Care Quality Commission

Sheffield Health and Social Care NHS Foundation Trust

Quality Report

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Core services inspected	CQC registered location	CQC location ID
Acute wards for adults of working age and psychiatric intensive care units	Michael Carlisle Centre	TAHFC
Long stay rehabilitation mental health wards for working age adults	Forest Close Michael Carlisle Centre	TAHXM TAHFC
Forensic inpatient / secure wards	Forest Lodge	TAHXN
Wards for older people with mental health problems	Grenoside Grange	TAHXP
Community-based mental health services for older people	Fulwood House	TAHXK
Community mental health services for people with learning disabilities or autism	Fulwood House	TAHXK
Community-based mental health services for adults of working age	Fulwood House	TAHXK
Primary Medical Services	Jordanthorpe Health Centre	TAH54
Wards for people with a learning disability or autism	Intensive Support Services	TAHEC
Health based places of safety	The Longley Centre	TAHCC
Substance misuse services	Fulwood House Michael Carlisle Centre	TAHXK TAHFC

Summary of findings

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

Summary of findings

Ratings

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

Overall rating for services at this Provider	Good
Are services safe?	Requires improvement
Are services effective?	Good
Are services caring?	Good
Are services responsive?	Good
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

At this inspection, carried out in November 2016 we changed the overall rating of the provider from requires improvement to good. We changed the overall rating for effective and responsive from requires improvement to good. However, the overall rating of the safe domain is unchanged.

We rated the following core services as good:

- Forensic inpatient/secure wards.
- Substance Misuse Services.
- Community Based Mental Health Services for Adults of Working Age.
- Wards for older people with mental health problems.
- Community-based mental health services for older people.
- Acute wards for adults of working age and psychiatric intensive care units.
- Wards for people with learning disabilities or autism.
- Community mental health services for people with a learning disability or autism.

We rated the following core services as requires improvement:

- Long stay/rehabilitation mental health wards for working age adults.
- Mental health crisis services and health-based places of safety.
- Primary Medical Services

We rated Sheffield Health and Social Care NHS Foundation Trust (the trust) as good overall because

- The trust had a clear vision and values which were supported by a set of strategic objectives which were developed with the involvement of patients, carers and staff. Most staff felt involved in changes and able to contribute to the continuous development of services. Staff could explain the trust's values and observations showed that staff demonstrated these in practice. Staff knew who senior managers were. There were posters displayed to show who senior figures within the trust were and information to explain their roles. Staff told us that senior managers regularly spent time on the wards.
- The leadership, knowledge and commitment of the non-executive directors of the trust was exceptional and the trust council of governors were knowledgeable and well informed and were clear about their role and responsibility to hold to account the non-executive directors of the trust.
- Staff were supportive of each other, and told us they were proud of their teams.
- The trust had excellent patient and public involvement and demonstrated a commitment to social inclusion. The trust was a host organisation for an employment scheme for adults with mental health problems, learning disabilities and complex needs. It paid the living wage to patients who have obtained employment within the trust. The opiate service recruited and trained ambassadors (people who had previously used the service) to support and inspire newer clients.
- The trust demonstrated a caring ethos towards its patients and the community it served. Feedback from patients and carers regarding their care and treatment was mostly positive. Staff were professional, caring and supportive of patients and their carers in all the services we visited. Staff supported patients to use advocacy services and the wards and services we inspected had established good links with adult advocacy services. Observations of interactions between staff and patients showed that staff treated patients with respect, kindness and had a positive rapport. Staff knew patients and their needs in detail. Wards and community based services for older people with mental health problems had developed caring and innovative ways for patients to maintain relationships with loved ones.
- Staff in most services, made holistic assessments of patients' needs and care plans were developed with patients and carers, and multi-disciplinary teams worked together to support patients in their recovery. Staff received weekly continuous professional development suitable for their role. Nurses were encouraged to become non-medical prescribers and undertake training in psychosocial interventions to enhance their skills.

Summary of findings

- On wards for older people with mental health problems, there was a very good programme of meaningful activity.
- The trust scored better than the England average overall for cleanliness, condition, appearance and maintenance, dementia friendly and disability in the 2016 Patient Led Assessment of the Care Environment data. The trust knew the population they provided services to and worked to ensure that services were accessible and that staff at all levels were representative of the communities they served.
- The trust had worked hard to significantly reduce the number of patients with mental health problems who had to be cared for outside of the local area over the past two years.
- The community enhancing recovery team had a well-established partnership with a local housing association. The partnership meant the trust was able to return patients from out of area placements to Sheffield with the team supporting patients to manage their own independent tenancies.
- The trust had in place a policy which described how it would meet its responsibilities under the Counter Terrorism and Security Act 2015 and meet the health requirements of PREVENT.

However:

- The trust did not ensure that all of the premises from which it provided patient care were safe. Staff had not undertaken environmental risk assessments, including identification of ligature risks and blind spots in all areas. The ligature risk assessment of the liaison psychiatry premises did not state what actions were required to mitigate all identified risks in areas accessible to people using the service. Seclusion rooms did not meet all the requirements of the Mental Health Act Code of Practice in relation to providing a safe environment for the management of patients presenting a risk to others. There was no policy or procedure to accommodate patients of the same sex in the same area. Bungalow 3 in the intensive rehabilitation service was not clean at the time of the inspection. In substance misuse services, staff did not always consider infection control procedures when using client rooms to activate drug screening tests.
- At the time of the inspection, the percentage of staff completing mandatory training averaged 60% compared with the trust's mandatory training target of 75%. Trusts should ensure that staff maintain their skills knowledge and training to carry out their roles safely and effectively and are up to date with changes to best practice. The trust's senior management team were aware of the poor compliance with mandatory training. They had started to deal with these issues and were introducing changes. However, poor compliance with mandatory training had the potential for a negative impact on patient care and safety.
- Staff did not always manage or monitor the administration of medicines well. This included not always undertaking or recording issues relating to the management of medicines including physical observations after giving medication. In the long stay rehabilitation services, staff did not follow National Institute for Health and Care Excellence guidance (G10 'Violence and aggression: short-term management in mental health, health and community settings) when using rapid tranquilisation. On wards for people with learning disabilities, medicines were administered from the main ward office as the clinic room was located outside the main ward area.
- At the health based place of safety, staff did not undertake people's physical observations or keep these under review if necessary.
- Qualified staffing cover was inconsistent in the long stay rehabilitation service. Staff in the community enhancing recovery team had not taken appropriate action as a result of a safeguarding concern.
- Blanket restrictions were in place in the long stay rehabilitation services, wards for older people and forensic services. Patients on G1 ward at Grenoside did not have access to their bedrooms during the day.
- In the community team for adults of working age, we found the service had waiting lists of up to nine weeks and there was no system of monitoring the risks of people who were on the waiting list. There were inconsistencies in the way in which lone working was managed in the community teams for adults of working age.
- Risk assessment and management processes were not always robust. Staff did not always complete risk

Summary of findings

assessments for people using the place of safety. In substance misuse services, we found that over a third of clients did not have updated risk assessments or risk management plans.

- Managers in some core services reported having limited oversight relating to their team's performance. Robust governance structures were not in place in Community based mental health services for adults of working age, Substance misuse services, Community-based mental health services for older people, mental health crisis services and health-based places of safety and Wards for people with learning disabilities or autism.
- The trust overall compliance for mandatory training on the Mental Capacity Act level one was 31% and Mental Capacity Act level two was 41%. Deprivation of Liberty Safeguards level two training across the trust was at 47%. Staff knowledge of the Mental Capacity Act and related Code of Practice was poor in some areas.
- In the long stay/rehabilitation wards the service offered a number of activities, however, most of those activities were social activities and there were limited activities which focussed on rehabilitation.

Summary of findings

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

We always ask the following five questions of the services.

Are services safe?

Requires improvement

We rated safe as requires improvement because:

- As at 13 October 2016, the mandatory training compliance for trust wide services was 60%; against the trust target of 75%.
- Some environments were not always fit for the purpose they were used for. The ward environment for people with learning disabilities did not allow for patients to have access to areas of therapeutic benefit. This was due to the sensory room being located outside the main ward area. Medicines were also administered from the main ward office as the clinic room was located outside the main ward area. It was also used as a consultation room for the community team. The activity centre used by patients in the intensive rehabilitation service, did not have a nurse call system and was not connected to Forest Close's personal alarm system. The environment of bungalow 3 at the intensive rehabilitation service was not clean. In substance misuse services, we saw staff did not always consider infection control procedures when using client rooms to activate drug screening tests.
- Environmental risk assessments, including identification of ligature risks and blind spots had not been completed in all areas. However the trust had undertaken some remedial work to address ligature risks and was planning some additional work. On the forensic ward, we found a number of ligature risks which included taps and door handles. We found the ligature risk assessment did not state the specific locations of ligature points and management plans contained limited and basic information on how staff managed these risks.
- Stanage ward, Burbage ward and Dovedale ward at the Michael Carlisle Centre were not compliant with same sex accommodation guidance as defined in the Department of Health guidance for eliminating mixed sex accommodation.
- In Forensic services and the intensive rehabilitation service, safe staffing levels were not maintained. This had impacted on the delivery of care to patients in a number of ways including, issues with safety in the prescribing, administration and monitoring of medication and from February to October 2016

there were 15 incidents of low staffing reported, and there were eight occasions where one nurse was left to cover two or more units. In the forensic services, a number of shifts were not covered by bank or agency staff.

- Staff in the community enhancing recovery team had not taken appropriate action as a result of a safeguarding concern.
- Issues relating to the management of medicines were identified in the intensive rehabilitation services. These issues had not been identified via a system of quality assurance within the service. Data we reviewed showed that only 62% of eligible staff were up to date with their medicines management training. We also identified issues with how staff managed incidents of rapid tranquilisation and saw that only 55% were up to date with their rapid tranquilisation training.
- Staff on some wards, imposed blanket restrictions on patients which were not informed by an individual risk assessment. On the forensic low secure ward, staff were searching all patients on return from unescorted leave and limiting access to certain areas of the ward without an individualised assessment of risk. In the intensive rehabilitation services, doors to some of the areas designated for patients' use were locked via a keypad. None of the patients had the code for this at the time of our inspection. Also, the front doors of Bungalow 1, Bungalow 1a and Bungalow 2 were locked at all times and required a key code to open. Although all of the doors had a sign on the main door which advised informal patients of their right to leave at any time, none of the patients including the informal patient knew the key code to the main door. Patients on G1 ward at Grenoside did not have access to their bedrooms during the day.
- The community team for adults of working age had waiting lists of up to nine weeks. Following the initial assessment at the point of referral, staff did not monitor those patients on the waiting list to detect increases in their level of risk. There were inconsistencies in the way in which lone working was managed in the community teams for adults of working age.
- In substance misuse services, we found that over a third of clients did not have updated risk assessments and risk management plans.

However:

Summary of findings

- The trust scored better than the England average overall for cleanliness, condition, appearance and maintenance, dementia friendly and disability in the 2016 Patient Led Assessment of the Care Environment data. Most of the wards and services we visited were clean and well maintained.
- Most wards and community services had emergency alarm provision: either fixed service alarms, access to personal alarms, or both.
- Although there was low compliance with safeguarding children training, staff said they were clear about the procedures to follow for both adult and child safeguarding and were able to describe how to access safeguarding guidance.

Are services effective?

Good

We rated effective as good because:

- Patients had their physical healthcare needs assessed on admission to most services. On-going support and monitoring was provided, including access to specialists where required.
- The community enhancing recovery team had a well-established partnership with a local housing association. The partnership meant the trust was able to return patients from out of area placements to Sheffield with the team supporting patients to manage their own independent tenancies.
- The community mental health team for adults of working age psychologists had produced patient workbooks that could assist staff in providing effective interventions. Staff demonstrated a good source of local knowledge around resources they could use to enhance a patient's treatment and recovery.
- The opiate service recruited and trained ambassadors (people who had previously used the service) to support and inspire newer clients. Staff received weekly continuous professional development suitable for their role. Nurses were encouraged to become non-medical prescribers and undertake training in psychosocial interventions to enhance their skills.
- In services where care and treatment was provided to patients detained under the Mental Health Act, we found they met the requirements of the Code of Practice in most areas.

However:

- At the health based place of safety we found that staff did not undertake people's physical observations and keep these

Summary of findings

under review if necessary. There was no evidence of any physical health checks in six of the eight records we reviewed and no information to state whether these had been attempted.

- Whilst the rehabilitation service offered a number of activities we saw that most were social activities and there were limited activities which focussed on rehabilitation. This was echoed in the feedback from some patients who told us that the activities were mostly good but were not rehabilitation.

Are services caring?

We rated caring as good because:

Good

- Observations of interactions between staff and patients showed that staff treated patients with respect, kindness and had a positive rapport. Staff knew patients and their needs in detail.
- Patients told us that staff treated them well and they felt respected.
- Carers told us that they felt involved in the care of their relative and had positive relationships with staff.
- Staff supported patients to use advocacy services and the wards and services we inspected had established good links with adult advocacy services.
- Patients were orientated to wards and services and were involved in decisions around their treatment and care. Where patients were unable to attend multidisciplinary meetings directly their views and opinions were communicated in other ways.

However:

- In substance misuse services, staff did not evidence whether clients had been offered and accepted a copy of their care plan.

Are services responsive to people's needs?

We rated responsive as good because:

Good

- On wards for older people with mental health problems, there was a comprehensive programme of meaningful activity. Innovative ways of communicating with patients had been developed. These included, utilising electronic technology, a ‘paro seal’, an interactive tablet and simulated presence therapy. Outside space was used to enable patients to take part in gardening and growing fruit and vegetables. Patients were involved in baking for themselves and others. There were

breakfast groups and various discussion groups. Activities were tailored to individual patient needs. The local community were involved with services. Staff were supported in developing new ways to engage with patients. The service had received no complaints and a large amount of compliments.

- Services were continually reviewed and developed to respond to the needs of patients and improve care and treatment offered.
- The trust knew the population they provided services to and worked to ensure that services were accessible and that staff at all levels were representative of the communities they served.
- Service users, carers and staff were consulted and involved in the design and development of new services and there was evidence of the trust listening to and learning from patients.
- In the forensic services, advocates led community meetings on the wards for patients. Patients had the opportunity to give feedback on the service.
- The trust had effective systems for managing inpatient admissions and discharges. All wards had an admission process which included welcoming new patients onto the ward. Most wards had a welcome pack for new patients.
- There were effective multidisciplinary meetings including clinical reviews and bed management meetings. Communication was clear and risk was discussed and management plans agreed.
- Wards could increase the number of beds in order to meet demand. Burbage, Stanage and Maple wards had dedicated band 6 discharge nurses who worked to address barriers to possible discharge and assisted in accessing the most appropriate discharge support packages of care.
- Staff across the different functions in the community mental health teams worked flexibly and collaboratively to ensure a seamless treatment journey for the patient. The teams held discharge meetings to develop all required plans prior to a patients discharge. The community mental health teams offered group activities to help patients support each other and to identify external resources to promote a patient's recovery.
- The community learning disability team had introduced a weekly multi-disciplinary allocation meeting. This meeting was attended by the specialist leads including but not exclusive to psychology, occupational therapy and psychiatry.

Summary of findings

- Patients in the community based services for learning disability or autism could be seen at a venue of their choice for any of their appointments. Information was available in formats patients could understand. The service was working to access hard to reach patients.

However:

- In forensic services, the pay phone on the assessment ward did not have a hood which meant that patients' using the phone did not have privacy when making phone calls.
- The trust do not operate a 24 hour a day, full time, dedicated crisis service. Support for people in a crisis is accessed via several services in the trust. Four community mental health teams operate from 9.00am until 5.00pm. These teams have the responsibility for providing crisis support to people within these hours. A separate assertive outreach team operates between 8.00am and 8.00pm and provides intensive community treatment and support to adults with severe and enduring mental health problems and complex needs.
- In the mental health crisis service, some people said the out of hour's team did not always call back or called at a time when their crisis had passed. There were some delays in response from the out of hour's team at night to the emergency department and some people in the place of safety experienced waits of several hours to be assessed. Referral to the out of hour's team was by telephone with no other information about alternative ways people could self-refer where they may be unable to use this method.
- Although staff were actively seeking alternative placements, the intensive rehabilitation service still had eight patients whose length of stay significantly exceeded the maximum intended in the service specification.

Are services well-led?

