

Requires improvement

South West Yorkshire Partnership NHS Foundation
Trust

Community-based mental health services for older people

Quality Report

Fieldhead Hospital
Ouchthorpe Lane
Tel: 01924 327000
Website: www.southwestyorkshire.nhs.uk

Date of inspection visit: 7 - 11 March 2016
Date of publication: 24/06/2016

Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/unit/team)	Postcode of service (ward/unit/team)
RXG10	Fieldhead Hospital Ouchthorpe Lane Wakefield West Yorkshire WF1 3SP	CMHT for older people, Church Street, Darfield, Barnsley	S73 9LG
RXG10	Fieldhead Hospital Ouchthorpe Lane Wakefield West Yorkshire WF1 3SP	Ossett Health Centre Older peoples service, New Street, Ossett	WF5 8AG
RXG10	Fieldhead Hospital Ouchthorpe Lane Wakefield West Yorkshire WF1 3SP	Kirklees Outreach Team, Ground Floor, Large Mill, St Thomas Road, Huddersfield	HD1 3LT

Summary of findings

RXG10

Fieldhead Hospital
Ouchthorpe Lane Wakefield
West Yorkshire
WF1 3SP

CMHT North Kirklees, 2nd Floor
Beckside Court, 286 Bradford
Road, Batley
WF17 5PW

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

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

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

Summary of findings

Ratings

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

Overall rating for the service

Requires improvement



Are services safe?

Good



Are services effective?

Requires improvement



Are services caring?

Good



Are services responsive?

Requires improvement



Are services well-led?

Good



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

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

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

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

Summary of findings

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Summary of findings

Overall summary

We rated Community Mental Health service for older adults as requires improvement because:

- There were long waiting times from referral to treatment. Access to psychological therapies was limited causing long waiting times in some areas.
- Not all services had a full multidisciplinary team complement.
- It was difficult for staff within teams to ensure records all held the same information as some services used paper and others used computerised systems. In addition, the use of different systems meant there was duplication of work when recording information.
- Some patients' care records did not reflect the involvement of the person and their wishes for care and treatment.
- Trust wide learning events were carried out following incidents however attendance at these was not mandatory.
- There was no crisis service for older people.

However:

- Managers were able to assess required staffing levels and ensure enough staff were available to provide care. Staff knew what their responsibilities were in relation to safeguarding and what they needed to do to keep themselves and patients safe.
- Staff we spoke with understood the Mental Capacity Act and we saw evidence of this put into practice. Best interest meetings were carried out when required and documented in care records. Regular multi-disciplinary team (MDT) meetings were carried out and were used to discuss patients' care and any concerns that may have arisen since the last meeting.
- Staff treated patients and carers with dignity and respect. Appointments were rarely cancelled and patients told us that staff were very accessible. Staff made time to speak with patients and their carers. Patients were encouraged to ask questions and participate in their care and treatment decisions.
- Staff knew about the duty of candour and were aware of the types of incidents that should be reported. Learning events were carried out following incidents and staff were given debriefs and support.

Summary of findings

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

Are services safe?

We rated safe as good because;

- Clinic rooms were clean, tidy and well maintained.
- Staff had caseloads that were within guidelines issued by the Department of Health. This allowed staff to give patients the care required.
- The great majority of care records that we reviewed contained risk assessments that were reviewed regularly.
- Crisis and contingency plans were in place for patients. This meant that if a patients' mental health deteriorated there was a plan on how this could be managed safely with a view to improving their health and preventing unnecessary hospital admissions.
- Staff were confident about raising concerns. Staff knew how to report safeguarding issues and felt supported by managers to do so.

However:

- Staff in Barnsley felt there was a lack of specialised staff within the team. Our inspection team reviewed the specialisms within the Barnsley team and also felt there were significant gaps.
- Trust wide learning events were carried out following incidents however attendance at these was not mandatory.

Good



Are services effective?

