Rotherham Doncaster and South Humber 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	Great Oaks Swallownest Court Trust Headquarters - Doncaster	RXE92 RXE12 RXE00
Longstay/rehabilitation wards for working age adults	Trust Headquarters – Doncaster Swallownest Court	RXE00 RXE12
Forensic inpatient/secure wards	Trust Headquarters – Doncaster	RXE00
Wards for older people with mental health problems	Great Oaks Trust Headquarters –Doncaster Woodlands Unit	RXE92 RXE00 RXE07
Wards for people with learning disabilities or autism	Trust Headquarters – Doncaster	RXE00
Mental health crisis services and health based places of safety	Trust Headquarters – Doncaster	RXE00
Community based mental health services for working age adults	Trust Headquarters – Doncaster	RXE00
Community based mental health services for older people	Trust Headquarters – Doncaster	RXE00

Summary of findings

Specialist community mental health services for children and young people	Trust Headquarters – Doncaster	RXE00
Substance misuse services	New Beginnings - Doncaster Trust Headquarters -Doncaster	RXEX3 RXE00
Community health services end of life care	Trust Headquarters -Doncaster	RXE00
Community health services for adults	Trust Headquarters – Doncaster	RXE00
Community health services for inpatients	Trust Headquarters – Doncaster	RXE00
Community health services for children, young people and families	Trust Headquarters – Doncaster	RXE00
Adult Social Care	10a-10b Station Road 88 Travis Gardens Domiciliary Care Service	RXE74

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	Requires improvement 
Are Mental Health Services safe?	**Requires improvement** 
Are Mental Health Services effective?	**Requires improvement** 
Are Mental Health Services caring?	**Good** 
Are Mental Health Services responsive?	**Good** 
Are Mental Health 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

Contents

Summary of findings

Overall summary

When aggregating ratings, our inspection teams follow a set of principles to ensure consistent decisions. The principles will normally apply but will be balanced by inspection teams using their discretion and professional judgement in the light of all of the available evidence.

We rated Rotherham Doncaster and South Humber NHS Foundation Trust (the trust) as **Requires Improvement** because:

- Community mental health services for people with learning disabilities or autism at the Ironstone Centre did not have enough staff to meet the needs of people who used the service. We also identified shortages of community nursing staff in some locations.
- Medication management was not overseen effectively and different systems had been allowed to evolve in different areas of service. The community-based mental health teams did not have regular pharmacist support to ensure safe and effective administration of medicines. This had been identified as 'high risk' by the trust on the pharmacy risk register. In the community-based mental health services for adults of working age there was no consistent approach to medication management to support safe practices. In the substance misuse service, staff who were not suitably trained or competent administered medications in the social detoxification service at New Beginnings. The service had no consistent approach to recording medicines patients brought with them on admission and no clear protocols for stock control and storing patients' own medicines. There was only limited oversight of the process and it was not audited.
- Staff did not consistently monitor the physical health needs of patients of mental health services,which could result in some people's physical health needs not being met. In the community health inpatients service, Hawthorn and Hazel wards did not complete venous thromboembolism risk assessments in line with guidance from the National Institute for Health and Care Excellence (NICE) relating to adults admitted to hospital as inpatients.
- Not all risk assessments were completed, up to date and of good quality. Some lacked relevant information and important detail.
- At the time of the inspection, the percentage of staff completing mandatory training averaged 77% compared with the trust's mandatory training target of achieving 90% by 31 December 2015. Compliance with compulsory training, appraisal of work performance and managerial supervision was inconsistent across services and the trust was not meeting its own targets. 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. Staff who had not completed mandatory training could have been unaware of important changes in the trust's policies and procedures.
- The trust's senior management team were aware of the poor compliance with mandatory training and inconsistencies in recording which staff had completed some or all of the training. They had started to deal with these issues and recognised deficiencies in appraisals and were introducing changes. However, poor compliance with mandatory training had the potential for a negative impact on patient care and safety.
- The trust was not fully complying with its responsibilities under duty of candour and people did not always receive a timely apology when something went wrong. The trust did not provide enough guidance for staff on their responsibilities under the duty of candour.

However :

- There was a culture of collective responsibility between teams and services, and openness and transparency in communicating generally.
- People who used the trust's services were supported and treated with dignity and respect and were involved as partners in their care. Feedback provided by people who use the trust's services was generally positive. Staff were caring, engaged and supportive towards patients. People and staff were working together to plan care and there was evidence of shared decision-making and a focus on recovery.
- We rated the responsiveness of the community health services for children, young people and families as outstanding. The service planned and delivered care

Summary of findings

that met people's needs and was responsive to the changing needs of the local population. They also used innovation in care to meet the needs of local people and hard-to-reach groups.

- The trust handled complaints to a good standard, with managers and staff listening and responding to complaints and concerns and resolving issues quickly where possible.
- While in some clinical areas staff had problems with recording information on the trust's IT system, such as mandatory training, there were systems to monitor performance information.
- The chief executive had been in post for only three months at the time of the inspection, but had received a handover from the previous chief executive and demonstrated an understanding of what the key issues were for the trust. She was improving quality and staff across the organisation were clear about how the trust should develop. The board and senior team had the experience, capacity and capability to put the trust's strategy into effect. The trust leadership team actively engaged with staff, people who use the services, their representatives and stakeholders.

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:

- Community mental health services for people with learning disabilities or autism at the Ironstone Centre did not have enough staff to meet the needs of people who used the service. We also identified shortages of community nursing staff in some locations.
- Medication management was not overseen effectively and different systems had been allowed to evolve in different areas. The community-based mental health teams did not have regular pharmacist support to ensure safe and effective administration of medicines. This had been identified as 'high risk' by the trust on the pharmacy risk register. In the community-based mental health services for adults of working age there was no consistent approach to medication management to support safe practices. In the substance misuse service, staff who were not suitably trained or competent administered medications in the social detoxification service at New Beginnings. Not all risk assessments were completed, up to date and of good quality. Some lacked relevant information and important detail.
- Not all interview rooms were fitted with alarms to ensure staff and service user safety.
- Lone worker practices varied at different locations in order to meet the risks and requirements of the specific services. Some staff were lone working all day and had no contact with the team until 5pm. This meant there was no assurance regarding staff safety for many hours.
- In the specialist community mental health children and young people's service, risk assessments on the electronic system were poor, incomplete, or not updated. Also in that service, there was no system to monitor or give a point of contact for people referred and waiting for an assessment.
- The substance misuse service did not provide safe care.Staff did only basic risk assessments and completed them inconsistently and did not review them regularly. In 14 records reviewed, staff had done only a basic risk assessment and substance misuse was not identified as a risk factor. There were ligature points (places where someone intent on self-harm could tie something to strangle themselves) there and we did not see evidence that service users were individually risk assessed to include the possible risk of them using a ligature.

Summary of findings

There was no female-only lounge at New Beginnings, this will be required as the service moves towards being an inpatient service in order to meet the Department of Health's guidance on mixed sex accommodation.

- The trust was not fully complying with its responsibilities under duty of candour and people did not always receive a timely apology when something went wrong. The trust did not provide sufficient guidance for staff on their responsibilities under the duty of candour.
- At the time of the inspection, the percentage of staff completing mandatory training averaged 77% compared with the trust's mandatory training target of achieving 90% by 31 December 2015. Compliance with compulsory training, appraisal of work performance, and managerial supervision, was inconsistent across services and the trust was not meeting its own targets. 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. Staff who had not completed mandatory training could have been unaware of important changes in the trust's policies and procedures.
- The trust's senior management team were aware of the poor compliance with mandatory training and inconsistencies in recording which staff had completed some or all of the training. They had started to deal with these issues and with the recognised deficiencies in appraisals. However, poor compliance with mandatory training had the potential for a negative impact on patient care and safety.

However:

- We found that staff reported incidents of harm or risk of harm through an electronic reporting system and the trust investigated serious incidents using a root cause analysis process. Staff received feedback about incidents to help prevent recurrence. We saw examples of learning from incidents, such as a serious a medication incident at the hospice in 2014 that led to changes in practice.
- Staff were knowledgeable about safeguarding people from abuse and the trust had systems to safeguard adults and children. However, training figures on safeguarding were inconsistent. In some areas, trust data showed that no staff had received safeguarding training. For example, no staff at St John's Hospice day services were recorded as having received either level one children's or adults safeguarding training.

Are services effective?

We rated effective as requires improvement because:

Requires improvement

Summary of findings

- There were gaps in management and support arrangements for staff, such as appraisal of work performance and supervision.
- Not all staff could access all clinical information on patients as the trust used both paper and electronic records. This was confusing and risked information not being available when required, which could have a negative impact on staff's ability to provide safe and effective care and treatment.
- On the acute wards for adults of working age, and in psychiatric intensive care units, there were no positive behavioural support plans in the clinical notes of the patients who had experienced an episode of seclusion.
- Staff did not consistently monitor the physical health needs of patients of mental health services,which could result in some people's physical health needs not being met. In the community health inpatients service, Hawthorn and Hazel wards did not complete venous thromboembolism risk assessments in line with guidance from the National Institute for Health and Care Excellence (NICE) relating to adults admitted to hospital as inpatients.
- The systems described as being in place which should have been followed to ensure effective communication between families/ carers appeared not to be routinely followed.
- There was no evidence of any effective auditing process to ensure effective communication processes/systems were being followed.
- There were some inconsistencies in how people's mental capacity was assessed.

However,

- We found the trust was making good use of technology and telemedicine in community children's and young people's services.

Are services caring?

Good

We rated caring as **good** because

- People were supported and treated with dignity and respect and were involved as partners in their care.
- Feedback provided by people who use the trust's services was generally positive and staff were seen to be caring, engaged and supportive towards patients.
- People and staff were working together to plan care and there was evidence of shared decision-making and a focus on recovery.

Summary of findings

- People were supported to maintain their relationships with those close to them. They were enabled to manage their own health and care when possible and to maintain independence.

However:

- Staff's involvement with carers was not consistent .We heard mixed responses from families about their involvement in decisions being made about discharge.

Are services responsive to people's needs?

Good

We rated responsive as **good** because:

- We found that the needs of different people were taken into account in planning and delivering services, for example in terms of age, disability, gender, pregnancy and maternity status, race, religion or belief or sexual orientation.
- All buildings used for therapies in children and adolescent mental health services were accessible to disabled people.
- On the wards for older adults, the trust had sought advice and guidance from the King's Fund on layout to ensure it was dementia friendly.
- Chaplains visited the wards to see individual patients, and staff ensured these visits could take place in private.
- We rated the responsiveness of the community health services for children, young people and families as outstanding. The community health services for children, young people and families planned and delivered services that met people's needs and were responsive to the changing needs of the local population. It also used innovation in care to meet the needs of local people and hard-to-reach groups. This included ensuring additional resource was available when the service noted low breastfeeding uptake. This took into account equality and diversity needs and the needs of people in vulnerable circumstances. The service provided access to translation and interpretation services, and had links with new migrants to the area and the local lesbian, gay, bisexual and transgender (LGBT) community.
- Children and young people could access services in a variety of ways, in a manner and at a time to suit them. We saw examples of learning from complaints. This included the use of action plans to inform improvements.
- The trust was developing a physical health and wellbeing strategy to improve physical health monitoring.

However:

Summary of findings

- We found that occupancy levels in the long stay rehabilitation wards were at times above 100% as beds were used for new admissions that were allocated to patients who had been given leave. This was because patients were often moved from acute wards to the long-stay rehabilitation wards to make space for emergency admissions. Although a bed management policy supported this process, the practice enabled long 'sleep over' type stays on wards and one patient had moved wards 11 times in seven months.

Are services well-led?

Good

We rated well led as good because:

- The leadership, governance arrangements and culture promoted the delivery of high quality person-centred care.
- Staff across the trust knew and understood its vision, values and strategic goals.
- Quality received sufficient coverage in board meetings and in other relevant meetings below board level.
- Performance issues were escalated to the relevant committees and the board through clear structures and processes.
- The senior leadership team were knowledgeable about quality issues and priorities and they understood what the challenges were and had taken actions to tackle most of them.
- Performance information was being used to hold management and staff to account.
- Although the trust's chief executive was relatively new in post, the board and senior team had the experience, capacity and capability to ensure that the strategy would be turned into action. The appointment process of the new chief executive evidenced the board's effective selection, development and succession process.
- The leadership team engaged with staff, people who use the services, their representatives and stakeholders.
- There was a culture of collective responsibility between teams and services.
- Staff were able to raise concerns and those who had done so, including whistle blowers, were being supported.

However:

- Problems with IT systems impacted on the recording of and access to clinical information as well as the collection of data on important areas such as mandatory training. The trust had started taking action to increase the number of staff having managerial appraisals of their work performance but without significant improvement so far.

Summary of findings

- Whilst we found an open and honest culture, compliance with the trust's responsibilities to people who use services under the duty of candour was poor.

Summary of findings

Our inspection team

Our inspection team was led by:

Chair: Phil Confue, Chief Executive, Cornwall Partnerships NHS Foundation Trust

Head of Hospital Inspection: Jenny Wilkes, Care Quality Commission

Team Leaders: Jonathan Hepworth (Mental Health), Care Quality Commission

Cathy Winn (Community Health Services), Care Quality Commission

Caroline Mitchell (Adult Social Care), Care Quality Commission

The team included CQC inspectors and specialists comprising an advanced nurse practitioner, consultant psychiatrists, consultant nurses, district nurses, end of life care nurses, health visitors, junior doctors, Mental Health Act reviewers, mental health social workers, a modern matron, nurses (Registered General Nurses, Registered Mental Nurses and Registered Nurses for Learning Disabilities), occupational therapists, a paediatric nurse, pharmacy inspectors, physiotherapists, psychologists, a school nurse, senior managers, social workers and specialist registrars and experts by experience (who had personal experience of using or caring for someone who uses the type of services we were inspecting).

