Good

Sheffield Health and Social Care NHS Foundation Trust

Community-based mental health services for adults of working age

Quality Report

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Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
TAHXK	Fulwood House	South East Locality Community Mental Health Team	S12 4QN
TAHXK	Fulwood House	North Locality Community Mental Health Team	S5 8BE
TAHXK	Fulwood House	South West Locality Community Mental Health Team	S11 9AR

This report describes our judgement of the quality of care provided within this core service by Sheffield Health and Social Care NHS Foundation Trust. Where relevant we provide detail of each location or area of service visited.

Summary of findings

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

Where applicable, we have reported on each core service provided by Sheffield Health and Social Care NHS Foundation Trust and these are brought together to inform our overall judgement of Sheffield Health and Social Care NHS Foundation Trust.

Summary of findings

Ratings

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

Overall rating for the service	Good 
Are services safe?	**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

We rated community based mental health services for adults of working age as good because:

- The teams we visited included a full range of staff disciplines. Staff worked in a collaborative manner and were flexible in their approach across the different functions delivered in each location. This meant a patient's treatment journey was seamless from referral to discharge.
- The duty teams responded to urgent referrals without delays. They included staff across the different functions and in various disciplines. This meant that they were able to respond quickly to queries from GPs, patients and carers.
- Staff across the teams were introducing new collaborative care plans for all patients. These plans included holistic and personalised interventions and were being used as a live document for all staff.
- Managers shared lessons learnt from incidents and complaints through team meetings, emails and supervision. They facilitated staff development days and sessions within each function area and across full locality staff. These days enabled staff to share good practice and specialised knowledge. Staff felt supported and were able to develop any specialist areas of interest.
- Staff were respectful and supportive in their interactions with patients. They considered the needs of families and carers and involved them in the patient's care where this had been agreed.Patients co-produced their care plans and were empowered to maintain independence.
- Staff were mostly happy in their roles. They felt involved and had opportunities for development.

However:

- Staff had not completed mandatory training units required by the trust. This meant that they were not always confident or knowledgeable in carrying out the duties necessary for their roles. In particular, staff did not always embed capacity or consent consideration, or safeguarding discussions into their everyday practice.
- The community teams all had waiting lists for a patient's first appointment and the commencement of treatment. The waiting lists were up to nine weeks.Whilst staff ensured patients already in treatment received regular care plan and risk assessment reviews, patients on the waiting lists were not monitored. This meant that staff did not detect changing levels of risk for patients waiting to be seen.
- Lone working protocols were mostly reliant on a buddy system. This meant that if the buddy was otherwise distracted, there were no other safety checks on a staff member's welfare.
- Not all patients' needs were reflected in their care and treatment plans. In particular, patients' needs around ongoing physical health monitoring and holistic recovery orientated objectives. The trust had recognised this and were implementing improvements. However, these improvements were still in their infancy and therefore not evident for all patients across the teams.
- Managers had limited oversight of their team's performance. They were unable to use the trust's systems to extract information relating to their service and had developed localised systems which varied from information collated at trust level.

Summary of findings

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

Are services safe?

Requires improvement

We rated safe as requires improvement because:

- Staff were not compliant with the trust's mandatory training. Staff had not reached the expected compliance in 17 out of 21 training courses required.
- Teams did not monitor patients on waiting lists to detect increases in their level of risk.
- Staff were not always confident in conducting safeguarding investigations.
- Safeguarding discussions were not always considered during multi-disciplinary conversations.
- Protocols to ensure the safety of staff working alone in the community were not robust.

However:

- Premises were clean, tidy and secure.
- Staff carried out regular risk assessments for patients on their caseload including plans to manage identified risks.
- Lessons learnt from incidents occurring within the community mental health teams for adults were shared across all teams.
- Overall vacancy levels, sickness and staff turnover were all below or similar to the trust average.

Are services effective?

Good

We rated effective as good because:

- There was a full range of mental health disciplines to provide input into a patient's care. They met regularly to discuss each patient with a holistic approach.
- The service's psychologists had produced patient workbooks that could assist staff in providing effective interventions.
- Staff had a good source of local knowledge around resources they could use to enhance a patient's treatment and recovery.

However:

- Training compliance for the Mental Capacity Act was low. Staff had varied confidence and knowledge in applying the principles of the Mental Capacity Act to their everyday practice or what processes they would take if required to conduct a capacity assessment.
- Not all patients had effective care plans that included personalised, holistic and recovery focussed objectives.

Summary of findings

- Adequate physical health monitoring did not occur for all patients. This had been recognised by the trust and improvements were in place.

Are services caring?

Good

We rated caring as good because:

- Staff were kind, respectful and supportive to patients.
- Patients were involved in their care and able to give feedback on the service they received.
- Families and carers were involved in the patient's care where this was agreed.

Are services responsive to people's needs?

Good

We rated responsive as good because:

- Staff across the different functions in the community mental health teams worked flexibly and collaboratively to ensure a seamless treatment journey for the patient.
- Recovery teams held discharge meetings to develop all required plans prior to a patients discharge.
- Teams offered group activities to help patients support each other and to identify external resources to promote a patient's recovery.

