Requires Improvement

sheffield health and social care NHS Foundation Trust

Quality Report

Fulwood House
Old Fulwood Road
Sheffield
S10 3TH
Tel: 0114 271 6310
Website: www.shsc.nhs.uk

Date of inspection visit: 28 – 31 October 2014
Date of publication: 09/06/2015

Core services inspected	CQC registered location	CQC location ID
Acute wards for adults of working age and psychiatric intensive care units (PICUs)	Michael Carlisle Centre The Longley Centre	TAHFC TAHCC
Long stay/rehabilitation mental health wards for working age adults	Forest Close	TAHXM
Forensic inpatient/secure wards	Forest Lodge	TAHXN
Wards for older people with mental health problems	Michael Carlisle Centre The Longley Centre Grenoside Grange	TAHFC TAHCC TAHXP
Health-based places of safety	The Longley Centre	TAHCC
Community-based mental health services for older people	Fulwood House	TAHXK
Community-based mental health services for adults of working age	Fulwood House	TAHXK
Adult Social Care	136 Warminster Road - SHSC Respite Service Hurlfield View Longley Meadows Supported Living Service Wainwright Crescent Woodland View	TAHX1 TAH52 TAH67 TAH61 TAHYR TAH95

Summary of findings

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

Summary of findings

Ratings

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

Overall rating for mental health 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?	**Requires Improvement** 
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

We saw that the seclusion rooms on the acute wards and the 136 suite did not meet all of the requirements of the MHA Code of Practice in relation to providing a safe environment for the management of patients presenting as a risk to others. We identified a number of ligature points in all of the inpatient areas. There was evidence to show that ligature points were being managed by the trust in the low secure wards, the learning disabilities service, rehabilitation wards and the older people's wards at Grenoside Grange. However It was not always clear that ligature risks were being fully mitigated in the acute admission and PICU wards. The inspection team also identified ligature risks that had not been identified by the trust on the acute inpatient wards Stanage and Burbage. We found there was inconsistent qualified staffing cover at the rehabilitation wards at Forest Close. Often there were two qualified staff working across three wards which left two unqualified staff on duty on one of the wards. There were also inconsistencies with regards to the level of junior doctor support across the wards. Staff working in the ward area told us that the junior doctors focussed on patient needs. This meant they spent less time on the wards where patients had less complex needs. The resource of staffing at night time to manage the out of hours and crisis demands meant that out of hours provision was not fully safe or responsive to people's needs. We looked at compliance with Department of Health guidance on same sex accommodation (SSA) and the Mental Health Act (MHA) Code of Practice (CoP) throughout the inpatient services. We found compliance with SSA with the exception of the rehabilitation wards at 1a and 3 Forest Close. We identified the following concerns around medicines management:

- In some acute wards physical observations following rapid tranquillisation were not always fully recorded.
- In some treatment rooms on the acute adult and older people's wards we found refrigerators were not always properly monitored by ward and pharmacy staff to make sure that medicines were always stored at the correct temperature.
- In some acute adult and older people's wards entries in the controlled drug register did not always include the signature of the witness observing administration and on the acute wards we found that sometimes the dose given was not recorded.
- In the CMHTs there were concerns with nursing staff repackaging medicines which should only be carried out by pharmacy staff and the safe storage of medicines.
- In the CMHTs there was no dedicated pharmacist input to support the safe and effective management of medicines.

However we saw that: Services had effective systems in place to capture clinical incidents and accidents and to learn lessons from them effectively.Overall staff had a good awareness of safeguarding procedures and knew how to raise alerts where necessary when they knew or suspected abuse was occurring.Data provided at trust level about training uptake showed significant gaps in mandatory training. Up to date lists of staff training uptake could not always be provided from some of the teams we visited. This system was not effective in monitoring the trusts training uptake. Gaps in training included:

- Limited Mental Capacity Act (MCA) refresher training in acute services.
- Levels of staff training around safeguarding adults were low on the Dovedale wards.
- No training specific provided to staff working in the section 136 suite.

We saw some areas of poor practice around MDT working:

- In the acute inpatient services patients were not usually invited into the MDT meeting but were instead offered time with any professional on an individual basis on request. This meant that it was not always clear that patients were fully participating in their care.
- In the rehabilitation services we found some inconsistencies with the level of engagement some patients had with their multi-disciplinary team (MDT) meetings and a lack of proactive involvement of

advocacy to support these patients to be more involved in their care reviews. The MDT notes we looked at did not always record who had attended the MDT reviews or the patients' views.

We found some inpatient services did not always adhere to the Mental Health Act Code of Practice.

- Staff were not completing the appropriate records to evidence adherence to the Mental Health Act.
- Some records did not show that patients had been told about their rights under the Mental Health Act.
- The recording of episodes of seclusion including the time the doctor attended seclusion and the cogent reasons if there is a delay in attendance.
- The legal authorisations T2 (certificate of consent to treatment) and T3 (certificate of second opinion) for treatment were not kept with the medicines charts.
- In rehabilitation services we found on some wards MHA documentation was not readily present and available for inspection for all detained patients.
- In both acute inpatient and rehabilitation services we found that issues regarding adherence to the Mental Health Act (MHA) had been identified in previous MHA monitoring visits had not been addressed effectively.

We found the following areas in need of improvement around capacity to consent:

- In the acute inpatient services there were issues with adherence to the Mental Health Act Code of Practice particularly around capacity to consent for treatment.
- In the adult community teams it was not always recorded when the person had chosen for others not to be involved.
- In rehabilitation services we found inconsistencies regarding the application of the Mental Capacity Act and Deprivation of Liberty safeguards across the wards. There was a lack of evidence to demonstrate that patients' capacity to consent or dissent to treatment was assessed and documented.

However in the forensic service there were many examples of how the wards had integrated best practice within the care and treatment they provided to patients and their carers in line with the National Institute for Health and Clinical Excellence (NICE) and national guidance. In the forensic service 100% mandatory training achieved for all staff. Overall the trust was providing a caring service for patients. Throughout the inspection we saw examples of staff treating patients with kindness, dignity and compassion. The feedback received from patients was generally positive about their experiences of the care and treatment provided by staff. Staff were mostly knowledgeable about patients' needs and showed commitment to provide patient led care. The services held a range of regular patient meetings and some carer meetings to support relatives and carers of patients on the wards. Patients were also facilitated to access external service user groups such as Service User Network (SUN:RISE) and Sheffield African Caribbean Mental Health Association (SACMHA). Patients had regular access to advocacy including specialist independent mental health advocacy (IMHA) for patients detained under the Mental Health Act. There were areas of good practice:

- There were innovative service user involvement initiatives for patients using adult community mental health services
- We found the CLDT was proactive in its approach to gaining feedback from patients and their families
- Forensic services supported patients and their relatives to keep in contact with technology such as SKYPE.

However there were areas of poor practice:

- In older peoples inpatient services, at Dovedale we saw patients were not consistently involved in care planning and at Grenoside patients were not involved in their life stories and person centred plans.
- In rehabilitation services there was a lack of proactive involvement of advocacy to support these patients to be more involved in their care reviews.
- At the section 136 suite there was no formal mechanism to obtain feedback from people detained under section 136.

The resource of staffing at night time to manage the out of hours and crisis demands meant that out of hours provision was not fully safe or responsive to people's needs. There were no overall systems to record how the limitations on the out of hours service impacted on patient care to monitor its' responsiveness. There were a number of pressures within the community mental health teams.Prior to our visit, the Trust had identified concerns regarding the management of new referrals in the CLDT because people had waited significant periods of time before being assessed by professionals within the service.

Summary of findings

The Trust had completed a full review of each patient in response to this and we could see evidence of improvements beginning to be made. In the rehabilitation services the service had identified that 23 patients did not require the in-patient hospital care they were currently receiving at 1, 2 and 3 Forest Close. Despite these figures no delayed discharges had been reported to the trust from Forest Close in the previous six months. The needs of some of these patients had changed over the years they had been at Forest Close with their physical health needs' being more complex and requiring more nursing input than their mental health needs. It was not evident how the service had developed or planned services to effectively meet the changing needs' of this patient group.

However we found that:Access, discharge, transfer of care and bed management was effectively managed throughout most inpatient and community services. Patients' diversity and human rights were respected. Attempts were made to meet patients' individual needs including cultural, language and religious needs. People's individual, cultural and religious beliefs were taken into account and respected as demonstrated by the content of the care plans and observation at clinical meetings. We saw that complaints were well managed. The complaints within each service were looked into and responded to. Where complaints were not upheld, managers would still look at what could be learned or improved. We found evidence to show that managers had taken timely action in response to complaints which they had received. The trust had a strategy with the overall vision and values and most staff told us they understood the vision and direction of the trust and showed professional commitment to these values. There was a clear governance structure that included a number of committees that fed directly into the Board. Services were overseen by committed and experienced managers who oversaw the quality and clinical governance agenda. There were regular meetings for managers to consider issues of quality, safety and standards. Lines of communication from the board and senior managers to the frontline services were mostly effective, and staff were aware of key messages, initiatives and the priorities of the trust. Staff understood the management structure and where to seek additional support. The trust participated in external peer review and service accreditation. However there was variance in how staff across services learnt lessons from incidents, audits, complaints and feedback from patients. We saw that in some areas, local governance arrangements were good whilst in others they were not effective. Sheffield Health and Social Care NHS Foundation Trust are registered to provide adult social care service from six locations. These locations were inspected as part of the inspection process. Reports of the finding of these services have also been produced. The aggregated for these services are as follows.

Longley Meadows

Overall rating for this service -Requires improvement

Are services at this location safe? -Requires improvement

Are services at this location effective? -Good

Are services at this location caring? -Good

Are services at this location responsive? - Requires improvement

Are services at this location well-led? -Requires improvement

Hurlfield

Overall rating for this service -Requires improvement

Are services at this location safe? -Requires improvement

Are services at this location effective? -Requires improvement

Are services at this location caring? -Requires improvement

Are services at this location responsive? -Good

Are services at this location well-led? -Requires improvement

Woodland View

Overall rating for this service -Inadequate

Are services at this location safe? -Inadequate

Are services at this location effective? - Inadequate

Are services at this location caring? -Requires improvement

Summary of findings

Are services at this location responsive? -Requires improvement

Are services at this location well-led? -Requires improvement

136 Warminster Road

Overall rating for this service -Requires improvement

Are services at this location safe? -Requires improvement

Are services at this location effective? -Good

Are services at this location caring? -Good

Are services at this location responsive? -Requires improvement

Are services at this location well-led? -Requires improvement

Supported living Mansfield View

Overall rating for this service -Good

Are services at this location safe? -Requires improvement

Are services at this location effective? -Good

Are services at this location caring? -Good

Are services at this location responsive? -Good

Are services at this location well-led? -Good

Supported living Wainwright Crescent

Overall rating for this service -Requires improvement

Are services at this location safe? -Requires improvement

Are services at this location effective? -Requires improvement

Are services at this location caring? -Good

Are services at this location responsive? -Outstanding

Are services at this location well-led? -Requires improvement

Aggregated rating for the adult social care services provided

Overall adult social care rating - Requires improvement

Are adult social care services safe? - Requires improvement

Are adult social care services effective? - Requires improvement

Are adult social care services caring? - Requires improvement

Are adult social care services responsive? - Requires improvement

Are adult social care services well-led? - Requires improvement

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?

