Requires improvement

Sheffield Health and Social Care NHS Foundation Trust

Long stay/rehabilitation mental health wards for working age adults

Quality Report

Fulwood House
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Sheffield
South Yorkshire
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Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
TAHXM	Forest Close	1 Forest Close	S35 OJW
TAHXM	Forest Close	1a Forest Close	S35 OJW
TAHXM	Forest Close	2 Forest Close	S35 OJW
TAHXM	Forest Close	3 Forest Close	S35 OJW
TAHCC	Fulwood House	Community Enhancing Recovery Team	S11 9BF

Summary of findings

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

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

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

Summary of findings

Ratings

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

Overall rating for the service	Requires improvement 
Are services safe?	**Requires improvement** 
Are services effective?	**Requires improvement** 
Are services caring?	**Good** 
Are services responsive?	**Good** 
Are services well-led?	**Requires improvement** 

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

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

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

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

Summary of findings

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Overall summary

We rated long stay/rehabilitation mental health wards for working age adults as requires improvement because:

- We found that the trust could not always maintain safe staffing levels for the intensive rehabilitation service. The service had a high vacancy rate of 17% for qualified nurses and 27% for nursing assistants. The service had eight instances between February and October 2016 where one nurse was left to cover two or more units. One recent instance had left a member of staff lone working on a unit for five hours.
- We identified several concerning issues in the intensive rehabilitation service. Average compliance with mandatory training was below the trust target. We found issues with safety in the prescribing, administration and monitoring of medication. Not all premises were clean. Cleaning records had gaps and did not accurately reflect the cleaning on the units.
- The community enhancing recovery team had not responded appropriately to a patient who made disclosures to several members of staff. Managers had dealt with the safeguarding concern without consulting with the trust safeguarding team, making a report on the trust incident reporting system or documenting formally their response. The service did not provide any feedback to the patient.
- The intensive rehabilitation service and the community enhancing recovery team did not have an effective governance system in place. The services were unable to respond quickly to requests for information from the inspection team. The intensive rehabilitation service did not have 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. The community enhancing recovery team did not have an effective system which documented safeguarding concerns. Neither the intensive rehabilitation service nor the community enhancing recovery team were compliant with the trust's supervision policy.

However:

- The intensive rehabilitation service had worked to address the issues with care planning identified in the previous inspection which meant that care planning had improved. Care plans were holistic and recovery-orientated with all plans focussed on achieving eventual discharge.
- The community enhancing recovery team had a well-established partnership with South Yorkshire Housing Association. The partnership meant that the trust was able to return patients from out of area placements to Sheffield with the team supporting patients to manage their own independent tenancies
- Almost all patient feedback was positive about both services. Patients in the intensive rehabilitation service told us that staff always had time for patients and that staff encouraged patients to push themselves in their recovery. Interactions between patients and staff in the community enhancing recovery team were respectful and friendly.
- Staff in both the intensive rehabilitation service and the community enhancing recovery team had a good understanding of the trust vision and values. They were able to describe how these guided the work of the services.

Summary of findings

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

Are services safe?

Requires improvement

We rated safe as requires improvement because:

- The intensive rehabilitation service had a high vacancy rate of 17% for qualified nurses and 27% for nursing assistants. The service did not consistently maintain safe staffing levels and had eight instances between February and October 2016 where one nurse was left to cover two or more units. One recent instance had left a member of staff lone working on a unit for five hours.
- We found that staff in the community enhancing recovery team had not taken appropriate action as a result of a safeguarding concern. A patient had made consistent disclosures to a number of staff members, which each reported to the management team. There was no consultation with the trust safeguarding team, no consideration evident as to whether the disclosures met the threshold for a safeguarding concern and staff had not made any report on the trust's incident reporting system. Whilst the manager told us the concerns were found to be unsubstantiated there was no formal investigation in order to determine this outcome and no feedback to the patient about the findings.
- Average compliance with mandatory training in the intensive rehabilitation service was below the trust target. Thirteen courses were below the trust compliance target of 75%. In the community enhancing recovery team ten courses were below the trust compliance target.
- We found issues with safety in medication prescribing, administration and monitoring. One incident of rapid tranquilisation was not properly documented. Observations were not recorded according to the trust policy and documentation was confusing and contradictory. The service was not consistently or fully documenting observations for a patient on clozapine. One patient prescribed sodium valproate had not received information about the potential side effects of treatment.
- Bungalow 3 in the intensive rehabilitation service was being used as a patient activity centre and was not clean. Cleaning schedules could not be found prior to October 2016. The cleaning schedules that were found from October 2016 were not complete and did not accurately reflect the cleaning of the unit.