However:

- All the teams inspected had waiting lists of up to nine weeks.
- There were some delays in authorisations for available inpatient beds.

Are services well-led?

Good

We rated Well-led as good because:

- Staff were aware of the trust's values and knew who the senior managers were.
- Managers had sufficient authority and the ability to submit concerns to the trust risk register.
- Staff had opportunities to give feedback on the service and felt able to raise concerns without fear of victimisation.
- Staff reported that they were happy in their roles and worked together as one team.

However:

- Managers had limited oversight relating to their team's performance.

Summary of findings

Information about the service

Sheffield Health and Social Care NHS Foundation Trust provide community services for adults of working age with mental health problems. There are four community mental health teams that sit within the trust's community directorate. These are based across the city of Sheffield as follows:

- South East Team
- South West Team
- North Team
- West Team

The purpose of the teams are to provide a service for adults within a community setting. The types of conditions treated include psychosis, schizophrenia, bipolar disorder, severe depression, anxiety, personality disorder and post-traumatic stress disorder.

Each of the four teams focus on four functions:

- Access – for assessments and short term interventions
- Recovery – for longer term interventions
- Home Treatment – for short term intensive interventions for people who may otherwise require a hospital admission.
- Early Intervention – for suspected first episode psychosis and for those who have At Risk Mental State

The community mental health teams also respond to calls relating to people with immediate and crisis mental health problems during the normal working day (Monday to Friday 9am – 5pm). Outside these hours, these calls are managed by a crisis team.

During this inspection, we visited three out of the four teams. These were the South East team, the South West team and the North team.

The Care Quality Commission last inspected the trust in October 2014 where it was rated as requires improvement in the safe and responsive domains. We rated caring, effective and the well-led domains as good. This resulted in an overall judgement of requires improvement. The concerns we identified on the visit have since been addressed.

Our inspection team

The team was led by

Chair: Beatrice Fraenkel, Deputy Chief Inspector, Care Quality Commission

Head of Hospital Inspection: Jenny Wilkes, Head of Hospital Inspection (North East),

Care Quality Commission

Team leaders: Jennifer Jones, Inspection Manager, Care Quality Commission

The team that inspected community services for adults of working age consisted of an inspector, a doctor, a nurse, a social worker and an expert by experience.

Why we carried out this inspection

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

Summary of findings

How we carried out this inspection

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

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

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

During the inspection visit, the inspection team:

- visited three of the four community mental health teams and looked at the quality of the environments where outpatient appointments were held
- attended and observed seven visits to patients in their own homes
- observed four appointments held at the locations visited
- spoke with 33 patients who were using the service
- spoke with six carers of patients using the service
- spoke with the managers for each of the teams
- spoke with 36 other staff members; including consultants, doctors, nurses, pharmacists, administrative staff and other allied mental health professionals
- attended and observed hand-over meetings and multi-disciplinary meetings
- observed a patient activity group
- collected feedback from patients using comment cards
- looked at 23 care records of patients
- looked at 14 medication records of patients
- carried out a specific check of the medication management
- looked at policies, procedures and other documents relating to the running of the service.

What people who use the provider's services say

We spoke with 33 patients who were using the service and six carers. Both patients and carers were mostly positive about the care and treatment they received. They told us that staff were committed, helpful and respectful. Patients told us that they were involved in their care plans throughout their journey with the service and felt staff responded supportively to their questions and issues. Three patients believed that the care they received had saved their lives and given them something to look forward to. A new patient to the service felt empowered to start their recovery journey. One patient told us that staff did not listen to them. Another patient felt that staff did not follow through proposed actions, communicate with each other and return calls as agreed.

Carers told us that they were able to seek support with a simple phone call and that staff involved them in the care of their family member or friend where this had been agreed.

Areas for improvement

Action the provider MUST take to improve

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

Summary of findings

Action the provider SHOULD take to improve

- 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 that 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.

Sheffield Health and Social Care NHS Foundation Trust

Community-based mental health services for adults of working age

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
South East Locality Community Mental Health Team	Fulwood House
North Locality Community Mental Health Team	Fulwood House
South West Locality Community Mental Health Team	Fulwood House

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.

Mental Health Act training was not part of the trust mandatory training programme for staff working in this service. However, some staff had received training on the updates to the Code of Practice. The service was also delivering specific training relating to Section 135 (2) of the Act for non-approved mental health professionals in order to alleviate pressure on the approved staff and therefore reduce delays. Staff were able to source advice from their team's approved mental health professionals when needed. They also referred to the Mental Health Act office as a central point for additional advice and administrative support.

Staff adhered to consent to treatment and capacity requirements for patient on community treatment orders. The required authorities matched prescribed medications and were attached to patients' medication cards.

Patients had access to independent mental health advocates and staff knew how to support patients to access these services.

Detailed findings

Mental Capacity Act and Deprivation of Liberty Safeguards

Mental Capacity Act training was included in the trust's mandatory training units. There was a compliance target of 75%. None of the community mental health teams had met this target. Staff had varied knowledge of the Act and how to record this. Senior staff felt that generally, staff did not embed consideration of the Act into their everyday practice.

