Care Quality Commission

Sheffield Health and Social Care NHS Foundation Trust

Fulwood House

Quality Report

Old Fulwood Road
Sheffield
S10 3TH
Tel:01142716310
Website: sct.nhs.uk

Date of inspection visit: 04-06/05/2016
Date of publication: 15/08/2016

Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
TAH XK	Trust Headquarters		S10 3TH

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

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

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

Summary of findings

Ratings

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

Overall rating for the service

Are services well-led?

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

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

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

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

Summary of findings

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Summary of findings

Overall summary

The findings of this inspection do not impact on the ratings from the last inspection, undertaken in November 2014.

At this inspection we found the following areas of good practice:

- The trust had a clear vision and values, supported by a set of strategic aims and there was a clear governance structure and arrangements.
- Surplus funds were used to improve quality and safety for patients.
- The board assurance framework had 14 identified risks, which had clear links to the trust's strategic objectives, none of these risks, was rated as high.
- Following a review undertaken by the Good Governance Institute, a change in executive roles is to take place to ensure a balance between roles and capacity to deliver each portfolio.
- There was service user involvement in service design, planning and evaluation.
- The chief executive and chief nurse spent time each month in a clinical area and staff told us they valued this.
- The chief nurse and the medical director were trained as coaches and were providing training and individual coaching to staff in the organisation.
- Learning from incidents and complaints was visible at all levels of the organisation.
- The trust participated in external peer review and service accreditation.
- There was a commitment to engage with people who use the services of the trust in planning, implementing and evaluating services across the trust.

However:

- The uptake of mandatory training was below the trust target of 80%.
- We found a number of policies that had not been reviewed on time.
- Redecoration and improvements were required to some areas in a unit for people with dementia. Improvements, which had been identified as being necessary to provide a more suitable environment for people with dementia, had not been completed.
- The trust had not implemented the 2015 MHA code of practice across all services of the trust.
- Compliance with mandatory Mental Health Act, Mental Capacity Act and Deprivation of liberty training was very low for all staff and was not monitored for effectiveness by senior management of the trust.

Summary of findings

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

Are services well-led?

We found the following areas of good practice:

- The trust had a clear vision and values, supported by a set of strategic aims. Staff understood the vision and values and the vision for their individual services. There was clear governance structure and arrangements, with a number of committees reporting directly to the board. Staff at all levels understood the trust governance structures and could describe the governance arrangements for their own service.
- We saw where surplus funds were used to improve quality and safety for patients.
- The trust had identified strategic risks to the organisation and had developed a board assurance framework. The framework listed 14 identified risks which had clear links to the trust's strategic objectives; none of these risks were rated as high.
- Following a review undertaken by the Good Governance Institute, a change in executive roles was to take place to ensure a balance between roles and capacity to deliver each portfolio.
- There was service user involvement in service design, planning and evaluation.
- The chief executive and chief nurse spent time each month in a clinical area and staff told us they valued this.
- The chief nurse and the medical director were trained as coaches and were providing training and individual coaching to staff in the organisation.
- The trust participated in external peer review and service accreditation.
- Learning from incidents and complaints was visible at all levels of the organisation.
- There was a commitment to engage with people who use the services of the trust in planning, implementing and evaluating services across the trust.

However,

- The trust did not have in place a system for reporting on trust wide levels of managerial supervision. However, we saw systems managers used to monitor supervisions and appraisals at service level.
- Mandatory training was below the trust target of 80%.
- We found a number of policies that had not been reviewed on time.
- Redecoration and improvements were required to some areas in a unit for people with dementia. Improvements, which had been identified as being necessary to provide a more suitable environment for people with dementia, had not been completed.

Summary of findings

Information about the service

Sheffield Health and Social Care NHS Foundation Trust provides services across the city of Sheffield to a population of approximately 564,000 and employs approximately 3,000 staff. The trust is the main provider of mental health, learning disability, substance misuse and community rehabilitation services, and provides range of primary care and specialist services to the people of Sheffield. It also provides some specialist services to people outside of Sheffield.

