

South West Yorkshire Partnership NHS Foundation Trust

Inspection report

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

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

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

Ratings

Overall rating for this trust

Requires improvement 

Are services safe?

Requires improvement 

Are services effective?

Good 

Are services caring?

Good 

Are services responsive?

Requires improvement 

Are services well-led?

Good 

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

Summary of findings

Background to the trust

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

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

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

The trust has seven active locations. These locations are spread across different hospital sites. They include, the Dales, Halifax, Priestley Unit, Dewsbury, Poplars Community Unit for the elderly, Pontefract, Enfield Down, Holmfirth, Fieldhead hospital, Wakefield, Kendray Hospital, Barnsley and Lyndhurst, Halifax. There are 499 beds across the trust over 32 wards.

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

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

We last inspected South West Yorkshire NHS Partnership Foundation Trust in January 2017. At that inspection we rated the trust good overall but as requires improvement for the responsive key question. We found that the trust did not comply with regulation 18 staffing, regulation 9 person- centred care and regulation 12 safe care and treatment.

During 2017 the trust had 15 Mental Health Act reviewer visits. The common themes from these visits highlighted lack of information on wards regarding Independent Mental Health Advocacy, CQC and how to complain. They also highlighted a lack of involvement with patients and carers in care planning, blanket restrictions and documentation issues relating to section 17 leave and section 132 rights.

Overall summary

Our rating of this trust went down . We rated it as Requires improvement  

What this trust does

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

Key questions and ratings

We inspect and regulate healthcare service providers in England.

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

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

Summary of findings

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

What we inspected and why

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

We inspected six complete core services in total. We selected these services based on our previous rating of the services and on intelligence we held through our monitoring of the services.

We inspected acute wards for adults of working age and psychiatric intensive care units and community mental health services for people with a learning disability or autism because at our last inspection in January 2017 we rated them as requires improvement.

The four other services we inspected as part of our continual checks on the safety and quality of healthcare services were:

- forensic inpatient and secure wards
- wards for people with a learning disability or autism
- community based mental health services for adults of working age
- specialist community mental health services for children and young people.

All of these services had been rated good at the last inspection.

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

What we found

Overall trust

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

- We rated acute wards for adults of working age and psychiatric intensive care units, community-based mental health services for adults of working age and specialist community mental health services for children and young people as requires improvement.
- We rated the key questions of safe and responsive as requires improvement.
- The trust did not have a trust wide approach to reducing restrictive practices across inpatient wards.
- At our last inspection in 2017 we identified that the trust should ensure that they continue to work to meet the strategic aims for pharmacy and medicines optimisation. At this inspection we found that this had not happened. There was no strategy, or future plan, for the development of medicines optimisation within the trust and there was no formal workforce plan and limited workforce mapping to establish the workforce needs of the organisation.
- Although the trust had completed a recent review of the freedom to speak up guardian and had increased resources within this role, with a clear plan moving forward, we found that not all staff were aware of this role.

Summary of findings

- The trust had not fully embedded the equality, diversity and inclusion agenda into the culture of the organisation. We could see progress had been made and the benefit of this for staff and patients however further work was needed to secure this across all of the organisation.
- The trust did not have a clear process in place to risk assess complaints when they were received.
- Not all of the human resource files contained all the required paperwork needed to satisfy the fit and proper person requirement.
- There was no process in place to identify whether a mental capacity assessment for treatment was completed at the time of a patient admission.

However:

- We rated the key questions of effective, caring and well led as good overall. Our rating took into account the previous rating of the four services not inspected this time.
- We rated forensic inpatient services, wards for people with a learning disability or autism and community mental health services for people with a learning disability or autism as good.
- The trust had an established, experienced board with strong leadership, all staff we spoke with described leaders as approachable and visible. The trust had a clear vision, set of values and strategy which were person centred and focused on sustainability. Staff felt supported, valued and were proud of the work they did.
- There was an open culture with good reporting of incidents and learning from when things went wrong. Although our inspection team identified some lapses in procedures, we could see there was a good governance structure in place with systems and processes to support board oversight. We saw evidence that the trust were aware of the issues we had identified as a concern and had given these issues consideration.
- The trust had a good learning from deaths process in place; incident reporting was good with thorough investigations. Learning from incidents and complaints was made available trust wide and the trust held learning events following the completion of all death investigations, this was an opportunity to explore recommendations and share learning across the organisation.
- The trust had strong relationships with partners investing in these relationships to ensure sustainable care.

Are services safe?

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

- Staff did not always undertake risk assessments of patients in line with the trust policy.
- Not all inpatient areas had nurse call systems in place to ensure that patients could summon assistance if needed.
- Fire assessments had not been reviewed at the required frequency at all community sites and not all sites conduct environmental risk assessments which meant that the services were not doing all they could to identify the potential risks of the environment.
- Some ward staff did not monitor and record clinic room temperatures, fridge temperatures or defibrillators in accordance with the trust policy. We found issues with medicines management in some areas and some clinic rooms contained out of date medical equipment.
- The specialist community mental health service for children and young people did not always manage to fully staff the out of hours on call service. We saw gaps in rotas, a negative impact on staff morale and incidents recorded.
- Staff on acute inpatient wards did not adhere to the trust policy or Mental Health Act Code of Practice in the management of patients in seclusion.

Summary of findings

- Staff on acute inpatient wards did not undertake the required physical monitoring following the administration of rapid tranquilisation. We reviewed 14 records of rapid tranquilisation and found that they all lacked the required monitoring of physical observations.
- Referral to treatment in some areas exceeded the 18 week patient waiting time but there was a commitment to provide 18 psychological assessments per month with the intention of reducing waiting times to three months by August 2018.

However:

- Managers supported a culture of candour, staff reported incidents, and demonstrated a culture of openness and honesty when things went wrong. Managers shared learning from incidents and staff made changes that improved patient safety.
- Services we visited were all clean, tidy and well maintained. Cleaning records for all sites were up to date and demonstrated that domestic staff cleaned the premises regularly. Business continuity plans for emergencies were all in place.
- Staff understood how to protect patients from abuse and worked closely with the trust's safeguarding team to ensure they referred concerns and alerts appropriately.
- In community locations, therapy and clinic rooms had alarms and staff responded when they were used.
- Staff followed up with children and young people receiving treatment and monitored risk for people on the waiting lists. Staff contacted young people who were waiting to be seen and invited them to half-day workshops. Young people would have a risk assessment completed with them and their treatment expedited if risks had increased.
- Managers prioritised reducing restrictive physical interventions and staff understood the principles of least restrictive practice with regards to physical interventions. Patients told us they understood why staff used restrictive interventions such as seclusion and restraint, and that staff did not hurt them.

Are services effective?

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

- Patients had access to physical healthcare on the wards.
- Staff completed initial assessments of all patients and reviewed the care and treatment needs of patients regularly.
- Teams included a range of specialists required to meet the needs of people using the service and there was good multidisciplinary working between teams.
- Staff used recognised rating scales, such as Health of the Nation Outcome Scales and other scales to rate severity and to monitor outcomes.
- Staff felt supported in their roles and most said they received regular supervisions and appraisals. Staff could access additional training beneficial to their roles. Non-medical staff felt supported and most received regular supervision and yearly appraisals. Service provided staff with opportunities to develop their skills and knowledge.
- Staff received training the Mental Capacity Act and Mental Health Act and demonstrated a good understanding of the legislation. Staff completed capacity assessments and best interest discussions when patients did not have capacity to make specific decisions about their care and treatment.
- Staff provided a wide range of care and treatment interventions suitable for the patients using services.

However:

Summary of findings

- Staff on inpatient wards did not always complete Section 17 leave forms in full to ensure patients and their carers understood the requirements of the leave and had signed to show they agreed to this.
- Staff on some wards did not keep records of the assessment of patient's capacity and consent for treatment with medication prescription charts. This meant that staff could not easily check that completed assessments for capacity and consent were in place when they administered medication.
- Staff in forensic inpatient wards reported that they found it difficult to gain input from speech and language therapists because the service did not have an effective referral process.

Are services caring?

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

- Staff interactions with people using services demonstrated staff were polite, respectful and compassionate. Staff listened to people's viewpoints and checked their levels of understanding about their support.
- Staff provided compassionate care and clearly understood people's needs and feelings.
- People were involved in decisions about their care and treatment. People said they had good relationships with staff.
- The forensic inpatients service held regular events to promote relationships between patients and their families and carers. Examples of this included a Christmas dinner and a Mother's day afternoon tea prepared by patients to share with their families and carers.
- Most carers and families spoke positively about the service they received.

However:

- Care plans in some areas were not personalised to the patient and did not reflect the patient voice. Carers on acute inpatient wards reported that they were not involved in care planning and that staff did not keep them informed of their relatives' progress. Carers from the learning disability ward told us they needed more opportunity to discuss and learn about their relatives care and treatment.
- Carers from the specialist community mental health service for children and young people told us they were unclear how to offer feedback on the service. At the inpatient learning disability service the ward did not have a forum for people to give feedback on the service such as ward community meetings. Staff did not involve patients in menu planning and all patients were negative about the food. Patients views on food at the forensic inpatient service also mirrored this.
- At the forensic inpatient ward some patients told us that staff did not always knock on their door before entering or looking through the observation window into their bedroom.

Are services responsive?

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

- Acute inpatient wards had over 100% bed occupancy on seven of the nine wards and high numbers of out of area placements. When patients returned from leave, a bed was not always available for them.
- Staff on acute inpatient wards did not always record evidence that patients, carers and other professionals had been involved in discharge planning and the care plan and risk assessment was not always reviewed at the time of discharge.