We rated effective as requires improvement because;

- Not all services had a full MDT complement.
- It was difficult for staff within teams to ensure records all held the same information as some services used paper and others used computerised systems. In addition, the use of different systems meant there was a duplication of work when recording information.

However;

- Staff received regular supervision and appraisals.
- Comprehensive assessments were carried out and changes to need recorded.
- Capacity assessments were carried out and recorded.

Requires improvement



Are services caring?

We rated caring as good because;

Good



Summary of findings

- Staff spent time talking to patients and listening to what they said.
- Patients and their carers were involved in care and treatment decisions.
- Staff supported carers with wider concerns to ensure their health and wellbeing.
- Assessments of need were carried out and regularly reviewed.

Are services responsive to people's needs?

We rated responsive as requires improvement because;

- Referral to treatment times were long.
- There was no crisis service for older people out of hours.
- Both North Kirklees CMHT and Ossett CMHT average waiting times for treatment exceeded the 18 week national target.
- There was limited access to psychological therapies which caused long waiting times.

However:

- The focus for all teams was assisting patients to remain in the community and reduce admissions to hospital.
- Three of the four teams we inspected were able to quickly respond when patients were in crisis. However, in Barnsley there was a telephone answer machine which referred people to another team where cover was provided by on-call psychiatrists. This meant people in that area may have to wait for a long time before receiving support.
- Staff were aware of cultural differences and took these into account when visiting patients.
- Patients were encouraged to give feedback on the care received.

Requires improvement



Are services well-led?

We rated well-led as good because;

- Staff felt supported by local managers.
- Staff morale was good in teams we visited.
- Staff were encouraged to participate in learning events that would help increase their professional knowledge.

Good



Summary of findings

Information about the service

South West Yorkshire Partnership NHS Foundation Trust provides community mental health services for older people in Barnsley, Kirklees, Calderdale and Wakefield. Staff working in community mental health teams include

psychiatrists, psychologists, occupational therapists and nurses. Referrals are accepted for people who are over 65 years of age that have suspected dementia or mental health problem such as depression and anxiety.

Our inspection team

Our inspection team was led by:

Chair: Peter Jarrett, Retired Medical Director

Head of Hospital Inspection: Jenny Wilkes, CQC

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

Berry Rose, Inspection Manager, community health services, CQC

The team inspecting this core service included one inspector, two specialist advisors one who was a psychiatrist and one who was a registered mental health nurse and one expert by experience.

Why we carried out this inspection

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

How we carried out this inspection

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

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

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

During the inspection visit, the inspection team:

- Visited four different community mental health teams.

- Spoke with 14 patients who were using the service and collected feedback from three comment cards.
- Spoke with relatives of six patients who were receiving care.
- Spoke with the managers or acting managers for three of these services.
- Spoke with 16 other staff members; including one consultant psychiatrist, four support workers and 11 nurses.
- Looked at the care records of 24 patients who used services.
- Attended one clinic.
- Accompanied staff to four home visits.

Summary of findings

What people who use the provider's services say

We spoke with 14 patients and six carers. We observed a clinic attended by patients and accompanied staff on four home visits. All of the patients we spoke with were very positive about the care they received. Patients told us they felt supported and said that staff were available

when they were needed. Carers told us they were encouraged to participate in the planning of their relative's care and staff took time to support them to deal with the medical condition of their relative.

Good practice

Areas for improvement

Action the provider **MUST** take to improve

The trust must ensure they reduce the waiting times from referral to treatment.

The trust must ensure there is access to crisis services for older people.

Action the provider **SHOULD** take to improve

The trust should ensure they involve staff in learning from incidents.

The trust should consider how staff throughout the trust are made aware of lessons learnt following an incident.

