Report on actions you plan to take

Please see the covering letter for the date by which you must send your report to us and where to send it. **Failure to send a report may lead to enforcement action.**

Account number	TAH
Our reference	INS2-4772925591
Location ID	Not applicable
Trust name	Sheffield Health and Social Care NHS Foundation Trust

Regulated activity(ies)	**Regulation**
Assessment or medical treatment for persons detained under the Mental Health Act Treatment of disease, disorder or injury	Recommended 'Must do'
	How the regulation was not being met:
	Trust wide The trust must ensure that effective systems and processes are in place to monitor and manage staff access to clinical supervision.

Please describe clearly the action you are going to take to meet the regulation and what you intend to achieve

1. Clinical Operations to continue to review and report on current supervision compliance.

2. To review and update the current Trust supervision policy in line with Trust/staff requirements. To re-launch the supervision policy with a monitoring and recording system. **Timescale, 31 March 2019.**

3. Clinical Operations to monitor compliance against the Trusts updated supervision policy through the Clinical Operations governance structure to EDG. **With effect from 1 April 2019.**

Who is responsible for the action?	Associate Clinical Directors Deputy Nurse Directors

How are you going to ensure that the improvements have been made and are sustainable? What measures are going to put in place to check this?

- The revised and updated Trust policy will be approved through the Trust Policy

Governance Group. • Supervision performance data will be reviewed through the Clinical Operations performance and governance structure to EDG and remedial actions taken as required.	
Who is responsible?	Associate Clinical Directors Deputy Nurse Directors
What resources (if any) are needed to implement the change(s) and are these resources available?	
IMST to undertake further development of existing electronic supervision forms and reporting mechanisms to meet the requirements of the updated supervision policy.	
Date actions will be completed:	31 March 2019

How will people who use the service(s) be affected by you not meeting this regulation until this date?
There is no impact as we are confident that supervision is being delivered in a way that meets and/or exceeds regulatory requirements but falls below Trust expectation when judged against the current supervision policy standards.

Regulated activity(ies)	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act Treatment of disease, disorder or injury	**Regulation 12 Safe care and treatment** **Health and Social Care Act 2008 (Regulated Activity) Regulations 2014**
	How the regulation was not being met:
	The Trust must ensure that its telephone systems are fit for purpose and ensure there is a system in place to monitor the volume of calls to the Sheffield Health and Social Care Single Point of Access service.

Please describe clearly the action you are going to take to meet the regulation and what you intend to achieve

The Trust is reviewing the current telephone system configuration to ensure it meets the needs of the service. We will analyse how the telephone system is working and being used to remove any points of failure.

We will ensure the business processes are reviewed and re-engineered as appropriate to make sure the system is used efficiently. We will ensure operators are trained and supported in using the systems effectively.

We will put in place systems to monitor call volumes, queuing times, re-routing and abandoned calls to ensure management can oversee the ongoing effectiveness of the system and its use and IMST can analyse where and why calls are not being picked up and potentially abandoned.

The Trust has invested in improving its current telephony systems. This investment is being used to:

1. Implement Business Intelligence software that produces real-time actionable information enabling full and live management of resource. **Completed: 24 July 2018.**

2. Recruit a Consultant Analyst (expert in Skype for Business and Contact Centres) to support data quality and validation. **Competed: 22 October 2018**

3. Install and display dashboards into the Single Point of Access and Substance Misuse Services providing real-time telephony data. **Complete: 26 October, 2018**

4. Configure system to ensure call handers are logged onto all routes so queued callers can be routed to them, **Complete: 26 October, 2018**

5. Upgrade the current underlying telephony platform to the latest version of Microsoft Skype for Business. **Timescale: 31 December 2018.**

We have also approved a Trust Multi-Channel Communications Strategy to further enhance our capability to communicate effectively with service users via their preferred means of communication.

The Trust-wide Contact Centre Solution as part of the Multi-Channel Communication Strategy. The planned actions for this are:

1. Procure a Trust-wide Contact Centre Solution **Timescale: by 31 March 2019.**

2. Implement the Trust-wide Contact Centre Solution via a phased approach, starting with the Single Point of Access and Substance Misuse Services **Timescale: April 2019.**

Who is responsible for the action?	Associate Clinical Director Digital Programme Manager for Multi-Channel Communications Deputy Director of IMST

How are you going to ensure that the improvements have been made and are sustainable? What measures are going to put in place to check this?

Clinical Operations Change and Improvement Group and the Trust Business System Strategy Group to oversee implementation and receive regular updates on project progression.

Performance metrics to be reviewed at the SPA Project Group, SPA Team Governance Meeting and Quarterly Performance Reviews.

Who is responsible?	Associate Clinical Director Associate Director Deputy Associate Director Digital Programme Manager for Multi-Channel Communications Deputy Director of IMST

What resources (if any) are needed to implement the change(s) and are these resources available?

Provision and installation of dashboard for telephony monitoring at SPA and Substance Misuse Services. **Complete** (Procured and operational).

To support the service in its adoption of Contact Centre Solution the Trust has identified a comprehensive resource package that includes the following:

- Digital Programme Manager – In post
- Digital Business Analyst – in post
- Contact Centre Consultant Analyst – in post
- Network Engineer – in post
- Clinical Programme Lead – to be assigned

• Contact Centre Manager – business case to be developed • Local Business and Performance Managers – in post • Buildings and Admin Managers – in post • Telephony staff – in post • UC Analytics software – purchased and operational • Propriety Trust Contact Management Solution – in procurement process	
Date actions will be completed:	31 December 2018

How will people who use the service(s) be affected by you not meeting this regulation until this date?
Any compromise to patient safety is mitigated against by additional call handlers and the use of UC Analytics to understand call flow.

Report on actions you plan to take

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Account number	TAH
Our reference	INS2-4772925591
Location ID	Not applicable
Trust name	Sheffield Health and Social Care NHS Foundation Trust

Regulated activity(ies)	**Regulation**
Assessment or medical treatment for persons detained under the Mental Health Act Treatment of disease, disorder or injury	**Regulation 17 Good governance** **Health and Social Care Act 2008 (Regulated Activity) Regulations 2014**
	How the regulation was not being met:
	Forensic and Secure Wards The trust must ensure that policies are disseminated to staff and implemented in a timely manner.