Trust Headquarters - Sheffield Health and Social Care NHS Foundation Trust, Fulwood House, Old Fulwood Road, Sheffield, S10 3TH. Telephone: 0114 271 6310

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.

• 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 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.

• Hurlfield View.

• Longley Meadows.

• Supported Living Service.

• 136 Wainwright Crescent.

• Warminster Road.

• Woodland View.

These services were not inspected as part of this process, although we did consider the intelligence from recent inspections carried out at some of these locations to help us form a judgement. 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:

• Jordanthorpe Health Centre.

• Highgate Surgery.

• Central Health Clinic.

- Darnall Primary Care Centre.
- Mulberry Practice.

These services were not inspected as part of this process.

Our inspection team

Team Leader: Jennifer Jones, inspection manager, Care Quality Commission.

The team included a CQC inspection manager, two CQC inspectors and two specialist advisors who have experience of working at a senior level within health care organisations.

Summary of findings

Why we carried out this inspection

We carried out this inspection because concerns were raised during inspection at three adult social care locations within the organisation between February and May 2016. These concerns related to on-going breaches in the safe domain relating to medicines management.

There were also concerns regarding the governance arrangements to support learning. We undertook a focused inspection of the well-led domain to find out whether these problems were symptomatic of a wider governance issue.

How we carried out this inspection

We reviewed a range of information we hold about Sheffield Health and Social Care NHS Foundation Trust and asked other organisations to share what they knew.

We carried out an unannounced visit on 4, 5 and 6 May 2016. During the visit, we interviewed 14 staff from eight locations who worked within the service. We also interviewed:

- the chief executive
- deputy chief executive
- director of nursing and operations
- medical director
- finance director
- HR director
- chief pharmacist

We also spoke with someone who represented people who use the service.

We visited:

- Trust Headquarters.
- Maple Ward, which provides care for adults of working age with acute mental health needs.
- Forest Lodge, which provides care and treatment for men in a low secure environment.
- Forest Close, which provides inpatient care to support people with severe and enduring mental health problems.
- Ward G1, which provides assessment and treatment of people with severe dementia.
- Burbage ward, which provides care for adults of working age with acute mental health needs.
- Community Learning Disability Teams at 33 Love Street, which provides specialist health assessments, interventions and care for people with learning disabilities.
- Adult Community Mental health Team, Northlands Community Health Centre, which provides a service for adults with mental health problems.

We also considered information gathered by colleagues in the adult social care directorate of the Care Quality Commission from locations across the trust. The locations included two care homes for people with dementia, a unit that provides step down and respite care for people with mental health needs and two units, which provide respite care for people with a learning disability.

What people who use the provider's services say

We did not speak directly with people or patients who use services. We did speak with the head of the service user-monitoring unit. The service user-monitoring unit was recently established to ensure that the trust works collaboratively with those who use the services to drive quality improvement. All staff who worked in the service user monitoring unit had lived experience of the service. We were told that the board were committed to collaborative working, examples of this were:

- The service user strategy for the next two to five years was developed following a collaborative event with 150 staff, carers and service users. The strategy was to be presented at the trust board for ratification in May.
- Service users participated in recruitment panels. We were told that service user skills are seen as valuable in the recruitment of staff and that they sit on interview panels.

Summary of findings

- Clinical pathways were being planned and developed collaboratively from the beginning.
- There was a citywide service user network called SUN:RISE. This was a monthly forum, which enabled service users to be informed, involved and engaged in Trust business. It reports to the quarterly in-patient forum and to the in-patient and community directorates.
- The service user-monitoring unit was developing an audit strategy to measure the effectiveness of service user involvement and collaboration across the trust. At the time of our inspection two reports were presented to the trust board, these were the quality and dignity surveys and collaborative care planning.
- The trust had an appreciation scheme in which volunteers could claim the equivalent of the living wage for any work they do.
- The 2015 community mental health team service user survey showed the trust had an overall score of 6.7/10. The trust scored within average range for all areas except the crisis services. The trust had developed an action plan to address the specific issues which was due for overall completion in August 2016, although improvements to the crisis services were already in place.

