected all four of the core services rated as requires improvement for

effective. We changed the rating for the effective key question from requires improvement to good for two of the four core services we inspected, the long stay rehabilitation wards for adults of working age and the community mental health services for older people. The trust had addressed a number of the isues that caused us to rate it as requires improvement for effective last time.

- In March 2016, concerns were identified in services across the trust regarding recording keeping, the use of both paper and electronic records, and technical issues with the electronic patient record system which prevented staff accessing it when they needed to. Mental Capacity Act and Mental Health Act training was not mandatory, and there no plan in place to implement the Mental Health Act revised Code of Practice (2015) across the trust.
- At this inspection the trust had resolved almost all the technical issues, identified local working protocols to minimise clinical risks whilst the issues were being resolved, and addressed staff performance issues on the system via staff training, revised user guidance and email communications to all staff who used the system. Mental Health Act and Mental Capacity Act training was mandatory and the trust was on a trajectory to meet the trust 80% compliance target by the end of March 2017. They had an action plan to implement the revised Code of Practice across the trust, and almost all its policies, procedures and other documentation reflected the revised code.
- The issues identified in March 2016 in relation to the quality of the record keeping and access to the system had been resolved in the community mental health services for older people. All documentation was now kept on the electronic patient record system; assessments were detailed and care plans were holistic and person centred. The trust had acted on the findings in the long stay rehabilitation mental health wards at the last inspection and now completed regular multidisciplinary reviews to review patients' care and treatment. Staff had completed mental Health Act training or they were booked on the course and there was evidence that staff audited patients' consent to treatment records regularly and all patients detained under the Mental Health Act had the correct paperwork in place.

However:

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- We did not change the rating for the acute inpatient mental health wards for adults of working age and psychiatric unit or the forensic secure inpatient wards.
- At the inspection in March 2016 staff on all wards had not received appropriate supervision, and consent to treatment and capacity assessments were not completed and recorded appropriately. At this inspection, these issues had not been resolved and the average compliance rate for staff supervision was 18% in these services and understanding of the application of the Mental Capacity Act was poor across all wards. Staff struggled to explain the circumstances which would require a capacity assessment or a best interest decision.
- We recommended at the last inspection that the trust should ensure there is evidence that consent and capacity had been assessed in the patient notes for patients on the forensic wards where this was appropriate. At this follow-up inspection, this issue had not been resolved. Mental capacity assessments were not documented in patients notes and staff lacked the knowledge and awareness regarding the processes of completing and documenting mental capacity information. However, appraisal rates had increased at this inspection and staff inform patients of their rights and record this in patient notes at regular intervals, and all staff could access patient's electronic care records.

Are services caring?

Good

We rated caring as **good** because:

- At the last inspection we rated caring as good. Since that inspection we have received no information that would cause us to re-inspect a core service or change this rating.
- At these follow-up inspection visits between November 2016 and January 2017, staff across the organisation were kind, caring and compassionate in their approach with patients. We observed respectful and warm interactions with patients. In the services where we reviewed treatment records and the involvement of people in their treatment and care, care records were personalised and holistic with good evidence of patient involvement and participation.

Are services responsive to people's needs?

Requires improvement

We rated responsive as **requires improvement** because:

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- In March 2016, we rated five of the 14 core services as requires improvement for responsive, which led us to rate the trust as requires improvement overall for this key question.
- Between November 2016 and January 2017, we inspected four of the core services rated as requires improvement for responsive. We did not change the rating for the community mental health services for people with a learning disability or autism and the specialist community mental health services for young people.
- We did not reassess the community mental health services for adults of working age during these follow-up inspection visits because the trust's action plan completion date to meet the breach of regulation related to patient waits to access psychological therapies was March 2017. This means that the rating of responsive for this core service remains as requires improvement.
- In March 2016, there were long waits to access psychology in the community mental health teams for people with a learning disability or autism. At this inspection, nobody was waiting longer than 18 weeks to access psychology. However, waiting times to see members of the multidisciplinary team and for a range of specialist assessments were long in Barnsley and Kirklees, for example dysphagia, occupational therapy and physiotherapy.
- The trust was working with commissioners to reduce the waiting times in the specialist community mental health services and had an action plan in place to reduce wait times. Waiting times for treatment had improved in Calderdale and Kirklees, and Wakefield at this inspection. However, there were still significant delays within the Barnsley team and none of the teams were meeting the trust target for referral times.
- All community mental health teams had lengthy waiting lists for people to be assessed for autistic spectrum disorder.

However:

- We changed the rating for the responsive key question from requires improvement to good for the community mental health teams for older people and the acute mental health inpatient wards for adults of working age and psychiatric intensive care units.
- At these follow-up inspections the trust had addressed the issues identified in March 2016. All the teams in the community mental health services for older people had access to crisis services 24 hours a day, seven days a week. The service was

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meeting its nationally recognised targets for assessing patients within 14 days, and responding to urgent referrals in four hours. All patients could access psychological therapies in a timely way. Average bed occupancy had decreased on the acute inpatient mental health wards and psychiatric intensive care units since the last inspection which meant that patients were more likely to be able to return to a bedroom on the wards when they returned from leave.

Are services well-led?

Good 

We rated well-led as good because:

- In March 2016, we rated five of the 14 core services as requires improvement for well-led and we identified one breach of regulation in this key question for the trust. This led us to rate the trust as requires improvement overall for this key question.
- Between November 2016 and January 2017, we inspected all five of the core services rated as requires improvement for well-led and reviewed whether the trust completed the required action to meet the breach of regulation. We changed the rating for the well-led key question from requires improvement to good for all five core services we inspected, including the specialist community mental health services for young people, the forensic secure inpatient wards, the long stay rehabilitation wards for adults of working age, the acute inpatient mental health wards for adults of working age and psychiatric intensive care unit, and the community mental health services for people with a learning disability or autism.
- At this inspection improvements had been made in all these services in relation to concerns identified. For example at the long stay rehabilitation service there was a clear management structure including a practice governance coach, who took responsibility for ensuring the service used thegovernance structures effectively. We saw evidence of regular meetings taking place within the governance structure which demonstrated a clear link between front line staff and senior management. Performance indicators were now in place in the community mental health services for people with a learning disability and autism. Systems were in place to ensure the delivery of safe and quality care in these services, including audits.

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- In March 2016 these services did not have sufficient governance structures in place ensure effective monitoring of the service, for example audit systems and performance indicators. The long stay rehabilitation service did not have a governance lead post and had not identified failings.
- In addition, the non-executive and executive directors had an increased presence in the services across the organisation and the trio of managers, including a general manager, a clinical lead and a practice governance coach, in the service lines in each business delivery unit were more mature which had a positive influence on staff and service delivery. The trust had improved its approach to performance, governance and risk.Improvement had been made around communication and engagement with staff, and staff articulated a change in culture across the organisation and demonstrated a clear understanding of the organisation's vision and values, and the trust's direction of travel. The trust had revised and its governance structures to improve operational visibility at Board level and the internal meeting governance framework had been enhanced to provide increased levels of assurance.
- In March 2016, we identified that three of the new non-executive directors had not had Disclosure and Barring Service checks in line with the fit and proper person requirement and personnel files did not contain the evidence to confirm that all the relevant checks had been completed under the fit and proper person requirement.At this inspection, the trust had ensured that all its executive directors and non-executive directors met the fit and proper person requirement and all personnel files had the relevant documentation to demonstrate the checks completed in line with the requirement.

However:

- Whilst the trust had completed work in relation to its strategic aims for pharmacy and medicines optimisation, due to the size of this large-scale project some of these actions were behind target.
- Not all policies and documentation was in line with the revised Mental Health Act revised Code of Practice (2015).
- Supervision systems, the trust's work on equality and diversity and inclusion for service users and staff, the development of the freedom to speak up guardian role, and the systems to identify and review incidents of mortality, were all still in their infancy and required further embedding across the trust.

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Our inspection team

Our inspection team was led by:

Head of Hospital Inspection: Jenny Wilkes, CQC

Team Leader: Kate Gorse-Brightmore, Inspection Manager, mental health services, CQC

The team included one other inspection manager, two CQC inspectors, and specialist advisors. The specialist advisors were experienced at a senior level within safeguarding, equality and diversity, clinical governance and nursing.

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 the following services since our last comprehensive inspection of the trust undertaken between 7 and 11 March 2016:

- community based mental health services for older people
- rehabilitation/long stay mental health wards for adults of working age
- community mental health services for people with learning disabilities or autism
- forensic inpatient/secure wards
- inpatient wards for older people with mental health problems
- specialist community mental health services for children and young people
- acute inpatient wards for adults of working age and psychiatric intensive care units.

When we inspected the trust in March 2016, which included a review of the leadership and governance of the trust, we rated the trust as requires improvement overall. We rated the trust overall as good for caring, and as requires improvement for safe, effective, responsive, and well-led.

Following the March 2016 inspection, we told the trust it must make the following trust-wide actions in order to improve its wards and services:

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

We issued the trust with three requirement notices that related to leadership and governance of the trust. These related to the following regulations under the Health and Social Care Act (Regulated Activities) Regulation 2014:

- Regulation 5 Fit and Proper Person Requirement
- Regulation 17 Good governance
- Regulation 18 Staffing.

When we inspected the trust in March 2016, we rated the community-based mental health services for older people as requires improvement overall. We rated this service as requires improvement for effective and responsive, and good for safe, caring and well-led.

Following that inspection, we told the trust it must make the following actions to improve community based mental health services for older people:

- The trust must ensure they reduce the waiting times from referral to treatment.
- The trust must ensure there is access to crisis services for older people.

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- We also found concerns with the quality of patient records and the safe storage of records.

When we inspected the trust in March 2016, we rated the rehabilitation/long stay mental health wards for adults of working age as requires improvement overall. We rated this service as requires improvement for safe, effective and well-led, and good for caring and responsive.

Following that inspection, we told the trust that it must take the following actions to improve long stay/ rehabilitation mental health wards for working age adults:

- The trust must ensure that risk assessments are completed on admission and updated at regular intervals in addition to being updated following incidents and changes in presentation.
- The trust must ensure that patients who are prescribed high dose antipsychotic medication are subject to physical health monitoring including electrocardiograms in line with national guidance.
- The trust must ensure that patients have regular multidisciplinary review meetings to ensure timely and appropriate review of care and treatment.
- The trust must ensure that the leadership team ensures that governance structures are in place to monitor and improve the service.
- The trust must ensure that request for second opinion doctors are made in a timely manner.
- The trust must ensure T2 and T3 certificates are completed accurately and reviewed for errors. T2 and T3 forms are statutory certificates required under the Mental Health Act (1983) documenting the patient's consent to treatment and second opinion doctor input respectively.
- The trust must ensure all staff receive training in the Mental Health Act and Mental Capacity Act.

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 this service as requires improvement for responsive and well-led, and good for safe, effective and caring.

Following that 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.

When we last inspected the trust in March 2016, we rated forensic inpatient/secure wards as requires improvement overall. We rated the core service as requires improvement for safe, effective, and well-led and as good for caring and responsive.

Following that inspection we told the trust that it must take the following actions to improve forensic inpatient/secure wards:

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

When we last inspected the trust in March 2016, we rated wards for older people with mental health problems as good overall. We rated this service as requires improvement for safe, and good for effective, caring, responsive and well led.

Following that inspection we told the trust that it must take the following actions to improve the inpatient wards for older people with mental health problems:

- The trust must ensure that there are clear lines of sight on (The Poplars, Ward 19 and Chantry Unit).
- The trust must review the door handles on ward 19 to ensure the safety of the patients.

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When we last inspected the trust in March 2016, we rated specialist community mental health services for children and young people as requires improvement overall. This service was rated as requires improvement for safe, responsive and well-led, and good for effective and caring.

Following that inspection, we told the trust that it must take the following actions to improve specialist community mental health services for children and young people:

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

When we last inspected the trust in March 2016, we rated acute inpatient mental health wards and psychiatric intensive care unit for working age adults as requires improvement overall. This service was rated as requires improvement for safe, effective, responsive and well-led, and good for caring.

Following that inspection, we told the trust that it must take the following actions to improve acute wards for adults of working age and psychiatric intensive care units:

- The trust must ensure that staff are able to observe all areas of the ward on Trinity 2, Ashdale, Elmdale and Priory 2.
- The trust must ensure that staffing levels, skill mix and how staff are deployed is appropriate on all wards.
- The trust must ensure that staff receive appropriate supervision on all wards.
- The trust must ensure that consent to treatment and where appropriate, capacity assessments are completed and recorded appropriately.
- The trust must ensure high doses of medication are monitored.

We issued the trust with a further 17 requirement notices that affected these seven services, in addition to the three trust-wide requirement notices issued. These further requirement notices related to the following regulations under the Health and Social Care Act (Regulated Activities) Regulations 2014:

- Regulation 9: person centred care
- Regulation 11 Need for consent
- Regulation 12 Safe care and treatment
- Regulation 15 Premises and equipment
- Regulation 17 Good governance
- Regulation 18 Staffing

At the previous inspection in March 2016, we also inspected the community based mental health services for adults of working age and rated this service as good overall. This service was rated requires improvement in responsive and good in safe, effective, caring and well-led.

Following that inspection, we told the trust that it must take the following actions to improve the community based mental health services for adults of working age:

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

We issued the trust with one additional requirement notice that affected this service. This requirement notices related to the following regulations under the Health and Social Care Act (Regulated Activities) Regulations 2014:

- Regulation 9: person centred care

We have been monitoring the trust's progress in addressing this issue and in meeting the requirement of this regulation. This will be followed up at the next inspection.

We also made a number of recommendations following the inspection in March 2016, where we think the trust should take actions to improve services. We reviewed a sample of these recommendations across the mental health services that we inspected and in the well-led review we completed in relation to the leadership and governance of the trust. These included:

Trust-wide

- The trust should ensure that all the non-executive directors and the executive directors have accessible evidence that the individuals have been checked against insolvency, director disqualification,

bankruptcy and debt relief, and with Companies House, in with the fit and proper person requirement, which came into force for NHS bodies on the 1 October 2014.

- The trust should ensure that they comply with the requirements of regulation 20 of the Health and Social Care Act 2008 (regulated activities) regulations 2014, duty of candour. They should ensure that there is a clear written apology sent to patients, relatives in carers and details. They should also ensure that written details of the investigation into the incident, and the findings, are sent to the patients, relative or carer.
- The trust should ensure data collected regarding the use of restraint, seclusion and long-term segregation is accurate.

Community-based mental health services for older people

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

Long stay/rehabilitation mental health wards for working age adults

- The trust should ensure there is adequate space in the clinic room to carry out physical health examinations.

Community mental health services for people with learning disabilities or autism

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

Forensic inpatient/secure wards

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

Specialist community mental health services for children and young people

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

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

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

The rest of the recommendations from the March 2016 inspection that we think the trust should take action to improve the services, including in the community health services and the community mental health services for working age adults, will be followed up at the next inspection.

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?

We carried out short notice announced and unannounced inspection visits at the following South West Yorkshire Partnership NHS Foundation mental health services between the 1 November 2016 and 2 February 2017:

- community based mental health services for older people (1 - 2 November 2016)
- rehabilitation/long stay mental health wards for adults of working age (15 November 2016)
- community mental health services for people with learning disabilities or autism (5 December 2016)
- forensic inpatient/secure wards (6 – 7 December 2016)
- inpatient wards for older people with mental health problems (7 – 8 December 2016)
- specialist community mental health services for children and young people (12 – 13 December 2016)
- acute wards for adults of working age and psychiatric intensive care units (30 January – 2 February 2017).

We also carried out a 'well led review' of the trust between the 30 January and 1 February 2017.

During this inspection, we focussed on the breaches of regulation identified at the last inspection in March 2016, and those issues that had caused us to rate the trust as requires improvement for safe, effective, responsive and well-led. We also sampled the actions that we recommended the trust should take.

Before the inspection visits, we reviewed a range of information we hold about South West Yorkshire Partnership NHS Foundation Trust. We looked at information provided to us on site and requested additional information from the trust both immediately before and following the inspection visit relating to the services. This also included receiving feedback from external stakeholders, including commissioners.

