

# Sheffield Health and Social Care NHS Foundation Trust

## Inspection report

Fulwood House  
Old Fulwood Road  
Sheffield  
South Yorkshire  
S10 3TH  
Tel: 01142716310  
www.shsc.nhs.uk

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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 rating for this trust

Requires improvement 

Are services safe?	Requires improvement 
Are services effective?	Good 
Are services caring?	Good 
Are services responsive?	Good 
Are services well-led?	Requires improvement 

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

Sheffield Health and Social Care NHS Foundation Trust provides mental health, learning disability, substance misuse, community rehabilitation, primary care, specialist services and adult social care services.

It serves the 563,000 people of Sheffield. The trust employs 2,700 staff and provides services from 42 community and inpatient sites with more than 150 beds across the city. It has an annual budget of £128 million.

The trust was established in 2003 as Sheffield Care Trust and on 1 July 2008 became Sheffield Health and Social Care NHS Foundation Trust. It works with one clinical commissioning group, Sheffield CCG. The trust has been registered with CQC since 1 April 2010.

The trust provides primary medical services, mental health inpatient and community services and adult social care.

## Overall summary

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

## What this trust does

The trust provides services that are commissioned by:

- NHS England
- Sheffield Clinical Commissioning Group
- Sheffield City Council

The trust provides the following services:

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

The CQC has previously inspected locations registered to Sheffield Health and Social Care NHS Foundation Trust on 26 occasions. These inspections took place between October 2014 and November 2016.

# Summary of findings

## 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.

We inspected eight mental health core services. These were selected due to their previous inspection ratings or our ongoing monitoring identified that an inspection at this time was appropriate to understand the quality of the service provided.

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?*

## What we found

### Overall trust

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

- We rated safe, and well-led as requires improvement and effective, caring and responsive as good.
- We inspected eight core services on this inspection. The overall ratings for two of these core services went down to requires improvement and one core service remained rated as requires improvement. One core service improved to good and one core service improved to outstanding. We rated safe as requires improvement in five of the eight core services and inadequate in one core service we inspected. In rating the trust, we took into account the previous ratings of the core services not inspected this time.
- The trust had recently undertaken a major reconfiguration of services at the same time as restructuring the management. The senior leadership of the trust had not recognised a deterioration in safety of some services during these changes. Also, the reconfiguration of community services had led to some patients having lengthy waits for services and staff were concerned about their ability to provide a safe and effective service. The single point of access was not able to manage or monitor the volume of calls to the service and people requiring a mental health assessment were not always assessed quickly.
- Governance systems and processes had not ensured that staff were aware of or adhered to all policies and procedures or that they always reflected current national guidance and good practice. They had also not ensured that staff received regular clinical supervision. This was significantly lower than the trust target in most core services that we inspected.
- Trust managers did not ensure that learning from the investigation of incidents was shared effectively across the trust.

# Summary of findings

- There were not enough staff to provide safe care in three core services. This resulted in high caseloads in community teams, leave and activities being cancelled and a high use of agency and bank staff. This meant that one core service did not always have enough appropriately trained staff on duty.

However:

- The leadership team were aware of the current challenges and were taking action to address them. The senior leadership team were visible and accessible to staff, patients and carers. Managers at all levels promoted a culture that supported and valued staff. Staff knew about the trust's whistleblowing procedures and who the freedom to speak up guardian was and how to access their support.
- The trust was actively involved in the local integrated care system and accountable care partnership. They had good relationships with stakeholders and partners, including the local clinical commissioning group, police force and local authority.
- Mandatory training and staff appraisal rates were high and had significantly improved since our last inspection. However, this improvement had not been seen in two core services.
- Patients and carers were positive about the care staff provided. Patients felt that staff helped them in a respectful, caring, and compassionate way and helped them to understand and manage their own condition, care, and treatment where appropriate. Carers felt they got the support they needed.
- Staff, patients and carers were involved in planning and developing services and the trust had commissioned an independent review of the recently reconfigured community services in order to identify lessons learned and inform future changes.

## Are services safe?

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

- Nurse call alarms were not in place on the forensic wards and in the learning and recreation hub within the rehabilitation service. Alarms were not easily identifiable or accessible on one of the wards for older people.
- The seclusion room in the forensic wards did not comply with the Mental Health Act Code of Practice. The trust had failed to take action to ensure that the seclusion room was improved and there was no timescale for this work to be carried out.
- Environmental risk assessments, including the identification and mitigation of blind spots, reviewed following serious incidents were not always available for staff on the wards.
- Staff working on the acute ward for adults of working age were required to staff the health based place of safety which had seen a significant increase in usage over the past year. This, combined with a high vacancy rate of qualified nurses in this service, led to the service being unsafe. Sickness absence rates were high at the Mental Health Recovery North Service and Home Treatment Service which had resulted in high staff caseloads at the Mental Health Recovery North Service.
- The trust was frequently reliant on bank and agency staff to maintain safe staffing numbers and there was not always enough staff on duty trained in the use of physical interventions.
- Staff on the acute wards for adults of working age did not undertake the required physical health monitoring following the administration of rapid tranquilisation and nursing and medical reviews were not always completed during seclusion. The latest guidance was not always followed regarding physical health monitoring. Some patients on antipsychotic medication had not received the required level of monitoring or health checks in relation to their prescribed medication.

# Summary of findings

- The single point of access was not able to manage or monitor the volume of calls to the service; the team had no way of knowing how many people had not been able to access the service. People who had accessed the service and required a mental health assessment were not always assessed quickly. There were a number of people awaiting assessment under the Mental Health Act; one person had been waiting for 10 days.
- Processes for safeguarding children visiting Burbage ward were not robust.

However:

- Compliance rates for mandatory training were high and had significantly increased since our last inspection.
- The community mental health services for older people with mental health problems team had good oversight of people on the waiting list and contacted them regularly to manage risks.
- Staff across the services participated in safety huddles to help reduce harm to patients.
- The trust used the “respect” training method which emphasises the use of de-escalation techniques before resorting to physical interventions, such as restraint. The trust had one incident of prone restraint during the reporting period.
- The trust had a policy for managing restrictive interventions and blanket restrictions; staff used a least restrictive practice approach to care. There had been a reduction in the use of blanket restrictions.
- Within community mental health services staff responded quickly when a patient’s health suddenly deteriorated and there was good use of advance decisions and crisis plans.

## Are services effective?

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

- Staff across all services showed a good working knowledge of the Mental Health Act and the Mental Capacity Act and their responsibilities in relation to these. Staff protected the rights of patients who were subject to the Mental Health Act and followed the Mental Health Act Code of Practice.
- The trust had achieved its target of 90 percent for staff appraisal across all areas of the organisation.
- Services had a full range of specialists within the teams including psychiatrists, psychologists, nursing staff, recovery workers, support workers, occupational therapists, social workers, and other allied health professionals.
- Staff provided a range of care and treatment interventions, which were in line with guidance from the National Institute for Health and Care Excellence. They used recognised rating scales to rate severity and outcomes.
- There was innovative use of information technology to support and maintain independence for the patient group within the older people’s community mental health services.
- The wards for people with learning disabilities and autism participated in the STOMP (stop over medicating people with a learning disability) initiative. They worked with professionals within and outside of the trust to work together to reduce the use of anti-psychotic medications for people with learning disabilities.

However:

- The trust’s target for clinical supervision was 66 percent. Compliance was significantly lower than 66 percent in most core services.
- A new appointment system had been introduced in the crisis team which had led to staff not always having the time to read patients’ records prior to the appointment.
- Staff did not always follow the latest national guidance or best practice

# Summary of findings

- In the acute wards for adults of working age and psychiatric intensive care units audits which had been undertaken had not identified issues which we found on inspection.

## Are services caring?

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

- Staff were kind, caring and compassionate and were respectful of patients' personal, social and cultural needs.
- Staff respected patients' privacy, dignity and confidentiality.
- Patients and carers were positive about the care staff provided. Patients felt that staff helped them in a respectful, caring, and compassionate way. They felt they got the support they needed and were helped to understand and manage their own condition, care, and treatment where appropriate. Carers felt they received the help they needed.
- Staff involved patients and carers when appropriate in decisions about their care and treatment and patients had access to advocacy where appropriate.
- Patients and families had been involved in the redesign of services and were involved in designing future developments.
- The trust provided a range of opportunities for patients and carers to provide feedback about the services provided, including the option to feedback through a third party organisation.

However:

- Although we saw involvement of carers and relatives in patients' care and treatment records, the feedback we received from carers and relatives in the wards for people with learning disabilities and autism said they did not feel involved and poor communication was a problem.

## Are services responsive?

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

- The trust managed complaints well; patients knew how to complain and information was available to support the process. Staff investigated and responded to concerns and complaints and made improvements as a result of complaints. Older peoples services had received no complaints and 221 compliments in the last year.
- There was a recovery college which patients could access which gave patients the opportunity to learn about their illness and treatment and to gain recognised qualifications in subjects such as English and maths. Staff supported patients in accessing education and work opportunities and encouraged them to build and maintain relationships with the people who mattered to them.
- The rehabilitation service had a clear recovery focused-pathway that meant patients had a discharge plan at an early stage of their admission. The service had now discharged most patients who had a longer than expected length of stay.
- The trust had a vision to provide care based on personalisation and ensure that people could receive the right care and treatment without going into hospital. Services had been reconfigured in order to support the implementation of this, although some further work was required in community services
- Crisis services were flexible; patients who could not access the service could be seen at home or in the local community.
- Acute wards for adults of working age had a co-ordinated and effective approach to discharge from hospital. The process involved patients, discharge co-ordinators, community mental health staff and families. Average length of stay for patients in this and most other inpatient services had reduced.

# Summary of findings

- Patients were supported during transfers and referrals to other services and were accompanied if this was appropriate when they attended appointments with other services.

However:

- Some staff did not receive feedback concerning the outcome of complaints.
- Waiting times for some routine assessments were lengthy and there was a high rate of people not attending for assessments. There were a high number of calls to the crisis team and the telephone system was not fit for purpose. This meant that some people might have phoned the crisis line and not got through to a member of staff.
- Crisis services were not always delivered in a way that focused on people's needs. Appointments were made for mornings only and a double booking system had been introduced which did not always meet patients' needs.
- The interview rooms at Netherthorpe House lacked privacy. The rooms faced a noisy main road. The main office was also very busy which meant that staff could not always hear a patient on the telephone.
- Bed occupancy in the wards for adults of working age remained consistently high across the service.
- The accessible information standard had not been fulfilled, although there was a plan in place to address this, there was not enough resource to implement the plan effectively.

## Are services well-led?

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

- The senior leadership of the trust had not recognised a deterioration in safety and effectiveness of services during the reconfiguration of services and the implementation of a new management structure.
- Governance systems and processes were not robust. Not all policies and procedures reflected current national guidance and good practice. Where revised policies were in place they were not always adhered to and lessons learned from incidents was not effectively shared across the trust.
- There were not enough staff to provide safe care in three core services. This resulted in high caseloads in community teams. Leave and activities were cancelled on wards for people with learning disabilities and autism. On acute wards for adults of working age and psychiatric intensive care units there was a high use of agency and bank staff which meant that there was not always adequate numbers of staff on shift trained in the use of physical interventions.
- The reconfiguration of community services had led to some patients having lengthy waits for services and staff were concerned about their ability to provide a safe and effective service. The single point of access was not able to manage or monitor the volume of calls to the service and people requiring a mental health assessment were not always assessed quickly.
- Systems and processes in place had not effectively identified that clinical supervision rates across most services were low. Compliance was significantly lower than the trust target.
- The trust had not ensured that building work required to improve seclusion facilities in the forensic wards had been completed.
- Physical healthcare standards were inconsistent across the trust despite a physical healthcare strategy being in place.