Good practice

The head of the service user-monitoring unit is employed to ensure collaborative working between service users and that the trust drives quality improvement trust wide. Essential criteria for recruitment to this post included current involvement in services. The trust was also in the process of recruiting two service user engagement officer posts; again part of the essential criteria was that the person must have lived experience of services.

The trust had an appreciation scheme in which volunteers could claim the equivalent of the living wage for any work they do.

Areas for improvement

Action the provider MUST take to improve

Action the provider MUST take to improve

The trust must ensure that the 2015 Mental Health Act Code of Practice is implemented across all services of the trust.

The trust must ensure compliance with mandatory Mental Health Act, Mental Capacity Act and Deprivation of liberty safeguards training.

Action the provider SHOULD take to improve

Action the provider SHOULD take to improve

The trust should ensure that all policies are reviewed within the stated time on each policy.

The trust should have in place a system to plan, implement and learn from clinical audit across the organisation.

The trust should ensure that it has a system in place to monitor the frequency of management supervision across the organisation.

Sheffield Health and Social Care NHS Foundation Trust

Fulwood House

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Trust Headquarters	Fulwood House

Mental Health Act responsibilities

We do not rate responsibilities under the Mental Health Act 1983. We use our findings as a determiner in reaching an overall judgement about the Provider. We found that:

Staff Mental Health Act training was mandatory for clinical staff every three years and staff generally had a good understanding of the Mental Health Act and its application in the inpatient services we looked at. Mental Health Act training was classroom based and there was some training delivered locally at ward level. This was delivered by a nurse and a social worker and included some slides on the 2015 Mental Health Act code of practice. The Mental Health Act was supported by having an approved mental health professional attached to mental health community teams. Compliance with training was poor. The trust's mandatory training data for March 2016 showed that 26% of eligible staff had completed Mental Health Act training. The details of the 2015 Mental Health Act code of practice was not well understood across the organisation, in the community teams and some staff did not know there was a revised code. The trust had a number of policies and procedures they had identified as requiring updating in response to the Mental Health Act code of practice and an action plan. However, this action plan was not completed and there were a number of policies that required updating to meet the requirements of the code.

There was a central team that looked after the administration and access to advice on the Mental Health Act. This was supported by a governance group that fed into the trust board. Issues, which had arisen from Mental Health Act reviewer visits to the ward and the use of the Act were addressed and monitored at this group and it used audit information, from the inpatient areas to inform the process.

Audits were carried out locally and to address Mental Health Act compliance. Section 17, informing patients of their rights and consent to treatment under the Mental Health Act were all audited and fed into the governance structure.

We saw that staff in inpatient services had a good understanding of the Mental Health Act.

Detailed findings

Mental Capacity Act and Deprivation of Liberty Safeguards

Arrangements to monitor the trust's compliance with the Mental Capacity Act were not robust. An audit had been completed in July 2015, titled 'review of arrangements to obtain appropriate consent from service users', which highlighted a number of actions in relation to the use of the MCA and patient consent. The target date of October 2015 for all of the actions had passed and there was no update document available. There was some evidence of local audit of practice However, this was not co-ordinated or consistently fed back to the board and there was no assurance system in place.

Staff training for Mental Capacity Act and Deprivation of liberty safeguards was via e learning and there had been some training organised locally, which was face to face. Clinical staff were expected to complete level two training, which had a clinical focus and was mandatory. The trust had developed a workbook in conjunction with the local council, which supported the face-to-face training. Deprivation of liberty Safeguards training had not been updated on e-learning since the Supreme Court Judgement in 2014 in relation to Deprivation of liberty and the 'acid test'. We saw some evidence that staff in inpatient services had a good understanding of the Mental Health Act and Mental Capacity Act/Deprivation of liberty safeguards interface. However, this was not supported by trust policy or guidance. Approved mental health professionals were integrated into community mental health teams and some of these were best interest assessors. This provided some Mental Capacity Act/Deprivation of liberty safeguards expertise in the teams.