Good

We rated well-led as good because:

- There was good morale amongst staff within the teams. Teams were positive, professional, and supportive of each other. Staff told us they felt supported by their managers and their colleagues. Staff could explain the trust's values and observations showed that staff demonstrated these in practice. Staff knew who senior managers were. There were posters displayed to show who senior figures within the trust were and information to explain their roles. Staff told us that senior managers regularly spent time on the wards.

Summary of findings

- The trust had good relationships with its partners and stakeholders, including commissioners. The trust demonstrates an inclusive approach to patient and public involvement in all aspects of its business.
- There was an open culture and values based approach across the trust. Of particular note were the excellent service user involvement and the leadership, knowledge and commitment of the non-executive directors of the trust.
- The trust had been in a position of financial stability for a number of years which meant that senior leaders were able to focus on quality improvements.
- The trust has good service user engagement which is supported by a comprehensive strategy for further development for the next five years.
- The trust was a partner in the Sheffield Microsystem Coaching Academy in which coaches are trained in the art of team coaching and quality improvement to work with front line teams to help them redesign the services they deliver.
- Most services demonstrated they were committed to improving quality and supported innovative practice.

However:

- The trust had failed to ensure that staff undertook training that was considered mandatory.
- Managers reported having limited oversight relating to their team's performance. This related to mandatory training and supervision and appraisal information.
- The intensive rehabilitation service and the out of hour's team did not have a robust governance structure in place in order to assess, monitor and improve the quality of the service. This meant we identified areas of concern during our inspection which had not been identified by the services management team.

Summary of findings

Our inspection team

Our inspection team was led by:

Chair: Beatrice Fraenkel, Chair of Mersey Care NHS Foundation Trust

Head of Inspection : Jenny Wilkes, Care Quality Commission

Team Leaders: Jenny Jones, Inspection Manager, Mental Health Hospitals, CQC

Julie Harratt, Inspection Manager, Primary Medical Services, CQC

The team comprised a head of hospital inspection, two inspection managers, 11 inspectors, a pharmacy inspector, an assistant inspector, two data analysts, an inspection planner, seven doctors, a director of nursing, a nurse team manager, nine nurses, three occupational therapists, a physiotherapist, three social workers, specialist advisers on clinical governance and on equality and diversity, a non-executive director, and three experts by experience (people with experience of using learning disability or mental health services).

Why we carried out this inspection

We inspected this Sheffield Health and Social Care NHS Foundation Trust as part of our on-going comprehensive mental health inspection programme. This trust had a previous comprehensive inspection in October 2014 and was rated requires improvement.

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 the inspection team:

- Requested information from the trust and reviewed the information we received.
- Asked a range of other organisations for information including NHS Improvement, NHS England, clinical commissioning groups, Healthwatch, Health Education England, Royal College of Psychiatrists, other professional bodies and user and carer groups.
- Sought feedback from patients and carers through attending six detained patient groups and two carer groups and meetings.
- Received information from patients, carers and other groups through our website.

During the announced inspection visit from the 14 November to the 18 November 2016 the inspection team:

- Visited 28 wards, teams and clinics.
- Spoke with 146 patients and 27 relatives and carers who were using the service.
- Collected feedback from 154 patients, carers and staff using comment cards.
- Joined service user meetings.
- Spoke with 201 staff members.
- Supported 11 focus groups attended by over 370 staff.
- Interviewed 24 senior staff and board members.
- Attended and observed over 28 hand-over meetings and multi-disciplinary meetings.
- Joined care professionals for 14 home visits and clinic appointments.

Summary of findings

- Looked at 145 treatment records of patients.
- Carried out a specific check of the medication management across a sample of wards and teams.
- Looked at a range of policies, procedures and other documents relating to the running of the service.
- Requested and analysed further information from the trust to clarify what was found during the site visits.

We did not inspect the adult social care services managed by the trust.

Information about the provider

Sheffield Health and Social Care NHS Foundation Trust provide mental health, learning disability, substance misuse, community rehabilitation, primary care and specialist services to the 563,000 people of Sheffield. It employs 2,700 staff, has 19 locations registered with CQC and provides services from 42 community and inpatient sites with more than 150 beds across the city. It has an annual budget of £128 million.

The trust was established in 2003 as Sheffield Care Trust and on 1 July 2008 became Sheffield Health and Social Care NHS Foundation Trust (SHSC). It works with one clinical commissioning group, Sheffield CCG.

The trust provides:

- Acute wards for adults of working age and psychiatric intensive care units
- Forensic inpatient/secure wards
- Long stay/rehabilitation mental health wards for working age adults
- Wards for older people with mental health problems
- Wards for people with learning disabilities or autism
- Community mental health services for people with learning disabilities or autism
- Community-based mental health services for adults of working age
- Mental health crisis services and health-based places of safety.
- Substance Misuse services
- Primary Medical Services
- Adult Social Care locations

Services provided by the trust have been inspected 25 times since the trust was registered with CQC.

Sheffield Health and Social Care NHS Foundation Trust have been inspected under the new methodology of inspection (date of initial publication: 9 June 2015). The inspection was carried out on 28 – 31 October 2014 and overall, the trust was rated as requires improvement.

Following our inspection in October 2014, we rated safe, effective and responsive as requires improvement and rated caring and well-led as good. We found the following that the trust needed to improve:

- Seclusion rooms and the health-based place of safety did not meet all the requirements of the Mental Health Act Code of Practice in relation to providing a safe environment for the management of patients presenting a risk to others.
- There were potential ligature anchor points (places to which patients intent on self-harm might tie something to strangle themselves) in all inpatient areas.
- Qualified staffing cover was inconsistent on the rehabilitation wards at Forest Close.
- The level of junior doctor support was inconsistent across wards.
- Services outside normal working hours were not staffed well enough to make them safe or responsive to people's needs.
- Rehabilitation wards 1a and 3 at Forest Close did not comply with gender separation rules.
- Medicines were not always stored safely and administration of controlled drugs was not always recorded properly.
- We found significant gaps in the mandatory training staff should have received.
- We found areas of poor practice in relation to multidisciplinary team working (how different staff such as doctors, nurses, therapists worked together).

We issued five requirement notices against the provider;

- Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment. We found that the registered person had not protected people against the risk associated with unsafe premises. This was in breach of regulation 12(2) (d) of the Health and Social Care Act 2008 (Regulated Activities). The registered person had not

protected people against the risks associated with medicines. This was in breach of regulation 12(f) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Regulation 9 HSCA (RA) Regulations 2014 Person-centred care Regulation 9 HSCA (RA) Regulations 2014 Person-centred care. We found the registered person had not ensured the care and treatment of service users met their needs. This was in breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We found that the registered person did not ensure that care and treatment was designed with a view to ensuring their needs were met.
- Regulation 17 HSCA (RA) Regulations 2014 Good governance Regulation 17 HSCA (RA) Regulations 2014 Good governance. We found that the registered person had not protected people against the risk associated with the lack of proper information within written records. This was in breach of regulation 17(2) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
- Regulation 17 HSCA (RA) Regulations 2014 Good governance The 2015 MHA code of practice had not been implemented across all services of the trust. There was no trust monitoring of compliance with the Mental Capacity Act and there was no evidence that decisions made on behalf of people who lack capacity met the requirements of the Mental Capacity Act. This is a breach of regulation 17(1) (2) (a) (c).

The trust produced an action plan in response to the inspection and an update of the actions was provided at this inspection which stated that all action were complete. However during this inspection it was identified that there were actions outstanding in relation to safe staffing in the long stay and rehabilitation wards.

In 2016, we carried out unannounced inspections of the Adult Social Care locations within the Trust. These were rated as follows:

- 136 Warminster Road which provides respite care for adults with learning disabilities was rated as good.
- Hurlfield View which provides respite care for people with dementia was rated as good.
- Warminster Road, a supported living service for people with learning disabilities was rated as good
- Longley Meadows which provides short stay respite care for people with learning disabilities rated as requires improvement.
- Wainwright Crescent which provides respite support and step down support for people with mental health problems was rated as requires improvement.
- Woodland View, a care home providing accommodation for older people with a diagnosis of complex and advanced dementia who require nursing and personal care was rated as requires improvement.

Following concerns raised during the inspections of three of the trust's adult social care locations where we found continuing breaches of regulations in relation to medicines management and concerns regarding the governance arrangements to support learning in the trust we undertook an inspection of the well-led domain at the trust. We inspected well-led to find out whether the problems were symptomatic of a wider governance issue. The findings of the inspection did not result in changes to the ratings which were given in October 2014. However, we found a breach of regulation 18 HSCA (RA) Regulations 2014 Staffing relating to the implementation of the Mental Health Act Code of Practice 2015. The trust had failed to ensure that staff received mandatory training on the Mental Health Act, Mental Capacity Act and Deprivation of Liberty Safeguards.

What people who use the provider's services say

We received 154 comment cards from people who use the services. Sixty-two of the comments were positive about the care they received. Six comments were negative and 20 were neutral. Fifty-nine comment cards were blank and three were unclear. With few exceptions, the patients we met spoke positively about the support they received from the staff and the treatment they received. Patients and their carers told us that staff treated them with respect and dignity.

Most of the 29 patient Care Quality Commission comment cards we received in primary medical services were positive

about the service experienced. Patients said staff were helpful and treated them with dignity and respect. We spoke with seven members from the three patient participation groups (PPG). They also told us their dignity and privacy was respected.

We received mixed feedback from patients about the community based mental health team for adults of working age. One patient told us that staff did not listen to them. Another felt staff did not follow through proposed actions, communicate with each other or return telephone calls as agreed. However, carers were extremely complimentary about the service. Carers told us that they were able to seek support with a simple telephone call and that staff involved them in the care of their family member or friend where this had been agreed.

Comment cards from the intensive rehabilitation service included negative comments on how the service did not have enough managers during the week and that staff had been advised not to speak to the inspection team. However, during the inspection, staff in this service spoke with us and there was no evidence that they had been told not to.

Four clients who used substance misuse services told us they found it difficult to contact the services by telephone as the lines were often engaged.

In forensic services, patients told us they could access a range of different activities and advocacy and spiritual support was available. Three patients told us that they felt bored of the activities available. Patients told us they knew how to raise concerns or complaints and could give feedback on the service through patient community meetings.

We spoke with 10 people who used the out of hour's service. Six felt that staff were caring and supportive and were positive about the service they received. One said staff were down to earth, good at listening and very helpful at all times. However, some felt staff could be dismissive at times. One patient felt like their call was unwelcome and another said that whilst staff had been supportive, they felt some staff minimised how they felt.

Patients on wards for older people said wards were clean and comfortable. They told us that they were always treated with dignity and respect. Patients said they felt safe and staff treated them very well. The patients who were able told us they knew why they were in hospital and said staff were supporting them to get better. Relatives told us they thought the facilities were very good, gardens were nice and the wards were always clean. Most carers said they thought staffing numbers were good, although one relative thought that maybe it would be better with more staff at night time.

Good practice

Sheffield Health & Social Care NHS Foundation Trust (SHSC) won the Acute, Community and/or Primary Care Services Redesign category at the 2016 Health Service Journal (HSJ) Awards.

The trust was piloting the use of an electronic tablet to support staff who were undertaking routine observations on Stanage Ward. The tablet provided prompts and guidance to the staff member. This assisted in appropriate risk management plans and supported full compliance with the trust policy. The tablet saved staff time and reduced duplication. Entries made into the electronic tablet were immediately uploaded in to the patient's corresponding clinical record. Initial reports were very positive and staff were hopeful the trust would implement this good practice on other wards.

Each acute ward for adults of working age had a band 6 discharge coordinator. Ward managers told us there was a direct correlation between these roles being developed and a reduction in delayed discharges on the wards. The discharge coordinator role was to work specifically with patients to ensure a smooth discharge from inpatient care.

The community learning disability service had introduced a four-week appointment system alongside the clinical assessment and review meeting each week which had ensured that staff were properly deployed and waiting times for patients were reduced.

The trust have worked with Primary Care Sheffield to deliver consistent and improved access seven days a week, evening and weekend access to liaison, perinatal and older people's home treatment through a single point of access as part of the Prime Ministers Challenge Fund.

Summary of findings

The trust are working with a local housing provider who have secured funding to deliver Building Better Opportunities (BBO), an employment service for adults with mental health problems, learning disabilities and complex needs.

The trust has implemented the Safewards programme across all wards in the trust. This is an evidence based approach which aims to improve the safety of services.

In community services for people with a learning disability the posture management assessment clinic had allowed staff to work long term with patients to enable them to have good outcomes with their posture. Community learning disability teams had developed pathways to other services for example to employment, housing and palliative care to enable them to access the most appropriate services for patients. The team have introduced a Mindfulness programme which aims to meet the needs of people with a learning disability. The programme has been offered to 25 people so far and initial feedback has been positive.

The speech and language team won a Care Coordination Award for innovation from the Care Coordination Association for a project called "Improving service user care through effective learning and development" in October 2016. They worked with a private provider to ensure they could manage patients who had dysphasia in a way that treated the patient with dignity and ensured they were safe. The service had implemented new pathways including rapid response and dementia. Staff were encouraged to identify and develop pathways for staff to follow that would improve the service for patients.

The community based mental health service for older people was committed to innovation and research. Staff within the memory service were involved in research locally and nationally. The service achieved accreditation by the Memory Service National Accreditation Programme (MSNAP) and was working towards maintaining this in 2017.

In substance misuse services, the alcohol service used a digital alcohol-screening tool which enabled professionals from other services to screen patients and refer to the alcohol service immediately. The service responded quickly, often with same day appointments.

The Non-opiate service ran a clinic for clients using performance and image enhancing drugs (commonly known as steroids). Clients had their hormone levels monitored to check they were within safe limits. This enabled staff to give appropriate harm reduction advice.

The opiate service ran a wound management clinic and outreach service for those clients with venous problems. The clinic had won a national award from the Royal College of General Practitioners.

On wards for older people, staff had researched and developed innovative ways of communicating with patients living with dementia. Staff at Grenoside Grange had developed a tool to monitor various aspects of patients' care which were not covered on the trust's dashboard. This enabled the ward manager to monitor for themes and trends emerging. Volunteers were working with patients on Dovedale ward to develop a more user friendly patient satisfaction survey.

The Community Enhancing Recovery Team (CERT) was established in 2014 to provide wide ranging intervention to enable rehabilitation and recovery to people with complex needs, as an alternative to hospital admission. They work with people who have often had long or frequent admissions to acute services, open/locked rehabilitation and secure services. This initiative has enabled the reduction of bed based care and the need for people to be admitted to hospitals many miles away from their home town, family and friends. The team works with a variety of needs and deliver person centred care to people in their own homes. CERT has a partnership with a local housing association that provides housing to each person pertaining to their needs and wishes. Tenancy support workers support service users to maintain their home and live as independently as possible.

The trust has developed a resource pack for mental health workers to help them to better support and involve carers and young carers. The Carers strategy lead has worked closely with local carer organisations to improve links between adult mental health services in Sheffield.

The trust was not commissioned to provide child and adolescent mental health services, however it had provided, on a temporary basis, section 136 facilities for children and young people, which contractually they did not have to do. This has helped to reduce the number of children being taken into custody cells under section 136 of

the Mental Health Act. The trust was working collaboratively with Sheffield Children's Hospital Trust to purpose build section 136 suites for children. This is an example of where the trust has actively sought to put the needs of the patient at the forefront of provision, despite not being the commissioned provider of a service.

Areas for improvement

Action the provider MUST take to improve

Action the provider MUST take to improve

Trust wide

- The trust must ensure that staff are up to date with all required areas of mandatory training to bring them in line with the trust target.
- The trust must ensure that effective governance systems are in place across all services.
- The trust must ensure that it complies with guidance on mixed sex accommodation in all of its inpatient services.

Long stay rehabilitation:

- The trust must review blanket restrictions in the intensive rehabilitation service to ensure that care is personalised for each patient.
- The trust must ensure that the risk of harm to staff and service users using Bungalow 3 in the intensive rehabilitation service is mitigated.
- The trust must ensure that all areas used for patient care in the intensive rehabilitation service are clean.
- The trust must ensure that the intensive rehabilitation service maintains complete and accurate cleaning records.
- The trust must develop a quality assurance process which allows managers in the intensive rehabilitation service to identify areas for improvement in the service and ensure action is taken.
- The trust must ensure that the intensive rehabilitation service and the community enhancing recovery team comply with the trust supervision policy.
- The trust must ensure that the intensive rehabilitation service and the community enhancing recovery team have effective governance systems in place to share information in a timely manner.
- The trust must ensure that there is always at least one qualified nurse for each bungalow that admits patients in the intensive rehabilitation service.
- The trust must improve mandatory training compliance in the intensive rehabilitation service and the community enhancing recovery team.
- The trust must ensure that managers and staff in the community enhancing recovery team understand their individual responsibilities to respond to concerns about potential abuse when providing care and treatment, including investigating concerns.
- The trust must ensure that medicines are managed safely and where required, physical health monitoring and observations are carried out by staff and recorded.