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

Our findings

Safe and clean environment

Staff from the community mental health teams saw patients at the service locations as well as in patients' homes. Service premises were all clean, tidy and well maintained. Cleaning records were up to date and demonstrated that domestic staff cleaned the environments regularly.

Clinic rooms contained the necessary equipment required to carry out physical health examinations including couches, blood pressure monitors and weighing scales. Staff regularly checked equipment; this included daily temperature checks on the fridges used to stored medications. General equipment was in good condition and portable appliance testing had been carried out where appropriate.

The trust included hand hygiene in their mandatory training. Teams had an overall compliance rate of 57% against a target of 75%. However, we observed staff adhering to infection control principles. There were anti-bacterial hand washing gels in all areas and clinical staff had access to personal protective equipment such as aprons and gloves for carrying out examinations.

Premises were secure with keypad entry systems to gain access. There were alarms in most of the rooms where staff saw patients. Staff had use of portable alarms when an alarmed room was not available. We tested the alarm system in the North community mental health team where staff responded quickly and in sufficient numbers.

All locations had dedicated first aiders and fire wardens. There was clear signage to inform people what to do in the event of a fire or other emergency.

Safe staffing

The provider had sufficient staffing establishments across the teams to meet the needs of patients on caseloads. The trust did not use a staffing tool to establish the size of the workforce but took into account population size and patient need. Each team had a team manager, qualified nurses, support workers, a psychiatrist and a range of other allied mental health professionals.

The overall vacancy rate was less than 1% for qualified nurses and 5.4% for nursing assistants; all teams vacancy levels were below the trust average. The average sickness level was similar to the trust average of 6% with the highest sickness in the North team at 15.6% for senior medical staff (this was due to one medic who was currently off work sick). Staff turnover was 11 percentage points below the trust average of 16%. Managers informed us that staff mostly left for development opportunities. There were four staff on maternity leave in the north team and one staff member also on maternity leave in the south west team. The service was also due to be reconfigured in April 2017. This meant that seconded staff filled some current posts and some staff were on secondments elsewhere within the trust. Managers told us that they were having difficulties recruiting into vacant posts, as they were fixed term positions due to the planned restructure.

The trust had agreed for an additional permanent qualified nursing post for each of the community mental health teams; this was due to go out to recruitment at the time of our inspection.

Teams did not use agency staff. The North team were the only location using bank staff. These were three regular staff with backgrounds in community mental health for adults.

Caseloads varied across the different functions within each location as follows:

- Staff working in access teams had caseloads of approximately 15 in the South East, 10 in the North and 17 in the South West.
- Staff working in recovery teams had caseloads of approximately 30 in the South East, 30 in the North and 28 in the South West.
- Staff working in early intervention teams had caseloads of approximately 20 in the South East, 25 in the North and 26 in the South West.
- Staff working in home treatment teams had approximate caseloads of 12 patients covered by seven staff in the South East, 20 patients covered by 4 staff in the North and 17 patients seen by the South West home treatment team.

Requires improvement

Are services safe?

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

Staff mostly told us that their workload was manageable. They were able to keep care plans and risk plans up to date and rarely cancelled appointments. Each location also had a duty team. The duty team responded to unscheduled contacts across all the functions. If staff were unexpectedly absent, appointments were either absorbed within the teams or covered by duty staff. This would depend on the urgency and needs of the patient. Any re-arranged appointments would be contacted by a qualified member of staff to determine any concerns. However, although staff managed caseloads for allocated patients, all the teams had waiting lists of patients awaiting allocation and therefore waiting for a comprehensive assessment of their needs.

There were dedicated psychiatrists at all of the teams we visited and access to the medics was quick when required.

Staff were required to complete mandatory training units. These included units on adult basic life support, clinical risk assessment, dementia awareness, safeguarding and information governance. Staff had an overall compliance of 57% across all teams. The trust target was 75%. Seventeen of the 21 mandatory training courses for the service were below the trust's compliance target. For example, 53% of staff had completed mental capacity awareness training, 48% of staff had completed medicines management training, 53% of staff had completed health and safety training, 68% of staff had completed information governance training and 54% of staff had completed adult basic life support training. Training had not been attended from staff at all the locations in varying required topics; this was a general non-compliance throughout the service and not as a result of one team. This meant that some staff had not received the training or were not up to date with the necessary skills or information required to safely and effectively carry out their role. This could therefore lead to a negative impact on patient care.

Assessing and managing risk to patients and staff

Staff carried out an initial assessment of all new referrals to the service. This included a basic risk assessment to identify immediate needs and urgency. Staff in the access or duty teams were able to see urgent patients mostly on the day they received the referral. Where staff had deemed a patient's needs as non-urgent, the patient would be placed on a waiting list to be allocated for a comprehensive assessment to take place.

Care co-ordinators carried out a more detailed risk assessment on the patient's first appointment. Staff updated these regularly. We looked at 23 patient records. Twenty of these included up to date risk assessments along with plans on how identified risks would be managed. The three assessments that were out of date had appointments booked for review. The assessments and management plans reflected patient need and provided detail. Staff updated risk assessments routinely and when a patient's circumstances changed. Patient records also included plans detailing what actions would be taken if the patient's situation changed into a crisis.