There was a Mental Capacity Act practice development group that supported practice and contributed to training figures. Compliance with training was poor. The trust's mandatory training data for March 2016 showed Mental Capacity Act training for e learning at 2.5% and no classroom learning; Deprivation of liberty safeguards training e learning at 0.2% and classroom learning at 8.6%.

The policy for Mental Capacity Act and Deprivation of liberty safeguards was part of the 'Capacity and Consent to Care, Support and Treatment Policy'. This policy was past its review date and we saw a draft version dated March 2015. The policy did not outline how or where staff should record details of a capacity assessment. The policy did not comply with some of the requirements brought about by the 2015 Mental Health Act code of practice.

We saw records of best interest's decisions being made but no associated capacity assessment record, however, a pilot exercise was underway with the development of electronic recording of mental capacity assessments and best interests decisions on the electronic record 'insight'.

The organisation had some Deprivation of liberty safeguards authorisations in its learning disability service. There was no guidance available for staff to refer to when a decision regarding whether to use the Mental Health Act or Mental Capacity Act/Deprivation of liberty safeguards was required, however, in inpatient mental health services, we saw evidence of a good understanding of the Mental Health Act/ Deprivation of liberty safeguards interface and application in practice.

However:

Advice and guidance for Mental Capacity Act and Deprivation of liberty Safeguards was through a central department and staff we spoke to knew how to access this.

We saw that staff in inpatient services had a good understanding of the Mental Capacity Act/Deprivation of liberty Safeguards interface.

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

The trust had a clear vision and values, supported by a set of strategic aims. Staff understood the vision and values and the vision for their individual services. There was clear governance structure and arrangements, with a number of committees reporting directly to the board. Staff at all levels understood the trust governance structures and could describe the governance arrangements for their own service.

We saw where surplus funds were used to improve quality and safety for patients.

The trust had identified strategic risks to the organisation and had developed a board assurance framework which had 14 identified risks which had clear links to the trusts strategic objectives, none of these risks were rated as high.

Following a review undertaken by the Good Governance Institute, a change in executive roles was to take place to ensure a balance between roles and capacity to deliver each portfolio.

There was service user involvement in service design, planning and evaluation.

The chief executive and chief nurse spent time each month in a clinical area and staff told us they valued this.

The chief nurse and the medical director were trained as coaches and were providing training and individual coaching to staff in the organisation.

The trust participated in external peer review and service accreditation.

Learning from incidents and complaints was visible at all levels of the organisation.

There was a commitment to engage with people who use the services of the trust in planning, implementing and evaluating services across the trust.

However,

The trust did not have in place a system for reporting on trust wide levels of managerial supervision. However, we saw systems managers used to monitor supervisions and appraisals at service level.

Mandatory training was below the trust target of 80%.

We found a number of policies that had not been reviewed on time.

Redecoration and improvements were required to some areas in a unit for people with dementia. Improvements, which had been identified as being necessary to provide a more suitable environment for people with dementia, had not been completed.

Our findings

Vision and values

The trust had an overall vision, which was to be recognised nationally as 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, with the aim to be the first choice for service users, their families and commissioners. The trust defined its purpose as to improve people's health, wellbeing and social inclusion so they can live fulfilled lives in their community. The trust would achieve this by providing services aligned with primary care that meet people's health and social care needs, support recovery and improve health and wellbeing.

The trust identified five key strategic aims to enable them to achieve the vision and purpose:

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

The strategic aims were underpinned by the following values: respect, compassion, partnership, accountability,

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fairness and partnership. The values were displayed throughout the trust and staff spoke positively about the visions and values of the trust as well as the visions for their own services.

Good governance

The trust had a board of directors who provided overall strategic leadership. There was a council of governors that provided a link between the board of directors and the local community.