Summary of findings

- Waiting times for access to services, particularly psychological therapies within Barnsley, were still very lengthy this was a similar concern we found at our previous inspection. In the specialist community mental health service for children and young people four of the pathways were not meeting the 18 week referral to treatment standard. The autism spectrum disorder pathway was the longest; it averaged 99 weeks.
- Staff described difficulty in booking rooms at the Barnsley and Wakefield West sites. Staff were not always able to rebook appointments due to limited numbers of rooms available.
- In medium secure services, patient bedroom doors contained an observation window with an external curtain. This did not promote patient privacy and dignity as anyone could look through these. The trust had a plan to replace these by the end of 2018/2019.
- Across all of the forensic inpatient wards, staff administered medication to patients through the hatch of the clinic room door. This meant that patients did not have privacy when discussing with or accepting their medication from staff.
- Several community mental health services shared the premises at Wakefield. The large waiting room was impersonal and had no easy read information displayed.
- Staff and patients reported there was a lack of social and leisure activity on the wards.

However:

- Services supported patients of different sexual orientation, ethnicity and religion. We saw evidence of services supporting patients who were engaged in specialist services such as gender identity services and that staff handled issues of gender identity and sexuality in a sensitive manner.
- Most patients knew how to complain and staff managed complaints in line with trust policy.
- Services affected by waiting times to access specialist treatment had undertaken initiatives to try to reduce waiting times. This included setting up clinics and trying to provide further resource to meet demand.
- On wards for patients with learning disabilities and forensic inpatients, there was a clear pathway for referral and admission that was recovery focused and supported patients with a successful and timely discharge. Staff delivered patient centred care that took the needs of individual patients into account when they planned admissions to the ward.
- A recovery college provided a range of recovery and skill based courses at Newton Lodge for patients to access. Patients could access input from a tutor to work on education and a few patients had voluntary work.

Are services well-led?

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

- Services had clear leadership and governance structures. Leaders were visible and approachable and had a good understanding of the services. There were opportunities for leadership development and staff progression through the trust leadership and development programme. Staff were involved in succession planning through the business delivery unit workforce planning workshops.
- Staff felt respected, supported and valued. The trust's workforce strategy included emphasis on staff wellbeing and engagement. The workforce plan had offered staff the opportunity to attend wellbeing roadshows. This had included access to yoga sessions, counselling and staff retreats. Staff could raise concerns to leaders without fear of retribution and understood the trust's whistleblowing procedure. Managers supported a culture of candour, openness, honesty and transparency and staff behaviour and performance was consistent with the trust values. Staff felt proud of their work and were committed to making continuous improvements to the quality of the care they provided.

Summary of findings

- We identified that in some areas the quality of service provision had deteriorated. This was linked to a challenging environment and it was evident that senior managers had done their best. On the whole, systems and processes enabled senior leaders to have oversight of performance and areas that required improvement. It was recognised that on occasions this was difficult to manage due to external factors for example funding and national qualified staff shortages, however services made improvements in these areas through their governance processes. Services had clear meeting structures and processes to escalate concerns to appropriate committees. We reviewed local risk registers and saw that staff concerns matched the items identified.
- Staff knew the vision and values of the trust and we observed staff to demonstrate these values through their interactions with patients. Staff had the opportunity to contribute to changes through team meetings and consultations and the trust strategy had been developed with involvement of both internal and external stakeholders. The appraisal process was aligned to the trust values which enabled staff to see how their role supported achieving the trust goals.
- Patients and carers had access to information about the trust through its external website. Staff received information through the internal website, bulletins and emails. There was a monthly staff briefing that included information from the trust board and the executive management team meetings. Staff also had access to the customer service report which was produced each quarter and supported shared learning across each business delivery unit.

However:

- Managers in some inpatient settings did not have an effective system or process to assess, monitor, and review the blanket restrictions on the wards. Although some areas had taken some action to reduce blanket restrictions, we found that some restrictions remained. Staff had not completed individual patient risk assessments in relation to the restrictions.
- Some areas had a limited approach to obtaining the views of people who used the service and carers. Wards did not have an effective system or process to monitor and improve the quality of the experience of patients and how they could offer additional support to carers. Although wards had started to gather feedback from patients there was few patient and carer forums to gather their feedback. Overall, carers told us they needed more opportunity to discuss and learn about their relatives care and treatment.
- Not all staff had a clear understanding of the role and function of the Freedom To Speak Up Guardian.
- There were still excessive waits for treatments in some areas; this was a recurring issue from our last inspection. We could see work had taken place to improve waiting times for specialist treatments however, this remained a concern.
- There was not an effective approach to managing some of the community premises. Service had not implemented reviews of the environment or infection control audits. The service had not resolved identified security risks identified at the Barnsley site.

Ratings tables

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

Outstanding practice

We found outstanding practice relating to compassionate care and dealing with Disclosure and Barring. See the Outstanding practice section below for details.

Summary of findings

Areas for improvement

We found areas for improvement including breaches of 17 regulations that the trust must put right. We found 48 things that the trust should improve to comply with a minor breach that did not justify regulatory action, to prevent breaching a legal requirement, or to improve service quality. For more information on action we have taken, see the section on areas for improvement and regulatory action.

Action we have taken

We issued 12 requirement notices to the trust. This means that they have to send us a report stating what action it would take to meet these requirements.

What happens next

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

Outstanding practice

The trust had been chosen as the 'best organisation' in the 2017 Kate Granger awards for compassionate care.

Judges commended successes, and recognised the trust for its ambitious and innovative way of delivering care which makes a long-term, measurable difference to people's lives.

The trust reimburse employees initial Disclosure and Barring Service fees and all new starters were automatically enrolled into the mobile update scheme. This is an online service which allows applicants to keep their certificates up to date and employers to check certificates online. This means an applicant can take their certificate from one job to the next which will streamline delays often experienced whilst waiting for a Disclosure and Barring certificate to be issued. There was also a Disclosure and Barring Service Project taking place over the next two years to move all staff to the automatic mobile update service and that again will be reimbursed by the trust in terms of cost.

Areas for improvement

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

Action the trust **MUST** take to improve

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

Specialist Community Mental Health Services for Children and Young People

- The trust must ensure that all community environments are assessed, reviewed and secured so that they provide the appropriate level of security for the service being delivered.
- The trust must ensure that staffing issues around the out of hours on call service are monitored, reviewed and resolved.
- The trust must continue to take action to reduce waiting times and access to treatment times for the autism spectrum disorder specialist pathway.

Summary of findings

Community-based mental health services for adults of working age

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

Wards for people with a learning disability or autism

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

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

- The trust must ensure that staff adhere to their policy and the Mental Health Act Code of Practice in the care and treatment of patients in seclusion
- The trust must ensure that staff undertake the required physical health monitoring following the administration of rapid tranquilisation and that all episodes of rapid tranquilisation are documented correctly.
- The trust must ensure that staff adhere to their policies in the safe management of medicines and that medication administration records are signed when medication is being administered.
- Staff must ensure they assess patients' risk at the intervals outlined in the trust policy and that this is reflected on the risk assessment tool.
- The trust must ensure that staff complete Section 17 leave forms in full and this reflects that patients and their carers understand their responsibilities and the requirements of the leave.
- The trust must ensure that staff monitor and record clinic room temperatures, fridge temperatures and checks of emergency equipment in line with trust policy. The trust must ensure oxygen cylinders are in date and stored correctly
- The trust must ensure that patients have easy access to summon assistance from their bedrooms across all wards
- The trust must ensure that patients have sufficient access to therapeutic activity to meet their needs and support their recovery.
- The trust must ensure that patient and carer involvement in care and discharge planning is accurately reflected in records. The trust must ensure that the systems and process in place to monitor the performance of the ward are effective and are used to improve the care and treatment provided.

Forensic inpatient and secure wards

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

Action the trust SHOULD take to improve

Trust wide

- The trust should ensure they develop a new strategic aim and create a shared vision of this aim within the pharmacy department this should be supported by the new chief pharmacist appointment.

Summary of findings

- The trust should ensure a thorough risk assessment of complaints is in place so that the trust are assured that risks are assessed adequately and the complaint graded appropriately.
- The trust should ensure that all director human resource files contain the required paperwork to satisfy the fit and proper person requirements.
- The trust should continue to progress their development of the freedom to speak up guardian role and review the success of this role.
- The trust should ensure that progress continues with engagement and workforce planning in relation to equality, diversity and inclusion this work should be fully maximised and valued within the organisation.
- The trust should ensure there is a process to identify whether a mental capacity assessment for treatment was completed at the time of a patient's admission.

Specialist Community Mental Health Services for Children and Young People

- The trust should ensure that the lone working policy clearly identifies how staff are to keep themselves safe when lone working. Where lone working devices are used, the trust should ensure that action is taken to monitor and improve compliance. Where staff have no device robust local measures should be implemented.
- The trust should ensure that staff have access to all mandatory training so staff can meet the compliance target.
- The trust should review pathways that do not meet the 18 week referral to treatment standard.
- The trust should ensure that effective governance processes are implemented to monitor, review and improve systems and processes within the service.
- The trust should ensure that all staff can access the trust network.
- The trust should ensure that people that use the service understand how to give feedback including complaints, are informed of carer's assessments, and are able to communicate with the service regarding care provided.
- The trust should review the availability of rooms in order to schedule appointments.
- The trust should review infection control procedures at all sites.
- The trust should review how staff take part in clinical audits and how results are shared.
- The trust should review how staff meet requirements under the accessible information standard.
- The trust should review staff understanding of the organisation's vision and values and Speak Up Guardians.

Community-based mental health services for adults of working age

- The trust should ensure there is clear information present about what objectives people are working towards within care records, including timescales to achieve these. Records should evidence the person's wishes and involvement where appropriate.
- The trust should continue with their planned review of the transformation work. This should include reviewing access to, and provision of, services so it is equitable across the trust.
- The trust should continue to recruit into vacant posts to help ensure individual staff caseloads are not excessive.
- The trust should ensure that all staff are fully familiar about actions to take in the event of security incidents on premises.
- Assessments of the environment should be undertaken and reviewed at the appropriate frequencies.