During the inspection visits, the inspection teams:

- visited all five inpatient wards for older people with mental health problems
- visited all 11 forensic inpatient/secure wards
- visited both Enfield Down and Lyndhurst, rehabilitation wards
- visited all nine acute wards and psychiatric intensive care units across the three sites

Summary of findings

- visited the community mental health teams for older people in Barnsley, Ossett and Huddersfield
- visited the community mental health teams for people with learning disabilities and autism for Kirklees and Wakefield
- visited the community mental health teams for children and adolescents for Calderdale and Kirklees, and Barnsley
- observed how staff were caring for patients on all the wards and in the services we visited
- spoke with 68 patients/people who use the services
- spoke with eight relatives/carers of patients who receiving care and treatment
- spoke with 132 staff including activities coordinators, advocates, domestic staff, healthcare assistants, Mental Health Act administrators, nurses, occupational therapists, practice governance coaches, pharmacists, pharmacy technicians, psychiatrists, psychologists, junior doctors, physiotherapists, speech and language therapists, student nurses, social workers, and ward clerks
- spoke with 39 managers including practice governance coaches, team and ward managers, and acting ward managers
- reviewed 122 patients records, plus 13 seclusion records on the acute inpatient mental health wards and the psychiatric intensive care units
- reviewed medication records and medication management across the trust
- observed 12 meetings and activities including ward reviews, reflective practice sessions and ward-based patient activities.
- reviewed feedback and surveys completed by people who use the community mental health services for older people
- interviewed over 41 senior staff, board members, and representatives of the council of governors. These interviews included the chief executive, the chairman, the medical director, and the director of nursing, clinical governance and safety
- facilitated two focus groups with black, Asian and minority ethnic staff
- completed additional interviews with staff representing staff side and other unions, the freedom to speak up guardians, and the mental health act managers
- looked at policies, procedures and other documents relating to the running of the wards, services and the trust.

Information about the provider

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 medium and low secure services, and other specialist services, across Yorkshire and the Humber.

The trust was established in April 2002 and in May 2009, it became a foundation trust. Currently the trust has around 15,500 members comprising of local people, and also including staff from the trust.

In April 2011, the trust moved from being a specialist mental health and learning disability provider to an integrated and partnership-based provider of community and mental health services when a range of community services were transferred to the trust in Barnsley, Calderdale and Wakefield.

South West Yorkshire Partnership NHS Foundation Trust provides services across Barnsley, Calderdale, Kirklees and Wakefield which together have a population of more than one million people. The trust provides inpatient, community and day clinics as well as specialist services within West Yorkshire, The trust provide the following core services:

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

Summary of findings

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

• Forensic inpatient/secure wards

• Wards for older people with mental health problems

• Wards for people with learning disabilities or autism

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

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

• Specialist community mental health services for children and young people

• Substance misuse services

• Community-based mental health services for older people

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

• Community health inpatient services

• Community end of life care

• Community health services for adults

• Community health services for children, young people and families.

The trust works in partnership with other local NHS organisations, local authorities and other government departments, and voluntary organisations and has 13 registered locations serving mental health and learning disability needs, and it also provides community health services at 38 locations. These locations are spread across six hospitals sites including Dewsbury and District Hospital, Castleford and Normanton District Hospital, Fieldhead Hospital, Kendray Hospital, and Mount Vernon Hospital.

The trust employs around 4,600 staff, in both clinical and non-clinical support roles. It has an annual budget of approximately £235 million. At the time of this inspection, the trust's overall NHS Improvement risk rating under the single oversight framework was 2 – there are four segments that NHS trusts are categorised by, with 1 being the best and 4 being the worst.

South West Yorkshire Partnership NHS Foundation Trust has been inspected 15 times since registration with five locations inspected. It had nine compliance actions against two locations with an additional 12 improvement actions. These were followed up as part of the comprehensive inspection completed between 7 and 11 March 2016 using the Care Quality Commission new methodology. All previous areas of non-compliance had been addressed.

This most recent inspection focussed on areas of non-compliance identified in March 2016. These follow-up focused inspection visits began five months after the publication of the comprehensive inspection report on the 24 June 2016. We have re-rated the core services that have been the subject of this most recent focused re-inspection.

What people who use the provider's services say

During these inspection visits, we spoke with 68 people who used the services, and eight relatives or carers of people receiving treatment and care at the trust.

Patients, relatives and carers that we spoke with during this inspection all had positive things to say about the staff. They said that staff were caring, kind, understanding and compassionate. Patients and relatives told us that staff were knowledgeable and really helped the people they cared for and their families. The feedback from the surveys in the community mental health services for older people identified that all but one patient felt that they could discuss their needs with staff, and 90% of patients in the North Kirklees team felt that they were given the right amount of support at the right time. Similarly, patients on the forensic inpatient/secure wards felt that their needs were being met, that their leave was rarely cancelled, and there was sufficient activities on the wards. Patients on the long-stay/rehabilitation inpatient mental health wards felt involved in their treatment and care. Both patients and carers were consistently positive about the treatment and care provided on the acute inpatient wards for people with mental health problems, as well as the environment they received care in. Patients felt involved and able to input into their treatment.

However, two carers for people accessing support in the community mental health service for people with a learning disability or autism told us that there had been a wait for between six and nine months for an appointment

Summary of findings

for the person that they cared 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. Also, some patients on the acute inpatient wards for people with mental health problems told us that there was not always enough staff for them to have one to one time or go on escorted leave.

Good practice

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

Ward 18 employed a designated "carers' link worker". This was a unique role in the trust and was highly valued by both carers and staff on the ward. The carers' link worker was responsible for providing advice and support to carers which included signposting carers to services available in the community. The carers' link worker was also responsible for keeping carers informed about and involved with the care provided to patients on the ward.

Following an incident, staff on Trinity 2 had implemented a new contact card for patients and carers. Staff had recognised that the wording of the previous contact card did not encourage patients and carers to contact the ward unless there was an issue. The new contact card actively encouraged people to contact the ward if there were concerns and reassured both patients and carers that nursing staff were always available to speak to.

Areas for improvement

Action the provider MUST take to improve

Community mental health services for people with a learning disability and autism

- 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.

Forensic inpatient and secure wards

- The trust must ensure that all staff follow the correct procedures in line with trust policy and the Mental Capacity Act for patients who lack capacity. Assessments, best interest checklists and decisions should be clearly documented which include a rationale for any decisions made.

Community mental health services for children and young people

- The trust must continue to work towards reducing waiting lists across all community mental health services for children and young people, and all pathways, so that young people are not waiting excessive amounts of time for support and treatment.

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

- The trust must ensure staff on all wards have the necessary mandatory training to enable them to carry out their role.
- The trust must ensure that all staff receive appropriate supervision on all wards.
- The trust must ensure staff on all wards are aware of and working in accordance with current guidance in relation to the Mental Health Act and the Mental Capacity Act.

Action the provider SHOULD take to improve

Trust wide

- The trust should ensure they continue with their development work to meet the strategic aims for pharmacy and medicines optimisation in identified timescales.
- The trust should ensure that systems to support supervision are embedded across the trust and performance in relation to supervision monitored.

Summary of findings

- The trust should ensure that the remaining eight of the 42 policies identified at the time of the inspection are in line with the revised Mental Health Act revised code of practice (2015).
- The trust should ensure that progress continues in relation to their work on equality and diversity and inclusion for service users and staff and further embed this culture across the organisation.
- The trust should ensure that there is a clear plan for the development of the freedom to speak up guardian role for it to be embedded across the trust.
- The trust should continue to develop its systems to identify incidents of mortality, review these incidents to identify themes, outliers and learning.

Community mental health services for people with a learning disability and autism

- 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.

Forensic inpatient and secure wards

- The trust should ensure that all staff receive an annual appraisal in line with trust policy.
- The trust should ensure all staff are up to date with Mental Health Act, Mental Capacity Act and immediate life support training in line with the trust action plan.

Community mental health services for children and young people

- The trust should ensure they review new working processes so that the systems they have introduced and implemented are effective.

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

- The trust should ensure that agency staff are able to access and update patients' care records
- The trust should review the psychology input on all wards to ensure that patients can access psychological as well as pharmacological interventions.
- The trust should ensure that staff maintain a ward record of postponed or cancelled Section 17 leave.

South West Yorkshire Partnership NHS Foundation Trust

Detailed findings

Mental Health Act responsibilities

Training in the Mental Health Act became mandatory in the trust following feedback in March 2016 at the last inspection. Overall trust compliance in December 2016 was 21%. The trust was on a trajectory to meet their mandatory training target of 80% for this training by the end of March 2017 and training sessions had been planned for staff in to meet this trajectory within the timescale.

At the last inspection, we identified that the trust did not have an implementation plan in relation to the revised Mental Health Act Code of Practice (2015) and its implications for delivering care. The trust policies and procedures had not been updated and there was no consistent training. Some staff were not aware there was a revised Code of Practice.

In response, the trust reviewed its existing action plan in relation to the Code of Practice implementation, and completed a number of actions including training, which became mandatory, and a review of policies and procedures. The trust also submitted an action plan to the CQC in relation to their compliance with the Mental Health Act Code of Practice that was due for completion on the 31 March 2017, which the trust was on a trajectory to achieve.

At this inspection, the majority of the trust's policies complied with the revised Code of Practice (2015). However, three policies were not compliant, one policy was yet to be implemented, and four policies had their review dates extended. The trust confirmed in their factual accuracy response in April 2017 that all the policies were now up to date or scheduled for approval, for example the Section 136 policy which required agreement from external agencies. Where policies were waiting for approval from external agencies, the trust told us they had working drafts are in place.

The mandatory training, the code of practice action plan, and the audit plan, were monitored and reported through the Mental Health Act Committee, to the trust board.

The Mental Health Act associate managers we met with spoke positively of the trust's approach and the open dialogue between them and the trust.

Despite the low overall trust training compliance in relation to the Mental Health Act, staff in the services we visited at this inspection had a good understand of the Act and its application. Issues identified at the last inspection had been actioned, including the timeliness of the request for second opinion appointed doctors, the accurate completion of T2 and T3 consent to treatment certificates, and ensuring patients were informed of their rights.

Regular audits in relation to the application of the Mental Health Act across the trust were completed and the audit plan monitored at the Mental Health Act Committee.

Whilst all the acute mental health inpatient wards and psychiatric intensive care units had access to an independent mental health advocate, the process for referrals to the independent mental health advocate was not consistent in the service.

Detailed findings

Mental Capacity Act and Deprivation of Liberty Safeguards

Following the last inspection, the Mental Capacity Act and the Deprivation of Liberty Safeguards was agreed as mandatory training by the executive management team. Overall trust compliance in December 2016 was 46%. Training compliance was lowest at 29% across the forensic services. However the trust was on a trajectory to meet their mandatory training compliance target by the end of March 2017.

Mental Capacity and the Deprivation of Liberty Safeguards information was reported through the governance structures including the Mental Health Act/Mental Capacity Act sub group to the Mental Health Act Committee, and to the trust board.

At this inspection, there were pockets of good practice. We saw evidence in the community mental health services for older adults and on the psychiatric intensive care unit at Wakefield of staff considering consent and capacity routinely in their work, and completing detailed best interest assessments, in line with the trust's Mental Capacity Act policy.

However, the low compliance with training in the Mental Capacity Act was evident in the poor staff understanding of the Mental Capacity Act on the acute mental health wards and on the forensic wards. Staff lacked knowledge and understanding of how to implement the Mental Capacity Act, including the circumstances which would require a capacity assessment or a best interest decision. Inspectors could not locate any capacity assessments or any evidence of the best interest checklist being followed on the forensic learning disability wards, where patients are highly likely to have capacity issues.

The factual accuracy response received by the trust in April 2017 confirmed that the good practice in relation to how capacity assessments are undertaken, recorded and reviewed within their psychiatric intensive care unit at Wakefield, has now been rolled out within all their inpatient areas, including the forensic wards. This is so that these teams can start implementing similar processes and procedures to improve their record keeping practices in relation to the Mental Capacity Act and best interest assessments.

The trust completed regular record keeping audits across the business delivery units and services, which included checks to confirm a patient's capacity to consent had been recorded, to confirm a record of a best interest decision or meeting regarding the patient's care and treatment if it was appropriate, and whether this best interest decision was recorded in the care plan. However, these audits did not identify the concerns found on the forensic inpatient wards or the acute inpatient wards for working age adults with a mental health problem.

The trust had identified clinical record keeping as a topic in its internal audit strategic and operational plan 2016 - 2017. This clinical record keeping audit included checks to confirm a patient's capacity to consent had been recorded, to confirm a record of a best interest decision or meeting regarding the patient's care and treatment if it was appropriate, and whether this best interest decision was recorded in the care plan. These were completed across the business delivery units and services and the audits we reviewed confirmed that these audits were successful at identifying non-compliance with the Mental Capacity Act. However, there were still issues identified on the forensic secure inpatient learning disability wards and the acute inpatient wards for working age adults with a mental health problem.

Good

Are services safe?

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

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

Summary of findings

We rated safe as good because:

- In March 2016, we rated five of the 14 core services as requires improvement for safe. This led us to rate the trust as requires improvement overall for this key question.
- Between November 2016 and January 2017, we inspected all five of the core services rated as requires improvement for safe. We changed the rating for the safe key question from requires improvement to good in four of the five core services we inspected, including the wards for older people with mental health problems, the specialist community mental health services for young people, the forensic secure inpatient wards, and the long stay rehabilitation wards for adults of working age.
- In March 2016, we found that risk assessments were not completed on admission or reviewed at regular intervals. Staff were not safely monitoring the effects of high dose medication at Enfield Down, a long stay rehabilitation mental health ward. The specialist community mental health services for young people did not have a proactive system for monitoring risk for young people whilst they were on the waiting list. Some ligature risks had not been identified and blind spots had not been mitigated on some of the wards for older adults with a mental health problem. Staffing levels on the forensic secure inpatient wards were not always appropriate to meet patients' needs, clinic room temperatures were not safe for the storage of medicines, and positive behaviour support plans are implemented for all patients with learning disability or autism.
- At the inspection visits between November 2016 to January 2017, we found the trust had addressed all these issues. Risks arising from blind spots were mitigated by the use of mirrors, risk assessments and observations on the wards for older people with a mental health problem.Ligature audits were in place for each ward and were reviewed on an annual basis or as any risks changed. In the specialist community mental health services for young people, staff had devised a new process to review risks relating to young people on the waiting list and to respond to any changes in risk. Care records for patients on the long stay rehabilitation mental health wards contained up to date risk assessments and there was evidence that these were reviewed and updated within multidisciplinary meetings at least once a month. On this ward, the service had implemented a new audit process to monitor high-dose medication to ensure that patients were having the appropriate physical health checks. Staffing levels were sufficient in the forensic services to ensure that patients were able to take Section 17 leave, have one to one meetings and ward activities. On the forensic secure wards, positive behaviour support plans were in place for all patients with learning disability or autism. Clinic temperatures were managed to ensure that medication was stored at the correct temperature so it remained effective.

However:

- We did not change the rating for the acute inpatient mental health wards for adults of working age and psychiatric unit. The trust had taken action to address the breaches of regulation identified in March 2016, including the safe management of poor lines of sight on the wards, the identification, mitigation and elimination of ligature risks, audits to safely monitor the effects of high dose medication, staffing levels in the wards, and risk assessments and risk management plans were in place and reviewed. However, average compliance with mandatory training was below 75% and cardiopulmonary resuscitation training was 64% on these wards. This

meant that not all staff were trained in how to respond to patients in an emergency. However, the trust were on course to reach its trajectory of 80% compliance by the 31st March 2017 for this training.

- We changed the rating of safe from good to requires improvement for community mental health services for people with a learning disability or autism because at the last inspection in March 2016 we recommended that the trust should ensure their risk assessment tool is used consistently across the service. At this inspection staff could not quickly access risk assessments in two thirds of the care records we reviewed. They were either stored in different formats and/or different locations, or had not migrated to the new electronic system.

Our findings

Safe and clean care environments

At the last inspection in March 2016, both the inpatient wards for older people with mental health problems and the acute wards for adults of working age with mental health problems had wards where ligature points had not been identified on the ward ligature risk assessment and eliminated or mitigated. A ligature point is a place where someone intent on harming themselves might tie something round to strangle themselves. For example, the door handles on ward 19, one of the inpatient wards for older people with mental health problems, were identified as a ligature point. Wards in both these service also had areas where staff were unable to observe patients (blind spots) due to the layout of the wards that were not mitigated to ensure the safety of patients, or not mitigated using the least restrictive option.

At this follow-up inspection completed between November 2016 and February 2017, the trust had completed detailed ligature audits or environmental suicide and ligature risk assessments which identified ligature points on each ward for all its services, including the inpatient wards for older people with mental health problems, and the acute wards for adults of working age with mental health problems and psychiatric intensive care unit. Measures had been put in place to reduce the risks arising from these ligature points. On wards in both these services, individual patient records included risk assessments for that patient in relation to identified ligature points and the staff we spoke to had a good understanding of where ligature points were on their own wards and how these were managed safely. However, despite these ligature audits and either mitigation or elimination of the ligature risk, a patient on the acute wards for working age adults died as a result of a ligature in January 2017. This was being investigated at the time of the inspection.