Summary of findings

- Bungalow 1 in the intensive rehabilitation service had a fridge used to store food. Staff had repeatedly documented that the temperature was above the maximum allowed by the trust but had not taken remedial action.

However:

- Both the intensive rehabilitation service and the community enhancing recovery team undertook a comprehensive and regularly updated risk assessment of patients. Both services undertook in-reach work which allowed staff to assess risks prior to admission to the services.
- Bungalow 1, Bungalow 1a and Bungalow 2 had a fully equipped clinic room. There was evidence that staff checked clinic room and emergency equipment in line with the trust policy.
- Neither service had any serious incidents requiring investigation in the twelve months prior to inspection. Both services used an electronic system for reporting incidents and all staff knew how to report incidents. Staff in both services were able to describe incidents that had been investigated with learning shared within the team.

Are services effective?

Requires improvement

We rated effective as requires improvement because:

- Whilst the service offered a number of activities we saw that most were social activities and there were limited activities which focussed on rehabilitation. This was echoed in the feedback from some patients who told us that the activities were mostly good but were not rehabilitation.
- The service had a compliance rate for supervision of 60%. This was 20% lower than the trust average of 80%. However, staff told us that they received regular group supervision through weekly reflective practice sessions and weekly formulation meetings.
- Staff in the community enhancing recovery team showed a limited understanding of the Mental Capacity Act and were not able to describe how and when they would need to assess a patient's capacity.

However,

- Care plans were holistic and recovery-orientated with all plans focussed on achieving eventual discharge. In the community enhancing recovery team we saw that care plans were used as 'live' documents and updated continuously by all professionals.

Summary of findings

- Patients in the intensive rehabilitation service received regular physical health checks. In the community enhancing recovery service patients were registered with local general practitioners who took responsibility for physical health care.
- Staff in the intensive rehabilitation service demonstrated a good understanding of the Mental Capacity Act. Care records showed that staff considered capacity and assessed capacity appropriately. Best interest decisions were made appropriately after decision specific capacity assessments although we noted in one record that staff had not undertaken a capacity assessment or best interest decision for a patient prescribed sodium valproate.

Are services caring?

Good

We rated caring as good because:

- Almost all patient feedback was positive about both services. Patients in the intensive rehabilitation service told us that staff always had time for patients and that staff encouraged patients to push themselves in their recovery.
- We observed interactions between patients and staff in the community enhancing recovery team and saw that they were respectful and friendly.
- We saw patient involvement and participation in the care plans of patients from both the intensive rehabilitation service and the community enhancing recovery team.
- We spoke to two carers of patients in the intensive rehabilitation service and two carers of patients of the community enhancing recovery team. Carers told us they felt fully involved in the care being provided and that both services had ensured that they were given enough information about the service.

Are services responsive to people's needs?

Good

We re-rated responsive as good because:

- The intensive rehabilitation service had been redesigned since the last inspection. The new service was more focussed on discharge. The service had introduced a target of eighteen months for the average length of stay. It had reduced bed numbers and had discharged 32 patients during this process, including 12 patients between November 2015 and October 2016. Three of the 12 patients discharged in this period had been admitted since the service had relaunched.
- Both the intensive rehabilitation service and the community enhancing recovery team had clear admission criteria for

Summary of findings

referrals to the service. Both the intensive rehabilitation service and the community enhancing recovery team had a clear process for patients to make a complaint. Both services used the trust's FastTrack system to ensure that patients received a quick resolution to complaints.
- The intensive rehabilitation service had a four week menu which was regularly reviewed by patients in community meetings. Patients had access to a beverage bay where they could make hot drinks. Patients told us they were happy with the food quality.