However:

- The senior leadership team were visible and accessible to staff, patients and carers. Managers at all levels promoted a culture that supported and valued staff; staff felt supported by their managers and felt they could raise concerns or approach their managers. They knew about the trust's whistleblowing procedures and understood the role of the freedom to speak up guardian. We saw examples of how the guardian had supported staff to raise concerns.



# Summary of findings

- The staff across all services had good knowledge of the trust vision and values and demonstrated those values in their practices.
- The trust had involved staff, patients and carers in the design and development of services and was actively involved in the local integrated care system and accountable care partnership. They had good relationships with stakeholders and partners, including the local clinical commissioning group, police force and local authority.
- The trust leadership team were aware of the concerns raised by staff following the reconfiguration of community services and acknowledged that some lessons had been learned. They were now monitoring the impact of the reconfiguration and had commissioned an independent review which would include staff and patient feedback in the terms of reference.
- Staff had access to support for their own physical and emotional health needs, including access to counselling and physiotherapy. Since the introduction of the physiotherapy service the trust had seen a reduction in staff sickness due to musculoskeletal problems.

## 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. We took all ratings into account in deciding overall ratings. Our decisions on overall ratings also took into account factors including the relative size of services and we used our professional judgement to reach fair and balanced ratings.

## Outstanding practice

We found examples of outstanding practice:

In community mental health services for older people, teams used information technology in a number of innovative ways to maintain independence and reduce confusion for patients with a memory problem.

The team also had therapy dolls for people with dementia who showed symptoms of anxiety or distress and this is now common practice when caring for patients with a diagnosis of dementia. However, the team had recognised that some families find the idea or sight of this distressing to see their relative effectively playing with a doll. Therefore, the team kept journal articles with the dolls so they could use these to educate families on the evidence base around the use of this type of therapy. This helped families who may otherwise have struggled to see their loved one using a therapy doll and explain the reason why the dolls were therapeutic for patient with a diagnosis of dementia and were not being used as a toy.

The wards for older people with mental health problems had developed their own vision and values in collaboration with staff and patients, these values aligned with the trust vision and values.

## Areas for improvement

We found areas for improvement including 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.

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.



# Summary of findings

- The trust must ensure that policies are reviewed and updated to reflect current national guidance and best practice.

In acute wards for adults of working age and psychiatric intensive care units:

- The trust must ensure that staffing levels are sufficient to meet the needs of patients, including the use of physical interventions.
- 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.
- 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.

In Long stay or rehabilitation mental health wards for working age adults:

- The trust must ensure that patients have the necessary physical health monitoring in relation to their prescribed medication in line with current national guidance.

In Forensic wards:

- The trust must ensure that the seclusion room meets the minimum requirements of the Mental Health Act Code of Practice.
- The trust must ensure that nurse call systems are installed in all areas to which patients have access.
- The trust must ensure that policies are disseminated to staff and implemented in a timely manner.

In wards for older people with mental health problems

- The trust must ensure that there are systems and processes in place to routinely check the emergency equipment on each ward.
- The trust must ensure that there is easy access and signage to aid visibility to nurse call systems throughout ward G1.

In wards for people with a learning disability or autism:

- The trust must ensure that staff receive an induction in line with trust policy before they start work on the ward.
- The trust must ensure that there is the minimum number of staff trained in managing aggression and violence on all shifts as outlined in trust policy.
- The trust must ensure that managers review all incidents in a timely manner and provide feedback on lessons learned to staff.

In mental health crisis services and health based places of safety:

- 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.

At trust level:

# Summary of findings

- The trust should continue to monitor and review the impact of the reconfiguration of community services, including the waiting times for patients accessing the single point of access.
- The trust should continue to consider and monitor the impact of the implementation of the digital integrated mental health care programme on operational staff to prevent future risks to the organisation.
- The trust should ensure that that learning from incidents is shared with staff across all services.
- The trust should ensure that the accessible information standard is fully implemented.

In acute wards for adults of working age and psychiatric intensive care units:

- Burbage ward should ensure that its standard operating procedure for the 'green room' is updated to accurately reflect its purpose.
- The trust should consider how it can better support staff and patients to maintain a smoke free environment.
- The trust should ensure that care plans accurately reflect the needs of patients.
- The trust should consider how communication with carers and families can be improved, including how they can provide feedback to the service.
- The trust should ensure that all staff regularly receive clinical supervision and that this is accurately recorded.

In Long stay or rehabilitation mental health wards for working age adults:

- The trust should ensure that the required safety work on the alarm system in the learning and recreation hub is completed.
- The trust should ensure that staff check and dispose of out of date stock medical supplies and clearly identify all prescribed medicines that had reduced expiry dates.
- The trust should develop robust systems and processes to ensure staff always adhere to trust dress code, infection control policies and the service pathway.
- The trust should ensure that it holds all personal information about staff and patients in accordance with data protection rules.

In Forensic wards:

- The trust should ensure that all patients have access to a dedicated area where they are able to practice their religious or spiritual beliefs.
- The trust should ensure that patients are involved with the planning of their care and treatment.
- The trust should consider possible options to allow staff to observe all areas of the ward and eliminate blind spots.
- The trust should consider improving the access for people with mobility issues.
- The trust should ensure that staff are given regular clinical supervision.
- The trust should ensure that discharge planning is carried out, reviewed and recorded in patient care records.

In wards for older people with mental health problems:

- The trust should ensure there are effective processes in place for regularly checking equipment on Dovedale ward.
- The trust should ensure that the path to the garden on Dovedale ward is safe for patients.

# Summary of findings

- The trust should continue to undertake robust risk assessments and management plans in relation to mixed gender accommodation.
- The trust should review how they are using data to identify good practice and drive improvement.
- The trust should ensure that staff receive supervision in line with trust policy.

In wards for people with a learning disability or autism:

- The trust should ensure that they continue to monitor assaults on staff and put measures in place to improve staff safety on the ward.
- The trust should ensure that patient leave and activities are not cancelled due to staffing shortages.
- The trust should ensure that there are routine mechanisms to share lessons learned from trust-wide incidents and complaints with staff in the service.

In community mental health services for adults of working age:

- The trust should ensure that all its sites have assessed their arrangements for the provision of emergency medication and equipment to ensure the safety of the people who use the service and have clear procedures in place for dealing with medical emergencies.
- The trust should ensure that systems are in place and operating effectively to ensure staff are regularly assessing and recording the risks to the health and safety of patients and are doing all that is practicable to mitigate the risks identified.
- The trust should ensure that systems are in place and operating effectively to ensure staff across all its services are compliant with the mandatory training necessary to carry out their role.
- The trust should ensure it reviews the levels of staff sickness within all its teams to ensure caseloads are manageable.
- The trust should ensure that systems are in place and operating effectively to ensure staff are receiving regular clinical supervision.
- The trust should ensure clinic rooms are fit for purpose and allow patients to choose how they receive depot injections.
- The trust should ensure that systems are in place and operating effectively to ensure patients within all its services are fully aware of how to make a complaint.
- The trust should ensure that systems are in place and operating effectively to ensure care records and risk assessments are maintained and updated in collaboration with the patient and that all patients receive a comprehensive mental health assessment when admitted to its services which are recorded in patients' care records.

The provider should ensure that systems are in place and operating effectively to ensure that the people are able to get through to the service they use by telephone easily.

In crisis and health based places of safety:

- The trust should ensure that the waiting list for assessments is continuously monitored.
- The trust should ensure that staff have time to review risk assessments and patient notes before carrying out assessments.
- The trust should ensure that the time that patients wait for assessments is always recorded for the health-based place of safety.

# Summary of findings

In community service for older people with mental health problems:

- The trust should ensure that an effective system for monitoring the cleanliness of the physical health bag used by the teams is maintained and checked on a regular basis.

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

## Action we have taken

We issued requirement notices to the trust. That meant the trust had to send us a report saying what action it would take to meet these requirements.

Our action related to breaches of legal requirements in seven core services.

## 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.

## 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.

“We rated well-led at the trust as requires improvement because:”

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

- The senior leadership of the trust had not recognised a deterioration in safety and effectiveness of services during the reconfiguration of services and the implementation of a new management structure.
- Governance systems and processes were not robust. Not all policies and procedures reflected current national guidance and good practice. Where revised policies were in place they were not always adhered to and lessons learned from incidents were not effectively shared across the trust.
- There were not enough staff to provide safe care in three core services. This resulted in high caseloads in community teams. Leave and activities were cancelled on wards for people with learning disabilities and autism. On acute wards for adults of working age and psychiatric intensive care units there was a high use of agency and bank staff which meant that there was not always adequate numbers of staff on shift trained in the use of physical interventions.
- The reconfiguration of community services had led to some patients having lengthy waits for services and staff were concerned about their ability to provide a safe and effective service. The single point of access was not able to manage or monitor the volume of calls to the service and people requiring a mental health assessment were not always assessed quickly.
- Systems and process in place had not effectively identified that clinical supervision rates across most services were low. Compliance was significantly lower than the trust target.
- The trust had not ensured that building work required to improve seclusion facilities in the forensic wards had been completed.

# Summary of findings

- Physical healthcare standards were inconsistent across the trust despite a physical healthcare strategy being in place.

However:

- The senior leadership team were visible and accessible to staff, patients and carers. Managers at all levels promoted a culture that supported and valued staff; staff felt supported by their managers and felt they could raise concerns or approach their managers. They knew about the trust's whistleblowing procedures and understood the role of the freedom to speak up guardian. We saw examples of how the guardian had supported staff to raise concerns.
- The staff across all services had good knowledge of the trust vision and values and demonstrated those values in their practices.
- The trust had involved staff, patients and carers in the design and development of services and was actively involved in the local integrated care system and accountable care partnership. They had good relationships with stakeholders and partners, including the local clinical commissioning group, police force and local authority.
- The trust leadership team were aware of the concerns raised by staff following the reconfiguration of community services and acknowledged that some lessons had been learned. They were now monitoring the impact of the reconfiguration and had commissioned an independent review which would include staff and patient feedback in the terms of reference.
- Staff had access to support for their own physical and emotional health needs, including access to counselling and physiotherapy. Since the introduction of the physiotherapy service the trust had seen a reduction in staff sickness due to musculoskeletal problems.

