

South West Yorkshire Partnership NHS Foundation
Trust

Specialist community mental health services for children and young people

Quality Report

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Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/unit/team)	Postcode of service (ward/unit/team)
RXG10	Fieldhead Hospital	Calderdale and Kirklees community child and adolescent mental health services	HX1 1YR
RXG10	Fieldhead Hospital	Barnsley community child and adolescent mental health services	S70 1LP

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.

Summary of findings

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

Summary of findings

Ratings

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

Overall rating for the service

Good 

Are services safe?

Good 

Are services effective?

Good 

Are services caring?

Good 

Are services responsive?

Requires improvement 

Are services well-led?

Good 

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

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

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

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

Summary of findings

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Summary of findings

Overall summary

We have rated specialist community mental health services for children and young people as **good** overall because:

- Following our inspection in March 2016, we rated the services as good for effective and caring.
- During this most recent inspection, we found that the services had addressed the issues that had caused us to rate safe and well led as requires improvement following the March 2016 inspection. As a result, the service was now meeting the requirements of Regulations 12 and 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014.
- The service had introduced a process to help manage risks of young people on the waiting list. This had also helped to reduce waiting times within some teams. Staff had reviewed, and started to implement, new ways of working in order to try to make the service more appropriate for young people requiring support and treatment.

- Improvements had been made to the quality of information in records by way of additional and bespoke training for staff. Records 'champions' were in place at each team and staff reported that quality of data recording had improved.
- The service had taken action to improve and strengthen lone working practices by way of extra training. Staff had also taken action to review and improve the storage of prescription charts and to improve staff training compliance in basic life support.

However

- Although waiting times for treatment for young people had improved in Calderdale and Kirklees, and Wakefield, there were still significant delays within the Barnsley team with some young people waiting over 22 months. There were long waits across all teams for young people waiting to be assessed for autistic spectrum disorder and related conditions.

Summary of findings

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

Are services safe?

We rated safe as good because:

- Staff had devised a new process to review risks relating to young people on the waiting list and to respond to any changes in risk.
- The provider had reviewed their lone working practices and provided further training for staff to ensure they adhered to the trust guidelines.
- Training compliance for staff in basic life support had improved since our last inspection.

Good



Are services effective?

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

Good



Are services caring?

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

Good



Are services responsive to people's needs?

We rated responsive as requires improvement because:

- None of the teams were meeting the trust target for referral times. Although wait times for treatment for young people had improved in Calderdale and Kirklees, and Wakefield, there were still significant delays within the Barnsley team.
- All teams had lengthy waiting lists for young people waiting to be assessed for autistic spectrum disorder related conditions.

However:

- Staff had reviewed working practices and pathways across the service to try to streamline the service and help ensure young people had access to the most appropriate treatment for their needs.

Requires improvement



Are services well-led?

We rated well led as good because:

- Staff had reviewed and made changes to working practices within the service, for example, streamlining pathways to make these more meaningful and appropriate for young people.

Good



Summary of findings

- Staff at the service had undertaken records training and had access to 'champions' within the team who could provide further bespoke support. This had improved the accuracy of the data that staff used and enabled managers to review demand within the service

However

- As the new working practices were recent, there had not yet been any formal review or audits to assess these so there was little information about their effectiveness and also their sustainability.

Summary of findings

Information about the service

South West Yorkshire NHS Partnership Foundation Trust has four community child and adolescent mental health services which are provided across three districts. These are Barnsley, Wakefield and Calderdale, and Kirklees.

At the time of our inspection, the services operated from four sites, one in Calderdale and Kirklees, one in Barnsley and two in Wakefield. During our inspection, the two Wakefield sites were merging into one existing location within Wakefield. A general manager covered both Wakefield and Calderdale and Kirklees services. The Barnsley service had its own general manager.

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.

The trust also provides tier 2 services in Wakefield and Barnsley. Tier 2 provision at Calderdale and Kirklees is provided by a separate voluntary 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.

Our inspection team

Our inspection team was led by:

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

The inspection team consisted of one Care Quality Commission inspector from the mental health directorate.

Why we carried out this inspection

We undertook this inspection to find out whether South West Yorkshire Partnership NHS Foundation Trust had made improvements to their specialist community mental health services for children and young people since our last comprehensive inspection of the trust on 7 March 2016.

