Sheffield Health and Social Care NHS Foundation Trust

Inspection report

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We plan our next inspections based on everything we know about services, including whether they appear to be getting better or worse. Each report explains the reason for the inspection.

This report describes our judgement of the quality of care provided by this trust. We based it on a combination of what we found when we inspected and other information available to us. It included information given to us from people who use the service, the public and other organisations.

This report is a summary of our inspection findings. You can find more detailed information about the service and what we found during our inspection in the related Evidence appendix.

Ratings

Overall trust quality rating	Inadequate
Are services safe?	**Inadequate**
Are services effective?	**Requires improvement**
Are services caring?	**Good**
Are services responsive?	**Requires improvement**
Are services well-led?	**Inadequate**

We rated well-led (leadership) from our inspection of trust management, taking into account what we found about leadership in individual services. We rated other key questions by combining the service ratings and using our professional judgement.

Summary of findings

Background to the trust

The trust was initially established in 2003 as Sheffield Care Trust and on 1 July 2008, was authorised to operate as Sheffield Health and Social Care NHS Foundation Trust. The trust works with one clinical commissioning group, NHS Sheffield Clinical Commissioning Group. The trust also provides services which are commissioned by NHS England and Sheffield City Council.

The trust provides services from 31 inpatient and community sites and had 11 locations registered with the CQC (on 18 December 2019).

Trust Headquarters (Fulwood House)

Jordanthorpe Health Centre

Woodland View

The Longley Centre

Firshill Rise

Michael Carlisle Centre

Clover City Practice

Forest Close

Forest Lodge

Grenoside Grange

Wainwright Crescent

The trust provides the following services:

- acute mental health wards and one psychiatric intensive care unit for adults of working age
- long stay rehabilitation mental health wards for adults of working age
- forensic inpatient low secure wards
- wards for older people with mental health problems
- ward for people with learning disabilities or autism
- community-based mental health services for people with learning disabilities or autism, older people and for adults of working age
- mental health crisis services and health-based place of safety
- substance misuse and alcohol services
- primary medical services
- adult social care services

Summary of findings

- specialist services which include; community brain injury rehabilitation, neuro-enablement service, chronic fatigue service, relationship and sexual health service, gender identity service, community eating disorders service, adult autism and neurodevelopmental service, health inclusion, homeless assessment and support, improving access to psychological therapies, an electro compulsive therapy suite, community enhancing recovery team, community dementia support service, and an emotional wellbeing service.

The trust was last inspected between 30 May 2018 and 5 July 2018 using the current methodology.

At the inspection in 2018, we rated the trust as requires improvement overall with ratings of requires improvement in the safe and well led key questions. We rated the trust as good in the effective, caring and responsive key questions.

We issued requirement notices to the trust in respect of the following breaches of regulation:

- Regulation 12 HSCA (RA) Regulations 2014 safe care and treatment
- Regulation 15 HSCA (RA) Regulations 2014 premises and equipment
- Regulation 17 HSCA (RA) Regulations 2014 good governance
- Regulation 18 HSCA (RA) Regulations 2014 staffing

We told the trust that it must take the necessary actions below regarding these breaches of regulation to comply with its legal obligations.

These breaches of regulation related to concerns we found at; trust level

- The trust must ensure that effective systems and processes are in place to monitor and manage staff access to clinical supervision.
- 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 single point of access.
- The trust must ensure that policies are reviewed and updated to reflect current national guidance and best practice.

We also told the trust that they must make improvements in acute wards and psychiatric intensive care units, in long stay or rehabilitation mental health wards for working age adults, in wards for people with a learning disability or autism and in crisis and health based places of safety.

The trust provided us with an action plan demonstrating how it planned to meet these requirements. We have reviewed these actions during this inspection.

Our Mental Health Act reviewers had undertaken visits to ten of the eleven inpatient wards since our last inspection. Common themes deriving from these inspections were; environmental concerns, explaining patients' rights to them, evidence of patient involvement in care plans, discharge planning, staffing and seclusion reviews.

The trust had returned action plans in relation to the concerns raised during these visits. We reviewed the progress made on these action plans during this inspection.

Overall summary

Our rating of this trust went down since our last inspection. We rated it as Inadequate 

Summary of findings

What this trust does

Sheffield Health and Social Care NHS Foundation Trust provide services for; mental health, learning disability, substance misuse, community rehabilitation, primary care, specialist services and adult social care services. The trust has been registered with the Care Quality Commission since 1 April 2010.

The trust provides care to the people of Sheffield and employs 2432 staff. It has a budget of £128 million.

Key questions and ratings

We inspect and regulate healthcare service providers in England.

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs, and well-led?

Where we have a legal duty to do so, we rate the quality of services against each key question as outstanding, good, requires improvement or inadequate.

Where necessary, we take action against service providers that break the regulations and help them to improve the quality of their services.

What we inspected and why

We plan our inspections based on everything we know about services, including whether they appear to be getting better or worse.

At this inspection, we completed a well led review of the trust and inspected five of the core services delivered by the trust between 6 January 2020 and 5 February 2020. The five core services we inspected were:

•acute mental health wards and one psychiatric intensive care unit for adults of working age

•mental health crisis services and health-based place of safety

•forensic inpatient low secure wards

•community-based mental health services for adults of working age

•wards for older people with mental health problems

We identified these core services for this inspection based on previous inspection ratings, information relating to risk received through engagement and our ongoing monitoring, and the length of time since the service was last inspected.

Our comprehensive inspections of NHS trusts have shown a strong link between the quality of overall management of a trust and the quality of its services. For that reason, all trust inspections now include inspection of the well-led key question at the trust level. Our findings are in the section headed "Is this organisation well-led?" and we use the well led framework to review the trust's leadership and governance.

What we found

Overall trust

Our rating of the trust went down. We rated it as inadequate because:

- We rated safe and well led as inadequate, effective and responsive as requires improvement, and caring as good.

Summary of findings

- We rated three of the trust's core services inadequate overall, and two of the trust's services as requires improvement overall. In rating the trust overall, we considered the current ratings of the five services not inspected this time. The adult social care and primary medical services provided by the trust were not inspected this time, and their previous ratings were not aggregated into the trust's overall rating. We rated well-led for the trust as inadequate.
- At this inspection, three of the trust's core services had worsened since the last inspection. Acute wards and psychiatric intensive care units had worsened from a rating of requires improvement to inadequate. Wards for older people with mental health problems had worsened from a rating of good to a rating of inadequate and crisis and health-based places of safety had worsened from a rating of requires improvement to inadequate. Community mental health services for adults of working age had worsened from a rating of good, to a rating of requires improvement. We had not seen the required improvements in forensic wards and this service had maintained a ratings of requires improvement.
- The trust did not always provide consistently safe care. We identified issues during our inspections in relation to; staffing, mandatory training, safeguarding, the management of physical health, environmental safety, risk assessment processes and incident reporting and management.
- The trust did not always provide effective care. The trust had failed to appropriately monitor and deliver staff supervision and appraisal, and there were not audits in place to monitor adherence to the Mental Capacity Act. Specialist staff were not in place to deliver the range of care and treatment required.
- There were some pockets of culture within the organisation which was not caring and compassionate. This included that staff had used non-approved restraint techniques on one ward, and that care plans were not entirely person centred and recovery orientated.
- The trust was not always responsive to the needs of patients. Areas of the trust estate were not fit for purpose. Dormitory accommodation remained in use and the seclusion areas were not all private, comfortable and dignified. Some community services held long waiting lists and complaints were not always managed in line with the trust's own policy and in a timely way.
- The delivery of high quality care was not assured by the governance of the trust. There were low levels of staff satisfaction and the trust did not prioritise the supervision, training and appraisal of staff. Leaders did not always understand, manage and mitigate the risks faced by front line services. The information that was used to monitor performance and make decisions was not of high quality which had a direct impact on the quality and delivery of services. The trust had not addressed all the areas identified for improvement at the last inspection. Where leaders were cited on issues and risks they had not acted with enough pace to make required improvements.

However:

- We rated forensic inpatient wards as good in the effective, caring and responsive key questions. The caring key question was rated as good or outstanding across the trust other than in acute wards and psychiatric intensive care units (this considered the ratings of services not inspected this time).
- The trust encouraged staff to learn lessons from incidents and worked from a multi-agency approach to manage safeguarding across the organisation.
- When serious incidents had occurred, the trust had taken visible action to mitigate risks and had complied with action plans in making service improvements in line with regulation 28 reports.
- Staff interactions we observed during the inspection we kind, compassionate and respectful. The leaders of the organisation acted within the values of the trust.

Summary of findings

- The trust had good working relationships with partner organisations and was an active member of the accountable care partnership. The trust focussed on providing care across the city of Sheffield to meet the needs of the community.
- The trust encouraged patient and carer engagement and actively sought feedback on services to make improvements. They encouraged patients to become active partners in their care. The strategy for quality improvement was underpinned by patient and carer feedback and involvement.
- The trust were aware of the diverse needs of the population they served and put services in place to meet these needs.
- The trust continued to have a partnership in Uganda to share teaching and learning.
- Leaders were passionate about improving the care they delivered and keen to make improvements. They had attempted to seek assurance on the quality of care delivered via a variety of audits and research and via working towards the accreditation of some services.
- Leaders were aware of some areas requiring improvement and had begun to take action. They were working on; rebuilding relationships with staff, organisational development (including board and council of governors) development, improving the quality of data, and replacing the trust information technology systems. The trust were in the process of revising their strategy.
- The trust had maintained a strong financial position and there were limited cost improvement plans.

On the basis of this report, the Chief Inspector of Hospitals is recommending the trust be placed into special measures.

Are services safe?

Our rating of safe went down. We rated it as inadequate because:

- We rated the safe key question as inadequate in three of the core services we inspected and requires improvement in the other two services.
- Not all services and inpatient wards were safe, clean and fit for purpose. Seclusion suites were not fit for purpose and were not in line with guidance in the Mental Health Act Code of Practice. Dormitory accommodation remained in place on inpatient wards. There had been several sexual safety incidents and patients continued to smoke on the acute wards. The layout of the psychiatric decisions unit was not in line with guidance for eliminating mixed sex accommodation, and patient areas were not private and dignified. The sites used to deliver community services were not always clean and private. Staff in community services did not have access to the equipment required to support patients in an emergency.
- The trust's governance systems and processes had failed to address that there were not enough numbers of suitably qualified, competent, skilled and experienced staff working within the trust. This had an impact on quality and safety of care. Services did not have enough nursing and medical staff, who were experienced, knew the patients and received basic training to keep patients safe from avoidable harm. The trust used agency staff on the acute wards and psychiatric intensive care unit who were not trained in the management of violence and aggression. Most staff employed in the acute ward and psychiatric intensive care unit were newly qualified and did not have the experience required when asked to lead shifts. The trust continued to report high levels of staff sickness and poor staff retention. The trust were aware of these issues but had failed to act in providing interim staffing arrangements to maintain safety.
- The trust had not ensured that patients' physical health needs and needs in relation to the monitoring of side effects of their medications were always managed safely and in line with national guidance. There was limited specialist input from pharmacy staff. The trust did not have a physical health strategy.