## 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
Requires improvement ↔ Oct 2018	Good ↔ Oct 2018	Good ↔ Oct 2018	Good ↔ Oct 2018	Requires improvement ↓ Oct 2018	Requires improvement ↓ Oct 2018

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	Requires improvement ↔ Oct 2018	Good ↔ Oct 2018	Good ↔ Oct 2018	Good ↔ Oct 2018	Requires improvement ↓ Oct 2018	Requires improvement ↓ Oct 2018
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 ↔ Oct 2018	Good ↔ Oct 2018	Good ↔ Oct 2018	Good ↔ Oct 2018	Requires improvement ↓ Oct 2018	Requires improvement ↓ Oct 2018
Wards for older people with mental health problems	Requires improvement ↔ Oct 2018	Good ↔ Oct 2018	Good ↔ Oct 2018	Good ↔ Oct 2018	Good ↔ Oct 2018	Good ↔ Oct 2018
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	Good ↑ Oct 2018	Good ↔ Oct 2018	Good ↔ Oct 2018	Good ↔ Oct 2018	Good ↔ Oct 2018	Good ↔ Oct 2018
Mental health crisis services and health-based places of safety	Inadequate ↓ Oct 2018	Good ↔ Oct 2018	Good ↔ Oct 2018	Requires improvement ↓ Oct 2018	Requires improvement ↔ Oct 2018	Requires improvement ↔ Oct 2018
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 Mar 2017	Good Mar 2017	Good Mar 2017	Good Mar 2017	Good Mar 2017	Good Mar 2017
Substance misuse service	Requires improvement Mar 2017	Good Mar 2017	Good Mar 2017	Outstanding Mar 2017	Good Mar 2017	Good Mar 2017
<b>Overall</b>	Requires improvement ↔ Oct 2018	Good ↔ Oct 2018	Good ↔ Oct 2018	Good ↔ Oct 2018	Requires improvement ↓ Oct 2018	Requires improvement ↓ Oct 2018

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.



# Forensic inpatient/low secure services

Requires improvement  

## Key facts and figures

Forest Lodge is a forensic low secure mental health service which has a ward for assessment and another for rehabilitation of patients. This is the only forensic service provided by Sheffield Health and Social Care NHS Foundation Trust. The service provides care for male patients over the age of 18. Each ward has 11 beds, the assessment ward had the only en-suite bedroom facility. 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 November 2016. At that inspection, we rated the service as good overall. We rated safe as requires improvement and all other key questions; effective, caring, response and well-led as good.

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 and asked a range of other organisations for information.

During the visit, the inspection team:

- looked around both wards, including external areas
- looked at the seclusion room
- checked both clinic rooms and stock
- reviewed T2 or T3 papers for all patients
- reviewed cleaning records
- spoke with the manager of both wards
- interviewed six patients
- interviewed seven staff
- looked at the care records of eight patients
- looked at policies, procedures and other documents relating to the running of the service.

## Summary of service

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

- Staff did not provide information in alternative formats or languages. There were no information leaflets for patients whose first language was not English. Patients were not asked if they wanted to receive information in alternative languages or formats.
- Patients did not have access to nurse call systems. None of the rooms within the service was fitted with nurse call systems and patients were not provided with any form of hand held or personal device. This meant that patients could not summon help if they needed it.

# Forensic inpatient/low secure services

- The service produced a ward booklet for patients, which provided patients with the rules, and restrictions in relation to smoking but staff did not follow these. The implementation of the policy relating to contraband items was delayed as the ward manager was not aware of any updates.

However:

- Since our last inspection, work had been carried out to reduce ligature risks in the service. All the bathrooms in the service had been refitted with anti-ligature fittings. The doors in the service were in the process of being refitted with anti-barricade doors that had anti-ligature fittings.
- Patients were able to access courses through a recovery college, which allowed them to learn about their illness or gain recognised qualifications.
- Staff had a good understanding of the Mental Health Act, Mental Capacity Act and safeguarding.

## Is the service safe?

**Requires improvement** ● → ←

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

- Patients did not have access to nurse call systems. None of the rooms within the service was fitted with nurse call systems and patients were not provided with any form of hand held or personal device. This meant that patients could not summon help if they needed it
- Not all risk assessments were regularly reviewed.
- The seclusion room did not comply with the Mental Health Act code of practice. Although the trust had taken action to address the specific concerns identified during our last inspection, it was still not ideal. The trust have planned renovation work to ensure the seclusion room meets the code of practice with work due to commence in November 2018.

However:

- Staff had access to personal alarms. Staff could call for help with the use of personal infrared transmitter alarms that they carried with them. Staff were required to carry alarms with them at all times.
- The ward layout did not allow staff to see patients at all times. There was no closed-circuit television and no mirrors on the ward to allow staff to observe patients. Managers mitigated this on the assessment ward by ensuring that a nurse was positioned at a junction of 'blind corridors'.

## Is the service effective?

**Good** ● → ←

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

- Admissions were planned and access assessments were carried out prior to patients being admitted to wards.
- The service had access to a range of specialists required to meet the needs of patients. The multi-disciplinary team consisted of doctors, nurses, health care support workers, psychologists and occupational therapists.

# Forensic inpatient/low secure services

- Patients had access to physical healthcare when needed. Staff arranged for patients to see their own preferred specialists or ensured that they were registered with a local service.
- Staff used ratings scales to measure severity and outcomes. Staff used the health of the nation outcome scale and malnutrition universal screening tool.
- Care plans were holistic, personalised and recovery oriented. Care plans outlined the support patients required to meet their mental and physical health needs. Risk factors were identified in care plans and actions included to mitigate risks.
- Staff participated in local audits, including infection control audits, clinic room checks and health and safety audits. Concerns were highlighted and an action plan was drawn up which staff were required to complete.
- Staff explained patient rights under the Mental Health Act. Patients' rights were explained to them when they were admitted to the ward and regularly after that. Patients' rights were explained after there were changes in their care and treatment or if their legal status changed.
- Care records we looked at showed evidence of capacity assessments being completed and consent being sought for treatment. Where patients lacked capacity, we saw evidence of decisions being made in patient's best interest.

However:

- The rate of compliance with clinical supervision for staff was 44%. This was substantially below the trust target of 66%.
- We looked at the care records for eight patients who used the service and found that of these six contained a completed care plan and four had been regularly reviewed. Two of the patient records we looked at did not contain a completed care plan.

## Is the service caring?

Good ● → ←

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

- During the inspection, we observed staff interacting with patients in a way that showed care and understanding.
- The service scored 100% in the Patient Led Assessment of the Care Environment for privacy, dignity and well-being at 100%.

However:

- Although patients attended meetings to discuss care, care plans did not always reflect this. Four of the eight care records we looked at did not show any evidence of patient involvement. The manager and deputy manager told members of the inspection team that the service was to start collaborative care planning the week following our inspection.

## Is the service responsive?

Good ● → ←

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

# Forensic inpatient/low secure services

- Staff were trained in equality and diversity and there was a zero-tolerance approach to discrimination.
- Patients had access to a recovery college which gave them the opportunity to learn about their illness and treatment and to gain recognised qualifications in subjects like English and maths.
- There had been 15 discharges over the last 12 months. There were no delayed discharges from the service during the last 12 months.
- The average length of stay on the ward was in line with the expected stay in this type of service.
- Patients were able to personalise their bedrooms and were able to access outdoor space throughout the day. Patients had access to leisure and physical activities and were able to access food and drinks at all times of the day.
- Patients were given information on how to make a complaint. Patients we spoke to told us they knew how to make a complaint.

However:

- One patient who did not have English as a first language was not provided with information in another language and did not always have important documents translated for him.
- Not all bedrooms had en-suite facilities.
- There were limited activities available to patients at weekends.

## Is the service well-led?

**Requires improvement** ● ↓

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

- Although the service had implemented the recovery college, there were not enough structured or independent activities for patients at weekends.
- Managers had not ensured that staff received sufficient clinical supervision relevant to their roles.
- The implementation of the policy relating to contraband items was delayed as the ward manager was not aware of any updates.

However:

- Leaders had knowledge and experience to carry out their roles. Staff were supported by local managers and felt able to discuss concerns.
- The trust had identified possible concerns in relation to the seclusion room and had included the seclusion room on the risk register.
- The service appeared to be safe and proactive. Steps had been taken to ensure that patients and staff were kept safe on the wards despite the difficult layout.
- Incidents were reported and investigated in line with trust policy. Staff were informed of lessons learned from incidents.

## Areas for improvement

We found areas for improvement in this service. See the Areas for Improvement section above.

# Long stay or rehabilitation mental health wards for working age adults

Good  

## Key facts and figures

Sheffield Health and Social Care NHS Foundation Trust provides three long stay or rehabilitation mental health wards for working age adults based at Forest Close in Sheffield. All three wards provide accommodation for patients who are treated informally or under the Mental Health Act.

The bungalows provide a high dependency rehabilitation service for 30 patients, including adults with a diagnosis of a severe and enduring mental illness usually psychotic in nature and present with on-going difficulties relating to personal and social functioning, distressing symptoms, risk to self or others, vulnerability or co-morbid drug or alcohol issues. The bungalows admit people who require a longer stay in hospital for rehabilitation and require support to reach their optimum level of recovery. The service accepts all adults aged 18 years and over, irrespective of gender, ethnicity, sexuality, culture or physical abilities. There was no upper age limit for the service.

Bungalow one A provides accommodation for 14 male patients.

Bungalow one provides accommodation for eight female patients.

Bungalow two provides accommodation for eight female patients.

Forest Close has been registered with the Care Quality Commission since 2010 to carry out the following regulated activities:

- assessment and treatment for persons detained under the Mental Health Act 1983
- treatment of disease, disorder or injury
- diagnostic and screening procedures.

At the time of our inspection, there were 13 patients admitted to Bungalow one A, five patients admitted to Bungalow one and seven patients admitted to Bungalow two.

We previously carried out a comprehensive inspection of the long stay or rehabilitation mental health wards for working age adults in November 2016. We also inspected the community enhancing recovery team as part of that inspection. We rated the service as 'requires improvement' overall with a rating of 'requires improvement' in safe, effective, and well led, and 'good' in caring and responsive.

We told the service it must make some improvements because it did not meet six regulations. These were:

Regulation 9 Health and Social Care Act (Regulated Activities) Regulations 2014- Person centred care because the service provided limited therapeutic activities and had blanket restrictions for locked doors and cutlery.

Regulation 12 Health and Social Care Act (Regulated Activity) Regulations 2014 -Safe care and treatment because; Bungalow three was not connected to the personal alarm system that staff used to call for help in the other three bungalows on site.

Staff had not followed national guidance for prescribing sodium valproate and had not followed the trust policy following an incident of rapid tranquillisation.

Staff were not consistently undertaking and recording observations pre-administration and post-administration for a patient prescribed clozapine.

# Long stay or rehabilitation mental health wards for working age adults

Regulation 13 HSCA (RA) Regulations 2014 -Safeguarding service users from abuse and improper treatment because;

Three bungalows had blanket restrictions for locked doors and cutlery, which did not take account of the risks of individual patients.

The community enhancing recovery team had not taken appropriate action in relation to safeguarding concerns raised by a patient.

Regulation 15 HSCA (RA) Regulations 2014 -Premises and equipment because;

Bungalow three was unclean and cleaning schedules were not consistently maintained or accurate.

Cleaning schedules for bungalow one were not fully completed.

Regulation 17 Health and Social Care Act (Regulated Activity) Regulations 2014 -Good governance because;

There was not an effective quality assurance process to identify the impact of issues with medication management, recruitment of staff, training provision and the management of risks to staff and service users.

Team managers did not ensure that the service fully complied with the trust supervision policy.

Staff were not able to share information with the Care Quality Commission in a timely manner.

Regulation 18 HSCA (RA) Regulations 2014 -Staffing because;

There were 15 incidents of low staffing reported in a nine-month period and eight stated that one nurse covered more than one unit.

Mandatory training fell below 75% for 13 training elements for the intensive rehabilitation service and 10 training elements for the enhanced recovery service.

We also told the service that it should make a number of other improvements. This included:

Ensuring that staff took action when fridges used to store foods exceeds five degrees

Ensuring that eight patients who had a length of stay exceeding the service specification are discharged to more appropriate environments

Ensuring that staff in the community enhancing recovery team receive training in the Mental Health Act.