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

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

- The trust must take action to improve the overall waiting time for young people accessing treatment.

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

We issued the trust with two requirement notices for specialist community mental health services for children and young people. These related to:

- Regulation 12 HSCA (RA) Regulations 2014: Safe care and treatment
- Regulation 17 HSCA (RA) Regulations 2014: Good governance

Summary of findings

We also advised the trust about areas where they should consider taking further action to improve the service, however these issues did not constitute a breach of regulations. These were as follows:

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

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. This information suggested that the ratings of 'good' for effective and caring that we made following our March 2016 inspection were still valid. Therefore, during this inspection, we focused on those issues that had caused us to rate the service as 'requires improvement' for safe, responsive and well led.

We announced our inspection by giving a short notice period of 48 hours. This was so that the trust could make arrangements for necessary staff to be present to speak with us.

During the inspection visit, we:

- visited the Calderdale and Kirklees and the Barnsley community child and adolescent mental health services
- spoke with the deputy director of child and adolescent mental health services
- spoke with the two general managers who cover the four community child and adolescent mental health services.
- spoke with two practice governance coaches
- spoke with five other professionals including clinicians and therapists
- looked at a range of documentation related to the running of the service

What people who use the provider's services say

At this inspection we did not speak with any people using the service. Our findings from people during our last inspection remain relevant.

Summary of findings

Areas for improvement

Action the provider **MUST** take to improve

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

Action the provider **SHOULD** take to improve

- The trust should ensure they review new working processes so that the systems they have introduced and implemented are effective.
- The trust should ensure the service continues to improve staff compliance with basic life support training.

South West Yorkshire Partnership NHS Foundation Trust

Specialist community mental health services for children and young people

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Calderdale and Kirklees community child and adolescent mental health services	Fieldhead Hospital
Barnsley community child and adolescent mental health services	Fieldhead Hospital

Mental Health Act responsibilities

We did not review this area during this inspection. Our findings in relation to the Mental Health Act from our March 2016 inspection remain relevant.

Mental Capacity Act and Deprivation of Liberty Safeguards

We did not review this area during this inspection. Our findings in relation to the Mental Capacity Act from our March 2016 inspection remain relevant.

Are services safe?

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

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

Our findings

Assessing and managing risk to patients and staff

At our last inspection in March 2016 we found that processes to monitor people on waiting lists for assessment and treatment were not robust. This was because staff did not routinely and proactively monitor people on the waiting list in order to determine any changes in risk factors.

We reviewed what action the trust had taken to address this and discussed these measures with staff. Since our last inspection, teams had undertaken work to review young people who had been on waiting lists the longest amounts of time. This included the service sending opt in letters and telephone contacts to those waiting. We looked at an example of two records of Wakefield cases where staff had used this method and saw that the staff member making contact had updated the records with details of what action they had taken. A flow chart had been developed by staff at the Barnsley service to support this process. This included timescales for initiating contact and actions staff should take. Practitioners contacted young people on the waiting list to assess whether there had been any changes and whether they still required a service. They prioritised people who had been waiting the longest and who had no contact with the service within the previous three months. Dependent on any changes to the young person's risk levels, staff could then refer the young person for urgent allocation, signpost them elsewhere or pass on to the crisis team if this was deemed necessary.

The managers told us this process would be carried out regularly where people had been waiting three months or over. This meant that people could expect some contact from the service which would help inform professionals as to the young person's needs and risk levels and help manage these earlier.

At our last inspection we found that not all staff were following lone worker arrangements as they were not using the personal safety device that they had been issued by the trust. Since then, the lone working policy had been reviewed and sent out to all staff to embed understanding. Lone working training had been provided to staff and they were only able to access and use lone working devices on completion of their training and when they could demonstrate competence. Current lone working training compliance within the teams were as follows; Barnsley 88%, Calderdale and Kirklees - 96% and Wakefield - 100%

We also identified some concerns with the storage of FP10 prescription charts at our last inspection. FP10 charts are purchased by NHS organisations and used by authorised clinical staff to issue prescriptions to patients, who then present them at a community pharmacy. Following this, we saw that a clinician had taken a lead on reviewing and auditing storage practices of FP10 prescription chart to ensure staff followed appropriate guidance. This had involved a review of all clinicians' practice regarding the prescriptions.