Are services safe?

Requires Improvement

We rated the provider as requires improvement because:

We saw that the seclusion rooms on the acute wards and the 136 suite did not meet all of the requirements of the MHA Code of Practice in relation to providing a safe environment for the management of patients presenting as a risk to others. We identified a number of ligature points in all of the inpatient areas. There was evidence to show that ligature points were being managed by the trust in the low secure wards, rehabilitation wards and the older people's wards at Grenoside Grange. However It was not always clear that ligature risks were being fully mitigated in the acute admission and PICU wards. The inspection team also identified ligature risks that had not been identified by the trust on the acute inpatient wards Stanage and Burbage. We found there was inconsistent qualified staffing cover at the rehabilitation wards at Forest Close. Often there were two qualified staff working across three wards which left two unqualified staff on duty on one of the wards. There were also inconsistencies with regards to the level of junior doctor support across the wards. Staff working in the ward area told us that the junior doctors focussed on patient needs. This meant they spent less time on the wards where patients had less complex needs. The resource of staffing at night time to manage the out of hours and crisis demands meant that out of hours provision was not fully safe or responsive to people's needs. We looked at compliance with Department of Health guidance on same sex accommodation (SSA) and the Mental Health Act (MHA) Code of Practice (CoP) throughout the inpatient services. We found compliance with SSA with the exception of the rehabilitation wards at 1a and 3 Forest Close.We identified the following concerns around medicines management:

• In some acute wards physical observations following rapid tranquillisation were not always fully recorded.

• In some treatment rooms on the acute adult and older people's wards we found refrigerators were not always properly monitored by ward and pharmacy staff to make sure that medicines were always stored at the correct temperature.

• In some acute adult and older people's wards entries in the controlled drug register did not always include the signature of the witness observing administration and on some acute wards we found that sometimes the dose given was not recorded.

Summary of findings

• In the CMHTs there were concerns with nursing staff repackaging medicines which should only be carried out by pharmacy staff and the safe storage of medicines.

• In the CMHTs there was no dedicated pharmacist input to support the safe and effective management of medicines. However we saw that:

Services had effective systems in place to capture clinical incidents and accidents and to learn lessons from them effectively. Overall staff had a good awareness of safeguarding procedures and knew how to raise alerts where necessary when they knew or suspected abuse was occurring.

Are services effective?

Requires Improvement

We rated the provider as requires improvement because:

Data provided at trust level about training uptake showed significant gaps in mandatory training. Up to date lists of staff training uptake could not always be provided from some of the teams we visited. This system was not effective in monitoring the trusts training uptake. Gaps in training included:

• Limited Mental Capacity Act (MCA) refresher training in acute services.

• Levels of staff training around safeguarding adults were low on the Dovedale wards.

• No training specific provided to staff working in the section 136 suite. We saw some areas of poor practice around MDT working:

• In the acute inpatient services patients were not usually invited into the MDT meeting but were instead offered time with any professional on an individual basis on request. This meant that it was not always clear that patients were fully participating in their care.

• In the rehabilitation services we found some inconsistencies with the level of engagement some patients had with their multi-disciplinary team (MDT) meetings and a lack of proactive involvement of advocacy to support these patients to be more involved in their care reviews. The MDT notes we looked at did not always record who had attended the MDT reviews or the patients' views. We found some inpatient services did not always adhere to the Mental Health Act Code of Practice.

• Staff were not completing the appropriate records to evidence adherence to the Mental Health Act.

Summary of findings

• Some records did not show that patients had been told about their rights under the Mental Health Act.

• The recording of episodes of seclusion including the time the doctor attended seclusion and the cogent reasons if there is a delay in attendance.

• The legal authorisations T2 (certificate of consent to treatment) and T3 (certificate of second opinion) for treatment were not kept with the medicines charts.

• In rehabilitation services we found on some wards MHA documentation was not readily present and available for inspection for all detained patients.

• In both acute inpatient and rehabilitation services we found that issues regarding adherence to the Mental Health Act (MHA) had been identified in previous MHA monitoring visits had not been addressed effectively. We found the following areas in need of improvement around capacity to consent:

• In the acute inpatient services there were issues with adherence to the Mental Health Act Code of Practice particularly around capacity to consent for treatment.

• In the adult community teams it was not always recorded when the person had chosen for others not to be involved.

• In rehabilitation services we found inconsistencies regarding the application of the Mental Capacity Act and Deprivation of Liberty safeguards across the wards. There was a lack of evidence to demonstrate that patients' capacity to consent or dissent to treatment was assessed and documented. However in the forensic service there were many examples of how the wards had integrated best practice within the care and treatment they provided to patients and their carers in line with the National Institute for Health and Clinical Excellence (NICE) and national guidance. In the forensic service 100% mandatory training achieved for all staff.

Are services caring?

Good

We rated the provider as good because:

Overall the trust was providing a caring service for patients. Throughout the inspection we saw examples of staff treating patients with kindness, dignity and compassion. The feedback received from patients was generally positive about their experiences of the care and treatment provided by staff. Staff were mostly knowledgeable about patients' needs and showed commitment to provide patient led care. The services held a range of regular patient meetings and some carer meetings to support

Summary of findings

relatives and carers of patients on the wards. Patients were also facilitated to access external service user groups such as Service User Network (SUN:RISE) and Sheffield African Caribbean Mental Health Association (SACMHA). Patients had regular access to advocacy including specialist independent mental health advocacy (IMHA) for patients detained under the Mental Health Act. There were areas of good practice: • There were innovative service user involvement initiatives for patients using adult community mental health services

• We found the CLDT was proactive in its approach to gaining feedback from patients and their families

• Forensic services supported patients and their relatives to keep in contact with technology such as SKYPE. However there were areas of poor practice:

• In older peoples inpatient services, at Dovedale we saw patients were not consistently involved in care planning and at Grenoside patients were not involved in their life stories and person centred plans.

• In rehabilitation services there was a lack of proactive involvement of advocacy to support these patients to be more involved in their care reviews.

• At the section 136 suite there was no formal mechanism to obtain feedback from people detained under section 136.

Are services responsive to people's needs?

Requires Improvement

We rated the provider as requires improvement because:

The resource of staffing at night time to manage the out of hours and crisis demands meant that out of hours provision was not fully safe or responsive to people's needs.

There were no overall systems to record how the limitations on the out of hours service impacted on patient care to monitor its' responsiveness.

There were a number of pressures within the community mental health teams.

Prior to our visit, the Trust had identified concerns regarding the management of new referrals in the CLDT because people had waited significant periods of time before being assessed by professionals within the service.

The Trust had completed a full review of each patient in response to this and we could see evidence of improvements beginning to be made In the rehabilitation services the service had identified that 23

patients did not require the in-patient hospital care they were currently receiving at 1, 2 and 3 Forest Close. Despite these figures no delayed discharges had been reported to the trust from Forest Close in the previous six months.

The needs of some of these patients had changed over the years they had been at Forest Close with their physical health needs' being more complex and requiring more nursing input than their mental health needs. It was not evident how the service had developed or planned services to effectively meet the changing needs' of this patient group.

However we found that:

Access, discharge, transfer of care and bed management was effectively managed throughout most inpatient and community services. Patients' diversity and human rights were respected. Attempts were made to meet patients' individual needs including cultural, language and religious needs. People's individual, cultural and religious beliefs were taken into account and respected as demonstrated by the content of the care plans and observation at clinical meetings. We saw that complaints were well managed. The complaints within each service were looked into and responded to.

Where complaints were not upheld, managers would still look at what could be learned or improved. We found evidence to show that managers had taken timely action in response to complaints which they had received.

Are services well-led?

Good

We rated the provider as good because:

The trust had a strategy with the overall vision and values and most staff told us they understood the vision and direction of the trust and showed professional commitment to these values.

There was a clear governance structure that included a number of committees that fed directly into the Board. Services were overseen by committed and experienced managers who oversaw the quality and clinical governance agenda.

There were regular meetings for managers to consider issues of quality, safety and standards. Lines of communication from the board and senior managers to the frontline services were mostly effective, and staff were aware of key messages, initiatives and the priorities of the trust.

Staff understood the management structure and where to seek additional support. The trust participated in external peer review and service accreditation.

Summary of findings

However there was variance in how staff across services learnt lessons from incidents, audits, complaints and feedback from patients. We saw that in some areas, local governance arrangements were good whilst in others they were not effective.

Summary of findings

Our inspection team

Our inspection team was led by:

Chair: Alison Rose-Quirie, Chief Executive Office, Swanton Care Ltd

Team Leader: Graham Hinchcliffe, Interim Inspection Manager, Care Quality Commission

Head of Inspection: Nicholas Smith, Head of Hospitals Inspection, Care Quality Commission

The team included CQC inspectors and a variety of specialists who included:

- Consultant psychiatrists
- Director of nursing
- Experts by experience both users of services and family carers
- Governance leads
- Mental health and learning disability nurses
- Mental health and learning disability social workers
- Mental Health Act reviewers
- Occupational therapists
- Pharmacists
- Psychiatrists
- Psychologists
- Qualified nurses
- Student nurse

Why we carried out this inspection

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

How we carried out this inspection

To get to the heart of people who use services' experience of care, 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 a range of information we hold about the trust and asked other organisations to share what they knew.

We attended the trust's annual members meeting and invited patients and members of the public to meet with us. We also arranged a focus group Sheffield prior to the inspection, facilitated by a voluntary organisation. We carried out announced visits to all core services on 28, 29 and 30 October 2014. We carried out an unannounced visit to the learning disability community team on the 12 November and an unannounced visit to the out of hours crisis on 12 November 2014.

During the visit we held focus groups with a members of staff who worked within the service, such as nurses, doctors, psychologists, allied health professionals, and administrative staff.

We met with representatives from other organisations including commissioners of health services and local authority personnel. We met with people who use services who shared their views and experiences of the core services we visited.

We observed how patients were being cared for and talked with carers and/or family members and reviewed care or treatment records of 114 patients who use services. We looked at a range of records including clinical and management records.

During the inspection of the core services we spoke with 170 members of staff, 90 patients and 15 carers.

Summary of findings

Information about the provider

Sheffield Health and Social Care NHS Foundation Trust (SHSC) is the main provider of a wide range of specialist health and social care services to individuals and their carers or families in Sheffield. The trust has been registered with the Care Quality Commission since June 2010. They deliver care across 18 active locations, all of which are registered with the Care Quality Commission.
Trust Headquarters - Sheffield Health and Social Care NHS Foundation Trust, Fulwood House, Old Fulwood Road, Sheffield, S10 3TH. Telephone: 0114 271 6310
Services The Trust provide a wide range of health and social care services specialising in:

- mental health services for adults and older people
- services for people with learning disabilities
- services for people with drug and alcohol problems
- SCAIS Interpreting Service
- the Clover Group Practice
- long term neurological conditions
- a wide range of other specialist services, such as perinatal mental health, gender dysphoria services and psychology for people with physical health problems.