South West Yorkshire Partnership NHS Foundation Trust

Community-based mental health services for older people

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
CMHT for older people, Church Street, Darfield, Barnsley	Fieldhead Hospital Ouchthorpe Lane Wakefield WF1 3SP
Ossett Health Centre Older peoples service, New Street, Ossett	Fieldhead Hospital Ouchthorpe Lane Wakefield WF1 3SP
Kirklees Outreach Team, Ground Floor, Large Mill, St Thomas Road, Huddersfield	Fieldhead Hospital Ouchthorpe Lane Wakefield WF1 3SP
CMHT North Kirklees, 2nd Floor Beckside Court, 286 Bradford Road, Batley	Fieldhead Hospital Ouchthorpe Lane Wakefield WF1 3SP

Detailed findings

Mental Health Act responsibilities

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

South West Yorkshire Partnership NHS Foundation Trust do not routinely capture compliance information around MHA training, as this was not currently identified as mandatory. However, staff working in the teams we visited had participated in mental health legislation update training.

At the time of our inspection only one of the locations inspected had patients being treated under a Community

Treatment Order (CTO). A CTO was a legal order which sets out the terms under which a person must accept treatment whilst living in the community. We reviewed the records of a patient who was receiving treatment under a CTO and found all the required paperwork was present.

Information on advocacy services was available at all locations we visited, and staff we spoke with were aware of how to support patients to access advocacy.

Mental Capacity Act and Deprivation of Liberty Safeguards

South West Yorkshire Partnership do not routinely record how many staff have received recent training in the Mental Capacity Act (MCA) training, as this was not currently identified as mandatory. However, managers at the locations we visited kept their own records and were able to show that their staff had undertaken training in MCA.

Staff we spoke with understood the Act sufficiently to put it into practice. We saw evidence of written consent to treatment in all but one of the records we looked at. Where services used only computer records we found written

consent had been scanned and saved in the person's care record. Verbal consent was regularly recorded on patients' care records. Mental capacity assessments were recorded and capacity was assessed continually. We found evidence of best interest meeting in patients' care records.

Managers we spoke with told us they carried out audits to check the care records of patients were completed properly. We did not see these audits, however staff we spoke with confirmed they were carried out.

Are services safe?

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

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

Our findings

Safe and clean environment

Although three of the community mental health services had clinic rooms, patients were not expected to attend these sites. We looked at the clinic rooms in these locations and found them all to be clean tidy and well maintained.

There were appropriate infection control procedures in place and staff were aware of the steps they should take to reduce the risk of infection. Clinic rooms were not used for carrying out physical examinations as these were conducted by the patient's GP under shared care protocols.

Offices for community teams were situated in buildings throughout the trust. Patients were usually seen in their own homes. Where patients attended the offices of community teams, we saw there were alarms in interview rooms or staff had personal attack alarms which could protect them from the risk of personal attack. We found all locations had business continuity plans in place which would allow them to continue to care for patients if there was an emergency.

Safe staffing

The community mental health teams had not used a particular model on which to base their staffing levels and all were broadly based around the needs of patients under their care. However, the Kirklees Outreach Team was piloting a rota based on need and this was being evaluated to test its effectiveness.

The community mental health team (CMHT) in Ossett was partially funded by the local authority and were working to service level agreements, with some adjustments to accommodate patient need.

North Kirklees CMHT was changing to a new structure and their staffing levels had just been changed to reflect this. This change would have a positive impact on staffing levels and patient needs.

CMHT Barnsley had 12.9 whole time equivalent (WTE) staff, Kirklees Outreach Team had 15.6 WTE. North Kirklees CMHT had 13.8 WTE staff but this was to change the week after

our inspection due to the change in structure. CMHT Ossett had 4.8 WTE staff. None of the figures included staff from other disciplines, for example psychiatrists and occupational therapists.

Some of the staff we spoke with expressed concerns about the lack of specialist staff in the Barnsley team and reducing medical input within teams. We were told that there was a lack of psychologists and occupational therapists which some staff felt was unsafe. Our inspection team reviewed the specialisms within the Barnsley team and also felt there were significant gaps. Access to psychologists is an essential requirement and the lack of these specialists meant longer waiting times and the possibility of patients health deteriorating as a result.