Summary of findings

- The trust should ensure that people have sufficient information and opportunity to provide feedback about the service. This should include ensuring carers are aware of, and have access to, carer's assessments.

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

- The trust should consider ways of making the large waiting room at the Wakefield base more amenable to people accessing this service. It should also be compliant with the accessible information standard.

Wards for people with a learning disability or autism

- The trust should ensure that the female only lounge is clearly signed and that staff provide information for patients and carers about the arrangements for eliminating mixed sex accommodation
- The trust should ensure that staff keep records of the assessment of patient's capacity and consent for treatment with medication prescription charts.
- The trust should ensure that all staff are aware of and understand the role of the Freedom To Speak Up Guardian.

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

- The trust should ensure that work continues on bed occupancy numbers, out of area placements and readmissions to enable staff to provide therapeutic care and treatment that meets the needs of patients.
- The trust should ensure that restrictions placed on patients are based on an individual assessment of risk and need and that there is a formal process across the service to record and review these restrictions. The trust should ensure that informal patients are able to take their personal belongings when they leave the ward.
- The trust should ensure that discharge planning meets the requirements of the trusts policy and evidences the involvement of the patient, their carer's and other professionals.
- The trust should ensure consistent recording and monitoring across the service of when Section 17 leave is cancelled.
- The trust should ensure that the female only lounge on Walton ward is not restricted to other patients by using it as part of an extra care area.
- The trust should ensure that staff document a de-brief with all those involved following an incident of restraint.
- The trust should ensure that staff record all incidents using the electronic incident system and grade them accurately in terms of severity.
- The trust should ensure a formal risk assessment document is used by staff when secluding patients in non-designated seclusion rooms to enable them to adhere to the trust policy.
- The trust should ensure that patients and their families and carers are involved in the planning of their care and treatment. The trust should ensure that care plans are personalised and reflect the patient's voice.
- The trust should consider how it can better support staff and patients to maintain a smoke free environment.
- The trust should consider how to increase staff awareness and understanding of role of the Freedom to Speak Up Guardian across the service.

Forensic inpatient and secure wards

- The trust should ensure that staff adhere to safe medicines management practices
- The trust should ensure that medical equipment is within date to ensure it is safe to use.
- The trust should ensure that they meet the timescales in place to carry out work to replace door handles that could be used as fixed ligature anchor points.

Summary of findings

- The trust should ensure that staff working on Ryburn and Newhaven wards can access support from others quickly when needed.
- The trust should ensure that access to section 17 leave is not affected by staffing shortages.
- The trust should ensure that staff respect patient privacy when entering patient bedrooms or looking through observation panels.
- The trust should ensure that there is an effective referral pathway for speech and language therapy.
- The trust should ensure that patients have privacy when accepting and discussing their medication.
- The trust should consider reviewing the food provision to ensure this has variety and choice.

Is this organisation well-led?

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

We rated well led at the provider level as good

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

- Services had clear leadership and governance structures. Leaders were visible and approachable and had a good understanding of the services. There were opportunities for leadership development and staff progression through the trust leadership and development programme. Staff were involved in succession planning through the business delivery unit workforce planning workshops.
- Staff felt respected, supported and valued. The trust's workforce strategy included emphasis on staff wellbeing and engagement. The workforce plan had offered staff the opportunity to attend wellbeing roadshows. This had included access to yoga sessions, counselling and staff retreats. Staff could raise concerns to leaders without fear of retribution and understood the trust's whistleblowing procedure. Managers supported a culture of candour, openness, honesty and transparency and staff behaviour and performance was consistent with the trust values. Staff felt proud of their work and were committed to making continuous improvements to the quality of the care they provided.
- We identified that in some areas the quality of service provision had deteriorated. This was linked to a challenging environment and it was evident that senior managers had done their best. On the whole, systems and processes enabled senior leaders to have oversight of performance and areas that required improvement. It was recognised that on occasions this was difficult to manage due to external factors for example funding and national qualified staff shortages, however services made improvements in these areas through their governance processes. Services had clear meeting structures and processes to escalate concerns to appropriate committees. We reviewed local risk registers and saw that staff concerns matched the items identified.
- Staff knew the vision and values of the trust and we observed staff to demonstrate these values through their interactions with patients. Staff had the opportunity to contribute to changes through team meetings and consultations and the trust strategy had been developed with involvement of both internal and external stakeholders. The appraisal process was aligned to the trust values which enabled staff to see how their role supported achieving the trust goals.

Summary of findings

- Patients and carers had access to information about the trust through its external website. Staff received information through the internal website, bulletins and emails. There was a monthly staff briefing that included information from the trust board and the executive management team meetings. Staff also had access to the customer service report which was produced each quarter and supported shared learning across each business delivery unit.

However:

- Managers in some inpatient settings did not have an effective system or process to assess, monitor, and review the blanket restrictions on the wards. Although some areas had taken some action to reduce blanket restrictions, we found that some restrictions remained. Staff had not completed individual patient risk assessments in relation to the restrictions.
- Some areas had a limited approach to obtaining the views of people who used the service and carers. Wards did not have an effective system or process to monitor and improve the quality of the experience of patients and how they could offer additional support to carers. Although wards had started to gather feedback from patients there was few patient and carer forums to gather their feedback. Overall, carers told us they needed more opportunity to discuss and learn about their relatives care and treatment.
- Not all staff had a clear understanding of the role and function of the Freedom To Speak Up Guardian.
- There were still excessive waits for treatments in some areas; this was a recurring issue from our last inspection. We could see work had taken place to improve waiting times for specialist treatments however, this remained a concern.
- There was not an effective approach to managing some of the community premises. Service had not implemented reviews of the environment, including ligature risks, for any of its sites. The service had not resolved identified security risks identified at the Barnsley site.

Ratings tables

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

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

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

Ratings for the whole trust

Safe	Effective	Caring	Responsive	Well-led	Overall
Requires improvement ↓ May 2018	Good →← May 2018	Good →← May 2018	Requires improvement →← May 2018	Good →← May 2018	Requires improvement ↓ May 2018

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

Ratings for community health services

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

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

Ratings for mental health services

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

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

Community mental health services for adults of working age

Requires improvement  

Key facts and figures

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

The three sites we visited were based at:

- Wakefield: Drury Lane Health and Wellbeing centre
- Huddersfield (Kirklees): Folly Hall Mills
- Barnsley: Lundwood Health Centre

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

We last inspected community mental health services for adults of working age in March 2016. We rated the service as good overall. We rated the responsive key question as requires improvement, and gave a rating of good in the safe, effective, caring and well led key questions. We issued the trust with one requirement notice because of the excessive length of waiting times in some areas for access to psychological therapies. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, we found that this was still an issue within some teams.

This inspection took place between 13 and 15 March 2018. Our inspection was announced 24 hours in advance to ensure that people would be available to speak with us. We inspected the service using all the key lines of enquiry in the five domains (safe, effective, caring, responsive and well-led).

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

- visited three community bases where the services operated from
- spoke with 30 people, and 10 carers of people, who were using the service
- received two comment cards from one person using the service and their carer
- attended and observed nine home visits
- spoke with senior leaders who were members of the trio at each service
- spoke with nine team managers from the core teams, enhanced team, early intervention team and single point of access teams
- spoke with 32 other staff members including doctors, nurses, social workers, psychologists, occupational therapists, support workers and administrative staff

Community mental health services for adults of working age

- observed one multidisciplinary meeting and one allocations meeting
- looked at the care and treatment records of 27 patients
- looked at policies, procedures and other documents relating to the running of the service.

Summary of this service

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

- Staff did not always review and update people's risk assessments and management plans at necessary intervals and following serious incidents. We found some shortfalls in relation to information in care plans not being personalised and lacking clear objectives.
- There were still long waiting times for people accessing specific individual therapies which was an issue we found at our previous inspection. Staff did not routinely monitor people waiting for therapies where they had long waits. There were differences in how and when people were able to access services through the single point of access teams within the different localities.
- There was low compliance with some areas of mandatory training for staff, including personal safety training. Staff found the availability of some of the courses was lacking which meant it was difficult to book on courses.
- Some people and their carers were not aware of how to provide feedback about the service and had not the opportunity to give any. Most carers we spoke with had not been offered, and were not aware of carers assessments.
- Although environments were well maintained, some environmental assessments were not completed at the necessary frequencies. The site at Lundwood did not have accessible toilet facilities.

However:

- We observed staff to be kind, caring and compassionate during their interactions with patients. Patients and carers spoke positively about the staff and reported staff were caring and listened to them.
- The transformation work undertaken at the service meant staff now worked in integrated teams on the same site. We saw good evidence of multidisciplinary working and staff said this improved how they worked together to better meet the needs of people.
- Most premises had accessible facilities and staff could provide information for people in format to meet their needs.
- Staff felt supported in their roles and had access to further training and development opportunities. Staff spoke positively about their managers and felt able to speak about any concerns.
- We saw some good evidence in care records of comprehensive care planning and risk assessment. There were good levels of information within progress notes to show what support people were receiving.

Is the service safe?

Requires improvement  

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

Community mental health services for adults of working age

- Staff did not always review and update people's risk assessments and management plans in accordance with trust policy. There were instances where clients had no risk assessments present and where staff had not reviewed risk assessments following serious incidents.
- There was low compliance with some areas of staff mandatory training in relation to safety. For example, training in aggression management had a compliance rate of 69% in March 2018. Staff said there was limited availability for some of these courses.
- Some staff caseloads were high, particularly within the core teams although most staff felt able to manage these.
- All sites we visited had a fire risk assessment in place which was subject to annual or bi-annual review. The fire assessment for the Barnsley site had a review date of February 2016 but there was no documentation to show that this had been completed. This meant that the trust could not evidence that fire assessments had been reviewed at the required frequency at all sites.