We also identified in March 2016 that training compliance in basic life support was low for staff within the service and recommended the service should improve this. The percentages of staff trained for each team at that time were; Barnsley 12%, Calderdale and Kirklees 31% and Wakefield 47%. Managers told us that the low figures were in large part due to the fact that this training had only become mandatory a short time prior to our last inspection. Since that time, further staff had completed this training and current compliance levels had increased as follows; Barnsley 54%, Calderdale and Kirklees 61% and Wakefield 73%. Additional training was booked in for staff who were yet to complete this.

Are services effective?

Good 

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

Our findings

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

Are services caring?

Good 

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

Our findings

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

Are services responsive to people's needs?

Requires improvement 

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

Our findings

Access and discharge

At our last inspection in March 2016, we found that young people were on waiting lists for long periods of time. The trust target from referral to initial assessment was 35 days. The trust provided details regarding the length of time people were waiting for an initial assessment between April and November 2016. The average waiting time for each district was as follows:

- Barnsley: 57 days; (Last inspection, figures from April 2015 to January 2016: 66 days)
- Calderdale and Kirklees: 36 days; (Last inspection, figures from April 2015 to January 2016: 24 days)
- Wakefield: average wait 61 days; (Last inspection, figures from April 2015 to January 2016: 41 days)

Following our inspection, the trust provided subsequent updated waiting time information which covered the time period from June 2016 to December 2016. These were as follows:

- Barnsley: 22 days
- Calderdale and Kirklees: 35 days
- Wakefield: 58 days

The trust advised that some wait times could be explained by parental choice, for example, where parents may choose to delay the appointment which could lead to extended waits in some cases. The updated figures showed that Calderdale and Kirklees, and Barnsley were within trust target. All teams' initial wait times showed an increase from our last inspection which meant further improvements were required in order to meet the target.

The trust also provided data regarding the length of time young people were waiting to start treatment following assessment for young people on waiting lists between April and November 2016. There was no trust target for the waiting time for treatment:

- Barnsley: average wait 254 days; longest wait 691 days

(Last inspection, figures from April 2015 to January 2016: average wait 146 days; longest wait 594 days)

- Calderdale and Kirklees average wait 107 days longest wait 147 days

(Last inspection, figures from April 2015 to January 2016: average wait 140 days; longest wait 896 days)

- Wakefield average wait 142 days longest wait 299 days

(Last inspection, figures from April 2015 to January 2016: average wait 187 days; longest wait 913 days)

Following our inspection, the trust provided subsequent updated waiting times for young people to start treatment following assessment which covered the time period from June 2016 to December 2016. These were as follows:

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

Since our last inspection, Calderdale and Kirklees and Wakefield teams had reduced their average wait times and had achieved a significant reduction in their longest wait times. Barnsley team showed an increase in both average waits and longest wait time. This showed that further improvements were still required in order to make waiting times equitable for all young people requiring the service.

The assistant director and managers told us waiting lists had built up over periods of time. Staff told us about various initiatives to try to target these. For example, the manager at Barnsley where waits were longest told us they were looking at possible group work sessions where young people may be suitable for these. Additional training had been provided to staff to deliver certain therapies. The greatest impact on waiting list reduction had been at Calderdale and Kirklees. The manager and staff said this was due to the model of the 'single point of access team', which operated as a tier two service, and which had been strengthened by additional funding. Barnsley and Wakefield teams were in the process of further strengthening and embedding their tier two systems to try to reduce longer wait times in these areas.

Managers and staff spoke about the importance and benefits of having a robust tier two service in place. Calderdale and Kirklees staff said it meant that referrals via the single point of access could be effectively screened and streamlined prior to entering the tier three system. The intention was that young people could be allocated straight into pathways to wait for appropriate treatment, as opposed to having additional waits for first assessment.

Are services responsive to people's needs?

Requires improvement 

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

The service was trying to replicate this in Wakefield and Barnsley so they could be more timely and responsive to young people's needs where they required tier three intervention. In the Barnsley service, staff absences in the tier two service had impacted upon capacity and therefore availability and accessibility of the service which in turn impacted upon wait times. There were plans in place to address this via additional staffing resources.