Please describe clearly the action you are going to take to meet the regulation and what you intend to achieve

1. A local policy dissemination and implementation plan will be developed by the Senior Nurse Manager and the Senior Operational Manager to ensure all the multi-disciplinary team understand their roles and responsibilities in respect of policy and its application in practice. **Timescale, 30 November 2018.**

2. The implementation plan will be monitored at the Forest Lodge governance meeting. **Timescale, 30 November 2018.**

Who is responsible for the action?	Senior Operational Manager Senior Nurse Manager

How are you going to ensure that the improvements have been made and are sustainable? What measures are going to put in place to check this?

• Policy/implementation is a standing agenda item on the monthly Forest Lodge governance meeting. • The governance meeting notes are reviewed. • By observing and auditing clinical practice. • Through clinical and line management supervision.	
Who is responsible?	Senior Operational Manager Senior Nurse Manager
What resources (if any) are needed to implement the change(s) and are these resources available?	
None identified.	
Date actions will be completed:	30 November 2018

How will people who use the service(s) be affected by you not meeting this regulation until this date?
Remedial action was immediately taken by the service to ensure that the points raised by the CQC, which were specific to the smoke free policy, at Forest Lodge have been addressed.

Regulated activity(ies)	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act Treatment of disease, disorder or injury	**Regulation 12 Safe care and treatment** **Health and Social Care Act 2008 (Regulated Activity) Regulations 2014**
	How the regulation was not being met:
	Acute Mental Health Wards and Psychiatric Intensive Care Units The trust must ensure that staffing levels are sufficient to meet the needs of patients, including the use of physical interventions.

Please describe clearly the action you are going to take to meet the regulation and what you intend to achieve

The Trust will:

1. Embed effective use of e-rostering: health roster and safecare (patient acuity and dependency tool) in order to undertake staffing establishment reviews based on clinical need, in line with national guidance and requirements, to determine Actual Funded Establishments (AFE). Using these results to identify any staffing establishment shortfalls and submit via the business planning process. **Timescale, 31 March 2019.**

2. Review Respect training capacity available versus demand and submit a bid to address any shortfall via business planning process. **Timescale, 31 March 2019.**

Who is responsible for the action?	Deputy Directors of Nursing Deputy Associate Directors Head of Education, Training and Development

How are you going to ensure that the improvements have been made and are sustainable? What measures are going to put in place to check this?

- The minimum number of Respect trained staff by shift will be monitored via E-rostering.

- Safecare information will be subject to ongoing review at team governance, quarterly performance and Safer Staffing Group meetings. **Timescale, 30 November 2018.**

- The level of Respect trained staff, including night shifts, will be monitored and reviewed in ward governance and quarterly performance meetings. **Timescale, 31 March 2019**.

Who is responsible?	Nurse Consultants Senior Operational Managers

What resources (if any) are needed to implement the change(s) and are these resources available?

Funding to support substantive staffing as identified through safecare system. Sufficient Respect training capacity.	
Date actions will be completed:	31 March 2019

How will people who use the service(s) be affected by you not meeting this regulation until this date?
Currently, the ward reviews staffing levels linked to acuity and demand on a shift by shift basis, adjusting staffing levels as appropriate to meet changing needs. The majority of additional shifts undertaken are through the wards own staff via bank. If insufficient Respect level staff are rostered, resources are flexed across the acute bedded system. E-rostering Confirm and Challenge meetings commenced in September 2018 in line with national guidance and best practice requirements.

Report on actions you plan to take

Please see the covering letter for the date by which you must send your report to us and where to send it. **Failure to send a report may lead to enforcement action.**

Account number	TAH
Our reference	INS2-4772925591
Location ID	Not applicable
Trust name	Sheffield Health and Social Care NHS Foundation Trust

Regulated activity(ies)	**Regulation**
Assessment or medical treatment for persons detained under the Mental Health Act Treatment of disease, disorder or injury	**Regulation 12 Safe care and treatment** **Health and Social Care Act 2008 (Regulated Activity) Regulations 2014**
	How the regulation was not being met:
	Acute Mental Health Wards and Psychiatric Intensive Care Units The trust must ensure that staff undertake the required physical health monitoring following the administration of rapid tranquilisation and ensure nursing and medical reviews are completed during seclusion.

Please describe clearly the action you are going to take to meet the regulation and what you intend to achieve

Physical health monitoring following administration of rapid tranquilisation:

1. Re-issue the Rapid Tranquilisation Policy and Procedure to all qualified ward staff via email and formally document receipt and discuss via ward meetings. **Timescale, 30 November 2018.**

2. Posters regarding physical health monitoring following rapid tranquilisation to be displayed in all ward areas. **Timescale, 30 November 2018.**

3. The Nurse Consultant will review and standardise physical health monitoring processes post rapid tranquilisation on wards to ensure that physical health monitoring takes place after every rapid tranquilisation. **Timescale, 30 November 2018.**

4. To incorporate minimum standards for physical health checks into the restrictive practice Insight development to monitor compliance. **Timescale, 31 March 2019.**

Nursing and medical reviews for people in seclusion:

1. Re-issue Seclusion Policy (highlighting seclusion review schedule) to all staff via email and formally document receipt and discuss via ward meetings. **Timescale, 30 November 2018.**

2. Copies of seclusion review schedules to be displayed in staff areas e.g. seclusion lobby. **Timescale, 30 November 2018.**

3. The Nurse Consultant will review and standardise seclusion processes on wards to ensure that nurse and medic reviews for people in seclusion are carried out in a timely manner. **Timescale, 30 November 2018.**

4. To incorporate minimum standards for seclusion reviews into the restrictive practice Insight development to monitor compliance. **Timescale, 31 March 2019.**

Who is responsible for the action?	Inpatient Nurse Consultants Senior Operational Managers Ward Managers IMST Lead

How are you going to ensure that the improvements have been made and are sustainable? What measures are going to put in place to check this?