Teams had waiting lists of up to nine weeks. Following the initial assessment at the point of referral, staff did not monitor these patients to detect increases in their level of risk. This was because the teams had not allocated these patients to a care co-ordinator and were still awaiting a full comprehensive assessment. Staff communicated appointments via the telephone or in a letter; this included informing them of the team's contact number. Staff were therefore reliant on the patient to contact the service if they felt necessary whilst waiting for an appointment.

Under Section 75 of the NHS Act 2006, responsibilities for undertaking adult safeguarding enquiries and investigations for persons with mental health needs within the Sheffield area had been delegated from the local authority to Sheffield Health and Social Care NHS Foundation Trust. This meant that staff had a responsibility to make enquiries and investigate safeguarding allegations where a person was believed to be experiencing mental health problems. Staff from the community mental health teams used the expertise of specialists in their teams to support them to do this, for example, social workers and approved mental health professionals. There were also 17 safeguarding managers across the three teams inspected to assist as required. The electronic data system they used had a section specifically for safeguarding information; the trust used this information to provide further guidance and monitoring. Safeguarding was included in the trust's mandatory training. The teams' overall compliance for level two adults safeguarding was 71%. Staff had a good understanding of safeguarding and the processes they were required to take. Some staff informed us that they felt alone on occasions where they were required to investigate safeguarding concerns that they had raised in the first instance. Staff did not always include safeguarding

Requires improvement

Are services safe?

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

considerations when discussing patients. For example, we observed a multi-disciplinary meeting where staff did not discuss possible safeguarding concerns around a recently assaulted patient or a female patient with young children.

The trust pharmacy dispensed medications to the community teams for some patients. Staff then filled compliance boxes provided by the pharmacy to assist patients in the medication regimes. A recent incident had resulted in a patient receiving incorrect medications following a staff member incorrectly filling a compliance box. This was because staff had not removed unrequired medication from the service's drug cupboard. At the time of the incident, there were no formal checks to ensure correct medications when this process occurred. Following the incident, the trust revisited medicines management requirements with staff, implemented a systems to ensure unrequired medications were returned to the pharmacy and arranged regular communication systems between the community teams and the pharmacy department. The trust's medicines management policy was also updated to encourage (with support) patients to fill their own compliance boxes or for arrangements to be put in place for medications to be dispensed and prepared via the patient's GP.

Systems were not robust to ensure the safety of staff working alone in the community. The trust had a lone working policy. The community mental health teams also had an additional protocol. The policy and additional protocols stated that staff should 'buddy' up with a colleague who worked similar hours. The expectation was that they should agree times to check each other's safety. Staff from the South East team checked in with their colleague at the end of each day, the South West team checked in at the end of each lone visit. The North team had less robust check in times defined at the time of our visit but adopted the protocols used in the South West team on the day of our inspection. Teams also used white boards to display staff whereabouts and when they had returned. However, no member of staff had the delegated responsibility of checking the board to ensure staff's safe return following community visits. This meant that a staff member's safety was reliant on one co-worker who may also be on community visits and therefore open to possible distraction. Staff did attend in pairs for first visits and where there was known concerns. Staff also had access to hand held personal alarms in the South East and South West teams. At the time of our inspection, the North team had personal alarms on order.

Track record on safety

There had been 11 serious incidents reported across the community mental health teams between 1 April 2015 and 31 March 2016. Nine of these were relating to apparent, actual or suspected self-inflicted harm. One was an apparent, actual or suspected homicide and one related to natural causes. Investigations following these incidents had improved practice. For example, an investigation into an attempted homicide resulted in improved joint working and communication with the local domestic violence team. In addition, processes for recording all information from referral were improved and added checks implemented from staff in duty teams.

Reporting incidents and learning from when things go wrong

Staff were able to describe and give examples of what constituted an incident and how to report it. However, all managers felt that staff did not always report less significant incidents. This meant they were unable to effectively capture all trends and themes for future learning. To rectify this, managers were using team meetings and supervisions to promote the need to record all incidents and ensure staff recognised the extent of the requirement to record even low-level occurrences. In addition, the South East team invited staff from the risk department to explain to their teams how they could use the information to populate both local and trust wide risk registers.

Managers from each team reviewed all incidents. Staff from varying levels across the trust investigated incidents depending on the seriousness. Managers shared lessons learnt among the community mental health teams in team meetings and supervisions. Managers invited specialists in to meetings to enhance the lessons. For example, the South West team included the trust pharmacist in a lessons learning session to educate staff around changes in anti-depressant medication for a patient following an incident and investigation.

Staff across all the community mental health teams also attended half-yearly lessons learnt days to share

Requires improvement

Are services safe?

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

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 adults community teams.

Following serious incidents, staff had the opportunity for a de-brief and were supported by managers.

Are services effective?