However:

- Whilst the service offered a number of activities we saw that most were social activities and there were limited activities which focussed on rehabilitation. There were limited facilities for patients to self-cater.
- One patient in the intensive rehabilitation service felt that the service did not offer enough activities that were focussed on rehabilitation.
- The intensive rehabilitation service had designated a member of the inpatient staff team as care coordinator for patients which does not follow good practice.
- Although staff were actively seeking alternative placements, the intensive rehabilitation service still had eight patients whose length of stay significantly exceeded the maximum intended in the service specification.

Are services well-led?

Requires improvement

We rated well-led as requires improvement because:

- The intensive rehabilitation service did not have an effective quality assurance process to identify the impact of issues with medication management, recruitment of staff, safe staffing levels being maintained, training provision and the management of risks to staff and patients.
- The community enhancing recovery team did not have adequate systems and processes in place maintain accurate records of safeguarding concerns. Managers produced a fact finding report in response to a safeguarding concern we raised during the inspection. The report stated that there had been no police involvement in the safeguarding concern which we later found to be incorrect. The team manager advised this was because the information had been removed from the trust's system and therefore not possible to locate.

Summary of findings

- Neither the intensive rehabilitation service nor the community enhancing recovery team were compliant with the trust's supervision policy.
- The intensive rehabilitation service and the community enhancing recovery team did not have an effective governance system in place to allow it to respond quickly to requests for information.
- We saw examples where the service manager had limited authority to influence change and that these were having a direct impact on the service. The service manager had difficulties securing agency staff and addressing maintenance issues.
- Not all staff fully understood the concept of whistleblowing. Staff told us they felt they could raise concerns to service managers and most felt their concerns would be responded to. None of the staff suggested that they would raise concerns to external organisations.

However:

- Staff knew and were positive about their local managers. The local managers told us they felt well supported by their immediate line managers. Staff knew the most senior managers in the trust and told us that they visited the units regularly.
- Staff in both the intensive rehabilitation service and the community enhancing recovery team had a good understanding of the trust vision and values and were able to describe how these guided the work of the services.
- Both the intensive rehabilitation service and the community enhancing recovery team had local risk registers. The intensive rehabilitation service had a risk register for each unit and managers could describe the process for escalating risks to the directorate risk register.

Summary of findings

Information about the service

Forest Close is an inpatient rehabilitation service provided by Sheffield Health and Social Care NHS Foundation Trust. The service is based in Middlewood, North-West Sheffield. It is composed of three separate units and an additional unit used as activity centre. These were:

- Bungalow 1 – an eight bedded unit for females
- Bungalow 1a – a 14 bedded unit for males
- Bungalow 2 – an eight bedded unit for females

Forest Close provides high dependency inpatient rehabilitation services for people with severe and enduring mental health needs who require support to reach their optimum level of recovery and who are usually detained under the Mental Health Act. 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. The service states that each service user is encouraged to build on their strengths, to improve their quality of life to a point where discharge is appropriate, or to maintain their level of recovery at Forest Close. The intended length of stay at Forest Close is no more than eighteen months.

Up until July 2016 Bungalow 3 was an eight bedded unit for females. However, at the time of inspection this unit was closed to admissions and did not have any patients currently admitted. The unit is planned to undergo a refurbishment in 2017 but at the time of the inspection, Bungalow 3 was being used as an activity centre for patients admitted to Bungalows 1, 1a and 2.

We last inspected the services provided by Sheffield Health and Social Care NHS Foundation Trust in October 2014. At the time, long stay/rehabilitation mental health wards for working age adults were found to be non-compliant with four regulations. These were:

- Regulation 9 Health and Social Care Act (Regulated Activities) Regulations 2014 Person-centred care
- Regulation 10 Health and Social Care Act (Regulated Activities) Regulations 2014 Dignity and respect
- Regulation 12 Health and Social Care Act (Regulated Activities) Regulations 2014 Safe care and treatment
- Regulation 17 Health and Social Care Act (Regulated Activities) Regulations 2014 Good governance

The ratings were:

- Safe: Requires improvement
- Effective: Requires improvement
- Caring: Good
- Responsive: Requires improvement
- Well-Led: Requires improvement

CQC issued four requirement notices following the inspection in 2014. We reviewed these requirement notices as part of the inspection and we found continued breaches of three regulations.