Ensuring that staff in the community enhancing recovery team receive training in the Mental Capacity Act and care records reflect considerations of capacity in staff interactions with patients.

Ensuring that patients in the intensive rehabilitation service are allocated a care co-ordinator from an appropriate community based mental health team.

The Mental Health Act Reviewer inspected the service in January 2017 and July 2017, and raised some concerns about staff adherence to the Mental Health Act. This included blanket restrictions because the sensory relaxation area was locked, issues with patient involvement in care plans and timely reviews, limited patient and carer views in their care plans, risk management plans not evident and section 17 leave forms that did not have review dates or old ones struck through.

The service provided the Care Quality Commission with action plans about improvements to address all the concerns.

# Long stay or rehabilitation mental health wards for working age adults

We completed this inspection on the 5 - 7 June 2018. We inspected all three wards and all of the key questions for safe, effective, caring, responsive, and well led. At this inspection, we did not inspect the community enhanced recovery team as part of the long stay/rehabilitation mental health wards for working age adults. However, we reviewed all the improvement actions that the service made as part of this comprehensive inspection in 2018 and we found the service had made improvements.

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 this service and requested information from the trust.

During the inspection visit, the inspection team:

- visited the wards, looked at the quality of the environment and observed how staff were caring for patients
- spoke with seven patients who were using the service and reviewed their comments on one comment card
- spoke with four carers of patients who were using the service
- spoke with the senior managers of the service, and ward managers
- spoke with 26 other staff members including medical staff, qualified nurses and support staff, psychology and occupational and art therapy, and pharmacy staff
- looked at the care and treatment records of 12 patients
- reviewed medication management including the medication administration records of 13 patients
- attended and observed six meetings including ward handovers, multi-disciplinary meetings, and patient activities
- looked at policies, procedures and other documents relating to the running of the service.

## Summary of this service

Our rating of this service improved. We rated it as good because:

- The trust had acted upon our feedback from our previous inspection of this service and there had been overall improvements in the safety of patient care. However, we raised some issues that the service should take to make further improvements.
- The service protected people from avoidable harm and abuse. The wards had taken action to improve the environments, increase qualified nurse staffing, increase mandatory training compliance, and improve patients' physical health care monitoring. Staff took action to reduce blanket restrictions and restrictive practices.
- Patients received effective care and treatment that met their needs. Staff now provided activities and therapies that supported patients' recovery. Staff planned and delivered care and treatment that was in line with current evidence based standards and completed care plans that were person-centred. Staff always involved patients in decisions about their care and treatment and supported them to have good outcomes for their recovery.
- Staff treated patients with dignity and respect and encouraged patients to be partners in their care. Staff were compassionate and had a strong person-centred culture of care. They were committed to maintaining caring and supportive relationships. The feedback from patients, carers and other stakeholders was overall positive about the way staff treat them.



# Long stay or rehabilitation mental health wards for working age adults

- The service organised and delivered care that provided flexibility for staff to meet patients' needs. Staff focused on recovery and discharged patients to alternative placements when they reached their optimum level of recovery. The facilities promoted the comfort, dignity, and privacy of patients and met the needs of all people who used the service.
- The leadership, culture, and governance arrangements promoted the delivery of high quality care across the service. Managers were highly visible and approachable and staff morale was positive. Senior staff were knowledgeable about the service and had a consistent approach to engage staff in performance and service improvements.

However:

- Patients had not received the monitoring required in relation to some prescribed medication.

## Is the service safe?

**Requires improvement**   

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

- The service still needed to complete work on the alarm system in the learning and recreation hub.
- Not all staff adhered to infection control principles stated in the trust dress code policy.
- Staff did not routinely check and dispose of stock medical supplies or identify opening dates of all prescribed medicines that had reduced expiry dates. This meant that dressings were out of date and staff could not identify when some medicines such as liquids and creams should be disposed.
- Some of the policies and guidelines relating to medicines that the staff were using did not refer to the latest national guidance, this meant that staff might not be following the most up to date best practice for safe medicines management.
- Some patients had not had the blood tests required in relation to their prescribed medication in the last six months.

However:

- The service had acted on the recommendations from previous inspections and made overall improvements in the safety of patient care.
- Staff carried out regular checks to make sure that the environments and equipment that staff used were safe, clean, and well maintained. This included the learning and recreation hub, which was a place that patients used daily for activities and therapies.
- Qualified nurse staffing and mandatory training compliance had improved across all three wards. This meant there was enough adequately trained and skilled staff on duty across the service to provide safe care.
- Staff now always monitored patients' physical health conditions. Some staff received extra training about physical health care and they had the equipment they needed to carry out necessary checks.
- Staff assessed and managed risks well. Staff reduced blanket restrictions and used least restrictive interventions where they could. This meant the use of restraint was very low across the service.

## Is the service effective?

**Good**  

# Long stay or rehabilitation mental health wards for working age adults

Our rating of effective improved. We rated it as good because:

- Staff provided effective care and treatment that they planned and delivered in line with current evidence based guidance. The service now provided a recovery college where patients accessed suitable recovery focused activities and therapies.
- Suitably skilled, experienced, and competent staff carried out comprehensive assessments of patients' needs. The service had improved the arrangements for staff supervision that meant staff now had the support they needed to carry out their roles.
- All patients now had an identified care-co-ordinator in the community involved in their care. Staff worked together with patients and community providers to plan discharges effectively.
- Staff protected the rights of patients who were subject to the Mental Health Act and followed the Mental Health Act Code of Practice. Staff always considered patients capacity to make decisions about their care and treatment and provided them with the support they needed.

However:

- The occupational therapy outcome tool was not embedded across all three wards. This meant that not all patients' outcomes were identified and was not in keeping with best practice guidance or the service pathway.
- Some staff said they did not always have enough time to handover all the information they needed to at handover times with night staff. This meant that these handovers could be less effective.

## Is the service caring?

Good ● → ←

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

- All patients and carers that we spoke with were positive about the care staff provided. Patients felt that staff helped them in a respectful, caring, and compassionate way and carers felt they got the support they needed.
- Staff always involved patients and carers where appropriate in decisions regarding their care and treatment. They respected patients' privacy and confidentiality and supported patients to maintain their independence.
- Staff provided a range of opportunities for patient and carer feedback about the service they provided. Patients felt they had enough opportunity to be involved and carers were positive about their level of involvement.

## Is the service responsive?

Good ● → ←

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

- Staff planned and delivered care that was flexible to meet individual patient's preferences and needs. Patients and their families felt informed and welcomed by staff when they were admitted to the service.
- The service had a clear recovery focused-pathway that meant patients had a discharge plan at an early stage of their admission. The service had now discharged most patients who had a longer than expected length of stay.

# Long stay or rehabilitation mental health wards for working age adults

- The facilities and premises were appropriate for the services and supported patients with additional needs. The service was beginning to review how they organised and delivered care so that they could continue to meet the needs of the local population.
- It was easy for patients to raise their concerns and complaints if they wanted to. Staff investigated concerns and complaints as they arose and made improvements because of complaints.

## Is the service well-led?

**Good** ● ↑

Our rating of well-led improved. We rated it as good because:

- Managers regularly monitored that staff adhered to good practice and took action to maintain high quality care. The service now had effective quality assurance, governance processes and all three wards had made the required improvements from previous inspections.
- While the service had no timescale or confirmed plans for completion of the safety work in the learning and recreation hub, managers ensured other safety precautions were in place and included information on the service risk register.
- Managers were highly visible and approachable and staff knew them well. Staff felt valued and supported to do their jobs and demonstrated behaviours towards patients and each other that reflected the trust vision and values.
- Staff shared a collective person-centred and recovery-focused responsibility for the service. Staff engaged with patients and carers in the service to make improvements.
- There was a strong focus on continuous learning and improvement across the service. Managers were involved in reviewing the service and used the trust improvement methodology to make changes. All staff were engaged in working towards achieving accreditation for the service.

However:

- Managers could not provide assurance about the completion of safety work at the learning and recreation hub or that staff always held effective handover meetings.
- Managers did not have robust system or processes that ensured staff always adhered to the dress code and infection control policy, and the service pathway.
- The service displayed personal information about staff and patients in communal areas. It was not clear that everyone had given permission for information sharing in this way.

## Areas for improvement

We found areas for improvement in this service. See the Areas for Improvement section above.

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

Requires improvement  

## 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. The majority of patients were detained under the Mental Health Act at the time our inspection, there were no patients with deprivation of liberty safeguards in place.

We have carried out four Mental Health Act monitoring visits across the service between February 2017 and May 2018. Following 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 availability of information about the Care Quality Commission, eliminating mixed sex accommodation and blanket restrictions.

We previously inspected the acute and psychiatric intensive care unit services between 14 November and 17 November 2016 and the service was rated good overall. The inspection report was published 30 March 2017 and we found some areas for improvement. We rated the service as requires improvement in one key question (safe) and rated the service as 'good' in caring, effective, responsive and well led. Since the last inspection, the trust had addressed the breach of Regulation 12 Safe Care and Treatment.

During this inspection we:

- visited all four ward environments and observed how staff are caring for patients
- reviewed 17 care records, four restraint records, seven rapid tranquillisation records and six seclusion records
- attended one multi-disciplinary review meeting, one handover and safety huddle
- interviewed 18 patients, reviewed feedback from eight comment cards and met with patients at two focus groups
- spoke with eight carers
- interviewed two senior managers responsible for the services
- interviewed 29 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

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

- completed a review of medicines management on each ward, including the review of 40 prescriptions
- reviewed a range of other documents, policies and procedures.

## Summary of this service

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

- A high number of posts for qualified nurses were unfilled and there was a reliance on bank and agency staff to maintain safer staffing numbers. Despite the use of bank and agency staff, there was not always the required number of staff on duty to undertake physical interventions safely.
- Demand on staff time, acuity and staffing levels remained a constant challenge.
- Staff did not always manage medications correctly.
- Staff did not receive regular clinical supervision.
- Patients subject to restrictive interventions, such as seclusion or rapid tranquilisation, did not always receive appropriate monitoring or support.
- Safeguarding procedures for children visiting the service were not always robust.
- The service was not always well led. The service did not effectively use its systems and processes to ensure actions were identified and change was implemented. Audits within the service were not regularly completed or effective at identifying issues.

However:

- The service had a positive and proactive approach to least restrictive practice.
- The service undertook comprehensive assessment of patients' mental and physical health upon admission to hospital. Assessment and management of patient risk was thorough.
- Staff received mandatory training and annual appraisal.
- The trust promoted a culture that supported and valued staff. Staff across the service were committed to delivering the best quality care.
- Patients and carers spoke positively about the service. Engagement by the trust was good.

## Is the service safe?

**Requires improvement** ● → ←

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

- Managers did not ensure environmental risk assessments included the identification and mitigation of blind spots. They did not review these risk assessments following serious incidents nor did they ensure that copies were available on the wards.