Good

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

Our findings

Assessment of needs and planning of care

On referral, the duty teams in each location carried out an initial assessment to determine the patient's priority in terms of need. Duty teams included at least two qualified staff who consulted with the psychiatrist attached to the team. Staff then completed a comprehensive assessment of a patient's needs on their first appointment. This included exploring their current situation, historical details, physical health, medications, family, social circumstances, employment, financial situation, safeguarding, abuse, forensic information and substance misuse. The assessment identified a patient's strengths and their goals. Following this process, staff and patients developed plans for their care and treatment.

The trust had introduced new collaborative care plans they were implementing into the community teams for adults. The new plans encourage staff to develop collaborative relationships with patients and to put patients' views at the centre of their treatment. The revised plans guided staff through a person-centred approach that they could reflect on their electronic systems for all staff to use as a working document. There was a target for all patients to have a collaborative care plan in place by the end of March 2017. We looked at the records of 23 patients. All patients had either a care plan which was in the old style format or the newer collaborative plan. 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.

All information needed to deliver care was stored securely on the trust's electronic system. All disciplines were able to access this information if needed. Staff also had access to some information from a patient's GP, for example, blood results.

Best practice in treatment and care

Staff were aware of the National Institute for Health and Care Excellence guidelines to inform their everyday practice. For example, staff in the early intervention teams were working within National Institute for Health and Care Excellence guidance to promote patient understanding and engagement on first presentation of psychosis. New updates in guidance were cascaded to staff through operational mangers meetings, team meetings and supervisions. Staff from the individual teams also attended practice development sessions to ensure they were aware of, and following best practice.

Patients had access to appropriate psychological therapies. All community teams included psychologists and cognitive behavioural therapists in their staffing. In addition there were cognitive behavioural therapists in each early intervention team. These staff provided therapies recommended by the National Institute for Health and Care Excellence, for example, mindfulness and dialectical behaviour therapy. The psychology team had worked in partnership with peer support service users to produce workbooks to help staff work with patients. 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.

Staff used a variety of approaches to measure a patient's severity and outcome. This depended on the needs and the diagnosis of the patient. Tools used included the Adult Self Reporting Scale and the Wender Utah rating scale for patients with attention deficit hyperactivity disorder.

Care records included interventions to support patients with their employment, housing and benefit needs. Both the South West and the South East teams included an employment and education worker for staff to refer into. Staff in the North team used the expertise of workers with social care backgrounds for guidance. Staff also referred into local organisations, for example, Citizens Advice and tenancy support.

Staff considered the physical health needs for patients at the start of their treatment as part of the assessment process. They liaised with the patient's GP for health information prior to a patient's care programme approach meeting and had access to GP records where this was agreed. However, all the teams had recognised the need to improve ongoing monitoring. We looked at 23 records; six of these had no evidence of a physical health review. These patients still had the old style care plans. We did observe discussions in multi-disciplinary meeting around physical health. There was also evidence of communication

Are services effective?

Good

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

between medical staff and GPs relating to a patient's specific needs, for example, diabetes and weight management. These considerations occurred without a formal review process. To assist staff with improved monitoring, the trust had introduced a new physical health checklist to the computerised records system approximately six weeks prior to our inspection. The checklist aligned to the new collaborative care planning process and prompted staff to carry out regular reviews. In addition to this, the North and South West teams had recently commenced physical health clinics delivered by medical or nursing staff. We reviewed this in January 2017 and found that the South West team had continued to deliver physical health clinics every four weeks and both the North and West team were delivering weekly physical health clinics. The trust used the care programme approach to coordinate care. Staff contacted a patient's GP prior to the annual review meetings. The GPs were invited to attend their patient's review; if this was not possible they were requested to provide a health summary. Figures supplied by the trust showed that 1369 patients receiving care through the community adults services were supported through the care programme approach. Of these, 95% had received a timely review which included a physical health review.

There were no formal systems in place to ensure patients on prescribed lithium or antipsychotic medications, for example, clozapine received regular monitoring. However, our evidence showed good practice being followed as required. We observed discussions between patients and psychiatrists relating to the side effects. We saw effective involvement from the trust's pharmacist and evidenced communication with GPs. Some staff used the Liverpool University Neuroleptic Side Effect Rating Scale with patients to enable them to self-rate the side effect of antipsychotic medications. We saw evidence in records and from an observed appointment of communication with patients' GPs. The provider had developed a guidance tool for GPs to support patients prescribed by the community mental health services. Additional to this, the trust and GPs followed a shared care protocol for bipolar disorder. This outlined the best practice for prescribing and monitoring patients maintained on lithium. The trust had participated in a series of lithium monitoring audits since 2008. The audits demonstrated sustained improvements in lithium, thyroid and renal monitoring. All new patients initiated on lithium had the required tests carried out prior to initiation, for example, epidermal growth factor receptor tests. Audits evidenced, that 90% of patients maintained of lithium had these tests done at least twice yearly and 85% had their lithium levels measured at least three times per year.

Staff participated in clinical audits to monitor the service's performance and make necessary changes. These included an audit in the South East home treatment team relating to discharged patients, an audit by a doctor around patients using depots and the high risk of cardiac arrest and an audit around patients driving to provide guidance to medical staff for discussions with patients using medications. Teams also regularly audited compliance with care programme approach reviews, care plans and risk assessments.