Physical health monitoring following administration of rapid tranquilisation:

- Information regarding the process for physical health monitoring (including the SOP), will be disseminated to staff. Staff will be required to sign on receipt of the information and discussions will be evidenced in the minutes of ward meetings. **Timescale, 31 December 2018.**

- Compliance monitored and evidenced by clinical audit and shared in ward and team governance meetings. **Timescale, 31 December 2018.**

Nursing and medical reviews for people in seclusion:

- Assurance of disseminated information will include evidence of signed staff lists and minutes in ward meetings. **Timescale, 30 November 2018.**

- Compliance monitored and evidenced by clinical audit and shared in ward and team governance meetings. **Timescale, 31 December 2018.**

Who is responsible?	Senior Operational Managers

	Nurse Consultants
What resources (if any) are needed to implement the change(s) and are these resources available?	
IMST development time.	
Date actions will be completed:	31 March 2019

How will people who use the service(s) be affected by you not meeting this regulation until this date?
Lead Nurse Consultant identified for restrictive practice to work with ward teams to achieve consistent good practice.

Report on actions you plan to take

Please see the covering letter for the date by which you must send your report to us and where to send it. **Failure to send a report may lead to enforcement action.**

Account number	TAH
Our reference	INS2-4772925591
Location ID	Not applicable
Trust name	Sheffield Health and Social Care NHS Foundation Trust

Regulated activity(ies)	**Regulation**
Assessment or medical treatment for persons detained under the Mental Health Act Treatment of disease, disorder or injury	**Regulation 12 Safe care and treatment** **Health and Social Care Act 2008 (Regulated Activity) Regulations 2014**
	How the regulation was not being met:
	Acute Mental Health Wards and Psychiatric Intensive Care Units The trust must ensure that medicines are stored and managed safely and emergency equipment is checked in line with the trust policy.

Please describe clearly the action you are going to take to meet the regulation and what you intend to achieve

Equipment and medication in stock has been checked by Ward Managers and Pharmacy to ensure that it is appropriately stored and managed and any remedial action taken. **Completed, July 2018.**

Emergency Equipment:

1. Re-issue the emergency equipment checklist, underlining the importance of a weekly compliance check to all Ward Managers. **Timescale, 16 November 2018.**

2. Develop a monthly record sheet to evidence monitoring of the weekly compliance check and re-issue this to Ward Managers for implementation. **Timescale, 16 November 2018.**

3. Communicate the standard operating procedure (SOP) D22, Assembling and Distribution of Emergency Trays, to staff via email and ward meetings. **Timescale, 31 December 2018.**

Medicines Storage:

1. Re-issue the existing Medicines Management Policy and Procedure to all staff via email and discuss via ward meetings. **Timescale, 16 November 2018.**

2. Review pharmacy SOP regarding labelling of patients' own medication, to include date opened sticker on all dispensed bottled medication. **Timescale, 16 November 2018.** Implement updated procedure. **Timescale, 30 November 2018.**

3. Review and revise Nursing SOP CD2, Dispensing of Controlled Drugs and CD3, Drugs Stock Checks in Wards regarding receipt of controlled drugs by the ward and stock balance checks respectively. **Timescale, 31 December 2018.** Implement. **Timescale, 31 January 2019**

4. As part of a ward daily checklist, ensure fridge and clinic room temperatures are recorded and acted upon if there is deviation from normal range **with immediate effect.**

Who is responsible for the action?	Emergency Equipment: Inpatient Nurse Consultants Ward Managers Medicines Storage: Inpatient Nurse Consultants Chief Pharmacist

How are you going to ensure that the improvements have been made and are sustainable? What measures are going to put in place to check this?

Emergency Equipment:

- Information regarding the process for ensuring emergency equipment is checked (including the SOP), will be disseminated to staff. Staff will be required to sign on receipt of the information and discussions will be evidenced in the minutes of ward meeting. **Timescale, 31 January 2019.**
- Review of monthly check sheets to be included on the ward governance meeting agenda. **Timescale, 31 January 2019.**

Medicines Storage:

- Information regarding the process medication management (including the SOP) will be disseminated to staff. Staff will be required to sign on receipt of the information and discussions will be evidenced in the minutes of ward meeting. **Timescale, 31 January 2019.**
- Review of monthly check sheets to be included on the ward governance meeting agenda. **Timescale, 31 January 2019.**

Who is responsible?	Nurse Consultants Senior Operational Managers Chief Pharmacist
What resources (if any) are needed to implement the change(s) and are these resources available?	
None identified	
Date actions will be completed:	31 January 2019

How will people who use the service(s) be affected by you not meeting this regulation until this date?
Equipment and medication in stock has been checked by Ward Managers and pharmacy staff who have undertaken top-ups to ensure that it is appropriately stored and managed and any remedial action taken.

Report on actions you plan to take

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Account number	TAH
Our reference	INS2-4772925591
Location ID	Not applicable
Trust name	Sheffield Health and Social Care NHS Foundation Trust

Regulated activity(ies)	**Regulation**
Assessment or medical treatment for persons detained under the Mental Health Act Treatment of disease, disorder or injury	**Regulation 12 Safe care and treatment** **Health and Social Care Act 2008 (Regulated Activity) Regulations 2014**
	How the regulation was not being met:
	Acute Mental Health Wards and Psychiatric Intensive Care Units The trust must ensure that child visitors are safeguarded from potential abuse.

Please describe clearly the action you are going to take to meet the regulation and what you intend to achieve

1. A copy of the Trust's Visits by Children Policy has been sent to all staff on Burbage ward with an explanation of the incident and variance from the policy that led to concerns being identified. **Completed, July 2018.**

2. The Trust's safeguarding training for all staff is to include reference to the Trust's Visits by Children Policy and underlying principle of decisions being determined by the child's best interests. This has been agreed with the Corporate Safeguarding Team and has taken effect in training delivered. **Completed, 11 October 2018.**

3. Local process for child visits as indicated in the Trust Policy is to be developed and circulated to all ward staff. **Timescale, 30 November 2018.**

Who is responsible for the action?	Senior Operational Managers Nurse Consultants Safeguarding Lead

How are you going to ensure that the improvements have been made and are sustainable? What measures are going to put in place to check this?

• The Ward Manager and Deputy Ward Managers are to ensure understanding of the policy and local procedure are checked with all nursing staff and they sign to confirm receipt of this. **Timescale 31 December 2018.** • Assurance of disseminated information to be evidenced in ward and team governance meetings. **Timescale 31 January 2019.**	
Who is responsible?	Ward Managers (overseen by Senior Operational Managers) Safeguarding Lead
What resources (if any) are needed to implement the change(s) and are these resources available?	
None identified.	
Date actions will be completed:	31 January 2019

How will people who use the service(s) be affected by you not meeting this regulation until this date?
A child visiting is only allowed with prior arrangement and direct supervision by a member of staff to ensure children are not left unattended.