Summary of findings

- Staff did not always manage risks to patients well. In mental health wards for older people, falls risks assessments and associated management plans had not been completed adequately. On these wards, staff did not always complete the required observations of patients. In community mental health services, risk assessments were not always completed and/or updated and there was a lack of documented crisis planning.
- Staff did not always record incidents of seclusion and restraint with the required detail in line with the Mental Health Act Code of Practice. This meant it was not possible to ascertain whether this was only used after attempts at de-escalation had failed. Staff had used non-approved restraint techniques in acute wards and the psychiatric intensive care unit.
- The trust had a process for the reporting of incidents, and an incident management framework and investigation process. However, staff did not always recognise and report incidents accurately. This meant that the board had limited oversight of risks in front line services. The investigation process was complex, and the layers of reporting requirements had led to delays in making reports in a timely manner to the clinical commissioning group. Investigation reports were thorough, but the conclusion of reports was often that care was 'good' despite system errors. This meant that the trust was not able to make the required improvements where improvements were required. One of the four serious incident action plans we reviewed was poor quality.
- The trust did not analyse and record the number of referrals made about safeguarding children and young people.
- We issued a letter of intent to the trust because staff had allowed the admittance of four young people aged 16 – 17 to the psychiatric decision unit. Some of these young people remained on the unit overnight. Their accommodation was shared with adults and the required safeguards were not in place. The trust agreed to stop allowing this practice with immediate effect.

However:

- Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. The trust held regular lessons learned events and annual safety events to share learning across the trust.
- The trust worked well with other agencies to protect patients from abuse and provided safeguarding training.

Are services effective?

Our rating of effective went down. We rated it as requires improvement because:

- We rated the effective key question as requires improvement in four of the five core services we visited and rated effective as good in forensic wards.
- Care plans were not always person centred, they did not always reference the patient's voice or opinion on their care and were not recovery orientated. There was a lack of evidence of discharge planning.
- The trust did not undertake audits of the Mental Capacity Act and staff did not have all the tools they required to support patients when making best interest decisions.
- The trust's governance systems had failed to ensure that all staff received the appropriate supervision and appraisal necessary to enable them to carry out the duties that they are employed to perform. This was a concern at our previous inspection of the trust.
- Teams did not have the full range of specialists required to meet the needs of patients. This included gaps in the provision of psychology, pharmacy, section 12 Doctors and occupational therapy in some services.
- The trust did not offer training in the Mental Health Act to staff working in community mental health services.

However:

Summary of findings

- Staff used some recognised rating scales to assess and record severity and outcomes. They also participated in clinical and national audit, benchmarking and quality improvement initiatives.
- Managers provided an induction programme for new staff.
- The teams had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.
- The trust had a mental health legislation committee to ensure compliance and monitoring of areas of responsibility under the Mental Health Act. Audits showed clear action plans which had made improvements. The training provided ensured that staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and discharged these well.

Are services caring?

Our rating of caring stayed the same. We rated it as good because:

- We rated the caring key question as good in four of the five core services we visited during the inspection. In acute wards and psychiatric intensive care units, we rated caring as requires improvement.
- Staff in front line services understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition. Staff we observed treated patients with respect, compassion and kindness.
- Leaders were committed to working for the trust and cared about the communities in which the trust worked.
- The trust encouraged the voice of patients and carers as partners in their care. They ensured that patients had access to independent advocates and staff informed and involved families and carers appropriately. The trust engaged with patients and their carers to involve them in services and received feedback to improve services.

However:

- In acute wards and the psychiatric intensive care unit, staff did not always treat patients with kindness and compassion. Staff had used non-approved restraint techniques with some patients.
- The trust had not always maintained contact with patients and their families during or following the investigation of serious incidents.
- In mental health wards for older people, two of the care records we reviewed had a care plan which contained punitive or insensitive language.

Are services responsive?

Our rating of responsive went down. We rated it as requires improvement because:

- We rated the responsive key question as requires improvement in three of the five services we visited, and good in forensic wards and community mental health services for adults of working age.
- The design, layout, and furnishings of inpatient services did not support patients' treatment, privacy and dignity. Not all patients had their own bedroom with an en-suite bathroom and could not always keep their personal belongings safe. Seclusion suites were overlooked and did not always contain a bed.
- There were lengthy waiting lists in community services. This included delays to Mental Health act assessments in the community and in health based places of safety.
- The trust did not always manage beds well and this impacted on the ability of community services to fulfil their function. Staff reported lapses and delays when completing Mental Health Act assessments due to bed availability.

Summary of findings

- The trust treated concerns and complaints seriously and investigated them, however this was not always done in a timely manner in line with the trusts own policy.

However:

- The trust were able to meet the needs of all patients who used the services including those with a protected characteristic. Staff helped patients with communication, advocacy and cultural and spiritual support.

Are services well-led?

Our rating of well-led went down. We rated it as inadequate because:

- In response to our findings, we issued a warning notice to the trust under Section 29A of the Health and Social Care Act. This limited the rating of this key question, to a rating of inadequate.
- We rated the well-led key question as inadequate in three of the five services we visited and requires improvement in the two other services.
- Local leaders did not ensure that risks in front line services were always escalated appropriately to ensure action by senior leaders.
- There were several governance processes which did not operate effectively in the services we visited. This included processes for managers to deliver and monitor compliance with maintaining skilled staff via mandatory training, supervision and appraisal. The required audits were not in place for leaders to measure the quality of service delivery and compliance with legislation and guidance.
- In community services, governance systems had not measured all risks to patients. This included a lack of access to emergency equipment, and a lack of monitoring of waiting lists.
- We found recording issues in all the services we visited in relation to; the management of risk, care planning, the recording of incidents and the appropriate recording of seclusion incidents. This meant that not all staff had maintained a contemporaneous patient record.
- Local leaders had not ensured that there were systems in place to ensure staff were able to monitor the physical healthcare needs of patients.
- The management of staffing was a concern across all the services we visited. Managers had not ensured that services were delivered safely, with the correct number of suitably qualified staff. This had a direct impact on the quality of care, the availability of specialist staff and had resulted in significant delays in accessing treatment.

However:

- Local leaders had a good understanding of the services they managed. They were visible in the services they managed and approachable for patients and staff. Staff felt that they had good relationships with local leaders. However, local leaders did not always escalate risks and concerns about the safety of their services to more senior leaders in the organisation to allow risks to be managed and mitigated.
- Staff felt able to raise concerns without fear of retribution and the majority were aware of how to contact the trust's freedom to speak up guardian.
- Other than in mental health wards for older people, and in crisis services, staff knew and understood the provider's vision and values and how they were applied in the work of their team.
- Teams had access to the information they needed to provide safe and effective care and most used that information to good effect.

Summary of findings

Ratings tables

The ratings tables show the ratings overall and for each key question, for each service, and for the whole trust. They also show the current ratings for services or parts of them not inspected this time.

Our decisions on overall ratings also considered factors including the relative size of services and we used our professional judgement to reach fair and balanced ratings.

Outstanding practice

Areas for improvement

We found areas for improvement including 47 breaches of legal requirements that the trust must put right.

We found things that the trust should improve to comply with a minor breach that did not justify regulatory action, to prevent breaching a legal requirement, or to improve service quality.

For more information, see the Areas for improvement section of this report.

Action we have taken

We issued one warning notice and eight requirement notices to the trust. Our action related to 47 breaches of legal requirements in five core services and in relation to the overall governance of the trust. That meant the trust had to send us a report saying what action it would take to meet this requirement.

For more information on action we have taken, see the sections on areas for improvement and regulatory action.

What happens next

We will check that the trust takes the necessary action to improve its services. We will continue to monitor the safety and quality of services through our continuing relationship with the trust and our regular inspections.

Outstanding practice

Areas for improvement

Action the trust MUST take is necessary to comply with its legal obligations.

Action a trust SHOULD take is to comply with a minor breach that did not justify regulatory action, to prevent it failing to comply with legal requirements in future, or to improve services.

We told the trust that it must take action to bring services into line with eight regulations in respect of 47 breaches of legal requirements. This action related to five core services and the overall governance of the trust.

Action the trust MUST take to improve:

Trustwide:

- The trust must ensure that effective governance systems are in place to assess, monitor and improve the quality and safety of the services. (Regulation 17).
- The trust must monitor the numbers of child safeguarding referrals made by staff. (Regulation 17).

Summary of findings

- The trust must ensure that there are robust arrangements in place for monitoring and auditing compliance with the requirements of the Mental Capacity Act. (Regulation 17).
- The trust must ensure that it monitors mandatory training, supervision and appraisal compliance at service level to maintain oversight of compliance. (Regulation 17).
- The trust must ensure that accurate and contemporaneous records are kept in line with the fit and proper persons regulation. (Regulation 17)
- The trust must ensure that human resources processes are in place, and that these are completed in line with trust policy. Including; disclosure and barring checks, and professional registration checks. To ensure that staff are suitably qualified. (Regulation 18).
- The trust must ensure that a physical health strategy is implemented, and that there is monitoring of compliance with this. The trust must provide staff with robust standard operating procedures to ensure that patients' physical health and the side effects of medication are monitored appropriately. (Regulation 17)
- The trust must ensure that all services have the required amount of experienced and specialist staff, including pharmacy services. (Regulation 18)
- The trust must ensure that it has robust governance processes in place to ensure oversight of incident reporting. (Regulation 17)
- The trust must ensure the incident investigation reports highlight all areas of required improvement and appropriate actions are taken. (Regulation 17)
- The trust must ensure that all complaints are monitored and responded to in a timely manner and in line with their own policy. (Regulation 16)
- The trust must ensure that there is a designated nurse for safeguarding children. (Regulation 13)

In forensic inpatient / secure wards

- The trust must ensure staff monitor fridge and freezer temperatures in the therapy kitchens and take appropriate action if the temperatures are out of range. (Regulation 17)
- The trust must ensure all staff complete mandatory training. (Regulation 18).
- The trust must ensure that staff complete appraisal and supervision with the required frequency. (Regulation 18).
- The trust must ensure there is an audit of compliance with the Mental Capacity Act. (Regulation 17)

In community mental health services for working age adults

- The trust must ensure that all actions from the East Glade Centre fire risk assessment are completed in a timely manner to ensure the safety of patients and staff. (Regulation 12)
- The trust must ensure that all premises and equipment used are clean, calibrated and properly maintained. (Regulation 12)
- The trust must ensure that an appropriate risk assessment is completed for the lack of emergency medication and equipment on sites and if the assessment shows a need, ensuring those medications and equipment are available. (Regulation 12)
- The trust must ensure that staff fully assess, manage and mitigate the risks to the health and safety of patients and this is evidenced in all risk assessments and risk management plans. (Regulation 12)