There was a clear governance structure, which had five committees which reported directly to the trust board. These were:

- Remuneration and Nominations Committee
- Finance and Investment Committee
- Quality Assurance Committee
- Audit and Assurance committee
- Workforce and Organisation Development Committee

These committees were supported by 11 further groups and committees, which made up the trust wide strategic and operational governance structure. There were five operational directorates within the trust which each had their own governance structures reporting into the trust wide governance structure. The staff we spoke with understood how issues were reported up and down the governance structure in the organisation. We found that there were good governance processes in all the locations we visited.

Performance against key indicators, including quality and risk standards, human resources, service delivery, social inclusion and finance was reported monthly to the trust board. The report included the current position and whether there had been any change since the previous report. The report was supported by a dashboard summary that gave more detailed information against each indicator.

The trust had a planned surplus of £2.4 million at the end of the 2015/16 financial year. It was able to use this money to support improvements in quality and safety. These included a programme of refurbishment of taps, which had previously been identified as a ligature risk across the inpatient directorate. A ligature point is a place to which a patient intent on self-harm might tie something to strangle themselves.

The trust had also used some of this money to recruit three new pharmacists. This decision was taken after an inspection by the CQC in February within adult social care locations, which identified a number of issues regarding the safe storage and administration of medicines. They had recruited a full time pharmacist who will work with the community teams, a full time pharmacist working in the specialist directorate/older people and a full time pharmacist who will work with the learning disability and substance misuse directorate. We were told how work within the care homes, which had been the subject of the CQC inspections, would be the focus of the pharmacist working in the specialist directorate.

The trust did not expect to have such a surplus of funds at the end of this financial year and it was acknowledged that this was a risk to the trust and that the financial targets for the forthcoming year would be challenging.

The trust had in place a quality, improvement and assurance strategy for 2016 to 2021, which was led at board level by the medical director. The strategy has five key components, which include:

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

The trust had identified strategic risks to the organisation and had developed a board assurance framework, which had 14 identified risks, which had clear links to the trust's strategic objectives; none of these risks was rated as high. In April 2016, NHS internal audit had provided the trust with significant assurance that there was a sound system of internal control designed to meet the trust's objectives and those controls were generally being applied consistently.

Mandatory training is that determined essential for an organisation for the safe and efficient running in order to reduce organisational risks and comply with policies and government guidelines. The trust had a standard compliance target across all subject areas, this was 80%.

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We found that mandatory training completion rates, as stated in the trusts mandatory compliance matrix, dated 31 March 2016 were significantly lower than 80%, compliance ranged from 0% to 66.9%. Examples of this are:

- Fire safety, 63.2%
- Basic life support, 45.6%
- Mental Capacity Act, 2.5%
- Information Governance, 66.9%
- Rapid tranquilisation, 9.3%

However, the compliance rate had improved in all but 7 out of the 19 mandatory training subjects since the previous matrix, dated 31 December 2015. At service level, we saw that each service had systems in place to monitor mandatory training and supervisions for staff. Training information had recently started to be cascaded from a central team to each service so they could monitor their training, training records showed where gaps were and where training figures needed to improve. Ward managers told us that they were aware of mandatory training requirements, but sometimes struggled to send staff on the training.

Managers told us about specialised training they had been able to access, which had been supported by the Trust. For example, one staff member had undertaken an information technology course financed by the trust and used this to devise their own information technology system for monitoring service performance on the ward. Other managers told us about extra training they had been supported to access in order to develop further. The manager at G1 told us that managers of the services within that directorate had undertaken job swaps for periods. They said this had been valuable and enabled them to gain an understanding first hand, of how the other services worked.

Within the community directorate, training for dialectical behaviour therapy, which is therapy designed to help people change patterns of behaviour that are not helpful, such as self-harm, suicidal thinking and substance abuse had been rolled out for staff working with people with complex personality disorders.