Skilled staff to deliver care

A full range of experienced and qualified mental health disciplines provided input to a patient's care and treatment. These included psychiatrists, clinical psychologists, occupational therapists, mental health nurses, social workers and recovery support workers. There was also an employment and education worker who supported staff in the South East and South West teams and a cognitive behavioural therapist in the North and South West teams. Both South East and South West teams had staff employed who were qualified as non-medical prescribers. All teams also included administrative staff to support managers and staff.

Staff felt supported and received regular and effective supervision every four to six weeks. Supervision rates within the teams were 75%, below the trust target of 80%. This was due to missed supervisions for staff on maternity leave and in seconded positions elsewhere in the trust. Staff were also able to participate in reflective practice supervision. Staff attended this in groups giving staff the opportunity to share concerns and seek peer support.

Staff received, and were mostly up to date with annual appraisals. This meant they had clear goals and objectives, which their manager reviewed regularly. This allowed the manager to identify improvements and assess the quality of care staff provided. All teams were over 95% compliant with annual appraisals.

Teams held regular meetings within their function and locality. There were also full locality meetings. Additionally, the community directorate held twice-yearly forums for

Are services effective?

Good

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

staff across all the teams in the service to meet giving them the opportunity to share practice, understand performance requirements, update on new initiatives and build effective relationships.

Additional to mandatory training, the trust supported staff to participate in related specialist training courses. These included staff who were attending training in cognitive behavioural therapy and a staff member training to become a social worker. Managers supported staff to develop roles in their specialist area. For example, a member of staff in the South East team had a practice interest in maternal mental health and was able to work with patients in that group. In addition, the South West team had a member of staff who was able to develop their role working with trans-cultural patients.

Multi-disciplinary and inter-agency team work

Each community team held multi-disciplinary meetings within their function area at least weekly. Staff of all disciplines attended the meetings. They worked collaboratively discussing each patient in turn. This included managing risk, treatment pathways, changes in presentation, capacity issues, physical health needs and carer's needs. Each discipline contributed effectively to discussions. This provided a good decision making forum with personalised and holistic discussions. Teams had an effective relationship with the trust's pharmacy that provided advice on medications as necessary.

Although each staff member had a defined role in either the access, early intervention, home treatment or recovery team, it was clear that all disciplines were flexible across the four functions within each community team. This meant that a patient's care was not ring-fenced by one function and the patient was therefore able to receive the expertise necessary at any particular time.

Staff told us that relationships with GPs were mostly positive and there was a good communication exchange. This was evident in the records we observed.

Teams also covered crisis care during working hours; a separate crisis team responded outside of normal working hours. Staff used the trust's electronic data system to communicate any patient information to the crisis team and vice versa. There was a night time log of calls where actions were incomplete or detailing potential risks which was seen by the operational managers. This was to ensure all concerns were followed through. Staff also used email as an additional safeguard to alert care co-ordinators of crisis calls.

Staff had good knowledge of local resources that they could signpost to patients. This enhanced their treatment and on-going recovery. For example, they used a partnership recovery organisation which encouraged enterprise and peer support. In the North, staff worked in partnership with leisure centre staff to facilitate exercise groups for patients with psychosis. We also observed staff supporting a patient to meet with a housing officer to review their eligibility for housing based on medical needs. Staff directed patients to community activity groups and community services to help with personalised budgets.

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

Mental Health Act training was not part of the trust's mandatory training for staff working in the community teams. However, the North team had a planned training day to provide staff with a greater understanding of the Act and the Mental Health Act Code of Practice. Staff had access to approved mental health professionals in the community mental health teams and sought advice and support from them when needed. Staff also referred to the Mental Health Act office as a central point for advice and administrative support.

The service was in the process of delivering specific training to staff that are not approved mental health professionals relating to Section 135 (2) of the Mental Health Act. The purpose of this was to enhance their understanding of their role and enable them to not necessarily require an approved mental health professional to apply for warrants if needed. This would mean response times would improve therefore reducing delays.

We looked at the treatment records of patients that were subject to community treatment orders. A community treatment order is part of Section 17 of the Mental Health Act. The order allows a patient to leave hospital and for community teams to provide treatment safely in the community. Treatment orders mean that patients are required to keep to certain conditions. For example, a condition could be for a patient to take their medication as needed. The trust conducted monthly audits of the records of patients subject to community treatment orders. Mental Health Act paperwork was in place in all records reviewed.

Are services effective?

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Staff adhered to consent to treatment and capacity requirements and prescribed medications matched the legal authority corresponding to the order. These were attached to the patient's medication cards.

Advocacy information was available for patients in the teams we visited and staff were aware of how to support patients to access advocacy services.

Good practice in applying the Mental Capacity Act

The Mental Capacity Act applies to those patients aged 16 and over who are treated informally rather than detained under the Mental Health Act 1983 or subject to a community treatment order.