Community Based Mental Health Services for Adults of Working:

- The trust must ensure that staff receive mandatory training to meet trust targets.

Substance Misuse Services:

- The trust must ensure that staff use client rooms appropriately and adhere to infection control procedures.
- The trust must ensure that all clients have an up to date risk assessment and risk management plan, ensuring staff document this information using the correct tools. Any client without an up to date risk assessment must be reviewed immediately.

Wards for older people with mental health problems:

- The trust must ensure that Dovedale ward complies with mixed sex guidance.
- The trust must ensure that the seclusion room on G1 ward complies with the Mental Health Act Code of Practice with regard to seclusion room facilities.

Summary of findings

- The trust must ensure that staff are up to date with all required areas of mandatory training to bring them in line with the trust's target.

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

- The trust must ensure that staff undertake a risk assessment in relation to each person using the service. This must include information about potential risks and plans for how any identified risks are to be mitigated. It must be clear what level of observation each person using the service requires. This is in accordance with trust policy for the place of safety.
- The trust must ensure that people using the place of safety receive a full set of physical observations and monitoring of people's physical health is carried out where necessary. This is in accordance with trust policy for the place of safety.
- The trust must ensure that staff within the place of safety ensure that completed documentation provides an accurate, complete and contemporaneous record in respect of each person using the service. This must include information to show which staff have completed entries within people's records and when these have been completed.
- The trust must ensure that areas accessible to people using the service in the psychiatric liaison team have clear guidance in place about how staff are to mitigate identified risks.
- The trust must ensure that there are appropriate systems in place to identify and share learning from incidents across each team with a view to improving the service.
- The trust must have the ability to, and be able to demonstrate, how they capture and utilize feedback within all teams in order to influence service provision as appropriate.
- The trust must ensure that the out of hours service has robust and suitable systems and processes in place to effectively assess, monitor and improve the quality and safety of the service. This should enable them to monitor response times and identify any trends and themes within these.
- The trust must ensure that staff are suitably trained to help ensure they have the necessary skills, knowledge and competence to deliver safe care. Staff must have regular supervisions to help identify and address any support needs.

Forensic inpatient/secure wards:

- The trust must ensure that staff receive up to date mandatory training.
- The trust must ensure that restrictive practice is based on individual patient risk and not applied to all patients routinely as a blanket restriction.
- The trust must ensure that the seclusion suite is compliant with the requirements of the Mental Health Act Code of Practice.
- The trust must ensure that ligature audits and environmental risk assessments clearly identify the location of ligature risks and contain detailed risk management and mitigation plans.
- The trust must ensure that work is completed according to the business case submitted to the trust to reduce and remove the ligature risks identified.

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

- The trust must ensure ward accommodation complies with all aspects of same-sex guidance
- The trust must ensure the staff undertake mandatory training.
- The trust must continue to work to reduce the number of potential ligature anchor points.
- The trust must review the decision to provide a crash mat and not a bed, to repair the intercom on Burbage ward, to review the door openings and ability to lock these back to improve safe use of the ensuite bathrooms and to review the potential ligature anchor points, blind spots and antitamper effectiveness of some fixtures and fittings

Community-based mental health services for older people:

- The trust must ensure that all staff have received up to date mandatory training.

Action the provider SHOULD take to improve

Action the provider SHOULD take to improve

Trust wide

Summary of findings

- The trust should continue to review and monitor the effectiveness of medicines governance processes and medicines optimisation across the trust.

Long stay/rehabilitation:

- The trust should ensure that staff on Forest Close take action when the temperature in fridges used to store food exceeds 5 degrees.
- The trust should ensure that the remaining eight patients who have a length of stay which exceeds the service specification are discharged to more appropriate placements.
- The trust should ensure that staff in the community enhancing recovery team receive training in the Mental Health Act.
- The trust should ensure that staff in the community enhancing recovery team understand the Mental Capacity Act and that care records reflect considerations of capacity in staff interactions with patients.
- The trust should ensure that patients in the intensive rehabilitation service are allocated a care coordinator from an appropriate community based mental health team.

Community Based Mental Health Services for Adults of Working Age:

- The trust should ensure that staff have full support to carry out investigations relating to safeguarding and that staff embed safeguarding considerations into their discussions.
- The trust should ensure there are robust processes in place to protect staff who are working alone in the community.
- The trust should ensure all patients have a collaborative care plan, which is personalised, holistic, and recovery focussed.
- The trust should continue to improve processes to monitor a patient's physical health needs including adequate monitoring for patients prescribed antipsychotic medications.
- The trust should ensure that managers have an accurate overview of their team's performance.
- The trust should ensure they monitor and manage waiting lists for patients.
- The trust should ensure that staff monitor patients on waiting lists to detect any increases in their level of risk.
- The trust should ensure that staff are confident in adhering to the Mental Capacity Act to embed consent and capacity considerations into their everyday practice.

Substance Misuse Services:

- The trust should review the mandatory training requirement for the substance misuse service and ensure that staff are compliant with mandatory training.
- The trust should ensure all clients have up to date, person-centred care plans that are personalised, holistic and focus on recovery from substance misuse and treatment.
- The trust should ensure risk management plans include actions staff should take if a person misses appointments.
- The trust should ensure clinical staff undertake routine quality audits of care records.
- The trust should ensure that processes are in place that allow for the submission of accurate information and data about key performance issues. Managers were unable to use the trusts' systems to extract information about their teams performance. They had developed local systems to monitor key performance indicators but this data was different from that supplied by the trust.
- The trust should ensure the service can deal efficiently with the volume of daily telephone calls received. Clients and other professionals must be able to contact the service with the minimum of delays.
- The provider should ensure that equipment at each location is in date.
- The provider should ensure that bins used for the safe disposal of needles are assembled and used in line with good practice and infection control procedures.

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

- The trust should review how it can further improve response times to ensure that people do not have excessive waits to be assessed.

- The trust should review whether there are any safe, neutral facilities available in which out of hour's staff would be able to conduct face-to-face assessments.
- The trust should review how it ensures access to the out of hour's service, and that there is guidance for people who have difficulties with communication about how to access the service.
- The Trust should continue to review and work with relevant organisations towards implementation of a 24 hour dedicated crisis service.

Forensic inpatient/secure wards:

- The trust should ensure that independent multidisciplinary team reviews of seclusion are promptly undertaken as outlined within the Mental Health Act Code of Practice.
- The trust should review the facilities at Forest Lodge for the provision of dedicated space for patients to practice their spiritual and religious beliefs.
- The trust should ensure that there are enough staff on shift to meet the minimum staffing requirements of the wards.
- The trust must ensure that patients' privacy and dignity is upheld when taking medication.
- The trust should review activity timetables regularly to ensure that meaningful and engaging activities are available across the seven day week for patients to access.
- The trust should ensure that the waiting time from referral to assessment for admission to the assessment and rehabilitation wards is reduced.
- The trust should ensure that staff involve patients in the development of their care plans.

Wards for people with learning disabilities or autism:

- The trust should ensure that staff carry out assessments of patients' capacity to make decisions, in line with the Mental Capacity Act Code of Practice. They must also provide evidence which clearly shows how decision making has taken place regarding best interest processes.
- The trust should ensure that the use of advocacy is consistently recorded in patient notes, and that advocates are routinely invited to take part in decision making processes to support the patient.
- The trust should ensure that storage of medication does not compromise infection control. Also, that the environment where medication is administered is free from distraction so that errors are prevented.
- The trust should ensure that all staff are competent and trained in the use of Respect interventions when dealing with aggression and violence.
- The trust should ensure that completion levels for the mandatory training for autism awareness, dementia awareness and Deprivation of Liberty Safeguards meet the trust target.
- The trust should ensure that the manager reviews and signs off incident reports to ensure they have an overview of what is happening on the ward.

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

- The trust should continue to roll out the improved access to supervision for all ward based staff.
- The trust should consider the wording of Standard Operational Procedure - Green Room and Ensuite Observation pod. This should clearly state a patient is free to leave the room at any point, and that physical intervention to prevent this would mean the patient was subject to an episode of seclusion.
- The trust should continue to progress its plans to eliminate dormitory type accommodation.

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

- The trust should ensure that mental capacity assessments are carried out in line with the Mental Capacity Act Code of Practice and that best interest principles are followed in relation to decisions being made about patients care.
- The trust should ensure that regard to the Mental Capacity Act is embedded in day to day practice such as in discussion in professionals meetings. Staff should be able to evidence such discussion.
- Staff should have a consistent level of understanding of how the Mental Capacity Act applies to their own role.
- The trust should ensure that patients have an advanced plan in place so carers know what to do in the case of an emergency.

Summary of findings

Community-based mental health services for older people:

- The trust should ensure a responsive system is in place for when alarms are activated in the memory service.
- The trust should ensure clinical room stock is routinely checked for expiry dates and records are maintained, accurate and up to date.
- The trust should ensure that keys are not kept in external locks of doors within the memory service. This meant it was possible for people to be locked in rooms and this was an increased risk to their safety.

The trust should ensure care plans are person centred.

Care Quality Commission

Sheffield Health and Social Care NHS Foundation Trust

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.

The trust had systems in place to support the administration and governance of the Mental Health Act. A team of Mental Health Act administrators were based within the trust; they were managed by the Mental Health Act administration manager. A mental health legislation manager had been appointed and was due to take up post in January 2017. They will manage the Mental Health Act administration team and provide the link between the clinical networks and the trust governance structures.

A Mental Health Act Committee met three monthly in the trust and this group ensured compliance with mental health law across the trust. The Mental Health Act committee provided quarterly and annual reports to the board.

The trust had systems in place to monitor adherence to the Mental Health Act within each locality by weekly ward reports which provided an overview of each detained patient's status. However, on wards for people with learning disabilities we found an incident where a patient's section had lapsed. This meant the monitoring systems were not robust.

The trust had policies and procedures in place that comply with the Mental Health Act and Code of Practice (2015) to renew or discharge individual patient's detention under the Mental Health Act. We found the majority of policies and procedures on the Mental Health Act were in line with the revised Code of Practice (2015).

The trust compliance for mandatory training in the Mental Health Act was 58%. At service level training compliance ranged from 33% in the acute wards for working age adults to 94% in inpatient forensic wards. Mental Health Act training was mandatory for all qualified inpatient staff across the trust but was not mandatory for staff working in community services.

Staff generally understood their responsibilities under the Mental Health Act and how it related to their service. However, independent mental health advocates told us that information on wards was not situated appropriately and therefore not readily available to patients.

Mental Capacity Act and Deprivation of Liberty Safeguards

The trust overall compliance for mandatory training on the Mental Capacity Act level one was 31% and Mental Capacity Act level two was 41%. Deprivation of Liberty Safeguards level two training across the trust was at 47%.

Feedback we received from independent mental capacity advocates was that they were concerned that they were not receiving as many referrals as they should be. They felt that

Detailed findings

staff's understanding of mental capacity and best interest processes were not consistent. They gave examples of where patients had been discharged from inpatient areas across the trust and had not been referred to their team.

The trust has made 121 Deprivation of Liberty Safeguards applications (1 March and 31 August 2016) and 63% of these were regarding Hurlfield View (community-based mental health services for Older People). Twenty-six Deprivation of Liberty Safeguards were received into CQC from the trust during this period which equates to less than 21% of the Deprivation of Liberty Safeguards applications made by the trust. However, the trust's performance in this area is dependent on the local authority's capacity to process applications and the local authority Deprivation of Liberty Safeguard team has seen a significant increase in applications which has led to a backlog of applications. This, in turn had an impact on the number of notifications to CQC.

Requires improvement

Are services safe?

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

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

Summary of findings

Our findings

We rated safe as requires improvement because:

Safe and clean care environments

Patient Led Assessment of the Care Environment assessments are self-assessments undertaken by teams of NHS and private/independent health care providers, and include at least 50 per cent members of the public (known as patient assessors). They focus on different aspects of the environment in which care is provided, as well as supporting non-clinical services such as cleanliness. In 2016, the assessments highlighted for the first time how well the premises from healthcare providers are equipped to meet the needs of people with disabilities.

The trust scored better than the England average overall for cleanliness, condition, appearance and maintenance, dementia friendly and disability in the 2016 Patient Led Assessment of the Care Environment data. At location level, the trust also scored better than the England average for all of these with the exception of the disability section of the assessment at the Longley Centre which scored 71% compared to the England average of 97%.

Most of the wards and services we visited were clean and well maintained. We reviewed health and safety check documentation and saw actions were identified to correct any issues. The majority of wards and services adhered to infection control principles including hand washing, cleaning schedules and had personal protective equipment readily available for staff use. Services which were not clean at the time of the inspection were provided from bungalow 3 at the intensive rehabilitation service. Cleaning schedules were also found to be incomplete in this area. In substance misuse services, we saw staff did not always consider infection control procedures when using client rooms to activate drug screening tests.

The practices within primary medical services maintained appropriate standards of cleanliness and hygiene. We observed the premises we visited to be clean and tidy. A practice nurse at each site was the infection prevention and control clinical lead who liaised with the local infection prevention teams to keep up to date with best practice. Risk assessments to ensure the safety of the premises such as control of substances hazardous to health and infection prevention and control had been carried out. There were inconsistencies in the way that legionella risks were monitored. (Legionella is a term for a particular bacterium which can contaminate water systems in buildings). The Darnall and Jordanthorpe sites had up to date copies of the risk assessments. However, the Mulberry risk assessment dated 21 October 2008 and Highgate risk assessment dated 15 August 2014 had not been reviewed. All sites were taking some actions, such as flushing unused outlets, to reduce the risk of legionella.

Environmental risk assessments, including identification of ligature risks and blind spots had been completed in most areas. A ligature point is a place where a patient intent on self-harm might tie something to strangle themselves. These risk assessments were regularly updated and contained a description of what action would be taken to reduce identified risks if they could not be removed.

However, there were a number of services where ligature risks were identified during the inspection. On the forensic ward, we found a number of ligature risks which included taps and door handles. The ligature risk assessment did not state the specific locations of ligature points. The management plans contained limited and basic information on how staff managed these risks. On wards for older people and acute wards and psychiatric intensive care units, risks to patients remained. We saw that blinds in the Mulberry and Jordanthorpe sites did not meet the advisory Department of Health guidance, February 2015, relating to blinds and blind cords in that some of the blinds had looped cords which could create a risk of serious injury due to entanglement.

On Stanage and Burbage wards there were no reduced ligature bedrooms available to allocate to higher risk

patients as an effective risk management strategy. Following the inspection, we raised our concerns about the ligatures on Stanage, Burbage and Maple wards with the trust. They took immediate action and have developed an action plan to avoid delay in reducing the ligature risks. The action plan states that a number of bedrooms will have anti ligature fixtures and fittings fitted to make them suitable for patients who may be at higher risk of attempted suicide. It is also noted that we saw plans which were in place to reprovide acute inpatient services into purpose built units similar to the recently built state of the art psychiatric intensive care unit.

Dovedale ward did not comply with the same sex accommodation guidance as defined in the Department of Health guidance for eliminating mixed sex accomodation, bedrooms were not en-suite therefore male and female patients were using communal bathrooms. There was a male patient occupying a bedroom on the female section of the ward. Staff told us that the male patient had agreed to use the bathroom on the male section of the ward. However, this still meant that female patients may be in a state of undress whilst travelling from their bedroom to the bathroom. During our inspection we observed this to be the case.

Stanage ward and Burbage ward each provided services for men and women. Each ward had women only lounges. Individual rooms and bays had ensuite facilities. The exception to this was on Burbage ward where three bedrooms with no bathroom facility were ring fenced as male only accommodation. Stanage and Burbage ward had same-sex dormitory bedrooms. However, individual bedrooms were allocated to either males or females. Staff considered the allocation of rooms nearest to the staff office based on self-harm or harm to others risk assessments. Aside from that, patients were given the next available room. This meant that male and female bedrooms were co-located throughout the wards. There was no policy or procedure to accommodate patients of the same sex in the same area (for example, men at one end of the corridor and women at the other). This could have compromised patients' privacy and dignity.