In relation to the door handles that were identified as a ligature risk on Ward 19, one of the inpatient wards for older people during the March 2016 inspection, the trust had completed a review on the door handles on all inpatient wards across the trust and two different door handles were trialled in Ward 18, Ward 19 and in the forensic services. Following feedback, a refit programme began in November 2016 and was completed in January 2017. At the time of the inspection all door handles on Ward 19 had been replaced with anti-ligature handles.

Risks arising from blind spots across the trust, including the inpatient wards for older people with mental health problems and the acute wards for people with mental health problems, were mitigated by the use of mirrors, risk assessments and staff observations.

The wards and community team bases that we visited during this inspection were visibly clean, and where we reviewed infection control principles, and the provision and the maintenance of all equipment on the wards, for example on the acute wards, we had no concerns. In addition, infection control prevention and control service delivery had been further embedded across the trust due to the further maturity of both the infection control systems and the trio of managers within the service line for each business delivery unit, as well as the clear governance structures. These governance structures included clear communication routes to the board and to the wards, Annual audits and the resulting action plans, walk rounds, and benchmarking against national guidance, were all in place to ensure infection prevention and control systems were effective.

The trust was also now compliant with their commissioning for quality and innovation (CQUIN) national goals for flu vaccinations, moving from 33% of staff vaccinated across the trust to above 75% at the end of December 2016. This was due to peer to peer vaccinations, promoting patient safety and educating staff.

Good

Are services safe?

The trust was in the process of developing its new estates strategy for the next five years (2017 – 2022). Senior managers and non-executives told us that this would include the disposal of sites no longer needed and plans to make the best use of their existing buildings. Community mental health and community service hubs have been opened and new non-secure wards on the Fieldhead Hospital site were being built at the time of the inspection.

Safe staffing

At the last inspection in March 2016, we had concerns about staffing levels and skill mix in the acute wards for adults of working age and the psychiatric intensive care units, as well as in the forensic services. Staffing levels did not always meet the trust safer staffing levels and this impacted adversely on activities, escorted leave, and potentially patient and staff safety. In addition, during the last inspection staff in both these services consistently raised with the inspection team that they had concerns about the staffing levels on the wards including the number of staff vacancies, and the numbers of bank and agency workers. Inspectors reported that that there appeared to be no clear plan with regard to staffing, particularly at service level, at that inspection.

At this inspection, we reviewed the trust's approach to safe staffing. There was a commitment from all members of the trust board to maintain 'appropriate' rather than minimum staffing levels, as well as planned fill rates, as their safer staffing target.

The trust used a tool to identify the appropriate levels of staffing for each ward. This was developed in May 2015 to consider variables within a ward-based environment, including patient numbers, acuity, serious incident reporting, observation and mental health act requirements, diagnosis, risk, levels of security required, and was underpinned by the national institute of health and care excellence for different inpatient services, for example the minimum level of registered nurses should be at a 1:8 ratio to patients for adult acute wards. The planned staffing for inpatient wards based on routine e-rostering was reviewed in January 2017 using the decision support tool, and planned staffing levels exceeded planned appropriate numbers.

The planned staffing numbers could not be amended unless an application was made to the Director of Nursing and Quality and a case made to justify the request, for example a reduction in patients. However, ward managers told us that they were able to increase staffing levels where required, for example in response to increased acuity and we were given examples of instances where this had happened in both the forensic services and the acute services.

The trust reported and published planned and actual nursing staffing on their inpatient wards on a monthly basis as required by NHS England. The trust had a target of 90% for their safer staffing fill rate and an escalation threshold of 80% for registered nurses in the staffing-mix on wards. They reported monthly on these targets using the integrated performance report. We also observed communication with the staff about safer staffing and the trust approach towards this. This communication included actively encouraging an incident report submission if staff felt staffing levels and/or skill mix had been compromised.

At the time of this inspection the trust had 66 whole time equivalent qualified nursing vacancies compared to 64 at the previous inspection in March 2016, and 39 healthcare assistant whole time equivalent vacancies at this inspection compared to 16 previously. Some wards in both the forensic and the acute services were carrying increased vacancies since the last inspection. There had been a reduction of 94 qualified nurses across the trust since the last inspection to 1451 whole time equivalent qualified nurses and the number of nursing assistants remained the same at 726. However, since the last inspection in March 2016 the trust had transferred the 0-19 children's services to one of the local councils. This resulted in the transfer of 101 qualified nurse posts and 41 unqualified nurse posts. Therefore, the figures for qualified and unqualified staff across the trust actually demonstrated a net increase of 7 qualified and 41 unqualified nurses since the last inspection.

The trust wide turnover and sickness rates for the 12 months prior to the 30 January 2017 remained the same as the inspection in March 2016 at 11% and 5% respectively.

Safer staffing requirements were supported at business delivery unit level by staff working flexibly to cover areas of high demand and where appropriate the trust used different staff disciplines to offer support. The trust had developed contingency plans and situational reports in hotspot areas to respond to staffing challenges resulting from lack of capacity and/or increased demand.

Good

Are services safe?

The trust also showed a commitment to adhering to safer staffing levels through its use of regular bank and agency staff on the ward despite some of the financial implications. Senior managers told us that whilst they were committed to reducing agency spend, as a board, they were committed to maintaining the appropriate staffing levels on all inpatient wards, including in response to increased levels of acuity. The number of shifts across the trust filled by bank or agency staff to cover sickness, absence or vacancies in the three month period prior to the inspection in January 2016 for the inpatient wards was 7971 and the number of shifts not covered was 820 (This equated to 2% of all shifts on the mental health wards). A tendering exercise was ongoing to appoint a staffing agency, which met the quality standards set by the trust. The trust had exceeded its agency cap by 89% at the end of quarter three of the financial year. The trust agency cap was £5.1 million and the trust spend at the end of December 2016 was £7.6 million. This had an impact on the trust in relation to its financial rating with National Health Service Improvement and the trust stated this as one of the three main finance and performance risks for the inspection. Agency spends and the associated safety, financial and quality risk were discussed at the board meeting we attended during the inspection, including plans to address agency use and the associated spend.

In June 2016 the trust enhanced bank payments to attract staff to do additional hours on the wards to reduce the need for external agency staff. They centralised the staff bank and opened it seven days a week to increase the capacity of supplementary staff and improve the efficiency of securing additional staff when they are required. They had also recruited new staff onto the bank with a broader range of skills and had plans to continue this recruitment.

The integrated performance report submitted to the trust board for the January 2017 board meeting showed that the trust exceeded their 90% fill rate for the whole of the last quarter and consecutively for each month October 2016 to December 2016, with no inpatient ward falling below 90% fill-rate. In November and December 2016, on day duty, there were three occasions in both months where registered nursing levels were escalated to the trust as they were below 80%, one in the acute services and one in the forensic services. This was due to a variety of reasons including vacancy rates, sickness, and maternity leave. Safe staffing levels were still maintained on these occasions due to the trust deploying staffing from other services or increasing the numbers of unqualified staff. However, staff in the acute service continued to report there was insufficient staffing. Some patients on the acute wards and the forensic wards said that section 17 leave did not always take place or one to one meetings due to staffing levels, although there was good evidence, particularly in the forensic services that patients' section 17 leave and meaningful activities took place and was not affected adversely by insufficient staff on the wards.

The trust demonstrated a commitment to achieve its longer-term plans in relation to the safer staffing fill rate across the trust, the reduction of agency spend, and workforce development, through the implementation of a number of measures that had been further embedded since the last inspection.

The trust had a safer staffing project manager in place who submitted monthly safer staffing exception reports to the business delivery units and to the executive management team, highlighting staffing challenges and action taken. The group included staff-side representation, and was chaired by the Director of Nursing and Quality. The group reviewed the current safer staffing challenges and oversaw the trust's overall approach to resolving the staffing challenges through the safer staffing action plan. It also included workforce planning, outlined in the trust's clinical workforce development plan 2016 -2018.

To understand the staffing pressures and required actions, trends and hotspots, and to focus on recruitment information, the trust held two recruitment summits since the last inspection. These were led by directors and attended by operational and corporate leads. The summits generated actions in eight areas including gathering intelligence, raising the profile of the trust, enhancing recruitment processes, safer staffing, local and national recruitment campaigns, developing a flexible and skilled workforce, improving job satisfaction, and bank and agency use.

In an attempt to address recruitment and retention the trust had identified funding for a specialist recruitment agency to help improve their recruitment processes and to support a range of initiatives aimed at increasing the capacity and capability of the workforce, including overseas recruitment. Also, since our last inspection, the

trust had completed targeted monthly recruitment drives of newly qualified and returning to practice nurses. In the eight months following our last inspection, the trust has recruited over 60 nurses.

To develop and increase the capability of the workforce, the trust had developed an enhanced preceptorship for newly qualified registered nurses and offered additional support and training to equip registered nurses to complete their revalidation. They had also developed a nursing associate role underpinned by a relevant academic programme. Prior to this inspection they had advertised 11 posts in the forensic services and 12 posts elsewhere across the trust. Apprenticeships for non-registered staff had been introduced for 60 band two staff each year. The trust were finalising the development of a career structure to enhance staff opportunities across all areas of service which would be identified in its three year strategic workforce plan and its first leadership and management development plan; both due for publication shortly after this inspection.

Staffing, recruitment and workforce development planning, including leadership and management development, were all identified on the corporate risk register along with relevant control measures and actions. Local and specialist commissioners told us that they had an open dialogue with the trust around staffing and they felt the trust were doing all they could to address these issues. They said the trust were committed to the right staffing levels rather than the minimum staffing levels, and put patients and staff safety first in their decisions around staffing.

At the last inspection in March 2016, the trust was in breach of regulation 18 because training in the Mental Health Act including the Code of Practice (2015), and training in the Mental Capacity Act, was also not mandatory. Compliance with this training was not routinely recorded or monitored for effectiveness across the trust. We identified breaches of regulation in the long-stay and rehabilitation services for adults of working age as staff were not adequately trained in the application of the Mental Health Act and Mental Capacity Act, and in the forensic and secure services where there was a concern that staff training data in the Mental Health Act, the Mental Capacity Act, and intermediate life support, was not monitored. At the last inspection, we also recommended that the community mental health services for children and young people should ensure staff are up to date with basic life support training.

The trust target for mandatory training was 80%. The trust had achieved over 80% compliance in eight of the 14 mandatory training courses, including the Sainsbury's risk assessment tool (95%), safeguarding children (88%), safeguarding adults (90%), information governance (87%), infection control and hand hygiene (84%), food safety (84%), fire safety (86%), and equality and diversity (90%). The trust had 78% compliance in two other mandatory training courses - aggression management and moving and handling.

The trust informed us that the compliance figures included staff for example on long-term sick and maternity leave which may have impacted on the overall compliance figures.

The trust had introduced mandatory clinical risk training and cardiopulmonary resuscitation training since our last inspection. These programmes had been provided throughout the financial year and the trust were on course to reach its trajectory of 80% compliance by the 31st March 2017. At this inspection in on the 30 January 2017, compliance for cardiopulmonary resuscitation was 70% and clinical risk was 54%.In the forensic/low secure services, overall compliance was 61%. On the acute wards for adults of working age with a mental health problem and psychiatric intensive care units, the overall compliance was 64%.

However, we were concerned that on one ward, Trinity 1, only 24% of staff had received training in cardiopulmonary resuscitation, and on Trinity 2 and Ward 18, less than 50% of staff had received the training. The low compliance with cardiopulmonary resuscitation meant that staff may not have the skills to respond in an emergency situation. The trust's policy for rapid tranquilisation, as required medication and psychotropic medication, stated that at least one member of staff per shift should be trained in cardiopulmonary resuscitation. Rapid tranquillisation is when medicines are given to a person who is very agitated or displaying aggressive behaviour to help quickly calm them. This is to reduce any risk to themselves or others, and allow them to receive the medical care that they need.

At this inspection, training in the Mental Health Act including the Code of Practice (2015), as well as training in the Mental Capacity Act, was mandatory and a detailed training needs analysis followed to ensure the mandatory training provided matched the competencies and needs of the staff.

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Are services safe?

The trust started to monitor the compliance with this training and reported the outcomes to the trust board via the workforce performance wall of the integrated performance report from November 2016. However, figures for this training for the trust overall remained low, and overall compliance across the trust was 46% for the Mental Capacity Act and Deprivation of Liberty Safeguards, and 21% for the Mental Health Act, including the Code of Practice 2015.

Senior managers and ward managers told us that almost half of all staff had received the previous Mental Health Act and the Mental Capacity Act training in the last three years and a review of this training by the trust in March 2016 confirmed that compliance was at 47% at that time. The compliance rate stated included only the newly introduced mandatory training and did not include previous training rates. The trust was in the process of mapping and accrediting previous training to allow the compliance rate to accurately reflect the training staff had received.

The trust had set a trajectory of meeting their 80% mandatory compliance rate for both Mental Capacity Act and Mental Health Act training by the end of March 2017. Although the trust recognised this was a challenge, staff we spoke with thought this was achievable and in the services we visited, inspectors were shown details of planned training up to the end of March 2017.

Assessing and managing risk to patients and staff

At the inspection in March 2016, whilst risk assessment and management was generally of a good standard across the trust, risk assessments were not completed on admission at Enfield Down, a long stay rehabilitation mental health ward, or reviewed at regular intervals. We found that the specialist community mental health services for young people did not have a proactive system for monitoring risk for young people whilst they were on the waiting list. In addition, we recommended that the trust should take action to ensure that the risk assessment tool was used consistently, and that risk assessments and risk management plans were in place in the community mental health services for people with learning disabilities and the acute inpatient mental health wards for adults of working age.

At these inspection visits, patient records in the long stay rehabilitation mental health services and on the acute mental health inpatient wards and psychiatric intensive care units contained up to date risk assessments completed with the risk assessment tool, as well as risk management plans. These were reviewed and regularly updated in line with the trust policies and procedures. However, in the community mental health services for people with a learning disability or autism, 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.

During the comprehensive inspection in March 2016, we found little evidence of positive behavioural support plans or an equivalent in care records we reviewed for people on the forensic secure inpatient wards with a learning disability. One patient in long term segregation with autism and challenging behaviour did not have a positive behavioural support plan at the time of the inspection. Positive behaviour support plans are an intrinsic part of the treatment process for patients with learning disability or autism as defined by guidance from NHS England (Transforming care for people with learning disabilities, 2015). We also recommended that the trust take action to ensure that the data collected on restraint, seclusion and segregation was accurate or detailed enough to ensure patients were safeguarded. For example, it was not clear from the data whether prone restraint was used intentionally or how long for.

During these follow up inspection visits, we reviewed the trust's information relating to its patient safety strategy 2015 – 2018, including the management and monitoring of restrictive interventions. The trust remained committed to its approach towards reducing its restrictive interventions, including safe wards initiatives that had already been successful in reducing conflict and containment on the wards that had implemented it.

The trust had implemented a number of initiatives relating to positive behavioural support on the forensic inpatient wards. Staff had received a briefing paper about positive behaviour support plans and a specific training programme was due to be introduced for the learning disability pathway. Those patients with challenging behaviour all had a positive behavioural support plan in place in line with the National Institute of Health and Care Excellence guidance, (NG11), challenging behaviour and learning

disabilities: prevention and interventions for people with learning disabilities whose behaviour challenges, and the Department of Health, positive and proactive care: reducing the need for restrictive interventions.

The trust reported no long-term segregation in the last six months. However, since the last inspection the trust had updated its long terms segregation policy. It now includes additional governance processes and is in line with the Mental Health Act Code of Practice (2015).

The trust reported the number of incidents of use of seclusion between June and December 2016 was 315. Acute wards for adults of working age and the psychiatric intensive care units reported 75% of these incidents, with the greatest proportion reported on Trinity one (psychiatric intensive care unit). The forensic inpatient/secure wards reported 23%, with the largest number of seclusions reported on Bronte ward. Wards for older people with mental health problems reported 1%.Senior clinicians and managers completed seclusion reviews in line with the trust's seclusion policy and toolkit, with each review aimed at ending seclusion. Seclusion was monitored via the management of violence and aggression trust action group. Ward managers, members of the trios, and assistant directors representing services and business delivery units were members of the group. Patient safety representatives and managing aggression and violence leads also attended.