Sheffield Health and Social Care NHS Foundation Trust provides services across the city of Sheffield to a population of 553,000. The trust provide mental health, learning disability, substance misuse, community rehabilitation, and a range of primary care and specialist services to the people of Sheffield. We also provide some of our specialist services to people outside of Sheffield. The trust does not provide any children's mental health services. It provides the following core services:

- Acute wards for adults of working age and psychiatric intensive care units (PICUs)
- Long stay/rehabilitation mental health wards for working age adults
- Forensic inpatient/secure wards
- Wards for older people with mental health problems
- Mental health crisis services and health-based places of safety
- Community mental health services for people with learning disabilities or autism
- Community-based mental health services for older people

Sheffield Health and Social Care NHS Foundation Trust has a total of 18 registered locations providing mental health and learning disability services, including five hospitals sites:

- Forest Lodge
- Forest Close
- Michael Carlisle Centre
- The Longley Centre
- Grenoside Grange

The trust is also registered to provide community health services from Fulwood House. The trust also provides adult social care services from five locations. These services were inspected as part of this process:

- Hurlfield View TAH52
- Longley Meadows TAH67
- Supported Living Service TAH61
- 136 Wainwright Crescent TAHYR
- Warminster Road TAHX1
- Woodland View TAH95

The individual reports for each of these services can be found on the CQC website. The trust also provides primary medical services from five locations. These services were not inspected as part of this process:

- Jordanthorpe Health Centre TAH54
- Highgate Surgery TAH84
- Central Health Clinic TAH 23

The organisation has an annual income of approximately £130 million, and employs more than 3,000 members of staff. Sheffield Health and Social Care NHS Foundation Trust has been inspected on 24 occasions since registration. These inspections have occurred at 13 locations out of the 18 active locations. Only the Supported Living Service location was found to be non-complaint. The 5 locations that have not been inspected are Central Health Clinic, Darnall Community Health, Highgate Surgery, Jordanthorpe Health Centre, Brierley Medical Centre. The reports of the inspections at these locations were published between January 2011 and March 2014.

Summary of findings

What people who use the provider's services say

Overall, patients we spoke with told us that staff treated them with dignity. Patients said they could approach staff with any issues they had and staff treated them with respect and care.Overall people were happy with the service they were receiving and the support which was provided to them. Patients were complimentary about staff and told us the staff were kind, caring and treated them with dignity. On the wards, we saw patients were being supported by kind and attentive staff. We observed that staff showed patience and gave encouragement when supporting patients. Relatives and carers told us staff were responsive to their needs and treated them with dignity and respect. Patients who used the services told us that they felt safe. People using the services were positive about the staff and the care they received and felt involved. Comment cards Before the inspection, we left comment cards in various places throughout the trust for people to write their comments down about their experiences of the trust services. People posted their comments in sealed boxes which we opened and looked at as part of the inspection.

- Thirty four comment cards were received in total
- Of the 32 cards received back 23 were positive, eight were negative and three cards contained negative and positive elements.
- Top five ranking sites which had the most returned cards were;
  - Eating Disorders Service, St George's- 10 positive, one negative
  - East Glad Community Team- one positive, two negative, one mixed
  - Forest Road- three positive
  - Trust Headquarters- three negative
  - Intensive Support Service (PICU) 11 positive, two negative

Top three positive comments

- Eighteen positive comments about staff (caring, helpful, listened to, respect & dignity, made to feel welcome, understanding, first class care)
- Six positive comments about the services that the trust provided to patients.
- Four positive comments about the environment (safe, relaxing, clean)

However

- Three negative comments were received about patients feeling that they were being passed around the service without diagnosis
- Two negative comments received about overuse of external consultancies instead of using front line staff to problem solve.

Good practice

We found the following areas of good practice:

- Patients on Stanage ward had access to innovative touch screen technology providing information on a range of subjects including the ward services, Mental Health Act rights, medication information and services available to the patients in hospital and in the community.
- Patients on the acute wards had timely access to psychology input, with psychologists embedded within the multi-disciplinary teams.
- There were innovative service user involvement initiatives to facilitate patients to comment on community mental health services, including the employment of peer workers, service users involved in interviewing community staff and other initiatives
- There was integrated health and social care working within the community teams including nurses acting as Approved Mental Health Professionals and community psychiatric nurses providing social circumstance reports
- At Dovedale 1 and 2 the psychologist led formulation meetings. This involved in focusing on patients who were hard to engage with or had behaviour which

challenged. The meeting mapped out the patient core values and motivations to find ways patients of engaging in successful and meaningful interactions with the patient to aid their recovery.

- At Grenoside the team were using an excellent 'antipsychotic checklist' to monitor the impact of changes to a person's prescribed medicines.This meant changes to patient medicines were regularly monitored to see the effect this had upon them so their medicines were regularly reviewed.
- At Grenoside we saw the use of soft dolls placed about the two areas of the ward. These were not toys but could be used as part of patents' treatment to lessen their distress. We saw patients using them as a means of comfort, by touching and stroking them.
- At Grenoside ward was involved in research on the use of a robotic seal.It had the ability to learn and remember its own name, and learned the behavior that resulted in a pleasing stroking response and repeated it. The seal was an interactive toy used to managing distressed and disturbed behavior. This was not used to deceive patients. The seal was being used by the trust as part of a clinical joint project with the University of Sheffield.
- At Grenoside the consultant psychiatrist had completed work on the development of a clinical leadership model using a person centered approach and evidence based practice. For example using a neuro psychiatric inventory, this was used to assess neuropsychiatric symptoms of patients with Alzheimer's disease and other dementias. It captured treatment related behavioural changes in patients receiving anti dementia medication and other psychiatric medicines. The RC used this on the admission and discharge assessment of patients and used outcome measures to improve care and treatment.
- At the CLDT staff had been provided with electronic tablets, this meant time was saved as staff completed their patient records sometimes during their visits or immediately following their visit. This meant staff did not have to keep returning to the office thus saving time.
- In rehabilitation services, a wellbeing clinic based on the Pinecroft Recovery ward which was held on a monthly basis for all patients. Patients' physical health needs where reviewed and monitored during these clinics. Each patient had their own separate wellbeing clinic care file.
- At Pinecroft ward, there was a pharmacy medicines information drop in session to provide information to patients on their medication

In forensic services:

- Each member of the multi-disciplinary team (MDT) provided a weekly summary of the patient's progress to the team. These were projected onto a screen for all to view. The discussion and outcome of the MDT meeting was up-dated onto the screen in 'real time'.
- Following each CPA meeting, patients' were shown a copy of the draft CPA documentation and were given the opportunity to add their views before it was finalised.
- On the rehabilitation unit there were robust step down procedures to support patients in managing their own medicines.
- The service had set up training for patients and staff to attend on risk assessments to promote joint learning.
- The wards had a 'fast track' complaints system in place which enabled patients or visitors to raise an informal complaint if they did not wish to make a formal complaint.
- There was an excellent range of recreational and therapeutic activities and facilities to support patient's recovery. This was enhanced by external support links the wards had developed with local faith leaders, specialist advocates, Sheffield College and the Open University.
- Patient's had access to SKYPE and mobile phones if appropriate to keep in touch with family.

Summary of findings

Areas for improvement

Action the provider MUST or SHOULD take to improve

The provider must ensure that the seclusion rooms on the acute wards and the 136 suite meet the requirements of the MHA Code of Practice in relation to providing a safe environment for the management of patients presenting as a risk to others.

The provider must ensure that ligature risks are fully mitigated in the acute admission and PICU wards.

The provider must ensure there are consistent qualified staffing levels at Forest Close.

The provider must review and ensure adequate staffing at night time to manage the out of hours and crisis demands.

The provider must ensure compliance with Department of Health guidance on same sex accommodation (SSA) and the Mental Health Act (MHA) Code of Practice (CoP) at the rehabilitation wards at 1a and 3 Forest Close.

The provider must ensure medicines management is effective in the acute adult wards, older people's wards and CMHTs.

The provider must ensure that data held centrally on mandatory training reflects current training uptake and is monitored to encourage uptake in line with the trust targets.

The provider must ensure that all patients are invited and encouraged to be involved in their multi-disciplinary meetings, CPA meetings or ward rounds and this is documented.

The provider must ensure that all services adhere to the Mental Health Act Code of Practice in relation to documentation and capacity to consent. The provider must ensure that the out of hours crisis service is reviewed for its responsiveness using systems to record how the limitations impacted on patient care.

The provider must ensure the on going monitoring of the waiting lists for access to the CLDT including internal referrals to therapeutic services.

The provider must ensure a review of the needs of the patients in the rehabilitation services and ensure appropriate plans are made for any patients requiring transfer or discharge.

The provider should ensure that junior medical cover at the rehabilitation wards 1, 2 and 3 Forest Close meet the needs of the service.

The provider should ensure specific training is provided to staff working in the section 136 suite.

The provider should ensure that patients are encouraged to be involved in care planning at Dovedale and in their life stories and person centred plans at Grenoside Grange.

The provider should ensure that patients are encouraged to be involved accessing advocacy in their care reviews in rehabilitation services.

The provider should ensure that there is a mechanism to obtain feedback from people detained under section 136.

The provider should ensure that a consistent audit programme is rolled out across rehabilitation services.

sheffield health and social care NHS Foundation Trust

Detailed findings

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 the provider as requires improvement because: We saw that the seclusion rooms on the acute wards and the 136 suite did not meet all of the requirements of the MHA Code of Practice in relation to providing a safe environment for the management of patients presenting as a risk to others. We identified a number of ligature points in all of the inpatient areas. There was evidence to show that ligature points were being managed by the trust in the low secure wards, rehabilitation wards and the older people's wards at Grenoside Grange. However It was not always clear that ligature risks were being fully mitigated in the acute admission and PICU wards. The inspection team also identified ligature risks that had not been identified by the trust on the acute inpatient wards Stanage and Burbage. We found there was inconsistent qualified staffing cover at the rehabilitation wards at Forest Close. Often there were two qualified staff working across three wards which left two unqualified staff on duty on one of the wards. There were also inconsistencies with regards to the level of junior doctor support across the wards. Staff working in the ward area told us that the junior doctors focussed on patient needs. This meant they spent less time on the wards where patients had less complex needs. The resource of staffing at night time to manage the out of hours and crisis demands meant that out of hours provision was not fully safe or responsive to people's needs. We looked at compliance with Department of Health guidance on same sex accommodation (SSA) and the Mental Health Act (MHA) Code of Practice (CoP) throughout the inpatient services. We found compliance with SSA with the exception of the rehabilitation wards at 1a and 3 Forest Close. We identified the following concerns around medicines management:

Detailed findings

- In some acute wards physical observations following rapid tranquillisation were not always fully recorded.
- In some treatment rooms on the acute adult and older people's wards we found refrigerators were not always properly monitored by ward and pharmacy staff to make sure that medicines were always stored at the correct temperature.
- In some acute adult and older people's wards entries in the controlled drug register did not always include the signature of the witness observing administration and on some acute wards we found that sometimes the dose given was not recorded.
- In the CMHTs there were concerns with nursing staff repackaging medicines which should only be carried out by pharmacy staff and the safe storage of medicines.
- In the CMHTs there was no dedicated pharmacist input to support the safe and effective management of medicines.

However we saw that: Services had effective systems in place to capture clinical incidents and accidents and to learn lessons from them effectively. Overall staff had a good awareness of safeguarding procedures and knew how to raise alerts where necessary when they knew or suspected abuse was occurring.