Our review of the seclusion facilities within the trust identified that there were concerns with provision in a number of services. These were wards for older people, acute wards and psychiatric intensive care units and the forensic ward. At Grenoside Grange, the seclusion facilities were not fit for purpose. The facility was built before the revised Mental Health Act Code of Practice 2015. Managers told us there were plans to renovate the room in 2017.

The seclusion facilities on the acute wards were adapted from the existing ward space. Each of these was due for improvement as part of a planned building redesign due to complete in 2018. At the time of this inspection there were issues that we asked the trust to address. These included: reviewing the decision to provide a crash mat and not a bed; to repair the intercom on Burbage ward; to review the door openings and ability to lock these back to improve safe use of the ensuite bathrooms; and to review the ligature risks, blind spots and anti-tamper effectiveness of some fixtures and fittings. The trust responded quickly and provided an action plan which details action that has already been taken and actions that will be undertaken in the weeks following the inspection.

During our inspection, we raised issues identified with the seclusion suite on the forensic ward to the trust in relation to meeting the requirements of the Mental Health Act Code of Practice 2015. The trust submitted an action plan to us to detail the action taken in response to these concerns.

Adherence to the Mental Health Act Code of Practice was inconsistent across services in relation to the carrying out of independent multidisciplinary team reviews of seclusion. On G1 ward at Grenoside Grange, we reviewed two seclusion records and found that one record had been fully completed. The other did not fully record the observations of the patient whilst in seclusion. This was not line with the Mental Health Act Code of Practice Guidance.

Most wards and community services had emergency alarm provision: either fixed service alarms, access to personal alarms, or both. Where alarms were not in place, the need for these was mitigated. However, the activity centre used by patients in the intensive rehabilitation service, did not have a nurse call system and was not connected to Forest Close's personal alarm system. This meant staff were unable to call for assistance should an incident occur.

The Trust had an audit programme to assess medicines handling in accordance with the Trust's medicines policies and national guidance. The trust participated in relevant POMH UK (Prescribing Observatory for Mental Health UK) audits to facilitate benchmarking of prescribing practice against other similar trusts and against national guidance.

Are services safe?

Pharmacists also monitored the use of high dose and combined antipsychotic medication, to raise awareness and minimise any increased risks of adverse events. The outcome of these audits was shared at the Medicines Management Committee and with the relevant Directorates.

Since our previous inspection in October 2014, the pharmacy department had submitted a successful business case for pharmacist support in community mental health teams. This role was under development and benefits realisation had not been completed. However, pharmacy was part of the multidisciplinary approach to reviewing medicines processes in Community Mental Health teams and there was positive feedback about the increased pharmacy presence from the community directorate. Trust pharmacists also work within the trust's five GP practices to support medication review and medicines safety through the implementation of national alerts and completion of medicines related audits.

In June 2016, the trust commissioned an independent review regarding the effectiveness of the processes in place across the trust for learning from medication incidents. The report summary noted there was only "Limited assurance in relation to the management of medication incidents with a low severity rating". The chief pharmacist had shared the findings with the trust board as part of the "Medicines optimisation – medicines safety report". Actions plans were in place and progress was being monitored for re-audit in quarter four 2016. The under reporting of medication errors and insufficient investigation of no harm/low harm incidents was included on the pharmacy risk register (9 Moderate).

At the time of our visit, weaknesses in the timeliness and quality of medicines incident reviews remained. This meant that learning was not always effectively captured resulting in delays in the implementation of ways to reduce reoccurrence. For example, the trust's medicines safety officer noted in October 2016 that there was failure to fully complete an incident review for a serious medication incident involving an error in the filling of a compliance aid by trust nurses, in a community mental health team in July 2016. However, a further review was underway at the time of our visit, with plans to share learning at a Directorate wide learning event in December 2016.

The trust's medicines safety officer was also liaising with the risk department to review medication incident reports to highlight areas where incidents were incompletely reviewed.

We had raised concerns about the use of compliance aids at our previous inspection in October 2014. Community Mental Health Teams advised us that although there may be exceptional circumstances where these were used, they were no longer routinely filled by nurses in the community teams. The community medication guidelines were being reviewed with a target date for completion of December 2016. The Trust had also highlighted concerns about medicines reconciliation, particularly on inpatient wards, and was implementing a new protocol to try to reduce the number of incidents relating to this.

We found the arrangements for managing medicines in primary medical services, including emergency medicines and vaccines, in the practice kept patients safe (including obtaining, prescribing, recording, handling, storing, security and disposal).

The clinic rooms on wards were fully equipped and locked. They contained a medicines fridge, resuscitation equipment, emergency drugs and a 'grab bag'. A grab bag is a small, accessible bag which contains emergency equipment for first aid. Where clinic rooms did not have an examination couch, staff conducted physical assessments in patient bedrooms. Medicines were stored securely in the clinic rooms and checks of the room and fridge temperatures were completed to ensure they were suitable for medicines storage. However, on the ward for people with learning disabilities, we observed that medicines were stored in and administered from the main ward office as the clinic room was located outside the main ward area. This meant that staff had to prepare medication for the patients in a busy environment which could lead to errors.

There were supplies of emergency equipment and medication available in all services which were checked regularly to ensure they were fit for use and appropriate levels were available.

Safe staffing

The trust has a total of 2,655 substantive staff with 393 staff employed in central and corporate functions. The trust had a 16% turnover rate, 3% vacancies. The trust had a 6% sickness rate (as at 31 July 2016), which is above the national average of 5%. Wards for older people with mental

health problems had the highest number of qualified nurse vacancies with 6%. Two core services had turnover rates above the trust average of 16% with mental health crisis services and health-based places of safety having the highest rate of 37% (seven leavers and 19 substantive staff) followed by wards for people with learning disabilities or autism with 23% (six leavers and 26 substantive staff members). Eight of the 12 core services have sickness rates above the trust average of 6% with substance misuse having the highest rate of 11%.

Across all inpatient services, staffing levels were based on patients' needs. Ward managers and nurses in charge of shifts in most services had the autonomy to increase staffing levels where this was required. Staffing levels in most areas allowed patients to be supported in activities and allowed for one to one time with named nursing staff. For patients detained under the Mental Health Act there were very few occasions when section 17 leave had to be cancelled as a result of staffing issues.

Managers in all services told us they were well supported by the trust human resource team, where appropriate, to manage the staffing levels. However, in the intensive rehabilitation service, the service manager told us that getting agency staff was difficult and required the authorisation of more senior managers and as such the service relied on bank staff or staff working flexibly or overtime.

During the inspection of the intensive rehabilitation service in 2014, we found that the wards did not have a dedicated qualified nurse on the wards at all times. At this inspection, we found that these concerns had not been addressed. Data we reviewed from February to October 2016 showed there had been 15 incidents of low staffing reported. The service was proactive at escalating incidents of low staffing to the trust board in a monthly staffing capability report. The service used bank staff to cover 27 shifts in a three month period between 1 May 2016 and 31 July 2016, and the service was not able to provide information on the number of shifts not filled by bank or agency staff where there is sickness, absence or vacancies. Data we reviewed relating to use of bank and agency staff in forensic services showed there were 129 shifts which were not covered. This meant there were times when there were not enough staff on duty to meet the needs of the patients.

We were informed by Sheffield Clinical Commissioning Group that performance on the trust's 20 priority mandatory training topics had been poor for more than a year and despite efforts to support improvements, a Contract Performance Notice was issued in June 2016. A remedial action plan was agreed and this will be monitored until fully achieved, it was reported that gradual improvements had been made.

The trust's risk register (July 2016) contains a moderate risk of non-achievement of trust's target for staff attending statutory and mandatory training. Mandatory training compliance was a concern at the previous inspection in 2014 and the trust has continued to be unable to meet their training target at this inspection.

The trust overall compliance rate was 75% and above for training in equality and diversity and clinical risk management. Overall compliance for mandatory training in the Mental Health Act was 58%, Mental Capacity Act level one was 39% and level two was 41%, Deprivation of Liberty Safeguards was 47%.

The trust overall compliance rate was below 75% for training courses on immediate life support, adult basic life support, medicines management, safeguarding children level two and three, safeguarding adults level two, health and safety, fire safety two and three. Low compliance with essential and immediate life support meant that the provider could not assure themselves that all staff could respond to patients in a medical emergency.

In the community team for adults of working age, we found the service had waiting lists of up to nine weeks. Following the initial assessment at the point of referral, staff did not monitor those patients on the waiting list to detect increases in their level of risk.

The community based mental health service for older people had effective systems in place to manage caseloads. Staff within the community mental health team had caseloads of 20-30 patients at the time of inspection. All the community services for older people benefitted from a multi-disciplinary approach that supported the on-going monitoring and management of caseloads.

The CQC receive safeguarding notifications regarding providers. There are two types of safeguarding notifications, alerts and concerns. Safeguarding alerts describe instances where the CQC is the first receiver of information about abuse or possible abuse, or where we may need to take immediate action to ensure that people are safe. Safeguarding concerns describe instances where

the CQC is not the first receiver of information about abuse, and there is no immediate need for us to take regulatory action. For example, where the CQC is told about abuse, possible abuse or alleged abuse in a regulated setting by a local safeguarding authority or the police.

There were 19 safeguarding notifications recorded on our internal systems regarding the trust between 1 August 2015 and 31 August 2016. Forest close, The Longley Centre and Woodland View have the highest number with four each.

The trust wide safeguarding team comprised of three staff, this included an administrator. Due to sickness within the team, all safeguarding data management, training and additional requests were undertaken by the remaining staff member who was the safeguarding lead.

Feedback we received from the safeguarding lead was that an additional adult safeguarding database was kept as there were issues with the trust system. However, the trust safeguarding database was being updated to better capture safeguarding information and assist staff in managing the process. This project had been agreed by the Head of IT projects and a work and implementation plan was being developed to create new fully Care Act and Making Safeguarding Personal Compliant. Timescales given for completion of this was March 2017.

We examined a number of the safeguarding strategy meeting records. The records were detailed and included evidence of investigation and liaison work.

We were told that the safeguarding team did not monitor the trust's own safeguarding concerns: for example, where a member of staff had identified issues in their own team. These would be reported as incidents by staff, and the risk team would then notify the safeguarding team. This system relies on the risk team recognising the incident as a safeguarding incident and then informing the safeguarding team.

We looked at both the Safeguarding Adult and Safeguarding Children policies, both of which were in date. However, neither policy contained a clear supervision section.

Prevent is a government strategy which processes that are in place to help minimise the radicalisation of vulnerable people within the UK. All organisations providing health funded services are required to adhere to the requirements of the PREVENT strategy. This includes the training of all relevant front line staff in the responsibilities of PREVENT as well as introducing and embedding processes to identify and protect those who may be at risk of radicalisation as well as escalating concerns regarding potential terrorist events to the Police. The Trust had in place a policy which described how it would meet its statutory responsibilities under the Counter Terrorism and Security Act 2015 and meet the Health requirements of PREVENT.

The trust compliance rate for mandatory training on safeguarding children level two and three and safeguarding adult's level two was below 75%. Although there was low compliance with safeguarding children training, staff said they were clear about the procedures to follow for both adult and child safeguarding and knew how to access safeguarding guidance. All said they would report any concerns directly to a manager in the first instance. Incident reports showed that staff had liaised with the trust safeguarding team and made safeguarding referrals where they believed potential or actual abuse had occurred. However, during the inspection, we identified a concern relating to an incident where the community enhancing recovery team had not responded appropriately to a patient who made disclosures to several members of staff. Managers had dealt with the safeguarding concern without consulting the trust safeguarding team, making a report on the trust incident reporting system or documenting formally their response. The service had also not provided any feedback to the patient.

We saw how arrangements were in place to safeguard children and vulnerable adults from abuse in primary medical services. These arrangements reflected relevant legislation and local requirements. Policies were accessible to all staff and there was a lead member of staff for safeguarding at each site.

Assessing and managing risk to patients and staff

We looked at 145 care and treatment records during the inspection. Records, on the whole, contained up to date risk assessments and management plans which were reviewed regularly to ensure they were up to date and accurate. Services used the detailed risk assessment management tool, the trust's approved tool for assessing and managing risk. Across all services, staff discussed patient needs and any current risks within handover meetings. However, there were concerns at the mental health based place of safety that staff did not always assess people' risks to help maintain their safety. We reviewed the

care records of eight people and found that six had no risk assessments present and no evidence of what observation levels the people had required. In substance misuse services, staff used the trust electronic risk assessment rather than an assessment specific to substance misuse. This meant the quality of the risk assessment was dependent on the recording/documentation skills of the nurse, as the template used did not guide and support staff to consider all domains of risk associated with substance misuse.

The trust reported 385 incidents of restraint affecting 145 different service users between March and August 2016. There were 139 incidents of seclusion and no incidents of long-term segregation reported. Acute wards for adults of working age and psychiatric intensive care units had the highest number of restraint incidents with 238 (62%) and the highest number of incidents of seclusion 126 (91%). There were two incidents of prone restraint which accounted for less than 1% of the restraint incidents, of which none resulted in rapid tranquilisation. Prone restraint is when someone is held face down on a surface and is physically prevented from moving out of this position. There are concerns that face down, or prone, restraint can result in dangerous compression of the chest and airways and put the person being restrained at risk. Following the previous inspection in 2014, the trust established a trust wide Restrictive Interventions Group which reviews practice issues relating to seclusion, long term segregation and the use of physical restraint. An established programme is now in place to review current practices and deliver a range of improvement initiatives informed by the outcomes of the review. The review focussed on:

- The time people spend in seclusion.
- Ensuring that face down restraint is not used
- Adoption of reflective practice and other methods to review incidents of seclusion, which includes service user and staff experiences, including fears and anxieties of using seclusion.
- Developing a patient focussed 'toolkit' for use by service users who have been secluded or are at risk of further seclusion.

The focus includes psycho-education work involving distress tolerance, emotional regulation and relaxation and physical activity. Each directorate produced a monthly restrictive practice incident report which identified themes and trends in restrictive practices and gave a detailed breakdown of restrictive type by ward.

CQC received 44 direct notifications from Sheffield Health and Social Care NHS Foundation Trust between 1 August 2015 and 31 August 2016. Three of these related to deaths in detention at Forest Close (February 2016), the Michael Carlisle Centre (July 2016) and Woodland View (August 2016). There were 19 safeguarding notifications recorded on our internal systems regarding Sheffield Health and Social Care NHS Foundation Trust between 1 August 2015 and 31 August 2016, all of which are closed. The trust has not had any serious case reviews (SCR’s) in the last 12 months.

Track record on safety

We analysed data about safety incidents from three sources: incidents reported by the trust to the National Reporting and Learning System and to the Strategic Executive Information System and serious incidents reported by staff to the trust’s own incident reporting system. These three sources are not directly comparable because they use different definitions of severity and type and not all incidents are reported to all sources.

Providers are encouraged to report all patient safety incidents of any severity to the National Reporting and Learning System (NRLS) at least once a month. For Sheffield Health and Social Care NHS Foundation Trust, “50% of incidents were submitted more than 19 days after the incident occurred” which means that it is considered to be a consistent reporter.

The trust reported 4,204 incidents to the National Reporting and Learning System (NRLS) between August 2015 and 27 September 2016. When benchmarked, the trust was in the top 25% of reporters in the NRLS report covering 1 October 2015 to 31 March 2016. A high level of reporting is one indicator of an organisation that has a good safety culture. Eighty one per cent of incidents (3,411) reported to NRLS resulted in no harm, 15.5% (651) of incidents were reported as resulting in low harm, 2.7% (113) in moderate harm, 0.2% (seven) resulted in severe harm and 0.2% (7) resulted in death. The NRLS considers that trusts that report more incidents than average and have a higher proportion of reported incidents that are no or low harm have a maturing safety culture.

Requires improvement

Are services safe?

Trusts are required to report serious incidents to the Strategic Executive Information System. These include never events which are serious patient safety incidents that are wholly preventable.

Between 1 April 2015 and 31 March 2016, the trust reported one 'never event' which occurred in April 2016. The 'never event' related to an attempted suicide on one of the acute inpatient wards, where a collapsible rail had failed to collapse, no injuries were sustained. Trust staff reported 18 serious incidents in this time frame. The core service that reported the highest number of incidents was Community-based mental health services for adults of working age (11). The most common type of serious incident was self-inflicted harm meeting serious incident criteria (13). There was one incident reported to the Strategic Executive Information System but not in the trust's serious incident data. This related to an information governance breach. The trust has advised that this incident is subject to disciplinary investigations which are on-going at the time of the inspection.