Summary of findings

- The trust must ensure that all people who require a Mental Health Act assessment receive the assessment without delay. (Regulation 12)
- The trust must ensure that staff develop and maintain accurate, comprehensive and up to date care plans. (Regulation 17)
- The trust must ensure that quality assurance systems identify inconsistencies in the quality of care across the service and implement plans to address these inconsistencies. The trust must ensure that local clinical checks identify issues and staff should act on the results when needed. (Regulation 17)
- The trust must ensure that staff all staff complete mandatory training. (Regulation 18)

In acute wards and psychiatric intensive care units

- The trust must ensure that patients are cared for in environments which are private and dignified. This includes the removal of dormitory accommodation and ensuring the seclusion suites and CCTV cannot be overlooked and that patients' access to toilet facilities is appropriate. (Regulation 10)
- The trust must ensure that staff undertake physical health monitoring with all patients. This includes monitoring of long term health conditions, monitoring after the use of restrictive interventions, monitoring of the side effects of medication, and monitoring patients' physical health needs in line with national guidance whilst undertaking inpatient detoxification. (Regulation 12)
- The trust must ensure that it addresses the fire risk associated with patients smoking inside the wards. (Regulation 12)
- The trust must ensure that the premises used for seclusion are suitable for the purpose of which they are being used, properly used, properly maintained and appropriately located for the purpose they were being used. They must be in line with the Mental Health Act Code of Practice. (Regulation 15).
- The trust must ensure that staff report all incidents, including all incidents of rapid tranquilisation and restraint.
- The trust must ensure that staff maintain an accurate and contemporaneous record of patient care including seclusion records in line with the Mental Health Act Code of Practice. (Regulation 17)
- The trust must ensure that staff do not use non-approved restraint techniques including the use of mechanical restraint and in line with the trust's own policy (Regulation 13)
- The trust must ensure that it is able to meet the needs of all patients admitted to the ward and ensure that patients with complex needs which staff are unable to cater for are not admitted. (Regulation 9)
- The trust must ensure that sufficient numbers of experienced and suitably qualified staff are available on all shifts, and that staff are able to manage the high acuity of the ward. (Regulation 18)
- The trust must ensure that all staff complete mandatory training. (Regulation 18)

In mental health wards for older people:

- The trust must provide a range of treatment and interventions to ensure care and treatment of service users is appropriate, meets their needs, and reflects their preferences. (Regulation 9)
- The trust must ensure that staff complete appraisal and supervision with the required frequency as per the trust's own policy. (Regulation 18).
- The trust must ensure that patients are cared for in environments which are private and dignified. This includes the removal of dormitory accommodation on Dovedale ward. (Regulation 10).

Summary of findings

- The trust must ensure that care and treatment is provided in a safe way for service users. The trust must assess the risks to the health and safety of service users of receiving the care or treatment and do all that is reasonably practicable to mitigate any such risks. This includes the completion of risk assessments, the management of falls risks and ensuring the required observations of patients are undertaken. (Regulation 12).
- The trust must ensure systems and processes are established and operated effectively to ensure compliance including assessing, monitoring and improving the quality and safety of the services provided assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk. (Regulation 17)
- The trust must ensure that all staff complete mandatory training. (Regulation 18)
- The trust must ensure that there are enough staff deployed. (Regulation 18)

In crisis and health based places of safety:

- The trust must not admit any person under the age of 18 to shared accommodation in the psychiatric decisions unit. (Regulation 12)
- The trust must ensure that effective action is taken to reduce waiting times and manage patients waiting long periods of time in the emotional wellbeing service. (regulation 9)
- The trust must ensure that the availability of a section 12 doctor does not delay the assessment of patients detained in the section 136 suite. (Regulation 18)
- The trust must ensure that the layout and operations of the Decisions unit offers sufficient privacy, dignity and comfort to those using it. (Regulation 10)
- The trust must ensure that effective governance systems are put in place to oversee, monitor and support the operations of the crisis services. (Regulation 17)
- The trust must ensure that staff complete appraisal and supervision with the required frequency. (Regulation 18).
- The trust must ensure that all staff take part in clinical supervision. (Regulation 18)

We told the trust they should take the following actions:

Trustwide:

- The should continue to seek improvements to its telephony and information technology systems.
- The trust should ensure that it engages with staff in developing an LGBTQ+ network.

In forensic inpatient/secure wards

- The trust should ensure all ligature risks are documented on the appropriate ligature risk audit.
- The trust should ensure that liquid medicines are stored in line with good practice guidance.
- The trust should ensure that there is a consistent approach to documenting in patients' care and treatment records so staff can readily find information concerning updated risks and whether patients have copies of their care plans.
- The trust should ensure that patient care plans are recovery orientated and contain enough detail to reflect the full range of needs and goals identified.
- The trust should ensure there are sufficient numbers of staff on every shift that are trained in immediate life support and restraint interventions.

Summary of findings

- The trust should ensure that they continue to assess staffing levels on the night shift of the rehabilitation ward to ensure staff and patient safety in the event of an emergency.

In community mental health services for working age adults:

- The trust should ensure that all ligature assessments have been reviewed and actions are appropriate to control any potential ligature points.
- The trust should ensure that all staff have relevant mental health act training as patients can be subject to Mental Health Act regulations.
- The trust should ensure they monitor and have oversight of staff use of the buddy system.
- The trust should ensure that a dignity curtain is hung in the clinic room at the East Glade Centre.
- The trust should ensure that there is sufficient provision of psychology to meet the needs of the patients and patients are getting the treatment they require within wait time guidelines.

In mental health wards for older people

- The trust should ensure blind spots on Dovedale ward are identified and the risks mitigated.
- The trust should ensure that blanket restrictions are regularly reviewed on G1 ward.
- The trust should ensure that staff document decisions made in patients' best interests.

In crisis and health based places of safety

- The trust should ensure that patients being cared for in the Decisions unit are able to receive their own medications in a timely manner.
- The trust should ensure that staff carry out audits to assess compliance with the Mental Capacity Act.

Is this organisation well-led?

Our comprehensive inspections of NHS trusts have shown a strong link between the quality of overall management of a trust and the quality of its services. For that reason, we look at the quality of leadership at every level. We also look at how well a trust manages the governance of its services – in other words, how well leaders continually improve the quality of services and safeguard high standards of care by creating an environment for excellence in clinical care to flourish.

Our rating of well led went down. We rated it as inadequate because:

- In response to our findings, we issued a warning notice to the trust under Section 29A of the Health and Social Care Act. This limited the rating of this key question, to a rating of inadequate.
- Leaders had not understood and managed all the priorities and issues the trust faced. The board had not worked cohesively to successfully implement improvements. The trust had failed to make satisfactory progress since the last inspection in areas where we previously raised concerns.
- There continued to be systemic issues within the culture of the organisation. Staff and the trust governors told us they felt unheard and undervalued. Staff reported incidents of bullying. The staff survey results were consistently negative.
- Leaders were not sighted on key risk issues. Staff had been able to undertake high risk practices, such as the use of mechanical restraint and allowing shared accommodation between young people and adults, without this being brought to the attention of senior leaders and executives across the organisation.

Summary of findings

- The board did not have effective systems of assurance. Board sub-committees do not have access to quality data and performance information to allow them to effectively interrogate and challenge the accuracy of information and the quality of services.
- The trust had maintained a sound financial position and had plans to deliver its estates strategy through to 2023. However, the trust had failed to identify and act upon the risk its current inpatient estate posed to the safety, privacy and dignity of patients. This included the ongoing use of dormitory style accommodation.
- The trust did not ensure accountability for performance and take effective action to address risks or poor performance.
- The trust continues to rely on information technology systems which are not fit for purpose. This includes issues with telephone lines and the electronic patient record system.
- Human resources processes were not in line with trust policy this included concerns in relation to the management of the fit and proper persons requirement, disclosure and barring checks and checks of professional registration. The trust disciplinary and grievance processes were not always carried out in line with policy.
- The trust did not have an LGBTQ+ staff network.

However:

- The leadership team were compassionate and ambitious to make changes and improve the delivery of services, they were responsive to the immediate concerns we raised. They acted with integrity in being open and transparent about the difficulties they had faced.
- The trust engaged well with partner agencies including the accountable care partnership to provide services from a city-wide perspective.
- There were positive examples of how the trust is working to collaborate with service users and carers to make improvements to services.
- The trust continued to report to other organisations in line with guidance.
- The trust had a clear strategy for quality improvement.
- The trust had begun to act on managing and improving relationships with staff, including the use of mediation and listening into action.
- The trust had a freedom to speak up guardian who was known to the majority of services. Most staff understood the trust whistleblowing policy.

Ratings tables

Key to tables					
Ratings	Not rated	Inadequate	Requires improvement	Good	Outstanding
Rating change since last inspection	Same	Up one rating	Up two ratings	Down one rating	Down two ratings
Symbol *	➔➔	↑	↑↑	↓	↓↓
Month Year = Date last rating published					

* Where there is no symbol showing how a rating has changed, it means either that:

- we have not inspected this aspect of the service before or
- we have not inspected it this time or
- changes to how we inspect make comparisons with a previous inspection unreliable.

Ratings for the whole trust

Safe	Effective	Caring	Responsive	Well-led	Overall
Inadequate ↓ Jan 2020	Requires improvement ↓ Jan 2020	Good ➔➔ Jan 2020	Requires improvement ↓ Jan 2020	Inadequate ↓ Jan 2020	Inadequate ↓ Feb 2020

The rating for well-led is based on our inspection at trust level, taking into account what we found in individual services. Ratings for other key questions are from combining ratings for services and using our professional judgement.