Our findings

Track record on safety

The Strategic Executive Information System (STEIS) records serious incidents and never events. A never event is classified as such because they are so serious that they should never happen. Trusts have been required to report any never events through STEIS since April 2011.The trust had not reported any never events through STEIS. Serious Incidents are those that require an investigation. A total of 28 serious incidents were reported by the trust as having occurred between 1 September 2013 and 31 August 2014. These were spread across seven location categories, with the largest proportion (47%) occurring in patient homes. The most common incident type for the trust was 'suicide by outpatient' (in receipt of care)' which accounted for 53%. This was followed by 'Allegations against Healthcare Professionals' and 'Attempted Suicide by Outpatients and Inpatients', which together accounted for 28% of all incident types. Overall, no incidents related to unexpected deaths of patients (in and not in receipt of care) and 67% related to suicides (actual, attempted or suspected). Since 2004 trusts have been encouraged to report all patient safety incidents to the National Reporting and Learning System (NRLS) and since 2010, it has been mandatory for them to report all death or severe harm incidents to the Care Quality Commission (CQC) via the NRLS. There were 125 incidents reported by the trust to the NRLS between September 2013 and August 2014. These incidents were classed as follows; 12 of abuse, 83 moderate harm, eight severe harm and 22 deaths. Below is a breakdown of the 125 incidents that were reported as having occurred between September 2013 and August 2014.

Abuse

Twelve of the 125 incidents were categorised as 'abuse'. The 'abuse' incidents can be broken down as, 'physical' (six), 'sexual' (four) and other (two). 91% per cent of incidents were 'disruptive, aggressive behaviour (includes patient-to-patient)' and the remainder 'patient abuse (by staff/ third party)'.

Death

There was a total of 22 deaths reported during the specified period, These can be broken down as self-harm (15) and 'other' (seven). **Severe Harm** The eight incidents categorised as 'severe' were spread across three different categories:

- Self-harming behaviour - Suspected suicide (attempted) (five)
- Disruptive, aggressive behaviour (includes patient-to-patient) - Physical (two)
- Patient accident – Slips, Trips, Falls (one)

Moderate harm

There were 83 reported incidents of moderate harm. Access, admission, transfer, discharge (including missing patient) accounts for 42% of all moderate harm incidents. Patient Accident was the next highest at 18%. The incidents were spread across 10 different categories:

- Access, admission, transfer, discharge (including missing patient) (35)
- Patient Accident (15)
- Self harm (10)
- Infrastructure (including staffing, facilities, environment) (five)

- Clinical assessment (including diagnosis, scans, tests, assessments) (five)
- Treatment, procedure (four)
- Other (four)
- Medication (three)
- Implementation of care and on going monitoring / review (one)
- Infection Control Incident (one)

Every six months, the Ministry of Justice publish a summary of Schedule 5 recommendations which have been made by the local coroners with the intention of learning lessons from the cause of death and preventing deaths. There were no concerns regarding the trust in the most recent report (October 2012 – March 2013).

Learning from incidents

The provider had a system in place to capture clinical incidents and accidents and to learn lessons from them. All staff were able to explain the process they used to report incidents through the trust's reporting systems. The trust was in a transitional phase from a paper system of recording incidents to an electronic system. There was a clear plan in place to roll this out by all services by 2015 with training provided to each service. An incident form was completed by staff following any incidents. Managers and senior practitioners reviewed and graded the severity of incidents. Staff were aware of how to complete incident forms and their responsibilities in relation to reporting incidents. Staff told us that guidance on incident reporting was available on the intranet. Incidents were analysed by managers to identify any trends and appropriate action was taken in response to these. Regular feedback was provided to staff on serious incidents which occurred across the trust and the recommendations were discussed so that lessons were learnt. We saw that staff discussed incidents and lessons learnt at team meetings. The trustwide service user safety group met monthly. We saw evidence in the minutes of this group that serious incidents and lessons learnt are discussed regularly. The trust's risk management team produce monthly reports on incidents recorded by each ward and monitor particular themes of incidents. The minutes identified that the trust complete monthly safety bulletins where lessons learnt are shared with all staff via the intranet. Board summaries and minutes were reviewed which confirmed board level review of serious incidents and lessons learned.

Safeguarding

Overall staff had a good awareness of safeguarding procedures and knew how to raise alerts where necessary when they knew or suspected abuse was occurring. The trust has a safeguarding adults steering committee and minutes of those meetings go to the quality assurance committee and through that to the board. Board minutes demonstrated that safeguarding both adults and children was taken seriously. The trust undertook an audit of safeguarding in October 2013. The audit was undertaken to gain awareness of staff knowledge around trust polices, and structures to support safeguarding adults and children and to ascertain the level of staff understanding and confidence at using the safeguarding processes in the city. The board, following the outcomes of the audit, requested a report on the future training needs of staff in the organisation and took steps to improve the number of staff undertaking the training. **Safe and clean ward environment** All the wards we visited were clean. All but two wards we visited were well maintained. The exception was Pinecroft, a rehabilitation ward. We saw that the seclusion rooms on the acute wards and the 136 suite did not meet all of the requirements of the MHA Code of Practice in relation to providing a safe environment for the management of patients presenting as a risk to others. On Burbage ward we found the following:

- The seclusion room was unclean with stained walls, an unclean floor and a mattress and the toilet was not fully cleaned.
- The heating of the seclusion room was controlled from a panel outside of the room but it was broken so that this was not effective in controlling the temperature.
- A clock was situated outside the room but was not working so that patients in seclusion could not orientate themselves to the time.

On Burbage and Stanage wards:

- The seclusion room on Burbage had a blind spot in one corner where a patient could not be observed. The seclusion room on Stanage ward did not allow clear observation into all areas of the room.

On the section 136 suite:

- Facilities were cramped and often people being assessed had to use facilities on the main ward due to disturbing patients using the adjacent bedroom.

Seclusion

A trust policy on seclusion and long term segregation was in place and dated September 2013 with a review date of March 2014. There were 164 uses of seclusion, no incidents of long-term segregation (which the trust has only started recently recording) and 194 uses of restraint between 1st February and 31st July 2014. In only one instance on Forest Lodge low secure unit, a person was restrained in the prone position and subsequently the restraint resulted in rapid tranquilisation. There was high use of seclusion on the PICU and it was not always clear that seclusion was used as a last resort or for the shortest possible time. This meant that patients were at risk of being placed in seclusion for longer than necessary or for reasons other than the management of severely disturbed behaviour likely to pose a risk to other people. Many of the seclusion records either did not record the time the doctor was informed and attended or did not explain the reasons why the doctor was not able to attend immediately. Where longer episodes of seclusion or segregation occurred the regular reviews were not always adhered to. This meant that it was unclear if patients placed in seclusion received a timely medical review. We saw in ward areas, environmental risk assessments were undertaken regularly. The estates department undertook an annual risk assessment that included ligature points. The last assessment was completed in October 2014. This would result in an action plan for the estates team. There was evidence to show that ligature points were being managed in the low secure wards, rehabilitation wards and the older people's ward at Grenoside Grange. It was concerning that the risks were not being managed effectively in the acute admission and PICU wards at the Michael Carlisle Centre. The inspection team also identified ligature risks that had not been identified by the trust on the acute inpatient wards Stannage and Burbage.

Safe staffing

The highest percentages of permanent staff sickness were in the adult and older people's community teams. There were high levels of sickness in the CLDT and vacancies and sickness in acute inpatient wards. We found there was inconsistent qualified staffing cover at Forest Close. Often, there were two qualified staff working across three wards which left two unqualified staff on duty on one of the wards. There were also inconsistencies with regards to the level of junior doctor support across the wards. Staff working in the ward area told us that the junior doctors focussed on patient needs. This meant they spent less time on the wards where patients had less complex needs. The resource of staffing at night time to manage the out of hours and crisis demands meant that out of hours provision was not fully safe or responsive to people's needs. The resource of staffing at night time to manage the out of hours demand including the crisis function consisted of no more than two workers which had temporarily increased to three workers across Sheffield city wide during our visit. People in mental health crisis in Sheffield at night did not therefore have timely access to professional input by staff within the trust with the exception of those people assessed as requiring a Mental Health Act assessment.

A lack of adequate staffing led to the section 136 suite being closed on 47 occasions between January 2013 and September 2014. In the three month July to September 2014 the suite was closed on seven occasions. People are on occasions were left alone in the 136 suite due to staffing demands on the adult acute inpatient ward Maple ward over which the staff were shared. The acute inpatient wards were operating with higher levels of sickness levels and some staff vacancies. Whilst expected staffing levels were usually maintained, this was through utilising bank or agency staff who could not carry out the full range of clinical tasks. On occasions where the impact was deemed to be critical then an incident record would be completed.

Assessing and managing risk to patients and staff

We saw that all patients had a comprehensive risk assessment and management plan in place from admission. The risk assessments were updated regularly or following a serious incident. The provider had effective systems to assess and monitor risks to individuals. We found that risk assessments were in place and were comprehensive and holistic. The services used the detailed and risk assessment method (DRAM) which was completed when patients were referred and assessed. Following triage patients had a brief risk assessment and management plan (BRAM) completed before the more detailed DRAM assessment. Risk assessments were carried out by staff during patients' initial assessment and most reviewed or updated during care review meetings or if patients' needs changed. The trust had an corporate risk register which detailed ongoing risks. Individual care groups and teams also had risk registers specific to local risks. The responsible person and a target date for completion was clear and there was a progress on actions column. The trust had a board assurance framework (BAF) in place and a

corporate risk register. We saw evidence that the BAF had been presented for review to the executive team, the board and audit and assurance committee in April 2014. The trust also had a board risk profile. Trust board minutes showed that the board risk profile was discussed at every meeting and amendments noted.

Potential risks

Trust board minutes showed that the trust had plans in place in the event of a major emergency. This included the development of business continuity plans for all front line services. The minutes identified that the trust had conducted a desk top IT exercise and would follow that up with a controlled exercise to test back up systems as part of lessons learnt. The minutes confirmed that the trust had worked with the clinical commissioning group local implementation team and the local authority emergency planning group to develop the plans. We looked at compliance with Department of Health guidance on same sex accommodation (SSA) and the Mental Health Act (MHA) Code of Practice (CoP) throughout the inpatient services. We found compliance with SSA with the exception of the rehabilitation wards at 1a and 3 Forest Close.

Medicines Management

We identified the following concerns around medicines management:

- In some acute wards physical observations following rapid tranquillisation were not always fully recorded.
- In some treatment rooms on the acute adult and older people's wards we found refrigerators were not always properly monitored by ward and pharmacy staff to make sure that medicines were always stored at the correct temperature.
- In some acute adult and older people's wards entries in the controlled drug register did not always include the signature of the witness observing administration and on some acute wards we found that sometimes the dose given was not recorded.
- In the CMHTs there were concerns with nursing staff repackaging medicines which should only be carried out by pharmacy staff and the safe storage of medicines.
- In the CMHTs there was no dedicated pharmacist input to support the safe and effective management of medicines.