Report on actions you plan to take

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Account number	TAH
Our reference	INS2-4772925591
Location ID	Not applicable
Trust name	Sheffield Health and Social Care NHS Foundation Trust

Regulated activity(ies)	**Regulation**
Assessment or medical treatment for persons detained under the Mental Health Act Treatment of disease, disorder or injury	**Regulation 17 Good governance** **Health and Social Care Act 2008 (Regulated Activity) Regulations 2014**
	How the regulation was not being met:
	Acute MH Wards and PICU The trust must ensure that environmental risk assessments include the identification and mitigation of blind spots and that these are reviewed following serious incidents and copies are available on the wards.

Please describe clearly the action you are going to take to meet the regulation and what you intend to achieve

1. The Environmental Risk Assessment tool will be revised and updated to include a section on blind spot identification and mitigation. A review date and reason for review will be included in the tool. This will ensure that blind spots are identified, recorded and then shared with staff. **Timescale, 30 November 2018.**

2. To undertake a blind spot identification assessment and work with the Director of Facilities Management to reduce risks in these areas by environmental work where appropriate. **Timescale, 31 December 2018.**

Who is responsible for the action?	Director of Facilities Management Ward Managers Nurse Consultants Senior Operational Managers

How are you going to ensure that the improvements have been made and are sustainable? What measures are going to put in place to check this?	
• Environmental risk assessments will be updated to include blind spots and shared at team governance meetings.	
Who is responsible?	Deputy Directors Senior Operational Managers
What resources (if any) are needed to implement the change(s) and are these resources available?	
Funding proposals to be submitted as appropriate. Acute care reconfiguration phase 2 (Longley capital development) funding approval.	
Date actions will be completed:	31 December 2018

How will people who use the service(s) be affected by you not meeting this regulation until this date?
Staffing is deployed in line with localised clinical risk assessments.

Report on actions you plan to take

Please see the covering letter for the date by which you must send your report to us and where to send it. **Failure to send a report may lead to enforcement action.**

Account number	TAH
Our reference	INS2-4772925591
Location ID	Not applicable
Trust name	Sheffield Health and Social Care NHS Foundation Trust

Regulated activity(ies)	**Regulation**
Assessment or medical treatment for persons detained under the Mental Health Act Treatment of disease, disorder or injury	**Regulation 17 Good governance** **Health and Social Care Act 2008 (Regulated Activity) Regulations 2014**
	How the regulation was not being met:
	Acute MH Wards and PICU The trust must ensure that systems and processes are established and operated effectively to identify issues relating to staffing, supervision, recording following restrictive practice, cancelled section 17 leave and patients being unable to return to a bed on the ward following a period of leave.

Please describe clearly the action you are going to take to meet the regulation and what you intend to achieve

Staffing:

1. Embed effective use of e-rostering: health roster and safecare (patient acuity and dependency tool) in order to undertake staffing establishment reviews based on clinical need, in line with national guidance and requirements, to determine Actual Funded Establishments (AFE). Using these results to identify any staffing establishment shortfalls and submit via the business planning process. **Timescale, 31 March 2019.**

Supervision:

Please refer to the Trust wide response for the must do action, 'The trust must ensure that effective systems and processes are in place to monitor and manage staff access to clinical supervision.'

2. Supervision of clinical staff to be documented electronically. **Timescale, 31 January 2019.**
3. Supervision levels to be monitored at team and network level meetings. **Timescale, 28 February 2019.**

Recording following restrictive practice:

4. Performance against standards to be collated and reviewed at team and network level meetings. **Timescale, 31 March 2019.**

Cancelled Section 17 leave as a result of staffing levels:

5. All ward staff are aware of how to report resource related incidents via the Trust incident reporting system. Incidents relating to planned Section 17 leave cancelled at short notice are currently managed by the Trust incident management system. In addition, commencing in quarter 4, audits of Section 17 leave will be undertaken by ward managers to better understand practice and identify if there are lessons to learn. **Timescale, commencing quarter 4.**

Patients not being able to return to a bed following leave:

6. 24 hour Flow Coordinators will be in place from January 2019 and will monitor flow issues, including bed availability on return from leave and escalate any issues as required. In the interim, this continues to be managed through gatekeeping and escalation to Clinical Leaders. **Timescale, 31 January 2019.**

Who is responsible for the action?	Associate Directors Deputy Associate Directors Nurse Consultants Senior Operational Managers Flow Coordinators

How are you going to ensure that the improvements have been made and are sustainable? What measures are going to put in place to check this?

A full review of performance to be undertaken within:

- Clinical Operations governance systems
- Safer Staffing Group

Who is responsible?	Deputy Directors of Nursing Director of Operations and Transformation Clinical Director of Operations and Transformation

What resources (if any) are needed to implement the change(s) and are these resources available?

Governance Officer capacity.

Date actions will be completed:	30 April 2019

How will people who use the service(s) be affected by you not meeting this regulation until this date?
The Trust has a robust incident reporting system in place and staff routinely report incidents. These are reviewed via governance processes.

Report on actions you plan to take

Please see the covering letter for the date by which you must send your report to us and where to send it. **Failure to send a report may lead to enforcement action.**

Account number	TAH
Our reference	INS2-4772925591
Location ID	Not applicable
Trust name	Sheffield Health and Social Care NHS Foundation Trust

Regulated activity(ies)	**Regulation**
Assessment or medical treatment for persons detained under the Mental Health Act Treatment of disease, disorder or injury	**Regulation 12 Safe care and treatment** **Health and Social Care Act 2008 (Regulated Activity) Regulations 2014**
	How the regulation was not being met:
	Long Stay or Rehabilitation Mental Health Wards for Working Age The trust must ensure that patients have the necessary physical health monitoring in relation to their prescribed medication in line with current national guidance.

Please describe clearly the action you are going to take to meet the regulation and what you intend to achieve

Please refer to the Trust wide response for the must do action, 'The trust must ensure that policies are reviewed and updated to reflect current national guidance and best practice.'