Ratings for mental health services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Acute wards for adults of working age and psychiatric intensive care units	Inadequate ↓ Jan 2020	Requires improvement ↓ Jan 2020	Requires improvement ↓ Jan 2020	Requires improvement ↓ Jan 2020	Inadequate ↓ Jan 2020	Inadequate ↓ Jan 2020
Long-stay or rehabilitation mental health wards for working age adults	Requires improvement Oct 2018	Good Oct 2018	Good Oct 2018	Good Oct 2018	Good Oct 2018	Good Oct 2018
Forensic inpatient or secure wards	Requires improvement →← Jan 2020	Good →← Jan 2020	Good →← Jan 2020	Good →← Jan 2020	Requires improvement →← Jan 2020	Requires improvement →← Jan 2020
Wards for older people with mental health problems	Inadequate ↓ Jan 2020	Requires improvement ↓ Jan 2020	Good →← Jan 2020	Requires improvement ↓ Jan 2020	Inadequate ↓↓ Jan 2020	Inadequate ↓↓ Jan 2020
Wards for people with a learning disability or autism	Requires improvement Oct 2018	Good Oct 2018	Good Oct 2018	Good Oct 2018	Good Oct 2018	Good Oct 2018
Community-based mental health services for adults of working age	Requires improvement ↓ Jan 2020	Requires improvement ↓ Jan 2020	Good →← Jan 2020	Good →← Jan 2020	Requires improvement ↓ Jan 2020	Requires improvement ↓ Jan 2020
Mental health crisis services and health-based places of safety	Inadequate →← Jan 2020	Requires improvement →← Jan 2020	Good →← Jan 2020	Requires improvement →← Jan 2020	Inadequate →← Jan 2020	Inadequate ↓ Jan 2020
Community-based mental health services for older people	Good Oct 2018	Good Oct 2018	Outstanding Oct 2018	Outstanding Oct 2018	Good Oct 2018	Outstanding Oct 2018
Community mental health services for people with a learning disability or autism	Good Oct 2018	Good Oct 2018	Good Oct 2018	Good Oct 2018	Good Oct 2018	Good Oct 2018
Community-based substance misuse services	Requires improvement Oct 2018	Good Oct 2018	Good Oct 2018	Outstanding Oct 2018	Good Oct 2018	Good Oct 2018
Overall	Inadequate ↓↓ Feb 2020	Requires improvement ↓ Feb 2020	Good →← Feb 2020	Requires improvement ↓ Feb 2020	Inadequate ↓ Feb 2020	Inadequate ↓ Feb 2020

Overall ratings for mental health services are from combining ratings for services. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Wards for older people with mental health problems

Inadequate 

Key facts and figures

Sheffield Health and Social Care NHS Foundation Trust provides inpatient services for older people with mental health problems. The service is available to people over the age of 65 years old who have or may have a mental health illness and who live within the boundaries of NHS Sheffield Clinical Commissioning Group. The service is accessed primarily via the trust's community mental health services for older people. The service also accepts referrals via adult and older people liaison psychiatry services and emergency referrals in consultation with the trust's on-call registrar team.

The trust provides two wards for older people with mental health problems:

- Dovedale ward is an 18 bedded ward for older men and women who require hospital care for acute functional mental health conditions. This may include the acute phase of a severe mental illness such as schizophrenia, bi-polar disorder or severe depressive disorder and for those with a dual diagnosis of severe mental illness and drug/alcohol, or learning disability, or people with personality disorder and acute mental health needs. The ward is based in the Michael Carlisle Centre in South-West Sheffield. Patients can be admitted voluntarily or detained on the ward under the Mental Health Act.
- Ward G1 is a 20 bedded (funded for 16) ward for the assessment and treatment of older men and women with organic mental health conditions such as severe dementia and associated challenging or highly distressing behaviour. Ward G1 is divided up into two areas, G1a and G1b. The ward is based in Grenoside Grange Hospital in North Sheffield. The majority of patients are detained on the ward under the Mental Health Act.

This inspection took place on 14 and 15 January 2020 and we inspected all of the key questions. Our inspection was unannounced which meant that staff did not know that we were coming to inspect the service. On the day of inspection there were 18 patients on Dovedale ward, of which 15 were detained under the Mental Health Act and three patients were admitted voluntarily. There were 13 patients on G1 ward, of which 11 patients were detained under the Mental Health Act, one patient was admitted voluntarily, and one patient was subject to Deprivation of Liberty Safeguards.

The service has previously been inspected three times. At the last inspection in May/June 2018 we rated this service as good overall. We rated the domains of effective, caring, responsive and well-led as good. We rated the domain of safe as requires improvement. Following the last inspection, we identified two breaches of regulation and told the trust it must take action to improve. The trust breached regulation 12 because the service did not have systems and processes in place to routinely check the emergency equipment on each ward and the service did not have easy access and signage to aid visibility to nurse call systems throughout G1 ward.

We also identified five areas where the trust should take action to make improvements within the service. All identified areas for improvement including the actions the trust should have taken to improve following the last inspection were reviewed during this inspection.

Prior to the inspection, we reviewed all the information we held about the services and requested additional information from the trust. We undertook reviews of the service's compliance with the Mental Health Act on Dovedale ward in November 2019 and on G1 ward in December 2019. Our Mental Health Act reviews identified areas of concern

in relation to timely reviews of seclusion by nursing and medical staff, blanket restrictions, patients' observations, patients receiving one to one time with nursing staff and patients receiving explanations of their rights under the Mental Health Act. Our inspection identified areas of improvement which were in line with the findings of our reviews of compliance with the Mental Health Act.

During the inspection visit, the inspection team:

- visited both wards, looked at the quality of the environment and observed how staff were caring for patients
- spoke with 11 patients using the service
- spoke with 13 carers or relatives of people using the service
- spoke with three leaders of the service including the service managers and team managers
- spoke with 20 other staff including consultant psychiatrists, independent mental health advocates, healthcare support workers, nurses, occupational therapists, and pharmacists.
- looked at the care and treatment records of 14 patients
- reviewed 16 patient medication records
- reviewed 12 patient observation records, six records of rapid tranquilisation and seven seclusion records
- attended and observed three patient activities and multidisplinary team meetings
- offered staff, patients and carers on both wards the opportunity to provide feedback via comment cards
- reviewed a range of policies and procedures and other documents relating to the running of the service.

Summary of this service

Our rating of this service went down. We rated it as inadequate because:

- The service did not provide safe care and treatment. Staff did not assess and manage risk to patients and themselves well. Staff did not complete and record patients' observations in line with prescribed observation levels. The service had high rates of vacancies and sickness and low rates for mandatory training compliance in specific courses which meant the service did not have enough staff who knew the patients and received basic training to keep people safe from avoidable harm. Staff did not report incidents consistently and there was limited evidence of staff using incidents to improve practice.
- The service did not consistently provide effective care and treatment. The range of treatment and care did not meet national guidance and best practice. Managers did not consistently support staff with regular supervision. Staff did not record consistently decisions made in patients' best interests appropriately.
- The service was not consistently responsive to peoples' needs. The design, layout, and furnishings of Dovedale ward did not consistently support patients' treatment, privacy and dignity. The service relied on dormitory accommodation to provide four of the eighteen beds on Dovedale ward which meant not all patients had their own bedroom with an en-suite bathroom.
- The service was not well-led. Our findings from the other key questions demonstrated that governance processes did not operate effectively at team level to manage performance and risk well. Leaders had not ensured there were

structures, processes and systems of accountability for the performance of the service and to identify, understand, monitor, and reduce or eliminate risks. Staff did not know the trust's vision and values and how they were applied in the work of their team. Staff did not know how to use the whistle-blowing process and about the role of the Speak Up Guardian.

However:

- Staff were caring. Staff were respectful, responsive and treated patients and families with compassion and kindness. Patients and carers were positive about the service. Staff involved patients and families in making decisions about their care and in shaping the future of the service.
- The service was responsive to peoples' needs.

Is the service safe?

Inadequate 

Our rating of safe went down. We rated it as inadequate because:

- Staff did not manage risks to patients and themselves well. Staff did not consistently act to prevent or reduce risks. Staff did not always make effective plans to mitigate the risks identified in risk assessments or update risk management plans following incidents. This meant that patients were not always safe and were at high risk of avoidable harm.
- Staff did not consistently follow procedures to minimise risks where they could not easily observe patients. We identified gaps in the records of constant observation, 15-minute observations or routine observations in almost all of the observation records we reviewed. Seclusion records showed staff did not always complete medical and nursing reviews in line with national guidance.
- The service did not have enough nursing and medical staff, who knew the patients and received basic training to keep people safe from avoidable harm. The service had high vacancies, high sickness rates and low compliance with mandatory training in immediate life support and manual handling. There were frequent staff shortages. Night shift fill rates for qualified staff on Dovedale ward were consistently below 90%.
- The service managed patient safety incidents inconsistently and there were unacceptable levels of falls incidents with serious injuries. Staff knew how to report incidents however, staff did not consistently report incidents which involved the use of rapid tranquilisation. Managers told us they investigated incidents and shared lessons learned with the whole team, however staff told us they rarely received feedback from incidents. Most staff did not recognise or understand the duty of candour.
- Both wards provided care for both male and female patients within mixed sex accommodation and the number of breaches of mixed sex accommodation guidance had increased since the last inspection
- Staff did not consistently record and store all medicines in line with the trust's medicines optimisation policy.
- Managers did not ensure that blanket restrictions were reviewed on a regular basis.
- The trust did not have a procedure in place to support staff and ensure patients' privacy and dignity in incidents which resulted in transfers of patients from Dovedale ward to the seclusion rooms at the Michael Carlisle Centre. We identified during our inspection of other services provided by the trust that these seclusion rooms were not fit for purpose.

However:

Wards for older people with mental health problems

- Most wards areas were safe, clean well equipped, well furnished, well maintained and fit for purpose.
- Staff completed risk assessments for all patients. Staff used restraint and seclusion only after attempts at de-escalation had failed. Staff followed best practice guidance when using seclusion and in relation to physical health monitoring following the use of rapid tranquilisation.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.
- Staff had easy access to clinical information and it was easy for them to maintain high quality clinical records.
  - Staff in most cases followed systems and processes to safely prescribe and administer medicines.

Is the service effective?

Requires improvement 

Our rating of effective went down. We rated it as requires improvement because:

- Staff provided a limited range of treatment and care for patients. The range of treatment and care did not meet national guidance and best practice.
- The ward teams included or had access to a limited range of specialists required to meet the needs of patients on the wards. Managers did not consistently support staff with regular supervision.
- Staff did not record decisions made in patients' best interests appropriately.

However:

- Staff assessed the physical and mental health of all patients on admission. They developed individual care plans which were reviewed regularly through multidisciplinary discussion and updated as needed. Care plans reflected patients' assessed needs, and were personalised, holistic and recovery-oriented although there were inconsistencies in how staff detailed plans to address specific areas of assessed needs.
- Managers provided an induction programme for new staff. Managers ensured non-medical staff received annual appraisals.
- Staff ensured that patients had good access to physical healthcare and supported them to live healthier lives. Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit.
- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and discharged these well. Managers made sure that staff could explain patients' rights to them.
- Staff supported patients to make decisions on their care for themselves. They understood the trust policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly for patients who might have impaired mental capacity.

Is the service caring?

Good 

Our rating of caring stayed the same. We rated it as good because:

Wards for older people with mental health problems

- Staff treated patients with compassion and kindness. They respected patients' privacy and dignity. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.
- Staff made efforts to involve patients in care planning and risk assessment and actively sought their feedback on the quality of care provided. They ensured that patients had easy access to independent advocates.

However:

- Care records did not evidence that staff gave carers information on how to find the carer's assessment.
- Two of the 14 records had a care plan which was contained punitive or insensitive language, however this was not reflective of the majority care plans we reviewed.

Is the service responsive?