Referrals for young people to be assessed for autistic spectrum disorders were held separate to the general waiting lists. The trust provided waiting time data for these referrals as at November 2016 which were as follows:

- Calderdale and Kirklees: - longest wait 853 days
- Wakefield: - longest wait 399 days
- Barnsley: - longest wait 594 days

Following our inspection, the trust provided subsequent updated waiting times as at 31 December 2016. These were as follows:

- Calderdale and Kirklees: longest wait 884 days
- Wakefield: longest wait 398 days
- Barnsley: longest wait 592 days

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

Since our last inspection, staff had undertaken work reviewing the different treatment pathways into the service and produced flowcharts to help achieve consistency for young people accessing the service. These provided guidance and information about a young person's transition through the service from referral to completion of treatment. The aim was to standardise services and improve access, and subsequently wait times, for young people by ensuring they met the necessary criteria for the treatment. They also helped staff to signpost young people on to other appropriate support where they did not.

Are services well-led?

Good 

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

Our findings

Good governance

At our last inspection we informed the trust that the service must ensure audits were undertaken to ensure new systems and ways of working became embedded in practice and that quality standards were being followed. At this inspection, we spoke with staff about various audits that had taken place or were in the process of being undertaken to monitor different aspects of service performance.

The service undertook annual audits of care records as part of the trust wide audit program. These were due to commence in the two weeks following our inspection. Managers told us that the outcome of audits would then be used to identify and address any areas for improvement.

Managers had also taken action to implement and monitor the lone working procedures which staff were required to follow. Further training had been rolled out for staff and once all training had been completed, there were plans to audit effectiveness of lone working practices. This was due to take place early in 2017.

Clinicians told us that if they wanted to undertake audits to review service delivery or to improve and develop services, they were encouraged to do so. They gave examples of how they used audits to review new processes and to gain experiences of people using the service. For example, one audit underway at the time of our visit was to obtain the experiences and views of young people on the waiting lists. Staff also talked about initiatives they were using to try to improve quality standards in other ways. The Barnsley service had recently held an open day for families to attend and meet professionals involved with the service. Staff told us that feedback from families was that it had been helpful, and given them a greater understanding of the different support networks. The service was looking at other ways to facilitate future events, such as holding these in various community locations.

Governance meetings took place every three months between the teams. This was also used as a forum to share information, working practices and new processes which

may be beneficial to the other teams. One example of good practice which was shared amongst the teams was the waiting list risk assessment chart that Barnsley staff had developed.

The service used an electronic records system to document information relating to referrals and people's care plans, risk assessments and other relevant documentation. At our last inspection, we identified some shortfalls where risk information had not been fully completed where required on the system. We also had some concerns around governance because the service had experienced a number of incidents concerning breaches of confidentiality

Since our last inspection, the service had provided mandatory training to staff about how to use the computer system and the expectations of what information staff should record and for what purpose. Each service had records 'champions' in place who took a lead on the electronic records system and were accessible to staff to provide further individual training and support. Staff told us about bespoke training that had been delivered by the champions. We spoke with one clinician who was a records 'champion' and had produced some training slides that they had shared with their team. They told us, and staff agreed that it was useful that a clinician had produced the training as they understood the remit and necessity of what information they needed to input and retrieve. All staff we spoke with were positive about the training and felt confident that records and data had improved which helped to ensure information was correctly recorded. As a result, the service was able to identify numbers of people on waiting lists and numbers on team caseloads which they were not able to readily obtain at our previous inspection.

A newsletter had also been introduced to share information to all staff across the service. We saw a copy of the latest one which included details about upcoming audits and initiatives being implemented across the teams. Managers and staff told us there was a changing culture to empower clinicians to put forward ideas and share practice. Clinicians took turns to chair team meetings to help foster the culture of involvement in influencing the service.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	<p>Regulation 9 HSCA (RA) Regulations 2014 Person-centred care</p> <p>How the regulation was not being met:</p> <p>People requiring the service were not always receiving the support and treatment to meet their needs.</p> <p>Waiting times for treatment in the Barnsley team were still lengthy for some young people who had accessed the service.</p> <p>All three teams had lengthy waits for young people requiring assessment for autistic spectrum disorders and related conditions.</p> <p>Regulation 9 (1) (a) (b)</p>