However there were areas of good practice around medicines management:

- Pharmacists were fully integrated into MDTs for inpatient services to support and ensure best outcomes from the use of medicines.
- An electronic prescribing and medicines administration system was in place on all wards and helped support safe and effective prescribing.
- Patients and their carers were provided with information about their medicines and a pharmacist was available to support this.
- Patients were supported to make decisions about their medicines.
- The trust completed medication audits and regularly reviewed best practice guidance to improve outcomes for patients.
- Grenoside Grange were using an 'antipsychotic checklist' to monitor the impact of changes to a person's prescribed medicines.
- At Forest Lodge, on the rehabilitation unit there were robust step down procedures to support patients in managing their own medicines.

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 the provider as requires improvement because:Data provided at trust level about training uptake showed significant gaps in mandatory training. Up to date lists of staff training uptake could not always be provided from some of the teams we visited. This system was not effective in monitoring the trusts training uptake. Gaps in training included:

- Limited Mental Capacity Act (MCA) refresher training in acute services.
- Levels of staff training around safeguarding adults were low on the Dovedale wards.
- No training specific provided to staff working in the section 136 suite.

We saw some areas of poor practice around MDT working:

- In the acute inpatient services patients were not usually invited into the MDT meeting but were instead offered time with any professional on an individual basis on request. This meant that it was not always clear that patients were fully participating in their care.
- In the rehabilitation services we found some inconsistencies with the level of engagement some patients had with their multi-disciplinary team (MDT) meetings and a lack of proactive involvement of advocacy to support these patients to be more involved in their care reviews. The MDT notes we looked at did not always record who had attended the MDT reviews or the patients' views.

We found some inpatient services did not always adhere to the Mental Health Act Code of Practice.

- Staff were not completing the appropriate records to evidence adherence to the Mental Health Act.
- Some records did not show that patients had been told about their rights under the Mental Health Act.
- The recording of episodes of seclusion including the time the doctor attended seclusion and the cogent reasons if there is a delay in attendance.
- The legal authorisations T2 (certificate of consent to treatment) and T3 (certificate of second opinion) for treatment were not kept with the medicines charts.
- In rehabilitation services we found on some wards MHA documentation was not readily present and available for inspection for all detained patients.
- In both acute inpatient and rehabilitation services we found that issues regarding adherence to the Mental Health Act (MHA) had been identified in previous MHA monitoring visits had not been addressed effectively.

We found the following areas in need of improvement around capacity to consent:

- In the acute inpatient services there were issues with adherence to the Mental Health Act Code of Practice particularly around capacity to consent for treatment.
- In the adult community teams it was not always recorded when the person had chosen for others not to be involved.
- In rehabilitation services we found inconsistencies regarding the application of the Mental Capacity Act and Deprivation of Liberty safeguards across the wards. There was a lack of evidence to demonstrate that patients' capacity to consent or dissent to treatment was assessed and documented.

However in the forensic service there were many examples of how the wards had integrated best practice within the care and treatment they provided to patients and their carers in line with the National Institute for Health and Clinical Excellence (NICE) and national guidance. In the forensic service 100% mandatory training achieved for all staff.

Requires Improvement

Are services effective?

Our findings

Assessment and delivery of care and treatment

In the forensic service we have rated this area as outstanding as there were many examples of how the wards had integrated best practice within the care and treatment they provided to patients and their carers in line with the National Institute for Health and Clinical Excellence (NICE) and national guidance. We found all wards assessed the needs of each patient before they were admitted. Care plans provided specific details of interventions, which should be put in place if the patient's mental health deteriorated, to prevent a relapse of their illness. Staff undertook a risk assessment of every patient on admission. This was to ensure that patient need could be safely met and that the level of security was consistent with the level of risk the individual posed. Across most services, physical healthcare assessments took place. Clear assessment and physical health check was undertaken and any ongoing physical health problems were followed up appropriately. People had a comprehensive and holistic assessment completed as part of the assessment process. This included people's social, cultural, physical and psychological needs and preferences. This also included risk assessment from identified risks and a care plan was then developed with the person to meet their identified needs. The care plans we looked at were regularly reviewed, centred on the needs of the individual person and demonstrated knowledge of current, evidence-based practice. **Outcomes for people using services** Since July 2012, the trust have undertaken a staff and patient safety audit. This is in line with NICE guidance CG25. This was last completed in March 2014 when 103 staff (from 8 wards) and 16 patients (from 3 wards) took part. The trust used various performance dashboards to monitor performance across the organisation. These had a number of indicators to monitor outcome performance. At the time of the inspection it was in the process of developing its information system to provide more robust data on individual team performance after it had been identified that data was not always useful. The trust participated in various national audits and monitored this through a clinical audit plan. This included the National Audit of Schizophrenia in 2013/14, National Audit of Psychological Treatment 13/14 and the National audit of Psychological Therapies and the Prescribing Observatory for Mental Health (POHM-UK). POHM–UK run national audit-based quality improvement programmes open to all specialist mental health services in the UK. The aim is to help mental health services improve prescribing practice in discrete areas. The trust undertook audits in 2012/13 to ensure prescribing of substance misuse, prescribing anti-dementia drugs and antipsychotics for people with dementia were in line with NICE guidance. The trust participated in a Commission for Quality and Improvement (CQUIN) measure around NICE guidelines for Falls and the NHS National Safety Thermometer. The trust also ran a number of local audits, some ongoing and others to look at specific issues. We saw that there were a number of local audits which were carried out which were able to measure standards in terms of development and improvement within the service. These audits included care planning, safeguarding, infection control, MHA adherence, medication and health and safety. The services monitored their performance in order to drive improvement. However we found the following:

- The trust's annual infection prevention and control audit was not up to date
- The rehabilitation services had limited and inconsistent audits in place to monitor the quality of service delivery across the wards. For example; there was an audit of care plans to support the collaborative care and risk planning at Pinecroft ward and 1a Forest Close but there were no care plan audits undertaken on the other wards. At Forest Close, we found audits were not always effective.
- Some clinical and electrical equipment had not been tested.

Staff skills

The 2013 Department of Health NHS staff survey was open to 416,000 NHS staff and the trust had a response rate of 49%. The trust scored within the worst 20% of mental health trusts nationally on the key finding relating to staff undergoing health and safety training. The trust's score was almost 30% below the national figure. The trust scored within the best 20% of mental health trusts nationally on key findings relating to staff feeling satisfied with the quality of work they are able to deliver, staff receiving job-relevant training, staff working extra hours and work pressure felt by staff.

Training, supervision and appraisal

Requires Improvement

Are services effective?

Data provided at trust level about training uptake showed significant gaps in mandatory training. We spoke with senior managers and this was often attributed to the difficulties in managing the Electronic Staff Record (ESR system) as this was not fit for purpose and did not always factor in different methods of training within individual services. Managers told us that training uptake was therefore more effectively monitored locally through the electronic training records and local email reminders, however up to date lists of training uptake could not always be provided from some of the teams we visited. This system was not effective in monitoring the trusts training uptake. Gaps in training included:

- Limited Mental Capacity Act refresher training in acute services.
- Levels of staff training around safeguarding adults were low on the Dovedale wards.
- No training specific provided to staff working in the section 136 suite.

In February 2014 the trust had commissioned an external review of mandatory training uptake within the trust in order to identify shortfalls in training uptake. The key areas for improvement were:

- Managers are not familiar with the contents of the Trust's Mandatory Training Policy and therefore may not be fully conversant with their compliance responsibilities;
- The Trust's Training Needs Analysis is not being consistently used by managers to identify and plan mandatory training;
- In a significant number of instances, managers did not maintain a local record of the mandatory training needs of their staff. This is compounded by limited communication on the requirements for mandatory training;
- Contrary to the Trust's policy on mandatory training a number of teams/services permit staff to self book mandatory training; and
- Limited evidence to support regular reporting against compliance with mandatory training requirements.

There was an action plan in place with responsible people and timescales to ensure that these issues were addressed by the trust. Training for staff consisted of mandatory training and more specialist training related to the service they worked in. The trust monitored the staff in relation to compliance with mandatory training. We saw that where staff were overdue training, systems were mostly in place to provide prompts to ensure this occurred. We saw areas of good practice around training such as:

- Staff were well supported to attend additional specialist training and development opportunities in older people's community teams. For example, the recognising and assessing medical problems in psychiatric settings (RAMPPS) physical care training programme.
- Joint training for patients and staff to attend on risk assessments in Forensic services.
- 100% mandatory training achieved in forensic services.

We saw that staff received appropriate supervision and support. Staff on the wards commented favourably on the support and leadership they received from the respective ward managers. Staff told us that they received supervision which consisted of both individual management supervision and group clinical supervision. There was an induction programme in place for all new staff including a mandatory induction day covering basic topics such as safeguarding. There were also local induction programmes in place. However these were not always consistent across all services and were not centrally monitored. Information provided by the trust showed that as of 23 October 2014, 96% of all staff had an up to date appraisal in place.

Multi-disciplinary working

We saw some areas of poor practice:

- In the acute inpatient services patients were not usually invited into the MDT meeting but were instead offered time with any professional on an individual basis on request. This meant that it was not always clear that patients were fully participating in their care.
- The older people's community teams did not have social workers embedded within the team. This team experienced difficulties in accessing social service staff for best interest meetings for vulnerable patients needing extra supervision.
- In the rehabilitation services we found some inconsistencies with the level of engagement some patients had with their multi-disciplinary team (MDT) meetings and a lack of proactive involvement of

advocacy to support these patients to be more involved in their care reviews. The MDT notes we looked at did not always record who had attended the MDT reviews or the patients' views.

In all other areas patients received regular multi-disciplinary input from managers, medical staff, registered nursing and non-registered nursing staff and other professionals including occupational therapists, speech and language therapists, physiotherapists and psychologists. We observed multi-disciplinary meetings and there was comprehensive information available on patients to ensure that all members of the nursing and multi-disciplinary team were kept up to date on current issues with patients and to inform decisions about future holistic care needs. We saw the following good practice:

- We saw examples in older people's services where patients did not take part due to the acuity of their mental health, so the consultant would make contact with the patients following the meeting. Multi-disciplinary meetings also included relatives.
- In CMHTs the team had established positive working relationships with a range of other service providers such as the inpatient wards, general practitioners, and local independent services such as the Sheffield Crisis House provided by the charity Rethink.
- In the forensic services each member of the MDT provided a weekly summary of the patient's progress to the team which was projected onto a screen for all to view. The discussion and outcome of the MDT meeting was up-dated onto the screen in 'real time'.
- In the forensic services discharge was planned from point of admission under the framework of the Care Programme Approach (CPA) in line with best practice.
- The trust worked with South Yorkshire Police. A pilot scheme called the street triage team (STT) was based with the Netherthorpe House offices which ran daily with community mental health nurses working alongside the local police.
- There was a joint agency policy in place for the implementation of section 136 of the Mental Health Act. This policy and procedure has been jointly agreed by South Yorkshire Police (Sheffield Policing District), Sheffield Health and Social Care Trust, Sheffield Teaching Hospital and Yorkshire Ambulance Service. Links with the police in the operation of section 136 were good. Good joint working relationships were in place at both a strategic and operational level and attendance at the quarterly monitoring meetings was good with representatives from a variety of agencies present.