Requires improvement 

Our rating of responsive went down. We rated it as requires improvement because:

- The design, layout, and furnishings of the ward did not consistently support patients' treatment, privacy and dignity. Not all patients had their own bedroom with an en-suite bathroom.
- Patients could not make hot drinks and snacks at any time.

However:

- Staff managed beds well. A bed was available when needed and that patients were not moved between wards unless this was for their benefit. Staff made plans to support patients' discharge.
- The service met the needs of all patients – including those with a protected characteristic. Staff helped patients with communication, advocacy and cultural and spiritual support.
- Staff used a full range of rooms and equipment to support treatment and care. The service had quiet areas and rooms where patients could meet with visitors in private. Staff supported patients with activities outside the service and to maintain family relationships.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and wider service.

Is the service well-led?

Inadequate 

Our rating of well-led went down. We rated it as inadequate because:

- Our findings from the other key questions demonstrated that governance processes did not operate effectively at team level to manage performance and risk well. The delivery of high quality care was not assured by the leadership and governance of the service.
- Leaders had not ensured there were structures, processes and systems of accountability for the performance of the service. There was limited evidence that staff discussed and learned from the performance of their service.

Wards for older people with mental health problems

- Leaders had not managed performance well using systems to identify, understand, monitor, and reduce or eliminate risks. They had not ensured risks were dealt with at the appropriate level by escalating concerns to senior leadership teams.
- Managers had not ensured staff understood the trust's vision and values and how they were applied in the work of their team.
- Staff did not know how to use the whistle-blowing process and about the role of the Speak Up Guardian.
- The information collated by the service was not analysed to understand performance and to enable staff to make decisions and improvements.

However:

- Leaders were visible in the service and supported staff to develop their skills and take on more senior roles.
- Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet.
- The service engaged well with patients, staff, equality groups, the public and local organisations to plan and manage appropriate services.
- Leaders encouraged innovation and participation in national accreditation networks.

Areas for improvement

We found areas for improvement that the trust must put right. We also found things that the trust should improve to comply with a minor breach that did not justify regulatory action, to prevent breaching a legal requirement, or to improve service quality.

For more information, see the Areas for improvement section of this report.

Mental health crisis services and health-based places of safety

Inadequate 

Key facts and figures

Sheffield Health and Social Care NHS Foundation Trust provide a range of mental health, learning disability and substance misuse services to the people of Sheffield.

The trust has four teams that make up the crisis services and they operate one health-based place of safety, which can accommodate two people.

As part of this inspection we visited crisis teams and the health-based places of safety based at the Longley Centre and Neverthorpe, including:

- single point of access
- Psychiatric Decisions Unit
- health based place of safety

This inspection took place between 7 and 8 January 2020. Our inspection was announced 24 hours before we visited, to give the teams the opportunity to gain consent from patients for us to observe certain activities.

We previously inspected this service in May and July 2018. We rated the service as requires improvement overall. We rated the safe key question inadequate, with ratings in the effective and caring key questions as good and rated the responsive and well led key questions as requires improvement. At this inspection we found that the service was in breach of some regulations of the Health and Social Care Act (Regulated Activities) regulations, and told the trust to take the following action:

- the trust must ensure that Mental Health Act assessments are carried out in a timely manner.
- the trust must ensure that its crisis 24/7 telephone line is fit for purpose.

Prior to the inspection, we reviewed all the information we held about the service. We also held a range of focus groups with staff and patients in the several months prior to the inspection.

During the inspection visit, the inspection team;

- visited crisis teams at the Longley Centre and Neverthorpe and carried out a tour of the environment at each service
- visited the health-based place of safety and carried out a tour of the environment
- spoke with five patients using the service,
- spoke with two senior managers of the service and one deputy director
- spoke with 10 other staff including; doctors, nurses, healthcare assistants and approved mental health practitioners
- looked at the care and treatment records of 11 patients, including three from the health-based place of safety
- observed a range of meetings including patients' appointments, team huddles and handover meetings
- reviewed a range of policies, procedures and other documents relating to the running of the service.

Mental health crisis services and health-based places of safety

Summary of this service

Our rating of this service went down. We rated it as inadequate because:

- We issued a warning notice under Section 29A of the Health and Social Care Act in relation to this service. This limited the rating in this key question to inadequate.
- The service did not provide safe care and treatment. Staff did not assess and manage risk to patients waiting for services. The service had low rates for mandatory training compliance in specific courses which meant the service did not have enough staff who knew the patients and received basic training to keep people safe from avoidable harm. The service did not always recognise and act on incidents which highlighted a risk to patient safety, such as allowing the admission of young people to shared accommodation with adults in the Psychiatric Decisions Unit. The service did not use serious incidents as a method of learning and act to make the required improvements to care.
- The service did not consistently provide effective care and treatment. Managers did not consistently support staff with regular supervision. Not all staff had received training in the Mental Health Act, and the service did not audit its adherence to the Mental Capacity Act. The service did not have access to all the required specialist staff to meet the needs of patients because there was a lack of availability of Section 12 Doctors which caused delays in assessment.
- The service was not consistently responsive to peoples' needs. The design, layout, and furnishings of the Psychiatric Decisions Unit did not ensure that people using it could maintain their privacy and dignity. Care was not always available due to closures of the health based place of safety.
- The service was not well-led. Our findings from the other key questions demonstrated that governance processes did not operate effectively at team level to manage performance and risk well. Leaders had not ensured there were structures, processes and systems of accountability for the performance of the service and to identify, understand, monitor, and reduce or eliminate risks. Staff did not know the trust's vision and values and how they were applied in the work of their team.

However:

- The physical environment of the health-based places of safety met the requirements of the Mental Health Act Code of Practice.
- Staff from different disciplines worked together as a team to benefit patients.
- Staff treated patients with compassion and kindness. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.
- Leaders had the skills, knowledge and experience to perform their roles and staff felt respected and valued.
- Staff felt able to raise concerns without fear of retribution and knew how to contact the trust's freedom to speak up guardian.
- The services met the needs of all patients who use the service – including those with a protected characteristic. Staff helped patients with communication, advocacy and cultural support.

Is the service safe?

Inadequate 

Our rating of safe stayed the same. We rated it as inadequate because:

Mental health crisis services and health-based places of safety

- We issued a warning notice under Section 29A of the Health and Social Care Act in relation to this service. This limited the rating in this key question to inadequate.
- Staff did not adequately assess and mitigate the risks of young people being cared for in the Psychiatric Decisions Unit. Young people had been cared for by the service in shared facilities with adult patients, sometimes overnight. The service had not ensured that the correct safeguards were in place.
- The service did not have enough staff, who received basic training to keep patients safe from avoidable harm. Not all staff had carried out the necessary mandatory training that the trust said they should. Ten mandatory courses were below the trust target of 80% and eight of those were below 75%. There were often delays to Mental Health Act Assessments, and the health based place of safety had been closed, due to the availability of staff.
- The service did not adequately assess and manage the risks to people waiting for services. Staff did not monitor patients on waiting lists to detect and respond to increases in level of risk.
- The service had not implemented actions and learning, and made the required improvements following serious incidents.
- Patients being cared for in the Psychiatric Decisions Unit experienced delays in the receipt of their own medications.
- The Psychiatric Decisions Unit was not compliant with guidance on eliminating mixed sex accommodation.

However:

- The service used systems and processes to safely prescribe, administer, record and store medicines. Staff working for the mental health crisis teams regularly reviewed the effects of medications on each patient's physical health.
- Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.
- Staff assessed and managed risks to patients using the crisis service and themselves. They responded promptly to sudden deterioration in a patient's health. When necessary, staff working in the mental health crisis teams worked with patients and their families and carers to develop crisis plans. Staff followed good personal safety protocols.
- The physical environment of the health-based places of safety met the requirements of the Mental Health Act Code of Practice.

Is the service effective?

Requires improvement 

Our rating of effective went down. We rated it as requires improvement because:

- The service did not always have access to the full range of specialists required to meet the needs of patients under their care. A lack of availability of Section 12 doctors caused delays to assessments.
- Managers had not supported staff with supervision and opportunities to update and further develop their skills. Data showed that only 30% of all staff working in the service had attended clinical supervision. Although the trust had implemented a new system to record supervision, it was not effective.
- The service did not monitor and audit how well it adhered to the Mental Capacity Act.
- Not all staff had received training in the Mental Health Act, at the time of the inspection, only 56% of staff had received this training.

However

- Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients received the best care they could. The teams had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation,
- Staff working for the mental health crisis teams provided a range of care and treatment interventions that were informed by best practice guidance and suitable for the patient group. They offered physical health advice to patients.
- Managers provided an induction programme for new staff.

Is the service caring?

Good  

Our rating of caring stayed the same. We rated it as good because:

- Staff treated patients with compassion and kindness. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition,
- Staff in the mental health crisis teams involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided. They ensured that patients had easy access to advocates when needed.
- Staff informed and involved families and carers appropriately.

However:

- Several patients told us that they felt the layout of the Psychiatric Decisions Unit didn't help them maintain their privacy and dignity during their stay. This was due to the shared sleeping accommodation and a lack of private space to see visitors.

Is the service responsive?

Requires improvement  

Our rating of responsive stayed the same. We rated it as requires improvement because:

- The health-based place of safety was not always available when needed. The service was sometimes closed due to staff shortages. The service was not always available when this was needed as the beds had been used as an overflow from the acute ward.
- Patients were not always assessed in a timely manner in the health based place of safety due to Section 12 approved doctor availability.
- The design and layout of the Psychiatric Decisions Unit did not ensure the privacy, dignity and comfort of patients. Up to four patients shared a room, sleeping on reclining chair, sometimes overnight. There were no privacy curtains in place, and the doors into the shared rooms contained glass viewing panels which were not obscured.

However:

Mental health crisis services and health-based places of safety

- The mental health crisis service was available 24-hours a day and was easy to contact, including through a dedicated crisis telephone line. The referral criteria for the mental health crisis teams did not exclude any patients who would have benefitted from care.
- The services were able to meet the needs of those with a protected characteristic. Staff helped patients with communication, advocacy and cultural support.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff.

Is the service well-led?

Inadequate 

Our rating of well-led went down. We rated it as inadequate because:

- We issued a warning notice under Section 29A of the Health and Social Care Act in relation to this service. This limited the rating in this key question to inadequate.
- Our findings from the other key questions demonstrated that governance processes did not operate effectively at team level and that performance and risk were not managed well.
- Leaders had failed to implement improvements to mandatory training and clinical supervision rates.
- Leaders had not implemented processes to ensure the management and measurement of risk to patients waiting for treatment.
- Staff did not have access to the vision, values and strategy of the trust and did not have a good understanding of them.
- Leaders and staff had not recognised and acted upon the risks presented by the admission of young people to the Psychiatric Decisions Unit.
- There was not a system in place to audit key areas such as adherence to the Mental Capacity Act and referrals made in relation to safeguarding children.