However:

- The trust was attempting to recruit into posts where teams had vacancies and staff arranged cover.
- Risk assessments were of good quality and we observed staff to consider risks in team discussions and with people using the service.
- Community sites we visited were clean and well-maintained.
- The service had systems in place to protect staff safety when lone working and staff adhered to lone working guidance.
- Incidents were discussed in team meetings and staff received debriefs and support following serious incidents.

Is the service effective?

Good   

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

- Staff completed an initial assessment for each person receiving support and treatment from the service.
- The service was able to offer a range of care and treatment interventions in line with recognised good practice.
- The teams included a range of specialists required to meet the needs of people using the service and there was good multidisciplinary working between teams.
- Staff felt supported in their roles and most said they received regular supervisions and appraisals. Staff could access additional training beneficial to their roles.
- Staff received training in the Mental Capacity Act and Mental Health Act and demonstrated a good understanding of the legislation.

However:

- Staff undertook initial assessments for people using the service but it was not always clear what plans of care people were working towards.

Community mental health services for adults of working age

Is the service caring?

Good   

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

- Staff interactions with people using the service demonstrated that staff were polite, respectful and compassionate. Staff listened to people's viewpoints and checked their levels of understanding about their support.
- People using the service and their carers spoke highly of the staff and said they were always caring and listened to them. They felt staff had time for them and their needs.
- Staff respected people's confidentiality and ensured that carers were involved when this was in accordance with the person's wishes.

However:

- Care plans and information in people's records were not personalised and lacked the views of the person although progress notes were more detailed.
- People using the service and their carers were not familiar with methods to provide feedback about the service and how they were able to do this.
- Most carers had not received information about how to access a carer's assessment and were not aware of this.

Is the service responsive?

Requires improvement   

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

- Waiting times for access to services, particularly psychological therapies within Barnsley, were still very lengthy this was a concern at our previous inspection.

However:

- The service model had transformed in order to try to better meet the needs of the people using the service. This was due to be reviewed in September 2018
- The service had undertaken initiatives across teams to try to reduce waiting times. This included setting up clinics and trying to provide further resource to meet demand.
- Most people were aware of how to raise complaints and told us they would feel able to do so. Staff tried to resolve complaints locally where possible.
- The facilities were able to accommodate the needs of people using them. The premises included environments where staff could see people for clinical treatments.

Is the service well-led?

Good   

Community mental health services for adults of working age

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

- Team leaders had a good understanding of the services they managed and where improvements were needed. Staff felt supported by their managers and had effective leadership.
- The trust had systems for senior leaders to monitor performance and the effectiveness of the service. Areas for further development and improvement were discussed with team managers.
- Team leaders were supported in their role and were had access to information relevant to their teams and management role.
- There were opportunities for leadership development and staff progression in management roles.
- Staff knew and demonstrated the values of the trust. There were opportunities for staff to be engaged with, and contribute to, changes within the service.

However:

- The service had not recognised or taking necessary action in relation to the low compliance with mandatory training and the shortfalls around risk assessment and records.
- There were still excessive waits for treatments in some areas which was a recurring issue from our last inspection.

Areas for improvement

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

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

Good  

Key facts and figures

South West Yorkshire Partnership NHS Foundation Trust provides community services for people with a learning disability across Barnsley, Calderdale, Kirklees and Wakefield. The trust had fully restructured the service since our previous inspection and had a community team based at each location. The community teams comprised a nursing team, multidisciplinary team and an intensive support team. In addition, Wakefield also had a psychology team. The local clinical commissioning groups commissioned each community team.

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

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

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

Regulation 12 HSCA (RA) Regulations 2014 Good governance.

We carried out this inspection on 13-15 March 2018. We inspected the service and all of the key questions of safe, effective, caring, responsive, and well led. Our inspection was announced at short notice to enable us to observe routine activity.

During the inspection, the inspection team:

- visited three of the four community teams
- spoke with 12 people who were using the service
- spoke to 14 carers of people who use the services
- spoke with 22 staff members; including health support workers, nurses, occupational therapists, physiotherapists, psychiatrists, psychologists, and speech and language therapists
- interviewed two operational managers and four senior service managers
- attended three multi-disciplinary meetings, one outpatient clinic and one therapy session
- accompanied staff on 14 visits.
- looked at 17 patient records
- looked at policies, procedures and other documents relating to the running of the service.

Summary of this service

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

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

- The trust had acted upon our feedback from the previous inspection of this service. People's risk assessments were available and easily accessible in all the electronic care records we reviewed. They were up to date and demonstrated staff assessed, managed, and monitored people to protect them from avoidable harm and abuse.
- The teams we visited included a full range of staff disciplines. Staff worked in a collaborative manner and were flexible in their approach across the different functions provided in each location.
- People received effective care and treatment. Staff planned and provided care and treatment that was in line with current evidence based standards and best practice. Staff completed care plans that were holistic, personalised, and involved people in decisions about their care and treatment.
- There were sufficient numbers of skilled and experienced staff in the community teams. Staff felt their caseloads were manageable. All staff met the trust's compliance target for appraisals, supervision and mandatory training. Staff we spoke with felt valued and well supported by their clinical leads.
- Staff provided compassionate care and clearly understood people's feelings, preferences and their social needs. People were involved in decisions about their care and treatment. Communication with people was clear and individualised. Staff used open questions and simple language. They gave people time to respond and provided appropriate levels of verbal prompting if necessary.
- The trust had acted upon our feedback from the previous inspection of this service. They had restructured the service to include multi-disciplinary teams providing a more joined up approach. This led to a significant reduction in waiting times with improved access to a range of specialist assessments. The community teams had a clear pathway that provided flexibility for staff to provide care that met the needs of individual patients. The intensive support teams responded to urgent and crisis referrals within the recommended referral wait times.
- The service had a clear and effective leadership structure. Senior staff were knowledgeable about the service and committed to making continuous improvements. Staff morale was positive overall and the culture of the service was consistent with the trust values.

However

- The base at Wakefield was in the city centre and also used by several mental health services. The location and multi-discipline use of the base presented staff with challenges regarding retention of health support workers and agile working. The waiting area was large and impersonal, with no easy read information displayed.

Is the service safe?

Good  

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

- The service community bases we visited were all clean, tidy and well maintained. Business continuity plans for emergencies and the appropriate health and safety, and fire checks were in place.
- There were sufficient staff to manage caseloads and keep patient records up to date.
- Staff were trained in key skills. Mandatory training rates showed compliance and were above or met the trust targets.
- Staff used a recognised risk assessment tool and completed risk assessments that they reviewed regularly and kept up to date for all patients.
- There were systems in place to enable the intensive support team to respond promptly to changing situations and sudden deterioration in people's health.

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

- Staff understood how to protect patients from abuse and worked closely with the trust's safeguarding team to ensure they referred concerns and alerts appropriately.
- Staff had access to essential information. They received training to use the electronic recording system and reported no concerns using the system.
- The community teams encouraged and supported people to access their GP and manage their medicines safely.
- Staff reported incidents and managers shared learning from incidents and implemented changes to improved patient and staff safety if appropriate.

Is the service effective?

Good   

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

- People's care plans were based on the individual needs identified during the comprehensive inspection.
- Positive behaviour support plans were in place for people seen by the intensive support team
- Staff provided a range of care and treatment options. Interventions used were those recommended by evidence-based guidance.
- Staff supported people to access mainstream services for their physical healthcare needs, including their need for an annual health check.
- Non-medical staff felt supported and received regular supervision and yearly appraisals. The service provided them with opportunities to develop their skills and knowledge.
- There was a full range of mental health disciplines in each community team. They held regular team meetings and discussed new referrals and people's progress holistically.
- Staff had a good source of local knowledge around resources they could use to enhance a patient's treatment and recovery.
- Staff demonstrated a clear understanding of the Mental Capacity Act. Best interest decisions were well recorded where decisions were made about patients who lacked capacity.

Is the service caring?

Good   

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

- Staff provided compassionate care and clearly understood people's needs and feelings.
- People were involved in decisions about their care and treatment. People said they had good relationships with staff.
- Communication with people was clear and individualised. Staff helped people to communicate and receive information in a way that they could understand.
- Carers told us that staff provided them with information they needed to support and understand the care and treatment provided.

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

Is the service responsive?

Good  

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

- The service had a clear pathway that provided a stepped approach to care and treatment.
- Waiting times for access to the multidisciplinary team and for a range of specialist assessments did not exceed the maximum wait period.
- Staff offered patients flexibility in the times and place of their appointments to accommodate preferences and employment needs.
- Staff supported and encouraged people to engage with the wider community. People had access to education, work opportunities and community activities.
- Staff complied with the Accessible Information Standard and provided information in accessible formats for people using the service.
- Patients and their carers told us they knew how to raise complaints if the need arose. Community teams supported people to raise formal complaints and received feedback following investigation into the complaint.

However:

- Several community mental health services shared the premises at Wakefield. The large waiting room was impersonal and had no easy read information displayed.

Is the service well-led?

Good   

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

- The service had a clear and effective leadership structure. They were experienced, knowledgeable and passionate about their service.
- The leadership and culture of the service reflected the trust's vision and values.
- Staff felt respected, supported and valued by their immediate line managers, individual teams and colleagues within the service.
- Senior managers had a good understanding of the service and governance systems and processes. Senior managers and community teams held regular meetings to review, discuss and share essential information.
- The service had one risk on the corporate risk register, which was due to be reviewed and removed.
- People, their carers had access to information about the trust through its external website. Staff received information through the internal website, bulletins and emails.
- Staff liaised with GPs and police to develop a more proactive approach and increase understanding of reasonable adjustments when engaging with people.