The Community Enhancing Recovery Team is an intensive rehabilitation and recovery team which delivers bespoke packages of care to people in their own homes as an alternative to hospital admission. The team will see people currently placed in locked rehabilitation hospitals, often outside of the city. The team offered high-intensity non-residential support for people to return to Sheffield and live in their own accommodation. Referrals were accepted for adults aged 18 or over at the time of referral. Patients had to be Sheffield residents with Sheffield clinical commissioning group responsible for providing or commissioning their health care. Patients were admitted to the service from more secure/controlled access inpatient rehabilitation units, usually provided by the independent sector.

The team is based at the Michael Carlisle Centre in Nether Edge, South-West Sheffield.

Our inspection team

Chair: Beatrice Fraenkel

Head of Inspection: Jenny Wilkes, Care Quality Commission

Team Leaders: Jenny Jones, Inspection Manager (Mental Health) Care Quality Commission

Summary of findings

The team that inspected the long stay/rehabilitation mental health wards for working age adults comprised one inspector, one consultant psychiatrist, one registered mental health nurse, one occupational therapist and one observer.

Why we carried out this inspection

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

How we carried out this inspection

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

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

Before the inspection visit, we reviewed information that we held about these services, asked a range of other organisations for information, and sought feedback from patients at three focus groups.

During the inspection visit, the inspection team:

- visited the intensive rehabilitation service at Forest Close
- visited the community enhancing recovery team at the Michael Carlisle Centre
- looked at the quality and safety of the environment at all four bungalows at Forest close.
- spoke with the service manager of the intensive rehabilitation service
- spoke with two unit managers of the intensive rehabilitation service and the team leader of the community enhancing recovery team
- interviewed 28 staff from the intensive rehabilitation service and nine staff from the community enhancing recovery team including doctors, nurses, occupational therapists, and nursing assistants.
- spoke with 11 patients from the intensive rehabilitation service and four patients from the community enhancing recovery team
- spoke with two carers from the intensive rehabilitation service and two carers from the community enhancing recovery team
- reviewed 15 comment cards from patients and carers reviewed ten care records of patients of the intensive rehabilitation service and three care records of patients of the community enhancing recovery team
- observed three patient activities in the activity centre of the intensive rehabilitation service
- observed two handover meetings of the intensive rehabilitation service
- observed a multidisciplinary team meeting, a reflective practice session, the service morning meeting and a medication round in the intensive rehabilitation service
- looked at policies, procedures and other documents relating to the running of the service.

What people who use the provider's services say

We spoke with 11 patients from the intensive rehabilitation service and four patients from the community enhancing recovery team. We also spoke with two carers from the intensive rehabilitation service and two carers from the community enhancing recovery team. Carers and patients were mostly positive about the staff and the care and treatment they received.

Summary of findings

Patients from both services told us that staff were encouraging and supportive. Carers of patients in both services told us that they felt involved by the services in the patient's care and treatment. Whilst most patients praised the services, we did receive negative feedback from one patient in the intensive rehabilitation service who felt that the service did not provide activities that were sufficiently focussed on rehabilitation.

We received 15 comment cards in total for the rehabilitation and long stay services. Eight comment cards had positive feedback about the services. Four cards related to the community enhancing recovery team. Comments included how the service treated people with respect and that the staff cared for patients. Positive comments about the intensive rehabilitation service stated that staff were friendly, supportive and willing to listen to complaints.

Seven cards had a mixture of positive and negative comments about the service or left unclear feedback. All were from the intensive rehabilitation service. Negative comments included how the service did not have enough managers during the week and that staff had been advised not to speak to the inspection team.