However:

- Leaders had the skills, knowledge and experience to perform their roles, had a good understanding of the services they managed, and were visible in the service and approachable for patients and staff
- Staff felt able to raise concerns without fear of retribution,
- Staff felt respected and valued and were given feedback when they did their jobs well.
- Teams had access to the information they needed to provide safe and effective care and used that information to good effect.
- Staff had recognised that after a period of change, leaders were responsive to supporting them and a more positive culture had developed.

Outstanding practice

Mental health crisis services and health-based places of safety

Areas for improvement

We found areas for improvement that the trust must put right. We also found things that the trust should improve to comply with a minor breach that did not justify regulatory action, to prevent breaching a legal requirement, or to improve service quality.

For more information, see the Areas for improvement section of this report.

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

Inadequate 

Key facts and figures

Sheffield Health and Social Care Trust provides three acute mental health inpatient wards for adults of working age and one psychiatric intensive care unit. The wards can provide care and treatment for up to 64 patients. Services are provided at the Michael Carlisle Centre and Longley Centre as follows:

The Michael Carlisle Centre;

- Burbage Ward – 19 bed mixed sex ward (Includes five detox beds)
- Stanage Ward – 18 bed mixed sex ward

The Longley Centre;

- Maple Ward – 17 bed mixed sex ward
- Endcliffe psychiatric intensive care unit – 10 bed mixed sex ward

The service was able to admit patients who were detained for treatment under the Mental Health Act (1983), those with deprivation of liberty safeguards in place and informal patients. Most patients were detained under the Mental Health Act at the time our inspection, there were no patients with deprivation of liberty safeguards in place.

The inspection was undertaken between 7 January 2020 and 9 January 2020. The inspection was unannounced. We visited all four wards during this inspection as part of our planned inspection programme. We inspected the following key questions; safe, effective, caring, responsive and well led.

We have carried out four Mental Health Act monitoring visits across the service between July and December 2019. Following each these visits, the trust provided an action statement telling us how they would improve the service and improve adherence to the Mental Health Act and Mental Health Act Code of Practice. Issues identified at these visits included the seclusion rooms not meeting the requirements of the code of practice, issues with patient involvement in care plans and patients being read their rights.

We previously inspected the acute and psychiatric intensive care unit services in June 2018 and the service was rated requires improvement overall. We rated the service as requires improvement in the safe and well led key questions and rated the service as 'good' in the caring, effective, and responsive key questions.

The inspection report was published October 2018 and we found some areas for improvement. We found the trust to be in breach of regulations within the Health and Social Care Act (Regulated Activities) Regulations 2014 for the following reasons:

- The trust must ensure that staffing levels are sufficient to meet the needs of patients, including the use of physical interventions.
- 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.
- The trust must ensure that medicines are stored and managed safely, and emergency equipment is checked in line with the trust policy.
- The trust must ensure that child visitors are safeguarded from potential abuse.

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

- 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.
- 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.

We reviewed each of these breaches of regulation as part of this inspection.

Prior to the inspection, we reviewed all the information we held about the services and requested additional information from the trust. We also held a range of focus groups with staff and patients prior to the inspection.

During this inspection we:

- visited all four ward environments and observed how staff are caring for patients
- reviewed the care and treatment records of patients
- attended three multi-disciplinary review meetings, and three handover meetings.
- interviewed 22 patients, and reviewed feedback from eight comment cards.
- spoke with one carer
- spoke with two senior managers responsible for the services
- interviewed 16 other staff including ward managers, doctors, nurses, occupational therapists, psychologist, pharmacist, health care assistants, chaplaincy, domestic staff and a clinical governance officer and Mental Health Act officer
- completed a review of medicines management on each ward
- reviewed a range of other documents, policies and procedures.

Summary of this service

Our rating of this service went down. We rated it as inadequate because:

- The ward environments were not always safe and clean. Although the wards had enough nurses and doctors, a large proportion were newly qualified. Demand on staff time, acuity and staffing levels remained a constant challenge. The service used agency staff who were not always suitably trained to the requirements of the wards.
- Patients subject to restrictive interventions, such as seclusion or rapid tranquilisation, did not always receive appropriate monitoring or support. Two of the seclusion suites did not meet the requirements of the code of practice.
- Staff did not always manage medicines safely and follow good practice guidance when managing safeguarding concerns.
- Patient care plans were prescriptive and did not show how patients were involved in their care and treatment.
- The service was over occupancy on beds and there was constant pressure on the system when someone required an inpatient bed.
- The trust had not responded effectively to issues and risks which had been identified and governance processes did not always identify issues.

However,

- Staff provided a range of treatments suitable to the needs of the patients and in line with national guidance about best practice. Staff engaged in clinical audit to evaluate the quality of care they provided.
- The ward teams included or had access to the full range of specialists required to meet the needs of patients on the wards. Managers ensured that these staff received training, supervision and appraisal. The ward staff worked well together as a multidisciplinary team and with those outside the ward who would have a role in providing aftercare.
- Staff understood and discharged their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005.
- Staff treated patients with compassion and kindness and understood the individual needs of patients. They actively involved patients, families and carers in care decisions.
- The service had a positive and proactive approach to least restrictive practice.
- Staff assessed and managed risk well. Patients had a comprehensive assessment of their needs and staff completed care plan goals to meet these needs.

Is the service safe?

Inadequate 

Our rating of safe went down. We rated it as inadequate because:

- The wards were not always safe, well equipped, well furnished, well maintained and fit for purpose. Areas of the ward environments were unsafe and not fit for purpose. The seclusion rooms were not fit for purpose and were overlooked by staff areas on one ward, did not contain beds and patients in seclusion had no access to ensuite bathroom facilities. Patients had access to cigarettes and lighters which was against ward policy and there was evidence of smoking in the ward bedroom areas and gardens. This created a significant fire risk. Wards had mixed sex accommodation and we saw reports of sexual safety incidents being made. Some patients reported that they did not feel safe in mixed sex and dormitory accommodation.
- The management of clinical rooms and equipment was poor. One ward had a chair in place of an examination coach, the temperatures of medication fridges and clinical rooms were not always monitored. Not all staff were aware of where ligature cutters were kept and available to staff in an emergency.
- The service had enough nursing staff; however, they did not have the required levels of experience and training to keep patients safe from harm. A large proportion of the qualified nursing staff had under two years' experience. The trust had not put mitigation in place to support newly qualified staff when managing wards with high acuity of patients. Seven of the mandatory training courses did not meet the trust target for staff completion.
- Staff told us that they understood how to protect patients from abuse and staff had training on how to recognise and report abuse but not all staff knew how to apply it. However, we found several incidents where patients had not been protected from harm, this included the use of non-approved restraint techniques on four occasions, a lack of safeguarding care planning for one patient. The service did not monitor and report on the referrals made to safeguard children which meant that the trust lacked oversight of this matter.
- People were at risk because staff did not regularly review the effects of medications on each patient's physical health. Staff did not always monitor and record observations of patient's physical health following rapid tranquilisation, when using Clozapine medication and during detoxification from alcohol and opiates. Staff did not always monitor the physical health of patients with long term health conditions, such as diabetes.

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

- The service did not always manage patient safety incidents well. We found that incidents were not detailed and not always correctly categorised and reported. This reduced the oversight and understanding of risks for the senior leadership team.

Is the service effective?

Requires improvement 

Our rating of effective went down. We rated it as requires improvement because:

- Care plans did not always reflect the patients' assessed needs. They were not personalised, holistic and recovery-oriented. Not all patients had a discharge plan in place.
- Not all patients had valid consent to treatment certificates in place as required by the Mental Health Act.
- Appraisal rates were low on some wards.
- The trust did not audit compliance against the Mental Capacity Act.
- The wards were not therapeutic in nature. Although patients and staff had access to psychology, this was not full time and posts were shared between wards. Patients had access to occupational therapy and activities, but high levels of acuity meant that patients did not always participate.

However:

- Staff assessed the physical and mental health of all patients on admission. They developed care plans, which they reviewed regularly through multidisciplinary discussion and updated as needed.
- Managers provided an induction programme for new staff. Staff reported that they received regular supervision.
- Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. The ward teams had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.
- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice. Managers made sure that staff could explain patients' rights to them.
- Staff supported patients to make decisions on their care for themselves. They understood the provider's policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly for patients who might have impaired mental capacity.

Is the service caring?

Requires improvement 

Our rating of caring went down. We rated it as requires improvement because:

- The service was not prioritising a caring environment. There were incidents where patients' privacy and dignity had not been respected while in seclusion.
- Patients gave mixed feedback about how staff treated them on the wards. Some patients reported staff behaving in an aggressive manner towards them.

However

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

- The staff we observed treated patients with compassion and kindness. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.
- Staff attempted to involve patients in care planning and risk assessment and actively sought their feedback on the quality of care provided. They ensured that patients had easy access to independent advocates.
- Staff informed and involved families and carers appropriately.

Is the service responsive?

Requires improvement 

Our rating of responsive went down. We rated it as requires improvement because:

- There were high bed occupancy levels which reached above 100%. Staff reported that there was pressure on beds within the service. This meant that a bed was not always available when needed. Staff reported concerns about patients being discharged before they were ready due to bed pressures within the service. Two patients were inappropriately placed on the wards and had been there for sustained periods of time.
- The design, layout, and furnishings of the ward/service did not support patients' treatment, privacy and dignity. Most patients had their own bedroom with an en-suite bathroom and could keep their personal belongings safe, however three wards had dormitory style bedrooms with beds which were separated by curtains. There had been several incidents of sexual safety and some patients reported that the mixed sex wards made them feel unsafe.

However,

- The food was of a good quality and patients could make hot drinks and snacks at any time.
- Staff attempted to meet the needs of all patients who used the service – including those with a protected characteristic. Staff helped patients with communication, advocacy and cultural and spiritual support.
- There were a range of rooms which patients could use including lounge, recreation rooms and dining room.

Is the service well-led?

Inadequate 

Our rating of well-led went down. We rated it as inadequate because:

- The service had systems and processes in place to monitor and assess risk. However, there were significant failures in audit systems and processes. Ward level audits were either not effective at identifying these issues or action did not take place to address the issues identified at all, or in a timely way. Incidents were not accurately recorded and reported which reduced the oversight and understanding of senior leaders.
- The trust was not acting or acting in a timely manner in response to risk or when improvements were needed, including in response to the findings at our last inspection. At the last inspection we raised concerns about mandatory training, clinical supervision and the monitoring of rapid tranquilisation. These remained areas of concern at this inspection.
- Leaders were out of touch with the issues effecting front line staff and had not identified and understood the risks and issues described by staff during the inspection. Staff on the inpatient wards were often stressed and under significant

amounts of pressure. A large proportion of the staff were newly qualified and experienced staff had left or were due to leave. The trust had not put mitigation into place to support newly qualified staff and had not taken into account the impact on safety of employing temporary staff who are not trained in the required aspects of safe care and treatment and unable to access and record into patient records systems.