1. Forest Close has a physical health monitoring form based on the (national) Lester guidelines and all staff are required to use this form consistently and appropriately. Compliance will be audited by the Governance Administrator on a weekly basis. **Complete. Timescale, July 2018**

2. As the CQC raised a specific point in relation to patients prescribed Clozapine, an audit has been completed, which identified those patients without a fasting plasma glucose result within the relevant time frame. These patients are encouraged to have a fasting plasma glucose blood test. Patients who refuse this will have alternative blood tests that do not require fasting. **Completed. Timescale July 2018**

3. The clozapine policy is being updated by pharmacy to ensure full compliance with current

national guidance. **Timescale, 31 January 2019.**	
Who is responsible for the action?	Consultant Psychiatrists Chief Pharmacist Governance Administrator
How are you going to ensure that the improvements have been made and are sustainable? What measures are going to put in place to check this?	
• Forest Close includes the completion of the physical health monitoring form in the weekly audit performed by the Governance Administrator and is reported in to team governance meetings on a monthly basis. **Complete. Timescale, July 2018** • The audit of patients currently prescribed clozapine will be reviewed to ensure all results have been returned and that they are on track to be completed before the deadline or that there are recorded repeated refusals from the patient.	
Who is responsible?	Governance Officer Consultant Psychiatrists Senior Operational Manager
What resources (if any) are needed to implement the change(s) and are these resources available?	
None identified.	
Date actions will be completed:	16 November 2018

How will people who use the service(s) be affected by you not meeting this regulation until this date?
There should be minimal impact on service users. We already request routine HbA1c monitoring and frequently random plasma glucose on all patients prescribed antipsychotics. NICE guidelines recommend HbA1c or fasting plasma glucose (PH38 Type 2 diabetes: prevention in people at high risk). The impact on service users is reduced by timing the blood test to coincide with the patients next planned routine monitoring sample being taken.

Report on actions you plan to take

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Account number	TAH
Our reference	INS2-4772925591
Location ID	Not applicable
Trust name	Sheffield Health and Social Care NHS Foundation Trust

Regulated activity(ies)	**Regulation**
Assessment or medical treatment for persons detained under the Mental Health Act Treatment of disease, disorder or injury	**Regulation 15 Premises and equipment** **Health and Social Care Act 2008 (Regulated Activity) Regulations 2014**
	How the regulation was not being met:
	Forensic and Secure Wards The trust must ensure that the seclusion room meets the minimum requirements of the Mental Health Act Code of Practice.

Please describe clearly the action you are going to take to meet the regulation and what you intend to achieve

The Trust has approved a business case for a new seclusion room at Forest Lodge which will meet the minimum requirements of the Mental Health Act Code of Practice**.** The architect plans and building requirements were approved by the Head of Capital Development, Clinicians and Managers on 1 October 2018.

1. A tender for contract and schedule of work is to be produced by the Head of Capital Development, Managers and Clinicians. **Timescale, mid-November 2018.**

2. A tender award **is scheduled. Timescale, mid-December 2018.**

3. Commencement of work. **Timescale, mid-January 2019, anticipated completion May 2019.**

Who is responsible for the action?	Head of Capital Development Associate Director

	Clinical Nurse Manager Senior Operational Manager
How are you going to ensure that the improvements have been made and are sustainable? What measures are going to put in place to check this?	
• The seclusion room will be compliant with the Code of Practice when the building work is completed.	
Who is responsible?	Head of Capital Development Associate Director Project Manager Clinical Nurse Manager Senior Operational Manager
What resources (if any) are needed to implement the change(s) and are these resources available?	
Resources agreed through the business planning process.	
Date actions will be completed:	31 May 2019

How will people who use the service(s) be affected by you not meeting this regulation until this date?
The original seclusion room will continue to be used until building work commences, whilst this room does not meet required standard it offers the safest possible facility until new provision is completed. A plan to manage risk during building work will be agreed and signed off within Clinical Operations.

Report on actions you plan to take

Please see the covering letter for the date by which you must send your report to us and where to send it. **Failure to send a report may lead to enforcement action.**

Account number	TAH
Our reference	INS2-4772925591
Location ID	Not applicable
Trust name	Sheffield Health and Social Care NHS Foundation Trust

Regulated activity(ies)	**Regulation**
Assessment or medical treatment for persons detained under the Mental Health Act Treatment of disease, disorder or injury	**Regulation 12 Safe care and treatment** **Health and Social Care Act 2008 (Regulated Activity) Regulations 2014**
	How the regulation was not being met:
	Forensic Secure Wards The trust must ensure that nurse call systems are installed in all areas to which patients have access.

Please describe clearly the action you are going to take to meet the regulation and what you intend to achieve

1. The Head of Capital Development is leading a review of nurse call alarm systems to be undertaken in collaboration with an external company and Senior Managers and Clinicians. **Timescale, 31 December 2018.**

2. Following the review, a business case will be developed to ensure that a nurse call system is installed in areas in which patients have access to. **Timescale, 31 January 2019 (subject to completion of business case).**

3. The business case to go through internal Trust business planning cycle meetings for approval. **Timescale, 28 February 2019.**

4. Work to install nurse alarm call system to be fitted following agreement of business case to commence. **Timescale, March/April 2019.**

5. Staff training/induction for the new system will be provided overseen by the Clinical Nurse Manager, Ward Manager and the Head of Capital Development. The training will be provided on completion of the scheme**.**

Who is responsible for the action?	Associate Director Senior Operational Manager Head of Capital Development Clinical Nurse Manager
How are you going to ensure that the improvements have been made and are sustainable? What measures are going to put in place to check this?	
Assurance will be gained through the installation and completion of the new nurse call system in patient accessible areas.	
Who is responsible?	Associate Director Senior Operational Manager Head of Capital Development Clinical Nurse Manager External Contractors
What resources (if any) are needed to implement the change(s) and are these resources available?	
Funding will be required from Trust Business Planning processes.	
Date actions will be completed:	31 March 2019

How will people who use the service(s) be affected by you not meeting this regulation until this date?
A current plan of staff deployment in key ward areas and the Trust Observation Policy continues to be utilised to manage any risks to service users.

Report on actions you plan to take

Please see the covering letter for the date by which you must send your report to us and where to send it. **Failure to send a report may lead to enforcement action.**

Account number	TAH
Our reference	INS2-4772925591
Location ID	Not applicable
Trust name	Sheffield Health and Social Care NHS Foundation Trust

Regulated activity(ies)	**Regulation**
Assessment or medical treatment for persons detained under the Mental Health Act Treatment of disease, disorder or injury	Recommended 'Must do'
	How the regulation was not being met:
	Trust wide The trust must ensure that policies are reviewed and updated to reflect current national guidance and best practice.