Why we carried out this inspection

We inspected this NHS trust as part of our ongoing comprehensive mental health inspection programme.

How we carried out this inspection

To get to the heart of 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 visiting, we reviewed information we held about Rotherham, Doncaster and South Humber NHS Foundation Trust (the trust) and asked other organisations to share what they knew. We held listening events at each main hospital location for detained patients. We also met with groups of carers before the inspection at a number of hospital locations.

We carried out an announced visit between 14 September and 18 September 2015. We visited Laurel ward the following week due to an unexpected death on the ward and we inspected the early intervention service in Manchester during the week beginning 21 September for logistical reasons.

During the visit, we:

- held focus groups with staff who worked in the service, including nurses, doctors, psychologists, allied health professionals, and administrative staff
- met with 460 trust employees
- met with representatives from other organisations, including commissioners of health services and local authority personnel
- met with 179 patients, who shared their views and experiences of the core services we visited
- observed how patients were being cared for
- reviewed 312 care and treatment records and medication administration charts of patients who use services.
- spoke with 94 carers or relatives of people who use the service.

Summary of findings

- looked at a range of records including clinical and management records.

Information about the provider

Rotherham Doncaster and South Humber NHS Foundation Trust provided services across Rotherham, Doncaster, North and North-East Lincolnshire, and Manchester. These included community and inpatient mental health and learning disability services, and drug and alcohol services. The trust also had services for working age adults, older people, and children and young people. The trust provided community health services across Doncaster and had recently been awarded the contract to provide school nursing in Scunthorpe.

•**Foundation Trust status:**Rotherham Doncaster and South Humber NHS Foundation Trust has been a foundation trust since 2007.

•**Commissioning:**The trust works with NHS England, Rotherham Clinical Commissioning Group (CCG), Doncaster CCG, Manchester CCG and North Lincolnshire CCG.

•**Trust Headquarters:**Woodfield House, Tickhill Road Site, Weston Road, Balby, Doncaster, DN4 8QN.

Inpatient beds

• Number of total trust inpatient beds: 336

• Number of trust locations providing inpatient beds: 17

Staff Total

• 3,700 staff (full time and part time) and about 200 volunteers.

Previous year's financial position: 2013/14

• Operating expenditure on health and social care in 2013/14 totalled £155.4 million.

The trust had diversified from mental health and learning disability services to include community services, such as district nursing and health visitors, with 115,000 people using services in 2014.

The trust provided services through seven business divisions:

1. Adult Mental Health Services

2. Children and Young People's Mental Health Services

3. Forensic Services

4. Learning Disability Services

5. Older People's Mental Health Services

6. Substance Misuse Services

7. Doncaster Community Integrated Services

The trust provided the following core services that we inspect at every inspection:

Mental health wards:

- Acute wards for adults of working age and psychiatric intensive care units.
- Long stay/rehabilitation mental health wards for working age adults.
- Forensic inpatient/secure wards.
- Wards for older people with mental health problems.
- Wards for people with learning disabilities or autism.

Community-based mental health and crisis response services:

- Community-based mental health services for adults of working age.
- Community-based mental health services for older people.
- Mental health crisis services and health-based places of safety.
- Community mental health services for people with learning disabilities or autism.
- Specialist community mental health services for children and young people.

Community Health Services:

- Community health services adult.
- Community health services children and young people.
- Community end of life.
- Community inpatient.

We also inspected the following services that the trust provided:

Adult social care services.

Summary of findings

- 88 Travis Gardens
- 10a-10b Station Road
- Domiciliary Care Services

Substance misuse services

- New Beginnings – social detoxification
- Community substance misuse services

With regards to the trust's substance misuse services, a letter was sent to the trust on 27 August 2015 from the CQC issuing the notice of the decision to add the New Beginnings location for the treatment of disease, disorder, or injury. The registration certificate was issued on 14/09/15. On the day of the inspection New Beginnings was registered as a hospital inpatient based service. However, CQC recognises that at the time of the inspection the service was undergoing a period of transition and was operating as a social detoxification. This has been reflected in the report when referring to the New Beginnings service.

There had been 19 inspections at eight locations registered to Rotherham Doncaster and South Humber NHS Foundation Trust. These inspections had taken place between September 2012 and January 2014. All locations were compliant with the essential standards, now the fundamental standards.

What people who use the provider's services say

Focus Groups

Before the inspection, we spoke with service users and their carers across the trust. We facilitated six focus groups for detained patients at three hospital locations, covering Doncaster, Scunthorpe and Rotherham, and ran three focus groups for carers at three hospital locations.

At the Rotherham detained patients' focus group, a general point was made that 'there is no dedication to quality care here'. Other patients agreed that summed up the current situation.

Staff attitudes were discussed at length. Some were identified as being kind others were reported to laugh or say horrible things to or about patients in front of them.

Patients at Rotherham said that children could not visit on the ward and although there was a family room it was very small with three chairs and little equipment and no space to play.

Patients told us medical reviews could be intimidating. They can go in with an advocate but no one listened to them.

The outside area on one ward was reported to be dirty. Patients said the cleaning internally was OK but sometimes it seemed like dirt got pushed around the floor.

Food had improved a lot 'this week'.

Halal food was available but there was only one meal choice.

At the focus group for detained patients in Doncaster, some patients said that the ward they were on felt safe and the environment was clean, safe and nicely furnished. Patients had their own rooms with ensuite facilities. They had a lockable safe to store valuables and could personalise their bedrooms.

Patients at the Doncaster focus group were positive about the range of activities and their access to them. Patients from the secure wards said they could make complaints and the unit the manager was available and would speak with patients to resolve complaints or concerns. Their physical health needs were met and if they were physically ill there was good access to GP services.

On the secure services rehabilitation ward, patients told us that they could cater for themselves and that the food was good. Patients said they got help from the occupational therapist to cook. However, patients who were not able to cook for themselves said that food quality was not good and they did not always get what they ordered.

Detained patients in Scunthorpe told us that while there was good peer support, they did not always feel that staff were supportive. One patient said the quality of staff was variable – some were better than others. However, patients said they would talk to staff if they wished to complain. They felt they would be listened to if they raised any issues. All said they knew why they were in hospital. Staff had explained what their rights were if detained under the MHA.

Summary of findings

They were not all aware of having an advocacy service or Independent Mental Health Advocate, They said information about an IMHA was on the wall but they didn't understand what one was.

No one at the focus group could tell us who their care coordinator/named nurse was, or about their discharge plans.

Patients said that there was a wide range of activities available, including colouring, music, air hockey and pool. Some patients said lights on the wards were left on all night, that the doors banged and that staff woke patients when doing their nightly checks. Patients did not understand why staff did not use the observation screen in bedroom doors for night observations.

Food was described as being OK, with meals at regular intervals. If patients had personal money, they could make arrangements for take-away meals to be delivered to the ward.

Patients could have visitors in private, could ring friends and family and could have their mobile phones as long as they agreed not to take photos. They could ring someone if they were upset and maintain contact with family and friends.

All patients reported feeling safe on the wards.

The carers' focus groups fed back that they wanted more information on the care and treatment provided and information on access to the wards for visits.

Comment Cards

During the inspection we received 127 comments cards from people who use services at the trust across 31 locations.

- Of these, 98 were positive (77%), 21 negative (17%) and 8 mixed (6%).
- St John's Hospice had the most cards received with 14, 13 of which were positive.
- Negative comments were mainly about different people turning up making things confusing (learning disability, early interventions), long waits in child and adolescent mental health services, things promised and not provided,and people saying that they were not being listened to or ignored (Clearways, ICT and Amber lodge).
- Positive comments were mainly about very helpful and caring staff, feeling listened to and a clean environment.
- Great Oaks had nine comment cards all of which were negative, highlighting disrespectful staff, lack of curtains and privacy, property going missing, patients being unnecessarily restrained, staff delay in prescribing medication, lack of towels, and lack of support to patients with no family.

Friends and Family Test

Friends and family test results showed that 86% of staff were either 'likely' or 'extremely likely' to recommend the trust as a place to work and 79% as a place to receive care. The national averages are 61% and 76% respectively.

Patient Opinion

Patient opinion rates trusts using stars.

The trust scored the following (rating 1-5 stars):

Accessibility – 3.4 stars

Environment –3.8 stars

Information – 3.2 stars

Involved – 3.2 stars

Listening – 3.1 stars

Medical – 0

Nursing –0

Social support – 3.2 stars

Respect – 3.1 stars

Timeliness 3.1 stars

Comments left on the site included

What is good?

- Addiction services were described as having very helpful staff.

What could be improved?

- There were multiple comments relating to contacting the crisis team and being told that no help was available. One service user suffering from agoraphobia said they had been in the house for 15 days with no help.

- There were also multiple comments relating to lack of follow-up care from the crisis resolution and home treatment team. One comment said the team did not make contact with a service user after three days of waiting, putting them in danger of self harm.
- One service user commented that they were discharged from their keyworker without any warning or preparation.

Good practice

We found the following good practice:

Community health services for children, young people and families

- The service had developed local education and health aids, including 'pants on the line' (a tool to educate about inappropriate sexual contact) and the clinic in a box (a sexual health kit that could be collected by young people and taken away).
- The service had developed a system called 'Roots of Empathy' that involved working with primary school children to build empathy and to prevent bullying. The system involved introducing a baby into a primary school class. We were told that evidence from Canada had shown that it reduced the level of bullying. The initiative had been funded by NHS England.

Community health services for adults

- The wheelchair service was proactive in managing response to treatment so that seasonal trends were anticipated.
- Telehealth had been developed in response to the needs of patients with long-term conditions.
- The respiratory specialist service had an innovative system for managing oxygen intolerance.
- The specialist falls service facilitated the falls and balance group for patients attending a 12-week balance programme. We reviewed positive patient feedback about the programme.
- The dietetics service used the MUST tool innovatively to support community nurses offering "Food First" advice.

Domiciliary Care Service

- There was good, clear guidance for staff about what people liked to eat and drink and how they needed to be supported, and people were involved in choosing what they ate. People's comments, and our observations indicated they were happy with the meals provided. We saw specialist dietary needs had been assessed and catered for and people received a well-balanced diet.
- People were supported to maintain good health, had access to healthcare services and received ongoing healthcare support.

88 Travis Gardens, a care home for people with a learning disability, in Hexthorpe

- People's needs had been identified and we observed people's needs were met by staff. Staff put a lot of emphasis on observations, especially for signs of any discomfort, as people could not always communicate their needs verbally. There was very positive interaction between people and the staff supporting them. Staff used touch as well as words and tone to communicate with people to good effect. Staff spoke to people with understanding, warmth and respect and gave people lots of opportunities to make choices. The staff we spoke with knew each person's needs and preferences in great detail, and used this knowledge to provide tailored support to people.

Mental health crisis services and health-based places of safety

- Patients could seek help 24 hours a day, seven days a week, across the service. At Great Oaks, the advanced nurse consultant had recently received the Queen's Nurse award. The title of Queen's Nurse indicates a commitment to the values of community nursing, high standards of practice, excellent patient-centred care and a continuous process of learning and leadership.

There were good examples of partnership working across the service:

- At Great Oaks, research projects were planned in partnership with the University of Derby and Sheffield Hallam University.

Summary of findings

- In Doncaster, the street triage team had won the trust's award for partnership working and the Doncaster district police diversity achievement of the year award. The perinatal service had made links with mother and baby mental health units, child and family services, midwives, health visitors and substance misuse services.
- Rotherham and Doncaster operated a liaison and diversion service, in partnership with Together and in collaboration with South Yorkshire Police, criminal justice agencies and local CCG commissioners. The street triage team had reduced detentions under section 136 of the Mental Health Act 1983 by 32% in Rotherham and by 23% in Doncaster.

There were excellent examples of developments to improve services for patients and excellent commitment to quality improvement across all the teams:

- In Doncaster, a perinatal mental health service had been set up and patients were being helped to develop wellness recovery action plans (WRAPs).
- In Rotherham, there was a dedicated service for deaf patients with mental health problems and crisis contingency plans were being introduced for patients who had regular episodes of needing crisis care.
- At Great Oaks, a 'perfect week' was planned for early October and the service had significantly reduced waiting times for mental health assessments for patients with learning disability and autism. There were multiple levels of supervision that helped staff develop and a drive to increase participation in research.

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

- The inpatient services at Mulberry house were to undertake the "perfect week". This involved a whole system approach to the management of admissions and discharges into the ward beds, and to review the use of crisis care pathways and respite provisions.

Community mental health services for people with learning disabilities and autism

- People we spoke with particularly commended the service provided at The Solar Centre. We observed people using the service and saw that regardless of their abilities everyone was included in all the activities on offer. It was clear the activities were enjoyed by everyone.
- Funding had been obtained to enable a 12 month Section 117 project which was providing intensive support to people subject to a 117 section under the Mental Health Act. As a result of this project a new 'waiting and rating' tool had been developed across the service.

Wards for older people with mental health problems

- The service had a cognitive stimulation programme to support patients with impaired cognitive functioning.
- The service had sought advice and guidance from the King's Fund to ensure wards were dementia-friendly.
- The service had contributed to National Institute of Health Research (Help Beat Dementia) study.
- The service had published a booklet in 2015 on the application of music and art therapy for people with dementia in the Woodlands.
- The electro convulsive therapy clinic was accredited as excellent by the Royal College of Psychiatrists
- The service had developed a piece of work across all wards on the reduction of falls in older patients.

Substance Misuse Services

- Peer mentor schemes had been developed in all services. Dedicated staff recruited service users to the schemes through an application process and provided ongoing support. Training packages had been developed to give service users the skills and knowledge to become mentors. Peer mentors from New Beginnings worked across the services in Doncaster and three had progressed into jobs in the services.