None of the four teams we visited used agency staff and when bank staff were used they were well known to the teams and had relevant experience. North Kirklees CMHT had a high level of sickness over the previous 12 months at 19.8% due to five staff members being off sick. The national NHS average was 4.7% by comparison.

Caseload numbers varied across the four teams depending on patient need and level of complexity. None of the staff we spoke with had concerns about the number of patients they had on their individual caseload. Department of health guidelines for community mental health teams recommend a maximum caseload of 35 per whole time equivalent. None of the staff we spoke with had a caseload that was above this number. The manager in each team reviewed caseloads during supervision.

All the services we visited had a psychiatrist attached to the team. There was an on call psychiatrist available for out of hours provision. Staff and patients told us there was good access to psychiatry.

The trust had a core programme for mandatory training which included safeguarding adults, safeguarding children, equality, diversity and human rights, information governance and hand hygiene. The trust did not however include the Mental Health Act (MHA) or the Mental Capacity Act (MCA). The compliance rate for mandatory training was high for all the services we visited. CHMT Ossett recorded the highest with 96% and Kirklees Outreach Team the lowest with 89%. The trust target was 80%.

Are services safe?

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

Assessing and managing risk to patients and staff

We reviewed the care records of 24 patients and found each had a risk assessment and risk management plan in place. These were completed at the start of the patient's involvement with the community teams and were part of the initial assessment process.

Risk assessments were regularly reviewed in most cases. However one of the care records we looked at showed the risk assessment was due to be reviewed in May 2015 and this had still not been done at the time of our inspection. Another record showed a risk assessment which should have been reviewed in February 2016 had not been done.

Care records contained crisis and contingency plans. Copies of these plans were shared with patient's carers. They were used to help carers know what to do in a crisis situation. Staff knew how to respond if there was a sudden deterioration in the health of patients. All of the patients who used services had a 24 hour contact telephone number where they were able to get help.

Staff were aware of their responsibilities in relation to safeguarding patients. All four of the teams we visited had achieved compliance with mandatory training, which included safeguarding.

Each community mental health team covered a particular geographical area some of which included outlying communities. Staff in these teams followed the trust's lone working policy with some teams developing their own protocols, which ran alongside the policy to ensure staff safety. For example some teams used white boards or had a code word which was used to alert office staff when they may be at risk. In addition, if there were concerns about a person who used the service or there was a known risk, staff would work in pairs. All the staff we spoke with told us they felt safe at work.

There had been no safeguarding alerts or concerns relating to any of the community mental health teams between 1 January 2015 and 31 December 2015.

Track record on safety

There were ten recorded serious incidents between 30 June 2014 and 19 September 2015. Five of these incidents were unexpected deaths of patients. The remaining five were related to patients inflicting harm on themselves. We did not review the investigations which related to these incidents. We did not see any evidence that learning events were carried out following these incidents.

Reporting incidents and learning from when things go wrong

Staff we spoke with told us they felt confident about reporting incidents. Staff were aware of what they should report and told us the trust carried out investigations of incidents.

Following incidents the trust had learning events which were used to share lessons learnt from incidents. Managers we spoke with told us attendance at these events was not mandatory. However managers did tell us they fed back during meetings and staff supervisions. We saw minutes of staff meetings showed incidents had been discussed. It was not clear if discussions held included incidents that occurred throughout the trust or if it just related to the area in which they worked.

Staff we spoke with told us they had de-briefs and were fully supported following incidents. Staff were aware of the duty of candour and knew the importance of being open and honest if things went wrong. We saw records that documented things that had been recorded as part of the duty of candour.

Are services effective?

Requires improvement 

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

Our findings

Assessment of needs and planning of care

Staff working in community teams completed comprehensive assessments of each person who used the service's needs. Letters relating to patient assessments were sent to their GP. We found assessments of need were reviewed if patient needs changed and also when patients were discharged and subsequently re-referred.