Please describe clearly the action you are going to take to meet the regulation and what you intend to achieve

1. The Trust will undertake a baseline audit of all existing Trust policies and establish current policy status. **Timescale, 30 November 2018.**

2. The Trust will review its guidance on the development of policies to ensure that its contents is concise and clear for all staff

3. Out of date policies are being identified to the responsible Executive Lead for appropriate action. Subject matter experts are being deployed to ensure that national guidance and current best practice are embedded in the revised policies. **Timescale, 30 November 2018**

4. The system is being reviewed by the Executive Directors led by the Director of Corporate Governance (Board Secretary) to ensure polices are closely monitored and those approaching review date are flagged with the responsible Executive Lead in a timely manner. **Timescale, 30 November 2018**

5. Oversight of the performance of the system is undertaken by the Policy Governance

Group (PGG) on a monthly basis. Position statements will be reported to the Executive Director Group (EDG) on a monthly basis. **Timescale, 31 December 2018.**

6. Work will be undertaken by the Director of Corporate Governance (Board Secretary) to improve policy accessibility via the internet and intranet.

7. The maintenance of up to date, accessible and in line with national guidance and best practice policies will be ensured by establishing a robust system supported by a dedicated resource. The resource to include clinical expertise and administrative support. **Timescale, to be confirmed by Margaret**

Who is responsible for the action?	Director of Corporate Governance (Board Secretary)

How are you going to ensure that the improvements have been made and are sustainable? What measures are going to put in place to check this?

- Policy Governance Group
- Executive Director Group

Who is responsible?	Director of Corporate Governance (Board Secretary)

What resources (if any) are needed to implement the change(s) and are these resources available?

Temporary additional administrative support commences 30 October 2018.

Consideration will be given to the appropriate level of dedicated administrative and senior clinical resource required to take responsibility for:

- policy and standard operating procedure (SOP) development
- policy content and quality assurance
- policy launch
- policy and best practice guidance implementation (e.g. NICE guidance)
- auditing of clinical practice in relation to policy, SOP and best practice guidance
- policy review and updating
- clinical staff training and development

Funding will be considered through internal Trust business planning cycle meetings for approval.

Date actions will be completed:	30 April 2019

How will people who use the service(s) be affected by you not meeting this regulation until this date?

The Trust cannot be fully assured that service and care delivery is in line with current national guidance and best practice and is therefore a potential risk to staff and patient safety.

Report on actions you plan to take

Please see the covering letter for the date by which you must send your report to us and where to send it. **Failure to send a report may lead to enforcement action.**

Account number	TAH
Our reference	INS2-4772925591
Location ID	Not applicable
Trust name	Sheffield Health and Social Care NHS Foundation Trust

Regulated activity(ies)	**Regulation**
Assessment or medical treatment for persons detained under the Mental Health Act Treatment of disease, disorder or injury	**Regulation 12 Safe care and treatment** **Health and Social Care Act 2008 (Regulated Activity) Regulations 2014**
	How the regulation was not being met:
	Wards for Older People The Trust must ensure that there are systems and processes in place to routinely check the emergency equipment on each ward.

Please describe clearly the action you are going to take to meet the regulation and what you intend to achieve	
All emergency equipment weekly checks are in place. 1. All emergency equipment will continue to be checked weekly. Checks collated.	
Who is responsible for the action?	Senior Operational Manager
How are you going to ensure that the improvements have been made and are sustainable? What measures are going to put in place to check this?	
• Ward Manager and Senior Operational Manager to review completion of checks and outstanding actions on a weekly basis and include on the agenda of Team Governance Meetings. **Timescale, with immediate effect**	
Who is responsible?	Senior Operational Manager

What resources (if any) are needed to implement the change(s) and are these resources available?	
None identified.	
Date actions will be completed:	31 January 2019

How will people who use the service(s) be affected by you not meeting this regulation until this date?
There is a system in place for checking on a weekly basis to maintain patient safety.

Report on actions you plan to take

Please see the covering letter for the date by which you must send your report to us and where to send it. **Failure to send a report may lead to enforcement action.**

Account number	TAH
Our reference	INS2-4772925591
Location ID	Not applicable
Trust name	Sheffield Health and Social Care NHS Foundation Trust

Regulated activity(ies)	**Regulation**
Assessment or medical treatment for persons detained under the Mental Health Act Treatment of disease, disorder or injury	**Regulation 12 Safe care and treatment** **Health and Social Care Act 2008 (Regulated Activity) Regulations 2014**
	How the regulation was not being met:
	Wards for Older People The trust must ensure that there is easy access and signage to aid visibility to nurse call systems throughout ward G1.

Please describe clearly the action you are going to take to meet the regulation and what you intend to achieve

1. A review of the current provision and process for nurse alarm call system on G1 was undertaken. **Completed October 2018.**

2. To increase signage above the existing alarm call buttons to maximise visibility for residents, relatives and staff. **Timescale, 30 November 2018.**

3. Order and install additional alarms to increase accessibility and maximise use of current system. **Timescale, 31 January 2019.**

Who is responsible for the action?	G1 Ward Manager

How are you going to ensure that the improvements have been made and are sustainable? What measures are going to put in place to check this?

- Senior Operational Manager to verify installation of new alarms and signage. **Timescale, 28 February 2018.**

Who is responsible?	Senior Operational Manager
What resources (if any) are needed to implement the change(s) and are these resources available?	
Procurement of additional alarms and signage/installation.	
Date actions will be completed:	28 February 2019

How will people who use the service(s) be affected by you not meeting this regulation until this date?
Current processes and systems on the ward ensure that patients' needs are met which mitigates safety concerns.

Report on actions you plan to take

Please see the covering letter for the date by which you must send your report to us and where to send it. **Failure to send a report may lead to enforcement action.**

Account number	TAH
Our reference	INS2-4772925591
Location ID	Not applicable
Trust name	Sheffield Health and Social Care NHS Foundation Trust

Regulated activity(ies)	**Regulation**
Assessment or medical treatment for persons detained under the Mental Health Act Treatment of disease, disorder or injury	**Regulation 18 Staffing** **Health and Social Care Act 2008 (Regulated Activity) Regulations 2014**
	How the regulation was not being met:
	Wards for People with Learning Disabilities or Autism The trust must ensure that staff receive an induction in line with trust policy before they start work on the ward.