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

- Staff did not record and monitor clinic room temperatures, fridge temperatures and emergency equipment. They did not manage patient-only medication effectively nor did staff always record the receipt of controlled drugs in line with trust policy.
- Staff vacancies across this core service were significantly higher for qualified nursing staff in comparison to the wider trust. To maintain safer staffing numbers the trust was reliant on the use of bank and agency staff. Despite use of agency and bank staff, the service did not always have adequate numbers of staff on shift trained in the use of physical interventions.
- The service did not adequately manage smoke free environments. During this inspection we consistently saw evidence that smoking had occurred in outdoor spaces on Burbage, Stanage and Maple wards. We saw patients smoking frequently and staff did not challenge any patients.
- Staff did not undertake the required physical health monitoring following the administration of rapid tranquilisation and nursing and medical reviews were not always completed during seclusion.
- Processes for safeguarding children visiting Burbage ward were not robust.

However:

- Staff and patients had access to alarms in the event of an emergency.
- The wards complied with the guidance on eliminating mixed sex accommodation.
- The programme of work for all seclusions room had been completed.
- Medical staff provided 24-hour cover to the wards.
- The compliance rate for mandatory and statutory training was 86%.
- The care records that we reviewed all contained an accurate and up to date risk assessment.
- All wards had access to a fully equipped and organised clinic rooms. The storage of medication was good.
- The trust prioritised a least restrictive practice approach to care and treatment.
- All wards were clean and well maintained. Both locations scored highly on the patient led assessment of care environments.

## Is the service effective?

Good   

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

- The 17 care records that we reviewed showed that all patients received a comprehensive assessment of their mental and physical health needs when they were admitted to hospital. Care plans were holistic, personalised and recovery-orientated and were reviewed and updated regularly.
- The evidence we gathered supported the conclusion that care and treatment interventions were provided in line with national guidance.
- Multi-disciplinary team working was effective to support positive outcomes for patients.

However:

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

- Staff did not receive regular clinical supervision. Between 1 March 2017 and 28 February 2018, the rate of clinical supervision for staff across the four wards was 36%. This was substantially below the trust target of 66%. The problem of staff records showing low uptake of supervision was a widespread one in the trust.

## Is the service caring?

Good ● → ←

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

- Patients gave positive feedback about the service. Patients told us staff were caring, reassuring and professional.
- Patients were involved in their care and treatment.
- Carers had access to monthly carers meetings.
- Patients were able to give feedback about the service through community meetings and patient questionnaires.

However:

- Not all carers knew how to provide feedback to the service.

## Is the service responsive?

Good ● → ←

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

- The service had a co-ordinated and effective approach to discharge from hospital. This inclusive process involved patients, discharge co-ordinators, community mental health staff and families.
- Length of stay had reduced, readmissions were low and out of area placements were minimal.
- Patients were supported to maintain contact with their local community. The service also had links with local community organisations and charities to support employment, education and the health and wellbeing of patients.
- Patients knew how to complain and information was available to support this process. The service had a low number of complaints.

However:

- Bed occupancy remained consistently high across the service.
- Burbage and Stanage wards did not have dedicated rooms off the ward for children visiting the service.

## Is the service well-led?

Requires improvement ● ↓

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



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

- The inspection identified a number of lapses of governance. These included a failure to properly carry out checks to maintain the safety of the ward environment and emergency equipment, to store medicines safely, to ensure that staff received regular supervision or to undertake health monitoring after giving rapid tranquillisation.
- The service had processes in place to monitor the performance of wards and a programme of audits; however these were not always consistent or effective in implementing change.

However:

- Managers at all levels promoted a culture that supported and valued staff. Staff spoke warmly about their teams and immediate managers.
- The service had a live risk register and this linked into the crisis and emergency care network risk register. Staff vacancies were identified as a current risk.

## Areas for improvement

We found areas for improvement in this service. See the Areas for Improvement section above.

# Community-based mental health services for older people

**Outstanding** ☆ ↑

## Key facts and figures

Sheffield Health and Social Care NHS Foundation Trust provided community mental health services for older people with memory problems and mental health problems across the city.

There were four community mental health teams for older adults at the trust and they consisted of:

- Dementia rapid response team - This team provides assessment, care and treatment to people with a working diagnosis of dementia and who are experiencing some degree of crisis or difficulty.
- Community mental health team for older people – This team offers prompt assessment, treatment and ongoing support for people aged over 65 who have long term severe or enduring mental illness.
- Memory assessment service - This team provided assessment, diagnosis and treatment to service users with memory problems.
- Functional Intensive Community Service (FICS) – This team provides short term intensive home treatment to older people with a functional mental health problem.

At our last inspection in November 2016 we rated the trust's community mental health services for older people as good overall with ratings for key questions as follows:

Safe as requires improvement. This was because:

- The service at Edmund Road did not ensure clinical room stock was routinely checked for expiry dates. Records for these clinical checks were not maintained, accurate or up to date. At this inspection we found that this was fully resolved.
- Staff left keys in external locks of doors within the memory service, and could not give an explanation for why they did this. This was a potential risk to staff and patients. At this inspection we found that this was fully resolved.
- There were inconsistencies in the numbering of rooms in relation to the fire panel and personal alarm activation. This meant responses were slow. At this inspection we found that this was fully resolved.
- Not all staff had completed or were current with their mandatory training. This included key training in basic life support and managing violence and aggression. At this inspection we found that this was fully resolved.

We rated effective, responsive and well Led as good and caring as outstanding. This led to an overall rating of good for this core service. We re-inspected all five key questions.

The inspection was short term announced (staff knew we were coming) one working day before our visits to ensure everyone we needed to talk to was available. We inspected two of the four community teams, the dementia rapid response team and the community mental health team.

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

During the inspection visit, the inspection team:

- interviewed the senior operational manager
- interviewed both the team managers.
- spoke to nine other staff including nurses, occupational therapists and senior nurse practitioner

# Community-based mental health services for older people

- interviewed three consultant psychiatrists and a junior doctor
- observed five home visits to patients
- spoke to four patients and five carers both in person and on the telephone
- toured the building and carried out a check of the clinic room
- observed one multidisciplinary team meeting
- observed one team meeting
- looked at eleven patient care records
- observed the work of the triage team for one hour.

## Summary of this service

Our rating of this service went up. We rated it as outstanding because:

- The environment was clean, tidy and well maintained. The building was bright and welcoming and there was clear signage for visitors.
- Staff completed risk assessments for all patients and they were detailed and addressed risk and how to manage it appropriately.
- Mandatory training for the team was all above 80%.
- Staff received meaningful supervision and appraisal on a regular basis.
- Assessments were comprehensive and completed in a timely way. Service users were seen quickly from being referred.
- Staff were kind and caring towards service users and carers. Staff were highly praised by service users and they were observed to be empathic and sensitive.
- Staff had reached out to harder to reach communities by attending groups for the South East Asian community, the Chinese community and the Somalian community. Here they spoke about mental health and the support that their team could offer.
- There was a strong emphasis on maintaining patients' links with the local community with lots of groups for older people and an active service user group who made decisions and gave feedback on proposed changes to the service.
- There were strong links with external services such as care homes and GPs. Staff met regularly to discuss service users with complex needs.
- The senior team had good oversight of staff performance including sickness, supervision and appraisal. Staff feedback about the support they received from managers was universally positive.

## Is the service safe?

**Good** ● ↑

Our rating of safe improved. We rated it as good because:

# Community-based mental health services for older people

- The building was bright and welcoming as well as clean and well maintained.
- The clinic room was clean and tidy and all medication was stored correctly. Equipment was checked and cleaned and we saw evidence that this was done regularly.
- There was adequate levels of staff and low levels of sickness and vacancies.
- Caseloads were manageable for staff. This was overseen by managers using a caseload management tool to rate depending on the complexities of each patient.
- There were no waiting lists for either team.
- The team had good oversight of people on the waiting list and contacted them regularly to manage risks.
- Mandatory training was all above 80%.
- The team had a good understanding of safeguarding and knew how and when to report.
- There had been no recent serious incidents but staff were able to talk through previous incidents that had happened and how learning was communicated following them.

However:

- There was a physical health bag which staff took out on visits. It contained equipment such as blood pressure machine, thermometer and weighing scales. The records relating to the cleaning of the physical health bag showed it had not been cleaned since January 2018. This was cleaned whilst we were on site.

## Is the service effective?

Good   

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

- Assessments of patients' needs were comprehensive and well documented.
- All patients had a care plan in place. These were up to date, personalised and recovery orientated.
- The teams used information technology in a number of innovative ways to maintain independence and reduce confusion for patients with a memory problem. This included the use of "just checking," an activity monitoring system that allows people to remain in their own homes for longer by showing the team their capabilities on a day to day basis and can identify if sequencing is maintained in day to day activities. At the time of our inspection, a "buddy system" was used for a patient who liked to walk out but sometimes got lost. This was a GPS tracking device which allowed a family member to monitor where the patient walked to without having to follow them or even stop them going out. Photographic diaries were used for patients who had trouble remembering who family members were.
- Staff supervision was taking place consistently. All teams recorded staff supervision figures. The senior management team had good oversight of staff supervision figures.
- Staff were up to date with annual appraisals. At the time of our inspection the trust were in their appraisal window but we could see how this was documented and monitored.
- Staff had a good understanding of the Mental Health Act and the Mental Capacity Act relevant for their role. Training was at 100% and 93% respectively.

# Community-based mental health services for older people

## Is the service caring?

**Outstanding** ☆ → ←

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

- Feedback from all people that used the hospital including patients and carers was universally positive. They told us that staff go the extra mile to ensure patients receive person centred care.
- Staff were continually respectful and positive in their approach to patients. There was a strong visible person centred culture and the relationships between the staff and patients were strong, caring and supportive.
- The personal, social and cultural needs of patients were always taken into account and care was tailored to support and encourage those needs.
- Patients were true partners in their care. They were fully involved in decisions about their own care with staff recording how involved they were or could be in each part of their care plan.
- Patients could attend the patient group and were able to voice their opinions and give feedback on proposed changes at the service.

## Is the service responsive?

**Outstanding** ☆ ↑

Our rating of responsive improved. We rated it as outstanding because:

- The service was tailored to meet the needs of the patient group. Patients were actively involved in their care and the staff were flexible to ensure those needs were met.
- Patient choice was kept at the forefront of the service.
- The in depth assessment process that could be staggered over a few visits to suit the needs of patients meant that patients were given time to speak with the staff and ask questions.
- Staff ensured patients were not only encouraged but supported to be a part of their local community despite their diagnosis.
- There were no waiting lists for the service.
- The service had not received any complaints in the last 12 months. There was a system for handling complaints which staff were aware of.
- The facilities were suitable for people requiring disabled access. There was a slope to enter the building, accessible toilets and there was a stair lift down to the bottom floor.
- There was access to interpreters and/or signers when required and leaflets and posters could be translated into other languages if needed.
- Staff had reached out to harder to reach communities by attending groups for the South East Asian community, the Chinese community and the Somalian community. Here they spoke about mental health and the support that their team could offer.

# Community-based mental health services for older people

## Is the service well-led?

Good   

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

- The staff at the community teams for older people were clearly putting into practice the vision and values of the trust.
- The morale of all staff was high and the team were committed to providing good quality care to all patients. It was clear that staff felt part of a productive team and had support from the senior team to do their job to a high standard.
- Staff sickness was well managed by managers within the teams. Managers followed the staff sickness policy which was effective in reducing sickness rates.
- Staff all reported they were able to voice their opinion and were listened to felt empowered within their role and were encouraged to develop their skills and knowledge via specialist training.
- The teams had students from different disciplines joining them on a regular basis and feedback from students was positive.
- Team managers were experienced and knew the service well, they were open to change and staff gave only positive feedback about them.