The NHS Safety Thermometer measures a monthly snapshot of areas of harm including falls and pressure ulcers. The trust reported 15 new pressure ulcers between August 2015 and August 2016. November 2015 reported the highest number with three, prevalence rate of 1.41%.

The trust reported nine falls causing harm during the time specified. The highest monthly number of falls causing harm was reported in May 2016 with two (1.04%). Seven of the months reported no cases.

The trust reported three catheter and new urinary tract infection cases in the time specified. August 2016 reported the highest number of cases with two (1.11%). No cases were reported for 11 of the months.

Reporting incidents and learning from when things go wrong

In the period 1 January 2013 to 22 September 2016, there were three concerns regarding the trust which were made to the trust regarding the following Report to Prevent Future Death reports. A moderate risk is included in the trust's Board Assurance Framework (2016 – 2017) dated July 2016 that incidents and complaints reoccur/potential for litigation and/or Coronial or Ombudsman rulings as a result of ineffective learning/inadequate processes.

The Trust did not investigate serious incidents in a timely manner and did not always take effective action following investigation following concerns. The commissioners told us on occasions it had been necessary to invoke contractual sanctions in relation to this.

Between 1 October 2015 and 31 March 2016, the trust have reported 18 serious incidents. The core service that reported the highest number of incidents was Community-based mental health services for adults of working age (11). The most common type of serious incidents were Apparent/actual/suspected self-inflicted harm meeting serious incident criteria (13). The number of the most severe incidents recorded by the trust incident reporting system is broadly with that reported to Strategic Executive Information System. This give confidence in the accuracy and validity of the information reported. Strategic Executive Information System (STEIS) is NHS England's web-based serious incident management system, through which provider's record incidents.

Staff across all services knew what type of incidents should be reported and how to report them. We saw evidence of learning and improvement following incidents in some core services, for example in long stay/rehabilitation wards medication rounds were undertaken by staff working in pairs following an incident where a staff member had been assaulted. In substance misuse services a recent incident led to a staff debrief and learning around supporting clients with emerging mental health issues. Staff across all the community mental health teams for adults of working age also attended half-yearly lessons learnt days to share experiences and learning from incidents. However, staff told us this did not include trust wide learning that was relevant and was only in relation to incidents within the adult community teams.

In primary medical services we reviewed safety records, incident reports and minutes of meetings where these were discussed. We saw evidence that lessons were shared and action was taken to improve safety in the practice.

Staff told us how they were supported following incidents and the trust facilitated post incident debriefs for staff which were facilitated by a psychologist. Teams across services were able to describe how they learned from incidents within their own areas and directorates. However, we found little evidence of how learning was shared trust wide.

Are services safe?

In the acute wards for adults of working age, Endcliffe ward was leading with the roll out of 'safe wards'. This project encourages the implementation of 10 interventions to minimise conflict on wards and maximise safety and recovery. Different initiatives had been introduced on to the ward and feedback communicated through the ward leadership and business meetings. We saw that leadership meetings addressed issues such as verbal threats, intimidation, and racial abuse towards staff and how to better support staff and patients experiencing this. This included a senior staff member following up any reported incident. This was not only to offer support to the victim but also to speak directly to, or follow up in writing, with the alleged perpetrator. This was to be clear what language and behaviours were not acceptable. These were in line with NHS zero tolerance and trust policies. Feedback we received from the clinical commissioning group was that serious incident investigation reports have at times not been completed within the required timescales. For the 'never event' logged in April 2016 (relating to non-functioning collapsible curtain tracks), the investigation report was more than two months overdue at the time of inspection. The delay in completing serious incident investigations means that the trust is not implementing learning from incidents in a timely manner.

Duty of Candour

Since November 2014, trusts had a responsibility to be open and honest with service users and other 'relevant persons' (people acting lawfully on behalf of service users) when things go wrong with care and treatment, giving them reasonable support, truthful information and a written apology. This is called the duty of candour. The trust has a 'Statutory Duty of Candour/Being Open Policy'. The policy outlines all the relevant duties and a process linked to the National Department of Health and NHS Litigation Authority guidance that provides staff with clear guidance on the steps required to meet the duty fully.

The risk department provided information for staff on the Duty of Candour trust wide via a risk bulletin special which included NHS Litigation Authority guidance on saying sorry when things go wrong. This bulletin also included examples of the duty in practice.

The risk department has delivered training to various trust-wide forums including the leadership development forum and the quality improvement group, all directorate senior manager's governance meetings and local teams and services across the trust. The training included an introduction to the electronic reporting system for the Duty of Candour. Several local services and teams have also received bespoke training on how to meet the Duty of Candour.

The electronic reporting system is configured to notify the trust's risk manager of all incidents classified as moderate and above as they occur. The risk department reviews all incidents (including near misses) classified in this way, on a monthly basis and feeds this information back into directorate governance teams as a regular monthly agenda item. All potential Duty of Candour incidents are reported to the executive directors group on a quarterly basis.

The Trust could evidence that all 93 incidents reported in quarters one and two 2015/16 and classified as moderate and over, had been reviewed by the clinical risk manager as potential Duty of Candour cases. In total five of these patient safety incidents were reported in the trust wide incident management performance reports as being confirmed Duty of Candour cases and where, in each case the Duty of Candour had been appropriately applied.

Anticipation and planning of risk

The trust has in place a policy emergency preparedness, resilience and recovery (EPRR) responses to major or critical incidents. A major incident is an occurrence that presents serious threats to the health of the community, or causes such numbers or types of casualties, as to require special measures to be implemented. A critical incident is any localised incident where the level of disruption results in the organisation temporarily or permanently losing its ability to deliver critical services, patients may have been harmed or the environment is not safe, requiring special measures and support from other agencies, to restore normal operating functions.

The primary medical services had a group business continuity plan in place for major incidents such as power failure or building damage. The plan included emergency contact numbers for utility companies.

An adverse weather and other emergency conditions policy outlines how the trust will respond to actual or anticipated adverse weather (or other similarly impacting emergency conditions) to safely maintain services.

Are services safe?

The policies outline roles and responsibilities as well as providing instruction and guidance for staff when dealing with the unplanned or unexpected emergency circumstances.

Good

Are services effective?

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

Summary of findings

Our findings

We rated effective as good because:

Assessment and delivery of care and treatment

We reviewed 145 care and treatment records and saw there was a comprehensive assessment of each patient's needs on admission to most services. This assessment was holistic, covering a wide range of needs including physical and mental health. The majority of patient care plans were developed from this assessment, were individualised and accurately stated how the patients' needs would be met, focusing on outcomes, strengths and goals. Patients' care plans included key contacts and important telephone numbers.

In the Intensive rehabilitation service, our inspection in 2014 identified significant issues with care planning. At this inspection in November 2016, we reviewed ten care records and found care plans were personalised. The care plans were written collaboratively with patients and centred on listening to the individual's needs and wishes. Care plans were holistic and addressed all aspects of the patient's emotional, physical health and social needs. The trust had introduced new collaborative care plans which were being implementing by the Community-based mental health services for adults of working age. The new plans encourage staff to develop collaborative relationships with patients and to put patient's views at the centre of their treatment. The revised plans guided staff through a person-centred approach that they could reflect on the patients electronic care record, which was then used by all staff as a working document.

We saw examples of how recognised evidence based assessment tools were in use across services, this included Addenbrookes Cognitive Examination, General Health Questionnaire and the Bristol Activities of Daily Living Scale within the memory service. Carers also received assessment of their needs, again using a number of recognised tools. In primary medical services practices assessed needs and delivered care in line with relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines

Prior to admission to the forensic service, a joint medical and nursing assessment was completed for all prospective patients referred to the service. Information from this assessment formed part of their assessment of needs on admission to the service.

In Community based mental health services for adults of working age, there was a clear difference in the quality of the care plans depending on whether it was of the older style or the newer collaborative plans. Two out of the 23 care plans looked at were out of date. Eighteen care plans were personalised, holistic and recovery orientated. The remaining five care plans were limited in their personalisation, holistic objectives or direction towards recovery; these were all older style care plans. In community-based mental health services for older people, all 34 care records reviewed contained an up to date comprehensive assessment of need. However, the quality of care plans across the service was inconsistent. We reviewed 15 care records in the memory service, care plans were in place and up to date. Our observations were that person centred care was taking place. However, 13 records did not reflect the person-centred approach which we observed within the service. In addition, the service were not using the collaborative care plan. This is to be implemented in January 2017.

On wards for older people, patients had a 'This Is Me' document to provide staff with an insight into their life and skills. Staff told us these documents were written where possible in conjunction with patients and where communication was difficult relatives and carers would be involved. Most patients and carers we spoke to said they had been involved in decisions regarding their planned care and had agreed their care plan.

Outcomes for people using services

Good

Are services effective?

The trust supported the physical health needs of patients through a physical health examination on admission and the provision of on-going support to meet any needs identified from the assessment. This included support to attend primary care and acute hospital appointments, and dental care. In all services we visited we saw treatment was in line with national guidance from the National Institute of Health and Care Excellence and local policies reflected national guidelines.

The community enhancing recovery team considered physical health care need in collaboration with primary care services. When a patient entered into the service they would be registered with a local general practitioner who would have primary responsibility for physical health care. Staff could also undertake physical health assessments as required in the patient's homes.

At the health based place of safety, we found that staff did not undertake people’s physical observations and keep these under review if necessary. There was no evidence of any physical health checks in six of the eight records we reviewed and no information to state whether these had been attempted. This meant that people were potentially at risk of unsafe care in relation to their physical health needs.

In community based mental health services for adults of working age, there was no clear pathway for monitoring patients on prescribed lithium or antipsychotic medications, for example, clozapine. However, our evidence showed good practice being followed as required.

Monitoring patients taking medications such as clozapine and lithium is important as there could be implications for a person’s physical health if this is not carried out. This meant that adequate monitoring was therefore reliant on staff ensuring patients attended regular GP appointments and that communication links with the GP were robust.

In Substance misuse services, the treatment outcome profile was a monitoring instrument developed by the National Treatment Agency for staff to use throughout treatment. The services were required to submit data routinely for all clients accessing the service to Public Health England. For the year ending 30 September 2016 the alcohol service had 30.6% of clients discharging successfully from treatment (national average 39.3%). In the same period, the opiate service had 3.9% of opiate using clients discharging successfully from treatment (national average 6.8%). The non-opiate service had achieved 37.3% successful discharges for non-opiate using client (national average 40%).

The intensive rehabilitation service had introduced a programme which provided activities for patients seven days a week. However, the majority of activities were more social than focussed on rehabilitation. This was echoed in the feedback from some patients who told us that the activities were mostly good but was not rehabilitation. Opportunities to engage in rehabilitation focussed on activities of daily living were limited. Patients had limited access to facilities which enabled them to cater for themselves. Domestic staff handled laundry on all units. We saw limited examples of patients managing their own budgets.

The trust became smoke free in May 2016 and over 50 staff have been trained as smoking cessation practitioners. Free nicotine replacement therapy is available to all in-patients. Staff are also offered six weeks of free nicotine replacement therapy to support them.

The practices within primary medical services used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. (QOF is a system intended to improve the quality of general practice and reward good practice). The most recent published results showed the provider had achieved 98% of the total number of points available. They were not an outlier for QOF or any other national clinical targets. There was some evidence of quality improvement in the practices, including clinical audit. We reviewed some audits completed in the last two years, two of these were completed audits where the improvements had been implemented and monitored.

The chief executive described how he felt that although there was a lot of audit activity in the trust there had been no real strategic approach and there had been a culture of services undertaking audits of their choosing with no central oversight to ensure audits were meeting the priorities of the organisation. He went on to describe how audits were now tied into the quality agenda and quality systems. The trust have participated in 31 clinical audits as part of their Clinical Audit Programme 2015 – 2016.

Staff skill

Good

Are services effective?

The trust invested in the training and development of its staff. Staff told us they had support from the trust to access training which was pertinent to their role and allow for career development. In the community enhancing recovery team, three nurses told us they had undertaken a course on psychosocial interventions provided in partnership with Sheffield University. The team had been effective in managing to return patients from out of area placements to Sheffield with the team supporting patients to manage their own independent tenancies. In the community-based mental health services for older people, we spoke to one member of staff who had published several research papers, all of which had an older adult focus. Staff within primary medical services had the skills, knowledge and experience to deliver effective care and treatment. They had in place a detailed and extensive induction programme for all newly appointed staff and they could demonstrate how they ensured role-specific training and updating for relevant staff. For example, for those reviewing patients with long term conditions.

The trust's overall appraisal rate for non-medical staff was 86% and 95% for medical staff as of 31 July 2016. The trust score for the number of staff appraised in the last 12 months in the NHS Staff Survey 2015 was better than the national average for combined MH / LD and Community trusts.

The trust target for clinical supervision was 80%. The average clinical supervision rate for community based mental health services for older people was 62% as of 31 July 2016. As of 31 July 2016, 59 of 62 permanent medical staff had an appraisal in the last 12 months, which equates to 95%. The trust advised the clinical areas where appraisal rates were lower than 75% included Intensive Support Service (Firshill Rise) with 72%, Substance Misuse - Alcohol with 50% and the Community Intensive Support Service with 14%.

The trust advised that at 31 July 2016 100% of their 41 doctors had been revalidated.

Multi-disciplinary working

Care and treatment is provided to patients through a multidisciplinary framework. The multi-disciplinary team in most areas included doctors, registered nurse, speech and language therapy, social workers, psychologists, physiotherapy and occupational therapy. Services had regular multi-disciplinary and review meetings to discuss each patient's care and treatment. Meetings were centred on the patients' needs, risks and their recovery. Patients and carers were supported to attend the meetings which demonstrated the focus of involving people in their care. We saw staff had a good knowledge of patients during discussions in these meetings. The care programme approach supported the delivery of effective multi-disciplinary care and treatment to patients. The care programme approach is a co-ordinated approach used in assessing, planning and reviewing services with the patient. We observed care programme approach meetings in two services and saw that these were attended by the patient, their relative, a consultant psychiatrist, a mental health nurse and a social worker. Nursing handover meetings took place at each shift change. Staff discussed each patient's presentation and issues such as risk management or safeguarding. Where there had been significant changes in relation to patient care or new patients admitted to the service, we observed staff would stay on shift in order to complete the handover.

Staff in the trust maintained links with other teams within the trust and with external agencies. In the community enhancing recovery team, staff described a good example of partnership working between the team and a local housing association and stated that as a result of this partnership, 27 patients had been able to return to live in Sheffield.

The community mental health services for working age adults had produced workbooks that could assist staff in providing effective interventions in partnership with peer support service users, The workbooks titled "discovering who helps me", "understanding emotional sensitivity for patients with borderline personality disorder" and "understanding is the first step to acceptance and only with acceptance can there be recovery" were being used by most staff and linked to steps in the new collaborative care plans.

The non-opiate service had two ambassador volunteers at the time of our inspection. These were former clients who were free of illicit substances or alcohol use and had successfully completed the ambassador training programme. Their position was to support newer clients and act as positive role models. In addition, there were four carer ambassadors to support families of clients.

Information and Records Systems

Good

Are services effective?

Staff used the trust's electronic patient records, to store and access patient information. They all had individual logins and passwords to maintain confidentiality. Staff in the out of hour's team had access to electronic tablets. They did not all use these as some felt they were not always reliable. They updated electronic records where necessary on return to the office and we observed staff doing this.

Consent to care and treatment

The trust had a Mental Capacity Act policy in place. Staff understanding of the Mental Capacity Act varied across services but they were aware of the trust policy and key issues in relation to capacity and consent. In community based mental health services for adults of working age, staff were unable to tell us where they would access forms to assess a person's mental capacity or where to record it. Managers and medical staff felt capacity and consent was not fully embedded into everyday practice. Potential impact of this could be that people may not have their rights protected where there are issues relating to their mental capacity. Staff on the wards for people with a learning disability or autism did not consistently carry out two-stage assessments of patients' capacity to make specific best interest decisions, in line with the Mental Capacity Code of Practice. However they did use all tools available to them such as pictorial leaflets and sign language specialists to support patients to make decisions about their care and treatment.

Mental Capacity Act Level 1 and Level 2 training are not mandatory training courses for all staff at the trust. As at 13 October 2016, the overall compliance rate for Mental Capacity Act Level 1 training across the trust is 30% and 40% for Level 2 training.