Please describe clearly the action you are going to take to meet the regulation and what you intend to achieve

1. All staff working on the ward will receive an induction in line with HR Policy (HR009) Induction. This states:

   - By the end of day 1 the staff member will be booked in to attend Corporate Welcome and Core Mandatory training.
   - All new employees will receive a local induction of their area of work, the team and their role. The ward has a Local Induction checklist and the form for this should be completed, signed by the new employee and line manager and sent to HR.
   - A fire, security and a health and safety briefing must take place on day 1 of employment, to ensure the safety of the member of staff themselves, as well as patients and visitors.
   - Within four weeks of commencement to post the induction checklist will be sent by line manager to HR.

Timescale, with immediate effect.

Who is responsible for the action?	Ward Manager

	Senior Operational Manager
How are you going to ensure that the improvements have been made and are sustainable? What measures are going to put in place to check this?	
• The ward manager is undertaking a feedback review from recent new starters regarding their experience of the local induction with a view to improving the process and the quality of the information provided. • The ward manager will manage the induction process in line with policy and escalate any issues or exceptions to the Senior Operational Manager. • The Senior Operational Manager will monitor the performance of the Ward Manager in delivering inductions **until 30 June 2019,** to ensure practice is embedded.	
Who is responsible?	Ward Manager Senior Operational Manager
What resources (if any) are needed to implement the change(s) and are these resources available?	
None identified.	
Date actions will be completed:	30 June 2019

How will people who use the service(s) be affected by you not meeting this regulation until this date?
All staff employed by the ward have received a full induction.

Report on actions you plan to take

Please see the covering letter for the date by which you must send your report to us and where to send it. **Failure to send a report may lead to enforcement action.**

Account number	TAH
Our reference	INS2-4772925591
Location ID	Not applicable
Trust name	Sheffield Health and Social Care NHS Foundation Trust

Regulated activity(ies)	**Regulation**
Assessment or medical treatment for persons detained under the Mental Health Act Treatment of disease, disorder or injury	**Regulation 12 Safe care and treatment** **Health and Social Care Act 2008 (Regulated Activity) Regulations 2014**
	How the regulation was not being met:
	Wards for People with Learning Disabilities or Autism The trust must ensure that there is the minimum number of staff trained in managing aggression and violence on all shifts as outlined in trust policy.

Please describe clearly the action you are going to take to meet the regulation and what you intend to achieve

1. The service will use the safecare tool to plan e-rostering and ensure there is a safe level of staffing within the ward. **Timescale, with immediate effect.**

2. To ensure all regular bank and agency staff are offered Respect level 3 training. **Timescale, with immediate effect.**

3. To ensure all incidents where the number of staff on the ward are not sufficient to safely manage aggression and violence are recorded electronically as an incident on the Trust's E-Incident system (Ulysses). **Timescale, with immediate effect.**

4. A review of staffing levels is to be undertaken by Deputy Chief Nurse to ensure staffing levels are in line with national recommendations and service need. Timescale, January 2019.

Who is responsible for the action?	Ward Manager Senior Operational Manager Deputy Chief Nurse

How are you going to ensure that the improvements have been made and are sustainable? What measures are going to put in place to check this?

- E-rostering takes account of the number of staff who are Respect (management of aggression and violence) trained and it is the managers responsibility to ensure numbers are sufficient to manage clinical acuity/risk on the ward.
- E-rostering Check and Challenge Meetings commenced September 2018 in line with national guidance and best practice.
- Feedback from review of staffing.
  - By on-going recording using E-Incident - all incidents will be reviewed by the service manager and learning/remedial actions undertaken.
- Number of staff trained and incidents of insufficient staff logged at the monthly ATS clinical governance meeting and escalated up through the governance and performance framework.
- Trends/lessons learnt discussed and actions responded to.

Who is responsible?	Ward Manager Senior Operational Manager Deputy Chief Nurse

What resources (if any) are needed to implement the change(s) and are these resources available?

Respect training capacity.

Date actions will be completed:	31 January 2019

How will people who use the service(s) be affected by you not meeting this regulation until this date?

Current e-rostering and training plan is designed to mitigate against insufficient Respect trained staff being on duty to minimise risk to service users.

Report on actions you plan to take

Please see the covering letter for the date by which you must send your report to us and where to send it. **Failure to send a report may lead to enforcement action.**

Account number	TAH
Our reference	INS2-4772925591
Location ID	Not applicable
Trust name	Sheffield Health and Social Care NHS Foundation Trust

Regulated activity(ies)	**Regulation**
Assessment or medical treatment for persons detained under the Mental Health Act Treatment of disease, disorder or injury	**Regulation 17 Good governance** **Health and Social Care Act 2008 (Regulated Activity) Regulations 2014**
	How the regulation was not being met:
	Wards for People with Learning Disabilities or Autism The trust must ensure that managers review all incidents in a timely manner and provide feedback on lessons learned to staff.

Please describe clearly the action you are going to take to meet the regulation and what you intend to achieve

All incidents are recorded electronically on the Trust's E-Incident system (Ulysses).

1. All outstanding incidents have been reviewed. **Completed September 2018.**

2. All incidents to be reviewed by the Senior Operational Manager and/or Deputy Manager within five days and learning/remedial actions undertaken and shared with the team. **Timescale, with immediate effect.**

3. Senior Operational Manager to audit compliance **with effect from 1 November 2018.**

Who is responsible for the action?	Senior Operational Manager Ward Manager

How are you going to ensure that the improvements have been made and are sustainable? What measures are going to put in place to check this?

• The performance of reviewing incidents in line with policy and procedure will be reported through the ATS clinical governance meeting as a regular agenda item. • Any exception reports will be taken to the quadrant meeting by the Senior Operation Manager as required.	
Who is responsible?	Senior Operational Manager
What resources (if any) are needed to implement the change(s) and are these resources available?	
None identified.	
Date actions will be completed:	1 November 2018

How will people who use the service(s) be affected by you not meeting this regulation until this date?
Managers do not wait until reviews are completed to take action and feedback to the team. This is addressed immediately as required; therefore the safety of service users is mitigated.