Between the 1 June 2016 and 31 December 2016, the trust reported that staff used physical restraint on 985 occasions, 29% of these occasions was in the 'prone position'. Prone restraint involves holding a person in a chest-down position whether the person has their face down or has their face to the side. On Trinity one (a psychiatric intensive care unit) there were 151 incidents of restraint in the same time period last six months and just under a third resulted in the use of prone restraint. Elmdale acute mental health ward recorded 102 restraints, a quarter of these were using prone restraint.

All restraint data was collated via the trust's electronic incident recording system. Individual ward managers and team leaders reviewed and signed off each individual incident. These incidents were also monitored via the management of violence and aggression trust action group.

In response to the last inspection, from 1 July 2016, the trust collected data for the duration of prone restraints on their electronic incident recording system. Where the duration was over 15 minutes, staff were asked to provide a rationale. For all prone restraints, staff are asked to give an explanation on the electronic form as to why it was not possible to use another position.

As part of the sign-up to safety campaign the trust had committed to reducing the use of restraint by 30% by 2018 and data provided by the trust showed that the trust wide use of prone restraint declined between November 2015 and October 2016. The trust introduced a target in July 2016 of 90% for all prone restraints to have a duration of less than three minutes. In January 2017, 78%.were under this timeframe.

Any unexpected outcomes, for example longer periods in prone restraint or unusually higher use of prone restraint in a clinical area received additional scrutiny by the management of violence and aggression trust action group. The performance data on restraint was reported to the trust board via the integrated performance report.

Staff we spoke with about the use of prone restraint during this inspection, told us that they tried to avoid the use of prone restraint or use it for the shortest time possible.

Safeguarding

At the inspection in March 2016, we found that the trust had robust governance arrangements in place to safeguard adults and children. Staff had good knowledge of how to identify a safeguarding concern and the procedures to follow.

At this inspection, we reviewed the trust's approach to safeguarding to assure ourselves that safeguarding remained one of the trust's highest priorities and that governance approaches continued to be robust. We also reviewed the trust's ongoing actions in relation to the Saville report, and the trust's whole family approach to the 'think family' agenda.

At this inspection, comprehensive governance systems remained in place. The director of nursing and quality was the trust's executive lead for safeguarding. Safeguarding activity and practice within the trust was provided to the trust board via the clinical governance and clinical safety committee, the safeguarding strategic sub-group and the safeguarding children and adult's operational group.

Good

Are services safe?

Safeguarding was a standing agenda item at business delivery unit and operational management group meetings, as well at ward team meetings. All ward managers and above had oversight of the safeguarding incidents through the trust incident dashboard, as all safeguarding incidents were recorded on the trust's electronic recording system.

Training compliance in both safeguarding adults and safeguarding children level 1, 2 and 3, was above the trust mandatory training compliance rate of 80%. An audit had been completed since the last inspection to confirm the training was supporting staff in their practice. Policies and procedures, and safeguarding supervision for all staff, to support practice were in place. An audit programme in place to ensure that safeguarding children and adults systems, policies and procedures are working effectively. The safeguarding team have identified 11 audits for 2017/2018. The safeguarding team worked closely with external agencies and participated in safeguarding adult and child challenge events.

We reviewed six adult safeguarding referrals and seven child safeguarding referrals. The trust safeguarding procedure was followed in all cases. Incidents were investigated where this was appropriate, there was evidence of contact with the trust's safeguarding team, and records were updated. There was evidence of liaising with other professionals, and attendance at multi-agency meetings. Actions and timescales were identified.

In response to Saville inquiry, the safeguarding team had updated the visitors' policy. There were procedures to access the electronic Disclosure and Barring Service system. A panel, including a member of the safeguarding team, was in place to review Disclosure and Barring Service concerns that were received by the electronic system against an agreed threshold.

The trust had completed a range of actions to embed the whole family approach across the trust and to ensure the child was visible in the adult services, including specific training and guidance, working with an expert by experience to tell their story, update the assessments to allow ongoing assessment of the child in the adult record, audit and ward and team visits and learning events, participating in local initiatives like the child sexual exploitation group and perinatal services, and employing a child social worker in the adult mental health services.

The trust has approximately 120 Safeguarding Children Link Professionals working within mental health services and children's services whose role was to act as a resource within their clinical area on issues relating to safeguarding children and sign post staff as appropriate. The group met on a quarterly basis to share learning from local and national serious care reviews and domestic homicide reviews and so the 'Think Family' approach was strengthened within these sessions, and the learning championed in their own teams.

Where a child under 18 was admitted onto an inpatient mental health ward, the safeguarding team provide the staff with support to ensure that the needs of the child were met and to quality assure risk assessments and care plans.

Medcines Management

The trust's pharmacy department was engaged in a major medicines supply project due to local service level agreements ending. Progress against the project actions were closely monitored by pharmacy and at board level and this was identified on both the trust's organisational risk register and the pharmacy risk register. There were plans to continue to review pharmacy capacity and dispensary staffing during the transition period, completion of building work and implementation of the new dispensary computer system. Tendering was also underway for Electronic Prescribing and Medicines Administration as part of the trust's review of electronic care records, working towards the NHS England ambition for paper-free NHS 2020. However, initial plans to pilot electronic discharge had been delayed due to issues with the existing clinical records system.

This major project meant that some of the strategic aims for pharmacy and medicines optimisation were behind target. For example, proposed work for developing a model for pharmacy services agreed with each business delivery unit and for the development of pharmacy performance dashboards had been delayed. Additionally, a current trust Commissioning for Quality and Innovation target for reducing omitted doses was not met. However, this was being discussed at board level and the number of dose omissions was reducing. Similarly, the National Patient Safety Agency and National Institute for Health and Clinical Excellence guidance requirement for medicines reconciliation within 24 hours was not achieved.

Good

Are services safe?

The trust had assessed pharmacy staffing against the Sainsbury Report. (Delivering the Government's mental health policies – services, staffing and costs. The Sainsbury Centre for Mental Health; London: 2007) and found that staffing was sufficient to provide services to the inpatient services but not to the community teams. However, the Calderdale community team was looking to fund dedicated pharmacist support. Similarly, there were plans to establish a working group across primary and secondary care to review the prescribing of psychotropic drugs to reduce their inappropriate use as identified in the national Stopping Over-medication of People with Learning Disabilities pledge, to include support from pharmacy. Additionally, as part of pharmacy workforce planning a review of pharmacy roles and responsibilities was underway.

We saw that action was taken to address concerns highlighted through audit and review of incidents. For example, a medicines bulletin about the risks of 'potting up' medicines contrary to trust policy was shared trust wide in response to reported incidents of this practice.

At the inspection in March, there were concerns around the monitoring of high dose anti-psychotic medication on the acute inpatient mental health wards and at Enfield Down long stay rehabilitation mental health ward. The Royal College of Psychiatrists (2014) define high-dose medication as antipsychotic doses that are above the maximum stated in the British National Formulary which provides national guidance on recommended maximum doses. Temperatures in the clinic rooms exceeded the level for the safe storage of medicines on the forensic inpatient wards. Storage at high temperatures can prevent the medication being effective. We also recommended that the trust take action to ensure prescription pads were stored securely.

At these inspection visits, we confirmed that the trust had taken action to address all areas identified for improvement.

Audits of prescription pad security had been completed, and clinic room temperatures were monitored and mitigated. We saw evidence of regular physical health monitoring for patients on high dose antipsychotic medication and comprehensive recording on both the long stay rehabilitation and acute inpatient mental health wards.

Track record on safety

In December 2016, the trust reported 1,078 incidents, including eight patient safety incidents resulting in severe harm and death, and 26 patient safety incidents resulting in moderate or severe harm and death.

In November 2016 the trust reported 22.9% medicine omissions on the NHS safety thermometer.

The last inspection in March 2016 was shortly after the publication of Mazar's report in December 2015. Therefore at this inspection, we reviewed the trust's response to Mazar's independent review into the deaths of people with a learning disability or mental health problem in more detail.

We requested data from the trust for the number of deaths reported via the trust's electronic incident recording system between 1 July 2016 and 31 December 2016. This included both patient safety and non-patient safety related deaths.

South West Yorkshire Partnership NHS Foundation Trust reported 371 deaths in this time period; Barnsley Mental Health and Substance Misuse services reported 42% of the total deaths, Kirklees reported 20%, and Wakefield reported 19% (72). Of the 371 deaths, 82% were categorised as 'death – natural or due to known physical causes,' 20% as 'apparent suicide,' and 8% as 'death-unknown.'

'Deaths – natural or due to known physical causes' was the highest category of reported deaths within the trust for this six-month period totalling 306 deaths. Reviewing these deaths in more detail, three wards/teams reported three times as many known deaths when compared to all wards/teams. This included the memory services in Barnsley (101 deaths), the community mental health services for older people in Barnsley (30 deaths), and the Kirklees care home liaison team (31 deaths). The memory services in Wakefield reported the highest number of incidents for the category 'death – cause unknown' with seven of the 31 deaths.

Of the 20 incidents reported for 'apparent suicide', three of the wards/teams have reported two incidents each in the six month time period between 1 July 2016 and 31 December 2016, including the care management team in South Kirklees, the community mental health team for working age adults in Pontefract, and the intensive home based treatment team in Kirklees.

However, at the time of inspection the trust data did not include where a person had died in line with the recent CQC Learning, Candour and Accountability report. The trust was in the process of improving the trust's electronic incident recording system to include this data.

The trust was part of the Northern Alliance, where a consistent approach to the learning identified in the MAZARs independent review commissioned by NHS England at another trust, was being identified. The trust completed a retrospective review of deaths and was in the process of developing a mortality review group, though this was still in its infancy at the time of the inspection. However, the trust had completed the foundation work including the provision of mortality review training, identifying codes on the electronic incident recording system to identify and categorise deaths to allow ongoing monitoring, and identified the pathways for each category of death, for example expected unnatural, unexpected unnatural. The trust currently had a weekly clinical risk meeting where serious incidents were reviewed, including deaths, which was attended by a number of executive directors and assistant directors including the medical director, the chief executive and the assistant director of patient safety. The trust continued to participate in the Learning Disabilities Mortality Review, which is part of the National Clinical Audit and Patient Outcome Programme. The Learning Disabilities Mortality Review Programme is primarily to support local areas to review the deaths of people with learning disabilities.

The trust was leading on the West Yorkshire sustainability and transformation plan suicide prevention plan and had implemented a three year suicide prevention plan in response to the learning identified from suicide investigations and the link with quality of care. A business delivery unit lead had been established and the action plan involved collaboration with local authorities and partner agencies on suicide prevention.

Reporting incidents and learning from when things go wrong

At the last inspection in March 2016, for the most part, there was a positive culture within the trust to reporting incidents and there were effective systems to support staff to do so, including an electronic incident recording system and the policy ' Incident Reporting and Management Procedures (including Serious Incidents)' due for review March 2017. However, we identified a localised issue in the community mental health services for older people. We recommended that the trust should ensure they involve staff in learning from incidents and to consider how staff throughout the trust are made aware of lessons learnt following an incident.

At this inspection visit in January 2017, systems in relation to reporting incidents and learning from them across the trust were more robust and further embedded. Staff were

learning from incidents at a national level, a trust level, and a local level, including in the community mental health services for older people. Learning lessons and changing systems so incidents don't reoccur was a key area identified in the trust's patient safety strategy 2015 - 2018.

This patient safety strategy was monitored and evaluated by the patient safety team and there was a clear process to communicate information to the trust board. The action plan was monitored and evaluated through Clinical Governance and Clinical Safety Committee.

Senior staff held monthly meetings open to all staff looking at serious incidents and what learning would take place. This included learning events at trust and business delivery units, where incidents were reviewed and lessons learnt could be disseminated to all services where the outcomes were applicable. Learning from incidents was embedded into team meetings and supervision, and disseminated via the trust intranet, the fortnightly report produced by the customer service team that included detailed information on recommendations from investigators and required actions, and the bi-annual 'Our Learning Journey' report. This meant that all staff had an opportunity to receive this information on incidents and the learning identified. For example, two serious incidents that occurred on the acute wards, including an incident in January 2017 immediately prior to this inspection, resulted in reviews and changes across the trust.

We reviewed five serious incident records, including three patient deaths, an attempted suicide, and an incident where a patient had attempted to abscond. All records reviewed had been appropriately logged with the strategic executive information system. This framework supports providers in responding appropriately to serious incidents through supporting those affected and identifying learning from serious incidents. An appropriately qualified individual undertook each investigation. We observed detailed investigations of each incident, including findings,

notable practice and recommendations. We observed that in each incident both staff and patients had been provided with support, ranging from a debrief by the team manager to a letter to a patients next of kin. Lessons learnt were clear and mechanisms for sharing this learning were clearly recorded.

On Trinity 2 acute wards for people with mental health problems a serious incident was still under investigation following a patient death in January 2017. The patient had ligatured from a radiator in their bedroom. As a result of this incident the trust had undertaken a review of radiators across the service, identifying where the radiators were on each ward which posed a ligature risk. The ligature risk assessments for wards with this type of radiator were updated and the trust was in the process of ordering and replacing the radiators. We found that staff on both the affected ward as well as other wards within the trust were aware of this incident and the steps that were being taken to learn from the incident and prevent its reoccurrence.

Duty of Candour

At the last inspection in March 2017, we found that where incidents met the threshold for the application of the duty of candour, Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, the trust response did not always meet the requirement of the regulation. The written details of the investigation into incidents, and the findings, were not always sent to the patients, families or carers, and letters sent to them did not always have a clear message of apology contained within them. We recommended that the trust should address these issues.

During this inspection, the investigations and finding of the incidents that we reviewed that met the threshold for the duty of candour had been shared with patients, families and carers, with evidence that a clear written apology had been sent.

Since the last inspection, the trust had provided training for staff working in priority areas on the duty of candour and offered bespoke training to individual teams. Training was not mandatory but had been added to the trust training prospectus, and was available for staff to book on across all trust sites. At the time of this inspection 353 members of staff had completed the duty of candour training. The training was advertised via the trust internal communications and the trust's ward manager network.

The trust also ensured that the intranet was updated with information relating to duty of candour. This approach had resulted in a more thorough completion of the electronic incident report and the inclusion of patients, carers and relatives in lessons learned and service improvement. The trust had identified funding for a part-time duty of candour post, with additional administration support to further bolster their approach to meeting the duty of candour regulation.

The trust monitored and reviewed the duty of candour incidents on their electronic recording system and had introduced monthly reporting on duty of candour incidents to their operational management group in order to identify any hotspots and to escalate any exceptions. Duty of candour incidents were reported to the board via the integrated performance report, as well as any exceptions or breaches in relation to duty of candour. Between 1 October 2016 and 31 December 2016, there were 83 duty of candour applicable incidents and the trust's integrated performance report stated that there were no exceptions or breaches in relation to applying this regulation.

The trust submitted their quality compliance report to the all their commissioners that included the information on duty of candour and told us that commissioners actively questioned duty of candour in relation to the serious incident reports submitted. The trust now reviewed two incidents per quarter at their bi-monthly meetings with commissioners in Calderdale, Kirklees and Wakefield.

Anticipation and planning of risk

The trust's executive management team regularly scanned the external environment and

cross referenced this horizon scanning with the risks identified and managed as part of the

trust risk register and the board assurance framework. The executive management team reviewed the organisational risk register on a monthly basis. In addition the Executive

Management Team periodically reviewed and refreshed a Political, Economic,

Social, Technological, Legal/ Regulatory, and Environmental analysis of external factors

and a view of the trust's strengths, opportunities, weaknesses and threats in response to

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those circumstances. The Political, Economic, Social, Technological, Legal/ Regulatory, and Environmental analysis and strength, weakness, opportunities and threats analysis was reviewed at the board meeting we attended as part of the inspection visit in January 2017 in the context of the recent strategy refresh. The trust had revised the board assurance framework to ensure the risks on the risk register reflected the trust's current position and was aligned to the trust's revised strategic objectives. Since the last inspection, the trust had introduced a framework to support the management of risk to an agreed level of accountability, which they referred to as their 'risk appetite framework.' Tendering and other financial decisions and transformation changes for example were considered in the context of this framework.

The trust had contingency plans in place for emergencies and major incidents. They successfully implemented an emergency contingency plan in response to a recent fire on Trinity 2, the psychiatric intensive care unit. The trust, staff teams and all the support services had worked together to ensure that the service continued with minimum disruption in a challenging new environment. Staff on Trinity 1 and Trinity 2 told us that they had felt supported after the fire which had caused their wards to be relocated.

Good

Are services effective?