Long stay/rehabilitation mental health wards for working age adults

- Service users and staff at Coral Lodge held activities in February 2015 as part of national Time to Talk Day campaign. The campaign aimed to get people around the UK to have a conversation for just five minutes about mental health.

Community-based mental health services for older people

Summary of findings

- Young onset dementia day care offered carers respite and was designed to help keep patients engaged and in the community.
- The service ran support groups for male carers and for people with Huntingdon's disease and their carers.

Areas for improvement

Action the provider MUST take to improve

An action that a provider of a service MUST take relates to a breach of a regulation that is the subject of regulatory action by the Care Quality Commission. Actions that we say providers SHOULD take relate to improvements where there is no breach of a regulation

Action the provider MUST take to improve:

Community mental health services for people with learning disabilities and autism

The trust must ensure that:

- the Ironstone Centre has enough staff to keep people receiving services safe
- staff complete risk assessments and update them within given timescales or where a change in risk is identified
- staff complete environmental risk assessments for all locations to ensure the safety of people who use services and staff
- psychiatry rooms used by Rotherham Community Learning Disability Team are made safe for staff and people who use services
- staff are protected from potential harm by providing access to audible alarms.

Substance Misuse Services

The trust must ensure that:

- staff responsible for administering medication in the social detoxification service are suitably trained and competent.
- staff complete comprehensive risk assessments for each service user and review them regularly.
- staff prepare care plans that are comprehensive, recovery-focused and take into account each service user's physical, mental, and social conditions in the treatment of their illness, and review the care plans regularly.

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

- The trust must review its seclusion policy to ensure that the use of a seclusion garment is detailed in the procedures.

Long stay/rehabilitation mental health wards for working age adults

The trust must ensure that:

- all bags used for storing emergency equipment are well maintained and fit for the purpose of delivering equipment safely in an emergency situation
- staff check that all fridge thermometers record the highest and lowest temperatures daily, reset thermometers daily and record it to help ensure the safe storage of medication and reduce any adverse effects on patients of taking medication damaged by not being kept at the correct temperature
- medication is administered in accordance with prescription charts and that any reason for a dose not being administered is recorded at the time to show safe compliance with prescribed medication, reducing the risk of any adverse impact on the patient
- staff complete mandatory training to achieve its standard target of 90% and provide systems to record accurately which staff have been trained to help them maintain the necessary skills to provide safe care to patients.

Specialist community mental health services for children and young people

- The trust must ensure that staff complete risk assessments and prepare complete care plans and keep them up to date.

Wards for older people with mental health problems

The trust must ensure that:

- staff have detailed comprehensive knowledge of the Mental Capacity Act and its application to ensure patients are cared for in accordance with the correct legal framework

- daily nursing notes reflect the care and treatment of patients to ensure care is being delivered in accordance with care plans and risk assessments.

Community health inpatients

The trust must ensure that:

- staff complete venous thromboembolism risk assessments on all patients admitted and that compliance is monitored as part of the safety thermometer measures of safety.

Trust wide Duty of Candour:

The trust must ensure that:

- staff identify and manage incidents triggering the duty of candour
- verbal and written apologies are made to the relevant people and recorded in line with the trust's responsibilities under the duty of candour.

Action the provider SHOULD take to improve

Community mental health services for people with learning disabilities and autism

The trust should ensure that:

- care records reflect people's capacity to make decisions where mental capacity is in question
- care records are regularly reviewed and up to date
- Mental Health Act training is provided to all appropriate staff.

Substance Misuse services

The trust should ensure that:

- complaints procedures are accessible to all service users
- effective audit systems are used across the division in relation to care records.
- a female-only lounge is available at all times in the social detoxification service

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

The trust should:

- ensure that managers undertake routine audits to monitor compliance with the trust seclusion policy and take action if staff are failing to follow required procedures
- consider installing specialist mirrors to reduce blind spots in the main corridors of the acute admissions wards and the bedroom area of the Mulberry plus area
- continue with the plan to ensure compliance with mandatory training across the inpatient wards, particularly to tackle low compliance with training on safeguarding of people from abuse and management of violence and aggression
- ensure that consent to treatment is being recorded in all case records
- ensure that section 17 leave risk assessments are completed before patients take leave
- ensure that female-only lounge areas are provided for all wards
- prioritise the roll-out of positive behaviour support plans for individuals who may be subject to restrictive practices such as restraint and seclusion
- ensure that oxygen cylinders are securely stored in cylinder holders or an appropriate trolley
- repair the blinds in the seclusion rooms on Kingfisher ward and in Mulberry house to improve natural light in those rooms and identify alternative arrangements to maintain privacy if the blinds are open
- change the lighting in the seclusion room on Kingfisher ward to enable lights to be dimmed
- ensure that the clock is replaced in the seclusion facility at Mulberry house to enable patients in seclusion to maintain awareness of the time of day.

Wards for people with learning disabilities or autism

The trust should ensure that:

- managers provide clinical supervision to staff in line with its policy
- mandatory training complies with its target of 90% in all areas.

Long stay/rehabilitation mental health wards for working age adults

- The trust should ensure that tools used to calculate minimum staffing levels on wards are robust. Ward staff should be involved in agreeing the levels and ensuring they are maintained. Sufficient staff should be employed as part of the nursing establishment to enable the minimum levels to be achieved and safe staffing information displayed on the trust website should relate to the agreed minimum levels

Summary of findings

- the trust should monitor the ongoing use of locum psychiatrists to reduce any negative impact on the consistency of patient care.

Specialist community mental health services for children and young people

The trust should ensure that:

- staff receive mandatory training in equality and diversity and in conflict resolution in line with its own target
- non-medical staff receive managerial appraisal of their work performance
- Mental Health Act (MHA) and Mental Capacity Act (MCA) mandatory training is completed on induction training as a once-only session; the trust should ensure a more robust training schedule for MHA and MCA.
- communication with people who use the service who are waiting for assessment after referral is improved, ensuring patients have a point of contact.

Wards for older people with mental health problems

- The trust should ensure that all member of the multidisciplinary team work in an integrated and effective way.

Community-based mental health services for older people

The trust should ensure that:

- all care plans across the community mental health teams are personalised and recovery-focused
- staffing levels and caseloads for community mental health teams follow Department of Health guidance.

Community health inpatients

The trust should:

- develop a consistent and accurate record of mandatory training
- The service should ensure the vision and strategy are clearly documented and linked to the trust's strategic objectives.review the process of recording risk.

Community End of Life Care

The trust should:

- ensure staff receive mandatory training and that it is recorded
- review use of inpatient hospice beds to enable the needs of the population to be safely met in a timely manner.

Community health services for children, young people and families

The trust should:

- ensure that local training and appraisal records are reviewed to help make trust-wide training and appraisal data accurate
- engage with the local acute trust to ensure that data being used to plan health visits to new mothers is accurate and communicated in a timely manner
- review how it manages and measures caseloads for health visitors and school nurses
- continue to take action to meet its target in regard to breastfeeding.

Rotherham Doncaster and South Humber 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 service provider.

The trust had clear governance systems for meeting its responsibilities under the Mental Health Act (MHA). Lead MHA administration staff had been in post for several years and understood their roles well. Staff in these posts received ongoing training to support them as well as regular supervision and appraisal of their work performance by the MHA Manager. Staff we spoke with on the wards said the service was responsive and supportive. The service enabled the trust to discharge its responsibilities under the MHA.

Detention papers on files both on the wards and in the MHA offices were generally in very good order and we were told that there was a comprehensive system of scrutiny that involved MHA administrators, doctors and ward nurses who all used scrutiny checklists.

The trust had a clear system to ensure that patients' rights were read to them on admission and that this was regularly repeated according to the trust's policy.

Patients were routinely referred to the local independent mental health advocacy (IMHA) service following detention. We saw that the IMHA service had a strong presence on the wards.

The MHA manager had identified where the Code of Practice (CoP) introduced in April 2015 had changed from the previous version. The trust had an implementation plan following the introduction of the new code. This plan recognised that a review of many of the trust's policies was required. The implementation plan had a projected end date of the end of October 2015. We were told that staff training sessions had been planned until the end of September 2015, although some staff we spoke with on the wards had not yet had dates for their training and were not expecting to receive it by the end of September 2015.

Staff received training related to the Mental Health Act covering tribunals, patient rights, code of practice, consent to treatment and specific consent issues relating to children and young people.

Mental Capacity Act and Deprivation of Liberty Safeguards

The trust has trained 95% of it's staff in the specialised children and young people's mental health services on MCA and deprivation of liberty safeguards (DoLs).

Training on the MCA was part of the trust induction programme for new staff and was given as one-off training in conjunction with MHA training. However, despite this, our inspectors found varying degrees of knowledge about the MCA and its use.

Detailed findings

There was a trust policy on MCA which was available to all staff via the trust's intranet.

We found good practice regarding consent, mental capacity assessment and implementation of deprivation of liberty safeguards in some areas, such as community health inpatients wards. However, we found inconsistencies in the recording of mental capacity assessments in other areas such as community nursing.

Within the mental health services, staff followed good practice regarding consent to care and treatment with a few exceptions. For example, in the older adults community service, we found that staff carried out capacity assessments on all patients consenting to informal admission to inpatient service. This was regardless of the nature of the patient's illness. If a patient had a mental illness and was ill enough to merit a transfer from the community mental health team to inpatient services, it was sufficient to overturn a presumption of capacity and trigger assessment of capacity. On the wards for older people, staff did not have sufficient understanding or knowledge of applying the Mental Capacity Act.

However, staff recorded discussions and decisions clearly in do not attempt cardio-pulmonary resuscitation (DNACPR) forms; the forms we viewed were completed with the signature and date by the appropriate senior medical practitioner.

On the wards for people with learning disability and autism, we found that 100% of staff were trained in the Mental Capacity Act and that 'best interest' meetings were held and recorded and consideration was given to the Mental Capacity Act to ensure that the least restrictive option was considered. Staff were aware of the trust's deprivation of liberty safeguards procedures.

In the specialist services for children and young people, of the 21 care records reviewed during the inspection, only three were found to have capacity taken into consideration and recorded. Six records out of 21 care records showed evidence of informed consent.

'Gillick Competence' can be used to decide if a child under 16 years can consent to medical treatment without permission or knowledge of their parent. We were told that the Gillick competence was in use within

the trust, but there was no evidence produced to support this. In addition, we found no evidence to show that MCA use within CAMHS was audited.

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

We rated safe as requires improvement because:

- Community mental health services for people with learning disabilities or autism at the Ironstone Centre did not have enough staff to meet the needs of people who used the service. We also identified shortages of community nursing staff in some locations.
- Medication management was not overseen effectively and different systems had been allowed to evolve in different areas. The community-based

mental health teams did not have regular pharmacist support to ensure safe and effective administration of medicines. This had been identified as 'high risk' by the trust on the pharmacy risk register. In the community-based mental health services for adults of working age there was no consistent approach to medication management to support safe practices. In the substance misuse service, staff who were not suitably trained or competent administered medications in the social detoxification service at New Beginnings. Not all risk assessments were completed, up to date and of good quality. Some lacked relevant information and important detail.

- Not all interview rooms were fitted with alarms to ensure staff and service user safety.
- Lone worker practices varied at different locations in order to meet the risks and requirements of the specific services. Some staff were lone working all day and had no contact with the team until 5pm. This meant there was no assurance regarding staff safety for many hours.
- In the specialist community mental health children and young people's service, risk assessments on the electronic system were poor, incomplete, or not updated. Also in that service, there was no system to monitor or give a point of contact for people referred and waiting for an assessment.
- The substance misuse service did not provide safe care.Staff did only basic risk assessments and completed them inconsistently and did not review them regularly. In 14 records reviewed, staff had done only a basic risk assessment and substance misuse was not identified as a risk factor. There were ligature points (places where someone intent on self-harm could tie something to strangle themselves) there and we did not see evidence that service users were individually risk assessed to include the possible risk of them using a ligature. There was no female-only lounge at New Beginnings, this will be required as the service moves towards being an inpatient service in order to meet the Department of Health's guidance on mixed sex accommodation.
- The trust was not fully complying with its responsibilities under duty of candour and people did not always receive a timely apology when something went wrong. The trust did not provide sufficient guidance for staff on their responsibilities under the duty of candour.
- At the time of the inspection, the percentage of staff completing mandatory training averaged 77% compared with the trust's mandatory training target of achieving 90% by 31 December 2015. Compliance with compulsory training, appraisal of work performance, and managerial supervision, was inconsistent across services and the trust was not meeting its own targets. 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. Staff who had not completed mandatory training could have been unaware of important changes in the trust's policies and procedures.
- The trust's senior management team were aware of the poor compliance with mandatory training and inconsistencies in recording which staff had completed some or all of the training. They had started to deal with these issues and with the recognised deficiencies in appraisals. However, poor compliance with mandatory training had the potential for a negative impact on patient care and safety.

However:

- We found that staff reported incidents of harm or risk of harm through an electronic reporting system and the trust investigated serious incidents using a root cause analysis process. Staff received feedback about incidents to help prevent recurrence. We saw examples of learning from incidents, such as a serious a medication incident at the hospice in 2014 that led to changes in practice.
- Staff were knowledgeable about safeguarding people from abuse and the trust had systems to safeguard adults and children. However, training figures on safeguarding were inconsistent. In some areas, trust data showed that no staff had received safeguarding training. For example, no staff at St John's Hospice day services were recorded as having received either level one children's or adults safeguarding training.

Detailed findings

Our findings

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 (NRLS) and to the Strategic Executive Information System (STEIS) 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. For example, the NRLS does not collect information about staff incidents, health and safety incidents or security incidents.

Providers are encouraged to report all patient safety incidents of any severity to the NRLS at least once a month. The average time taken for the trust to report incidents to NRLS was 14 days which means that it is considered to be a consistent reporter.