Assessment and treatment in line with Mental Health Act

The trust had clear systems to check Mental Health Act forms and documents for all patients. Mental Health Act compliance audits were carried out each week on all wards. The results are fed back to all clinical and service directors, ward managers, consultants and executive director leads. It is also monitored on a monthly basis by the Mental Health Act Committee and reported in quarterly reports to EDGE.

The trust had systems in place to support the administration and governance of the Mental Health Act. A team of Mental Health Act administrators were based within the trust; they were managed by the Mental Health Act administration manager. A mental health legislation manager had been appointed and was due to take up post in January 2017.

A Mental Health Act Committee met three monthly in the trust and this group ensured compliance with mental health law across the trust. The Mental Health Act committee provided quarterly and annual reports to the board.

Overall adherence to the Mental Health Act within each locality was monitored by weekly ward reports which provided an overview of each detained patient's status. This included information about section 132 rights, consent to treatment information, section 62, section 17 leave, care plans and physical healthcare information. We were told that the Mental Health Act administration team monitor this information.

The trust had policies and procedures in place that comply with the Mental Health Act and Code of Practice (2015) to renew or discharge individual patient's detention under the Mental Health Act.

The trust compliance for mandatory training in the Mental Health Act was 58%. At service level training compliance ranged from 33% in the acute wards for working age adults to 94% in inpatient forensic wards. We found Mental Health Act training was mandatory for all qualified inpatient staff across the trust but was not mandatory for staff working in community services.

Staff generally understood their responsibilities under the Mental Health Act and how it related to their service. Staff and patients told us there was good access to independent mental health advocates and patients were able to refer themselves or be referred by staff. However, independent mental health advocates told us that information on wards was not situated appropriately and therefore not readily available to patients. They said they felt staff in some areas of the trust did not have the appropriate knowledge regarding referral processes and also in enabling patients to access support they may require with managers hearings.

There were five Mental Health Act Reviewer visits between 1 September 2016 and 27 September 2016, all were unannounced. Over the five visits there were 11 issues

Are services effective?

found at locations across the trust. The highest category for issues was Purpose, Respect, Participation, least Restriction with five issues, equating to 45.5% of the total. Consent to treatment was the next most common issue.

Good

Are services caring?

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

Summary of findings

Our findings

We rated caring as good because:

Dignity, respect and compassion

The Friends and Family Test was launched in April 2013. It asks people who use services whether they would recommend the services they have used; giving the opportunity to feedback on their experiences of care and treatment. The trust scored better than the England average for recommending the trust as a place to receive care in the Patient Friends and Family Test. The trust scored also better than the England average in relation to privacy, dignity and wellbeing in the 2016 Patient Led Assessment of the Care Environment assessments. However, Michael Carlisle Centre and Grenoside Grange had site scores worse than the England average.

Across all wards and teams, the majority of patients spoke very highly of the staff and the quality of care they received. Patient's and carers told us staff were kind, caring and supportive. In Community-based mental health services for older people, one patient told us that the level of respect they received from staff during group work enhanced their feelings of being an equal and knowing they were not alone. Another patient told us staff were "utterly brilliant and treated patients with upmost respect and dignity." We observed warm and positive interactions between staff and patients. It was obvious that staff knew their patients well and that they took a genuine interest in supporting them through their recovery. In services for people who had learning disabilities, patients had a communication passport, which described how they communicated their needs, wishes and feelings and how they liked to be cared for.

On Dovedale ward, patients' privacy and dignity was compromised due to there being clear glass on the doors leading from the public area into the patient bedroom corridor. This meant that patients could be seen by members of the public walking to other parts of the hospital. We fed this information back to the trust during the inspection and the issue was rectified immediately.

Involvement of people using services

All wards had an admission process which included welcoming new patients onto the ward. Most wards had a welcome pack for new patients and wards had information boards which contained information about the ward and how to contact other services such as the Care Quality Commission and advocacy services.

All detained patients had access to an independent mental health advocate and contact details were displayed on most wards. The majority of the detained patients we spoke with during the inspection said they had seen and spoken to an independent mental health advocate. However, it was not clear that staff in the place of safety made all people aware of how to access advocacy or support whilst using the service. One person told us they would have liked to speak with an advocate whilst in the place of safety but had not been aware of how to go about this.

Results from the national GP patient survey showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment. Results were in line with local and national averages

When asked; most patients and carers reported that they were involved in decisions about their care and treatment. In forensic services, we observed seven ward round meetings and one care programme approach meeting. We saw that staff involved patients during meetings. They listened to patients' views and took the time to ensure that they clearly explained information to involve patients in decisions made about their care and treatment. In Community-based mental health services for older people, carers told us they were consulted with and involved in discussions about care. In substance misuse services, client feedback was sought through family and friends questionnaires, which were located in reception areas at each location.

Good

Are services caring?

Patients were able to feedback on the service through weekly community meetings on the inpatient wards. On wards for older people, these were well attended by staff and patients and decisions were made about the day-to-day running of the service. The minutes from these meetings were available and typed up with clear evidence of discussions, actions and issues being taken forward and resolved. In services for patients with learning disability, patients had the opportunity to give feedback on the care that they received. Most patients and their carers told us that they received stakeholder surveys in an accessible, easy to read format. On the acute wards and psychiatric intensive care units, wards displayed 'you said we did' posters on dedicated boards. These gave feedback about issues patients have raised.

Emotional support for people

The trust had introduced an annual compassion conference which is coproduced by staff and patients with the focus on providing compassionate care for patients and supporting staff to be compassionate to themselves and their colleagues.

The primary medical services computer system alerted GPs if a patient was also a carer. The practice had identified 187 patients as carers (1% of the practice list) across the four sites. Written information was available to direct carers to the various avenues of support available to them. A two hour Carers' Clinic was hosted by Carer's in Sheffield every six weeks at the Darnall site. Patients could self-refer or be referred by practice staff for support.

The trust is a participant in the Mindful Employer national scheme which aims to provide support for employers in retaining and recruiting staff who experience stress, anxiety, depression and other mental ill health. It provides employers with practical tools, resources, techniques and useful contacts to maximise positive mental health at work.

Good

Are services responsive to people's needs?

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

Summary of findings

Our findings

We rated responsive as good because:

Planning and delivery of services

Commissioners described the trust as innovative and one that always actively seeks to identify and meet the needs of the population. The trust knew the population they provided services to and worked to ensure that services were accessible and that staff at all levels were representative of the communities they served.

The ward manager told us that updates from the ward dashboard meetings were discussed at a daily inpatient bed management meeting. This meant the bed management meeting could plan for possible admissions to the inpatient wards. The weekly community flow meeting looked at the patient flow across directorates and issues being raised in bed management.

The services with longest referral to initial assessment waiting times include Bungalow 3, Forest Close (Long stay/rehabilitation) at 304 days, Bungalow 1a, Forest Close (Long stay/rehabilitation) at 238 days, Adult Autism and Neurodevelopmental Service at 183 days, Bungalow 1, Forest Close (Long stay/rehabilitation) at 151 days and Forest Lodge Rehabilitation Ward (Forensic/secure ward) at 127 days.

There were a total of 61 readmissions within 90 days reported by the trust between 1 February 2016 and 31 July 2016 across 12 wards. The wards with the highest number of readmissions were Stanage Ward with 20 followed by Burbage ward (excluding detox) with 18 – both wards are at the Michael Carlisle Centre. The large majority (94%) of these wards are acute wards for adults of working age and psychiatric intensive care units. Each acute ward for adults of working age had a band 6 discharge coordinator. Ward managers told us there was a direct correlation between these roles being developed and a reduction in delayed discharges on the wards. The discharge coordinator role was to work specifically with patients to ensure a smooth discharge from inpatient care.

Average wait times for assessments in the place of safety were eight hours. This was in excess of Royal College of Psychiatrists' guidelines of three hours and the trust's own policy of two to three hours. Staff chased up teams to speed up response times and reported excessive waits. The manager said the most problematic time was between 4 and 5pm when community mental health teams handed over assessment responsibilities to the out of hours team. The trust was currently reviewing the possibility of making approved mental health practitioners a citywide service, as opposed to the current model of them working in sectors, with an aim to prioritising assessment requests and speeding up response times. No one had stayed at the place of safety in excess of the 72 hour period allowable under a section 136.

The trust do not operate a 24 hour a day, full time, dedicated crisis service. Support for people in a crisis is accessed via several services in the trust. Four community mental health teams operate from 9.00am until 5.00pm. These teams have the responsibility for providing crisis support to people within these hours. A separate assertive outreach team operates between 8.00am and 8.00pm and provides intensive community treatment and support to adults with severe and enduring mental health problems and complex needs. Referrals into the outreach team are made from other mental health teams or a health professional. The trust had been in discussion with the commissioners with regard to implementing a 24 hour service from January 2017 by merging liaison and out of hours services, however, due to circumstances which were beyond the control of the commissioners or the trust this process had ended which meant the merge would no longer be happening. We were informed by the trust and the commissioners that other options were now being pursued in relation to the provision of 24 hour crisis services.

Access to the out of hour's team was via telephone where individuals left a voice message. There was no provision for people to access the service who were not able to

Good

Are services responsive to people's needs?

communicate in this manner. If staff were aware of someone with alternative communication needs they would try to facilitate this. One example was a staff member who supported a person by way of email exchanges. However, this was reliant on the person's needs already being known to services or them having someone able to request alternative communication on their behalf.

Diversity of needs

The trust ensured that the inpatient facilities were suitable for patient care and treatment. Most inpatient services were able to offer a full range of rooms and equipment to support patient treatment and care. Patients confirmed they could access appropriate bathing and shower facilities and the main areas of the ward, including their allocated bedrooms. Across the inpatient services, wards had quiet areas, access to outside space and female only lounges. However, Stanage ward, Burbage ward and Dovedale ward at the Michael Carlisle Centre were not compliant with same sex accommodation guidance as defined in the Department of Health guidance for eliminating mixed sex accommodation.

Patients could access hot drinks and snacks when they wanted. Patients could bring in personal items to personalise their bedrooms if they wished.

The occupational therapy teams on the wards for older people were very proactive in the work they did with patients. Activities were meaningful and available seven days a week. On G1 ward patients went out picking apples, others then peeled and chopped the apples. Everyone who wanted to be was involved in making an apple crumble. Staff told us that the main emphasis of any activity was to try to reduce the stress of patients from when they were first admitted. Staff worked with patients and carers to celebrate where they were now. Staff on G1 ward told us they had tried poetry with a new patient who had dysphagia and through poetry; the patient was far more able to speak. Other ways of engaging was to do painting, sanding and other repetitive type roles which gave patients a sense of achievement and wellbeing.

Staff had developed a horticulture group; some of the patients had grown their own tomatoes and strawberries. Patients had access to what staff called a 'man shed' and a greenhouse with some basic gardening tools. Staff at G1 had been supported to visit Denmark to be trained on the ethical delivery of 'paro seal'. The 'paro seal' was a therapeutic robot baby harp seal, which was intended to be very cute and to have a calming effect on and elicit emotional responses in patients. Students had visited the ward to see the 'paro seal' in action by staff. This meant students learnt about dementia and helped to reduce the stigma. Empathy dolls were used well on the ward. Empathy dolls have been found to reduce the stress in some dementia patients. During our visit, one patient kept an empathy doll in their bedroom and staff said this had helped the patient.

Information leaflets were available in all inpatient services and in waiting areas of most community services which provided information to patients and their carers regarding treatment, local services, and patient's right to complain. The information leaflets and posters were in English. Staff on the acute ward and psychiatric intensive care unit assured us this reflected the demographics of the ward at that time and they could easily access the same information in a range of formats and languages if required. Staff could access interpreters and or signers through a service contracted to provide this to the trust.

Patients confirmed they had access to food to meet any dietary requirements including religious and ethnic groups or dietary preferences. Patients confirmed they had access to appropriate spiritual support. Michael Carlisle centre and Longley centre had a multi faith room that was available for patients, visitors and staff. There was a dedicated multi faith room within the psychiatric intensive care unit on Endcliffe ward. There was a chaplaincy and spiritual care group and there were information leaflets promoting the service and detailing how to refer. The place of safety had leaflets available in the five most commonly spoken languages within the area although there was no information about how people could access advocacy support. There were information leaflets in the liaison service waiting room for people to access including how to make complaints.

The trust was not commissioned to provide child and adolescent mental health services, however it had provided, on a temporary basis, section 136 facilities for children and young people, which contractually they did not have to do. This has helped to reduce the number of children being taken into custody cells under section 136 of the Mental Health Act. The trust was working collaboratively with Sheffield Children's Hospital Trust to

Good

Are services responsive to people's needs?

purpose build section 136 suites for children. This is an example of where the trust has actively sought to put the needs of the patient at the forefront of provision, despite not being the commissioned provider of a service.

The liaison psychiatry team currently supported some older people by way of a supported discharge service. This was facilitated by three support workers whose role was to support people on discharge from hospital in their own home up to a period of two weeks. The service also provided specialist clinics to meet people's needs and had input into clinics run by the acute trust.

In the substance misuse services, there was a Saturday morning telephone service available to clients for anyone who needed to speak with a healthcare professional. Clients accessing the opiate service who had prescribing issues mainly used this service. The alcohol service had adapted and revised the alcohol audit tool into a visual, easy to use, digital alcohol-screening app. This was for other health staff and social workers to use with their clients when considering a referral to the service. The app allowed workers to make immediate referrals into the service and led to staff being able to offer clients same day appointments.

The non-opiate service operated a mobile needle exchange three times a week in geographically isolated areas. In addition, outreach workers delivered harm reduction advice at pharmacies and charitable organisation for vulnerable people. There was a student pathway, with the service attending and providing advice during fresher's week. The service also delivered drugs awareness training sessions at local acute hospitals. There was a monthly multi-agency pregnancy and assessment group meeting and appropriate pathways with social services and midwives for pregnant clients.

There was a team of multi-faith chaplains working across the trust. We spoke to the chaplain team leader who told us the chaplaincy team were well supported by the trust. The board had approved the spiritual care strategy and had requested annual updates. The team held a welcome event for a new Muslim chaplain which was attended by the chief executive of the trust. A chaplain visited the wards on a regular basis and they worked with people of all faiths to ensure patients received the spiritual support that was important to them. In the forensic service, the wards facilitated visits from the hospital chaplain and imam to meet with patients. Patients told us that staff supported them to celebrate Eid. One patient told us that the imam did not speak or understand their spoken language. Two patients told us that the wards did not have access to dedicated space to practice their religion. One patient used another communal area and another used their bedroom to practice their religion.

Right care at the right time

Information was provided to patients about local services on admission in the service information pack. Patients were informed of their rights at regular intervals under the Mental Health Act. All patients told us that if they wanted to make a complaint they could do this by using a 'fast track' form. This related to the trust's procedure for making low level complaints.

The trust has worked proactively with the clinical commissioning group with regard to achieving the new national targets (relating mainly to access). For example, the early intervention target (50% of referrals seen within 2 weeks of referral), involved the establishment of a working group which was well attended by clinical and managerial staff.

Clients in the community based services for learning disability or autism could be seen at a venue of their choice for any of their appointments. Information was available in formats clients could understand. The service was working to access hard to reach clients.

The Royal College of Psychiatrists describe bed occupancy rates as a main driver of in-patient care standards in acute wards and wards for older people with mental health problems. A bed occupancy rate of 85% is seen as optimal. This enables individuals to be admitted in a timely fashion to a local bed, thereby retaining links with their social support network, and allows them to take leave without the risk of losing a place in the same ward should that be needed. Delays in admission, which result from higher rates of bed occupancy, may cause a person's illness to worsen and may be detrimental to their long-term health.

The trust provided details of bed occupancy rates between 1 February 2016 and 31 July 2016. Burbage, Stanage and Maple wards all had bed occupancy rates over 100%. Managers told us that bed occupancy above 100% related to the dates additional beds had been created on the wards in order to avoid an out of area admission occurring. These beds were created by re-commissioning beds which

had been mothballed following service redesign. Commissioners confirmed no patients were admitted to an acute ward outside of the Sheffield area in the previous two years.

Between 1 February 2016 and 31 July 2016 there were a total of 39 delayed discharges. The wards with the highest numbers of delayed discharges were:

- G1 at Grenoside Grange (Wards for older people with mental health problems) with 20;
- Maple ward at the Longley Centre (Acute wards for adults of working age and psychiatric intensive care units) with 8;
- Burbage ward at Michael Carlisle Centre (Acute wards for adults of working age and psychiatric intensive care units) with 5.