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

Summary of findings

We rated effective as good because:

- In March 2016, we rated four of the 14 core services as requires improvement for effective and we identified three trust-wide breaches of regulation in this domain. This led us to rate the trust as requires improvement overall for this key question.
- Between November 2016 and January 2017, we inspected all four of the core services rated as requires improvement for effective. We changed the rating for the effective key question from requires improvement to good for two of the four core services we inspected, the long stay rehabilitation wards for adults of working age and the community mental health services for older people. The trust had addressed a number of the issues that caused us to rate it as requires improvement for effective last time.
- In March 2016, concerns were identified in services across the trust regarding recording keeping, the use of both paper and electronic records, and technical issues with the electronic patient record system which prevented staff accessing it when they needed to. Mental Capacity Act and Mental Health Act training was not mandatory, and there no plan in place to implement the Mental Health Act revised Code of Practice (2015) across the trust.
- At this inspection the trust had resolved almost all the technical issues, identified local working protocols to minimise clinical risks whilst the issues were being resolved, and addressed staff performance issues on the system via staff training, revised user guidance and email communications to all staff who used the system. Mental Health Act and Mental Capacity Act training was mandatory and the trust was on a trajectory to meet the trust 80% compliance target by the end of March 2017. They had an action plan to implement the revised Code of Practice across the trust, and almost all its policies, procedures and other documentation reflected the revised code.
- The issues identified in March 2016 in relation to the quality of the record keeping and access to the system had been resolved in the community mental health services for older people. All documentation was now kept on the electronic patient record system; assessments were detailed and care plans were holistic and person centred. The trust had acted on the findings in the long stay rehabilitation mental health wards at the last inspection and now completed regular multidisciplinary reviews to review patients' care and treatment. Staff had completed mental Health Act training or they were booked on the course and there was evidence that staff audited patients' consent to treatment records regularly and all patients detained under the Mental Health Act had the correct paperwork in place.

However:

- We did not change the rating for the acute inpatient mental health wards for adults of working age and psychiatric unit or the forensic secure inpatient wards.
- At the inspection in March 2016 staff on all wards had not received appropriate supervision, and consent to treatment and capacity assessments were not completed and recorded appropriately. At this inspection, these issues had not been resolved and the average compliance rate for staff supervision was 18% in these services and understanding of the application of the Mental Capacity Act was poor across all wards. Staff struggled to explain the circumstances which would require a capacity assessment or a best interest decision.
- We recommended at the last inspection that the trust should ensure there is evidence that consent and capacity had been assessed in the patient notes

for patients on the forensic wards where this was appropriate. At this follow-up inspection, this issue had not been resolved. Mental capacity assessments were not documented in patients notes and staff lacked the knowledge and awareness regarding the processes of completing and documenting mental capacity information. However, appraisal rates had increased at this inspection and staff inform patients of their rights and record this in patient notes at regular intervals, and all staff could access patient's electronic care records.

Our findings

Assessment of needs and planning of care

At the last inspection in March 2016, we found that patients' needs were assessed and appropriate care plans were developed in partnership with the patients. However, there were issues in all the community mental health services for staff with regard to recording keeping and using the electronic patient record system. Staff were unable to upload and save information in some services, and were unable to access the system and retrieve this information when required. Some services did not have the necessary templates for their treatment on the system, and some teams were using both paper and electronic records. Not all staff were able to access the system, for example agency staff in the forensic inpatient services. This meant that staff were not always able to relevant patient information in a timely way. We told the trust that they must ensure care records are up to date and accessible in order to deliver people's care and treatment in a way that meets their needs and keeps them safe.

In response, the trust continued to identify the patient electronic recording system as an organisational risk and progress reports continued to be submitted to the systems development board and the executive management team, with oversight from the trust board. The trust implemented an improving clinical information working group and action plan, with the aim of resolving the issues identified, ensuring that the current electronic record system was the only place to store clinical records, and for meeting the national target to have a paperless NHS by 2020. Actions included working with the electronic system provider to resolve the technical issues, identifying local working protocols to minimise clinical risks whilst the issues were being resolved, and addressing staff performance issues on the system via staff training, revised user guidance and email communications to all staff who used the system.

At these inspection visits, the recommended actions had been completed in the community mental health teams for young people, for people with a learning disability and autism and for older people. Contemporaneous records were accessible within the same electronic system. All paper documentation was scanned onto the electronic system in a timely way, and the teams and services were in the process of becoming fully 'paper light.' The majority of the technical issues had been resolved including in the community mental health services for adults of working age, with the few remaining under investigation.

On the forensic wards the trust had taken steps to ensure all relevant staff had access to electronic records including regular agency staff where they had completed the required training. The trust had a guide for managers on access for temporary users on the system and clearly identified the procedure for temporary staff, such as agency staff, for accessing the system. However, agency staff including qualified agency nurses and nursing assistants in the acute mental health inpatient wards and psychiatric intensive care units, could not access the electronic record system. The agency staff received information for how to care for patients in ward handovers and trust staff inputted notes into care records on their behalf.

The trust was undertaking a consultation process with regards to future alternative record care systems. Staff were encouraged to share their views on the future of the clinical systems through the trust's online survey.

In response to several recent information governance breaches reported to the information commissioner's office, the information governance team had identified three points to improve information governance across the trust and cascaded these to staff through the monthly staff brief. Record keeping audits were completed to check systems were updated correctly by staff with patient information.

Best practice in treatment and care

Best practice, including the National Institute of Health and Care Excellence guidance was cascaded by the quality improvement and assurance team. At this inspection, we reviewed best practice on the acute inpatient wards for

adults of working age and staff used recognised ratings scales to assess and record severity and outcomes. Care records showed that staff used scales such as a mental health clustering tool, nutritional risk screening tool, a falls risk assessment tool, and the national early warning score tool. However, on these wards psychological interventions such as cognitive behavioural therapy for anxiety management, depression and coping skills was not routinely offered, and the provision of one to one psychological interventions was not consistent, in line with both the requirements for accreditation from the Royal college of Practitioners and the National Institute of Health and Care Excellence. Staff told us that this was because of the capacity limitations of the psychologists.

Ward consultants, clinical leads and the medical director told us that guidance from the National Institute for Health and Care Excellence was used when prescribing medication and was followed in relation to monitoring the potential physical side-effects of high dose antipsychotic medication.

At this inspection, we saw evidence of ongoing audit at organisation level, in the business delivery units and at team and service level. The trust had an identified annual audit programme based on the risks identified on its risk register, the board assurance framework, and the national context. The trust also continued to participate in national audits, including prescribing observatory for mental health audits and the national audit for schizophrenia.

The trust had identified a number of specific risks relating to Commissioning for Quality and Innovation target achievement and had action plans in place to increase their likelihood to achieve these targets. At the time of the inspection the trust had exceeded its Commissioning for Quality and Innovation target target for 75% of all front-line staff vaccinated for influenza.

In November 2016, the trust was achieving all its NHS Improvement performance targets.

Skilled staff to deliver care

At the last inspection in March 2016, whilst staff were experienced and qualified, with a range of skills and disciplines to deliver care appropriate to the needs of the different patient groups, not all staff received managerial or clinical supervision. On the acute wards for adults of working age, and the psychiatric intensive care unit, staff had not received either clinical or managerial supervision for some considerable time; in some cases this was over 12 months. The trust did not have effective systems in place to monitor supervision across the trust, including clinical supervision, and at local level in the forensic inpatient mental health services.

Following the last inspection, the trust revised its supervision framework and ensured it reflected the way a service was managed and the shift patterns, for example the 12 hour shift-patterns on the inpatient wards and the intensive home-based treatment teams. They provided in-house training to support the delivery of the framework, including training to increase the number staff that can act as supervisors/clinical supervisors. To ensure the new supervision framework offered a more flexible approach to supervision, the trust had introduced a supervision 'passport' and a list of supervisors. The aim of this was to allow staff to access supervision from a range of people and when it was available, rather than relying on one individual line manager. This was still being embedded across the forensic services and the trust. At the time of the follow-up inspection visits staff were being supported by the trust to understand the importance of using the passports and the new system.

A new central electronic database for recording supervision had been introduced to ensure that staff were receiving regular managerial and clinical supervision as described in the trust's 'supervision of the clinical workforce' policy. The trust expectation is for each clinician to have a minimum of 12 hours supervision per year. This system enabled supervisees, supervisors and managers to monitor and manage how supervision was accessed and captured, or where this was not happening across individuals and teams.

The database had been in place in forensic inpatient wards at the time of the inspection visit in December 2016 and had been rolled out further across the trust when we completed the final well-led and acute inpatient mental health wards and psychiatric intensive care units follow-up inspection visits at the end of January 2017.

Baseline data for compliance with staff supervision in the acute mental health inpatient services and the psychiatric intensive care units for September – December 2016 was low, average 18% across the wards. Some staff on these wards told us they received regular supervision whereas others told us it had been months since they had last received supervision.

Good

Are services effective?

At the follow-up inspection visit of the forensic services the supervision database could only record the amount of minutes of supervision each staff member had accrued. The trust were aware and there were plans to improve the recording system to suit the needs of the service. This meant that in the future the trust would be able to provide accurate data and be assured that supervision was being delivered.

The trust recognised that this new approach to supervision, the new systems and the increased profile of clinical supervision, was developmental work which was still being embedded. They recognised the importance of supervision in supporting the implementation of the trust's workforce development plan. At the time of these inspection visits, information was collected at trust level and was accessible to senior managers, business delivery units, senior, and ward managers. The trust were planning to use the database to monitor and audit supervision to ensure that it is completed against the clear standard stated in their policy, in the same way the trust monitors performance for appraisals.

At this inspection, staff on the acute mental health inpatient wards and psychiatric intensive care units told us they had received additional specialist training in personality disorders to support a change towards two single gender wards, as well as relevant physical health training.

The trust performance target for appraisal was 95%. Since July 2016 the trust overall compliance with appraisal was on an increasing trajectory each month, as were all of the business delivery units. The trust had increased overall compliance for appraisals of band five staff and above from 27% in July 2016 to 89% in December 2016, and from 57% to 93% in the same time period for band six staff and above. Calderdale and Kirklees district was the highest performing business delivery unit for both band six, and band five, and above appraisal rates of 99% and 94% respectively in December 2016. The specialist service business delivery unit had the lowest appraisal rate for both band six, and band, five nurses and above, at 83% and 63% in December 2016 respectively.

A robust medical appraisal system was in place including 360 degree feedback that included service line objectives, robust reviews and an annual report.

Communication about all workforce performance, including appraisals, was submitted to the trust board on the 'workforce performance wall' part of the integrated performance report, and shared with wards through a number of mechanisms, including the team briefing, 'The Brief.'

The trust had allocated nominated individuals to support staff with support and advice for revalidation in their professional registration.

Multi-disciplinary and inter-agency team work

At the last inspection in March 2016, we found that for the most part there was effective multi-disciplinary working between professionals and services, within and outside, the trust. However, at Enfield Down, one of the long-stay rehabilitation wards for patients with mental health problems, patients did not have regular multidisciplinary meetings and this was a breach of regulation. Also staff on the acute mental health inpatient wards told us that community mental health staff struggled to attend meetings on Ashdale and Elmdale.

At these follow-up inspection visits between November 2016 and the end of January 2017, we found that Enfield Down held weekly multidisciplinary reviews attended by a psychiatrist, nurse and occupational therapist with other professionals involved in that patient's care attending as appropriate. Patients attended a minimum of one review a month and could request additional reviews throughout the month if they wanted. On all the acute mental health inpatient wards, there were regular and effective multidisciplinary team meetings where patients were supported to attend and participate fully. Community mental health staff now regularly attended these multidisciplinary team meetings.

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

The trust made training in the Mental Health Act mandatory in March 2016 following feedback at the last inspection. Overall trust compliance in December 2016 was 21%. Figures in the Mental Health Act training had improved since the last inspection in the long stay and rehabilitation mental health wards to 72% but remained low in the forensic inpatient services at 15% at the end of December 2016. Whilst the trust recognised that it was a challenge to meet their mandatory training target by the end of March 2017, staff we spoke with thought it was

achievable, with 41 sessions available and training places booked by staff up to this date, including 70% of the medics. Training packages and content were identified for different staff based on their role and were underpinned by NHS England guidance, the Mental Health Act legislation, and the code of practice.

At the last inspection, we identified that the trust did not have an implementation plan in relation to the revised Mental Health Act Code of Practice (2015). Trust policies and procedures had not been updated and there was no consistent training. Some staff were not aware there was a revised Code of Practice.

In response, the trust had introduced a Mental Health Act/ Mental Capacity Act sub group that set part of the agenda for the Mental Health Act Committee, including new changes, and clinical and legal considerations. This reported into the Mental Health Act Committee, which was chaired by a non-executive director and had representation from executive and non-executive directors. The mandatory training, the code of practice action plan and the audit plan were monitored and reported through the Mental Health Act Committee, to the trust board. The training compliance was reported to the trust board via the workforce performance wall of the integrated performance report. This started in November 2016.

The trust reviewed its existing action plan in relation to the code of practice implementation following the last inspection. The trust also submitted an action plan to the CQC in relation to their compliance with the Mental Health Act Code of Practice that was due for completion on the 31 March 2017, which the trust was on a trajectory to achieve. Examples of actions taken since included, reminders to staff that the Mental Health Act Code of Practice (2015) was available on the intranet, and the introduction of the code of practice as an agenda item at business delivery unit meetings. The trust also removed outdated Mental Health Act Code of Practice information from the wards and teams and business delivery units reviewed operational practice, policies and procedures.

At this inspection, the majority of the trust's policies complied with the revised code of practice (2015), including annex B. However, the blanket locked door policy did not reference that the impact of a locked door policy should be considered and documented in patients' records. Also, the search policy for The Yorkshire Centre for Forensic Psychiatry was due for review in April 2016 and had not been updated in line with the Code of Practice (2015) as it referred to chapters in old code of practice. The customer services policy supporting the management of complaints, concerns, comments and compliments that was reviewed by the trust Board in January 2017 did not reference in the policy that information on how to make complaints to the CQC should be readily available. The policy for internet and social media access was due for discussion at the executive management team in February 2017, and a number of documents that were due for review in line with the code of practice had extended timescales for various reasons. These included, the human rights policy; the police assistance for people undertaking assessments with a view to applications under the act policy; the discharge and clinical handover document; and the restrictive interventions reduction programmes. The trust confirmed in their factual accuracy response in April 2017 that all the policies were now up to date or scheduled for approval, for example the Section 136 policy which required agreement from external agencies. Where policies were waiting for approval from external agencies, the trust told us they had working drafts are in place.

The Mental Health Act associate managers met quarterly as a managers' forum, which included a formal meeting with a representative of the trust. The chief executive attended the last two forums. The Chair of the forum attended the Mental Health Act Committee, where any concerns are addressed, and feedback was provided. Anything urgent was raised with the Mental Health Act manager. The associate managers we met with spoke positively of the trust's approach and the open dialogue between them and the trust.

Despite the low overall trust training compliance in relation to the Mental Health Act, staff in the services we visited at this inspection had a good understanding of the Act and its application. Issues identified at the last inspection, including the timeliness of the request for second opinion appointed doctors and the accurate completion of T2 and T3 consent to treatment certificates in the long stay and rehabilitation mental health services were rectified at this inspection. Also staff on the forensic wards were now informing patients of their rights and recording this in patient notes at regular intervals as set out in the Mental Health Act code of practice. Patients at this inspection confirmed they were regularly informed of their rights.

Good

Are services effective?

We saw evidence of regular audits in relation to the application of the Mental Health Act across the trust with the audit plan monitored at the Mental Health Act Committee. Audits included Section 132 informing patients of their rights, consent to treatment forms, second opinion appointed doctor requests, access to advocacy, and Section 17 leave. The trust had also recently started an annual audit of staff awareness of the Mental Health Act Code of Practice (2015).

Whilst all the acute mental health inpatient wards and psychiatric intensive care units had access to an independent mental health advocate, the process for referrals to the independent mental health advocate was not consistent in the service.

Good practice in applying the Mental Capacity Act

At the last inspection in March 2016, Mental Capacity Act (2005) training was not mandatory across the trust. There was no clear mechanism for the trust to monitor its compliance with the Mental Capacity Act or the Deprivation of Liberty Safeguards across the organisation. The Mental Capacity Act was not consistently understood, including on the acute wards for working age adults and psychiatric intensive care units and on the forensic wards. On these wards, capacity assessments with regard to consent to treatment were missing from care plans and from patient notes, and the best interest process was not always followed. Therefore we recommended the trust should take action in relation to this. Similarly, in the community mental health services for older adults we recommended that the trust should ensure that staff consistently record details of decisions within capacity assessments.