The trust reported a total of 5,397 incidents to the NRLS between 1 July 2014 and 30 June 2015. When benchmarked the trust were in the top 25% of reporters. 46% of incidents reported to NRLS resulted in no harm, 43% in low harm, 9% in moderate harm, 0.1% in severe harm and 1% 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.

The most commonly reported incidents were relating to 'implementation of care and ongoing monitoring / review (including pressure ulcers)' (31%), 16% were 'patient accidents', 12% were 'documentation errors' and 16% were associated with 'disruptive, aggressive behaviour'.

Trusts are required to report serious incidents to STEIS. These include 'never events' (serious patient safety incidents that are wholly preventable). The trust reported 68 serious incidents between 1 July 2014 and 30 June 2015. None of these were never events. 51% of these incidents related to the death of a patient. 31% of the incidents were related to pressure ulcers, 28% were the unexpected death of patient who was receiving community mental health services and 24% were regarding suspected suicides.

Between 1 February 2014 and 30 March 2015, trust staff reported 89 serious incidents. Of these 45% involved the death of a patient. The majority of these incidents were reported by the adult community mental health services who reported 45% of the serious incidents, 35% were reported by adult community health services. The commonest type of serious incidents were pressure ulcers (39%), unexpected death (26%) and attempted/suspected suicide (19%).

The number of the most severe incidents recorded by the trust serious incident reporting system is broadly comparable with that reported to STEIS. This gives us more confidence in the validity of the data.

CQC's mental health intelligent monitoring report about the trust published in June 2015 did not identify the trust as an outlier on any of the indicators relating to mortality for people using the service or in relation to the NHS staff survey findings on incident reporting.

The Ministry of Justice publish summaries of recommendations that have been made by coroners with the intention of learning lessons to help prevent future deaths. There was one report relating to the trust, published on 1 June 2015. This concerned a service user who hung themselves after being discharged home after a period of inpatient treatment. Two concerns were identified in the report:

- **Effective communication with families/carers:** The systems described as being in place which should have been followed to ensure effective communication between families/ carers appeared not to be routinely followed. Furthermore, there was no evidence of any effective auditing process to ensure effective communication processes/systems are being followed.
- **Early discharge plan** (a mechanism to try and ensure a seamless transition from inpatient care to community based care, in appropriate cases): Whilst the system had been adopted locally and was being re-evaluated, the coroner's report recommended that consideration should be given as to whether the guidance adequately incorporated the ethos and workings of the early discharge plan the service user was on. Witness knowledge and understanding of this pathway was variable.

Learning from incidents

There was evidence incidents were escalated through the electronic risk reporting system. There were processes in place for reporting, managing and investigating serious and untoward incidents within the trust. Staff understood

the types of incidents and events that should be recorded on the electronic risk reporting system. Staff informed us feedback following incidents was through individual email, discussion at team meetings, and directorate newsletter and line management supervision. There were arrangements in place for staff to be-debriefed by someone external to the unit team in the event it was required.

All serious incidents had been reported to the clinical commissioning groups within the agreed timescales or had agreed extension in place. The incidents are closed on STEIS by the respective clinical commissioning group.

Incidents were the responsibility of the patient safety manager. All incidents were reported on an IR1 form. The patient safety manager and relevant associate director to the business division would then determine whether the incident constituted a serious incident. We found the standard of investigation to be thorough identifying good practice and areas for improvement. Recommendations were appropriately reflected in action plans. The trust communicated lessons learnt from incident through governance meeting down to divisional level team meetings.

Overall, we concluded that incident reporting at the trust is good and learning from incidents is shared across the organisation.

Safeguarding

The trust had multi-agency procedures for safeguarding adults from abuse in each of the local areas in which the trust provided services. The procedures provided legal, policy and best practice guidance to all agencies and staff, and set out in detail the agreed local procedures to be followed where safeguarding concerns arose.

Staff throughout the trust were aware of what constituted a safeguarding alert and were confident in the reporting process. The trust had a clear policy and procedures for children's safeguarding.

The trust had a clear communication flow on safeguarding from ward and community level to an identified lead at board level. We were told that there was limited access to level three safeguarding training from local authorities (level 3 training is for clinical staff working with children, young people and/or their parents/carers). There had been 59 safeguarding alerts and concerns reported to CQC by the trust since April 2014.

At Rotherham child and adolescent mental health services, staff were appointed safeguarding supervisors and were a first line of contact for staff with problems.

Safeguarding standards were regularly reviewed by the Yorkshire and Humber safeguarding network and took account of relevant contemporary reports and guidelines. This included recommendations from the Winterbourne View, Francis and Savile inquiries.

Managers audited safeguarding policies and practice. Action plans were developed and compliance with them rated red, amber or green. In September 2015 the trust rated itself as amber or 'requires improvement' for the impact of safeguarding children training on staff knowledge, confidence and practice.

Whistle-blowing

The trust policy – Whistleblowing (disclosure of concerns on health care) –was to enable and encourage those working for the trust to raise any matters of concern sensibly, promptly and responsibly without fear of victimisation and to ensure that their interests were protected. The policy complied with the Public Interest Disclosure Act 1998 and the terms of the 'Speaking Up Charter'.

There have been 10 whistleblowing concern raised with the CQC for this trust since 01 April 2014.

We held focus groups during the inspection with a full range of staff representative of all grades and disciplines employed by the trust. Staff described good morale in their teams. People were generally happy in their job and felt part of a supportive team. Staff said they would feel confident about raising concerns without fear of recrimination.

Assessing and monitoring safety and risk

The trust used a board assurance framework to provide the board of directors with evidence that the organisation's principal objectives were being met. The framework was designed to focus the board on controlling principal risks threatening achievement of those objectives. The framework was reviewed and discussed quarterly, as demonstrated by board papers. Assurance is provided through the trust's governance structures and are

discussed and challenged through relevant assurance groups within the trust and are subject to semi-independent scrutiny via a non-executive director, whose analysis is reported to the Audit Committee.

Minutes demonstrated that the framework was also regularly discussed as part of the trust performance and assurance group, whose purpose was to assure the board that trust-wide legislative, regulatory, contracted performance and service delivery standards and targets were met.

The trust had systems for regular recording, reporting and monitoring of risks through their risk registers. The trust-wide risk register reflected high level concerns. Local risks registers at divisional level were clearly aligned to service need or cascaded down from the trust's priorities. Risks at divisional level were also escalated up to the trust-wide risk register. Risks were identified through a number of routes, including serious incidents, service reviews, response to not achieving key performance indicators, performance and clinical issues, and specific service problems. Senior leadership teams ensured there was a level of scrutiny in deciding which risks should be escalated between divisional and the trust-wide registers. They also had the overview of all risks to identify trends and themes.

The trust had a safety improvement plan with five key focus areas:

1. Suicides

2. Falls

3. Restrictive Interventions

4. Pressure Ulcers

5. Medication Errors

Safe and Clean Environments

Kingfisher ward in the acute and psychiatric intensive care unit service and the social detoxification unit at New Beginnings substance misuse service did not have female-only lounges. This meant that the trust was not meeting the Department of Health's guidance on same sex accommodation. Otherwise, all wards complied with same sex accommodation guidance defined in the Mental Health Act Code of Practice. All bedrooms were single with ensuite facilities. Patients did not have to walk through an area occupied by the other sex to reach toilets or bathrooms. Staff explained how they allocated bedrooms to achieve an effective gender separation.

The seclusion room in the intensive support unit at Amber Lodge low secure ward smelt of urine, although we saw evidence that the area was cleaned regularly. Staff said that urine had at some point in the past got underneath the protective lino and had seeped into the concrete floor. This meant that the smell could not be removed unless the seclusion facility was refurbished.

Wards had regular patient-led assessments of the care environment (PLACE). The most recent had been in February 2015. These assessments demonstrated that the trust had made some improvements in key areas over 12 months. It also indicated that cleanliness scores for wards remained slightly below the England average of 98%. St John's Hospice in Doncaster was the only location out of seven that scored above the national average at 99%. The other locations' scores for cleanliness ranged between 85 and 96%. All but one location, St Catherine's, scored above the average for England of 90%. These ratings looked at the overall condition of the patient area, the maintenance and appearance.

Seclusion

The trust had a management of seclusion policy. This was issued in October 2014 and had a review date of October 2017.

Between 1 November 2014 and 30 April 2015, the acute wards for working age adults and psychiatric intensive care units had 109 episodes of seclusion, forty-two incidents were recorded on Kingfisher ward and Skelbrooke recorded 40.

The only episode of long-term segregation in the six months before our inspection was an individual patient in the inpatient service for people with a learning disability and autism whose care was treated as long-term segregation.

The patient's individual needs were being met, their rights appropriately safeguarded and their dignity managed appropriately, with regular reviews from the multidisciplinary team and oversight from trust senior managers and external commissioners.

Detailed findings

Episodes of seclusion were recorded in a seclusion book, where ten-minute observations on each patient were recorded. These booklets detailed the seclusion care plan and included medical reviews, two-hourly nursing observations, multidisciplinary team discussions, and a detailed rationale about why the patient was placed in seclusion. It documented if restraint had been undertaken and included a body map detailing restraint points. These were placed in to the patient's care record when seclusion ended.

The seclusion room in the intensive support unit at Amber Lodge, a low secure forensic service, had a blind spot. Consequently, the door to the toilet area was permanently locked as it could not be observed from the viewing pane in the door. The hinges on the toilet door were not anti-ligature and would pose a risk if the door were left open. Patients did not have access to the toilet and were instead using paper bedpans.

On acute wards for adults of working age and psychiatric intensive care units there was an article of clothing on Kingfisher ward called a 'strong suit'. The strong suit was designed to be resistant to tearing to help prevent patients who were at risk from self harming from making a ligature from torn clothing when in seclusion. The strong suit had been damaged and the bottom part of the suit was not being used at the time of the inspection. We were concerned that if only the top of the strong suit was being used this would not ensure privacy and dignity for patients. This was raised at the time of the inspection and the trust removed the garment. We were assured by the trust's senior management team that the item of clothing would not be used as it was not fit for purpose at the time of the inspection.

Also on the acute wards for adults of working age and psychiatric intensive care units, there were no positive behavioural support plans in the clinical notes of the patients who had been secluded. Behavioural support plans should be used to detail positive interventions to support patients at times of difficulty to prevent seclusion.

Restraint

The trust had a policy for reducing restrictive interventions in the form of restraint. The policy was issued in January 2013, to be renewed in January 2016. There were information leaflets detailing the intention to reduce restrictive physical interventions on wards and key staff had undertaken the trust training. There was a plan for more staff to be trained in the interventions. The policy was being put into effect by the head of health, safety and security, who reported to the risk management sub-group with an annual report and a half-yearly update report.

The trust's policy on reducing restrictive interventions had the following aims:

- to remove as far as practicable and possible incidents of work-related violence and aggression
- to raise awareness among all staff, patients and others of the potential for work-related violence and aggression and factors that might contribute to disturbed behaviour
- to promote a culture focused on early recognition, prevention and de-escalation of potential violence and aggression, using techniques that minimise the risk of its recurrence.

The policy also cites Articles 2 (Right to Life), 3 (Prohibition of Torture), 5 (Right and Liberty and Security of Person) and 8 (Right to Respect for Private and Family Life) of the Human Rights Act and how these must be adhered to in managing violence and aggression.

Between 1 November 2014 and 30 April 2015, the trust recorded 660 incidents of restraint involving 135 patients. Sixty-eight (10%) of incidents overall involved prone restraint, five (7%) of which resulted in rapid tranquilisation.

Medicines Management

Ward staff said the pharmacist team were a good support if they had any medicines queries, and that trust pharmacists were involved in running a medicines-related education programme throughout the trust. Staff also said that the limited pharmacist resource meant pharmacists were not always able to attendance ward multidisciplinary team meetings. This had been recognised as an area for development by the trust's senior management team, with plans to establish priority services where pharmacist support to ward MDT meetings would have the greatest impact. A business case for this had yet to be developed. Regular face-to-face meetings between patients and pharmacists were not held routinely but patients could meet with a specialist mental health pharmacist to discuss

medication choices, risks and benefits on request. In the community, pharmacists had engaged with carers at events to answer questions about medicines in mental health.

Pharmacists completed a weekly in-depth check of a sample of medication cards across the inpatient wards. The results were shared at the medicines management committee and showed continuous improvements had been made over the last twelve months. Additionally, the trust's patient safety bulletin had been used to highlight issues that might arise from the pharmacy "10 point review", although this tool had not yet been developed to check and monitor medicines management in the community mental health teams.

There was no consistent approach to completing and recording medicines reconciliation on admission to the service, or clear protocols for stock control and the storage of patients own medicines. Medical and nursing staff checked and confirmed patients' medicines on admission to wards but the trust audit showed that this was only completed for 67% of inpatients in August 2015, which was below the average of 72% for England.

Examples of how the lack of pharmacist support to the community-based mental health teams impacted on medicines management:

- Community-based mental health services for adults of working age had no consistent approach to medication management to support safe practices. There was a lack of oversight regarding medication management and different systems had been allowed to evolve.
- Long stay/rehabilitation mental health wards for working age adults had gaps in medication administration records. It was not clear if patients had been absent from the ward, or if the gaps were missed doses of medication, which might impact negatively on patients' health and wellbeing.
- In the substance misuse services, we found that staff who were not suitably trained or competent administered medications in the social detoxification service service at New Beginnings.

However, new systems were being piloted in the access team to provide an audit trail for medicines handling, with plans to develop these for roll-out across community teams. We saw that the trust's draft medicines optimisation strategy highlighted the benefits of securing additional pharmacist support to community teams, prioritising medicines reconciliation and communication. We also found that there had been changes in practice following investigation of medication errors. For example, a serious medication incident at the hospice had led to changes in practice.