We looked at the care records of 24 patients. We found 17 care records were personalised. The other seven records did not reflect what the individuals said about their care.

We found all but one of the 24 records were holistic and recovery focussed. Recovery focussed means helping patients to be in control of their lives and build their resilience to avoid admission to hospital. Without exception all of the patients we spoke with told us they were involved with planning their care and all but two told us they had a copy of their care plan.

The trust used an electronic records system (RIO) however some locations were still using paper records and others were in transition. At Ossett CMHT staff used two different computer systems which weren't compatible with each other. This was because there was a partnership between the trust and the local authority and meant the same information had to be entered twice. At Barnsley CMHT staff were using computerised records but still had paper records because not all information had been transferred. One of the records we looked at on RIO had several pieces of information missing however when we asked to see the paper record we were told it was at a different location that did not have access to RIO. This meant we were unable to check appropriate documentation was present and meant the information contained would not match.

Three of the services we visited used computerised records with the fourth using a combination of paper and computerised records. Computerised records could only be accessed by staff with the appropriate authority. Access to records was monitored to ensure records were kept secure.

The community mental health team in Barnsley kept paper records in a locked room to ensure they were secure.

Best practice in treatment and care

Staff and managers we spoke with told us they followed guidance issued by the National Institute for Health and Care Excellence (NICE) in relation to mental health. This included cognitive behavioural therapy (CBT), suicide prevention and psychological therapies.

All the teams worked closely with GPs in the area. Psychiatrists prescribed appropriate medication and GPs were able to manage repeat prescriptions. If a patient was prescribed anti-psychotic medication regular physical health checks were required. Staff were required to liaise with GP surgeries to ensure these were carried out and to ensure results of tests were known. This was important as results may mean a change in medication was required. We saw evidence of changes being made following health checks being carried out.

Information provided by the trust gave details of audits which had been carried out in relation to services. These audits covered the whole of the trust and not just the services we inspected. The audits that had been carried out are listed below;

- Clozapine Monitoring in the Community (presentation).
- Annual Health and Safety monitoring Audit report – 2014/15 (trust wide results)
- Trust mental health services clinical record keeping audit – summary report – May 2015.
- SWYPFT – Bed Management Report – March 2015.
- SWYPFT – Leadership Development Report – July 2015.
- SWYPFT – Performance Indicators Report – September 2015 (Draft)
- SWYPFT – Transformation Report – September 2015.

Managers told us clinical staff were actively engaged in clinical audits through supervision, MDTs and in line with the trust policy on clinical audits.

Skilled staff to deliver care

Staff told us they had received an appraisal in the last 12 months. The trust also provided information regarding appraisals which confirmed what staff had told us. 100% of non-medical staff had an appraisal carried out at 29 February 2016.

Are services effective?

Requires improvement 

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

All staff had managerial and clinical supervision. Managers told us staff at all the locations we visited had regular supervision sessions with all having 12 per year. This was confirmed by staff we spoke with.

The team at Ossett consisted of social workers, support workers, consultant psychiatrist, trainee psychiatrist, clinical psychologist, two approved mental health professionals, admin support and a care home liaison worker as well as the nursing staff. The other two teams had admin support, psychiatrists and nursing staff although they were able to access other support when needed.

Staff had access to specialist training. Some staff had completed training in CBT and psychological therapies to help them carry out their roles. Other staff had participated in the practice development unit accreditation through Leeds University. All staff had also carried out mandatory training which related directly to their roles and included aggression management caring approach, de-escalation and physical intervention.

Multi-disciplinary and inter-agency team work

Services worked together to ensure the care patients received met their needs. Members of each team varied.

We observed a multi-disciplinary meeting at CMHT Barnsley during our inspection. The meeting was attended by a psychiatrist, social worker, community psychiatric nurse, a student nurse, a support worker and two of the nurses attached to the team. During the meeting staff discussed a number of issues including, medication and side effects, access to memory clinics, vulnerable adults safeguarding and anxiety management.