Information and Records Systems

Executive directors informed us that it was introduced to monitor local service performance against sickness absence, stress, nursing day and night hours, health care assistant day and night hours, budget control, serious incidents, CPA 12 month reviews, percentages of patients with an agreed care plan, nutritional screening within 72 hours and delayed discharges. Staff told us that the dashboard reports were difficult to access and not always available. The trust were in the process of reviewing how data was presented at the time of the visit.

Consent to care and treatment

There was a trust policy for Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). The policy was drafted in April 2009 and due for review in May 2010. This policy did not reflect the recent changes to the act following the Cheshire West judgement. The trust reported that no Deprivation of Liberty Safeguard applications were made between February 2014 and August 2014. We found the following areas in need of improvement

- In the acute inpatient services there were issues with adherence to the Mental Health Act Code of Practice particularly around capacity to consent for treatment.
- In the adult community teams it was not always recorded when the person had chosen for others not to be involved.
- In rehabilitation services we found inconsistencies regarding the application of the Mental Capacity Act and Deprivation of Liberty safeguards across the wards. There was a lack of evidence to demonstrate that patients' capacity to consent or dissent to treatment was assessed and documented as per the MHA Code of Practice (CoP).

There were examples of good practice which included the following:

- In the acute inpatient services staff were working within the Mental Capacity Act to ascertain if the patient was agreeable to, or had capacity, to consent to care and treatment required for significant decisions.

Requires Improvement

Are services effective?

- In the adult community teams staff understood the process to follow should they have had to make a decision about or on behalf of a person lacking mental capacity to consent to proposed decisions, in accordance with the Mental Capacity Act (2005). The consent of the person had been sought in the care plans viewed. Family, friends and advocates were involved as appropriate and according to the person's wishes. Staff understood the process to follow should they have to make a decision about or on behalf of a person lacking mental capacity to consent to proposed decisions, in accordance with the MCA.
- In older people's inpatient services we saw capacity assessments were discussed in multidisciplinary team meetings and documented, with good detail. Care plans were in place for patients where necessary which explicitly addressed issues of capacity and consent
- In older people's community services capacity was recognised and records showed formal consent to care and treatment. Where patients' capacity to understand their care or treatment this was managed by use of the MCA.
- In forensic services we found evidence that patients' capacity to consent or dissent to treatment was assessed and documented in line with the Mental Health Code of Practice (CoP). Staff had received training in the Mental Capacity Act (MCA). They understood the process to follow should they have to make a decision about or on behalf of a person lacking mental capacity to consent to proposed decisions in accordance with the Mental Capacity Act.

Assessment and treatment in line with Mental Health Act

We found that application of the Mental Health Act across services was mostly good. We saw most of the documentation appeared to be completed in line with the requirements of the act. Patients had been made aware of their rights under the MHA and section 17 leave forms had been completed, authorised and copies of had been given to patients and others as per the MHA CoP in the majority of cases. However we found acute inpatient services did not always adhere to the Mental Health Act Code of Practice.

- Staff were not completing the appropriate records to evidence adherence to the Mental Health Act.
- Some records did not show that patients had been told about their rights under the Mental Health Act.
- The recording of episodes of seclusion including the time the doctor attended seclusion and the cogent reasons if there is a delay in attendance.
- The legal authorisations T2 (certificate of consent to treatment) and T3 (certificate of second opinion) for treatment were not kept with the medicines charts.

In rehabilitation services we found on some wards MHA documentation was not readily present and available for inspection for all detained patients. In both acute inpatient and rehabilitation services we found that issues regarding adherence to the Mental Health Act (MHA) had been identified in previous MHA monitoring visits had not been addressed effectively.

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 the provider as good because: Overall the trust was providing a caring service for patients. Throughout the inspection we saw examples of staff treating patients with kindness, dignity and compassion. The feedback received from patients was generally positive about their experiences of the care and treatment provided by staff. Staff were mostly knowledgeable about patients' needs and showed commitment to provide patient led care. The services held a range of regular patient meetings and some carer meetings to support relatives and carers of patients on the wards. Patients were also facilitated to access external service user groups such as Service User Network (SUN:RISE) and Sheffield African Caribbean Mental Health Association (SACMHA). Patients had regular access to advocacy including specialist independent mental health advocacy (IMHA) for patients detained under the Mental Health Act. There were areas of good practice:

- There were innovative service user involvement initiatives for patients using adult community mental health services
- We found the CLDT was proactive in its approach to gaining feedback from patients and their families
- Forensic services supported patients and their relatives to keep in contact with technology such as SKYPE.

However there were areas of poor practice:

- In older peoples inpatient services, at Dovedale we saw patients were not consistently involved in care planning and at Grenoside patients were not involved in their life stories and person centred plans.
- In rehabilitation services there was a lack of proactive involvement of advocacy to support these patients to be more involved in their care reviews.
- At the section 136 suite there was no formal mechanism to obtain feedback from people detained under section 136.

Our findings

Dignity, respect and compassion

Overall the trust was providing a caring service for patients. Throughout the inspection we saw examples of staff treating patients with kindness, dignity and compassion. The feedback received from patients was generally positive about their experiences of the care and treatment provided by staff. Staff were mostly knowledgeable about patients' needs and showed commitment to provide patient led care.

Involvement of people using services

The community mental health patient experience survey 2014 was conducted to find out about the experiences of people who receive care and treatment. Those who were eligible for the survey were aged 18 and above, receiving specialist care or treatment for a mental health condition and had been seen by the trust between 1 September 2013 and 30 November 2013. There were a total of 271 responses which was a response rate of 32% Overall, the trust was performing about the same as other trusts in all major areas of questioning except in the area of 'Planning Care.' Patients felt that their personal circumstances were not always taken into account when their plans of care were agreed and the trust were rated worse than other trusts in relation to this question. The trust were also rated worse than other trusts when involving a family member or another person the patient felt close to as much as the patient would like. All patients told us they felt that they were involved in their care. The services held a range of regular patient meetings and some carer meetings to support relatives and carers of patients on the wards. Patients were also facilitated to access external service user groups such as Service User Network (SUN:RISE) and Sheffield African Caribbean Mental Health Association (SACMHA). Patients had regular access to advocacy including specialist independent mental health advocacy (IMHA) for patients detained under the Mental Health Act. There were mechanisms for gathering feedback from patients and their families in place. Areas of good practice included:

Good

Are services caring?

- There were innovative service user involvement initiatives to facilitate patients to comment on community mental health services, including the employment of peer workers, service users involved in interviewing community staff and other initiatives that took into account the populations that the community mental health teams worked within.
- We found the CLDT was proactive in its approach to gaining feedback from patients and their families through measures such as 'how did you find us' questionnaires. There were groups and events in place such as the big health event, coffee mornings, links with the local Mencap and groups such as the improving health group and complex needs group where feedback on services was gathered and collated by the team.
- Forensic services supported patients and their relatives to keep in contact with technology such as SKYPE

However we found:

- In the CLDT patients told us they were well supported by the team and were involved in care planning. However care plans did not have clear objectives and goals for patients and nor were the always person centred. This had been identified through audit of care plans however no action had been taken.
- At older peoples inpatient services, Dovedale we saw patients were not consistently involved in care planning and at Grenoside patients were not involved in their life stories and person centred plans
- In rehabilitation services there was a lack of proactive involvement of advocacy to support these patients to be more involved in their care reviews.
- At the HBPoS there was no formal mechanism to obtain feedback from people detained under Section 136.

Requires Improvement

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 the provider as requires improvement because: The resource of staffing at night time to manage the out of hours and crisis demands meant that out of hours provision was not fully safe or responsive to people's needs. There were no overall systems to record how the limitations on the out of hours service impacted on patient care to monitor its' responsiveness. There were a number of pressures within the community mental health teams. Prior to our visit, the Trust had identified concerns regarding the management of new referrals in the CLDT because people had waited significant periods of time before being assessed by professionals within the service. The Trust had completed a full review of each patient in response to this and we could see evidence of improvements beginning to be made In the rehabilitation services the service had identified that 23 patients did not require the in-patient hospital care they were currently receiving at 1, 2 and 3 Forest Close. Despite these figures no delayed discharges had been reported to the trust from Forest Close in the previous six months. The needs of some of these patients had changed over the years they had been at Forest Close with their physical health needs' being more complex and requiring more nursing input than their mental health needs. It was not evident how the service had developed or planned services to effectively meet the changing needs' of this patient group. However we found that: Access, discharge, transfer of care and bed management was effectively managed throughout most inpatient and community services. Patients' diversity and human rights were respected. Attempts were made to meet patients' individual needs including cultural, language and religious needs. People's individual, cultural and religious beliefs were taken into account and respected as demonstrated by the content of the care plans and observation at clinical meetings. We saw that complaints were well managed. The complaints within each service were looked into and responded to. Where complaints were not upheld, managers would still look at what could be learned or improved. We found evidence to show that managers had taken timely action in response to complaints which they had received.

Our findings

Planning and delivery of services

Between January to March 2014, the trust's total bed occupancy was 85% compared to the England average of 87%. It is generally accepted that, when occupancy rates rise above 85%, it can start to affect the quality of care provided to patients and the orderly running of the hospital. Between January and June 2014, 10 locations at the trust had a bed occupancy rate of over 90%. These included the low secure services at Forest Lodge as well as the acute admission wards. We met with six clinical commissioning leads during the inspection to gather feedback about the planning and delivery of services. They provided us with positive feedback about the trusts single point of entry referral system and regarding transfer of provision in Barnsley which was achieved in one day. There were a number of concerns raised by the commissioners:

- Issues regarding delivering social care in a health setting. The trust did have a director of social care however commissioners believed this role could be developed.
- Concerns were raised regarding the seven day target for follow up from discharge from inpatient services into community services.
- Concerns raised around the early intervention in psychosis services which had been reconfigured and were no longer in place.
- Concerns around liaison psychiatry which had limited resources and the impact on the four hour target in the A&E department of the local acute service.

Access, discharge and bed management

Admissions into the acute beds at the Longley Centre were gate kept by the crisis staff within the community teams or out of hours team, or by Approved Mental Health

Requires Improvement

Are services responsive to people's needs?