Ninety-four per cent of staff had received an appraisal of their performance in the last year. All directors (clinical and professional) had a responsibility to ensure supervision took place and was recorded. Supervision leads were expected to monitor that their staff are receiving appropriate supervision and keep records showing that monitoring had occurred. The trust did not have in place a system for reporting on trust wide levels of managerial supervision, however, we saw systems managers used to monitor supervisions and appraisals at service level.

The overall sickness absence for the trust was 6% against a target of less than 5%. This is higher than the average rate for the NHS, which is 4%. Long term sickness absence contributed to 34% of the overall absence figure.

The trust used an electronic system for recording incidents. However, approximately 10 areas in the trust did not have access to this system and these areas were recording incidents on a paper-based system. We were told that the trust has a new director with responsibility for developing the information technology infrastructure to improve connectivity to the IT network across the organisation.

Learning from incidents and complaints was done in a variety of ways across the trust. We saw how each service directorate had incidents and complaints as a standing item on their governance agendas. The learning disabilities directorate had very clear and comprehensive governance framework that identified the purpose, membership and duties of all governance groups, with monitoring and reviewing serious incidents and responding to outcomes and lessons learned being on the terms of reference for the business and performance group.

Information regarding incidents, including sharing and learning from incidents, was reported to the trust board quarterly. We saw in a quarterly report that it had been identified that an area had reported a high number of incidents and the risk team were asked to prepare a more detailed report for the trust board regarding this. The report also included benchmarking against the national information. The trust was in the highest 25% of reporters of incidents. A high level of reporting is one indicator of an organisation that has a good safety culture

The trust board received information regarding complaints quarterly, we saw that the report contained facts and figures regarding complaints, but also contained summaries of the issues raised and the outcomes.

Managers gave feedback to staff following incidents and complaints. Within the inpatient areas we visited, all managers we spoke with were able to describe clear processes in place for dealing with, and learning from incidents. Managers at Maple ward and Burbage ward had

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recently had a serious incident on each ward. Both told us about the actions that were undertaken following these, learning shared with the teams and actions that were taken or identified to make improvements and prevent recurrence.

The trust had an on-call system in place for service managers so one could be contacted at all times out of hours. Staff we spoke with said senior management were supportive and would often attend in response to incidents. There were processes in place for debriefing from incidents for both patients and staff. This would normally involve input from psychology. Managers told us they would try to speak with patients individually to offer reassurance where applicable. Learning from incidents was discussed in team meetings.

In one of the units that provided respite care to people with learning disabilities a new monthly manager's tool had been introduced to ensure the assistant service director had an overview of the service and what improvements were required. This was being introduced in all the learning disability services to ensure consistency.

The information technology infrastructure in place at the time of our inspection did not support timely access to information at all areas across the trust, which meant that some areas were maintaining their own records at service level. This creates a risk that information may not be accurate or up to date. We were told by the director of finance that information technology connectivity and mobile data collection were a priority for the coming year.

Eight out of 10 policies that we saw had not been reviewed within the identified timeframe. These included the physical health policy, which was due for review in October 2013, and the seclusion and long-term segregation policy that was due for review in April 2015. Neither had been updated at the time of our inspection. We were told that four of the policies had been redrafted and were awaiting ratification and one was currently being rewritten. However, no work was identified which would lead to a review of three of the policies including the physical health policy. The deputy chief executive had presented a paper to the board in November 2015 that identified the options for ensuring a robust approach to the future development and review of policies within the trust; however, at the time of our inspection none of the options was in place to address the problem.

Leadership, morale and staff engagement

The chief executive worked a shift each month in a different clinical area and the chief nurse spent half a day per month in a clinical area. The trust was a partner in the Sheffield Microsystem Coaching Academy in which coaches are trained in the art of team coaching and quality improvement to work with front line teams to help them re-design the services they deliver. The chief nurse, finance and the medical directors were trained as coaches and were providing individual coaching to staff in the organisation. The chief nurse told us that she believed the coaching programme had the potential for transformational change because it gave people time and space to consider issues. The trust also ran Schwartz rounds for staff within the trust. A Schwartz round is a confidential meeting, where staff from different professions and backgrounds come together to discuss the non-clinical aspects of their work. Topics for discussion have included "what happens when your best isn't good enough," and "how does it does it feel when things go wrong."