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

Areas for improvement

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

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

Requires improvement   

Key facts and figures

South West Yorkshire Partnership Foundation NHS Trust provides seven acute mental health inpatient wards for adults of working age and two psychiatric intensive care units. The wards can provide care and treatment for up to 163 patients. Patients who receive care and treatment within can be detained under the Mental Health Act 1983 or informal. The acute mental health inpatient wards and psychiatric intensive care units were provided across four locations as follows:

The Dales Calderdale Royal Hospital, Salterhebble Halifax HX3 0PW

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

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

- Stanley Ward - 22 bed male ward (previously Trinity 2 ward)
- Priory 2 - 22 bed female ward
- Walton psychiatric intensive care unit - 14 bed mixed sex ward

Kendray Hospital, Doncaster Road Barnsley South Yorkshire S70 3RD

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

Priestley Unit, Halifax Road Dewsbury WF13 4HS

- Ward 18 - 23 bed mixed sex ward

We have carried out eight Mental Health Act monitoring visits across the service between January 2017 and February 2018. Following these visits, the trust provided an action statement telling us how they would improve the service and improve adherence to the Mental Health Act and Mental Health Act Code of Practice.

We previously inspected the acute and psychiatric intensive care unit services between 30 January and 2 February 2017. The inspection report was published 13 April 2017 and we found some areas for improvement. We rated the service as requires improvement in two key questions (safe and effective) and rated the service as good in caring, responsive and well led. The service was rated as requires improvement overall.

We carried out a responsive inspection of Ward 18, Priestley Unit, Dewsbury on 21 December 2017 following on from information of concern received. We looked at all the key lines of enquiry within the safe domain and selected key lines of enquiry from the effective domain.

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

During our inspection we:

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

- Toured all of the ward environments and observed how staff were caring for patients
- Reviewed 27 patient records, 19 restraint records, 14 rapid tranquilisation records and 15 seclusion records
- Attended two multi-disciplinary team reviews and two patient community meetings
- Interviewed 43 patients, reviewed feedback from 38 comment cards and met with patients at nine focus groups.
- We spoke with ten carers and met with carers at one focus group.
- Interviewed six senior managers responsible for the services
- Interviewed 58 other staff including: ward managers, doctors, nurses, occupational therapists, psychologists, therapy staff, healthcare assistants and domestic staff.
- Completed a review of medicines management on each ward
- Reviewed a range of other documents, policies and procedures.

Summary of this service

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

- Staff did not adhere to the trust policies and best practice in the management of patients in seclusion and the monitoring of patients' physical health following rapid tranquilisation. Staff did not document de-brief with patients following incidents of restraint. Staff did not always reflect incidents involving patients on risk assessment documents or grade them accurately.
- Staff did not fully complete medication administration records for 17 patients. Staff did not monitor clinic room temperatures, fridge temperatures and equipment in line with the trust policies.
- Staff did not assess the risk of patients in line with trust policy. Staff did not fully complete Section 17 leave documentation to ensure that patients and carers were informed of the requirements and responsibilities of Section 17 leave.
- Staff did not ensure that plans for patients' care, treatment and discharge involved patients and their families and carers. Care plans were not personalised and did not reflect the patient's voice.
- Not all patients had access to nurse call systems in their bedrooms to enable them to summon assistance if required.
- Seven of the wards had over 100% bed occupancy and the service had high numbers of out of area placements. Patients did not always have a bed available to them on return from leave.
- Governance systems and process were not effective in ensuring that change was implemented. Managers were aware of some of the key areas for improvement within the service; but these issues were still a concern at the time of inspection.

However:

- Patients reported staff treated them in a kind and caring manner. Staff involved patients in weekly multi-disciplinary review meetings and held regular community meetings to enable patients to provide feedback on the care and treatment they received.
- Staff used observation levels to maintain the safety of patients on the ward. Staff understood the needs of patients and adapted their practice to take into account their personal and social needs.

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

- Staff felt supported by their immediate managers and reported they worked well together within their teams. Staff had annual appraisals and were supported to access specialist training. Staff knew the vision and values of the trust.
- The service provided facilities to meet the needs of patients. All wards were clean and furnishings were well maintained.

Is the service safe?

Inadequate ● ↓

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

- Staff did not adhere to the trust policy or Mental Health Act Code of Practice in the management of patients in seclusion.
- Staff did not undertake the required physical monitoring following the administration of rapid tranquilisation. We reviewed 14 records of rapid tranquilisation all lacked the required monitoring of physical observations.
- Staff did not always complete medication administration records to evidence that patients had received their prescribed medication.
- Oxygen cylinders on some wards were not stored correctly or were out of date. Staff did not monitor and record clinic room temperatures, fridge temperatures or defibrillators in accordance with the trust policy.
- Staff did not undertake risk assessments of patients in line with the trust policy. Incidents involving patients were not always reflected on risk assessments or graded accurately.
- Not all wards had nurse call systems in patient bedrooms to ensure patients could summon assistance if needed.
- Staff did not document that patients had been de-briefed after incidents of restraint.

However:

- All wards were clean and furnishings were well maintained.
- Staff used increased levels of observation to maintain the safety of patients and staff.
- Staff knew how to identify signs of abuse and make a safeguarding referral if necessary.

Is the service effective?

Requires improvement ● → ←

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

- Staff did not always complete Section 17 leave forms in full to ensure patients and their carers understood the requirements of the leave and had signed to show they agreed to this.
- Care plans were not personalised to the patient and did not reflect the patient voice in 14 of the 27 care plans we reviewed. The trust had completed their own audit of patient records in February 2018 and had identified only one ward was above the 81% compliance target for care planning.
- We saw limited activity on the wards during our inspection. Staff and patients reported there was a lack of therapeutic activity on the wards.

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

However:

- Patients had access to physical healthcare on the wards.
- Staff reviewed the care and treatment needs of patients in weekly multi-disciplinary team meetings.

Is the service caring?

Good   

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

- Most patients reported that staff treated them well and we saw staff interacting with patients in a kind and supportive manner.
- Staff held community meetings and carers groups to enable patients and their families to give feedback on the service

However:

- Carers reported that they were not involved in care planning and that staff did not keep them informed of their relatives' progress.

Is the service responsive?

Requires improvement  

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

- The service had over 100% bed occupancy on seven of the nine wards and high numbers of out of area placements.
- When patients returned from leave, a bed was not always available for them.
- Staff did not always evidence that patients, carers and other professionals had been involved in discharge planning and the care plan and risk assessment was not always reviewed at the time of discharge.

However:

- The service supported patients of different sexual orientation, ethnicity and religion.
- Patients knew how to complain and staff managed complaints in line with trust policy.

Is the service well-led?

Requires improvement  

Our rating of well-led went down. We rated it as requires improvement because:

- Governance systems and process were not effective in ensuring that change was implemented. Managers were aware of some of the key areas for improvement within the service; but these issues were still a concern at the time of inspection.
- Staff did not know who the trust Freedom to Speak Up Guardian was and felt this role was not promoted across the trust.

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

However:

- Staff felt supported by their immediate managers and teams reported they worked well together.
- Staff knew the vision and values of the trust.

Areas for improvement

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

Specialist community mental health services for children and young people

Requires improvement  

Key facts and figures

The trust's specialist community mental health services for children and young people has four community child and adolescent mental health services which are provided across three districts. These are Barnsley, Calderdale and Kirklees, and Wakefield.

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

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

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

At the last comprehensive inspection in March 2016, the service had three key questions (safe, responsive and well led) rated requires improvement. We re-inspected those key questions in a follow up inspection in January 2017 and found the service had made improvements in the safe and well led domains, (re-rated as good). However we rated the responsive key question as requires improvement.

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

During the inspection visit, the inspection team:

- visited three of the office bases where specialist child and adolescent mental health community services were provided. (Kirklees, Barnsley and Wakefield West)
- spoke with 16 children and young people, families and carers that were using the service
- spoke with four of the six team managers of the services
- spoke with 26 other staff members; including doctors, lead clinicians, nurses, support workers, administrative staff, therapists, psychologists and mental health practitioners with a variety of professional backgrounds
- spoke with six senior leaders for the service
- observed one multidisciplinary meeting, three team meetings and one strategy meeting.
- attended one home visit, observed four outpatient appointments and support groups and observed two interactions with children and young people in waiting areas. During the inspection additional planned outpatient appointments were cancelled and there were no further home visits planned when we attended
- received one comment card from a person that used the service

Specialist community mental health services for children and young people

- reviewed 17 records including children and young people's risk assessments and care plans.

Summary of this service

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

- There was not an effective approach to managing the premises. The service did not complete environmental risk assessments or infection control audits in line with best practice guidance. The premises at Barnsley were not always secured using the appropriate level of security that was needed in relation to the services being delivered. Staff were not always able to rebook appointments due to availability of rooms at the Barnsley and Wakefield West sites.
- Staff were not always following the trust's procedures to keep them safe when on home visits or working out of hours. Some staff had no lone working device and staff that had, were not always using lone working devices in line with the guidance provided. There were not effective processes in place to monitor and improve compliance. This could place staff at risk.
- There were issues with connectivity to the trust network that affected staff. They struggled to access and remain in the trust's network due to connectivity issues and limited licences. Staff were not always able to access information or update records as a result.
- People that used the service said that they were unclear how to feedback on the service. Families and carers shared concerns about the length of the waiting lists and told us they sometimes found it difficult communicating with the service. Carers told us that they were not provided with information about how to access a carer's assessment.
- The out of hours on call service was not always fully staffed. We saw gaps in rotas and incidents recorded on the incident management system as a result. Four of the pathways were not meeting the 18 week referral to treatment standard. The autism spectrum disorder (ASD) pathway was the longest; it averaged 99 weeks.
- The senior leadership team had not successfully communicated the provider's vision and values to the frontline staff and none of the staff we spoke with knew who their organisation's Speak Up Guardians were, although they were aware of the whistleblowing procedures.