Professionals (AMHPs) following a Mental Health Act assessment. This ensured that there was proper consideration whether people require being as inpatients. Discharge discussions took place at daily MDT meetings with expected discharge dates set and reviewed regularly. There was good working links with the home treatment staff within the community mental health teams to facilitate discharge from the wards. Weekly meetings occurred with representatives from the community mental health teams CMHT to consider discharge planning. Patients were reported to be appropriately placed with no significant issues with delays on discharge. The wards were operating within safe bed numbers at the time of our visit. We heard that at times AMHPs had difficulty admitting patients to the acute wards and on occasions people had to be treated out of area but this was not occurring on a regular basis. In older people's services there was an effective approach to the assessment and admission of patients onto the wards. Patients' discharge was planned as part of their admission and was only delayed due to a lack of suitable placements in the community. We observed a referrals meeting taking place and noted that patient were allocated to staff according to their needs. Waiting times for services were monitored. Community staff told us that if an inpatient bed was needed for a person using the service this was nearly always available. They told us that access to inpatient beds could be arranged for patient in advance where there were concerns that they may not be able to maintain their safety at home. The community teams followed-up patients promptly after they were discharged from the in-patient mental health wards. They were good at meeting the target of follow-up within seven days. Information provided by the trust as part of our data pack was the proportion of patients on the care programme approach (CPA) who were followed up within 7 days of discharge was similar to the national average. The most recent quarter, June 2014 shows a score of 96.5%, just below the England score of 97%. Systems in place to ensure the effective transfer of patient from acute adult teams were good. Discussions took place between services to ensure the person was placed with the team that could best meet their needs. There was no strict age cut off for transition from one service to another. Decisions were based on the needs of the individual. Delayed transfers of care were measured by both the number of days delayed and number of patients who experienced delays had been variable over the period September 2013 to August 2014. There had been a gradual reduction in the number of delayed days at the trust from a peak of 422 in November 2013 to 237 in August 2014. The number of patients with a delayed transfer of care has fluctuated between nine in September 2013 to a peak of 16 in May 2014 to eight in August 2014. From this information we conclude the trust was responding appropriately to ensure patients' transfer of care was not delayed. The forensic service proactively promoted patients' recovery from admission through to discharge. They achieved this by ensuring each patient had access to the facilities and therapies they needed to assist them in the current stage of their recovery. The wards shared a philosophy of care focussed upon the principles of the recovery model. Staff took all practical steps to minimise restrictions on patients where possible, despite the low secure requirements of the service and legal restrictions imposed on patients. Despite the difficulties the forensic service faced securing suitable accommodation for some patients due to their complex needs' and past offending behaviour; every patient had a discharge plan in place. The average length of stay on the forensic wards was 18 months which was lower than average when compared to similar services. The lack of re-admissions post discharge from the wards provided evidence to show that the discharge process was effective and patients received the support they needed. We found some areas the required improvement: The resource of staffing at night time to manage the out of hours and crisis demands meant that out of hours provision was not fully safe or responsive to people's needs. There were no overall systems to record how the limitations on the out of hours service impacted on patient care to monitor its' responsiveness. For example, the delays in responding to telephone calls, the numbers of patients that had to be sent to accident and emergency and the occasions when the office was unstaffed due to out of hours staff having to attend a Mental Health Act assessment. Prior to our visit, the Trust had identified concerns regarding the management of new referrals in the CLDT because people had waited significant periods of time before being assessed by professionals within the service. The Trust had completed a full review of each patient in response to this and we could see evidence of improvements beginning to be made In the rehabilitation services the service had identified that 23 patients did not require the in-patient hospital care they were currently receiving at 1, 2 and 3 Forest Close. Despite these figures no delayed discharges had been reported to the trust from Forest Close in the previous six months. The needs of some of these patients

had changed over the years they had been at Forest Close with their physical health needs' being more complex and requiring more nursing input than their mental health needs. It was not evident how the service had developed or planned services to effectively meet the changing needs' of this patient group.

Diversity of needs

From the information provided to us by the trust it had scored within the worst 20% of mental health trusts nationally on key findings relating to staff having equality and diversity training. 35% of staff had received training compared to 65% national average. However patients' diversity and human rights were respected. Attempts were made to meet patients' individual needs including cultural, language and religious needs. People's individual, cultural and religious beliefs were taken into account and respected as demonstrated by the content of the care plans and observation at clinical meetings.There were designated multi-faith prayer areas which were geared toward different cultural and religious needs. Contact details for representatives from different faiths were provided and local faith representatives visited patients on the wards. We met with the chaplaincy team leader based at Michael Carlisle hospital. There was an active team with two support workers attached to the team. A Muslim chaplain had joined the team at the time of our visit. The team leader told us they attended patients' discharge meetings and could arrange some support from local churches if necessary. There were good links with groups from Black and Minority Ethnic Groups such as voluntary and faith organisations for people from Pakistani backgrounds and the Sheffield African Caribbean Mental Health Association. We were told that translation and interpretation service were available. The trust hosted Sheffield Community Access and Interpreting Service (SCAIS) which provided face to face and telephone interpreting services. This ensured that people had access to information in different accessible formats and interpreting services if necessary. We were given examples by staff where interpreters had been accessed to support people whose first language was not English to attend assessments. We saw there was access to information in other languages should it be required. This provided information to patients on the mental health act, advocacy and other useful information and could be available in different languages. In the CLDT patients using the service had varying levels of cognition and literacy. For many this meant that written information and leaflets needed to be simplified and available in a form more accessible for their needs. We observed good use of easy read signage or information displayed in the team bases and also easy read literature on the trusts internet page, such as a referral leaflet and information about the Mental Capacity Act 2005. Patients from black and ethnic minorities could be referred to staff based in the CMHT recovery teams who had specialist knowledge and skills around providing cultural sensitive services. Patients had access to advocacy including independent mental health advocates (IMHA) for patients detained under the Mental Health Act as required by the Code of Practice. The service could also access advocates from different backgrounds such as Caribbean advocates through local Citizens' Advice Bureau. Information was available on advocacy services for patients to access help and support. Children aged less than 16 years were not admitted to the section 136 suite as there were separate facilities within the Sheffield Children's Hospital to meet their needs. Patients commented favourably on the quality and portions of the food. Patients were given choice of food including vegetarian options. A choice of meals was available with effort made to ensure a varied range of cultural needs were met representing the needs of individuals and the multi-cultural nature of the communities the trust serves. We observed that; and were told by staff snacks and drinks were available over 24 hours if requested with any risks managed on an individual basis.

Right care at the right time

The Department of Health publishes monthly data relating to Delayed Transfers of Care across 242 acute and non-acute NHS trusts, including both the number of delayed days and the number of patients who experienced a delayed transfer of care each month. There had been a gradual reduction in the number of delayed days at the trust from a peak of 422 in November 2013 to 237 in August 2014. The number of patients with a delayed transfer of care has fluctuated between nine in September 2013 to a peak of 16 in May 2014 to eight in August 2014. Between January and June 2014 there had been a total of 36 readmissions in 5 locations. During the same time, there were 29 delayed discharges at 6 locations. Minutes of board papers were reviewed and we saw that delayed discharges had been discussed and the trust were working closely with the housing department of the council to try to address this. We received information from the trust prior to the inspection about the number of days patients waited

Requires Improvement

Are services responsive to people's needs?

for from initial assessment to onset of treatment. We received information about Fulwood House (Trust HQ) as this is where all the community teams are registered to with CQC. There were nine instances when the time between initial assessment and onset of treatment was over seven weeks.

Learning from concerns and complaints

Patient Opinion and NHS Choices offer people who use services a forum for honest and meaningful conversations between patients and providers. Taking into account duplicate entries across both Patient Opinion and NHS Choices websites, 50% of comments were wholly or largely negative, 25% were wholly or largely positive and 25% contained a roughly equal mix of both positive and negative. Issues highlighted include a lack of appropriate support, staff attitude and a lack of responsiveness from the trust. In the last 12 months, the trust received 164 formal complaints. Of these; 122 complaints were not upheld. Of these, 6 were referred to the Parliamentary and Health Service Ombudsman (PHSO) •23 complaints were upheld. Of these, 1 was referred to the Parliamentary and Health Service Ombudsman •19 complaints were under investigation at the time of our inspection. From information provided by the trust prior to the inspection, (The internal audit for 2013/14 for incidents and complaints published April 2014), which reported on data collected in 2012/13. The report included the actions the trust needed to take to ensure it was listening, responding to and learning from complaints. In the period 2013-2014 the Trust informed us of 164 complaints, 122 (78%) were not upheld. Patients who used the service knew how to raise complaints and concerns. Most patients and carers we spoke with told us they felt they would be able to raise a concern should they have one, and believed they would be listened to by staff. Information on how to make a complaint was displayed in most areas and patients were given written information about making complaints. We saw there was a complaints policy displayed in the ward areas and information about PALS, which support patients to raise concerns. Some information was in an easy read format. We were told most concerns were resolved locally, if the manager was unable to do this they would be raised through the trust complaints. We saw that complaints were well managed. The complaints within each service were looked into and responded to. Where complaints were not upheld, managers would still look at what could be learned or improved. We found evidence to show that managers had taken timely action in response to complaints which they had received. The trust produced a complaints report which highlighted the complaint and response to complaints which was published on the intranet. This helped to ensure that the service was open and accountable. Informal complaints were often reported as being raised and resolved at community meetings or through the trust's fast track system. The 'fast track' complaints system in place enabled patients or visitors to raise an informal complaint if they did not wish to make a formal complaint. This system meant that patients or visitors could receive a response to their complaint much quicker than a complaint made through the formal trust process. Relatives we spoke with were aware of the 'fastrack' form, which allowed patients or relatives to send their complaints directly to the CEO. Services held details of the fast track complaints that showed how these complaints had been looked at and resolved at local level. Patients reported confidence in the fast track complaints system to resolve their concerns quickly and locally. Formal complaints were discussed in various meetings including service and locality clinical governance meetings. The wards held regular community meetings with patients. Patients we spoke with confirmed they felt able to raise any issues informally within these meetings. They told us they felt listened to by staff.

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 the provider as good because: The trust had a strategy with the overall vision and values and most staff told us they understood the vision and direction of the trust and showed professional commitment to these values. There was a clear governance structure that included a number of committees that fed directly into the Board. Services were overseen by committed and experienced managers who oversaw the quality and clinical governance agenda. There were regular meetings for managers to consider issues of quality, safety and standards. Lines of communication from the board and senior managers to the frontline services were mostly effective, and staff were aware of key messages, initiatives and the priorities of the trust. Staff understood the management structure and where to seek additional support. The trust participated in external peer review and service accreditation. However there was variance in how staff across services learnt lessons from incidents, audits, complaints and feedback from patients. We saw that in some areas, local governance arrangements were good whilst in others they were not effective.

Our findings

Vision and values

The trust had a strategy with the overall vision of being a leading provider of high quality health and social care services and recognised as world class in terms of co-production, safety, improved outcomes, experience and social inclusion. The trust had a number of high level values which included respect, compassion, partnership, accountability, inclusion, fairness and ambition. Most staff told us they understood the vision and direction of the trust and showed professional commitment to these values. Most staff felt connected to senior management and the trust board. Trust messages were cascaded via a regular newsletter and in team meetings. Patients commented favourably that they received high quality care which showed staff were working within the stated values of the trust. However in the rehabilitation services most staff we spoke with did not know what the service or organisation values or philosophies were or did not identify with these. The trust had a plan and supporting vision for the service it was providing. This was supported by a governance structure where the team could review progress and monitor the quality of care provided. The provider's Quality and Service Development objectives were clearly laid out in the Quality improvement plans for the period 2014-15 to 2015-16.

1. **Responsive**: We will improve access to our services so that people are seen quickly.
2. **Safe**: We will improve the physical health care provided to our service users.
3. **Experience**: We will establish the Service User Experience Monitoring Unit to drive improvements in service user experience across the Trust
4. We will ensure care is safe through effective clinical risk assessment and care management.
5. We will ensure all services use pre and post treatment outcome measures.
6. We will build on mental health care clustering and identify the interventions and skills required for each care cluster.
7. We will align with commissioning intentions and redesign pathways of care to improve effectiveness and efficiency.

Enabling objectives

1. We will build improvement capability in the Trust and improve our ability to learn from complaints and serious incidents.
2. We will improve the efficiency and focus of mandatory training, including customer care.
3. We will strengthen staff engagement to improve the experience of staff to support and enable them to deliver compassionate care.
4. We will review and make changes to support worker training and development.