The trust provided mandatory training on the Mental Capacity Act at level one and level two. The trust provided us with figures for compliance as at 13 October 2016. The overall compliance for those required to attend level one training on the Mental Capacity Act in community services for adults was 18.1%. For level two training, overall compliance was 52.5%, with community mental health teams in the South East 36% compliant, 35% compliance for the South West teams and 40% compliance for the North teams.

Staff knowledge and confidence in applying the Mental Capacity Act was variable. Some staff informed us they felt confident. However, staff were unable to tell us where they would access forms to assess capacity or where to record it. Managers and medical staff felt capacity and consent was not fully embedded into everyday practice. One staff member informed us that they were responsible for a complex capacity assessment around a patient's sexual behaviour and had not received training.

Psychologists in the South West teams delivered skill-sharing groups every two months. On one of these sessions, staff shared knowledge relating to mental capacity assessments. We also observed a consultant conducting a capacity assessment during a patient's appointment and staff seeking consent from a patient to discuss their treatment with family members.

Good

Are services caring?

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

Our findings

Kindness, dignity, respect and support

Staff showed a caring and supportive attitude to patients. They were sensitive to their needs and showed a good understanding of the issues they faced. We observed staff interacting with patients with kindness and patience during appointments. Staff spoke about patients in a respectful manner.

Patients told us that staff were committed and empowered them in their recovery journeys. Of the 33 patients we spoke to, one patient felt their named worker did not listen to them as needed.

The involvement of people in the care that they receive

Patients were involved in their care plans. They received information relating to their medications and staff offered them treatment options. Care plans and care programme approach reviews were patient centred and mostly recovery focused. Patients told us they received a copy of their reviews. However, this was not recorded in six of the 23 records we looked at.

Family members and carers were involved in a patient's care where the patient had agreed to this. Staff considered their needs during multi-disciplinary meeting discussions and at individual patient appointments. We observed an appointment where staff involved family members in discussions relating to a change in the patient's medication. Staff were both familiar and confident with carrying out assessments of carers' needs.

Services had information leaflets relating to conditions, medications, advocacy services and support groups. These were accessible to both patients and their carers.

Patients were able to get involved in decisions about their service. For example, patients assisted in interviews for new staff. Patients had also co-delivered training around mental health to professional organisations and co-produced workbooks to compliment a patient's treatment. In the South East team, patients had completed questionnaires to contribute suggestions on the re-decoration of their reception area. The South West team had recently invited patients to give service feedback in a questionnaire; at the time of our inspection, managers were awaiting for responses to be collated.

The trust also facilitated a service user network, which comprised a central group complimented by smaller locality meetings. Services used these meetings to encourage patients to participate in developing services, to improve understanding of services and to listen and respond to their concerns. Occupational therapists led the monthly meetings at a local level and fed this back to governance and staff meetings.

Are services responsive to people's needs?

Good

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

Our findings

Access and discharge

Each community mental health location received referrals for their own locality via their duty teams. Duty teams carried out initial screenings and staff saw urgent referrals without delays. The trust had a target for staff to see referrals for assessment within two weeks. However, all teams had waiting lists beyond this target. Figures provided by the trust showed that there was a wait of 23 days from referral to assessments in the South West locality, 39 days in the South East locality and 62 days for the North team.

Duty teams also received general queries from GPs, patients and members of the public. Each duty team included a range of disciplines including medical staff and approved mental health professionals. This meant they were able to respond to incoming calls in a timely manner.

Staff were flexible in their roles and worked collaboratively across the differing functions. This resulted in a seamless treatment journey for patients if they moved from one function to another. For example, a patient would not experience any gaps in their care when moving from the access team into the recovery team. Staff working within the home treatment teams provided in-reach services for inpatients on the wards to ensure smooth transitions and to plan for a patient's on-going care in the community.

Staff liaised with local services to engage with patients who were reluctant, or found it difficult to engage. This included substance misuse services, the travelling community and working alongside the homeless team.

Teams attempted to re-engage with patients who were not maintaining appointments using phone calls, visits and letters. Staff contacted the referrer if they were unable to re-engage the patient.

When staff from the community teams saw patients and decided a hospital admission was required, there were some delays in accessing an inpatient bed. This was because the bed manager was required to seek further authorisation to use a bed from doctors who may have already been involved in the original decision. This authorisation could also be provided by one of the three assistant clinical directors for the trust. Any delays meant a patient was unable to access necessary treatment quickly and could delay other resources, for example, the police. Approved mental health professionals felt that this undermined their statutory role where a patient required detention.

Staff made plans prior to a patient's discharge from community mental health services. Staff from the recovery teams held quarterly meetings to discuss patients either already identified for discharge or for consideration. All disciplines attended the meetings to develop the necessary plans to prepare the patient. This included advance statements, relapse prevention interventions and on-going support. Staff had conversations with patients prior to their meeting so their preferences and needs were included.

The facilities promote recovery, comfort, dignity and confidentiality

Staff sometimes saw patients at the community team's location base. All premises had adequate rooms to see patients. Rooms were sound proof to protect privacy and were comfortable with good quality furnishings. All areas of the building were well maintained, light and airy with pictures displayed that promoted a friendly environment. Visitors had access to water if needed. There was a good range of information relating to the trust, other services and treatment. We observed, and patients told us, that the reception staff were friendly and welcoming.