- The trust had not taken timely enough action to respond to the issues of the estates on these inpatient wards. The wards were not fit for purpose and did not allow for dignified care, the trust had not taken action to improve safety in the interim that these services moved to a new location.

However,

- There was variable degree of experience at ward manager level. Some ward managers had the skills, knowledge and experience to perform their roles, had a good understanding of the services they managed. All local leaders were visible in the service and approachable for patients and staff.
- Staff felt able to raise concerns and felt supported by local managers.
- The trust had a vision for what it wanted to achieve and workable plans to turn it into action developed with involvement from staff, patients, and key groups representing the local community.
- Ward staff were supportive of their colleagues and worked together to achieve outcomes for patients.

Outstanding practice

Areas for improvement

We found areas for improvement that the trust must put right. We also found things that the trust should improve to comply with a minor breach that did not justify regulatory action, to prevent breaching a legal requirement, or to improve service quality.

For more information, see the Areas for improvement section of this report.

Community-based mental health services of adults of working age

Requires improvement 

Key facts and figures

Sheffield Health and Social Care NHS Foundation Trust's community services for adults of working age core service comprised five teams. During this inspection we inspected two teams based at two sites. These were the Mental Health Recovery Service South and the Home Treatment Service in their north location.

The community service for adults of working age delivers three broad levels of treatment and support, which are tailored to the individual needs of each patient:

- Enhanced support - intensive and assertive treatment and support for patients who present with a high level of enduring and/or complex mental health needs who would otherwise disengage.
- Active Recovery - treatment and support to patients who present with enduring and/or complex mental health needs.
- Case Management - low level support for service users requiring less frequent contact, for example, patients collecting medication monthly with no other unmet needs or requiring regular but minimal contact to ensure that universal support is effectively meeting their needs.

During this inspection, we inspected the two teams based at two sites. These were the Home Treatment Team North and the Mental Health Recovery Service South.

The Home Treatment Team provides short term intensive mental health support to individuals who would otherwise require admission to hospital.

The Mental Health Recovery Service South provides multi-disciplinary care to people with complex mental health issues. It aims to promote an optimum level of recovery, independence and social inclusion for everyone.

Our inspection was announced (staff knew we were coming) 24 hours prior to the visit to ensure that everyone we needed to talk to was available.

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

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

Before the inspection visit, we reviewed information that we held about the service. During the inspection, the team:

- looked around both buildings
- checked both clinic rooms
- reviewed twelve prescription charts
- spoke with both team managers, four senior practitioners and two senior managers

Community-based mental health services of adults of working age

- spoke with twelve patients and four carers
- interviewed fourteen other staff including clinical administrators, nurses, care coordinators, the flow coordinator, doctors, and support time recovery workers
- attended a handover meeting and a multidisciplinary meeting
- observed two home visits and two patient appointments
- looked in detail at the care and treatment records of twelve patients
- reviewed three comment cards
- looked at policies, procedures and other documents relating to the running of the service.

We last inspected the service in October 2018. At that inspection, we rated the service as good overall with good in all key questions.

Summary of this service

Our rating of this service went down. We rated it as requires improvement because:

- The service did not always provide safe care. Not all clinical premises where patients were seen were safe and clean. Staff did not record the assessment and management of patient risk well. Staff had not completed and kept up to date with mandatory training.
- Staff did not develop holistic, recovery-oriented care plans informed by a comprehensive assessment and in collaboration with families and carers. Not all patients could access a Mental Health Act assessment in a timely manner. Staff had not received training on the Mental Health Act.
- Staff did not always involve patients in care planning and risk assessment and did not seek their feedback on the quality of care provided. Staff did not always involve patients and give them access to their care plans.
- The average waiting time for psychological treatments in the Mental Health Recovery Service South team was more than the Royal College of Psychiatrists recommendations of 18 weeks. The clinic room at the Mental Health Recovery Service South did not have a dignity curtain in place where patients received depot injections. Staff did not always follow up patients who missed appointments.
- Telephone systems were not operating effectively to ensure that people are able to get through to the service they use by telephone easily. The information technology infrastructure did not work well. Governance systems were not always effective in identifying and acting on the concerns and risks within the service. Staff did not feel respected, supported or valued by senior management.

However:

- The service had enough staff, who knew the patients to keep them safe from avoidable harm. Staff responded promptly to sudden deterioration in a patient's health when they were aware of changes. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service.

Community-based mental health services of adults of working age

- Staff ensured that patients had good access to physical healthcare and supported them to live healthier lives. Managers supported staff with appraisals and supervision. Managers provided an induction programme for new staff. Staff from different disciplines worked together as a team to benefit patients. Teams had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.
- Staff treated patients with compassion and kindness. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition. Patients could give feedback on the service and their treatment. Staff supported, informed and involved families or carers.
- The service was easy to access. Staff assessed and treated patients who required urgent care promptly and patients who did not require urgent care did not wait too long to start treatment. The service met the needs of all patients – including those with a protected characteristic. Staff helped patients with communication, advocacy and cultural and spiritual support.
- Leaders had the integrity, skills and abilities to run the service. The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. Staff felt respected, supported and valued within their local teams and by their local leaders. The monthly governance report provided a wide range of oversight and managers were aware of many of the issues we identified.

Is the service safe?

Requires improvement 

Our rating of safe went down. We rated it as requires improvement because:

- Not all clinical premises where patients received care were safe, clean, well equipped, well furnished, well maintained and fit for purpose. Not all actions from fire risk assessments had been completed, the mitigation from some ligature risks was not appropriate and infection control was not managed well across all sites. Equipment at the East Glade Centre showed no evidence of being calibrated, cleaned or maintained regularly.
- The trust had not assessed their arrangements for the provision of emergency medication and equipment to ensure the safety of the people who use the service and did not have clear procedures in place for dealing with medical emergencies. We told the trust that it should ensure this was addressed during our inspection in 2018.
- Staff had not completed and kept up to date with all their mandatory training. This included safeguarding children (Level 2), basic life support, information governance, and mental capacity act (Level 2).
- There was not consistent recording, assessment of patient risk assessment, crisis plans and risk management plans.
- There was no oversight by management of the use of lone working protocols.
- The trust did not have systems and processes in place to monitor and review child safeguarding referrals.

However:

- The service had enough staff, who knew the patients to keep them safe from avoidable harm.
- Staff responded promptly to sudden deterioration in a patient's health when they were aware of changes.
- The service used systems and processes to safely prescribe, administer, record and store medicines. Staff regularly reviewed the effects of medications on each patient's mental and physical health.

Community-based mental health services of adults of working age

- The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

Is the service effective?

Requires improvement 

Our rating of effective went down. We rated it as requires improvement because:

- Staff did not always work with patients and families and carers to develop individual care plans and did not update them as needed. Care plans did not reflect the assessed needs, were not personalised, holistic or recovery-oriented. They did not involve comprehensive assessment of the entirety of patients' needs.
- The teams did not always have access to the full range of specialists required to meet the needs of patients under their care. There were waiting lists for psychologist and occupational therapy and at the time of our inspection, the Home Team Treatment Team did not have any dedicated psychologists.
- Not all patients could access Mental Health Act assessments in a timely manner.
- Staff had not received training in the Mental Health Act 1983 to be able to effectively understand and discharge their roles and responsibilities under the act.
- The service did not monitor and audit how well it adhered to the Mental Capacity Act 2005.

However:

- Staff ensured that patients had good access to physical healthcare and supported them to live healthier lives.
- Staff used recognised rating scales to assess and record severity and outcomes.
- Managers supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.
- Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. The teams had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.
- Staff supported patients to make decisions on their care for themselves. They understood the trust policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly for patients who might have impaired mental capacity.

Is the service caring?

Good 

Our rating of caring stayed the same. We rated it as good because:

- Staff treated patients with compassion and kindness. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.
- Staff ensured that patients had easy access to independent advocates.

Community-based mental health services of adults of working age

- Patients could give feedback on the service and their treatment. Forms, comment boxes and leaflets were available throughout the services.
- Staff made sure patients understood their care and treatment and found ways to communicate with patients who had communication difficulties.
- Staff supported, informed and involved families or carers.

However:

- Staff did not always involve patients in care planning and risk assessment and did not actively seek their feedback on the quality of care provided. Five out of the twelve patients told us they did not know how to feedback on the service
- Staff did not always involve patients and give them access to their care plans. Five out of twelve patients told us they had not been offered a care plan and only 2 patients said they had been offered one.

Is the service responsive?

Good 

Our rating of responsive stayed the same. We rated it as good because:

- The service was easy to access. Its referral criteria did not exclude patients who would have benefitted from care. Staff assessed and treated patients who required urgent care promptly and patients who did not require urgent care did not wait too long to start treatment.
- Staff monitored patients on waiting lists to detect and respond to increases in level of risk.
- The service met the needs of all patients – including those with a protected characteristic. Staff helped patients with communication, advocacy and cultural and spiritual support.

However:

- The average waiting time for psychological treatments in the Mental Health Recovery Service South team was more than the Royal College of Psychiatrists recommendations of 18 weeks.
- The clinic room at the Mental Health Recovery Service South did not have a dignity curtain in place where patients received depot injections.
- The design, layout, and furnishings of treatment rooms did not always support patients' treatment, privacy and dignity.
- Staff did not follow up patients who missed appointments.

Is the service well-led?

Requires improvement 

Our rating of well-led went down. We rated it as requires improvement because:

- The information technology infrastructure did not work well. The telephone system did not work well in Mental Health Recovery Service South. In October 2018 we told the provider to ensure that systems are in place and operating effectively to ensure that people can get through to the service they use by telephone easily. This had not been fully addressed

Community-based mental health services of adults of working age

- Governance systems were not always effective in identifying and acting on the concerns and risks within the service. This included issues with environmental risk assessments, low training compliance in some courses, care plans not reflecting the care delivered to patients, risk assessments and risk management plans not always reviewed regularly and updated, and lack of oversight of the use of lone working protocols.
- Staff did not feel respected, supported or valued by senior management.

However:

- Leaders had the integrity, skills and abilities to run the service. They were visible in the service and supported staff to develop their skills and take on more senior roles. Where there were concerns about risks for the service, local leaders escalated these to senior leaders for action.
- The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. They were aligned to local plans and the wider health economy. Managers made sure staff understood and knew how to apply them.
- Staff felt respected, supported and valued within their local teams and by their local leaders.
- Some systems and processes had ensured that teams had enough staff, staff received appraisals, incidents were managed well and learning from incidents was shared with staff. The monthly governance report provided a wide range of oversight and managers were aware of many of the issues we identified. Managers had begun to take action, but the strategies put in place were newly implemented and not embedded fully.
- The service engaged well with patients, staff, equality groups, the public and local organisations to plan and manage appropriate services. It collaborated with partner organisations to help improve services for patients.
- All staff were committed to continually improving services and had a good understanding of quality improvement methods. Leaders encouraged innovation and participation in research.