Staff from all teams worked with staff and patients in hospital wards. Staff spent time working with patients before being discharged from hospital. Assessments were carried out and plans for care were formulated to ensure patients received consistent and coordinated care.

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

Staff and managers of all the teams we visited told us that they had received training in the MHA. The manager of the CMHT at Ossett Health Centre told us the local authority

considered the need for training in MHA as mandatory. Managers of the other teams ensured that staff were trained as they felt it was necessary knowledge and staff confirmed this.

At the time of our inspection there was one person using the service that was on a Community Treatment Order (CTO). A CTO was a legal order which sets out the terms under which a person must accept treatment whilst living in the community. We reviewed the care records of the person on CTO and found all the necessary paperwork was completed and present.

All the teams we visited had advocacy information available for patients, and all staff we spoke with were aware of how to support patients to access these services.

Good practice in applying the Mental Capacity Act

Staff based at Ossett Health Centre had undertaken MCA training as part of the local authority's mandatory requirements. Staff in other teams had undertaken the training as managers of these teams felt it necessary in order to fulfil their roles.

Staff we spoke with showed a good understanding of the MCA. Where required we found capacity assessments for patients who used the service were recorded in care records. Staff we spoke with knew how to get specialist advice and were aware of who to contact to arrange best interest meetings. We saw evidence of best interest meetings and of capacity assessment reviews in care records.

We observed a best interest decision meeting taking place in relation to a person who was reluctant to attend services. The MDT considered the persons wishes and feelings and decided on a course of action in the person best interests.

Managers told us they carried out audits of care records which included checking the recording of capacity and best interests.

We reviewed the recording of consent in 20 care records. All the records we reviewed contained evidence of informed consent to treatment and interventions. We saw evidence of verbal consent being obtained during assessments and staff appointments with patients.

Are services caring?

Good 

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

Our findings

Kindness, dignity, respect and support

We spent time observing a clinic and accompanied staff on four home visits. We saw that interactions between staff and patients were positive. Staff were caring, kind and courteous to both patients and their carers.

Staff spent time listening to patients and their carers, treating them with respect and allowing them time to ask and respond to questions. Patients we spoke with told us they were involved in their care and felt supported. One of the patients we spoke with told us, “They never make me feel that they are rushing or wanting to go.” Another person told us, “They helped me to understand what was happening to me and she gave me some books to read and also talked to me on a one to one.”

During the clinic we observed the doctor undertake a review of the holistic needs of the person who used the service. The doctor discussed the person’s physical health, home life, sleep, diet and mood. There were also discussions around medication and changes the doctor wanted to make. We saw the doctor explained the risks involved with changing medication and asked permission to notify the GP of the outcome of the appointment.

Throughout our observations it was clear that staff knew the patients in their care. This was reflected in the feedback we received. One of the patients told us, “The doctor is very easy to talk to. He listens to me and remembers me.”

The involvement of people in the care that they receive

During our interviews with patients all but one told us they were involved in the planning of their care. Patients told us staff discussed their care and treatment with them and they felt involved in their treatment.

Staff carried out an assessment of patient needs when they first started using the service and we saw this was regularly reviewed as patient needs and illness changed. During clinic observations and home visits we saw staff checking with carers and supporting them. We witnessed the clinic doctor asking a carer how they felt and discussing carers support services that were available to them. One person told us, “As a carer I am encouraged to be involved in treatment options.” All the carers we spoke with told us staff helped them, providing emotional support and signposted them to people who could assist with more practical support like benefits entitlement.

Are services responsive to people's needs?

Requires improvement 

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

Our findings

Access and discharge

All CMHT services focussed on assisting patients to remain in the community and reducing admission to hospital where possible. We were told by managers in all the teams they were able to see patients for an initial assessment very quickly and there was no waiting list and people were usually seen within two days of a referral being received. However, figures provided by the trust (shown below) contradict this.