However:

- All areas were clean, had good furnishings and were well-maintained. The service had a range of rooms and equipment to support treatment and care. Therapy and clinic rooms had alarms and staff responded when they were used.
- Staff provided a wide range of care and treatment interventions suitable for the children, young people, families and carers that used the service. Staff completed a comprehensive mental health assessment that included a risk assessment for children or young person receiving treatment from the service. Care plans were personalised, holistic and recognised physical health needs. Age appropriate consent was recorded and reviewed.
- Safeguarding was embedded in the service and there were mechanisms in place to provide feedback and support staff following incidents. There were systems and processes in place monitor the effectiveness of the service.
- Staff in the service arranged appointments flexibly and provided choices on location and timings. Staff interaction with children and young people was friendly, informative, compassionate and respectful. Children and young people told us that they liked going to the service as they felt listened to and were not judged. Staff spoke directly to the child or young person and checked if they and their families or carers understood what was being asked. Carers and families spoke positively about the service once they had received an appointment.

Specialist community mental health services for children and young people

- The service had introduced a number of initiatives across the sites that had improved waiting times and reduced risk. The service had clear criteria for accepting referrals had a process to expedite urgent cases.
- Leaders understood the services they managed. Staff understood arrangements for working with other teams, both within the provider and external, to best meet the needs of the people using the service. Staff made suggestions about developing the service and implemented new groups to support the strategy. Leaders were proud of their staff and the care they provided. The provider recognised staff successes within the service via Trust Excellence Awards.

Is the service safe?

Requires improvement ● ↓

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

- The service did not complete environmental risk assessments in line with best practice which meant that the service was not doing all it could to identify the potential risks of the environment for children and young people using the service.
- Premises at Barnsley were not always secured using the appropriate level of security that was needed in relation to the services being delivered. Alarms were not always set and windows were not always locked. Fire risk assessments were out of date at the Kirklees site.
- Therapy and clinic rooms had cleaning wipes to wipe down toys and equipment after use but there was no way to confirm if the previous occupant had completed this. There was no hand gel in any of the rooms to aid staff in following infection control principles.
- Staff were not following the trust's procedures to keep them safe when on home visits or working out of hours. Staff were not using lone working devices in line with the guidance provided and not all staff had a lone working device that needed one within the service. This placed staff at risk.
- Compliance figures in one of the mandatory training courses, personal safety, did not meet the trust training target due to a lack of training available within the trust.
- There were issues with connectivity to the trust network that affected office based and agile workers. Staff were not always able to access children and young people's care records to update them.
- The service did not always manage to fully staff the out of hours on call service. We saw gaps in rotas, a negative impact on staff morale and incidents recorded as a result.

However:

- Therapy and clinic rooms had alarms and staff responded when they were used.
- All areas were clean, had good furnishings and were well-maintained. Cleaning records for all sites were up to date and demonstrated that the premises were cleaned regularly by domestic staff.
- The service used an established risk assessment tool in all but one of the records we viewed. Staff monitored risk to children and young people on the waiting list and had set up a clear process that was used service wide.
- Safeguarding was embedded in the service and there were mechanisms in place to provide feedback to staff following incidents. Following serious incidents staff were debriefed and offered support.

Specialist community mental health services for children and young people

Is the service effective?

Good ● ➡ ➡

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

- Staff completed a comprehensive mental health assessment for each child or young person receiving treatment from the service. Care plans were personalised, holistic and recognised their physical health needs. Staff supported children and young people to live healthier lives and provided psychoeducation for families and young people.
- Staff provided a wide range of care and treatment interventions suitable for the children, young people, families and carers that used the service.
- Staff used recognised rating scales, such as Health of the Nation Outcome Scales and other scales to rate severity and to monitor outcomes. Revised Children's Anxiety and Depression Scales were used throughout the assessment and treatment of children and young people.
- All of the teams included or had access to, a full range specialists required to meet the needs of children and young people using the service.
- Staff understood and followed the principles of the Mental Capacity Act for young people over 16 and recorded consent in line with Gillick competence framework.

However:

- The majority of staff told us they did not participate in clinical audit other than records keeping audits. Where audits had been undertaken, staff were unaware of the results.
- Although supervision rates had improved, data provided by the trust showed that not all staff across the service regularly accessing it. This could mean that staff are not getting the support required to do their jobs.

Is the service caring?

Good ● ➡ ➡

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

- Staff interaction with children and young people was friendly, compassionate and respectful. Children and young people told us that they liked going to the service as they felt listened to and were not judged.
- Staff explained the purpose of appointments, what the assessments would include and explained the possible outcome. Staff spoke directly to the child or young person and checked if they and their families or carers understood what was being asked.
- Staff involved children and young people when appropriate in decisions about the service, for example, in the recruitment of staff.
- Carers and families spoke positively about the service once they had received an appointment.

However:

- The majority of families and carers we spoke to were unclear on how to offer feedback on the service.

Specialist community mental health services for children and young people

- Carers told us that they were not provided with information about how to access a carer's assessment and staff were unclear if these were offered.

Is the service responsive?

Requires improvement   

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

- The service had worked hard to reduce waiting times since our last inspection however challenges in relation to funding remained. Four of the pathways were still not meeting the 18 week referral to treatment standard. The autism spectrum disorder (ASD) pathway was the longest; it averaged 99 weeks.
- Staff described difficulty in booking rooms at the Barnsley and Wakefield West sites. Staff were not always able to rebook appointments due to room availability.
- Staff did not always correctly capture the young people's needs in relation to the accessible information standard. This meant this information relating to their condition and might not be flagged to other services or staff.
- Of the 16 young people, families and carers we spoke with only two carers were certain that they had received information on how to complain.
- Families and carers shared concerns about the length of the waiting lists and told us they found it difficult communicating with the service when on the waiting list.

However:

- Staff followed up with children and young people receiving treatment and monitored risk for people on the waiting lists. The service had introduced a number of initiatives across the sites that had reduced waiting times.
- The service had clear criteria for accepting referrals that did not exclude children or young people who needed treatment and would benefit from it. The services had a process to expedite urgent cases.
- Staff in the service arranged appointments flexibly. They offered different locations, including schools and offices, and provided a choice in appointment times and dates.
- The service had a range of rooms and equipment to support treatment and care such as therapy rooms and bright waiting areas with toys for children and young people to use.

Is the service well-led?

Good   

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

- Leaders had a good understanding of the services they managed. They could clearly explain how teams were working to provide high quality care. They were proud of their staff and the care they provided.
- Staff made suggestions about developing the service and implemented new groups to support the strategy. The provider recognised staff successes within the service via Trust Excellence Awards.
- Staff understood arrangements for working with other teams, both within the provider and external, to best meet the needs of the people using the service.

Specialist community mental health services for children and young people

- We reviewed the community child and adolescent mental health service's risk register and saw that staff concerns matched the items identified. Issues that were identified such as waiting times and staffing had also been escalated to the organisation's risk register.
- There were systems and processes in place monitor the effectiveness of the service. Team managers had access to information to support them with their management role. This included information on the performance of the service, staffing and care of children and young people using the service.

However:

- The service's senior leadership team had not successfully communicated the provider's vision and values to the frontline staff and none of the staff we spoke with knew who their organisation's Speak Up Guardians were.
- There was not an effective approach to managing the premises. The service had not implemented any infection control audits or reviews of the environment, including ligature risks, for any of its sites in line with best practice. The service had not resolved security risks identified at the Barnsley site.
- Staff struggled to access and remain in the trust's network due to connectivity issues and limited licences. Staff were not always able to access information or update records as a result.
- People that used the service said that they were unclear how to feedback on the service. Some families and carers described chasing keyworkers for updates on their relative's condition.
- The service monitored its waiting list and identified ways to improve the service it provided however waiting times for treatment on the autism spectrum disorder pathway were still lengthy. There were no set targets for assessment to treatment in the Wakefield and Barnsley services.

Areas for improvement

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

Wards for people with a learning disability or autism

Good   

Key facts and figures

South West Yorkshire Partnership Foundation NHS Trust provides one ward called the Horizon centre for adults with a learning disability or autism. The ward provides care and treatment for up to eight patients who may be admitted informally or detained under the Mental Health Act 1983. The ward is based in Wakefield at Fieldhead Hospital.

The Horizon centre has been registered with the Care Quality Commission since 2009 to carry out the following regulated activities:

- Treatment of disease, disorder or injury,
- Assessment or medical treatment of persons detained under the Mental Health Act 1983
- Diagnostic and screening
- Nursing care

We carried out a Mental Health Act monitoring visit in July 2017. Following this visit, the trust provided an action statement telling us how they would improve the service and improve adherence to the Mental Health Act and Mental Health Act Code of Practice.

We previously carried out a comprehensive inspection on the ward in March 2016. We rated the ward as good overall with a rating of good in all five key questions of safe, effective, caring, responsive, and well led.

We carried out this inspection on 6-8 March 2018. We inspected the ward and all of the key questions of safe, effective, caring, responsive, and well led. Our inspection was unannounced (staff did not know we were coming) to enable us to observe routine activity.

At the time of this inspection, there were five patients admitted to the ward.