All the teams offered group activities to patients to promote their recovery. There was a recovery enterprise programme which was a 10 week programme covering a different topic each week such as healthy eating and personal care. The North team held a 'next steps' group to help patients identify external resources and activities in the community and to explore volunteering opportunities and further education. The South West team delivered art therapy classes that encouraged peer support. The trust also provided paid volunteering opportunities within their services for service users, for example, assisting on reception areas.

Meeting the needs of all people who use the service

The community mental health team's bases had access for people with mobility difficulties. There were interview rooms on ground level at all the services and disabled toilets if required. The trust provided an interpreting service where needed and information leaflets could be made available in different languages by request. We spoke with a patient who had limited sight, they told us that

Are services responsive to people's needs?

Good

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

information leaflets were not available in braille but they had received them in a larger print. They told us staff read out any information if they were experiencing difficulties. A further patient who had difficulties with reading and writing, informed us that the support workers provided assistance with online housing bids and other needs. The South West team had a staff member who was able to sign to assist patients with hearing impairments.

Listening to and learning from concerns and complaints

From the 1 September 2015 to 25 August 2016, community based mental health services for adults received 56 complaints. Of these, the South West team received 23 complaints, the South East team received nine and the North team received seven complaints.

The complaints mostly related to attitudes of staff and inadequate support. Following investigations, the trust had upheld nine complaints in the South West, five in the South East teams and one relating to the North Team. One complaint from the South West team had been referred to the ombudsman and was awaiting an outcome. The manager from the South West team believed this complaint related more to inpatient provision.

All services had information displayed so patients knew how to complain; they also had comments boxes in their waiting areas.

Managers dealt with the complaints in line with trust policy. They disseminated any learning through emails, meetings and in staff supervision.

Services also received and recorded the compliments they received. In the 12 months prior to our inspection, the South West team had received 73 compliments, the South East team had received 13 and the North team received eight compliments.

Are services well-led?

Good

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

Our findings

Vision and values

Sheffield Health and Social Care NHS Foundation Trust state their vision is to be recognised nationally as a leading provider of high quality health and social care services and to be recognised as world class in terms of co-production, safety, improved outcomes, experience and social inclusion. Their aim is to be the first choice for service users, their families and commissioners.

The trust had identified the following values to guide them to achieve their aim as:

- respect
- compassion
- partnership
- accountability
- fairness
- ambition

Staff were generally aware of the trust's values. Senior staff informed us that the values were reflected into operational practice through supervisions, meetings and appraisals.

Staff were aware of the senior managers within the trust. They told us of occasions when senior managers had visited the teams.

Good governance

The trust had effective systems in place to monitor and assess performance. This included information relating to supervisions, appraisals, training, incidents and complaints. However, managers had limited oversight of this information. During our inspection, they were unable to extract up to date data relating to training and supervisions from the trust wide systems. They had limited confidence in how to use the system effectively to capture an accurate picture of their individual services. To compensate for this, they had developed local methods of monitoring performance. However, this information differed from the data provided by the trust. Both trust wide systems and localised methods had identified similar shortfalls that required improvements such as mandatory training.

The service investigated and monitored incidents and complaints in order to improve. There were good structures in place to ensure managers informed staff of lessons learnt. However, there was no evidence to suggest that managers disseminated lessons learnt from other directorates to community teams.

Managers had sufficient authority to manage their teams and had the processes in place to raise issues at trust level.

Leadership, morale and staff engagement

Staff were mostly positive about the teams they worked in. They told us they enjoyed their work and that morale was reasonably high and that they felt part of one team. They received support from their colleagues, their managers and from staff in the other teams in their locality. This included staff at all levels and from the varying disciplines. The trust was due to reconfigure the community mental health teams in 2017; staff felt they had been included in the consultation process.

We saw examples where managers had considered staff wellbeing. Psychologists offered mindfulness sessions in all the teams. In the South East, staff had the opportunity to participate in a weekly yoga class.

We spoke with 39 staff members in total of varying disciplines and levels and across all three locations visited. One member of staff from the South East team felt morale was low and managers from each of the services felt their support was inconsistent due to changes in roles at senior management level.

Managers had received training in leadership through the trust and externally. Other staff told us there were opportunities to develop and to give feedback on service developments.

Staff knew the whistleblowing process and said they would be able to raise concerns if the need arose without fear of victimisation. The teams had no bullying or harassment cases at the time of our inspection.

Staff were open to patients and their families and carers when something went wrong. There was a general culture of transparency with managers actively encouraging staff to report incidents in order to promote improvement. The provider had a duty of candour policy, which staff understood and were able to give examples where this had been used.

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Good

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Commitment to quality improvement and innovation

Staff felt able to contribute to quality improvements through discussions in team meetings and supervisions.

The home treatment team in the South West were working towards the Royal College of Psychiatrists' accreditation.

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 18 HSCA (RA) Regulations 2014 Staffing How this regulation was not being met: Staff were not compliant with mandatory training across the service. This was a breach of regulation 18 (2) (a)