Fifty-nine per cent of the delayed discharges occurred in wards for older people with mental health problems. Figures provided showed that the reason for delayed discharge was that patients were waiting for 'enhanced care' beds. The average delay for patients ready for discharge but awaiting 'enhanced care' beds was 57 days. Staff told us they worked closely with other professionals to facilitate as quick a discharge as possible.

At the time of inspection, each acute ward for adults had a band 6 discharge coordinator. Ward managers told us there was a direct correlation between these roles being developed and a reduction in delayed discharges on the wards. The discharge coordinator role was to work specifically with patients to ensure a smooth discharge from inpatient care. These roles were ring fenced to focus on this work and were supernumerary to the staffing numbers on the wards. The discharge coordinators maintained close links with community services, went out to review new potential supported housing options, provided one to one support to go out to visit potential discharge placements and were the ward experts in submitting referrals to complex needs panels and securing funding.

In the community based mental health services for adults of working age, there were some delays in accessing an inpatient bed on the occasions where staff from the community teams saw patients and it was decided a hospital admission was required. Any delays meant a patient was unable to access necessary treatment quickly and could delay other resources, for example, the police. In the forensic services, there were no delayed discharges and no readmissions within 90 days reported by the trust between 01 February 2016 and the 31 July 2016. The Quarterly Mental Health Community Teams Activity return collects data on the number of patients on Care Programme Approach followed up within seven days of discharge from psychiatric inpatient care. The trust has been consistently above the target of 95% of patients on Care Programme Approach who were followed up within seven days after discharge. Apart from Q3 2015/16, the trust performance has been above the England average throughout the remaining three quarters in the period from 1 July 2015 to 31 June 2016.

Primary medical services held a register of patients living in vulnerable circumstances including homeless people, asylum seekers, refugees and those with a learning disability. Staff knew how to recognise signs of abuse in vulnerable adults and children and were aware of their responsibilities. They informed vulnerable patients about how to access various support groups and voluntary organisations. Information sharing included documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours. Staff worked with other professionals in the case management of vulnerable patients and informed vulnerable patients about how to access various support groups and voluntary organisations. Results from the national GP patient survey showed that patient's satisfaction with how they could access care and treatment was below local and national averages and on the day of the inspection people told us that they had experienced difficulties in getting appointments when they needed them. The trust shared documents which showed a number of actions to improve access had been implemented however we noted these had not sufficiently impacted on the service to provide any consistent improvement for patients.

Learning from concerns and complaints

The trust had a complaints and comments policy in place which was clear and easily understood. Across all services we saw information provided to patients and carers on how to complain. Many low level concerns were managed informally. The trust had two ways to raise concerns and make complaints. Anyone who wanted to make a complaint could make a formal complaint or use a fast track (this is a quickest process and a large proportion of

Good

Are services responsive to people's needs?

concerns are dealt with without escalating to formal complaint). Patients told us they could complete a 'fastrack' form to complain. A fastrack form is a quick way of getting comments and concerns to the corporate affairs team. Receipt of acknowledgement of the fastrack form should be received within two working days. A booklet was given to patients and carers on admission to services explaining how to make complaints.

The trust had a very low number of formal complaints. From September 2015 to August 2016, the trust had received 119 complaints. 47 complaints were upheld and two complaints are still on-going and awaiting a decision from the Parliamentary Health Ombudsman. Community mental health services for adults of working age received the highest number of complaints with 56 of which 21 were upheld. The trust received 807 compliments in the last 12 months. Wards for older people with mental health problems had the most compliments with 261 of the 807.

Despite the low number of formal complaints, the trust did not meet its target response time. Sheffield Commission Group reported that there were longstanding issues with performance on 25 day responses to formal complaints (a standard the Trust chose to adopt). Overall, at year end the trust response rate was at 45%, with particularly low response rates in the community and learning disability directorates (28% and 33% respectively in Q4). The trust states that urgent action has been taken with the implementation of rigorous processes to ensure that response times improve.

In April 2015, the trust conducted an annual survey of complainants to ascertain their experience of the process. A survey was sent to a randomised selection of people who had made formal complaints in the previous 12 months. 100 complainants responded of whom 97% found it easy to make a complaint, 90% felt that the trust took their concerns seriously, 90% were satisfied with the way their complaint was handled, 93% felt the chief executive's response was easy to understand and 90% felt that the trust was open and honest in its response. As a result of the feedback received, the content of the complaints leaflet was refreshed, the easy read complaints leaflet was re-designed and an audio file of how to complain was created and placed on the complaints page on the trust's website. Due to resourcing issues, the trust had not, as yet, carried out a complainant survey in 2016.

Learning from complaints was shared across the trust. The complaints team produced quarterly report which included data about complaints and learning. Where applicable, lessons learnt were also shared through quality assurance groups. However, although complaints received in primary medical services were satisfactorily handled, dealt with in a timely way with openness and transparency, there was no evidence that lessons were learnt from individual concerns and complaints or from analysis of trends and action.

Good

Are services well-led?

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

Summary of findings

Our findings

We rated well led as good because:

Vision, values and strategy

The trust has a vision to be recognised nationally as a leading provider of high quality health and social care services and recognised as world class in terms of coproduction, safety, improved outcomes, experience and social inclusion. "They will be first choice for service users, their families and commissioners."

The trust describes its purpose is to improve people's health, wellbeing and social inclusion so they can live fulfilled lives in their community. "They will achieve this by providing services aligned with primary care that meet people's health and social care needs, support recovery and improve health and wellbeing."

The vision and purpose are supported by five strategic aims:

1. To continually improve the quality and efficiency of our services in terms of safety, outcomes and service user experience;
2. To retain, transform and develop services along care pathways, enabling early intervention and meeting people's needs closer to home;
3. To recruit, develop, support and retain a skilled, committed and compassionate workforce with effective leadership at every level;
4. To build and develop partnerships that deliver improvements in quality for the benefit of our communities;
5. To continue to perform as a financially viable, effective and well governed organisation.

The values of respect, compassion, partnership, accountability, fairness and ambition form the guiding principles and underpinning behaviours for the way in which services are provided.

Staff were generally aware of the trust's values. Senior staff informed us that the values were reflected in practice through supervision, meetings and appraisals. They told us of occasions when senior managers had visited their teams. Staff also received a monthly newsletter from the chief executive of the trust; this was based on the trusts' values and vision. In forensic services, staff told us that senior managers regularly spent time on the ward and a member of the senior management team from within the trust led a patient reading group. In acute wards and psychiatric intensive care units, senior managers were based across the two locations and were well known on the wards by patients and staff. They were involved in decision making about admissions and discharges. They understood the operational pressures managing the acute wards and psychiatric intensive care unit. However, staff at the out of hours team told us that as they operated at times when the majority of other trust services did not, they felt disassociated from the wider trust at times, especially senior management level. Staff could not recall any instances of trust level staff attending the service to meet staff and to experience and see the team in operation.

Good governance

The trust had a board made up of a chief executive, a chair, four executive and five non-executive directors which provided overall strategic leadership. There were two directors who were members of the board in a non voting capacity. There was also a newly appointed director of corporate governance who reported directly to the chief executive.

There was a council of governors who provided a link to the communities served by the trust. The governors were knowledgeable and well engaged with the trust. The lead governor was involved in the recruitment of the current chair. They were clear about their role and responsibility to hold to account the non-executive directors of the trust and the lead governor was able to provide instances of where this had happened. They told us they felt valued by the trust and gave examples of how issues raised by them from within the community had been addressed by the trust. The trust had subscribed to the NHS Providers "Govern Well" programme to provide support and development for

the council of governors. The governors recognised that their makeup was not representative of the community and were actively seeking to recruit members from those groups under represented.

The executive management team provided executive oversight and decision making at board level. Below this were five directorates, each of which were led by a clinical and service director who reported to the deputy chief executive/executive director of operations. We were informed that the service director was ultimately the decision maker in the partnership, thus ensuring a system of accountability.

We attended a meeting of the trust board and saw how the committees provided assurance to the board, we also saw how the non-executive directors provided challenge and issues were debated. Governors questions was a standing agenda item and the governors felt questions raised were answered appropriately by the board. An action log from each board meeting is discussed at the next meeting to identify what has happened and whether actions have been completed. This ensures that issues are dealt with in a timely manner.

The Board of Directors set the strategic direction of the trust. This includes setting strategic objectives and ensuring that service user and staff safety is prioritised and that effective and robust risk management systems are in place throughout the organisation. The trust has 5 strategic objectives, these are:

- Developing Our Approach to Delivering Outstanding Quality Care & Support.
- Involving Service Users In Designing and Delivering Care and Support.
- Transforming the Services We Deliver.
- Maintaining Our Financial Sustainability.
- Workforce Engagement.

The strategic objectives form part of the trust's annual business plan and are reviewed annually through the trust's business planning cycle.

There was a clear governance structure which had committees providing assurance directly to the board. These were:

- Audit and assurance committee, which provides independent and objective oversight on the effectiveness of the governance, risk management and internal control systems of the trust. The committee's membership comprises all the non-executive directors of the board (excluding the trust chair).
- Finance and investment committee, maintains oversight of the trust's financial processes and quarterly submissions on the trust's financial performance to NHS Improvement, the independent regulator for NHS foundation trusts. The committee ensures that the trust's finances are managed within the allocated resources in order to deliver an effective and efficient service. Membership comprises both non-executive and executive directors.
- Quality assurance committee is responsible for providing assurance to the board on the effectiveness of the trust's systems and processes for safeguarding and improving the quality of the trust's services. Members of the committee include all the non-executive directors (except for the trust chair), the executive medical director, the executive director of nursing, professions and care standards, the executive director of finance and the deputy chief executive/executive director of operations. Also in attendance is a representative of NHS Sheffield Clinical Commissioning Group, the main commissioners of the healthcare services which the trust provides.
- Remuneration and nominations committee, is responsible for determining the remuneration and terms and conditions of service of the executive directors, including the chief executive, in order to ensure that they are properly rewarded having regard to the trust's circumstances. The committee is comprised of the non- executive directors and is chaired by the trust chair. The chief executive attends the committee in an advisory capacity.
- Workforce and organisational development committee is responsible for providing assurance to the board on the effectiveness of the trust's systems and processes for supporting employees in the provision and delivery of high quality, safe service user care and ensuring that the trust is meeting its legal and regulatory duties in relation to its employees. The committee is comprised of non-executive directors and executive directors and is chaired by the trust vice chair.

Good

Are services well-led?

Each clinical directorate had its own governance structures in place and we saw how they worked at individual directorate level. However, as each structure was developed individually, the trust did not have assurance that the information received to provide assurance is collected and measured systematically across the trust. We found examples in a number of services during the inspection of where governance arrangements were inconsistent and were not robust. The governance arrangements in place in these services did not ensure staff had received mandatory training, appraisals and supervisions, that staff were adhering to guidance relating to management of medicines, that managers were disseminating lessons learnt from other directorates to community teams and the identification and management of risks to staff and service users. The senior leadership in the trust recognised further development was required of the middle managers within the organisation in order to ensure robust and effective governance at service level.

In 2016, we carried out unannounced inspections of six Adult Social Care locations within the trust. Of these, three were rated as good and three were rated as requires improvement. Woodland view which provides accommodation for nursing and personal care for up to 60 older people with enhanced dementia needs was one of the locations which was rated as requires improvement. This location was inspected again in February 2017, the report of which is not yet published.

The trust had a board assurance framework which included those risks identified with a residual risk rated 15 and above linked to the trust's strategic objectives. A board assurance framework provides a structured means of identifying and mapping the main sources of assurance in an organisation, and co-ordinating them to best effect.

The trust has a risk management strategy which sets out staff roles and responsibilities in relation to risk management and describes the systems and processes for effective risk management.

The trust's corporate risk register states that there are 16 risks of which 10 were rated as higher risks. These were a combination of clinical, financial and reputational risks. The register identified action taken to mitigate these risks and was subject to regular review to reflect the current status of the risk and actions.

Risk registers were held at service level across the trust and managers were able to describe the process for escalating risks to the directorate and corporate level risk registers. However, the risks documented for the out of hours and liaison psychiatry teams did not all have timescales for review recorded within them. This meant it was unclear at what frequency these were to be reviewed and how the services could accurately monitor progress.

Relationships with stakeholders were positive regarding the trust overall. NHS England, one clinical commissioning group and the local authority commissioned services from the trust. The local clinical commissioning group stated that the staff were well motivated, well intentioned and dedicated. They report that the trust has in place sound governance processes and the local clinical commissioning group is represented on the trust quality assurance committee, which reports exceptions to trust board. Also reported by commissioners was a significant improvement in the clinical engagement in the commissioning and contracting of services, with the trust's clinical director now part of the contract management group. This has improved the responsiveness of the trust and the effectiveness of the meeting. However, they described inconsistencies in some of the trusts' corporate systems and processes. The recent appointments of the trust chair and medical director was viewed as positive and the belief is that the new chair will bring renewed fervour and challenge to the trust.

The trust has been in a financially stable position for a long time and therefore the culture of the board has been influenced by quality and finance has not dominated those conversations. An example is that the trust are currently subsidising a contract at Longley Meadows and Birch Avenue as the local authority are not in a financial position to take on the contract in full. However, the trust chief executive told us that this is not sustainable in the long term. During our inspection the trust received news that it would be required to make a significant cost saving in the next financial year that they had not previously been made aware of. We saw how the trust immediately put plans in place to identify the risks and understand the parameters of their negotiating position and the timescale for presenting this to the trust board for a decision on the trust response.

The trust's director of corporate governance had been in post for 11 weeks at the time of inspection. This was a new role as the previous role has incorporated both clinical and

corporate governance. The post holder reported directly to the chief executive and was clear that their role was to develop corporate functions and offered an opportunity to review the effectiveness of the functions, the necessity of these functions and to check that they were aligned with best practice.

Key areas being to be taken forward include:

- Ensuring the executive directors, non-executive directors and council of governors work together to ensure that the trust has the required accountability. A number of non-executive directors are nearing the end of office; therefore a contingency plan is being developed to ensure continued function.
- Undertaking a communication review of both internal and external communication processes.
- Embedding and taking forward the risk management of the organisation, including encouraging and enhancing discussion about identified risk at senior level, considering how that links with the board assurance framework so that that board are assured that the trust keeps its patients safe.
- Establishing a policy governance group, reconvening this group from a virtual group to an actual group. The aim of the group is to help people to understand their roles by having the policies and best practice to support this.

There is currently no action plan in place for corporate governance and therefore it is difficult to evidence what has been achieved. However, we were told this was something which would be considered in 2017.

Since taking up post in January 2016, the head of information technology has undertaken a review of the trust systems and infrastructure and described how they had been very encouraged with the level of clinical engagement with digital technology.

The current information technology system requires a refresh as it is not web-based and cannot support remote technology. There appears to be limited connectivity between the trust and location levels and the safeguard system is currently managed by the clinical governance team. The electronic patient record system is managed by the information technology department as it was designed and built in house. Going forward it is anticipated that the information technology manager will be the custodian of all information systems.

A digital strategy and action plan has been developed which has digital technology at the centre, with a plan to take the trust to a more wireless system, something which had previously been constrained by the national programme. The newly created role of business analyst works with the team to review systems and processes to identify potential improvements.

Also included in the plan is modernisation of the information technology department. The trust is actively seeking mentors in other organisations who have a shared portfolio, for example the universities.

Leadership and culture

We observed an open culture and values based approach across the trust. Of particular note were the excellent service user involvement and the leadership, knowledge and commitment of the non-executive directors of the trust. The trust demonstrated a caring ethos towards its staff, patients and the community is serves, this was echoed by feedback from patients, governors and stakeholders.

The trust participated in "Innov8", which aims to increase the diversity of NHS leaders. The trust was involved in a project which focussed on mentoring staff from all levels across the trust. Five board members were involved in this project.

In the twelve months prior to our inspection, the trust published their annual equality and human rights report which also includes information about progress on current trust equality objectives.

The trust's website has a section in relation to equality and diversity with links to trust documents relating to equality and diversity, including the equality and diversity action plan. There was a black and minority ethnic staff network group in place at the trust whose membership is aimed at staff who have a commitment to black and minority ethnic equality in employment and service provision. Core group members have the knowledge and personal experience to provide responses to queries from staff and provide and share relevant information with the group for distribution.

Good

Are services well-led?