## Outstanding practice

- The teams used information technology in a number of innovative ways to maintain independence and reduce confusion for patients with a memory problem. This included the use of “just checking,” an activity monitoring system that allows people to remain in their own homes for longer by showing the team their capabilities on a day to day basis and where extra support was needed. They also had an advanced version of the system that allowed them to attach sensors to items such as the fridge, kettle and tap to show if sequencing was maintained in day to day activities. At the time of our inspection, for a patient who liked to walk out but sometimes got lost the team also had a “buddy system” device. This was effectively a GPS tracking device which allowed a family member to monitor where the patient walked to without having to follow them or even stop them going out. Lastly for patients who had trouble remembering who family members were the team used a photographic diary where they could work with the patient and their families and record who the family member was and things they liked to do so when the page was turned it played the memories back. This not only helped to reduce agitation and confusion but it gave the families a nice activity to do together with the person with dementia.
- The team also had therapy dolls for people with dementia who showed symptoms of anxiety or distress this is now common practice when caring for patients with a diagnosis of dementia. However, the team had recognised that some families find the idea or sight of this distressing to see their relative effectively playing with a doll. Therefore, the team kept journal articles with the dolls so they could use these to educate families on the evidence base around the use of this type of therapy. This allowed staff to work with families to break down barriers to this type of intervention for the greater good of the patient. This helped families who may have otherwise struggled to see their loved one using a therapy doll and explain the reason why the dolls were therapeutic for patients with a diagnosis of dementia and were not being used as a toy.

## Areas for improvement

We found one area for improvement. See the Areas for Improvement section above.

# Mental health crisis services and health-based places of safety

Requires improvement   

## Key facts and figures

Sheffield Health and Social Care NHS Foundation Trust provided a crisis and out of hours service to people living in Sheffield. The single point of access dovetailed with the out of hours service, creating a single point of referral 24 hours a day, seven days a week to people who are between 18 and 65 years of age, who are registered with a GP practice in the city of Sheffield.

Single point of access and emotional wellbeing carried out triage, crisis assessment, routine assessments and brief interventions. Staff were co-located with out of hour's team and the citywide approved mental health practitioner service. They also work closely with the home treatment service and liaison psychiatry service.

Referrals were accepted from GPs or other clinical teams within Sheffield Health and Social Care NHS Foundation Trust. Referrals may also be accepted from other health or social care professionals, housing, voluntary sector, relatives and by self-referral.

This inspection was unannounced, which meant that staff did not know we were coming to inspect the service. Before the inspection visit, we reviewed information that we held about the services.

During this inspection the inspection team:

- looked at the quality of the physical environment at the team base and health based places of safety
- observed how staff were interacting and caring for patients
- spoke with seven patients and three carers
- spoke with the managers for each of the teams
- spoke with 14 staff members including doctors, nurses, psychologists, social workers and support workers
- attended and observed one multidisciplinary meeting.
- observed three initial assessments.
- looked at 20 care records
- reviewed mental health documentation.
- looked at a range of policies, procedures and other documents relating to the running of the service.

We last undertook a comprehensive inspection of the Crisis and Health Based Place of Safety in November 2016. At that inspection, we rated the services overall as requires improvement. We rated the key questions safe and well led as requires improvement and effective, caring and responsive as good.

## Summary of this service

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

- Staff were struggling to deal with the volume of calls to the crisis service. The team had no way of knowing how many people had not been able to access the service. The service had a significant waiting list and the telephone system was not fit for purpose in that people could not always get through.

# Mental health crisis services and health-based places of safety

- There was a significant delay in patients receiving a timely Mental Health Act assessment. At the time of the inspection there were 13 people awaiting a Mental Health Act assessment.
- Staff were not always given the time to fully review triage/risk information before providing care, treatment, and support. Patients had to repeat information or answer the same questions during assessments.
- Staff were providing a range of care and treatment interventions but this was not always documented in a written care plan.
- Multidisciplinary team meetings at Netherthorpe House took place regularly but their effectiveness was limited. There was no clear focus and meetings were held at the same time that assessment appointments took place, which meant that some staff could not attend.
- There was mixed staff morale across the teams. Some members of the single point of access/emotional wellbeing team did not feel valued or supported by the trust.

However:

- The trust had responded to the last inspection and made improvements to the health-based place of safety. Staff were now completing risk assessments, and carrying out physical health checks and observations as required. There were monthly audits of the activity in the health-based place of safety. Joint liaison meetings were taking place with representatives for all agencies.
- Although some staff did not feel valued, senior managers were aware of the issues in relation to the single point of access/emotional wellbeing service. Issues regarding the service were included on the risk register. Weekly meetings were taking place and plans for a crisis hub were being developed.
- Staff carried out an initial triage for all new referrals. Any emergency referrals were offered an assessment within four hours and any routine assessments were allocated to the emotional well-being service. All records reviewed contained a risk assessment.
- Staff were up to date with mandatory training and were receiving regular supervision and appraisals.
- The issues with the telephone system had been escalated and the trust had put some mitigation in place to support the system.

## Is the service safe?

**Inadequate** ● ↓

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

- Staff were not able to deal with the volume of calls to the crisis service effectively. The team were unable to establish how many people had not been able to access the service.
- The service was receiving a high number of people detained under Section 136 of the Mental Health Act. Staff from Maple ward were under increased pressure to deal with the volume of patients in the health-based place of safety.
- At the time of inspection there were 13 people awaiting a Mental Health Act assessment. One patient had been waiting for ten days. Incidents showed that there had been 16 incidents March 2018 – June 2018 of delayed Mental Health Act assessments.

However:



# Mental health crisis services and health-based places of safety

- All clinical environments were clean, tidy, and well maintained. Detailed environmental risk assessments were in place and staff adhered to infection control.
- The trust had recognised the pressures on the health based place of safety and were recruiting additional staff. The trust had also made attempts to mitigate the pressures associated with the telephone system.
- The single point of access was competing triage on the day of referral and any urgent referrals were seen within four hours.

## Is the service effective?

Good ● → ←

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

- There was a full range of clinical disciplines within the teams. Patients had access to a doctor, psychologists, social worker, and support worker to assist with housing and employment and an occupational therapist. Staff were experienced and qualified.
- Staff completed a comprehensive mental health assessment of each patient. There were good links with GPs to ensure physical healthcare needs were being met.
- There was effective handovers between the teams working within the crisis service. Staff were receiving regular management and clinical supervision and appraisals.
- Staff had a good understanding of the Mental Health Act and Mental Capacity Act and knew how to apply this in daily practice. Support from the trust in relation to these was available.

However,

- Staff were not recording written care plans. Staff assessed patients' needs and delivered care interventions but, in none of the ten records we reviewed, had staff made a record of these as part of a written care plan on the electronic system. Also, staff had failed to complete some of the Section 136 records from the health based place of safety.
- The service had introduced a new system for booking appointments, which meant that staff did not always have time to read patients' triage assessment. This meant that staff did not always know the patient's background and full risk assessment when completing an assessment.

## Is the service caring?

Good ● → ←

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

- Feedback from patients and their carers was positive. They told us that staff treated them with dignity, respect, and kindness. Staff were consistently caring and supportive towards patients. All patient and carers we spoke to were complimentary of the services.
- Patients were involved in assessments and in planning their care and treatment and had access to advocacy.
- Patients and families had been involved in the design of the service and were involved in designing future developments.

# Mental health crisis services and health-based places of safety

## Is the service responsive?

**Requires improvement** ● ↓

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

- There was a high rate of people not attending for assessments. The number of calls to the service was high and the telephone system was not fit for purpose. The service did not know how many people had been unable to get through.
- The Emotional Wellbeing Service, providing routine scheduled care had a waiting list and some patients were waiting seven to nine weeks for a routine assessment. The clinical commissioning group had set a target of three weeks for non-urgent assessments.
- Services were not always delivered in a flexible way. All assessment appointment times were in the morning and a double-booking system had been introduced which did not always meet patients' needs. Patients sometimes had to wait to be seen if both patients arrived at the same time.
- The interview rooms at Netherthorpe House faced a noisy main road and the noise sometimes made assessments difficult to hear. The main office was also very busy which meant that staff could not always hear a patient on the telephone.

However:

- There was some flexibility in that patients could be seen at home or in the community when they could not access services.
- Patients knew how to make complaints and staff supported patients who had issues or concerns with the service to raise these.

## Is the service well-led?

**Requires improvement** ● → ←

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

- Significant problems were identified with the service which put people at risk. The reconfiguration of the service had contributed to this situation.
- Staff did not feel positive about the service they were offering and felt at times it was unsafe. Staff felt that if they raised concerns they were not always listened to by senior managers.
- The trust was unable to monitor the number of people who had not been able to access the single point of access. Senior managers were in the process of reviewing the telephone system.

However:

- Leaders had the skills, knowledge, and experience to perform their roles. Although staff morale was low the senior operational manager at Netherthorpe House understood the challenges faced by staff. The team was new and the managers were aware of the issues with waiting lists, telephone line and staff morale. Leaders were visible in the service.

# Mental health crisis services and health-based places of safety

- The trust had a vision for a crisis hub, which would locate the crisis, and health based place of safety together on the same site. A working group had responsibility for ensuring these developments were in place for the autumn 2018.

## Areas for improvement

We found areas for improvement in this service. See the Areas for Improvement section above.

# Wards for people with a learning disability or autism

Good   

## Key facts and figures

Firshill Rise assessment and treatment service is a mental health ward for adults with a learning disability or autism provided by Sheffield Health and Social Care NHS Foundation Trust. The service is for male and female patients over the age of 18. The ward has seven bedrooms and one self-contained flat. Patients are admitted to the service because they have severe mental health problems and/or because they are presenting challenging behavior, which cannot be supported in the community or in mainstream adult inpatient mental health services.

We last inspected wards for people with a learning disability or autism in November 2016. At that inspection, we rated the service as good overall. We rated all key questions; safe, effective, caring, response and well-led as good.

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 and asked a range of other organisations for information.

During the visit, the inspection team:

- visited the ward, looked at the quality of the environment and observed how staff were caring for patients
- spoke with three patients
- spoke with four carers
- looked at six care and treatment records
- attended and observed three meetings including one handover, one governance meeting, and one discharge planning meeting
- spoke with 10 members of staff including the ward manager, a consultant psychiatrist, registered nurses, support workers, occupational therapists and psychologists
- spoke with staff who provided independent mental health advocacy for patients
- looked at seven medication records
- looked at policies, procedures and other documents relating to the running of the service.

## Summary of this service

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

- Staff participated and worked with outside agencies to promote and deliver the Stop Over Medicating People with a Learning Disability (STOMP) initiative. This is aimed at reducing the use of anti-psychotic medication for people with learning disabilities.

# Wards for people with a learning disability or autism

- Since our last inspection, the trust had undertaken work to build seclusion room and a new clinic room to improve patient care and experience. The service also met the King's Fund 'enhancing the healing environment'. The trust had implemented safety huddles within staff handover meetings to try to improve staff and patient safety and managers had introduced other measures to try to improve safety on the ward.
- Staff understood their responsibilities and had sound understanding of the Mental Health Act, Mental Capacity Act and safeguarding. Patients had access to a full range of multi-disciplinary professions and care plans were comprehensive and recovery oriented.
- All of the patient care and treatment records that we reviewed contained comprehensive assessments and holistic recovery oriented care plans.
- Observations showed positive interactions between patients and staff. Feedback from patients was positive about how staff supported them. Patients felt involved in their care and treatment and all patient care and treatment records contained comprehensive and holistic care plans. Patients left positive discharge messages for others.
- Staff understood the trust's visions and values and how they applied to their work.