During the inspection, the inspection team:

- Toured the ward environment and observed how staff were caring for patients
- reviewed three patient care and treatment records
- interviewed four patients
- interviewed seven relatives and carers of patients who were using the service
- reviewed three patient care and treatment records
- attended and observed one lunchtime activity, one interagency discussion, one handover, one long-term segregation review
- interviewed 12 staff including qualified nurses and support workers, medical and pharmacy staff, dietician, occupational therapy and psychology staff
- interviewed two ward managers and four senior service managers
- completed a review of medicines management on the ward and four medicine prescription charts
- reviewed four seclusion records, two records of incidents of restraint and one record about long-term segregation

Wards for people with a learning disability or autism

reviewed a range of other documents, policies, and procedures relating to the ward.

Summary of this service

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

- The trust had acted upon our feedback from our previous inspection of this service and there had been overall improvements in the safety of patient care.
- Following our previous inspection, the ward had taken action to reduce blanket restrictions. However, there was no system or process that supported how staff identified and reviewed blanket restrictions and some blanket restrictions remained.
- Staff had a culture of openness and honesty and safety was a high priority for all staff. Managers monitored the safety and quality of the service and took action to improve safety. Staff regularly assessed and monitored risks to patients, to protect them from avoidable harm and abuse.
- Patients received effective care and treatment. Staff planned and delivered care and treatment that was in line with current evidence based standards and best practice. Training for the Mental Health Act and Mental Capacity Act was now mandatory for all staff. Staff completed care plans that were holistic, personalised, and involved patients in decisions about their care and treatment.
- Staff provided person-centred care that patients' needs and treated patients with dignity and respect. Feedback we received from people who used the service was overall positive and we observed staff who were kind, caring, and respectful. However, we had concerns about the limited opportunities for patient feedback and carer support on the ward.
- The ward had a clear pathway that provided flexibility for staff to deliver care that met the needs of individual patients. Staff planned and managed admissions and discharges to the ward so that patients had timely access and successful discharges from the ward. The facilities promoted the comfort, dignity and privacy of patients and the ward planned to make further improvements to the environment.
- The ward needed to make further improvements in the arrangements for reviewing blanket restrictions and obtaining the views of people who used the service. However, staff morale was overall positive about managers who were highly visible and supportive. Senior staff were knowledgeable about the ward and committed to making continuous improvements.

Is the service safe?

Good   

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

- The ward had made a number of improvements based on the recommendations from previous inspections that improved patient safety and reduced blanket restrictions on the ward.
- The ward had acted to make the recommended improvements in the safety of medicines management that meant omissions in medication administration rarely occurred. Staff ensured that the ward environment, and equipment they used was safe, clean, and well maintained. Staff now had a robust system in place that meant they always recorded their checks of emergency equipment to ensure it was safe to use.

Wards for people with a learning disability or autism

- Mandatory training rates showed improvement over time and most mandatory training compliance was above or met the trust targets. Staff had a good understanding of the Mental Health Act in relation to the care of patients in seclusion and long-term segregation. This meant that all the necessary safeguards were in place to protect patients and provide safe care.
- The ward had enough regular staff with the right skills and experience to fill shifts. This meant staff had enough time for staff to spend with patients to maintain their safety and well-being. The ward had increased the arrangements for medical cover on the ward. Staff said medical cover had improved. Patients told us there was always enough staff to support them and they saw a doctor regularly.
- Staff used a recognised risk assessment tool and completed risk assessments that they reviewed regularly and kept up to date for all patients.
- Managers prioritised reducing restrictive interventions. Staff understood the principles of least restrictive practice and supported patients with positive behaviour support plans. Patients told us they understood why staff used restrictive interventions such as seclusion and restraint, and that staff did not hurt them.
- Managers supported a culture of candour, staff reported incidents, and demonstrated a culture of openness and honesty when things went wrong. Managers shared learning from incidents and staff made changes that improved patient safety.

However:

- Some blanket restrictions remained in place and the ward had no system or process that supported how staff identified and reviewed blanket restrictions.
- The ward provided a female only lounge that did not have clear signage and the door was not always open. The ward did not provide information for patients and carers about the arrangements for eliminating mixed sex accommodation.

Is the service effective?

Good   

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

- Staff provided effective care and treatment that they planned and delivered in line with current evidence based guidance. Staff received training in positive behaviour support and developed plans with patients to prevent behaviour that challenges.
- Suitably skilled, experienced, and competent staff carried out comprehensive assessments of patients' needs. A range of professionals worked collaboratively and met regularly with patients and their carers to review their care and treatment.
- The ward had made overall improvements in their adherence to the Mental Health Act and resolved most of the concerns from previous inspections. Staff completed capacity assessments and best interest discussions when patients did not have capacity to make specific decisions about their care and treatment. Staff participated in regular audits and managers completed action plans to ensure the ward made improvements.

However:

Wards for people with a learning disability or autism

- Staff did not keep records of the assessment of patient's capacity and consent for treatment with medication prescription charts. This meant that staff could not easily check that completed assessments for capacity and consent were in place when they administered medication.

Is the service caring?

Good   

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

- Staff treated patients with dignity and respect and provided patients with the emotional support they needed. Patients and their carers were positive about the way staff treated them. We observed staff were caring and used positive language during their interactions with patients.
- Staff knew patients well and helped patients to communicate and receive information in a way that they could understand. Staff involved patients and carers in their care and shared care plans with patients and carers.
- Staff promoted patients independence and supported them to maintain and develop social networks and relationships. Patients accessed activities that had therapeutic and social benefits over seven days per week.

However,

- The ward did not have a forum for people to give feedback on the service such as ward community meetings. Staff did not involve patients in menu planning and all patients were negative about the food.
- The ward did not have a forum for carers. Carers told us they needed more opportunity to discuss and learn about their relatives care and treatment.

Is the service responsive?

Good   

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

- The ward had a clear pathway for referral and admission that was recovery focused and supported patients with a successful and timely discharge.
- Staff delivered patient centred care that took the needs of individual patients into account when they planned admissions to the ward.
- The facilities and premises promoted patients' comfort, privacy, and dignity. The ward made adjustments for people who needed to access the ward and provided information in accessible formats for people with a learning disability.
- The ward had developed individual areas of care for one patient who was unable to tolerate sharing spaces with other patients and for one patient who required additional bedroom space to reduce their anxiety.
- Patients and their carers told us they felt confident to raise complaints with ward staff. Ward staff knew how to support people to raise formal complaints. Managers took action to improve the quality of care in response to complaints.

Wards for people with a learning disability or autism

Is the service well-led?

Requires improvement ● ↓

Our rating of well-led went down. We rated it as requires improvement because:

- Managers did not have an effective system or process to assess, monitor, and review the blanket restrictions on the ward. Although the ward had taken some action to reduce blanket restrictions, we found that some restrictions remained. Staff had not completed individual patient risk assessments in relation to the restrictions.
- The ward had a limited approach to obtaining the views of people who used the service. The ward did not have an effective system or process to monitor and improve the quality of the experience of patients. Although the ward had started to gather feedback from patients on discharge, the ward had no patient's forum to gather their feedback. Patients were not involved in menu planning, and gave overall negative feedback about the food the ward provided.
- The ward did not have an effective system or process to monitor and improve the quality of the experience of carers. Although the ward had started to consider how staff could offer additional support to carers, the ward had no carers' forum to gather their feedback. Overall, carers told us they needed more opportunity to discuss and learn about their relatives care and treatment.
- Not all staff had a clear understanding of the role and function of the Freedom To Speak Up Guardian.

However,

- Managers had identified improvement priorities and taken action to make improvements in the safety and quality of the ward. Reducing restrictive interventions was a priority and managers routinely reviewed incidents for themes and learning.
- Senior staff were aware of the risks within the service. The ward maintained safe staffing levels with flexible working arrangements and regular bank and agency staff. Managers were actively recruiting staff and supported staff development and well-being through effective supervision and appraisal arrangements.
- Staff felt supported and valued and spoke highly of the managers who were visible and approachable. Staff morale was overall positive and felt they could raise concerns without fear of victimisation.
- Managers supported a culture of candour, openness, honesty and transparency and staff behaviour and performance was consistent with the trust values. Staff felt proud of their work and were committed to making continuous improvements to the quality of the care they provided.

Areas for improvement

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

Forensic inpatient or secure wards

Good   

Key facts and figures

South West Yorkshire Partnership Foundation NHS Trust provides 11 secure mental health inpatient wards. The wards can provide care and treatment for up to 144 patients. All patients who receive care and treatment within secure services are detained under the Mental Health Act 1983. The forensic inpatient wards are all in Wakefield at Fieldhead Hospital.

The trust has seven medium secure wards in Newton Lodge at Fieldhead Hospital. These provide care and treatment to male and female patients with mental illness and male patients with learning disabilities. The wards are as follows:

- Bronte ward – a seven bed male psychiatric intensive care unit
- Hepworth ward – 15 bed male assessment ward
- Waterton – 16 bed male enhanced recovery ward
- Priestley – 17 bed male active recovery ward
- Johnson – 15 bed female assessment and recovery ward
- Appleton – eight bed male learning disability assessment ward
- Chippendale – a 12 bed male recovery learning disability ward

The trust has three low secure wards in the Bretton Centre and one low secure learning disability ward at Newhaven at Fieldhead Hospital. These wards provide care and treatment to male patients with mental illness or learning disabilities.

- Sandal – 16 bed assessment, care and treatment ward
- Thornhill – 15 bed care, treatment and recovery ward
- Ryburn – seven bed pre-discharge ward
- Newhaven 16 bed learning disability assessment and treatment ward

At the time of our inspection, the trust was also providing care and treatment to one patient on Gaskell ward in Newton Lodge.