Outstanding practice

- The Home Treatment Team North had nurses who worked within the acute wards. Staff reported that by having their own staff working with the patients whilst on the wards, they were more receptive to receiving treatment from the team and staff were able to support discharge from inpatients into the community seamlessly.

Areas for improvement

We found areas for improvement that the trust must put right. We also found things that the trust should improve to comply with a minor breach that did not justify regulatory action, to prevent breaching a legal requirement, or to improve service quality.

For more information, see the Areas for improvement section of this report.

Forensic inpatient or secure wards

Requires improvement 

Key facts and figures

Forest Lodge is a forensic low secure mental health service with two wards, one ward for the assessment of patients and one ward for rehabilitation. This is the only forensic service provided by Sheffield Health and Social Care NHS Trust. The service provides care for male patients over the age of 18. The service has 22 beds overall. The assessment ward has 10 beds and the rehabilitation ward has 12 beds. Patients are admitted to the service from prison or from other secure services. Patients who are admitted have a diagnosis of a severe and enduring mental illness who will usually have committed an offence or be a risk to others and be detained under the Mental Health Act 1983.

We last inspected the service in October 2018. At that inspection, we rated the service as requires improvement overall. We rated safe and well-led as requires improvement and all other key questions; effective, caring and responsive as good. The service was in breach of the following regulations: Regulation 12, safe care and treatment and Regulation 17, good governance.

The rehabilitation ward was last visited by a Mental Health Act reviewer in April 2018 and the assessment ward in October 2018. Although, at this inspection, we reviewed the wards adherence to the Mental Health Act, we did not reference the actions raised by our Mental Health Act reviewer because their visits were outside the scope of this inspection.

At this inspection, we rated the service as requires improvement overall because although, the trust had carried out the actions we told them to following our last inspection, there were new concerns about compliance rates for mandatory training and governance processes.

During this inspection, we inspected the whole core service and all five key questions; safe, effective, caring, responsive, well-led. Our inspection was unannounced (staff did not know we were coming) to enable us to observe routine activity.

Before the inspection visit, we reviewed information that we held about the service. During the visit, the inspection team:

- looked around both wards, including the external areas
- looked at the seclusion room on the assessment ward
- checked both clinic rooms
- reviewed a sample of Mental Health Act paperwork for patients
- reviewed a sample of seclusion records and rapid tranquilisation records for patients
- spoke with both the ward manager and the clinical services manager
- spoke with seven patients and two carers
- interviewed fourteen other staff including doctors, nurses, an occupational therapist, a psychologist, support workers and domestic staff
- attended a handover meeting and a patient group
- looked in detail at the care and treatment records of six patients
- looked at policies, procedures and other documents relating to the running of the service.

Forensic inpatient or secure wards

Summary of this service

Our rating of this service stayed the same. We rated it as requires improvement because:

- Not all risks were documented on the ligature risk audit and not all staff were up-to-date with all their mandatory training. The service did not monitor the numbers of staff on shift that had been trained in immediate life support. Minimum numbers of staff on the night shift on the rehabilitation ward were not always sufficient to ensure safety in an emergency.
- Not all care plans were holistic or recovery orientated. Staff could not always find information easily on the electronic patient record as they recorded things in different places.
- The trust did not collect enough information to monitor the service, like whether medical staff received supervision and appraisal and how many child safeguarding referrals the service made. The service did not monitor and audit adherence to the Mental Capacity Act
- Staff did not always monitor the temperature of the food fridges and freezers in the occupational therapy kitchens and some liquid medicines were not stored in line with good practice.

However:

- The ward environments were safe and clean. The wards had enough nurses and doctors during the day and staff assessed and managed risk well. They minimised the use of restrictive practices, managed medicines safely and followed good practice with respect to safeguarding adults.
- Staff developed treatment plans informed by a comprehensive assessment. They provided a range of interventions suitable to the needs of the patients and in line with national guidance about best practice. Staff engaged in audit to evaluate the care they provided.
- The ward teams included or had access to the full range of specialists required to meet the needs of patients on the wards. Managers ensured that these staff received supervision and appraisal. The ward staff worked well together as a multidisciplinary team and with those outside the ward who would have a role in providing aftercare.
- Staff understood and discharged their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, and understood the individual needs of patients. They actively involved patients and families and carers in care decisions.
- Staff planned and managed discharge well and liaised with services that would provide aftercare. As a result, discharge was rarely delayed for other than a clinical reason.

Is the service safe?

Requires improvement 

Our rating of safe stayed the same. We rated it as requires improvement because:

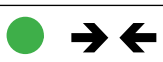
- Not all risks had been documented on the ligature risk audit and it was not always easy for staff to find where some information was stored on the patient electronic record.
- Not all staff were up-to-date with their mandatory training.

- Some liquid medicines were not stored in line with good practice.
- The trust did not monitor the number of child safeguarding referrals made by staff in the service.
- On the rehabilitation ward, there were sometimes just two staff on the ward at night which meant sometimes the nurse had to cover two wards if there was sickness which could not be covered.
- Staff did not always check the fridge and freezer temperatures in the therapy kitchens and there was no evidence they took appropriate action when temperatures fell outside the recommended ranges.

However:

- Both wards were clean, well equipped, well furnished, well maintained and fit for purpose.
- The service had nursing and medical staff, who knew the patients well.
- Staff assessed and managed risks to patients and themselves well and achieved the right balance between maintaining safety and providing the least restrictive environment possible in order to facilitate patients' recovery.
- Staff had the skills required to develop and implement good positive behaviour support plans and followed best practice in anticipating, de-escalating and managing challenging behaviour. As a result, they used restraint and seclusion only after attempts at de-escalation had failed.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.
- The service used systems and processes to safely prescribe and administer medicines. Staff regularly reviewed the effects of medications on each patient's physical health.
- The wards had a good track record on safety. The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

Is the service effective?

Good 

Our rating of effective stayed the same. We rated it as good because:

- Staff assessed the physical and mental health of all patients on admission. They developed individual care plans, which they reviewed regularly through multidisciplinary discussion and updated as needed.
- Staff provided a range of care and treatment interventions suitable for the patient group and consistent with national guidance on best practice. They ensured that patients had good access to physical healthcare and supported patients to live healthier lives.
- Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives.
- The ward teams included or had access to the full range of specialists required to meet the needs of patients on the wards. Managers made sure they had staff with a range of skills needed to provide high quality care. They supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.

Forensic inpatient or secure wards

- Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. The ward teams had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation and engaged with them early on in the patient's admission to plan discharge.
- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and discharged these well. Managers made sure that staff could explain patients' rights to them.
- Staff supported patients to make decisions on their care for themselves. They understood the provider's policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly for patients who might have impaired mental capacity.

However:

- Care plans were not always holistic or recovery-oriented. Four out of the six care plans we reviewed during the inspection lacked detail and were not recovery orientated.
- The service did not monitor and audit adherence to the Mental Capacity Act.
- The service did not monitor the appraisal and supervision rates of medical staff.

Is the service caring?

Good

Our rating of caring stayed the same. We rated it as good because:

- Staff treated patients with compassion and kindness. They respected patients' privacy and dignity. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.
- Staff involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided. They ensured that patients had easy access to independent advocates.
- Staff informed and involved families and carers appropriately.

However:

- Some care records did not contain evidence that patients had been asked if they wanted a copy of their care plan.

Is the service responsive?

Good

Our rating of responsive stayed the same. We rated it as good because:

- Staff planned and managed discharge well. They liaised well with services that would provide aftercare and were assertive in managing care pathways for patients who were making the transition to another inpatient service or to prison. As a result, discharge was rarely delayed for other than clinical reasons.
- The design, layout, and furnishings of the wards supported patients' treatment, privacy and dignity. Each patient had their own bedroom and could keep their personal belongings safe. There were quiet areas for privacy.
- The food was of a good quality and patients could make hot drinks and snacks at any time.

Forensic inpatient or secure wards

- Staff helped patients with communication, advocacy and cultural and spiritual support.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and the wider service.

Is the service well-led?

Requires improvement 

Our rating of well-led stayed the same. We rated it as requires improvement because:

- Some of the trust's governance processes were not robust. The trust did not monitor the number of supervision and appraisal sessions that medical staff participated in. They did not collect monitoring information about when staff made child safeguarding referrals.
- Staff had an inconsistent approach to documenting in patients care records which meant they could not always find information, such as whether patients had been offered a copy of their care plan.
- The trust did not ensure staff monitored therapy fridge temperatures or document all risks on the ligature risk audit.

However:

- Leaders had the skills, knowledge and experience to perform their roles, had a good understanding of the services they managed, and were visible in the service and approachable for patients and staff.
- Staff knew and understood the provider's vision and values and how they were applied in the work of their team.
- Staff felt respected, supported and valued. They reported that the provider promoted equality and diversity in its day-to-day work and in providing opportunities for career progression. They felt able to raise concerns without fear of retribution.
- Our findings from the other key questions demonstrated that performance and risk were managed well. The service had improved in all the areas where we told them they must improve following our last inspection.
- Ward teams had access to the information they needed to provide safe and effective care and used that information to good effect.
- Staff engaged actively in local and national quality improvement activities.

Outstanding practice

Areas for improvement

We found areas for improvement that the trust must put right. We also found things that the trust should improve to comply with a minor breach that did not justify regulatory action, to prevent breaching a legal requirement, or to improve service quality.

For more information, see the Areas for improvement section of this report.

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 the service provider was not meeting. The provider must send CQC a report that says what action it is going to take to meet these requirements.

For more information on things the provider must improve, see the Areas for improvement section above.

Please note: Regulatory action relating to primary medical services and adult social care services we inspected appears in the separate reports on individual services (available on our website www.cqc.org.uk)

This guidance (see goo.gl/Y1dLhz) describes how providers and managers can meet the regulations. These include the fundamental standards – the standards below which care must never fall.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care

This section is primarily information for the provider

Enforcement actions

We took enforcement action because the quality of healthcare required significant improvement.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance

Our inspection team

Brian Cranna, head of hospitals inspection, led this inspection. One executive reviewer and one board level director, an equality and diversity specialist advisor, a safeguarding specialist advisor, a Mental Health Act reviewer and a pharmacy specialist supported our inspection of well-led for the trust overall.

The team included a further ten inspectors and two assistant inspectors, an inspection manager, nine specialist advisors and three experts by experience.

Executive reviewers are senior healthcare managers who support our inspections of the leadership of trusts. Specialist advisers are experts in their field who we do not directly employ. Experts by experience are people who have personal experience of using or caring for people who use health and social care services.