Safe Staffing

Since April 2014 all hospitals have been required to publish information about staffing levels on wards, including the percentage of shifts meeting their agreed staffing levels. This initiative was part of the NHS response to the Francis report, which called for greater openness and transparency in the health service. The trust had published information about staffing levels on its website.

Vacancies:

Between 1 January 2015 and 31 March 2015:

- There was a 12% vacancy rate for qualified nurses.
- There was an 8% vacancy rate for nursing assistants.
- Laurel (ward for older people) had the highest number of vacancies for nursing assistants at 24%.

Staff Fill Rate:

The fill rate is the percentage of shifts actually covered by staff compared with the planned staffing level.

- April 2015 – On Mulberry ward 71% of registered nursing shifts were filled during the day while on Emerald ward 77% of night care staff shifts were filled.
- May 2015 –On Mulberry ward 71% of registered nursing staff daytime shifts were filled.
- June 2015 – On Emerald ward 71% of shifts for daytime care staff were filled.

These figures mean that Mulberry and Emerald wards were repeatedly staffed significantly below the planned level. Reduced staffing inevitably puts extra pressure on staff through trying to cope with additional work and puts patients at risk of receiving a reduced level of care and attention.

Rotherham child and adolescent mental health services (CAMHS) was undergoing a re-configuration led by a consultancy firm brought in by the trust, with recommendations that would increase staffing levels in the Rotherham service to 31 whole-time equivalent (WTE) staff.

Detailed findings

Doncaster CAMHS and Scunthorpe CAMHS staffing levels were estimated against commissioning needs and numbers of referrals. Data provided by the trust showed that Rotherham CAMHS was regularly using 15 agency staff a week, ranging from 22.5 hours a week to 37.5 hours a week. Doncaster CAMHS was using seven WTE agency staff per week, with Scunthorpe CAMHS using 3.6 WTE agency staff per week. This was to cover vacancies and staff long-term sickness. The operations manager for Rotherham CAMHS said the use of agency staff in their area was part of the strategy to bring down referral to assessment times but was not considered a financially viable long-term option.

Trust board papers showed that staffing levels and recruitment were routinely monitored and discussed at each meeting. For example it was confirmed at the trust board meeting that the clinical staffing review group review and adjust the minimum staffing levels and, if necessary, the baseline on an on-going basis.

The trust had developed inpatient staffing and dependency profiles for each area to provide assurance to the trust's senior management team that wards had the optimum number of staff at the right grade and experience. The profiles, last revised in July 2015, considered the complexity of both mental and physical health needs, clinical risk, acuity levels and the environment. They included measures to be taken when staffing levels fell below the minimum standards and clearly defined responsibility and accountability for staffing in the different business divisions.

However, despite this system, we found that staff at the Ironstone Centre, a community mental health service for people with learning disabilities or autism, had been working below their establishment levels for some considerable time. We spoke with three members of staff who told us they had serious concerns about their ability to provide safe and effective care to patients who used the service. We found no evidence that action had been taken to provide effective cover for a period of planned long-term sick leave of one staff member. This meant that the two remaining qualified nurses had carried caseloads of 52 patients and 65 patients. Due to significantly high caseloads, patients who used the service had been advised that routine appointments had been cancelled. Staff told us and we observed in case notes that due to the reduced staffing levels, records were not being completed and care plans, risk assessments and physical health checks had not been reviewed in a timely manner to ensure the delivery of safe and effective care and treatment.

Mandatory Training

At the time of the inspection, the percentage of staff completing mandatory training averaged 77% compared with the trust's mandatory training target of achieving 90% by 31 December 2015. Compliance with compulsory training, appraisal of work performance and managerial supervision was inconsistent across services and the trust was not meeting its own targets. 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. Staff who had not completed mandatory training could have been unaware of important changes in the trust's policies and procedures.

The trust's senior management team was aware that poor compliance with mandatory training and inconsistencies in recording of which staff had received the training had a possible negative impact on patient care and safety. They had started to deal with these issues and with the recognised deficiencies in appraisals.

Blanket Restrictions

We saw some blanket restrictions on patients' freedoms being used on the low secure forensic wards. On the low secure rehabilitation and recovery ward patients were risk assessed to see if they could safely manage the key to their room but patients on the intensive support ward were not and were not allowed keys. The forensic wards had restrictions on some items such as aerosol toiletries, razors and lighters, as those items were identified as being a risk to safety. The wards had arrangements for patients to use those items overseen by staff. Patients were not able to lock their rooms when they were not in them because only staff had keys. Patients could lock their rooms from inside but staff could still get in the rooms in an emergency. On one of the dementia wards, we saw that all doors were locked to patients during the daytime, leaving them with access to only two lounges.

Potential risks

In the CQC health-based place of safety survey in October 2014, the trust reported that it routinely collect data from their health-based place of safety to monitor the service.

Detailed findings

This included information about gender and ethnicity but not age, disability and protected characteristics. Data was also collected on the outcome of the assessment, the number of people who were transferred between places of safety, delays in initiating a Mental Health Act assessment for people brought to the place of safety, but not how many times people were turned away from the place of safety and the reason why. This could mean that the trust is not clear about the numbers of people who might need access to the place of safety and how many of those have protected characteristics.

Duty of Candour

The statutory duty of candour was introduced for NHS bodies in England from 27 November 2014.

The obligations associated with the duty of candour are contained in regulation 20 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The key principles are that NHS trusts have a general duty to act in an open and transparent way in relation to care provided to patients. This means that an open and honest culture must exist throughout the organisation. Appropriate support and information must be provided to patients who have suffered (or could suffer) unintended harm while receiving care or treatment.

We looked at a sample of investigations the trust had carried out in response to complaints and serious incidents that had occurred. Some people using services were told when they had been, or could be, adversely affected by a notifiable safety incident, given an apology and informed of actions taken as a result. However, the trust acknowledged that there had been a delay in implementing the specific steps relating to the Duty of Candour. This meant that verbal and written notifications had not been sent recorded or both for all relevant incidents. There were gaps in duty of candour actions taken for some known incidents, and some further incidents had not been actioned because they had not been identified. Apologies were not always recorded and the specified closure of the electronic record at 10 days was too soon to allow for the routine recording of correspondence after this time, such as during and after an investigation. This was a breach of the regulations.

Requires improvement

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

We rated effective as requires improvement because:

- There were gaps in management and support arrangements for staff, such as appraisal of work performance and supervision.
- Not all staff could access all clinical information on patients as the trust used both paper and electronic records. This was confusing and risked information not being available when required, which could have a negative impact on staff's ability to provide safe and effective care and treatment.
- On the acute wards for adults of working age, and in psychiatric intensive care units, there were no positive behavioural support plans in the clinical notes of the patients who had experienced an episode of seclusion.
- Staff did not consistently monitor the physical health needs of patients of mental health services,which could result in some people's physical health needs not being met. In the community health inpatients service, Hawthorn and Hazel wards did not complete venous thromboembolism risk assessments in line with guidance from the National Institute for Health and Care Excellence (NICE) relating to adults admitted to hospital as inpatients.
- The systems described as being in place which should have been followed to ensure effective communication between families/ carers appeared not to be routinely followed.
- There was no evidence of any effective auditing process to ensure effective communication processes/systems were being followed.
- There were some inconsistencies in how people's mental capacity was assessed.

However,

- We found the trust was making good use of technology and telemedicine in community children's and young people's services.

Our findings

Assessment and delivery of care and treatment

The trust participated in a number of national, local and clinical audits. These included:

- National Intermediate care Audit (2014)
- National Intermediate Care Audit (2015)
- National Audit of Schizophrenia (2014)
- antipsychotic prescribing in people with a learning disability (July 2015) Prescribing Observatory for Mental Health – UK (POMH-UK)
- re-audit of prescribing for people with a personality disorder POMH 12
- improving physical healthcare to reduce mortality in people with severe mental illness
- NHS Safety Thermometer-Falls (Fall safe)
- guidelines to staff on do not attempt cardiopulmonary resuscitation (DNACPR) orders
- re-audit of pressure ulcers
- phase 2 –Triangle of Care
- managing work-related violence re-audit
- infection prevention and control
- follow-up review of mandatory training
- review of arrangements to capture and act on service user and carer feedback.

Action plans were in progress where areas for improvement had been identified.

Community health services for adults participated in the National Intermediate Care Audit in 2015. The service achieved 75% or above on most standards in the 2014 results. The results for eight out of 10 standards had improved from the 2013 results. The two that had not improved were related to mandatory training. The audit lead had completed an action plan with timescale for improvement. During our inspection, we saw evidence of the service implementing the action plan. This included introducing dependency tools and informing patients of support available on discharge.

An audit programme assessed medicines handling in accordance with the trust's medicines policies and national

guidance, with the outcome of these audits being shared at the medicines management committee and clinical governance group. The trust subscribed to Prescribing Observatory for Mental Health (POMH UK) to enable audit of prescribing practice against national standards and to benchmark their performance against other similar trusts.

The 2014 POMH audit of prescribing for people with personality disorder placed the trust in the lower quartiles for compliance against targets. The quality of data collection was queried by the trust's medicine management committee and a subsequent re-audit in January 2015 showed improved compliance. To help ensure the quality of future data submissions, all data now had to be signed off by clinical directors. The national audit of schizophrenia showed prescribing practice was largely in line with the average for all trusts. However it was below average for monitoring of five risk factors – smoking, body mass index (BMI), glucose, lipids, and blood pressure.

We found that across the majority of the inpatient areas and the community teams, patients had their needs assessed and their care planned and delivered in line with evidence-based practice.

However, in community health inpatients, Hawthorn and Hazel wards did not complete venous thromboembolism risk assessments. This was not in line with guidance from the National Institute for Health and Care Excellence, which applies to all adults admitted to hospital.

Between 1 October 2014 and 31 March 2015, Ferns ward at Rotherham had the highest number of delayed patient discharges per month (44) and the highest number of days patients' discharges were delayed (602). Cusworth and Brodsworth wards had the highest number of readmissions within 90 days with 21 each. Delayed discharges over the 6 month period and readmissions were reported on 10 of the 29 wards. There were no delayed discharges or readmissions on all other wards.

The trust was making good use of technology and telemedicine in community children's and young people's services. For example, they had developed their own 'Talking Sense' e-clinic to allow young people (aged 11 to 19) to book an appointment to talk to their school nurse through online instant messaging.

Outcomes for people using services

The trust was not meeting targets set by NHS England for 2014/15 and its commissioning for quality and innovation (CQUIN) target for breastfeeding. However, the service had identified these issues and mitigating action was being taken to address them.

The trust was developing a physical health and wellbeing strategy to try to improve physical health monitoring. This had included discussion about the role and responsibilities of primary and secondary care in physical health monitoring and the interface between inpatient and community services.

Staff in the forensic service used evidence-based risk assessment tools to inform the care planning process. The wellness, recovery action planning tool and 'my shared pathway' were also used as self-management tools and to inform care planning. Patients had positive behavioural support plans, clinical guidelines, care plans and safeguarding care plans. Health of the nation outcome scales (HONOS) were used to assess and record severity and outcomes

The forensic service demonstrated good use of national guidance such as that from the National Institute for Health and Care Excellence (NICE). We noted references to guidance in multidisciplinary team meetings and patients' records relating to medicines, care and treatment. Staff described the dissemination process for newly published guidance and there were forums for their discussion. Therapeutic groups such as dialectical behaviour therapy sessions had started two weeks before our inspection and a sex offender treatment programme was due to start as part of planned interventions for the forensic service.

In the forensic service, there was evidence of good working practices with the provider and commissioners, and discharge was the focus of intervention and care across the service. There were good links with community teams and work was ongoing to reduce the difficulties with moving people into least restrictive environments in community-based settings. Staff from the service were forging links with local charities and had ongoing discussions with the commissioners of services.

The national audit of schizophrenia undertaken in 2014 identified that:

Requires improvement

Are services effective?

- Monitoring of physical health risk factors was below average in the trust and below what should be provided. It was particularly poor for monitoring of body mass index (BMI) and blood pressure, and intervention for abnormal blood pressure was below average.
- Availability and uptake of psychological therapies was about average for the trust but it was still well below what should be provided.
- Prescribing practice was in some respects above average in the trust. However, an inappropriately high proportion of service users in the trust on clozapine had received three or more antipsychotic medications before commencing clozapine.

The trust had started to address these issues as outlined previously. We concluded that overall the trust were using outcome measures and audits to review and improve care and treatment to the patients.

Staff skill

Seventy eight per cent of staff in the community-based mental health services for adults of working age had not received an appraisal in the last 12 months. There were 43% of staff who had not received an appraisal in the last 12 months.

In the community-based mental health services for adults of working age, on average, only 16% of staff had received an appraisal in the last 12 months. This is not in line with trust policy.

Staff appraisal rates within the community children and young person's services was as low as 25% in some areas.

Thirty-six doctors had been revalidated in the last 12 months which equated to 68%. The trust have

stated that a further 17 doctors are due to be revalidated by 14 July 2017.

The Rotherham and the Ironstone Centre community learning disability and autism team had diagnostic interview for social and communication disorders (DISCO) assessors. However, we were told that due to staff shortages the DISCO assessor at the Ironstone Centre had not been able to carry out any assessments since their training. The Ironstone Centre had recently been supplied with an electro cardiograph (ECG) machine but staff were waiting to be trained in its use.

Staff we spoke to across the trust all reported that training opportunities beyond the mandatory requirement were good. Training records supported this. The trust responded positively to requests for identified training that could enhance the delivery of care and the development of staff.

At Great Oaks, crisis and health-based place of safety service, there was a drive to increase participation in research. Staff told us about planned projects in partnership with the University of Derby, such as research into decision-making about treatment for patients diagnosed with personality disorders. Staff had also planned research into early discharge, to be carried out jointly with Sheffield Hallam University. We saw that these had been given ethics approval and funding applications had been made. Three research projects were expected to be identified following the "perfect week" exercise.