The specialist service director had been awarded the NHS Inspirational Leader of the Year (2015) Award by the NHS Leadership Academy for both the Yorkshire and Humber region and nationally. The awards recognise the achievements of NHS leaders who provide exceptional care to patients or support services from behind the scenes.

Staff we spoke with said they felt that senior managers listened to their concerns and had modified plans for the design of new clinical pathways following suggestions from staff. A member of staff from a community mental health team had been seconded to support the development of new clinical pathways. However, managers and deputy managers who worked in the care homes said there was lack of oversight by senior managers and very few managers visited those services.

Managers spoke highly of their staff teams and were proud of how staff put the values into practice, particularly in relation to caring for patients. Some teams had undergone significant changes. For example, the Longley centre had recently closed one ward and Forest Close had reconfigured their whole model and patient group. Managers told us that despite some unsettling and difficult times for staff, morale was good; staff had shown their resilience and had continued to provide quality care for patients throughout.

Are services well-led?

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The results of the 2015 NHS staff survey that were published in March 2016 showed that the percentage of staff who reported experiencing stress had reduced. However, the percentage of staff who reported experiencing bullying and harassment had increased. Staff motivation at work and making use of patient feedback was worse than average. The trust scored higher than the national average for staff recommendation of the organisation as a place to work or receive treatment.

A review of the executive roles was undertaken by the Good Governance Institute, which highlighted areas for change in executive roles to ensure a balance between roles and capacity to deliver each portfolio. The result of the review was to restructure the executive team, with effect from 16 June 2016. The trust consider the new structure would:

- Strengthen corporate governance.
- Increase and clarify leadership capacity for clinical governance.
- Separate assurance from operations.
- Provide additional capacity for the delivery of operations, strengthens programme and performance management.

In the current structure, the chief nurse had responsibility for nursing and operations and described the operations part of the role as all consuming. The new structure clearly identified roles and separated operational and governance responsibilities. The medical director would have responsibility for clinical governance and quality, the chief nurse would become the director of nursing, professions and care standards and the deputy chief executive would take on the role of operations director. These new roles would strengthen the clinical governance and quality assurance arrangements in the organisation.

Since November 2014 trusts had a responsibility to be open and honest with service users and other 'relevant persons' (people acting lawfully on behalf of service users) when things go wrong with care and treatment, giving them reasonable support, truthful information and a written apology. This is called the duty of candour. We found that staff had a good understanding of their responsibilities in relation to duty of candour and we saw examples of this in practice. The trust had been providing training to staff and capturing information regarding duty of candour following incidents since 2015. However, the trust did not have a policy in place on duty of candour until April 2016.

Fit and Proper Person Requirement

From 27 November 2014 a new regulation, The fit and proper person's requirement has applied to all NHS trusts, NHS foundation trusts, and special health authorities. Regulation 5 says that individuals, who have authority in organisations that deliver care, including providers' board directors or equivalents, are responsible for the overall quality and safety of that care. This regulation is to ensure that those individuals are fit and proper to carry out this important role and providers must take proper steps to ensure that their directors (both executive and non-executive), or equivalent, are fit and proper for the role.

Directors, or equivalent, must be of good character, have the necessary competence, skills and experience and be physically and mentally fit enough to fulfil the role. They must also be able to supply information including a Disclosure and Barring Service check and a full employment history.

We saw the trust had in place a system for checking compliance with regulation 5. We reviewed the personnel records of two executive directors and three none executive directors. All were found to be compliant with the requirements of the regulation.

Engaging with the public and with people who use services

SUN:RISE (Service User Network) is a monthly forum, which informed and enabled service users to be involved and engaged in trust business. The network reported to the quarterly in-patient forum and to the in-patient and community directorates. It was comprised of a business meeting followed by invited guest speakers and informal networking. It had a role as a user consultation group for service changes and research proposals. Members had active links to a range of other relevant groups both within and external to the trust. SUN:RISE had groups established the in-patient wards and in the community mental health teams.