All teams had a staff member taking calls for triage and where necessary patients would be seen as an emergency within twelve hours.

Out of hours cover varied with patients in Barnsley being given a telephone number which went through to an answer phone and referred them on to another number. In this area cover was provided by on-call psychiatrists who were linked to local hospitals. This meant patients may have to wait to be seen and there was no consistency of care. In other areas patients got assistance from NHS duty teams. This meant that out of hours cover was not always provided by staff with specialist knowledge and experience.

In North Kirklees CMHT a single point of access team was in place. There were on call staff available for patients who needed to be seen urgently however, these staff were not always members of CMHTs meaning consistency of care or knowledge of staff may be an issue.

There was no crisis service available for older adults within the community and this posed a serious risk to patients. None of the services had exclusion criteria based on age although we did see one case where a person was moved to a different team when they reached retirement age. When we asked about this we were told that it was a coincidence that a change in needs had been at the same time as changing age.

Teams would accept referrals for people who were presenting with mental health problems that may pose a risk and require urgent care, intensive support, assessment or treatment.

We spoke with patients and their carers who told us that teams responded quickly when they contacted them and

would return calls on the same day. During normal working hours patients who contacted the teams because of deterioration in their condition would usually have a response within four hours or at least that day.

The majority of appointments for all teams took place in patients' homes. Patients we spoke with told us appointments were rarely cancelled, and if appointments were cancelled they would receive a call explaining the reason and offering another appointment or another member of the team.

Referral to Treatment Times

The trust provided us with information about patient waiting times which included information about other teams. This information is shown in the table below.

Waiting times for older peoples services varied greatly by region. The average waiting time from referral to treatment for older peoples services is as follows;

- Barnsley CMHT 65 days
- Kirklees outreach team 4 days
- North Kirklees CMHT 158 days
- Ossett CMHT 133 days

These figures show that two of the four locations we visited as part of our inspection are not meeting national targets which are 18 weeks (126 days).

All the teams we visited had access to psychological therapies for patients, however availability and access varied. Figures provided by the trust showed the average wait for psychological therapies in some areas were well above others and this was not directly linked to the number of referrals. The details below show the average wait from assessment to treatment between 1 March 2015 to 29 February 2016;

- Barnsley CMHT 44 days
- Kirklees outreach team 2 days
- North Kirklees CMHT 80 days
- Ossett CMHT 77 days
- Priestly OPS Treatment team 683 days (we did not visit this location as part of our inspection)

Although we did not visit the Priestly Older Peoples Service Treatment Team, we felt it important to include these

Are services responsive to people's needs?

Requires improvement



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

figures as the waiting time shown exceeds the 18 week referral to treatment time expected within the NHS. There had been only two referrals to the Priestly team during the period mentioned.

Managers at North Kirklees CMHT told us some staff in their team had training in CBT and psychological therapies and these were provided to patients while they were waiting for their treatment to start. All the patients who were receiving this support were closely monitored.

The facilities promote recovery, comfort, dignity and confidentiality

Community health teams had access to interview rooms on site. In Barnsley staff reported the building to have a leaking roof, the building was old and in need of decoration. This had been reported but repairs had not been carried out at the time of our inspection. These problems did not impact on patient care. Kirklees Outreach Team was difficult to locate as the building was part of a site which also housed a bingo hall. There was no signage to direct people from the car park to the building. However, visitors to the site are usually provided with a map to help them locate the service.

All the teams had information about services and packs were provided to patients giving them details about where they could get help and who to speak to in a crisis.

Meeting the needs of all people who use the service

All the locations we visited were accessible by people with a disability. Lifts were available for people who had mobility problems. Staff who worked with patients with communication difficulties looked for non-verbal cues and

would speak with patient families. Staff also spent time speaking with others who knew patients well or were involved in patient's care, such as care home staff, in order to understand how best to communicate with individuals.

Although we did not see information leaflets in other formats, such as large print or other languages staff were able to tell how these could be accessed if required. Staff were able to access interpreters if required with some of the services having staff who were able to speak other languages.