Areas for improvement

Action the provider MUST take to improve

- The trust must review blanket restrictions in the intensive rehabilitation service to ensure that care is provided in a way that demonstrates that risks had been assessed on an individual basis.
- The trust must ensure that the risk of harm to staff and service users using Bungalow 3 in the intensive rehabilitation service are mitigated.
- The trust must ensure that managers and staff in the community enhancing recovery team understand their individual responsibilities to respond to concerns about potential abuse when providing care and treatment, including investigating concerns.
- The trust must ensure that all areas used for patient care in the intensive rehabilitation service are clean and that appropriate and timely action is taken for maintenance requests.
- The trust must ensure that the intensive rehabilitation service maintains complete and accurate cleaning records.
- The trust must develop a quality assurance process which ensures managers in the intensive rehabilitation service identify areas for improvement and action is taken to address concerns.
- The trust must ensure that the intensive rehabilitation service and the community enhancing recovery team comply with the trust supervision policy.
- The trust must ensure that the intensive rehabilitation service and the community enhancing recovery team have effective governance systems in place to share information in a timely manner.
- The trust must ensure that safe staffing levels are maintained for each bungalow that admits patients in the intensive rehabilitation service.
- The trust must ensure that staff are up to date with all required areas of mandatory training in the intensive rehabilitation service and the community enhancing recovery team to ensure it meets trust targets.
- The trust must ensure that medicines are managed safely and where required, physical health monitoring and observations are carried out by staff and recorded.

Action the provider SHOULD take to improve

- The trust should ensure staff in the intensive rehabilitation service carry out monitoring checks in relation to food safety and take remedial action when necessary.
- The trust should ensure managers and staff in the community enhancing recovery team report and use incidents and complaints to identify potential abuse and take preventative actions, including escalation, where appropriate.
- The trust should ensure that discharge plans are in place in the intensive rehabilitation service which ensures patients who have extended periods of admission to the service are reviewed regularly to ensure their placement in the service is appropriate for them.
- The trust should ensure that patients in the intensive rehabilitation service are allocated a care coordinator from an appropriate community based mental health team

Summary of findings

- The trust should ensure that all staff in the community enhancing recovery team have appropriate understanding of the Mental Health Act.
- The trust should ensure that staff in the community enhancing recovery team understand the Mental Capacity Act and that care records reflect considerations of capacity in staff interactions with patients.

Sheffield Health and Social Care NHS Foundation Trust

Long stay/rehabilitation mental health wards for working age adults

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
1 Forest Close	Forest Close
1a Forest Close	Forest Close
2 Forest Close	Forest Close
3 Forest Close	Forest Close
Community Enhancing Recovery Team	Fullwood House

Mental Health Act responsibilities

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

The intensive rehabilitation service achieved 85% compliance in Mental Health Act training which was higher than both the trust average and the trust target. The trust's Mental Health Act training module was not mandatory for community mental health services. The trust stated that qualified staff in the community enhancing recovery team had attended a social supervisor course which included training in the Mental Health Act.We found that staff in the community enhancing recovery team had a limited understanding of the Mental Health Act.

We found that most staff in the intensive rehabilitation service had a good understanding of the Mental Health Act

including the guiding principles, the different sections of the Act and the requirements for patients to have leave under the Act. Mental Health Act paperwork was properly scrutinised, properly stored and properly audited.

Patients had their rights under the Mental Health Act explained on admission and this was repeated every three months or after tribunals. Patients had access to an advocacy service.

Mental Capacity Act and Deprivation of Liberty Safeguards

Training in the Mental Capacity Act was significantly below the trust target in both the intensive rehabilitation service and the community enhancing recovery team. We found that staff understanding of the Mental Capacity Act was mixed between the two services.

Most staff in the intensive rehabilitation service that we talked to knew the principles of the Mental Capacity Act. They were able to give comprehensive descriptions of how capacity was assumed with patients and would be assessed on a decision specific basis. This was supported in care records. Staff recognised that the trust had a policy on the Mental Capacity Act and knew where to find it on the trust intranet.

Staff in the community enhancing recovery team had a limited knowledge of the Mental Capacity Act. We did not see any formal documentation of considerations of capacity in the care records we reviewed. Staff said it was not routine for the service to have to assess capacity.

Requires improvement

Are services safe?

By safe, we mean that people are protected from abuse* and avoidable harm

* People are protected from physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse

Our findings

Safe and clean environment

Intensive Rehabilitation Service – Forest Close

Forest Close was the collective name of three inpatient units, Bungalow 1, Bungalow 1a and Bungalow 2 which were based in North-West Sheffield. All three inpatient units were found to be clean, well-maintained and with good quality furnishings. The units were single sex at the time of inspection so met with national guidance on same-sex accommodation. The layout of the units allowed staff to observe all parts of the unit without obstruction. Bungalow 1, Bungalow 1a and Bungalow 2 had a nurse call system and a personal alarm system in place. Bungalow 3 did not have a nurse call system and was not connected to Forest Close's personal alarm system.