Multi-disciplinary working

There was good evidence of multidisciplinary working within the trust and with local networks. For example, in the forensic service multidisciplinary team discussions were delivered by a cohesive team, discussions were comprehensive and based on relapse prevention and recovery principles. These meetings were observed to be thorough, person-centred, inclusive and covered all essential standards of care.

We witnessed team members empowering patients to take the lead in managing their own condition and enabling patient choice.

On the acute wards for adults of working age and psychiatric intensive care units, in the multidisciplinary team meetings, patients were involved in the discussions and decision-making. We saw that carers' views were acknowledged even if the carers were not present at the meeting. There was evidence of close working with the access team who provided home treatment during leave and after discharge, and other community-based services.

In the specialist community mental health children and young people's service, staff held regular and effective multidisciplinary team meetings. At Doncaster children and adolescent mental health services (CAMHS), staff held three high risk assessment treatment meetings a week to discuss people who used the service and their care. Scunthorpe CAMHS held weekly, fortnightly and, in the case of looked

after children, six-weekly multidisciplinary team meetings, dependent upon the cluster. Rotherham CAMHS had a weekly clinical multidisciplinary team meeting every Tuesday, and an allocation meeting every Thursday.

Information and Records Systems

At service level, staff found the IT systems time-consuming and problematic. The trust used two systems to record patient information that were not linked to each other. This meant that information could not be shared across the different business divisions. At focus groups for staff, one consistent theme for feedback from staff was a desire for an improved IT system.

We found the following problems associated with the IT and record keeping systems:

- In specialist community mental health services for children and young people electronic records did not reflect the content of paper records, and information had not been scanned into the electronic system, although scanners were available.
- Risk assessments on the electronic system were poorly completed, incomplete or missing.
- In community-based mental health services for adults of working age information the trust provided showed that mandatory training completion rates were significantly lower than the trust target for teams. Although team managers informed us these figures were inaccurate and that completion rates were higher, the trust was not able to provide information to confirm this. This meant it was not possible to determine that staff had received the required training to keep people who used services safe.
- Service user information was not accessible to all staff members. The poor quality of the IT system had a negative impact on service user care, including the ability to provide accurate service user information.
- The computer system used was Silverlink. This appeared to be a secure system for storage of records but while trying to access records we found it slow and inefficient.

Data for board level reports was uploaded and collated using different methods depending on which system it was recorded on. A manual process was then required to provide the data in a consistent manner, which was open to human error.

In addition to the two systems used to capture patient information, the trust used a further system for staff records. This system provided the board with compliance information – for example, relating to mandatory training and appraisals. Managers at service level said they regularly kept their own separate records in addition to the trust's system. This was because the trust system did not always reflect the information provided by service managers.

Consent to care and treatment

The trust had an interim Mental Capacity Act Deprivation of Liberty Safeguards policy. This had been issued in March 2015. This identified improvements required in the quality of Mental Capacity Act training throughout the trust. Some staff we spoke with also told us the training they received on the Act was inadequate. This was on the trust-wide risk register. The trust had recruited a Mental Capacity Act lead due to start in October 2015. This role was to improve the quality of the training and therefore increase awareness for all staff.

We found good practice regarding patients' consent to treatment, assessment of patients' mental capacity to make decisions about their care and implementation of deprivation of liberty safeguards in some areas, such as community health inpatients wards. (Safeguards are intended to ensure that any restrictions on a patients' freedoms are the minimum necessary to provide the care they need.) However, we found inconsistencies in the recording of mental capacity assessments in other areas such as community nursing.

Within the mental health services, we found that there was generally good practice regarding consent to care and treatment with a few exceptions. For example, in the older adults community service, we found that staff carried out capacity assessments on all patients consenting to informal admission to inpatient service. This was regardless of the nature of the patient's illness. If a patient had a mental illness and was ill enough to merit a transfer from the community mental health team to inpatient services, it was sufficient to overturn a presumption of capacity and trigger assessment of capacity. On the wards for older people, staff did not have sufficient understanding or knowledge of applying the Mental Capacity Act.

However, we found discussions and decisions were clearly documented in do not attempt cardio-pulmonary resuscitation (DNACPR) forms. The forms we viewed were completed with the signature and date by the appropriate senior medical practitioner.

Assessment and treatment in line with Mental Health Act

We saw that the trust had clear governance systems for meeting its responsibilities under the Mental Health Act 1983 (MHA). There was a MHA manager who was line managed by the director of mental health. There were MHA administration offices on sites in Doncaster, Rotherham and North Lincolnshire. Lead MHA administration staff had been in post for several years and understood their roles well. Staff in these posts received ongoing training to support them as well as regular supervision and appraisal by the MHA Manager. Staff we spoke with on the wards said the service was responsive and supportive. The service enabled the trust to discharge its responsibilities under the MHA.

The trust met its responsibilities under the MHA code of practice by having regular forums for multi-agency discussion about procedures and implementation of section 136 of the MHA (which gives the police the power to take someone from a public place to a place of safety if they have a mental illness and need care). Multi-agency working groups took place at regular intervals and included representatives from the trust, the police, local authority commissioners, ward managers and sometimes ambulance staff. MHA administrators ensured that local accident and emergency departments and police custody suites were provided with the appropriate section 136 recording sheets for consistency across the trust. The introduction of street triage into parts of the trust had shown a significant reduction in the use of section 136 as a direct result of this change in practice.

The MHA manager had identified where the Code of Practice (CoP) introduced in April 2015 had changed from the previous version. The trust had an implementation plan following the introduction of the new code. This plan recognised that a review of many of the trust's policies was required. The implementation plan had a projected end date of the end of October 2015. We were told that staff training sessions had been planned until the end of September 2015, although some staff we spoke with on the wards had not yet had dates for their training and were not expecting to receive it by the end of September 2015.

Where people were detained under the Mental Health Act 1983 (MHA) evidence of their detention could be easily found in their patient files on the wards and was in good order. The approved mental health professional's (AMHP) report from the point of detention was also available. However, on one ward, we found that a patient's detention application contained a non-rectifiable error that had not been picked up. The error had been made on a Saturday when MHA administrative staff were not on duty.

The trust had a clear system to ensure that patients' rights were read to them on admission and that this was regularly repeated according to the trust's policy. MHA administration staff audited the reading and recording of patients' rights after admission. These staff also recorded that they had sent out information to patients' nearest relatives immediately following detention.

We found on the wards we visited that staff were not using easy read leaflets on the wards where patients had learning disabilities and dementia. This was despite the fact that many of these patients had it written on their records that they could not understand their rights under the MHA. Patients were, however, all routinely referred to the local independent mental health advocacy (IMHA) service following detention. There was evidence from some of our visits to the wards that the IMHA service had a strong presence.

The trust had been working to reduce blanket restrictions on patients' freedoms in order to comply with the Code of Practice. Internet and mobile phone use was generally not restricted. Blanket restrictions were however, used on several of the wards we visited. On one of the dementia wards, we saw that all doors on the ward were locked to patients during the daytime, leaving patients with access to only two lounges. On another ward we visited, none of the patients had access to a key to lock their own rooms or had space in their rooms to lock away their valuables.

We found that documentation relating to the use of section 17 leave was clear on files in the ward and that in most cases patients signed forms to indicate they had been informed about their leave. (Patients detained for treatment under the Mental Health Act may leave the

hospital only with leave approved under rules set out in Section 17 of the Act.) However, on several wards risk assessments relating to leave and evaluations of leave were not easily found in files. In some cases, risks relating to section 17 leave were only referred to within multidisciplinary team meeting minutes and in other cases not detailed anywhere in patient's notes. There was confusion on leave forms between escorted and accompanied section 17 leave. Escorted leave was referred to on several occasions that we saw, as being with either staff or family members.

The trust had processes to record that doctors had discussed treatment with patients before it started. There was evidence that safeguards under consent to treatment provisions of the MHA and relevant sections of the code of practice were being appropriately discharged. Second opinion approved doctors had been referred to where required and their discussion with statutory consultees kept on file. We saw that the correct safeguards had been applied to one patient on a ward who had been given electro-convulsive therapy.

We had concerns about the trust's ability to protect patients' dignity in some seclusion suites. In two of the seclusion suites that we saw, patients could not access ensuite facilities or adjoining toilet facilities while being discreetly observed. This meant that if it was considered a risk for them to be out of staff eyesight, as we were told was often the case, they would have to use cardboard bottles and containers instead of using the toilet. On one of these wards a seclusion garment known as a 'strong suit' was used routinely according to staff. The strong suit was designed to be resistant to tearing to help prevent patients who were at risk from self harming from making a ligature from torn clothing when in seclusion.This garment was damaged and so only the top half of it could be used. This was very short, and was worn instead of the patient's own clothing, leaving parts of the secluded patient's body exposed. It did not appear that the need to use this garment had been assessed through a risk assessment process. This did not promote patients' dignity while in seclusion. On another ward where seclusion was used, there were missing records indicating the end of seclusion times as well as missing doctor's signatures. On this ward there did not always appear to be a rationale for the use of seclusion clearly identified within behaviour support plans.

Staff received a variety of training sessions related to the Mental Health Act. These covered tribunals and patients' rights, the code of practice, consent to treatment and training specific to children and young people. However, Mental Health Act training was not on the trust's mandatory training matrix and so not included in their compliance figures.

We undertook a records review at two of the trust's MHA administrative locations. At one, every file contained recorded discussions with the patient in respect of capacity and consent to treatment. Whilst each of these files contained the mental capacity assessment (recorded on Mental Capacity Act form 1, there was a broad range of quality in how these forms were filled in. Some assessing doctors had merely ticked the boxes on these forms, whilst others had given a comprehensive account of what the patient had been told.

Staff we spoke with across the trust reported that training opportunities were good. The trust responded positively to requests for identified training that could enhance the skills of staff and therefore the delivery of safe and effective care. The trust had a dedicated learning and development team that provided access to a wide range of development opportunities to reflect the needs of the trust, including clinical and professional development, leadership and management, and vocational qualifications.

Good

Are services caring?

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

Summary of findings

We rated caring as **good** because

- People were supported and treated with dignity and respect and were involved as partners in their care.
- Feedback provided by people who use the trust's services was generally positive and staff were seen to be caring, engaged and supportive towards patients.
- People and staff were working together to plan care and there was evidence of shared decision-making and a focus on recovery.
- People were supported to maintain their relationships with those close to them. They were enabled to manage their own health and care when possible and to maintain independence.

However:

- Staff's involvement with carers was not consistent .We heard mixed responses from families about their involvement in decisions being made about discharge.

Our findings

Dignity, respect and compassion

We sought views from patients via the focus groups in the weeks before this inspection as well as meeting individually with people when we visited the wards. There were mixed views expressed by patients who told us that some staff were kind, respectful and helpful and that others could be patronising, or say horrible things to, or about, patients in front of them. We were also told that patients thought staff did not manage patient-to-patient bullying as well as they should. We saw many examples of positive interactions between patients and staff throughout the inspection visit. Patients told us, and we observed, that staff treated patients with respect and kindness and they were caring and compassionate.

Within the hospice, there was a holistic approach to care, with patients' physical, psychological, social and spiritual needs being addressed. We observed several examples where staff treated the whole family with care and compassion. This was especially the case when young parents with children required palliative or end of life care. The in-house counsellors spent time with children to get them to understand what was happening.

Involvement of people using services

The trust had performed better than most other trusts in questions relating to organisation of care, information provided during care and levels of involvement in one's own care or that of a relative.

We particularly commended the service provided at The Solar Centre. We observed patients using the service and saw that regardless of their abilities everyone was included in all the activities on offer. It was clear the activities were enjoyed by everyone.

The young onset dementia service was proactive in raising awareness both locally and nationally. Patients promoted national initiatives to raise awareness of the needs of people with young onset dementia.

In the forensic service, staff were seen to regard access to physical healthcare and health promotion as important. All patients had a health action plan and had routine monthly checks. They had good access to GP, dietetic and dental services. On the acute wards for adults of working age and psychiatric intensive care units, wards had welcome packs and patients confirmed they had received an orientation to the ward and a copy of the welcome pack when admitted. This included an information pack for carers. Patients told us their rights had been read to them regularly. These wards operated a named nurse system and they ensured that care-planning arrangements were regularly discussed and reviewed. In multidisciplinary team meetings, we saw that patients were encouraged to be involved in group and other activities and how alternatives such as individual sessions would be offered for those patients who felt unable to get involved. We observed patients involved in discussions about medications and being offered information about the types available to consider. Nurses were recorded that patients were being offered copies of their care plans.

Emotional support for people

Good

Are services caring?

Across the services, there was information visible and available about local advocacy services or Independent Mental Health Advocacy for detained patients.

The acute admission and rehabilitation wards had booklets for patients and carers that detailed the information they would need when admitted to the wards.

The trust had a carers' charter and a young carer charter and we saw examples of promotional posters and information leaflets.

The trust is a member of the 'Triangle of Care' project. This triangle is a 'therapeutic alliance between patient, staff and carer that promotes safety, supports recovery and sustains wellbeing'.

The local triangle of care meetings provided updates to the trust-wide triangle of care steering group and each unit was working toward completing its own action plan. The staff provided information to patients and carers about support available through the recovery college. However, despite this, carers on the acute admission wards said they did not feel they had access to the right sort of information when the person they cared for was admitted. None of the carers on the acute admission wards we spoke to could recall being offered a carer assessment. However, within the community health services, a monthly carer's café to support patients, relatives and carers within the inpatient wards had been developed.

The NHS Friends and Family Test response rates were similar to the England average. Eighty-six per cent of staff were either 'likely' or 'extremely likely' to recommend the trust as a place to work and 79% as a place to receive care. This is significantly above the national averages for these questions, which are 61% and 76% respectively.