Good

Are services well-led?

5. We will develop our recruitment processes to improve their efficiency and effectiveness and ensure values play a key part
6. We will develop partnerships with third sector and the housing department in order to deliver improved pathways of care.
7. We will deliver a plan to reduce our costs that is clear and achievable over the three year period.
8. We will deliver efficiencies, reduce bureaucracy and review our corporate services through our Optimising Value in Care Programme.
9. We will increase our investment in Information Management and Technology and establish a new approach for future development that includes staff involvement.

The provider had a clear plan in place to implement the objectives as laid out in the development plans (April 2014). **Governance** There was a council of governors who provided a link between the local community and the board of directors. The governors met quarterly and held the board to account. There was a clear governance structure that included a number of committees that fed directly into the Board. These included:

- Operational Delivery Group
- Research & Development Group
- BME Strategy Group
- Service User Safety Group
- Health & Safety Committee
- Policy Governance Group
- Quality Improvement Group
- Mental Health Act Group
- Psychological Therapies Governance Committee
- Safeguarding Children Group
- Safeguarding Adult Group
- Medicine Management Committee
- Infection, Prevention & Control Committee

The service directorates were split into five care groups:

- Specialist directorate
- Inpatient directorate
- Community directorate
- Learning Disability directorate
- Clover Group directorate

Governance structures ran through these care groups to Board. We saw evidence that minutes were escalated from the ward to the Board via the care group structures and meetings. We were also told that non-executive board members occasionally undertook quality visits from time to time to the wards and community teams. There was variance in how staff across services learnt lessons from incidents and complaints and feedback from patients. We saw that in some areas, local governance arrangements were good whilst in others they were not effective. We saw that issues raised earlier in this report regarding staff training and appraisal, were seen as an area of priority within the senior team. All of the executive and non-executive directors we spoke with were aware of the issues and the plans in place to address them. A clear multi-agency protocol was in place to oversee the operation of the health based place of safety, with all necessary agencies involved in the monitoring of operations. Services were overseen by committed and experienced managers who oversaw the quality and clinical governance agenda. Wards had their own objectives which highlighted locally determined governance improvements. There were regular meetings for managers to consider issues of quality, safety and standards. This included oversight of risk areas in the service such as incidents. These were being monitored regularly by senior staff in the service. This helped ensure quality assurance systems were effective in identifying and managing risks to patients using the service. Staff told us they received the information they needed from the trust through their manager or via the internal intranet so they were kept informed of developments which may impact on their work. Lines of communication from the board and senior managers to the frontline services were mostly effective, and staff were aware of key messages, initiatives and the priorities of the trust. Staff understood the management structure and where to seek additional support. Where we found issues which had not been picked up or addressed by the trust's own systems, we were assured that managers were already developing plans to address these in better ways to properly identify, address or manage the risks to patients. For example staff on Maple ward were monitoring the competing demands of the ward and managing the health based place of safety. Staff sickness rates at the trust have been consistently well above the England average for mental health and learning disability trusts over the two years between April 2012 and March 2014. The trust's average for the most recent quarter of data January to March 2014 was 1.3% higher than the average for Yorkshire and the Humber across all NHS organisations. Long term sickness was being dealt with in line with the trust policy. There was a high staff vacancy

rate at the CLDT due to staff retirement and staff leaving the service. Posts had not been 'back filled' when staff left their position. We spoke to the service manager about this who confirmed adverts had gone out to fill vacant post within the learning disability directorate.

Leadership and culture

Staff reported that morale was generally good. Staff told us they felt supported by the management across the services we visited. We saw evidence that staff at all levels had received regular supervision and appraisals. Staff spoke positively about their role and demonstrated their dedication to providing quality patient care. However the data provided at trust level about staff training uptake showed significant gaps in training. Managers told us that training uptake was monitored locally through the electronic training records and local email reminders, but when we asked for an up to date list of training uptake this could not be provided from some of the teams we visited. Most staff told us that they felt well supported by their managers and peers. Most of the staff told us that senior managers were accessible, approachable and encouraged openness. There was a whistleblowing procedure in place which staff were aware of and told us that they would raise any issues if they were unable to this this within the team. The Chief Executive Officer spent shifts working within services which staff told us was valuable and contributed to transparency. Executive and Non-executive directors (NED) visited serviced on a timetabled basis to engage with staff on the front line. Due to the reconfiguration of the learning disability service and newly appointed interim managers in place, we found they did not have a full oversight of issues we found in relation to this team. These were;

- Clinical leads were managing their own waiting lists and management did not have full insight or oversight of this.
- Access to risk assessments was difficult to locate on their computerised system, as individual staff had stored them in different places.

We discussed the first point during our initial visit with the service manager and following our second visit to the service we could see improvements had been made. We fed this back to the service managers about easy access to the risk assessments, who assured us they would address this issue.Staff told us that they did not feel respected, valued, supported, appreciated and cared for. They told us when they expressed concerns regarding the lack of resources, including nursing leadership, psychology, speech and language therapy and occupational therapy, they felt these were not taken seriously and no action had been taken. Incident records had been completed in relation to staffing issues however it was unclear what action was being taken to make improvements. Staff were unclear who the senior managers were. However the learning disability service had recently appointed new senior managers. **Continuous Improvement** The trust participated in external peer review and service accreditation. This included:

- Electroconvulsive Therapy Accreditation Service (ECTAS)
- Memory Services National Accreditation Programme (MSNAP)
- Psychiatric Liaison Accreditation Network (PLAN). Not accredited.
- The Quality Network for Perinatal Mental Health Services
- The Quality Network for Forensic Mental Health Services at Forest Lodge

We saw that clinical audits were carried out which were able to measure standards in terms of development and improvement within the services. This meant that the performance of the service was monitored in order to drive improvement. Commissioning for Quality and Innovation (CQUIN) targets set by commissioners. CQUIN targets were used to support improvements in the quality of services. Services listened to and engage with patients on an ongoing basis through patient engagement meetings throughout the services to ensure that patients received good quality care that met patients' needs. Patients could make a complaint or compliment through a fast-track form which was a trust initiative to allow feedback to go directly to the chief executive. However in rehabilitation services there was not a consistent approach to audits across the wards. For example; there was an audit of care plans to support the collaborative care and risk planning at Pinecroft ward and 1a Forest Close but there were no care plan audits undertaken on the other wards. The services held a range of governance and leadership meetings which were minuted which showed that there was a commitment to quality improvement. The issues discussed included, medical care and cover, serious untoward incidents, administration support to the teams, supervision of staff, transfers, team risk register, infection control and the clinic room environment. This meant that managers were overseeing the service and ensuring that issues were

Good

Are services well-led?

addressed and improvements noted. Data on performance was collected monthly. Performance measures included completion of staff training and appraisal and clinical measures such as the number of incidents and complaints reported. Performance against these targets was monitored by senior managers to ensure any shortfalls were addressed. Where performance did not meet the expected standard action plans were put in place and implemented to improve performance. Local governance arrangements were monitored through service performance dashboards. This allowed the service managers to monitor access to services via the number of referrals and assessment times. Performance indicators/activities monitored effectiveness of the service to ensure best use was made of the team resources. Data was monitored to ensure patients were seen by the appropriate clinician and that care was safe and coordinated. Data included information about team case loads and the numbers of referrals and discharges. However in rehabilitation services this data was not used on a monthly basis by ward managers to understand the areas which required improvement or good practice within their ward or across the service. The wards at Forest Close collated data on incidents, sickness and supervision on a monthly basis but it was not clear how this was used to improve service provision. The trust was in the process of rolling out microsystems. In some areas staff were being offered coaching on the use of microsystems to support the development of individuals and teams to support the improvement of health care. Microsystems are made up of staff who work together on a regular basis to provide care to patients. This includes the clinical care of patients by developing good practice, sharing information and identifying outcome for both patients and the service. Inpatient services were using the 15 step challenge to provide a way of understanding patients' and service users' first impressions. The 15 Steps have been co-produced with patients, service users, carers, relatives, volunteers, staff, governors and senior leaders, to help look at care through the eyes of patients and service users, to help capture what good quality care looks, sounds and feels like. Staff were positive about local initiatives and development groups which included them in the development of services. Initiatives such as the 'journal club 'in older peoples services and 'love and nuts' which was process to gather information about what staff 'love' about their work and what drove them 'nuts'. Love and nuts is a quality improvement tool used within the Microsystems Coaching Academy. For carers there was 'let's talk about dementia' carer sessions. The introduction of technology in care such In older people's inpatient services, paroseals and empathy dolls were used therapeutic interventions which engaged patients in older people's services. Community teams were also piloting remote working and the use of tablets as part of information technology. The team had put in strong application for entry for the Royal College of Psychiatrist's team of the year.The trust run an annual staff award ceremony to recognise achievements by staff, either individually or as a team and the focus is on service improvement.

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 12 HSCA (RA) Regulations 2014 Safe care and treatment Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment We found that the registered person had not protected people against the risk associated with unsafe premises. This was in breach of regulation 12(2)(d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. **How the regulation was not being met:** The registered person had not protected people against the risks associated with medicines because there was not a sufficient systems in place to manage medicines in the forensic services. This was in breach of regulation 12(f) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. How the regulation was not being met: The registered person had not protected people against the risks associated with medicines because there was not a sufficient systems in place to manage medicines in the forensic services. This was in breach of regulation 12(f) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. How the regulation was not being met: In some acute wards physical observations following rapid tranquillisation were not always fully recorded. In some treatment rooms on the acute adult and older people's wards we found refrigerators were not always properly monitored by ward and pharmacy staff to make sure that medicines were always stored at the correct temperature. In some acute adult and older people's wards entries in the controlled drug register did not always include the signature of the witness observing

Requirement notices

administration and on some acute wards we found that sometimes the dose given was not recorded. In the CMHTs there were concerns with nursing staff repackaging medicines which should only be carried out by pharmacy staff and the safe storage of medicines. In the CMHTs there was no dedicated pharmacist input to support the safe and effective management of medicines.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care Regulation 9 HSCA (RA) Regulations 2014 Person-centred care We found the registered person had not ensured the care and treatment of service users met their needs. This was in breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. How the regulation was not being met: **How the regulation was not being met:** We found that the registered person did not ensure that care and treatment was designed with a view to ensuring their needs were met. The care and treatment provided at 1, 2 and 3 Forest Close was not responsive in meeting the changing needs of patients. 23 patients within the service did not require in-patient care or treatment. Patients did not have an allocated care co-ordinator to support discharge planning as required under the Care Programme Approach. The wards did not have a dedicated qualified nurse on the wards at all times. One patient had acquired a grade 4 pressure ulcer.

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 HSCA (RA) Regulations 2014 Good governance

This section is primarily information for the provider

Requirement notices

We found that the registered person had not protected people against the risk associated with the lack of proper information within written records. This was in breach of regulation 17(2)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

How the regulation was not being met:

There was not an established system in place across the core service to assess, monitor and improve the quality and safety of the service provided in the carrying on of the regulated activity. There was a lack of evidence to demonstrate that any audits and performance monitoring systems were being used to identify issues which required addressing or to drive and improve performance across the core service. It was not clear how feedback from patients was being used to improve performance.