Staff were aware of cultural differences and these were taken in to account when arranging support for patients. For example not sending a male to visit a Muslim woman. One manager was able to give an example of how knowledge of different cultures had been useful recently.

Listening to and learning from concerns and complaints

Only one of the teams we visited had received any formal complaints in the last 12 months. There had been one complaint received by Ossett CMHT and this had been upheld. Managers at all locations confirmed patients were given a leaflet which gave them information on how to make a complaint. All the patients we spoke to told us they would be confident to make a complaint. Managers told us they dealt with informal complaints but would always offer to send complaints to trust headquarters if they felt it was required or if that was what patients wanted.

Patients we spoke with told us they were encouraged to give feedback about the service they received. One person we spoke with told us they had given feedback about an aspect of care they weren't happy about and as a result changes were made. Managers told us patients were sent a questionnaire when they were discharged. Questionnaires were sent to the trust headquarters to be reviewed.

Are services well-led?

Good 

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

Our findings

Vision and values

Staff we spoke with told us they knew who the senior managers in the trust were. However, staff were not clear when or if senior managers had visited individual teams. All of the staff spoke very highly of local managers; all felt supported and said they would be able to speak to their manager if they had any concerns.

All the locations we visited had the trust vision and values displayed. The trust vision, 'Enabling people to reach their potential and live well in their community' was clear as staff we spoke with told us their aim was to reduce admission to hospital and to help patients stay in their homes.

Although staff couldn't remember all of the trust's values they were able to tell us some. The values were;

- Honest, open and transparent.
- Person first and in the centre.
- Improve and be outstanding.
- Relevant today, ready for tomorrow.
- Families and carers matter.

From speaking with staff and observing care we saw staff at all locations were working in line with the vision and values of the trust. Staff displayed a caring manner and demonstrated with support provided that families and carers were valued.

All patients and their carers told us that staff were respectful and we saw evidence of honest and open communication.

Good governance

Staff were able to access mandatory training, some of which was available via eLearning. Some staff reported having to travel long distances for training sessions.

Local managers had managed the staff skill mix to ensure there was sufficient staff to ensure good quality care and treatment. There was enough staff in post to ensure cover in the event of holidays or unexpected illness. Local managers told us they felt they had sufficient authority and administrative support.

Staff we spoke with had a good understanding of the types of incidents and events that had to be reported. Team meetings included regular discussion of safeguarding, safety and governance issues. If incidents occurred team meetings were used to discuss lessons learnt. Staff had a good understanding of safeguarding procedures and there was evidence of the application of the MCA in practice.

When we spoke with managers about key performance indicators (KPI) they told us they did not work to KPIs. However, managers were able to tell us about targets for seeing patients.

Managers at the locations told us they were able to submit items to the trust risk register however, these needed to be reviewed by their managers.

Leadership, morale and staff engagement

Staff morale was high across all the teams we visited. Staff felt supported by their managers and felt they would be supported to deal with any concerns they may have.

The CMHT at Barnsley had a temporary manager in post that was also responsible for managing another service. North Kirklees had two managers in post who worked together to ensure patients were able to access support and staff were available for visits. Managers at North Kirklees also told us staff sickness levels had been high but this had improved greatly.

All the staff we spoke with were aware of the duty of candour toward patients and their carers, if something went wrong.

Commitment to quality improvement and innovation

Staff at the North Kirklees CMHT told us about changes that were to be made to the service. Managers told us they were moving to a model that would ensure care closer to home. Staff required were in post and would be based in two separate locations each providing care locally.

Some of the staff we spoke with told us they had been encouraged to participate in the practice development unit accreditation through Leeds University. This was a programme to help staff meet the changes implemented in the NHS modernisation agenda.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity

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

Patients were not able to access services in a timely manner.

Referral to treatment times exceeded the 18 week target.

This is a breach of regulation 9(1)(b)