However:

- Managers did not always have effective oversight of the service. At the time of our inspection, there were 71 incidents which required manager review. This is something we told the trust they should address following our last comprehensive inspection.
- Not all staff had received an induction or completed all of their required training before starting work on shift. Three training courses fell below 75% compliance and only 56% of staff were receiving clinical supervision in line with trust policy.
- Shortages of staff had an adverse impact on the quality of care. Support staff could not always attend multi-disciplinary meetings or be actively involved in other reviews of patients' care and treatment. This problem was compounded by a high rate of sickness.
- There were deficits in the induction and training of staff. Some staff had not completed induction or mandatory training before working shifts on the ward. There were thirteen shifts over a three-month period that did not include the minimum required number of staff who had completed training in managing violence and aggression and restraint. This posed a particular risk because the service was standalone without surrounding staff who could assist in an emergency.
- Carers did not always feel that staff listened to them and not all staff received feedback on the outcome of complaints.

## Is the service safe?

**Requires improvement** ● ↓

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

- Although managers had reduced the number of outstanding incidents waiting for manager review, there was still 71 incidents waiting for manager review. There were no mechanisms in place to enable managers to share lessons learned with staff about non-patient incidents or about incidents in the wider trust.

# Wards for people with a learning disability or autism

- Managers had not ensured that all new staff, including regular and agency staff, had completed an induction and that regular staff had completed all of the mandatory training requirements prior to starting work on the ward. Three mandatory training courses fell below 75% compliance. These were: adult basic life support at 73%, information governance at 69% and Mental Health Act at 67%. Staff had booked onto the required training courses.
- The ward had been operating with higher levels of agency staff than in the past and some regular staff thought they were not always familiar with the patients. Some staff and visitors did not feel safe on the ward because of the high number of assaults on staff.
- Staff sometimes had to cancel activities and patients' leave because there were not enough staff to facilitate them when staff had to be deployed to observe patients whose levels of observation had increased.

However:

- Since our last inspection the trust had created a new clinic room to store patients' medication. It had an examination couch and the required equipment to undertake physical health monitoring. The trust had also built a seclusion room at the service which met the requirements of the Mental Health Act code of practice.
- Staff participated in safety huddles at staff handover meetings aimed at improving staff and patient safety. Staff discussed patient risks frequently in handovers. They monitored patient incidents closely and had put behaviour support plans in place. Staff had not used any prone restraint with patients. Managers had introduced measures aimed at reducing patient assaults on staff and helping them to feel safer.
- Staff demonstrated sound understanding and knowledge of safeguarding and their responsibilities.

## Is the service effective?

Good   

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

- Staff understood their responsibilities under the Mental Capacity Act and the trust carried out audits to identify good practice and areas for improvement. Despite a low training rate at 68%, staff that we interviewed had a working knowledge of the Mental Health Act and managers carried out monthly audits of the application of the Mental Health Act.
- All of the patient care and treatment records reviewed contained comprehensive assessments and holistic recovery oriented care plans.
- Patients had access to a full range of multi-disciplinary professionals.
- Ninety three percent of staff received an appraisal of their performance.
- Teams held shift handovers to share pertinent information about patients to staff starting their shifts.

However:

- Only 56% of staff received regular clinical supervision in line with trust policy. Managers reported that staffing shortages had resulted in a need to prioritise covering the ward with staff and that this had meant supervision could not be carried out regularly.
- Due to difficulties in covering the service, support staff were not always able to attend multi-disciplinary meetings to review patients' care and treatment. This meant that they could not be as involved in decision making and they had raised this with the manager of the service.

# Wards for people with a learning disability or autism

- Not all staff had access to regular team meetings and not all new staff had completed a full induction before starting to work on the ward.

## Is the service caring?

**Good** ● → ←

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

- Observations of staff interactions showed that staff treated patients with respect and were interested in patients' well-being. Patients gave positive feedback about staff. They told us staff treated them well.
- Staff involved patients in care planning. They provided patients with documents in formats that they could understand including in different languages and easy read formats.
- Patients had access to regular community meetings and were involved in the interview process for recruitment of new staff.
- The service scored higher than the England average in the Patient Led Assessment of the Care Environment 2017 for privacy, dignity and well-being at 93.8%.

However:

- Although we saw evidence of involvement of carers and relatives in patients' care and treatment records, the feedback we received from carers and relatives was less positive. Some carers and relatives told us of not feeling involved and of gaps in communication from staff.

## Is the service responsive?

**Good** ● → ←

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

- Firshell Rise met the King's Fund 'enhancing the healing environment' standards. The service was purpose built and had an independent living flat for one patient.
- The service had worked to reduce the average length of stay for patients. In 2017, the average length of stay had reduced to 85 days from 122 in the previous year.
- Staff planned patients discharge as part of the assessment process. They also encouraged patients to leave positive discharge messages on a 'tree of hope' for current and future patients at the service.
- Staff included staff from community teams to attend and participate in discharge planning meetings.

However:

- The service did not respond promptly when patients reported that a communal television was not working. This was reported by patients and two months later, at the time of our inspection, this was still not working.
- Not all patients had access to a kitchen where they could make hot drinks and snacks for themselves.
- Some carers told us they did not feel listened to and did not always feel involved in the care of their loved one.
- Not all staff received feedback concerning the outcome of complaints.

# Wards for people with a learning disability or autism

## Is the service well-led?

Good   

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

- Staff understood how the trust's vision and values applied to their roles and the service in practice.
- Staff participated in the STOMP (stop over medicating people with a learning disability) initiative. They worked with professionals within and outside of the trust to work together to reduce the use of anti-psychotic medications for people with learning disabilities.
- The service had implemented developments from quality improvement projects including safety huddles and structured discussions to support staff and increase safety for staff and patients on the ward.

However:

- Shortages of staff had impacted upon the quality of care with a high reliance on agency staff. Managers did not always ensure systems operated effectively to ensure staff were inducted and trained before starting work on the ward. Not all staff received clinical supervision in line with trust policy.
- Systems and processes around managing incidents were not effective and did not ensure that all incidents were reviewed by managers in a timely way. This was something we told the provider they should address following our last inspection in November 2016. Despite improvements, there was still 71 incidents waiting for review at the time of this inspection.
- Sickness absence rates for the service were high. Managers reported incidents resulting in staff assaults and stress related factors impacted upon staff sickness.

## Outstanding practice

## Areas for improvement

### Action the trust **MUST** take to improve

- The trust must ensure staff receive an induction in line with trust policy before they start work on the ward.
- The trust must ensure there is the minimum number of staff trained in managing aggression and violence on all shifts as outlined in trust policy.
- The trust must ensure managers review all incidents in a timely manner and provide feedback on lessons learned to staff.

### Action the trust **SHOULD** take to improve

- The trust should ensure they continue to monitor assaults on staff and put measures in place to improve staff safety on the ward.
- The trust should ensure patient leave and activities are not cancelled due to staffing shortages.
- The trust should ensure there are routine mechanisms to share lessons learned from trust-wide incidents and complaints with staff in the service.



# Community-based mental health services of adults of working age

Good   

## Key facts and figures

Sheffield Health and Social Care NHS Foundation Trust's community mental health services for adults of working age core service comprised of five teams. The service delivers three broad levels of treatment and support, which are tailored to the individual needs of each service user:

- Assertive Outreach - intensive and assertive treatment and support for service users who present with a high level of enduring and/or complex mental health needs who would otherwise disengage.
- Active Recovery - treatment and support to service users who present with enduring and/or complex mental health needs.
- Case Management - low level support for service users requiring less frequent contact, for example, service users 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 three teams based at two sites. These were the Mental Health Recovery Service North, the Home Treatment Team and the Community Enhancing Recovery Team.

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 North 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 each individual.

The Community Enhancing Recovery Team is designed as an intensive rehabilitation and recovery team to deliver bespoke packages of care to people in their own homes as an alternative to hospital admission. The service provides support for people currently placed in locked rehabilitation hospitals, often outside of the city returning to Sheffield, living in their own accommodation.

The inspection was short-notice announced. We informed staff of our visit one working day before we arrived to ensure 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?

During the inspection visit, the inspection team:

- visited three of the five community teams for adults of working age
- spoke with the service managers of each team and two of the core service leads
- spoke with 25 staff members

# Community-based mental health services of adults of working age

- spoke with nine patients and two carers
- accompanied staff members on two visits to patients' homes
- received feedback from 12 people who used the service and one person who worked within the service via comments cards
- looked at 24 patient care records
- looked at 25 medication cards
- observed two multidisciplinary meetings and a daily team meeting
- checked the cleanliness and safety of the service environments
- looked at a range of policies, procedures and other documentation relating to the running of each service and their compliance with legislation and national guidance.

We previously inspected the service in November 2016 and rated the service as good overall, with a rating of requires improvement for safe. This was in relation to low staff compliance with mandatory training, which was a breach of Regulation 18 of the Health and Social Care Act (Regulated Activities) Regulations 2014 Staffing in the safe key question. We reviewed this breach as part of this latest inspection and have reflected our findings accordingly.

## Summary of this service

Our rating of this service improved. We rated it as good because:

- The service buildings were clean, tidy, wheelchair accessible and staff carried out environmental risk assessments and health and safety tests were up to date.
- Staff ensured that patients could provide feedback on the service they received. The feedback that we collected suggested that staff treated people with kindness, dignity and respect and were polite, caring and compassionate. The service ensured that patients had access to advocacy, signers, translators, spiritual support and speech and language therapists.
- Staff responded quickly when patients' health deteriorated, prioritised urgent referrals, encouraged patients to attend healthcare appointments and encouraged them to lead healthier lifestyles. Staff communicated with patients with communication issues using cue cards, easy read information and translators. They engaged with patients who failed to attend their appointments and supported patients in accessing education and work opportunities.
- Staff were skilled and experienced, were appraised and had access to specialist training for their role. Staff knew about safeguarding, whistleblowing, the duty of candour and handling complaints. Staff reported incidents appropriately and told us that they could raise concerns without fear of reprisals.
- Staff had a good understanding of the Mental Health Act and the Mental Capacity Act. We saw evidence in patients' care records that staff had undertaken mental capacity assessments when this was indicated. Staff involved other professionals within and external to the team when appropriate and helped patients to make decisions on their own behalf.
- Staff had carried out a range of clinical audits within the service between February 2017 and May 2018, including an audit in relation to the identification of carers and assessment of their needs. Staff were given opportunities to consider ideas for improving and innovating and participated in national audits.

# Community-based mental health services of adults of working age

However:

- The clinic room was too small for patients to receive depot injections in a seated position at the Mental Health Recovery North service.
- Staff at the Mental Health Recovery North service were not up to date with their mandatory training. Staff sickness absence rates were high at the Mental Health Recovery North and Home Treatment Team services which resulted in poor staff morale. Staff told us that their caseloads were high.
- Staff at the Mental Health Recovery North service did not update patient care plans or risk assessments regularly.