Report on actions you plan to take

Please see the covering letter for the date by which you must send your report to us and where to send it. **Failure to send a report may lead to enforcement action.**

Account number	TAH
Our reference	INS2-4772925591
Location ID	Not applicable
Trust name	Sheffield Health and Social Care NHS Foundation Trust

Regulated activity(ies)	**Regulation**
Assessment or medical treatment for persons detained under the Mental Health Act Treatment of disease, disorder or injury	**Regulation 12 Safe care and treatment** **Health and Social Care Act 2008 (Regulated Activity) Regulations 2014**
	How the regulation was not being met:
	Crisis & HBPoS The Trust must ensure that Mental Health Act assessments are carried out in a timely manner.

Please describe clearly the action you are going to take to meet the regulation and what you intend to achieve

1. Development of AMHP module on the Insight care records system to capture the date and time of the Mental Health Act (MHA) assessment referral, the date the MHA assessment is undertaken and the outcome of the MHA assessment. **Completed, October 2018.**

2. Ensure that AMHPs document as appropriate on Insight any reasons which result in a delay to the planned assessment and escalate where required. AMHP Manager to review Insight information. **Timescale, by 31 January 2019.**

3. To develop a set of Key Performance Indicators (KPIs) to measure progress and inform remedial action plans as required. **Timescale, 31 March 2019.**

4. Recruit up to establishment enabling AMHP working arrangements to be more flexible in order to meet demand at peak times. **Timescale, 31 March 2019 (subject to availability of suitable candidates).**

5. Create a 24/7 Crisis Hub co-located at the Longley Centre which will support a coordinated approach to the delivery of care for individuals in crisis, including access to timely MHA assessments. **Timescale, 31 March 2019.**

Who is responsible for the action?	AMHP Manager Central AMHP Team Senior Practitioner Senior Operational Managers

How are you going to ensure that the improvements have been made and are sustainable? What measures are going to put in place to check this?

- The new AMHP Insight module will produce a report to enable managers to have oversight to make decisions on the deployment of staff resources to better meet patient need.

- KPIs will be monitored at:
  - AMHP Governance and Team Meeting
  - AMHP Quarterly Performance Meeting
  - Bi-monthly Police/SHSC Liaison Meeting

  Timescale, with effect from 1 April 2019.

Who is responsible?	AMHP Manager Central AMHP Team Senior Practitioner Senior Operational Managers

What resources (if any) are needed to implement the change(s) and are these resources available?

Completion of the estates work at the Longley Centre to create the Crisis Hub.

Date actions will be completed:	31 March 2019

How will people who use the service(s) be affected by you not meeting this regulation until this date?

Any individuals identified as being at risk of admission and possibly requiring a Mental Health Act assessment are reviewed by the AMHP Manager, in conjunction with the referring team. Individuals identified are prioritised at least once daily and clinical resources are deployed accordingly based on clinical need and risk profile.

Regulated activity(ies)	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act Treatment of disease, disorder or injury	**Regulation 12 Safe care and treatment** **Health and Social Care Act 2008 (Regulated Activity) Regulations 2014**
	How the regulation was not being met:
	The Mental Health Crisis and Health Based Place of Safety The Trust must ensure that its crisis 24/7 telephone line is fit for purpose.

Please describe clearly the action you are going to take to meet the regulation and what you intend to achieve

The Trust is reviewing the current telephone system configuration to ensure it meets the needs of the service. We will analyse how the telephone system is working and being used to remove any points of failure.

We will ensure the business processes are reviewed and re-engineered as appropriate to make sure the system is used efficiently. We will ensure operators are trained and supported in using the systems effectively.

We will put in place systems to monitor call volumes, queuing times, re-routing and abandoned calls to ensure management can oversee the ongoing effectiveness of the system and its use and IMST can analyse where and why calls are not being picked up and potentially abandoned.

The Trust has invested in improving its current telephony systems. This investment is being used to:

1. Implement Business Intelligence software that produces real-time actionable information enabling full and live management of resource. **Completed: 24 July 2018.**

2. Recruit a Consultant Analyst (expert in Skype for Business and Contact Centres) to support data quality and validation. **Competed: 22 October 2018**

3. Install and display dashboards into the Single Point of Access and Substance Misuse Services providing real-time telephony data. **Complete: 26 October, 2018**

4. Configure system to ensure call handers are logged onto all routes so queued callers can be routed to them, **Complete: 26 October, 2018**

5. Upgrade the current underlying telephony platform to the latest version of Microsoft Skype for Business. **Timescale: 31 December 2018.**

We have also approved a Trust Multi-Channel Communications Strategy to further enhance our capability to communicate effectively with service users via their preferred means of communication.

The Trust-wide Contact Centre Solution as part of the Multi-Channel Communication Strategy. The planned actions for this are:

1. Procure a Trust-wide Contact Centre Solution **Timescale: by 31 March 2019.**

2. Implement the Trust-wide Contact Centre Solution via a phased approach, starting with the Single Point of Access and Substance Misuse Services **Timescale: April 2019.**

Who is responsible for the action?	Associate Clinical Director Digital Programme Manager for Multi-Channel Communications Deputy Director of IMST

How are you going to ensure that the improvements have been made and are sustainable? What measures are going to put in place to check this?

Clinical Operations Change and Improvement Group and the Trust Business System Strategy Group to oversee implementation and receive regular updates on project progression.

Performance metrics to be reviewed at the SPA Project Group, SPA Team Governance Meeting and Quarterly Performance Reviews.

Who is responsible?	Associate Clinical Director Associate Director Deputy Associate Director Digital Programme Manager for Multi-Channel Communications Deputy Director of IMST

What resources (if any) are needed to implement the change(s) and are these resources available?

Provision and installation of dashboard for telephony monitoring at SPA and Substance Misuse Services. **Complete** (Procured and operational).

To support the service in its adoption of Contact Centre Solution the Trust has identified a comprehensive resource package that includes the following:

- Digital Programme Manager – In post
- Digital Business Analyst – in post
- Contact Centre Consultant Analyst – in post

• Network Engineer – in post • Clinical Programme Lead – to be assigned • Contact Centre Manager – business case to be developed • Local Business and Performance Managers – in post • Buildings and Admin Managers – in post • Telephony staff – in post • UC Analytics software – purchased and operational • Propriety Trust Contact Management Solution – in procurement process	
Date actions will be completed:	31 December 2018

How will people who use the service(s) be affected by you not meeting this regulation until this date?
Any compromise to patient safety is mitigated against by additional call handlers and the use of UC Analytics to understand call flow.