In response, the Mental Capacity Act and the Deprivation of Liberty Safeguards was agreed as mandatory training by the executive management team. Overall trust compliance in December 2016 was 46%. Training compliance was lowest at 29% across the forensic services in the same month. However the trust was on a trajectory to meet their mandatory training compliance target by the end of March 2017.

Mental Capacity and the Deprivation of Liberty Safeguards information was reported through the governance structures in the same way as the Mental Health Act ; through the Mental Health Act/Mental Capacity Act sub group to Mental Health Act Committee to the trust board. Training compliance was reported to the trust board via the workforce performance wall of the integrated performance report and started in November 2016.

The proposed Mental Capacity Act training plan (including Deprivation of Liberty Safeguards) was discussed with the Local Authorities. Training plans were based on guidance that was issued by NHS England, with the aim for all clinical staff to understand the applications of the Mental Capacity Act and the Deprivation of Liberty Safeguards, have the ability to apply each of these legal frameworks and requirements to deliver care and treatment lawfully, and to be clear how best to record and evidence clinical practice. Mental Capacity Act training including the assessment of capacity and consent, best interests, advance decision-making, lasting power of attorney and Deprivation of Liberty Safeguards, were included in the medical staff induction.

At this inspection, we saw pockets of good practice. We saw evidence of staff considering consent and capacity routinely in their work, and completing detailed best interest assessments and documenting them, in line with the trust's Mental Capacity Act policy, in the community mental health services for older adults and in the psychiatric intensive care units. However, the low compliance with training in the Mental Capacity Act was evident in the poor staff understanding of the Mental Capacity Act on the acute mental health inpatient wards and on the forensic inpatient wards. We found that staff lacked knowledge and understanding of how to implement the processes involved regarding the Mental Capacity Act. Staff were unable to tell us how their policy relating to the Mental Capacity Act was implemented in practice and some were not aware of the policy.

Staff on these wards struggled to explain the circumstances which would require a capacity assessment or a best interest decision and inspectors could not to locate any capacity assessments or any evidence of the best interest checklist being followed on the forensic learning disability wards where patients nursed in this environment are highly likely to have capacity issues.

The factual accuracy response received by the trust in April 2017 confirmed that the good practice in relation to how capacity assessments are undertaken, recorded and reviewed within their psychiatric intensive care unit at Wakefield, has now been rolled out within all their inpatient

areas, including the forensic wards. This is so that these teams can start implementing similar processes and procedures to improve their record keeping practices in relation to the Mental Capacity Act and best interest assessments.

The trust had clinical record keeping identified in its internal audit strategic and operational plan 2016 - 2017. This audit included checks to confirm a patient's capacity to consent had been recorded, to confirm a record of a best interest decision or meeting regarding the patient's care and treatment if it was appropriate, and whether this best interest decision was recorded in the care plan. These were completed across the business delivery units and services, and areas for improvement in relation to this were identified in the audit outcome. This was confirmed in all the audits that we reviewed, including the inpatient learning disability services where 60% of records had evidence of best interest decisions and 40% of these decisions were recorded in the care plan.

Good

Are services caring?

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

Summary of findings

We rated caring as **good** because:

- At the last inspection we rated caring as good. Since that inspection we have received no information that would cause us to re-inspect a core service or change this rating.
- At these follow-up inspection visits between November 2016 and January 2017, staff across the organisation were kind, caring and compassionate in their approach with patients. We observed respectful and warm interactions with patients. In the services where we reviewed treatment records and the involvement of people in their treatment and care, care records were personalised and holistic with good evidence of patient involvement and participation.

Our findings

At the last inspection in March 2016 caring was rated as **good.** Since that inspection we have received no information that would cause us to re-inspect a core service or change the rating.

Kindness, dignity, respect and support

At these follow-up inspection visits, staff across the organisation were kind, caring and compassionate in their approach with patients. We observed respectful and warm interactions with patients. Feedback we received from patients, their relatives and carers about staff was almost always extremely positive, with the exception of a comment about the response of agency staff of one of the acute inpatient mental health wards.

The involvement of people in the care they receive

At this inspection, in the services where we reviewed treatment records and the involvement of people in their treatment and care, care records were personalised and holistic with good evidence of patient involvement and participation. Patients consistently told us that they felt involved in their treatment and care.

There was continued evidence of community meetings taking place regularly on the wards that we visited. These provided patients the opportunity to feedback onto the running of the ward and we saw changes made as a result of this feedback on the forensic wards.

Relatives and carer involvement was noted in the care and treatment of patients in the services that we inspected during this follow-up inspection.

On the acute inpatient wards, records demonstrated that relatives and carers were offered their own support and Ward 18 employed a designated “carers’ link worker.” This was a unique role in the trust and was highly valued by both carers and staff on the ward. The carers’ link worker was responsible for providing advice and support to carers which included signposting carers to services available in the community. The carers’ link worker was also responsible for keeping carers informed about and involved with the care provided to patients on the ward.

Requires improvement

Are services responsive to people's needs?

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

Summary of findings

We rated responsive as **requires improvement** because:

- In March 2016, we rated five of the 14 core services as requires improvement for responsive, which led us to rate the trust as requires improvement overall for this key question.
- Between November 2016 and January 2017, we inspected four of the core services rated as requires improvement for responsive. We did not change the rating for the community mental health services for people with a learning disability or autism and the specialist community mental health services for young people.
- We did not reassess the community mental health services for adults of working age during these follow-up inspection visits because the trust's action plan completion date to meet the breach of regulation related to patient waits to access psychological therapies was March 2017. This means that the rating of responsive for this core service remains as requires improvement.
- In March 2016, there were long waits to access psychology in the community mental health teams for people with a learning disability or autism. At this inspection, nobody was waiting longer than 18 weeks to access psychology. However, waiting times to see members of the multidisciplinary team and for a range of specialist assessments were long in Barnsley and Kirklees, for example dysphagia, occupational therapy and physiotherapy.
- The trust was working with commissioners to reduce the waiting times in the specialist community mental health services and had an action plan in place to reduce wait times. Waiting times for treatment had improved in Calderdale and Kirklees, and Wakefield at this inspection. However, there were still significant delays within the Barnsley team and none of the teams were meeting the trust target for referral times.
- All community mental health teams had lengthy waiting lists for people to be assessed for autistic spectrum disorder.

However:

- We changed the rating for the responsive key question from requires improvement to good for the community mental health teams for older people and the acute mental health inpatient wards for adults of working age and psychiatric intensive care units.
- At these follow-up inspections the trust had addressed the issues identified in March 2016. All the teams in the community mental health services for older people had access to crisis services 24 hours a day, seven days a week. The service was meeting its nationally recognised targets for assessing patients within 14 days, and responding to urgent referrals in four hours. All patients could access psychological therapies in a timely way. Average bed occupancy had decreased on the acute inpatient mental health wards and psychiatric intensive care units since the last inspection which meant that patients were more likely to be able to return to a bedroom on the wards when they returned from leave.

Our findings

Service planning

The trust continued to move forward with its five year transformation programme (2014 – 2016) to deliver flexible, cost effective services that continue to meet the needs of the people who use them. These ongoing plans were

overseen by the trust board. Board papers we reviewed included brief reports on each transformation project, with adherence to timescales, emerging issues, and a reminder of the benefits and quality impact.

At the time of the inspection, the trust was working with its partner organisations to ensure contracts for the next two years had been agreed in principle, and continued to identify and submit tender bids for contracts that would ensure the sustainability of the organisation, and enhance and diversify the services offered, particularly in a period of austerity for local commissioners which was identified as a risk to the organisation. The trust had been successful in securing a number of contracts, for example, to set up a new perinatal community health team to support communities in Barnsley, Calderdale, Kirklees and Wakefield, to deliver part of the Kirklees healthy child contract, and to provide input into the psychological environment of a local young offender institute.

Access and discharge

At the inspection in March 2016, some of the mental health wards had very high levels of bed occupancy. On the acute inpatient mental health wards this had an adverse impact on the quality of care as a bed was not always available for patients when they returned from leave. We recommended that the trust should take action to ensure where possible a bed is available when patients return from leave.

Average bed occupancy for the period 1 June 2016 to 31 December 2016 excluding patient leave across the trust was 83%, which was below the 85% bed occupancy recommended by the Royal College of Psychiatrists to deliver safe, quality care. Average bed occupancy for the same period including patient leave was 91%. Bed occupancy was similar to the previous inspection. There had been a reduction in the average bed occupancies on the acute inpatient mental health wards with four wards having average bed occupancy less than 85%, though Elmdale and Ward 18 had an average bed occupancy of more than 100% which was caused by patients being admitted to beds allocated to patients on leave from the ward. This meant that a bed might not always be available to a patient on leave who requires early readmission to the ward.

In the period 1 June 2016 to 31 December 2016 the trust had 172 out of area placements, compared to 44 in the six months prior to the previous inspection. Spend on out of area beds was identified as one of the contributing financial risks for the trust with the spend increasing by 400% in 2016/17 compared to 2015/16. Factors that influenced this increase in out of area placements included a reduced bed capacity of 12 due to a fire on the Fieldhead site in Wakefield and an increased demand due to patient acuity that exceeds the trust's existing capacity. The acute inpatient mental health wards in Wakefield; Priory 2 and Trinity 2 had the highest number of out of placements at 76.

The trust had taken a number of actions to reduce the use of out of area bed placements, and spend. This included the analysis of specific service demand which identified an issue in most services but particularly high demand for female acute beds and female psychiatric intensive care units beds, on top of the reduced internal capacity for male acute beds following the Trinity fire. The trust also identified learning from other trusts that had been successful in reducing out of area bed usage. They were also looking to safeguard additional capacity through an appraisal of its estate.

Operational management included ongoing out of area focus on pathways and patient flows, with a trust wide bed management team approach to ensure there was a consistent approach across the trust and reduced length of stay. Ensuring that wards were appropriately staffed allowed full bed capacity to be used. The trust created additional internal capacity due to an agreement with another organisation to utilise NHS beds at a lower rate than the private sector charge.

There were also initiatives in the business delivery units to reduce out of area placements, including ensuring all admissions to the Barnsley acute mental health wards since April 16 were gate kept prior to admission by the intensive home based treatment team, and work on the forensic female pathway had been successful in reducing the patient length of stay.

The chief operating officers told us that the number of out of area placements had been on a decreasing trajectory since August 2016 and by December 2016 they had reduced to 72. At the time of the inspection in January 2017, the number of out of area placements had reduced further to 11; four acute inpatient and seven psychiatric intensive care.

Requires improvement

Are services responsive to people's needs?

At the inspection in March 2016, there were long waiting lists for people to access the community mental health services for children and young people with people waiting on average four and half months as a minimum at all geographic locations, with the longest waits being between 18 and 24 months. In addition, the trust were not meeting their own targets from referral to assessment. Concerns were also raised about the waits in some teams to access treatment in the community services for older people, for example the North Kirklees community mental health team.

Access to psychological therapies exceeded 18 weeks in several of the trust core services, including the community mental health services for learning disabilities and autism, the community mental health services for older people, and the community mental health services for adults of working age.

During these inspection visits between November 2016 and February 2017, we reviewed waiting times from referral to assessment, and assessment to treatment, in the community mental health services for older people, the community mental health services for children and adolescents, and the community mental health services for patients with a learning disability and autism. We also reviewed the waiting times for patients to access psychological services in these community services.

We no longer had concerns about the waiting times to access treatment and psychological therapies in the community mental health services for older people. The waiting times for patients to access psychological therapies in the community services for people with learning disabilities had improved and this was no longer a breach of regulation.

However, at these inspections the waiting times that we reviewed for patients to access members of the multidisciplinary team and for specialist assessments were high in Barnsley and Kirklees, including speech and language therapy, physiotherapy, and occupational therapy. 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), 23 in total and 2 people waiting over 18 weeks. Forty-nine people were on the waiting list for physiotherapy with 17 people waiting over 18 weeks, and 66 people waiting for occupational health appointments, with 25 waiting over 18 weeks.

Processes were 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.

Waiting times in the community mental health services for children and adolescents had improved at the return inspection visit in December 2016; Staff had reviewed working practices and pathways across the service to try to streamline the service and help ensure young people had access to the most appropriate treatment for their needs. At the time of the follow-up inspection of the specialist community mental health services for young people in December 2016, none of the teams were meeting the trust target for wait times from referral to assessment of 35 days. However, data provided by the trust during the well-led inspection in January 2017 for wait times from referral for young people June – December 2016 showed that despite wait times for treatment for young people improving in Calderdale and Kirklees, and Barnsley, there were still delays within the Wakefield team. This showed that further improvements were still required in order to make waiting times equitable for all young people requiring the service. The trust advised that some wait times could be explained by parental choice, for example, where parents may choose to delay the appointment which could lead to extended waits in some cases.

The trust provided data at the time of the well-led inspection in January 2017regarding the length of time young people were waiting to start treatment following assessment. There was no trust target for the wait time from assessment to starting treatment for young people. Whilst these wait times had increased in Barnsley since the inspection in March 2016 and reduced in Calderdale and Kirklees, and Wakefield, all average wait times to start treatment had reduced in the period between the follow-up inspection of the specialist community mental health

Requires improvement

Are services responsive to people's needs?

services for young people inspection in December 2016 and the well-led inspection of the trust at the end of January 2017. Wait times for young people on waiting lists between June and December 2016 were as follows:

- Barnsley average wait 176 days;longest wait 765 days
- Calderdale and Kirkleesaverage wait 91 days longest wait 143 days
- Wakefield average wait 137 days longest wait 232 days

The assistant director and managers told us waiting lists had built up over periods of time. Staff told us about various initiatives to try to target these. For example, the manager at Barnsley told us they were looking at possible group work sessions where young people may be suitable for these. Additional training had been provided to staff to deliver certain therapies. The greatest impact on waiting list reduction had been at Calderdale and Kirklees. The manager and staff said this was due to the model of the 'single point of access team', which operated as a tier two service, and which had been strengthened by additional funding. Barnsley and Wakefield teams were in the process of further strengthening and embedding their tier two systems to try to reduce longer wait times in these areas. The service was trying to replicate this in Wakefield and Barnsley so they could be more timely and responsive to young people's needs where they required tier three intervention. In the Barnsley service, staff absences in the tier two service had impacted upon capacity and therefore availability and accessibility of the service which in turn impacted upon wait times. There were plans in place to address this via additional staffing resources.

We reviewed the waiting times for young people to be assessed for autistic spectrum disorder.

As of the 31st December, the numbers of young people waiting for an autistic spectrum disorder assessment was:

- < >
  Wakefield - 46 waiting, longest wait 13 months
- Barnsley - 44 waiting, longest wait 592 days

As of the same time period, the numbers of young people with a learning disability waiting for an autistic spectrum disorder assessment was:

- Barnsley – No waiting list
- Kirklees – 15 waiting, 13 waiting over 18 weeks
- Wakefield – 5 waiting, 4 waiting over 18weeks

The assistant directors and directors told us that waiting times for autistic spectrum disorder assessments were a known issue with regards to length of waits which were excessive, particularly within Calderdale and Kirklees. The trust confirmed that waiting times for patients to access autistic spectrum disorder assessments were a national problem. They said that commissioners were aware this was a problem area and that this was not limited to one community service. The services were aiming to target these waits with recent investment. However, the lengths of waits showed that the teams were not currently responding effectively to this specific demand and were not meeting the needs of young people and families requiring this service.

All waiting times were identified on the operational risk registers at business delivery unit level, and on the organisation, strategic risk register, with oversight from the trust board.

The facilities promote recovery, comfort, dignity and confidentiality

During this inspection in January 2017, we took the opportunity to review the environment of the secure, forensic inpatient wards as the outside courtyard in the low secure wards had been redesigned with the involvement of patients and staff. This courtyard on Ryder ward was pleasant but had limited furniture. Both the forensic secure inpatient wards and the acute inpatient wards with mental health problems, including the psychiatric intensive care units, had a full range of rooms and equipment to support treatment and care, as well as quite areas and access to outside space. We observed personalised bedrooms with secure storage.

At the last inspection in March 2016, we recommended that the trust should take action to address a number of issues in order to ensure all its facilities promoted recovery, comfort, dignity and confidentiality. The clinic room at Enfield Down, a rehabilitation and long-stay ward for adults with mental health problems was small and did not allow for physical examinations of patients to take place. A high proportion of patients complained about the quality of the food on the secure forensic inpatient mental health wards. On both the acute wards for adults of working age with mental health problems and the forensic wards there were

limited activities on weekends and patients complained that they wanted more. The weighing scales in two of the teams in the specialist community mental health services for young people were not in private areas.