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

We rated responsive as **good** because:

- We found that the needs of different people were taken into account in planning and delivering services, for example in terms of age, disability, gender, pregnancy and maternity status, race, religion or belief or sexual orientation.
- All buildings used for therapies in children and adolescent mental health services were accessible to disabled people.
- On the wards for older adults, the trust had sought advice and guidance from the King's Fund on layout to ensure it was dementia friendly.
- Chaplains visited the wards to see individual patients, and staff ensured these visits could take place in private.
- We rated the responsiveness of the community health services for children, young people and families as outstanding. Thecommunity health services for children, young people and familiesplanned and delivered services that met people's needs and were responsive to the changing needs of the local population. It also used innovation in care to meet the needs of local people and hard-to-reach groups. This included ensuring additional resource was available when the service noted low breastfeeding uptake. This took into account equality and diversity needs and the needs of people in vulnerable circumstances. The service provided access to translation and interpretation services, and had links with new migrants to the area and the local lesbian, gay, bisexual and transgender (LGBT) community.
- Children and young people could access services in a variety of ways, in a manner and at a time to suit them. We saw examples of learning from complaints. This included the use of action plans to inform improvements.
- The trust was developing a physical health and wellbeing strategy to improve physical health monitoring.

However:

- We found that occupancy levels in the long stay rehabilitation wards were at times above 100% as beds were used for new admissions that were allocated to patients who had been given leave. This was because patients were often moved from acute wards to the long-stay rehabilitation wards to make space for emergency admissions. Although a bed management policy supported this process, the practice enabled long 'sleep over' type stays on wards and one patient had moved wards 11 times in seven months.

Our findings

Planning and delivery of services

We saw evidence of a responsive approach to the planning and delivery of services. During 2015, the trust introduced a revised structure for community services. The service worked with commissioners, the neighbouring acute trust, social services and other stakeholders in two Doncaster-wide reviews of intermediate care and neurology services, which considered the holistic patient pathway. Community nursing was redesigned to follow a case management approach in a local team structure. Doncaster integrated community services was one of seven business divisions of the trust. Integrated community services operated in separate planned and unplanned care teams. Patients were seen initially by staff from the unplanned care team. The planned care team then took over the patient's ongoing care. Unplanned care was centrally located and included the out of hours service.

The inpatient services at Mulberry House were to undertake the "perfect week". This involved a whole system approach to the management of admissions and discharges into the ward beds, and to review the use of crisis care pathways and respite provisions.

The children and young people's service used a 'Health Bus' to enable healthcare providers to connect with families who traditionally do not access health promotion

Good

Are services responsive to people's needs?

advice and activities. Staff used the bus to visit hard-to-reach patient groups and communities, such as the traveller community and a community centre for asylum-seekers.

Community health services for adults were planned and delivered to meet the needs of patients, particularly those with complex conditions. The service met the needs of hard-to-reach groups, the traveller community and bariatric (obese) patients.

Scunthorpe child and adolescent mental health services premises had been freshly decorated as part of ongoing refurbishment. The building was being fitted with solar panels to provide heating and hot water. There was an education room for the complex and medical needs education team to meet the needs of those people who used the service and were struggling with education.

On the wards for older adults, the trust had sought advice and guidance from the King's Fund on the layout of the environment to ensure it was dementia friendly. There were pictorial prompts on doors at two levels and contrasting colours allowing differentiation between surfaces. The external garden areas were accessible, well designed and maintained. Patients were encouraged to help with the upkeep of these gardens and growing fruit and vegetables.

Diversity of needs

We rated the responsiveness of the community health services for children, young people and families as outstanding. It planned and delivered services that met people's needs and were responsive to the changing needs of the local population. It also used innovation in care to meet the needs of local people and hard-to-reach groups. This included full access to translation and interpretation services, and links with new migrants to the area and the local lesbian, gay, bisexual and transgender (LGBT) community.

The trust provided staff with access to interpreting services in the form of both face-to-face and telephone services. We were given a number of examples across the services of where this had been used to support people whose first language was not English.

All the children and young people's services reported good access to British Sign Language (BSL) interpreters and the specialist school nursing service provided care to, and had strong links with, the local communication specialist college.

Staff in specialist school nursing and the epilepsy nurses could either use or had an understanding of Makaton. Makaton is a language programme using signs and symbols to help people to communicate.

Ramps, lifts, and toilets for disabled people were available. At Rotherham child and adolescent mental health services, the doors to the interview rooms had the room numbers embossed in braille as well as numerals. Leaflets were printed in English at the service locations. However, each leaflet/booklet had a section on the back allowing for alternative language forms to be ordered from patient advice and liaison services. There were 14 alternative languages available, ranging from Amharic to Vietnamese. The leaflets could also be made available in large print, braille or on audiotape.

Right care at the right time

Overall, the trust was performing well on management of bed occupancy and meeting targets on assessments.

The crisis teams were the gatekeepers to the acute admission beds in the mental health service. The national threshold is to gatekeep 95% of all admissions to psychiatric inpatient wards.

The trust proportion of admissions to acute wards kept by the crisis resolution home treatment teams had been consistently above the England average for the entire period from July 2013 to March 2015. The England average was 98% and the trust was reaching over 99%. The referral system enabled patients to access help and support directly when they needed it, 24 hours a day, seven days a week. The mental health crisis services focused on helping patients to be in control of their lives and build their resilience so they could stay in the community and avoid admission to hospital wherever possible. They ensured discharge arrangements were considered from the time patients were admitted, to ensure they stayed in hospital for the shortest possible time.

It is generally accepted that when occupancy rates rise above 85% on mental health wards, it can start to affect the quality of care provided to patients and the orderly running

Good

Are services responsive to people's needs?

of the hospital. Between April 2014 and March 2015, the learning disability bed occupancy rate for the trust was below the national average with the exception of quarter one. The national rate was 80% while the trust occupancy rate at quarter four was 61%.

Equally, the mental health bed occupancy rate (for the same period of time) for the trust had been consistently below the national average. The national average was 89% but the trust was running at 84% at the end of quarter one, reducing to 72% at the end of quarter four.

Referral to assessment, and assessment to treatment times, were found to have improved. In Rotherham child and adolescent mental health community services 92% of referrals were seen within three weeks and 96% of all treatment began within 18 weeks.

The child and adolescent mental health services provided a duty service that covered calls or cases received between 5pm and 9pm. There was an out of hours service that covered from 9pm to 9am, with a 24-hour out-of-hours service at the weekend.

In the community health services, patients were assessed promptly and referral to treatment times consistently met the 18-week target. For example, the trust had met its target of 95% of patients being seen by a TB nurse specialist within 18 weeks of referral. The service had seen 100% of patients within this timescale.

The proportion of patients on the care programme approach who were followed up within seven days of discharge from psychiatric inpatient care remained above the England average from April 2014 to March 2015. The England average was 97% while the trust were performing at 99%.

However, during our inspection, we found that occupancy levels in the long-stay rehabilitation wards were at times above 100%. This was because patients were often moved there from acute wards to support emergency admissions near the person's home. There was a bed management policy to support this process but we noticed that this practice enabled long sleep-over type stays on wards and one patient had moved wards 11 times in seven months.

Bed occupancy at the hospice was not managed effectively due to limited medical cover. This meant patients who were eligible for admission were delayed or were admitted to other NHS wards. A referral meeting took place each morning Monday to Friday to accommodate patients on a waiting list to be admitted. We attended a referral meeting where six patients were waiting to be admitted and on that day only two patients were prioritised to be admitted. This was due to the availability of medical staff on that day who were only able to admit patients between 8.30am and 5pm.

Delayed Transfers of Care

Delayed discharges in the period 1 October 2014 to 31 March 2015 and readmissions were reported on 10 of the 29 wards.

Monitor (the body that makes sure that independent NHS foundation trusts are well led so that they can deliver quality care on a sustainable basis) uses a limited set of national measures of access and outcome objectives as part of its assessment of governance. Performance against these indicators is monitored on quarterly. Failure to meet at least four of these requirements at any given time, or failing the same requirement for at least three quarters, will trigger a governance concern. 'Minimising mental health delayed transfer of care' features in Monitor's outcome objectives. The trust's performance and assurance group monitors its performance against this indicator. Overall compliance with this indicator was 7% for April 2015.

The performance and assurance group paper for April was provided by the trust and highlighted the following:

- There had been a significant increase in the number of delays reported in mental health services for older people (MHSOP) in Rotherham since November 2014 which impacts on overall compliance and is the main contributing factor to the current position. A 'Performance Clinic' had been established, chaired by the Local Authority with representation from the trust and the CCG and was exploring the reasons for this increase. It is possible that the trust is 'starting the clock' on a delay too early and this is being explored further by the clinic. An action plan was in place to facilitate improved communication between the relevant parties to minimise delays and the compliance figure had fallen in March 2015.
- Adult mental health services in Doncaster have historically not reported delays. The work undertaken to implement electronic recording of DToC activity from 1st April 2015 has prompted this service to report delays in accordance with national guidance and this had contributed to an increase in overall compliance.

Good

Are services responsive to people's needs?

- A trust-wide review of delays reported during 2014/15 focussed on MHSOP in Rotherham and the results highlighted a lack of understanding of the process for recording when a patient is determined fit for discharge resulting in inaccurate reporting of activity. The trust had reviewed the paperwork used across MHSOP to record decisions in connection with a patient being determined fit for discharge.

Overall, the number of patients whose discharge from hospital had been delayed had risen by 47%, despite falling from June to September 2014 and from November to December 2014.

On wards for older adults, the average length of stay was variable between organic and functional mental illness wards. The data provided was as follows:

The Brambles: 197 days April, 99 in May, 71 in June and 108 in July 2015.

The Ferns: 43 days in April, 188 in May, 52 in June and 110 in July 2015.

The Glades: 114 days in April, 56 in May, 49 in June and July 2015.

Each patient had a discharge plan. We saw discharge plans clearly involving patients and carers. However, the involvement with carers was not consistent .We heard mixed response from families about their involvement in decisions being made about discharge.

Meeting the needs of all people who use the service

The mental health crisis services and health-based places of safety service had access to interpreting services that assisted them to support patients. Information leaflets were available in a range of languages and formats, including CD, audiotape and Braille. The team were meeting patients' individual, cultural and religious beliefs.

We saw details of a 'perfect week' planned to take place across the acute care pathway, including the mental health crisis service. 'Perfect week' is an initiative that aims to change behaviour and let services identify where they can work better. Planning involved staff reviewing services and identifying gaps.

Patient-led assessments of the care environment (PLACE) help organisations understand how well they are meeting the needs of their patients and identify where improvements can be made. They take place across all hospitals, hospices and independent treatment centres providing NHS-funded care and use information gleaned directly from patient assessors to report how well a site/ organisation is performing.

Following on from the 2014 PLACE assessments and as part of ongoing work linked with the 2015 assessment programme, the trust had made the following changes or service improvements:

- Introduced ward hosts/hostesses on the Tickhill Road site, Doncaster to improve the patients' mealtime experience.
- Created safer pedestrian access on the main pedestrian walkway at the Tickhill Road site Doncaster from the gated entrance to main reception by installing parking restrictors that prevent larger vehicles overhanging the walkway.
- Ensured that all ward areas clearly displayed the ward name and hospital site, both upon entering the ward and in the ward.
- Introduced large-faced clocks with the date in all areas where appropriate, to support dementia care.
- Developed a food and drink strategy to support the delivery of 'Eating for Health' for patients, staff and visitors.

Chaplains visited the wards to see individual patients and staff ensured these visits could take place in private. Staff escorted patients to the mosque when they required support.

Learning from concerns and complaints

In total, 47 mental health wards or units, had 147 formal complaints attributed to them between 1 November 2013 and 30 April 2015. Twenty-one of these were upheld and 23 were still under investigation by the trust.

- Rotherham child and adolescent mental health services had the highest number of complaints with 18, seven of which were upheld. (Three complaints were under investigation)
- Intensive Community Therapies had 13 complaints, three of which were upheld. (Two complaints were under investigation).
- The only complaint referred to the parliamentary health and social care ombudsmen (PHSO) occurred in the early intervention team but it was not upheld.

Good

Are services responsive to people's needs?

A total of 339 written compliments were received in quarter one of 2014/15 (trust wide), which was 44% less than in quarter four of 2013/14.

The inspection team used the CQC complaints review and tool to analyse five complaints against mental health services and four complaints cases against community health services using cases selected by the inspection team.

The tool used a framework based on good practice principles developed by the PHSO, local government ombudsman and Healthwatch set in 'My Expectations' published in November 2014, and standards developed by the Patients' Association. The principles the trust's practice were assessed against includes – how well people are supported, the simplicity of the process, use of risk assessments, thoroughness of investigations, standard of record keeping and whether the outcome led to change.

Support was provided to a good level for people through the offer and use of the patient experience team and complaints team and by providing details of the local Healthwatch in the acknowledgement letter. This was usually sent in the first few days after a complaint being made. These teams from the trust were often involved in helping people articulate the issues they had. The communication to people was in a respectful tone. Complaints were mentioned as an important source of information to improve services.

The complaints process was clear and simple. It was explained clearly in the trust leaflet sent out to people to acknowledge their complaint. However, there was a wide range of time taken to investigate. Of the 121 formal complaints cases responded to between 1 April 2014 and 31 March 2015, 46 cases took more than the trust's internal target of 40 working days to be responded to. We checked a mental health service case that was on the list of cases taking over 40 days and the time taken appeared to be because the person involved had made repeated complaints against multiple staff, which made the case complex to investigate.

It was unclear from the correspondence seen whether the cases were risk-assessed in terms of their potential to impact on the care of patients.

The investigation process appeared thorough and confidential. A senior member of staff (assistant director level) with knowledge of the service usually carried out the investigation, with a clinician leading when there were clinical issues. The issues as defined by the complainant were pursued to find out the reasons for any poor performance and the necessary actions mentioned. A balance was kept in the way evidence was gathered and assessed from complainants and their families and staff. Both sides of the story were reported and a transparent judgement made.