The service user experience-monitoring unit supported all areas of the trust, working with SUN:RISE to evaluate service user experience. The head of the service user monitoring unit was employed to ensure collaborative working between service users and the trust to drive quality improvement trust wide. Essential criteria for recruitment to this post included current involvement in services. The trust was in the process of recruiting two

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.

service user engagement officer posts; again part of the essential criteria was that the person must have lived experience of services. Results of audits undertaken by the service user experience monitoring unit, including collaborative care planning and the quality and dignity survey were reported to the trust board.

We saw that the changes to the way that care was being delivered through pathways was planned and developed together with service users.

The trust had held a service user conference that was attended by 150 service users, carers and staff to develop the service user engagement strategy for the next two to five years.

Commitment to quality improvement and innovation

The trust had a quality improvement and assurance strategy for 2016 to 2021, which set out what it will do to improve quality. The aim of the strategy is to:

- Provide excellent services that deliver a positive experience and promote recovery.
- Put the needs of people who use the services, their families and carers first.
- Be a centre of excellence and best practice within 5 years.
- Embed the principles of a learning organisation at all levels.
- Define how they understand quality of care through the use of clear outcome measures.

The strategy builds on work previously done in the trust and described how the trust wouldl continue to embed a culture of quality improvement across the organisation to achieve its aims.

We found the trust did not have a robust plan or strategy for clinical audit in place and there was a lack of oversight of clinical audits in general. The executive lead for clinical audit is the medical director and the operational lead for clinical audit sits with an associate medical director. The trust did not have a clinical audit manager in place that would monitor, maintain and report on clinical to the trust board and this was a gap in the assurance system. We were told that a job description has been developed for this post and an appointment was pending.

Although there was no overarching plan for clinical audit, staff participated in a range of clinical audits at each service. These included audits for compliance with the Mental Health Act, environmental audits, health and safety and care plan audits amongst others. Action plans were generated from audits where staff had identified areas for improvement. Managers either completed the audits or had oversight of these so they were aware of where any shortfalls may be. This showed that services had quality improvement systems that sought to improve patient care and outcomes.

The manager of an adult social care unit told us they completed daily, weekly and monthly audits, which included the environment, infection control, fire safety, medication and care plans. It was clear any actions identified had been addressed in a timely way.

The trust had transformed inpatient services over the past three years and had not needed to admit a patient outside of the city due to a lack of beds within the past 12 months. During this period, the number of suicides or serious incidents had not increased. There was a recognition that community mental health services needed to be more efficient and work was underway to develop clinical pathways. We saw evidence of collaboration between the inpatient and community directorates to improve access to the right service at the right time. An example if this was that the weekly community flow meeting which looked at the patient flow across directorates was held in the morning and the inpatient bed management meeting was held on the afternoon of the same day. Information from the morning meeting was passed to the bed management meeting to enable planning for possible admissions to inpatient wards.

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

- The Electroconvulsive Therapy Accreditation Service.
- The psychiatric Liaison Accreditation Network.
- The quality Network for Perinatal Mental Health Services.
- The quality Network for Forensic Mental Health Services.

The memory service, based at the Longley Centre had been accredited as excellent from memory services national accreditation programme, part of the royal college of psychiatrists.

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	Regulation 17 HSCA (RA) Regulations 2014 Good governance The 2015 MHA code of practice had not been implemented across all services of the trust. There was no trust monitoring of compliance with the Mental Capacity Act and there was no evidence that decisions made on behalf of people who lack capacity met the requirements of the Mental Capacity Act. This is a breach of regulation 17(1),(2)(a)(c)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing Compliance with mandatory Mental Health Act, Mental Capacity Act and Deprivation of liberty training was very low for all staff and was not monitored for effectiveness by senior management of the trust. This is a breach of regulation 18 (2)(a)