There were no seclusion rooms or use of seclusion at Forest Close. All three inpatient units had been refurbished during 2016. As part of the refurbishment, the units were modelled to a high anti-ligature standard. The service had undertaken a ligature risk assessment of the units in 2016 which detailed the actions to be taken to mitigate ligature risks. Also, some ligature risks, for example mobile phone chargers, were individually risk assessed for patients.

All three units had a fully equipped clinic room which was clean and tidy. Each clinic room had a fridge to store medicines. The fridge temperature in each clinic room was within the required temperature range and medicines in the fridges were in date, labelled and stored appropriately. Fridge temperatures were monitored with a daily record sheet. Each fridge had a store of emergency drugs which were labelled, in date and stored correctly. Each clinic room had resuscitation equipment stored in a 'grab bag'. A grab bag is a small bag used to keep resuscitation equipment together so staff can quickly access it in an emergency. Each grab bag contained the items that should have been in it and there was a record of weekly checks of the grab bag equipment in line with the trust's resuscitation policy. All three clinic rooms had equipment to monitor physical health including scales and a blood pressure machine. Each clinic room had a defibrillator. The blood pressure machine and defibrillator were clean and working and were checked weekly. None of the clinic rooms had an examination couch. Staff conducted physical assessments in patient bedrooms.

We saw that staff adhered to infection control principles. The trust had an infection control policy which was issued in June 2015. During the inspection we saw that staff followed the infection control policy and the 'guidelines for management and control of an outbreak of diarrhoea and vomiting', including effective hand hygiene, enhanced cleaning of the environment and equipment and isolation of affected patients.

We reviewed records for the temperature of frides used to store food for all four bungalows. On Bungalow 1 we noted that one fridge used to store foodstuffs had been recorded by staff completing the checks as seven degrees on 13 consecutive occasions in November 2016. The chart used indicated that the temperature should be between 0-5 degrees. The trust's food safety policy stated that food fridges should be kept below 5 degrees. We raised this with the service manager during the inspection who told us this would be investigated.

The patient-led assessments of the care environment look at cleanliness, condition, appearance, maintenance, dementia-friendly and disability standards of settings where care is delivered. However, due to the extensive refurbishment programme at Forest Close, all four of the bungalows were not included in the 2016 patient-led assessment of the care environment.

We reviewed cleaning records as part of our inspection. Staff did not always keep the records up to date. The units had a general cleaning schedule and a 'deep clean' schedule which was used in the unit kitchens to record deep cleans of specific equipment such as the oven or microwave. On Bungalow 2 we saw that there were gaps in deep clean records.

Bungalow 3, a former inpatient unit, was closed to new admissions and did not have any current admitted patients. We were told during the inspection that this Bungalow was reopened as an activity centre in August 2016 for patients admitted to Bungalow 1, Bungalow 1a and Bungalow 2.

Requires improvement

Are services safe?

By safe, we mean that people are protected from abuse* and avoidable harm

Bungalow 3 had significant issues in terms of cleanliness. The unit had a large kitchen which was being used as an activity kitchen for patients. The kitchen was not clean and appeared to have been left unclean for some time. We requested cleaning records for Bungalow 3. The service could not find cleaning records for Bungalow 3 prior to 3 October 2016. The cleaning records indicated that it was the responsibility of the occupational therapists to clean various areas of the kitchen. We interviewed the occupational therapist who told us that they had never been told about this responsibility. Staff were not clear who was responsible for cleaning the kitchen. We raised this during the inspection and the service manager told us that the service had faced significant issues due to high sickness in the housekeeping team. However, the service manager brought staff from other sites during the inspection to deep clean Bungalow 3 during our inspection. We were told that this had not been an easy process for them to arrange.