The trust had completed its second Workforce Race Equality Standard (WRES) report and second WRES action plan. Performance targets were agreed by the trust board in July 2016 and were being implemented through the framework of the trust's black and minority ethnic strategy. There are a number of strands of activity linked to this area that have taken place in the last 12 months. These include a mentoring programme for black and minority ethnic staff involving board members, continued focus on providing good quality Race Equality Cultural Capability (RECC) training and activity through the trust black and minority ethnic staff network group. Funding was agreed by the trust to support on-going development of this work stream.

The trust has focused on staff disability particularly with a view to the proposed development of the NHS disability standard and the findings of research underpinning this. In taking this forward the trust has been liaising with other provider trusts.

In terms of Equality Delivery System 2 in the last twelve months, the trust have worked alongside clinical commissioning group leads, local authority partners and the city 'equality engagement' group to identify priorities. Equality objectives have been reviewed and refreshed annually with a full review and update completed in October 2016.

The results of the annual General Medical Council national training survey 2016 showed Sheffield Health & Social Care NHS Foundation Trust to be a below average an outlier in relation to access to educational resources and study leave. This is a lower score than was achieved by the trust in the previous year. However, the trust scored above average for clinical supervision, workload and supportive environment.

Fit and Proper Person Requirement

From 27 November 2014, a new regulation, the fit and proper person's requirement has applied to all NHS trusts, NHS foundation trusts, and special health authorities. Regulation 5 says that individuals, who have authority in organisations that deliver care, including providers' board directors or equivalents are responsible for the overall quality and safety of that care. This regulation is to ensure that those individuals are fit and proper to carry out this important role and providers must take proper steps to ensure that their directors (both executive and non-executive),or equivalent, are fit and proper for the role. Directors, or equivalent, must be of good character, have the necessary competence, skills and experience and be physically and mentally fit enough to fulfil the role. They must also be able to supply information including a Disclosure and Barring Service check and a full employment history. We saw the trust had in place a system for checking compliance with regulation 5.We reviewed the personnel records of members of the executive team at our inspection in May 2016 and all were found to be compliant with the requirements of the regulation. At this inspection, we reviewed the personnel records of a new member of the executive team and we again found that the record was complaint with the requirements. We also viewed the personnel record of an executive director who was currently acting into the role. We found that the trust had followed a robust and comprehensive recruitment process and that it was in the process of gaining the assurances required under regulation 5. We saw a checklist of information requested under regulation 5 within the file as well as documents already received.

Engaging with the public and with people who use services

The trust has a service user engagement group the purpose of which is to improve the quality of service users' experience and engagement; ensure that all services are using service user experience to drive quality improvement, reduce stigma and reduce the cultural distance between service users and staff, ensure that service users are meaningfully engaged at all levels in the trust, and that the experience and knowledge of service users informs processes of quality assurance, governance and strategy development. Over the last 18 months, a number of strands of work have been led by service users and staff from service user engagement group which have created considerable impact:

1. Recruitment work stream is aimed to develop the way that the trust works with service users to recruit staff. Tasks have included understanding current procedure, researching best practice within other organisations, and scoping national guidelines.
2. Training work stream was implemented to develop the trust's approach to collaboration with service users in training.
3. Peer Support work stream scoped and identified trust actions in developing peer support.

Good

Are services well-led?

4. Recovery work stream is being used by teams to benchmark the extent to which recovery focussed practice is embedded in their practice.

In February 2016, approximately 120 people attended a conference facilitated by the trust entitled “Engage, Transform, Flourish”. The conference focussed on developing a strategy for collaboration and engagement with patient, carers and staff from across all services to build on work already undertaken. Feedback from the event will help shape and inform the strategy for 2016/17.

SUN:RISE (Service User Network) is a monthly forum which enables service users to be informed, involved and engaged in trust business. It reports to the quarterly In-patient forum and to the In-patient and Community Directorates via the SUN:RISE facilitator. It comprises a business meeting followed by invited guest speakers and informal networking. It has a role as a user consultation group for service changes and research proposals. Members have active links to a range of other relevant groups both within and external to the Trust.

SHINDIG is a city wide forum that meets 4 times a year and aims to provide opportunities for people living with dementia in Sheffield (and their family carers) to share ideas, views and opinions on local services and developments. The group is jointly organised by Sheffield Alzheimer’s Society and Sheffield Health and Social Care NHS Foundation Trust. Membership is not fixed and SHINDIG is attended by about 18 people with dementia, 12 family carers and 10 staff from voluntary, health, social care and academic organisations in Sheffield.

The trust has established a partnership with mental health services in Uganda and is working with partners in both countries to progress its work. Mental Health Uganda is a national organisation led from Kampala but run locally by service users. The trust is working with Mental Health Uganda in Gulu on peer support and livelihood programmes. Staff from the trust have also raised funds to help provide training to staff and essential services, such as running water to food preparation areas within a mental health hospital.

Quality improvement, innovation and sustainability

The trust have set out their quality goals for 2016/17 and look to continue to focus on our quality improvement goals in respect of:

- Improving access.
- Improving physical health.
- Improving the experience of people who use our services.

Within this programme the trust have a specific focus on improving safety in respect of improved physical health outcomes and reducing restrictive interventions.

Sheffield Health & Social Care NHS Foundation Trust won the Acute, Community and/or Primary Care Services Redesign category at the 2016 Health Service Journal Awards.

The trust’s transformation programme, Transforming Acute Mental Health Care in Sheffield, has created a new care pathway from the community right through to developing a new, purpose-built psychiatric intensive care unit which opened earlier this year. As part of this work discharge co-ordinators and psychologists are now based on each ward, a new team (the functional intensive community service) has been created for home treatment for older adults in crisis, a crisis house was commissioned and the crisis and home treatment teams for adults were enhanced. This work has resulted in substantially reduced lengths of hospital stays and, most importantly, no one has been sent out of city due to lack of bed availability for acute adult beds for the last two years.

The trust was a partner in the Sheffield Microsystem Coaching Academy in which coaches are trained in the art of team coaching and quality improvement to work with front line teams to help them redesign the services they deliver. To date there were 22 teams working with a trained microsystem coach across clinical and corporate services, 13 active microsystem coaches with a further eight enrolled for training and 47 staff had completed a two day microsystem quality improvement course.

The trust participated in external peer review and accreditation schemes and services from around the trust had gained accreditation in these schemes, including:

- The ECT Accreditation Service (ECTAS)
- The Home Treatment Accreditation Scheme (HTAS)
- The Memory Services National Accreditation Programme (MSNAP)
- The Psychiatric Liaison Accreditation Network (PLAN)
- The Quality Network for Forensic Mental Health Services

Good

Are services well-led?

- Positive Practice and Collaboration in Mental Health
- The Quality Network for Perinatal Mental Health Services.

Safewards is national evidence based structured approach which aims to improve the safety of services as well as the experience of patients. The programme has been implemented across all of the wards in the trust. They reported already seeing some benefits being reflected in patient surveys and now that the groundwork had been competed on this initiative they would continue to build on this in the coming year.

The Trust achieves ward to board assurance through the delivery of the quality improvement and assurance strategy was reviewed and approved by the Board of Directors in March 2016. This implementation plan describes the actions to be taken to ensure the strategy is implemented over the next year. The implementation plan will be reviewed annually and a revised plan for each year will be confirmed.

The strategy has 5 key components:

- Delivering quality by creating the conditions for all our staff and every team to engage successfully in quality improvement underpinned by effective team governance
- Ensuring measurable quality objectives are agreed across the organisation
- Ensuring effective, supportive and responsive trust governance and assurance systems
- Having clear arrangements to support delivery and accountability
- Ensuring we have accurate and appropriate information available about the quality of care provided at all level.

The Trust has worked closely with the Yorkshire and Humber Collaboration for Leadership in Applied Health Research and the Yorkshire and Humber Local Research Network to improve their services and increase opportunities for their patients to participate in research, when they choose do so. They have links with academic partners, including the Clinical Trials Research Unit and the School of Health and Related Research at the University of Sheffield, the School of Health and Wellbeing at Sheffield Hallam University and the National Centre for Sports and Exercise Medicine, to initiate research projects in the trust. In 2015, the trust started to use the Join Dementia Research tool designed by the National Institute for Health Research in association with Alzheimer's Research UK and the Alzheimer's Society to match service users who have expressed an interest in research with appropriate studies. In the past 12 months the trust has increased its research portfolio by 14%, examples of active research studies include:

- The STEPWISE trial, a National Institute for Health Research funded trial providing an educational intervention to prevent weight gain in schizophrenia.
- The SCIMITAR+ trial, another National Institute for Health Research funded trial of bespoke smoking cessation intervention for patients with severe mental ill health.
- The TRIumPH project, implementing a care pathway for people with psychosis which aims to promote good clinical practice and aligns with the National Institute for Health and Care Excellence quality standards (2015) and Mental Health Access and Waiting Times Standards (2015/16).

The trust subscribed to the Prescribing Observatory for Mental Health and the National Audit of Schizophrenia to enable audit of prescribing practice against national standards and to benchmark their performance against other similar trusts. The pharmacy department also led a number of other clinical audits, for example the use of high dose and combined antipsychotics medication, to raise awareness and minimise any increased risks of adverse events. The outcome of these audits was shared at the Medicines Management Committee and with the relevant Directorates. For example prescribing for people with a personality disorder and the use of antipsychotics in people with a learning disability.

The trust had an improvement plan in place for 2016/17 for primary medical services. This plan documented how the trust aimed to develop the organisation and redesign the services to make them more efficient and effective. At the time of the inspection the plan was not sufficiently detailed to identify specific actions or timescales.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care The trust did not ensure that people using the service have care or treatment that is personalised specifically for them because: In the intensive rehabilitation service patients had limited access to therapeutic activities. In the intensive rehabilitation service Bungalow 1, Bungalow 1a and Bungalow 2 had blanket restrictions for locked doors and cutlery which did not take into account the risks of individual patients. This was a breach of Regulation 9(3)(a)(b)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect Dovedale ward did not comply with the Mental Health Act Code of Practice on mixed sex accommodation. There was a male patient in a bedroom designated as a female area. Bathrooms were communal which meant female patients in a state of undress patients might be seen by the male patient. The female patients who had bedrooms allocated at the end of the area currently designated as the male half of the corridor (and male bathrooms) to access the main facilities of the ward. This was a breach of Regulation 10 (1) (2) (a)

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The trust did not prevent people from receiving unsafe care and treatment and prevent avoidable harm or risk of harm because: In the intensive rehabilitation service Bungalow 3 was not connected to the service-wide personal alarm system used on Bungalow 1, Bungalow 1a and Bungalow 2. The service did not have adequate mitigation in place to reduce the risk of harm. This was a breach of Regulation 12(2)(a)(b)(d) The trust did not ensure that medicines were managed safely and administered appropriately to make sure people are safe because: In the intensive rehabilitation service staff had not followed the trust policy following an incident of rapid tranquilisation. Staff had not followed national guidance in prescribing valproate for a patient. Staff were not consistently undertaking and recording observations pre-administration and post-administration for a patient prescribed clozapine. This was a breach of Regulation 12(2)(g) Risk assessments relating to the health, safety and welfare of people using services must be completed and reviewed regularly by people with the qualifications, skills, competence and experience to do so. Risk assessments should include plans for managing risks. Over a third of clients in substance misuse services did not have an up to date risk assessment or risk management plan.

Requirement notices

This was a breach of Regulation 12(2)(a)

Care and treatment was not provided in a safe way. We were not assured that staff had done all that was reasonably practicable to mitigate any risks.

Staff had not completed risk assessments for all people using the place of safety. Information was not present in all records as to the frequency that staff needed to observe people in the place of safety.

Staff had not completed physical health checks on all people using the place of safety.

Ligature risk assessments in the liaison psychiatry team did not clearly state what actions were required to mitigate all identified risks.

This was a breach of regulation 12 (1)(a)(b)

The seclusion rooms on Burbage, Stanage, and Maple could not accommodate a bed. Staff were unable to observe patients when they were using the ensuite due to blind spots. Staff could not lock back ensuite doors and they did not open two ways.On Burbage ward the intercom required attention due to feedback noise when it was used. On Maple ward there were dignity and privacy issues due to the location of the seclusion room.

The seclusion room in the forensic service did not allow staff to see patients in the toilet area of the suite. The door to the toilet could be used by patients for them to conceal themselves behind or used to injure themselves.

Ligature points were present throughout the forensic wards. A business case was put forward to reduce and replace items however, there was no timescale for this work as it had not been agreed. The ligature risk assessment was basic on the ward it did not identify where ligature points were and there was basic mitigation plans. Copies sent electronically by the trust contained more detail than assessments in use on the ward.

This section is primarily information for the provider

Requirement notices

There were multiple potential ligature anchor points in each of the bedrooms on Stanage, Burbage and Maple wards. On Stanage there were potential ligature anchor points due to the radiator cover in the seclusion room.

This was a breach of regulation 12 (2)(a)(b)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment **How the regulation was not being met:** The trust did not have effective systems and processes to investigate immediately, upon becoming aware of, any allegation or evidence of such abuse. In the community enhancing recovery team staff had not taken appropriate action in relation to safeguarding concerns raised by a patient. The concerns were not reported, escalated and investigated in line with the trust safeguarding policy. This was a breach of Regulation 13(3) In the intensive rehabilitation service Bungalow 1, Bungalow 1a and Bungalow 2 had blanket restrictions for locked doors and cutlery which did not take into account the risks of individual patients. In the forensic/secure services Forest Lodge had a blanket approach to searching all patients on return from unescorted leave. Staff asked all patients to show items in their possession and used a wand metal detector. Patients' care and treatment records did not contain an individual risk assessment to justify this practice in relation to individual patient risk. Care and treatment records contained standard blanket statements which outlined that Forest Lodge had a blanket approach to searching all patients on return from unescorted leave.

This section is primarily information for the provider

Requirement notices

This was a breach of Regulation 13(4)(b)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment The trust did not ensure that premises where care and treatment are delivered were clean because: In the intensive rehabilitation service Bungalow 3 was found to be unclean. Cleaning schedules for Bungalow 3 were not consistently maintained or accurate. Cleaning schedules for Bungalow 1 were not fully completed. This was a breach of Regulation 15(1)(a) The seclusion room on G1 ward at Grenoside Grange was not fit for purpose as it did not comply with guidance in the Mental Health Act Code of Practice. There was no two way intercom, no externally controlled heating/cooling. There were blind spots. This is a breach of regulation 15 (1)(2) In substance misuse services staff used client rooms to activate drug urine tests without regard for infection control procedures. This was a breach of regulation 15 (1)(c) (2)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983	Regulation 17 HSCA (RA) Regulations 2014 Good governance

This section is primarily information for the provider

Requirement notices

Diagnostic and screening procedures Treatment of disease, disorder or injury	The trust did not have effective governance systems to assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of patients in receiving those services) because: In the intensive rehabilitation service there was not an effective quality assurance process to identify the impact of issues with medication management, recruitment of staff, training provision and the management of risks to staff and service users. In the intensive rehabilitation service and the community enhancing recovery team managers did not ensure that the service fully complied with the trust supervision policy. In the intensive rehabilitation service and the community enhancing recovery team staff were not able to share relevant information with the Care Quality Commission in a timely manner This was a breach of Regulation 17(1)(2)(a)(b) Staff at the place of safety did not always maintain an accurate, complete and contemporaneous record in respect of each person using the service. There were omissions in documentation such as times, names and dates of entries. Systems within the out of hour's team were not fully robust to assess, monitor and improve the quality and safety of the services. There was a lack of suitable governance processes in place to oversee and measure team performance. The out of hour's team had no feedback mechanism to capture, and use, peoples' views of the service.

This section is primarily information for the provider

Requirement notices

There was a lack of learning from incidents at a shared team wide level. It was not evident how incidents were used to identify and improve practice within the service.

This was a breach of regulation 17 (1) (1) (a) (b) (c) (d) (e) (f)

Regulated activity	Regulation
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 The trust did not deploy sufficient numbers of suitably qualified, competent, skilled and experienced persons to meet the care and treatment needs of people using the service because: In the intensive rehabilitation service there were fifteen incidents of low staffing from February to October 2016. Eight incident reports specifically stated that one nurse covered more than one unit. This was a breach of Regulation 18 (1) In the intensive rehabilitation service the overall compliance rate for mandatory training was below the requirement. Thirteen courses were below 75% compliance. In the community enhancing recovery service ten courses were below compliance This was a breach of Regulation 18(2)(a) The trust had not ensured that staff had received sufficient training to ensure they had the required skills to perform their roles. This was a breach of Regulation 18(2)(a)

This section is primarily information for the provider

Enforcement actions

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.