Records were easily accessible, with a short summary of the key documents kept on a paper file. Electronic files stored the detailed records but we did not test these. The investigation findings were clearly explained in letters sent by the chief executive officer. Apologies were made when necessary and actions suggested where changes would be made. Complainants were told of the option to take any unresolved issue to the ombudsman as a complaint.

The number of written compliments received across the trust had decreased considerably each quarter since quarter two of 2013/14. The trust believed this to be a result of compliments not being captured as extensively as they had been previously. The patient experience team were planning to take further action in quarter two of, 2014/15 to improve the capture of compliments.

On the wards for older adults, every patient that was able to engage with us knew their named nurse and said that initially they would speak to them if they wanted to complain.

Overall, we concluded that complaints handling within the trust was to a good standard.

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

We rated well led as good because:

- The leadership, governance arrangements and culture promoted the delivery of high quality person-centred care.
- Staff across the trust knew and understood its vision, values and strategic goals.
- Quality received sufficient coverage in board meetings and in other relevant meetings below board level.
- Performance issues were escalated to the relevant committees and the board through clear structures and processes.
- The senior leadership team were knowledgeable about quality issues and priorities and they understood what the challenges were and had taken actions to tackle most of them.
- Performance information was being used to hold management and staff to account.
- Although the trust's chief executive was relatively new in post, the board and senior team had the experience, capacity and capability to ensure that the strategy would be turned into action. The appointment process of the new chief executive evidenced the board's effective selection, development and succession process.
- The leadership team engaged with staff, people who use the services, their representatives and stakeholders.
- There was a culture of collective responsibility between teams and services.
- Staff were able to raise concerns and those who had done so, including whistle blowers, were being supported.

However:

- Problems with IT systems impacted on the recording of and access to clinical information as well as the collection of data on important areas such as mandatory training. The trust had started taking action to increase the number of staff having managerial appraisals of their work performance but without significant improvement so far.
- Whilst we found an open and honest culture, compliance with the trust's responsibilities to people who use services under the duty of candour was poor.

Our findings

Vision, values and strategy

The trust had a clear strategic approach, setting out its vision in "leading the way with care". It defined its mission as promoting health and quality of life for the people and communities it served.

Five strategic goals outlined the trust's approach. They were to:

- continuously improve service quality (safety, effectiveness and patient experience) for patients and carers
- nurture the talent, commitment and ideas of staff in order to deliver excellent services
- ensure value for money and increased organisational efficiency whilst maintaining quality
- adapt and deliver services to meet agreed commissioned needs through enhanced multi-agency partnerships
- maintain excellent performance and governance and a strong market position; and improve further the trust's reputation for quality.

In consultation with service users, carers and other stakeholder, the trust had underpinned the strategic goals with the following values:

- passionate
- reliable
- caring and safe
- empowering and supportive of staff

Good

Are services well-led?

- open, transparent and valued
- progressive

Staff at all levels across the organisation understood the vision, values and strategic goals of the trust. From our observations at core service level and from what staff told us, there was good evidence that staff incorporated the values into service delivery.

The trust was financially sustainable, secure and able to meet the strategic goals. Its financial plan included a risk reserve enabling it to respond to possible risks– for example, provisions for service change and possible redundancies.

The trust had made a commitment to reducing avoidable harm in five areas, which are linked to the national Sign Up to Safety five national focus areas:

1. Putting safety first.

2. Continually learning.

3. Being open, honest and transparent with people about the progress being made to tackle patient safety issues and supporting staff to be candid with patients and their families if something goes wrong.

4. Taking a lead role in supporting local collaborative learning, so that improvements were made across all of the local services that patients use.

5. Being supportive and helping people understand why things go wrong and how to put them right by giving staff the time and support to improve and celebrate progress.

Good governance

The trust board of directors were accountable for the running of the trust. They provided the overall strategic leadership. The senior leadership team provided executive oversight and decision-making on the operations of the trust.

There was also a council of governors who provided a link between local communities and the board of directors.

Four policy and planning groups reported directly to the board of directors. These groups were:

- human resources and organisational development group
- clinical governance group
- performance and assurance group
- finance, infrastructure and business development group.

Four sub-committee groups further informed the board:

- audit committee.
- charitable funds committee.
- mental health legislation committee.
- remunerations committee.

Seven business divisions fed into the policy and planning groups and the sub-committees. Each business division had clinical governance groups.

While the governance structure gave the trust assurances around key areas (for example, risk, quality improvements, incident oversight and learning, staffing and training), we found that the structure itself lacked an overarching single point of reference between the divisional governance groups and the policy and planning groups.

There were seven separate structures all working independently at divisional level. This led to inconsistencies and a lack of co-ordinated oversight and some staff confusion. This could impede clear understanding of lines of responsibility and could therefore prevent decisive, timely, and effective actions from being taken to rectify problems. The structure was also regularly changing as leadership changed, leading to new priorities.

Trusts must ensure that they have an appropriately skilled, well trained and informed workforce who use their knowledge and skills effectively in their everyday practice. To achieve this, trusts must provide appropriate training, including some training that is mandatory, to ensure that all employees have the skills, knowledge and training to carry out their roles safely and effectively. We found that mandatory training completion rates at the trust were significantly lower than the trust's own target of 90% for most teams.

Similarly there was room for improvement in increasing the number of staff having annual appraisals of their work performance and regular managerial supervision. Managers used two supervision policies; one for clinical staff and one for non-clinical staff.

However, staff we spoke to across the trust all reported that training opportunities beyond the mandatory requirement were good. The trust responded positively to requests for identified training that could enhance the delivery of care and the development of staff.

Good

Are services well-led?

Staff participated in clinical audits and could describe changes made as a result of audits at divisional level.

Staff learnt from incidents, audits, complaints and service user feedback in a variety of ways. There were daily bulletins on the trust's IT system, quality matters items on the intranet, and information shared through divisional meetings and governance meetings. The trust also had an organisational learning forum. These met every two months and included compliments, incidents, complaints and a themed topic for learning at each meeting. Most staff we spoke with informed us that team meetings prompted discussions regarding further improvements and that this learning had been identified from the whole trust and not just their division.

The trust had systems for regular recording, reporting and monitoring of risk through their risk registers held by the trust board. There were systems for recording, reporting and monitoring the divisional risk registers on a regular basis. The organisational risk register reflected the areas of concern.

For example, organisational learning was on the trust's risk register as the trust recognised information from committees and groups was not always reaching all staff.

The trust recognised that data for management information lacked assurances regarding its quality and the trust's IT systems were also on the risk register. The trust used two systems to record patient information but these were not linked to each other. This meant that information could not be shared across the different business divisions and could impact negatively on patient care if clinicians could not access key information.

Data required for board level reports was uploaded and collated using different methods depending on which system it was recorded on. A manual process was then required to provide the data in a consistent manner, which was open to human error.

The clinical commissioning groups had also raised these concerns. The trust has developed an IT strategy for 2012-2017. The ICT Board provides the governance oversight of the ICT strategy. However, there were no confident assurances provided to us that all data produced was accurate. The impact of this gave the potential for clinical risks and a risk in relationships with commissioners who had expressed to us in a focus group a dissatisfaction with the quality of some of the data the trust gave them.

Leadership and culture

A culture of openness was found in the trust, with a policy covering 'being open' and the duty of candour. There was good awareness of the duty among most ward and service managers, and the medical director had held a session for doctors about the duty and the findings of the national enquiry into the failings at Mid-Staffordshire hospital. Slow implementation of systems to identify, implement and record the relevant incidents and actions had led to incomplete reports being submitted to the upper levels of the organisation, which gave an inaccurate picture of how effectively the trust was implementing the duty of candour. This had not been realised until the trust received our request for specific duty of candour data immediately before the inspection.

We attended both the public and private board meeting that took place during the inspection. The board stuck to the agenda and functioned effectively. All members had the opportunity for debate and challenge on the issues discussed. In the private section of the meeting, the board was thorough in its debate before decision-making. In the public meeting, people had the time to ask questions and received appropriate responses.

We held focus groups with staff representatives. Staff generally spoke very passionately about the care they provided for people using the services. Staff felt supported in new roles following service changes. During changes, the trust increased staff meetings from once every six weeks to monthly, recognising the increased communication staff needed for reassurances. Staff mostly told us they enjoyed their jobs and morale was generally good. However, some staff were concerned about discrepancies in grading and limited opportunities for progression. Some staff also told us that the regular changes in structure caused uncertainties in their continued employment.

The trust employed social workers in the various business divisions. However, it was not clear where the leadership was coming from within the organisation for the trust's social workers and for social care generally. There was no senior professional at board level with responsibility for social work and social care. The trust had a professional strategy document that included guidance for recruitment, revalidation and accreditation of social workers but it was unclear who was responsible for overseeing standards for this important staff group. This resulted in social workers

Good

Are services well-led?

feeling unsupported and restricted in their career progression. There was also no assurances that social workers employed by the trust received role-specific supervision or appraisals of their work performance.

Staff representatives met management every six weeks for a staff council meeting. We observed a meeting attended by union representatives, the trust's chief executive officer, the human resource director and director of finance. Staff and management interacted positively, with open and free discussions and consultations on trust policies and current business.

Service directors attended individual services on both a formal and informal basis for drop-in sessions with staff. The nursing director visited inpatient settings on a regular basis. Staff said that senior management were approachable.

Middle managers were encouraged to attend the trust programme "Fit for the Future". This programme was designed to support managers in their leadership development. Managers felt they had the autonomy required to develop services.

The trust dealt with poor performance promptly and in line with their disciplinary policy. Managers responsible for disciplinary hearings kept staff informed effectively and in a timely manner and reports were clear and detailed.

Fit and Proper Person Requirement

We reviewed the directors' personnel files to ensure they met the requirements of the fit and proper person regulation. All requirements had been met, with the exception of one file that did not contain two references. This director had been recruited a number of years before inspection. One file did not contain photographic identification.

Engaging with the public and with people who use services

Frontline staff had opportunities to be involved in some trust decisions. For example, the trust set up an interactive blog that was available for all staff to remark confidentially on organisational values. Staff attended review meetings and consultations in relation to trust restructuring and the trust asked frontline staff to contribute ideas.

Service users sat on the council of governors and were engaged in decision-making. The trust board received meeting minutes.

The trust used a 'happy or not' tool for receiving feedback from service users. This gave the trust instant feedback and a 'temperature check' of different areas. Young people also sat on interview panels for staff recruitment in children's and young people's services.

Quality improvement, innovation and sustainability

The trust's quality improvement strategy set out the organisation's quality improvement priorities. In 2014/15, the strategy was reviewed at the bi-annual business division quality and standards reviews, and progress reported through the clinical governance group. The review of the strategy confirmed the continuation of the quality workstreams for 2015/18.

The trust participated in external peer review and accreditation. This included:

- Memory services national accreditation programme (MSNAP) – Doncaster memory clinic and Rotherham memory service were accredited as excellent until October 2015 and April 2016 respectively.
- The quality network for forensic mental health services – Amber Lodge.
- Electro convulsive therapy accreditation standards (ECTAS) College centre for quality Improvement (CCQI) – Rotherham ECT – accredited as excellent (Rotherham provides ECT for all trust services).
- Accreditation for inpatient mental health services (AIMS - CCQI) – Laurel ward, part of the older people's wards, was part of the scheme, although not accredited at the time of the inspection.

In community health services for children, young people and families, we saw many examples of innovation including:

- The development of a smartphone application for asthma to help educate children. This was based on guidance from the National Institute for Health and Care Excellence (NICE) and was intended to increase awareness of asthma and reduce the nursing and clinical intervention required.

Good

Are services well-led?

- The development of an application to help children access school nursing services out of normal working hours and a text system to access school nursing services.
- A single point of access for all referrals into the 0-5 and 5-19 pathways. This allowed a simple access point to services and clear pathways were mapped to allow referrals to be appropriately placed.
- Development of local education and health aids, including 'pants on the line' (a tool to educate about inappropriate sexual contact) and the clinic in a box (a sexual health kit that could be collected by young people and taken away).
- The health visiting service managed a smoking cessation programme for families. As part of this, they used the services of psychologists who offered cognitive behavioural therapy (CBT). Figures provided by the trust showed that the percentage of mothers smoking at delivery had reduced from 22% in quarter one of 2013/4 to 17% in quarter four of 2014/15.
- A child sexual exploitation nurse was part of a team from social services and the police protecting children and young people who had been sexually exploited, were being exploited or were at risk of exploitation.
- The trust had achieved accreditation as United Nations Children's Fund (UNICEF) baby friendly stage 3.

The trust used a variety of ways of communicating with staff, including innovative use of social media and through YouTube clips on, for example, infection prevention. The infection prevention and control team prepared and released a video, which highlighted the work they did across the trust. The video provided a snapshot of the key components of the quality and standards that are crucial in promoting and maintaining patient safety.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Regulation 17 (2) (d) Good governance How the regulation was not being met; There was no effective system to ensure that staff were up to date with mandatory training. · There were different figures for mandatory training provided at trust level and at a local level. · Training data was not being accurately recorded in the IT system. This meant that the trust was failing to maintain accurate records relating to people employed. This was in breach of regulation 17 (2) (d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 20 HSCA (RA) Regulations 2014 Duty of candour Duty of Candour Regulation 20(2)(3)(4) Verbal and written notifications to the relevant person have not been sent for all incidents triggering the duty. There were gaps in Duty of Candour actions taken for some known incidents, and some further incidents had not been actioned because they had not been identified. Records of apologies were not always kept and the

This section is primarily information for the provider

Requirement notices

specified closure of the electronic record at ten days was too soon to allow for the routine recording of correspondence after this time, such as during and after an investigation. This was a breach of the regulations.

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.