At the follow-up inspections completed between November 2016 and the end of January 2017, the trust had addressed these issues.

Enfield Down had a fully operational clinic room with ample space for physical examinations.

The patient led assessment of the care environment produces a score for food and hydration which looks at the choice of food, meal times and access to menus. The trust's score was higher in comparison to national average of similar trusts. All patient menus were assessed by a dietician for a healthy balanced meal. Food quality and provision had improved on the forensic wards, with changes being made in response to patients' suggestions, for example theme nights and additional options for supper. However, patients on the acute wards commented that the menus could have more variety.

Occupational therapists and activities assistants on the forensic and acute wards mental health wards `offered a number of open groups for patients to join and activities were available at weekend, for example breakfast, art groups, and gym groups. On the forensic wards, 97% of patients had completed over 25 hours of meaningful activity in August, September and October 2016.

The trust action plan confirmed that the weighing scales in the specialist community mental health services were now all placed in an appropriate environment, which ensured privacy and confidentiality.

Meeting the needs of all people who use the service

At the last inspection, there were no breaches of regulation in relation to the trust meeting all the needs of the people who used the services.

We have received no information since the last inspection that would indicate this had changed; our inspection of the acute inpatient wards for patients with mental health problems and the psychiatric intensive care units confirmed that the trust continued to meet the needs of all its patients in that core service. Wards and services were accessible and special cultural or dietary requirements were catered for. Access to spiritual and religious support was available, and there was also access to interpreters, leaflets in alternative languages, and the internet site had a translation function. We observed information available on local services, patients' rights, how to complain, and how to access the advocacy services, in both the acute and forensic inpatient that we visited during these inspection visits.

Listening to and learning from concerns and complaints

At the inspection in March 2016, we found that the trust completed thorough investigations and detailed record keeping in relation to the complaints that they receive, including the root causes of the complaint, the evidence gathered, the recommendations and the suggested mechanisms for sharing the learning. We saw evidence that the trust was good at keeping the complainant updated on the progress of the complaint.

However, at that inspection records were not clear that these complaints had been appropriately risk assessed by an appropriate individual, for example by a medical director or the director of nursing, where a patient was involved. Some patients thought the trust were registering their complaints as concerns, where they were clear they wanted their issue addressed as a complaint. Finally, on the psychiatric intensive care unit at Fieldhead Hospital, information about how to complain was not displayed on the ward which meant patients may not be fully aware of how to make complaints.

Therefore, whilst there was no previous breach of regulation in relation to complaints, at this inspection we reviewed the complaints procedures and documentation.

At this inspection visit in January 2017 to review the trust leadership and governance processes, we confirmed that the trust had made improvements in this area and revised their complaints processes. The complaints now included risk assessment by an appropriate individual, for example by a medical director or the director of nursing, where a patient was involved. Also, members of the customer service team worked with complainants to identify the nature of the complaint and identify outcomes from the complaint. The chief executive now reviewed and agreed the final response to all complaints.

The trust had introduced the capture of compliments about their services from other professionals (partners) as well as from service users, carers and families since our last inspection in March 2016. The chief executive

Requires improvement

Are services responsive to people's needs?

acknowledged all compliments and this positive practice was now shared on the intranet, included as examples at new starter welcome events, and reported to the quarterly trust board, to commissioners and to local Healthwatch.

At this inspection in January 2017, we reviewed five complaints records. All five records demonstrated that people were supported to complain. The records demonstrated that the complaints were handled appropriately, with people being supported by an allocated customer service team member who they worked with to identify and agree outcomes for the complaint as identified in the complaints process. These agreed outcomes formed the basis of the final repose by the trust. Each record contained a toolkit to guide the lead investigator through the process of investigation.

All five complaint records included thorough investigations, excellent record keeping and the trust was particularly good at keeping the complainant updated on the progress of the complaint. Being open in relation to complaints as outlined in the trust's customer service policy, as well as duty of candour was reflected throughout the complaints process, and in the complaints that we reviewed.

Learning from complaints was also evident and the mechanism for sharing this was consistent. The customer service team produced a report every fortnight that included detailed information on open and closed complaints. From this information teams within each business development unit could easily identify any issues that were specific to their own service. In addition, recommendations by lead investigators and required actions were included in these reports. This information was shared with staff on the trust's intranet and through staff team meetings.

The trust's Customer Services Policy: supporting the management of complaints, concerns, comments and compliments for staff across the trust. This was reviewed annually. It was last reviewed in January 2016 and was reviewed in the board meeting we attended during the inspection visit in January 2017 as required.

The trust received 672 compliments between 1 April 2015 and 31 March 2016, with the trust wide Health Improvement and Wellbeing service receiving the most with 149. Three hundred and forty two complaints were received between 2015 and 2016, compared to 265 received in 2014-15. Seventeen complaints were referred to the ombudsmen, one complaint was partially upheld and two complaints were upheld. The highest number of complaints received in 2015 to 2016, identified communication as the most frequently raised negative issues, followed by values and behaviours of staff.

Performance in relation to customer service were now included in the trust's new integrated performance report that was introduced since our last inspection in March 2016. This report focuses on quality alongside key operational incidents, and so performance targets around customer service, including complaints about staff values and behaviours, and the patient response to the friends and family test in relation to recommending the service to others. Customer service reports were also produced on a quarterly and annual basis for the board. Equality data on the protected characteristics was presented for the complaints raised.

The integrated performance report for December 2016 and the customer service quarterly report to the board meeting we attended in January 2017 showed that the trust performance regarding the number of complaints for December 2016 and for quarter three relating to staff values and behaviours had reduced and the trust target was being met.

The community services were exceeding their performance target of 80% in the friends and family test for patients recommending the service to a friend but were slightly below this target in the mental health services at 71% for December 2016. This was mainly due to issues in the child and adolescent mental health services across the trust where the family and friends recommendation averaged 55% across these services in Calderdale and Kirklees, Barnsley and Wakefield. People accessing these services across the geographical areas stated the child and adolescent community mental health services were good with regard to the staff in the service but reduced waiting times could improve their experience.

At this inspection, complaints leaflets were observed on all the acute wards and psychiatric intensive care units. However, whilst there was complaint information available in the Newton Lodge forensic and secure ward reception area, there was no complaint information in the low secure services' reception for Thronhill and Sandall wards.

Good

Are services well-led?

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

Summary of findings

We rated well-led as good because:

- In March 2016, we rated five of the 14 core services as requires improvement for well-led and we identified one breach of regulation in this key question for the trust. This led us to rate the trust as requires improvement overall for this key question.
- Between November 2016 and January 2017, we inspected all five of the core services rated as requires improvement for well-led and reviewed whether the trust completed the required action to meet the breach of regulation. We changed the rating for the well-led key question from requires improvement to good for all five core services we inspected, including the specialist community mental health services for young people, the forensic secure inpatient wards, the long stay rehabilitation wards for adults of working age, the acute inpatient mental health wards for adults of working age and psychiatric intensive care unit, and the community mental health services for people with a learning disability or autism.
- At this inspection improvements had been made in all these services in relation to concerns identified. For example at the long stay rehabilitation service there was a clear management structure including a practice governance coach, who took responsibility for ensuring the service used the governance structures effectively. We saw evidence of regular meetings taking place within the governance structure which demonstrated a clear link between front line staff and senior management. Performance indicators were now in place in the community mental health services for people with a learning disability and autism. Systems were in place to ensure the delivery of safe and quality care in these services, including audits.
- In March 2016 these services did not have sufficient governance structures in place ensure effective monitoring of the service, for example audit systems and performance indicators. The long stay rehabilitation service did not have a governance lead post and had not identified failings.
- In addition, the non-executive and executive directors had an increased presence in the services across the organisation and the trio of managers, including a general manager, a clinical lead and a practice governance coach, in the service lines in each business delivery unit were more mature which had a positive influence on staff and service delivery. The trust had improved its approach to performance, governance and risk.Improvement had been made around communication and engagement with staff, and staff articulated a change in culture across the organisation and demonstrated a clear understanding of the organisation's vision and values, and the trust's direction of travel. The trust had revised and its governance structures to improve operational visibility at Board level and the internal meeting governance framework had been enhanced to provide increased levels of assurance.
- In March 2016, we identified that three of the new non-executive directors had not had Disclosure and Barring Service checks in line with the fit and proper person requirement and personnel files did not contain the evidence to confirm that all the relevant checks had been completed under the fit and proper person requirement.At this inspection, the trust had ensured that all its executive directors and non-executive directors met the fit and proper person requirement and all personnel files had the relevant documentation to demonstrate the checks completed in line with the requirement.

However:

Good

Are services well-led?

- Whilst the trust had completed work in relation to its strategic aims for pharmacy and medicines optimisation, due to the size of this large-scale project some of these actions were behind target.
- did not see a pharmacy model which supported each business delivery unit or related performance indicators to support the development and implementation of the pharmacy workforce strategy alongside the trust transformation plans.
- Not all policies and documentation was in line with the revised Mental Health Act revised Code of Practice (2015).
- Supervision systems, the trust's work on equality and diversity and inclusion for service users and staff, the development of the freedom to speak up guardian role, and the systems to identify and review incidents of mortality, were all still in their infancy and required further embedding across the trust.

Our findings

Vision, values and strategy

At the last inspection in March 2016, we commented on the trust strategy for 2014 -2019 where the transformation of services to ensure they continued to meet people's needs, provided the best outcomes, and value for money, were fundamental to the trust's long-term vision and strategic goals.

Prior to this inspection, the trust had completed an exercise to review and refresh the trust's strategy. This review included learning from the engagement and insight exercises with stakeholders, as well as from discussion sessions, online surveys, and social

Media. Input from workshops with the Members Council, Trust Board, and the Extended Executive Management Team was also included.

The trust's strategic goals are:

- Improve people's health and wellbeing
- Improve the quality and experience of all that we do
- Improve our use of resources

The trust's strategic choices have been identified as:

- We will take a place-based approach to the delivery of care. Except where a service based approach over a wider area is more appropriate e.g. forensic mental health.
- We will continue to be a combined provider of care with expertise in prevention, physical healthcare, learning disabilities and mental health.
- We will act as a system integrator, and in some places, we may host accountable care partnerships. We will do this alongside our service delivery activities.
- We will become an exemplar of co-production, valuing both the service user and clinical perspectives.

In order to focus the delivery of trust's mission and strategy, the trust had agreed a vision for the organisation for the next five years to "Become the leading operator of accountable care systems in West and South Yorkshire, by co-producing with people a holistic and recovery focused approach to improving health outcomes for everyone."

However a very small number of staff thought it was a challenge to align the wide trust vision to the different ideas and requirements of the commissioning teams for each locality.

The strategy refresh was discussed at the trust board in November 2016, and simplified, public-facing version to support the communication of the strategy across the organisation was agreed.

The trust leadership team continued to monitor and review progress on delivering the strategy at quarterly board meetings. They had also appointed a Director of Strategy to oversee the delivery of the strategy, with a focus on innovation and change as part of their work.

The trust mission statement is:

- We exist to help people reach their potential and live well in their community.

The trust values are:

- We must put people first and in the centre and recognise that families and carers matter
- We are always respectful and honest, open and transparent, to build trust and act with integrity

Good

Are services well-led?

- We will constantly improve and aim to be outstanding so we can be relevant today, and ready for tomorrow.

At the last inspection, we noted that the trust had worked closely with its stakeholders to develop this vision and their values, and that these appeared embedded in the business delivery units and reflected in the staff behaviours we observed during our inspection.

It was notable at this inspection that all the staff we spoke with, and at all levels, articulated and demonstrated a clear understanding of the organisation's mission and values. For example on the acute wards for people with mental health problems, member of staff was able to recall one or more of the trust's values and how these were translated in their behaviours. Senior managers and non-executive directors actively used the values throughout their communication with us and in their rationale for decisions. They demonstrated a clear, shared understanding of the trust's direction of travel in line with the trust's mission, values and strategy.

In addition to the values-based recruitment across the trust, where candidates' own values and behaviours are matched against the trust's values, new members of staff undertook a year-long values-based induction in which their values and behaviours were reviewed with their line manager once every three months.

At the previous inspection, staff told us they knew the managers in their local management structures up to the trio of managers in their service line, as well as the chief executive. They were less familiar with the senior managers in-between and the non-executive directors. At this inspection, the non-executive and executive directors described examples demonstrating an increased presence in the services across the organisation. On the wards and services where we asked staff about their awareness of senior managers, most staff knew who the senior managers were.

Good governance

Since the last inspection, the trust had appointed a new chief executive officer which had a significant positive impact on the organisation.

A number of changes had been made in response to the last inspection which identified a disconnect between the board and the wards and teams, including communication, and the lack of assurance regarding the information being presented to the board.

The directors' portfolios had been revised to simplify reporting relationships and to strengthen oversight and visibility through the organisation. District directors now had a greater presence in the trust senior management and governance structures; they attended the performance and monitoring trust board meetings and they were represented on the membership of the board sub committees. A new organisational management group had been set up, which met fortnightly and reported into the executive management team. It was chaired by district directors with operational and support service deputy directors as members and its main function was to link operational delivery with quality assurance, and ensure both vertical and horizontal communications, board to wards and across business delivery units.

The trust had improved its approach to performance, governance and risk and had introduced a new integrated performance report which focussed on quality alongside key performance indicators. It was discussed at the trust board where the district directors provided a summary of performance, risks and mitigating actions. The internal meeting governance framework had also been approved that provided three levels of assurance: frontline and operational, oversight of management activity, independent and objective.

There were now five non-executive directors at the trust, with one vacant post. The non-executive directors spoke positively of the changes made to improve operational visibility at board level, the reporting through the integrated performance report, and the trust's approach to emerging and existing risk through its new risk appetite framework. This framework supported the management of risk to an agreed level of accountability. The non-executive directors had a good understanding of the areas of concern across the trust and we observed healthy challenge from the non-executive directors at the board meeting we attended with confident responses from the trust executive management team. Non-executive directors gave example of how they had gained additional assurance, including attending wards and teams.

Good

Are services well-led?

Improvement had been made since the last inspection around communication and engagement with staff through a range of different mediums and arenas, for example huddles with chief executive and monthly briefings to staff from the trust board.

Staff articulated a change in culture across the organisation and all the staff we spoke with articulated and demonstrated a clear understanding of the organisation's values and were very clear about the trust's direction of travel. We saw examples of how staff at all levels demonstrated an ownership of their role, and took responsibility for resolving areas of concerns and the overall outcomes, including chief operating officers, assistant directors and staff on the wards and in teams.

The trio management structure, which included a general manager, a clinical lead and a practice governance coach, in the service lines in each business delivery unit was further embedded in the trust governance structures at this inspection. They owned and understood their influence which had improved the service delivery, the staff understanding of the transformation programme, and staff morale. A ward managers' network had also been introduced so peers could support each other and identify barriers and resources.

The trust was managing significant stress and pressure on its finances and elements of operational delivery, including out of area bed spend and agency spend. They continued to apply a safety first, always principle. At the time of this inspection, the trust's overall NHS Improvement risk rating under the single oversight framework was 2 – there are four segments that NHS trusts are categorised by, with 1 being the best and 4 being the worst. However, the trust had fallen to segment 3 for the 'use of resources' element of the overall NHS Improvement rating due to their agency spend. The trust had identified cost improvement programmes but stated that the year ahead remained challenging. The finance director was in continued discussions with NHS Improvement. The trust was performing on all other NHSI performance indicators. Progress was being made on areas of delivery, including achieving the commissioning for quality and innovation influenza vaccination target through engaging all the staff in the trust to support in achieving this target.

At the last inspection the trust itself was requires improvement in the well-led domain, as well as five core services, including the specialist community mental health services for young people, community mental health services for people with a learning disability or autism, the long stay rehabilitation mental health services, the acute inpatient mental health wards and psychiatric intensive care units, and the forensic secure inpatient wards. These services did not have sufficient governance structures in place ensure effective monitoring of the service, for example audit systems and performance indicators. The long stay rehabilitation service did not have a governance lead post and had not to identify failings.

At this inspection, improvements had been made in all these services in relation to concerns identified. For example at the long stay rehabilitation service there was a clear management structure including a practice governance coach, who took responsibility for ensuring the service had effective governance structures in place. We saw evidence of regular meetings taking place within the governance structure which demonstrated a clear link between front line staff and senior management. Performance indicators were now in place in the community mental health services for people with a learning disability and autism. Systems were in place to ensure the delivery of safe and quality care in these services, including audits.