Is the service safe?  **Up one rating**

**Good** 

Our rating of safe improved. We rated it as good because:

- Overall, 87% of staff within the core service were up to date with their mandatory training although during our inspection, compliance figures at the Mental Health Recovery North service were low in basic life support, health and safety, preventing falls, fire safety, Mental Capacity Act, dementia, autism awareness, domestic abuse and safeguarding.
- Staff made good use of advance decisions and crisis plans and responded quickly if a patient's health suddenly deteriorated.
- The services we inspected had effective lone working arrangements in place to keep staff safe whilst working in the community.
- Staff adhered to infection control procedures. Hand sanitising gel and washing facilities were available throughout the service buildings and the services had their own domestic staff who regularly cleaned the environment.
- Staff knew how to recognise possible signs of abuse, made safeguarding referrals when appropriate and reported incidents.
- Staff had access to essential information they needed to deliver safe care and treatment.

However:

- The clinic room was too small for patients to receive depot injections in a seated position at the Mental Health Recovery North Service.
- Staff sickness absence rates were high at the Mental Health Recovery North and Home Treatment Team services and staff told us their caseloads were high.
- Staff at the Mental Health Recovery North service did not update patient risk assessments in line with the service manager's expectation, which was a minimum of every six months. Seven out of the nine care records we looked at for this service contained evidence that risk assessments were not being updated in line with this expectation. Four care records contained no information about comprehensive mental health assessments.

Is the service effective?

**Good**   

# Community-based mental health services of adults of working age

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

- All services had a full range of specialists within the teams including psychiatrists, psychologists, nursing staff, recovery workers, support workers, occupational therapists, social workers, and other allied health professionals.
- Staff were experienced, qualified and had the necessary skills to deliver effective care and treatment to meet the needs of their patients. In addition to mandatory training, staff could access specialist training for their individual role. The trust's target rate for appraisal compliance was 90%. As at February 2018, the overall appraisal rates for non-medical staff within this core service was 96%.
- Staff provided a range of care and treatment interventions, which were in line with guidance from the National Institute for Health and Care Excellence. They used recognised ratings scales to rate patients' severity and outcomes. These included Health of the Nation Outcome Scales, Recovering Quality of Life, and the clustering tool.
- Staff encouraged patients to attend appointments with their GPs and other health professionals and encouraged them to lead healthier lifestyles.
- Staff had a good understanding of the Mental Health Act and Mental Capacity Act and we saw evidence in patients' care records that staff had undertaken capacity assessments, involved professionals within and external to the team when appropriate and helped patients to make decisions on their own behalf.
- Staff had carried out seven clinical audits within the service between February 2017 and May 2018 and took appropriate action in response to the findings.
- The multidisciplinary team worked effectively in collaboration with other services to deliver the best outcomes and support for their patients and there were effective links with other teams both within and outside the trust.

However:

- Staff were not receiving regular clinical supervision at all three of the services we inspected and the average compliance figure overall was only 48%.
- Four patient records at the Mental Health Recovery North service contained no evidence that staff had completed a comprehensive mental health assessment of the patients.
- Staff had not updated two patients' care plans in line with the service manager's expectation which was every six months as a minimum.

## Is the service caring?

Good   

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

- The people who used the service told us that staff treated them with kindness, dignity, respect and compassion, understood their individual needs, were interested in their wellbeing and helped them to understand and manage their own condition, care, and treatment.
- Staff involved patients in decisions about their care and treatment and patients were able to provide feedback on the service they received.
- Staff provided patients with details about advocacy services.
- Staff supported patients in accessing their chosen place of worship in the community and the trust's chaplaincy service.

# Community-based mental health services of adults of working age

- Staff used pictures, cue cards, easy read information and sought advice and guidance from speech and language therapists to help with patients with communication issues.

## Is the service responsive?

Good   

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

- The trust's Single Point of Access team triaged referrals based on the individual needs and ensured the services dealt with urgent cases as a priority and an out of hours service was available if patients needed assistance during the night.
- Staff attempted to engage with patients who were either reluctant to be involved with mental health care services or had been failing to attend their appointments.
- Staff supported patients during transfers and referrals to other services and accompanied patients when they attended appointments with other services.
- Staff supported patients in accessing education and work opportunities and encouraged them to build and maintain relationships with the people who mattered to them.
- The services made adjustments for disabled patients and patients with specific communication needs and patients had access to signers, translators and a telephone translation service.
- Staff handled complaints effectively and referred complaints to their service manager and the trust's corporate affairs team when required.

## Is the service well-led?

Good   

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

- Leaders had the skills, knowledge and experience to perform their roles and managers within the services had undertaken management and leadership training to develop them as leaders and enhance their skills.
- Staff knew how to use the trust's whistleblowing procedures and knew whom the trust's freedom to speak up guardian was and what their role entailed in respect of supporting staff to speak out and raise concerns.
- The trust had equality and diversity policies in place, which were available to all staff via the trust's intranet.
- Staff were able to discuss items for inclusion on their team's risk register and that of the wider trust and staff confirmed that their concerns were reflective of those contained within the risk registers.
- Staff were given time to consider opportunities for improvements and innovation during team meetings, reflective practice sessions and appraisal sessions.
- Staff had access to support for their own physical and emotional health needs.
- Staff within the service had participated in national audits.

# Community-based mental health services of adults of working age

- The trust worked in partnership with other organisations in leading a quality improvement methodology system called Microsystems which enabled frontline staff to train as coaches and work with teams to help improve the quality and value of care they deliver to patients.

However:

- Governance systems were ineffective in ensuring staff complied with their mandatory training, updated risk assessments regularly and that at the Mental Health Recovery North service, there were not any arrangements in place for acquiring emergency medication.
- Staff sickness absences were high at the Mental Health Recovery North service, and staff did not feel respected or valued by the wider trust, mainly due to fact that they perceived the trust had poorly handled the reconfiguration of the community mental health services for adults of working age.

# Wards for older people with mental health problems

Good   

## Key facts and figures

Sheffield Health and Social Care NHS Foundation Trust provides wards for older people with mental health problems over two sites. These were;

- G1 ward at Grenoside Grange Hospital – An 18 bedded mixed sex ward
- Dove dale ward at the Michael Carlisle Centre – An 18 bedded mixed sex ward

At our last inspection in March 2017 we rated wards for older people with mental health problems as good overall with ratings for key questions as follows:

Safe as requires improvement. This was because:

- Dovedale ward at the Michael Carlisle Centre did not comply with guidance on eliminating mixed sex accommodation. Male patients were allocated bedrooms in areas designated as female areas. There was a lounge designated as female only, however, this was at the end of the male bedroom corridor. Female patients had to walk through the areas designated for male patients to access communal facilities.
- G1 ward at Grenoside Grange had a seclusion room which did not comply with the Mental Health Act Code of Practice guidance. There was no two-way intercom or externally controlled heating and blind spots in the seclusion room.
- Mandatory training compliance was not within trust targets.

Following the inspection in March 2017 we rated effective, caring, responsive and well-led as good. This led to an overall rating of good for this core service.

We re-inspected all five key questions on this inspection. The inspection was unannounced. We inspected both wards for older people with mental health problems over two days.

Before the inspection, we reviewed information we had about the service.

During the inspection, the inspection team:

- Toured each ward and carried out a check of the clinic rooms
- Interviewed the ward managers of each ward
- Spoke to eleven staff members including an occupational therapist, nurses and support workers
- Interviewed two consultants and a junior doctor
- Spoke to seven patients and carers
- Observed one multidisciplinary team meeting
- Observed one handover
- Observed two lunch times
- Reviewed eight patient records
- Reviewed eight prescription charts.

# Wards for older people with mental health problems

Following the inspection, the inspection team:

- Interviewed the senior operational managers for each ward
- Interviewed the deputy director for the core service.

## Summary of this service

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

- The wards were bright, clean and well maintained.
- Each ward had a ligature risk assessment.
- Staff safeguarding training was at 95% and staff were aware of how to raise safeguarding concerns.
- All patient care plans that we reviewed were personalised, holistic and recovery focused.
- Multidisciplinary team meetings were patient focused.
- The culture within the service was a very positive one with staff being complimentary toward the managerial staff.

However:

- Dovedale ward's records of emergency equipment being had gaps which showed that checks were inconsistent.
- The walkway to the garden on Dovedale ward was slippery and could be dangerous for patients.
- The rate of clinical supervision for staff was below the trust target.
- Although good practice in relation to delayed discharges had been implemented across both wards, G1 ward had a disproportionate number of delayed discharges due to the nature of the patients.

## Is the service safe?

**Requires improvement**   

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

- Dovedale ward's records of emergency equipment being had gaps which showed that checks were inconsistent.
- The nurse call system on G1 were not easily visible for patients.
- The walkway to the garden on Dovedale ward was slippery and could be dangerous for patients.

However:

- The wards were bright, clean and well maintained.
- Both wards complied with same sex guidance.
- There were sufficient levels of staffing on each of the wards.
- Staff had undertaken a ligature risk assessment on each ward.
- The care records that we reviewed all contained comprehensive risk assessments that had been co-created with carers.



# Wards for older people with mental health problems

- Ninety-five percent of staff had undertaken training in safeguarding Staff that we interviewed were aware of how to raise safeguarding concerns.

## Is the service effective?

**Good** ● → ←

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

- All patients had a comprehensive assessment upon admission including a physical health check.
- Patients care plans were all personalised, holistic and recovery focused.
- Multidisciplinary team meetings were patient focused.
- Staff had a good understanding of Mental Health Act and Mental Capacity Act and training was at 97% for all staff.

However:

- The rate of clinical supervision for staff was below the trust target.

## Is the service caring?

**Good** ● → ←

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

- Patient and carer feedback was generally positive about the service.
- The personal, social and cultural needs of patients were taken into account.
- Staff were positive and respectful in their approach to patients.

## Is the service responsive?

**Good** ● → ←

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

- Staff and patients had access to therapy rooms, a clinic room, dining room and multiple lounges throughout the services. Dovedale ward had access to an indoor gym on site for patients to use. Both wards enabled patients to access outdoor space and each ward had gardening facilities where patients would grow their own fruit and vegetables. G1 had multiple outdoor spaces which were used for gardening, they also had a shed where patients could sand and chop wood if they wished.
- Facilities at both sites were suitable for patients requiring disabled access.
- The service had received no complaints in the 12 months prior to inspection.
- The service had received 221 compliments in the past 12 months.

However:

- Dovedale ward had a dormitory which up to four female patients had to share.

# Wards for older people with mental health problems

## Is the service well-led?

Good ● → ←

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

- The ward managers were experienced, knew their service well and were constantly seeking to improve.
- The culture within the service was a very positive one with staff being complimentary toward the managerial staff.
- Staff were involved in decisions about the service, including the design of the new ward.
- There were effective processes for monitoring risk.

## Outstanding practice

- Both wards at the service had developed their own vision and values in collaboration with staff and patients, these values aligned with the trust vision and values.

## Areas for improvement

We found areas for improvement in this service. See the Areas for Improvement section above.

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](http://www.cqc.org.uk))

**This guidance** (see [goo.gl/Y1dLhz](http://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

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Treatment of disease, disorder or injury

#### Regulation

Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

#### Regulated activity

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Treatment of disease, disorder or injury

#### Regulation

Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment

#### Regulated activity

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Treatment of disease, disorder or injury

#### Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance

#### Regulated activity

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Treatment of disease, disorder or injury

#### Regulation

Regulation 18 HSCA (RA) Regulations 2014 Staffing

# Our inspection team

The inspection was led by Jenny Wilkes, Head of Inspection and included an expert reviewer

Inspection teams were led by inspectors and each team comprised inspectors, specialist advisers, and 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.