We last completed a comprehensive inspection of the trust in March 2016. At that inspection, we rated the key questions safe, effective and well-led as requires improvement and the key questions caring and responsive as good. We undertook a focussed inspection of the forensic and secure services in December 2016 to see if the trust had made the required improvements in the safe, effective and well-led key questions. At that inspection, we re-rated the key questions safe and well-led as good. The rating of the key question of effective stayed as requires improvement. We issued the trust with one requirement notice in relation to Regulation 11 Need for consent of the Health and Social Care Act Regulated Activities Regulations 2014.

We told the trust that they 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.

Forensic inpatient or secure wards

We told the trust that they should take the following actions:

- 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.

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

During our inspection we:

- Toured all of the ward environments and observed how staff were caring for patients
- Reviewed 35 patient records and reviewed two seclusion records
- Attended 15 multi-disciplinary team reviews, observed one service user governance meeting and one community meeting
- Interviewed 42 patients
- Completed two focus groups with patients
- Received patient feedback on a further 23 comment cards.
- Interviewed five senior managers responsible for the services
- Interviewed 60 other staff including: ward managers, doctors, nurses, occupational therapists, social workers, psychologists, therapy staff, healthcare assistants and administrators.
- Completed a review of medicines management on each ward including 104 medicines cards.
- Spoke with six carers and relatives of patients using the service.
- Reviewed a range of other documents, policies and procedures.

Summary of this service

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

- The services had a clear leadership and governance structure. Systems and processes enabled senior leaders to have oversight of performance and areas that required improvement. The services had clear embedded pathways for care and treatment across the medium and low secure services. When serious incidents occurred, the trust ensured that these were investigated and frontline staff received information on lessons learnt.
- Newhaven ward had a specialist forensic outreach nurse to facilitate discharge and provide short-term support after discharge. The services had no delayed discharges and no readmissions within 28 days.
- The service had made improvements in the training compliance rates of Mental Health Act and the Mental Capacity Act. Most staff now had a reasonable understanding of their responsibilities.
- Physical health care was easily accessible and embedded into patients' care and treatment well.

Forensic inpatient or secure wards

- Staff ensured patients had access to therapies and activities to promote their care and treatment on the wards, within the services and at the recovery college. The services had sufficient space to facilitate sessions and activities. The service ran a number of events for patients and carers.
- Staff involved patients in their care and treatment. They treated patients with respect and provided support. Care plans were written in easy read format and alternative languages.

However:

- Patients did not routinely have access to a nurse call system but staff ensured on an individual basis that alarms were in place when required.
- Thornhill and Johnson wards had some issues with safe medicines management in relation to equipment, temperatures, secure storage and administration recording. Ryburn and Newhaven wards could not raise an external staff response quickly if required.
- The trust had a timescale to replace door handles that could be used as a ligature anchor point.
- Feedback from staff reported difficulties in gaining input from speech and language therapists. Staff and patients reported issues with staffing, leading to section 17 leave being cancelled. Patients provided mixed feedback about the food provided.
- Observation windows with an external curtain and staff administering medication through the hatch of the clinic room did not promote privacy and dignity. Six patients also told us staff did not always knock before entering their bedrooms or looking through observation windows.
- Feedback from patients and staff included some challenges in facilitating section 17 leave. It was unclear from the patient feedback whether this was due to patient expectations or because of agreed leave cancellation. However, records showed that only 14% of leave was cancelled due to staff shortages.

Is the service safe?

Requires improvement ● ↓

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

- Patients did not routinely have access to a nurse call system. We saw that for one patient, staff ensured that they had assistive technology to alert staff about their safety.
- On two out of the 12 wards, we found issues with medicines management. The clinic room on Johnson ward contained some out of date medical equipment and the temperature of the room had exceeded the recommended temperature on a few occasions. On that ward, we also found staff had not locked the medicines fridge. After our inspection, the trust confirmed that they had installed an air conditioning system to manage the temperature in May 2018. On Thornhill ward, staff had not signed for three medicines leaving gaps on the medicines charts.
- Ryburn and Newhaven wards were in standalone buildings and staff could not raise an external response quickly if required. The trust was working on a protocol to ensure staff could assist these services quickly when required.
- Wards had door handles in communal areas of the wards that could be used as ligature anchor points. The trust had a programme of works due for completion by the end of the 2018/2019 to replace these. Staff had identified these in ligature audits and there was some mitigation.

Forensic inpatient or secure wards

- Patients felt that they did not have enough opportunities to have section 17 leave. It was unclear from the feedback whether this was due to patient expectations or because of agreed leave cancellation. Staff told us that they thought that there was not enough staff to ensure that wards were safe and support all section 17 leave. However, records showed that only 14% of leave was cancelled due to staff shortages.

However:

- All areas were clean, had good furnishings and were well-maintained.
- Staff had completed and regularly reviewed comprehensive assessments of patient risk.
- The services had the restrictions expected for low and medium secure services. Staff carried out random searching in the medium secure service.
- When a serious incident occurred, staff were supported whilst the incident was investigated. Staff were informed of the lessons learned. The service held a learning lessons event and incorporated the lessons learnt into the staff induction.

Is the service effective?

Good  

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

- The trust had taken action to address the improvements required in relation to adhering to the trust policy on the Mental Capacity Act. The service had increased the amount of staff trained in the Mental Capacity Act and Mental Health Act significantly since our last inspection. Staff that we spoke with at this inspection had a reasonable understanding of their responsibilities.
- Patients had easy access to physical health care. The services had dedicated physical health care nurses and access to other medical professionals. Physical health care was embedded into patients' care and treatment well.
- The multi-disciplinary teams consisted of a range of specialists required to meet the needs of patients on the wards.
- Although the average clinical supervision rate was 65%, this was much higher than the trust average of 39%. Ninety eight percent of staff had received an appraisal of their performance. The service had introduced a supervision passport for staff to record live supervision and staff received much more supervision than their performance data suggested.

However:

- Staff reported that they found it difficult to gain input from speech and language therapists because the service did not have an effective referral process.

Is the service caring?

Good   

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

- The service held regular events to promote relationships between patients and their families and carers. Examples of this included, patients prepared a Christmas dinner and a Mother's day afternoon tea to share with their families and carers.

Forensic inpatient or secure wards

- Staff ensured that patients that required accessible copies of their care plans received them, either in an easy read format or in their first language. These assisted them to be involved and understand their care and treatment.
- Observations of staff interactions and most patient feedback showed that staff treated patients with respect and support when required.
- Staff involved patients and captured their views, and the views of some carers and relatives, in care plans and risk assessments.

However:

- Six patients told us that staff did not always knock on their door before entering or looking through the observation window into their bedrooms.

Is the service responsive?

Good  → ←

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

- The services had clear embedded pathways for care and treatment across the medium and low secure services. The pathways could be used to provide enhanced and reduced care flexibly when required. Patients' discharge was not governed by the pathway.
- Newhaven ward had a specialist forensic outreach nurse that worked to facilitate the discharge of patients from the ward onto alternative placements and support discharged patients in their placement for a short term.
- Patients had access to sufficient space and facilities to promote and support their care and treatment. Newton Lodge held a range of events accessible to all patients. Some of these included families and carers.
- A recovery college provided a range of recovery and skill based courses at Newton Lodge for patients to access. Patients could access input from a tutor to work on education and a few patients had voluntary work.
- Staff had developed easy read material and care plans in patients' first language to meet their needs.
- This service had no delayed discharges and no readmissions within 28 days.

However:

- In the medium secure services, patient bedroom doors contained an observation window with an external curtain. This did not promote patient privacy and dignity as anyone could look through these. The trust had a plan to replace these by the end of 2018/2019.
- Across all of the wards, staff administered medication to patients through the hatch of the clinic room door. This meant that patients did not have privacy when discussing with or accepting their medication from staff.
- We received mixed feedback about the food provided. Thirteen patients raised issues with the food stating that this was poor quality, tasted bland and they had limited choice.

Is the service well-led?

Good  → ←

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

Forensic inpatient or secure wards

- The services had a clear leadership and governance structure. Leaders were visible and had a good understanding of the services. The services had clear meeting structures and methods to escalate from and cascade information to frontline staff.
- Staff felt respected, supported and valued. They could raise concerns without fear of retribution. They understood the trust's whistleblowing procedure and were aware of the freedom to speak up guardian. One of the guardians worked within the low secure services.
- Systems and processes enabled senior leaders to have oversight of performance and areas that required improvement.
- The service had implemented recommendations made from the investigations of serious incidents. They held learning lessons events to share learning from incidents.
- Staff and patients participated in research projects and the service was part of the Quality Network for Forensic Mental Health Services.

However:

- We identified a small number of areas for improvement. These included some improvements that the trust had timescales to remedy including the replacement of door handles and observation panels and a response protocol for standalone services. Other areas for improvement included ensuring patient privacy and access to nurse call systems.

Areas for improvement

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

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

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

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

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

Regulated activity

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

Diagnostic and screening procedures

Treatment of disease, disorder or injury

Regulation

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

Regulated activity

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

Diagnostic and screening procedures

Treatment of disease, disorder or injury

Regulation

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

Regulated activity

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

Diagnostic and screening procedures

Treatment of disease, disorder or injury

Regulation

Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment

Regulated activity

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

Diagnostic and screening procedures

Treatment of disease, disorder or injury

Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance

Regulated activity

Regulation

This section is primarily information for the provider

Requirement notices

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

Diagnostic and screening procedures

Treatment of disease, disorder or injury

Regulation 18 HSCA (RA) Regulations 2014 Staffing

Our inspection team

Jenny Wilkes, Head of Hospitals Inspection led the inspection. An executive reviewer, Chief executive officer, supported our inspection of well-led for the trust overall.

The team included a head of hospitals inspection, one inspection manager, 14 inspectors, one bank inspector, one assistant inspector, 18 specialist advisors and three experts by experience.

The team was also supported by one inspection planner, one Mental Health Act reviewer and two medicines management inspectors.

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