At this inspection, systems were in place to ensure that the executive and non-executive directors fulfilled the fit and proper person requirement. The trust's approach to complaints included a thorough investigation and an open and transparent response. The duty of candour was adhered to throughout the trust and in relations to complaints and incidents. Robust systems were in place to safeguard vulnerable adults and children across the trust. The trust's electronic incident recording system was used across the trust in a variety of different arenas, and across wards and services, to identify trends/areas of concern that need to be addressed. The trust continued in its approach to reduce restrictive interventions and accurately recorded its use of restraint and seclusion. The trust were commitment to appropriate staffing levels, not just safe staffing levels, and had plans in place to recruit and retain staff.

Training in the Mental Health Act and the Mental Capacity Act was now mandatory, and there a plan in place to implement the revised Code of Practice across the trust. Most policies complied with annex B of the Mental Health Act Code of Practice (2015). Compliance with training and

appraisal was of a good standard across the trust but with some concerns on the acute inpatient mental health wards for the cardiopulmonary resuscitation training. Despite example of good practice on the psychiatric intensive care unit, there were also some concerns in relation to the application of the Mental Capacity Act on these wards and on the forensic inpatient wards. New systems had been implemented to ensure all staff had access to regular supervision and to monitor their attendance.

However, work in relation to equality and diversity, the freedom to speak up guardians and the mortality review group was all still in its infancy and required further development to embedding these approaches across the trust.

Waiting times in the community services, particularly the specialist community mental health services for children and young people remained high, especially for autistic spectrum disorder assessments. The trust was working with commissioners and partners to resolve these issues and was implementing changes in line with their transformation plans to reduce these waits.

We observed the organisational risk register and the risk registers at business delivery units which contained the risks identified by the senior managers we spoke with, including agency spend, out of area placements, waiting times and contract challenges.

Leadership and culture

The trust-wide turnover and sickness rates for the 12 months prior to the 30 January 2017 remained the same as the inspection in March 2016 at 11% and 5% respectively.

The trust had received seven formal grievances in the last 12 months and these were monitored by the human resources tracker. These were identified as stage two grievances in the trust's grievance and collective grievance procedure. We reviewed three of these stage two grievances and we saw full investigations in the stage two meetings, and actions and learning identified, as appropriate. Where information was gathered, it was shared with all parties and staff involved were made aware they could have a union, or other, representative, at these meetings. The human resource managers told us that most grievances would be classed as informal, stage one against the trust procedure and these were reported to line managers and usually resolved at this stage. This was corroborated by staff who told us that they felt able to raise concerns without fear of victimisation, and spoke positively about their work with their colleagues and their teams. There were no reported cases of bullying or harassment within the six months prior to inspection.

Staff knew that the trust had a policy which supported staff to speak up and raise concerns, including whistleblowing. The freedom to speak up role for the trust was still in its infancy. Six guardians had been identified and an intranet site for staff, including the freedom to speak up guardian details and a confidential email address had been created. They were passionate about the role and making it meaningful across the organisation, and embedding a culture where people felt able to raise concerns. However, there was no clear framework or overarching plan for this role, including the expectations and support for the guardians themselves. The director of nursing and quality had a designated role as the Caldicott guardian and for whistleblowing concerns.

There was good morale across most of the services that we inspected. Staff were positive and passionate about their role and teams.

Staff in teams, other than senior managers identified changes that they could make to improve services for the people who used them, and staff were involved in consultation about changes in the trust, including the electronic recording system and transformation. They were able to feedback their priorities through intranet surveys and on line platforms to the executive management team.

Staff at all levels told us how the internal communication within the trust had improved since the last inspection. The trust completed an internal communication snap-shot survey to compare how staff felt in December 2016 compared to autumn 2015, and there was an increase of 26% and 21% for how staff felt the trust kept them up to date with what was happening, and how the trust communicated and engaged with them, respectively.

The new chief executive had introduced weekly 'huddles' so staff could have direct access for discussions with him, and he produced a weekly round-up for staff called 'The View.' Also, a monthly team brief was cascaded to staff that shared key information from the trust board, called 'The Brief,' supporting communication from the trust board to the wards and teams. The trust had revamped the intranet and the weekly newsletter to further improve communication within the organisation.

Good

Are services well-led?

The trust were embedding the 'hello my name is' campaign across their organisation, which included a shadowing programme to help staff find out more about each other's roles.

These initiatives and increased communication had enhanced the transparent and open culture that existed across the trust. Members of the executive management team described an increase in transparency in their relationships with other stakeholders, for example commissioners. This was echoed by the commissioners we spoke with.

Staff at all levels across the trust, including the non-executives, demonstrated a culture that was committed to learning and improvement, and all gave examples of where they had inputted into the improvement of practice, systems and the governance of the organisation.

The trust complied with the duty on public bodies to publish equality objectives. The equality and inclusion forum were responsible for the implementation of the NHS Equality and Diversity System and Workforce Race Equality Standard. The Equality and Diversity System helps organisations measure equality performance and the Workforce Race Equality Standard was introduced to ensure employees from black and minority ethnic backgrounds have equal access to career opportunities and receive fair treatment in the workplace.

The equality and inclusion forum comprised of the chief executive, the chair, directors and two non-executive directors, and a representative of the members' council who, provided a connection to the community. This forum provided feedback directly to the trust board. The annual trust equality report was also discussed at this forum.

The trust had a combined action plan to deliver the work required for the Equality and Diversity System and Workforce Race Equality Standard. These actions also featured in the trust's organisational development strategy and action plan.

The focus for the trust's current integrated Equality and Diversity System and Workforce Race Equality Standard action plan (January 2017) is empowered, engaged and well supported staff. To improve their performance, the trust identified a number of actions, for example the trust planned to undertake analysis of disciplinary cases involving black, minority and ethnic staff for a two year reference period as staff from a black, minority and ethnic staff were 2.08 times more likely to enter a formal disciplinary process than white staff. The trust had no black and minority ethnic representation on the organisations board voting membership. Therefore the action plan identified working with a partner organisation to improve the equality and diversity of NHS Boards, and utilising the established links to the Insight Programme. This programme creates opportunities for individuals to shadow the trust board in order to support their application as a non-executive director.

The trust had supported the development of a black, Asian and minority ethnic (BAME) staff network. Although in its infancy, the purpose of the network was to engage with, and support, staff within the trust.

Fit and Proper Person Requirement

The Fit and Proper Persons Requirement (Regulation 5 of the Health and Social Care Act (Regulated Activities) Regulations 2014) ensures that directors of NHS providers are fit and proper to carry out this important role. From the 1 October 2014, it was a requirement for all NHS bodies to ensure that all its directors meet this fit and proper person requirement.

At our last inspection in March 2016 we identified that three of the new non-executive directors had not had Disclosure and Barring Service checks in line with the fit and proper person requirement. Also, personnel files of the six non-executive director's in post at the time of that inspection did not contain the evidence to confirm that all the relevant checks had been completed under the fit and proper person requirement, for example there was no evidence that the human resources department had made the relevant checks with regard to bankruptcy, director disqualification or insolvency.

At the time of this inspection there were 11 executive directors in post, six of whom had been appointed prior to the 1 October 2014, and five non-executive directors.

During this inspection on the 30 January 2017, we reviewed a sample of four executive directors' personnel files and four non-executive personnel files to confirm the trust compliance with the fit and proper person requirement. We also reviewed a trust briefing note dated January 2017 which contained confirmation that all the relevant checks in relation to the fit and proper person requirement for all 11 executive directors had been completed, including for those appointed prior to 1 October 2014. We reviewed this

information in the context of the relevant trust policies, including the Declaration of Interests Policy for Directors of the Trust Board, including Fit and Proper Person Requirement, was reviewed and agreed at the Board on the 31 March 2015, and the Trust Recruitment Policy.

We found the trust had made improvements in with regard to ensuring that all its executive directors and non-executive directors met the fit and proper person requirement. All the personnel files, including the three non-executive directors that were new in post prior to the last inspection, now had all the relevant documentation to demonstrate the checks completed to ensure they met the fit and proper person requirement, including confirmation of their disclosure and barring service checks.

All personnel files we reviewed also included confirmation that checks had been made for all these executive directors and non-executive directors with regard to bankruptcy, director disqualification or insolvency. They also included confirmation of due diligence checks, which included searches on the internet and social media.

Current references were not present for all executive directors and this was not a requirement of the trust recruitment policy. Where staff, including the medical director, the director of nursing and quality, and the director of human resources, organisation development and estates, had been in a previous role and transferred internally, the references on file where those appropriate for their initial role with the trust, not their current director role. Similarly where staff had been seconded from another organisation, like the director of corporate development, or moved to the trust as a result of a Transfer of Undertakings (Protection of Employment) Regulations 1981, for example the two district directors, the trust had no references specific to their post. The director of human resources informed us that in these instances the candidate's suitability for the role would be managed through the supervision and appraisal processes, or through the secondment and transfer processes.

We observed detailed appraisals in the executive director and non-executive director personnel files, including appropriate objectives and training, completed by the chief executive or the trust chairman as appropriate.

There was also evidence of the fit and proper person declaration completed by the chair and directors, as well as the annual reviews undertaken by the company secretary, in line with the trust's policy.

Engaging with the public and with people who use services

At the last inspection, we saw evidence of patient involvement in the delivery of their care, and their families and carers. People who used services and those who cared for them were involved in shaping the future of services through the consultation events related to large scale transformations plan identified in the trust's strategy 2014 – 2019. There was oversight from the board with communication through the governance structures from the business delivery units. However, not all the people who used services had felt involved in the trust's transformation projects, including the integration of psychological services in the acute and community mental health transformation projects.

At this inspection, in the services we re-visited patients told us they were involved in their care, and we saw evidence of this in the care plans we reviewed, including carer involvement. On the acute inpatient wards for people with mental health problems, three-quarters of the care plans included family and carer involvement and a fifth identified support offered and planned specifically for family and carers.

Since the last inspection, the trust held five 'strategy refresh' events to review their identity as an organisation and their direction of travel, which was attended by service users and carers. They also ran on-line surveys. All the views were fed into the trust's strategy development. Further engagement with stakeholders like GPs and also with people who used services, were identified on the trust's timeline plans for the integration of psychological services across the core and enhanced treatment pathways.

In 2016 the trust agreed a combined communications, engagement and involvement strategy.

There were good examples of continued patient, relative and carer and people with lived experience, involvement in activities across the trust, for example recruitment, attendance at the Board, involvement with the members' council, and the trust's excellence awards event. Co-production with people who use services was further

embedded through the local recovery colleges, where service users inputted and delivered some of the courses, and through the Creative Minds initiative that develops community partnerships and co- funds creative projects.

Other examples of where staff across the trust were involved in events to engaging with the public and people who use services, included a patient safety event on suicide prevention , a dementia friendly event, and 'forensic festival' to break down barriers between staff and service users and across the trust's entire secure estate, information stalls run by various teams across the trusts in local town centres, and a range of activities across the trust and in the local communities for World mental health day.

In November 2016 the trust's Equality, Diversity and Inclusion Summary report provided an update on the trust progress in relation to the Equality and Diversity System service goals for better health outcomes and improved patient access and experience. In partnership with the local authority and clinical commissioning groups, the trust held a series of engagement events to update local people on progress against these goals. It was agreed that the trust was at a 'developing stage' for all outcomes.

Additional work completed by the trust to promote equality and inclusion, included a conference to engage the local community leaders in the South East Asian population in an attempt to break down stigma and to encourage people to talk to their GPs to address issues in their infancy, rather than presenting in acute mental health services as had been identified. Work was also ongoing with local community schools where there was a high British, black, Asian and minority ethnic population to promote mental health awareness and a career in the NHS.

Quality improvement, innovation and sustainability

At this inspection, we reviewed the trust's ongoing participation in national accreditation and peer review schemes. Accreditation and peer review participation is important for reviewing services against national evidence-based, best practice and benchmarks, and for quality improvement

Trinity 1, a ward on the acute inpatient mental health wards and psychiatric intensive care unit in Wakefield, was Accreditation for Inpatient Mental Health Services (AIMS) accredited until July 2018; the Melton suite in Barnsley was at the review stage. Electro-convulsive therapy services at both Fieldhead Hospital and in Calderdale were accredited until June 2019 by the Electro Convulsive Therapy Accreditation Service. Memory services in Wakefield, Calderdale, Kirklees and Barnsley were accredited with the Memory Services National Accreditation Programme until dates in 2017 and 2018. The trust were also re-accredited against the Government's customer service excellence standard.

The trust was a member of the quality network for forensic mental health services for medium and low secure services. Newton Lodge, Bretton Centre and Newhaven unit had their last peer review in December 2014. They were also a member of the quality network for community child and adolescent mental health services, which were last peer reviewed in February 2014.

The trust participated in national audit programmes including the National Audit of Schizophrenia, and the Prescribing Observatory for Mental Health audits, including the monitoring of patients prescribed lithium in July 2016, rapid tranquilisation in November 2016, and prescribing and combining high dose antipsychotics on adult psychiatric wards was due to be completed in March 2017.

A trust-wide audit programme was in place for 2016-2017 based on internal risks identified through the risk register and board assurance framework, as well external environmental factors. We saw evidence of these audits completed throughout the year and actions taken in response, for example clinical record keeping and data quality which was monitored and actioned through the business delivery units, with information fed back up the governance structures through the audit committee to the trust board.

At the last inspection, quality impact assessments were applied to all areas of service change and transformation to consider the risks to quality and safety in relation to the identified cost improvement plans. Senior managers again provided examples of where these quality impact assessments had been used on recent changes, including rationalising the on-call rota and rationalising the workforce in Barnsley. The trust held a 'challenge event' where staff could suggest a proposal to improve care/ quality and had an I-Hub on-line platform for staff to share their ideas. These suggestions were used to inform the trust's strategic challenges and priorities.

There were further examples of innovative practice and cost improvements across the trust, including in the

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Are services well-led?

forensic, secure services where the trust won an award for its women's pathway for reducing length of stay, and also for its approach to its workforce through adding band two and four staff to free up band five nurses. The recovery colleges and the creative mind programme for promoting self-help and engaging communities in healthcare were both been recognised nationally, with the recovery colleges being awarded a volunteering quality award. Individual and team contributions to innovative practice and ideas were recognised at the trust's excellence awards, including an aphasia café supported by a speech and language therapist that enables people with the language impairment condition aphasia to develop their confidence communicating with others in a social environment, a children's therapy cycle group, and the delivery of Watsu therapy (aquatic bodywork used for deep relaxation) in an inpatient mental health setting.

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:** **Community Mental Health Services for People with a Learning Disability or Autism** We found that waiting times for members of the multidisciplinary team or specialist clinics in the community learning disabilities services were high in Barnsley and Kirklees. This had the potential to impact negatively on service users' wellbeing. People requiring the service were not always receiving the support and treatment to meet their needs. **Specialist Community Mental Health Services for Children and Young People** Waiting times for treatment in the Barnsley team were still lengthy for some young people who had accessed the service. All three teams had lengthy waits for young people requiring assessment for autistic spectrum disorders and related conditions. **Forensic Secure Inpatient Wards**

This section is primarily information for the provider

Requirement notices

Staff did not have the knowledge or understanding to implement the correct processes in line with the Mental Capacity Act.

- The best interests checklist was not being followed.
- Staff were not able to demonstrate how mental capacity should be documented.

This meant that patients were not enabled or supported to make, or participate in making, decisions relating to their care or treatment to the maximum extent possible.

This is a breach of Regulation 9 (1) (a) (b), (3)(b), 9 (5).

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:** **Community Mental Health Services for People with a Learning Disability or Autism** Staff could not quickly access risk assessments in 17 of 26 care records reviewed. **This is a breach of Regulation 12(2)(b)**

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **How the regulation was not being met:** **Acute inpatient mental health wards for adults of working age and psychiatric intensive care unit**

This section is primarily information for the provider

Requirement notices

The trust did not deploy sufficient numbers of suitably qualified, competent, skilled and experienced persons to meet the care and treatment needs of people using the service because:

Average mandatory training compliance was below the trust target in the service. Average compliance with cardiopulmonary resuscitation training was 64% which was below the trust target of 75%.

Staff had a limited understanding of the Mental Capacity Act. Compliance with Mental Capacity Act and Mental Health Act training was low on all wards.

Not all staff received regular supervision. Not all supervision was regularly documented on the trust's electronic database.

This is a breach of Regulation 18(1)(2)(a)