At Bungalow 3, there was a strong smell of drains. We raised this with the site manager who told us that this was a constant issue on Bungalow 1, 2 and 3 and that this was something regularly raised with the trust's estates department. The issue did not affect Bungalow 1a. The site manager was able to show us a list of dates and estates department job reference numbers which showed that the service was regularly raising this issue at least once or twice a month. The site manager told us that the trust was aware of the issue and was only able to offer ongoing repair work to the drains as a permanent solution required a prohibitively costly renovation of the drainage system.

Community Enhancing Recovery Team

The community enhancing recovery team operated from a designated space within the Michael Carlisle Centre. The community nature of the work of the team meant that the premises were predominantly a base for staff and were not routinely used by patients. The standard operating procedure for the community enhancing recovery team stated that 'clients will normally be visited in a non-clinical environment, most commonly their usual place of residence or some other community setting. Appropriate arrangements will be made if identified by risk assessment'. If the patient did not present any risks to staff then they were offered a choice when they entered the service on whether the staff would visit them in their homes or whether the patients would attend the team base. The team had seven rooms. Five rooms were for managers or staff. Two rooms were used for patients, a large room for training or groups and a smaller room for interviews. All rooms were found to be clean and tidy with good quality furnishing. The two rooms used for patient care were fitted with alarms.

Safe staffing

Intensive Rehabilitation Service – Forest Close

The new service's establishment levels were estimated as part of the service redesign work in January 2016. The service had a three shift pattern which provided 24 hour a day cover. Bungalow 1 and 2 had a minimum safe staffing establishment per unit of one qualified nurse and two nursing assistants during the morning and afternoon shift and one qualified nurse and one nursing assistants at night. Bungalow 1a which had a higher number of beds had a minimum safe staffing establishment of two qualified nurses and three nursing assistants during the morning and afternoon shift and one qualified nurse and two nursing assistants at night.

There were 106 substantive staff in post in the intensive rehabilitation service. The service had 24.5 whole time equivalent qualified nurses and 32.7 whole time equivalent nursing assistants.

The turnover rate of 15% was lower than the trust average of 16%. This equated to 15 staff leavers. The total staff sickness rate of 6% was equal to the trust average.

During the inspection in 2014, we noted that a high vacancy rate had led to situations where one qualified member of staff was having to cover two separate units. We judged this as unsafe and included the fact that 'the wards did not have a dedicated qualified nurse on the wards at all times' as a reason why a regulation was not being met.

Data provided by the trust for this inspection showed that the service had a total vacancy rate of 17% which was significantly higher than the trust's average of 3%. The vacancy rate just for qualified nurses in the service was 17% (4.1 whole time equivalent posts) and 27% (8.7 whole time equivalent posts) for nursing assistants. During this inspection, we saw how the high vacancy rate continued to have an impact on the service. This had led to an unsafe situation where one qualified member of staff had been left covering more than one unit. Staff in the service reported low staffing as incidents. From February to October 2016 there were 15 incidents of low staffing reported. Eight incident reports specifically state that one nurse covered two or more units. Six reports indicated that staffing was

Requires improvement

Are services safe?

By safe, we mean that people are protected from abuse* and avoidable harm

below the level required but did not specify whether it is a shortage in qualified nursing staff or nursing assistants. In the most recent report dated 29 October 2016, an incident occurred on one unit requiring three members of staff including the qualified nurse to attend. This left a member of staff lone working on one unit for a period of five hours. The service was proactive at escalating incidents of low staffing to the trust board in a monthly staffing capability report.

All staff said that they had enough time to have regular one to one time with patients. However, pressures from the high vacancy rate meant that one to one time was often shorter than they would like. We were told that activities were rarely cancelled although the service did not have a process which collated data on cancelled or postponed activities.

The service used bank staff to cover 27 shifts in a three month period between 1 May 2016 and 31 July 2106, and the service was not able to provide information on the number of shifts not filled by bank or agency staff where there is sickness, absence or vacancies.

The service manager told us that getting agency staff was difficult and required the authorisation of more senior managers and as such the service relied on bank staff or staff working flexibly or overtime. The regular use of bank staff meant they were familiar with the units and the ethos of the service.

Medical cover was provided by 1.1 whole time equivalent consultant psychiatrists, a 0.2 whole time equivalent speciality doctor and one whole time equivalent junior doctor. There was an out of hours on-call rota for consultants and a separate rota for junior doctors. The service had 2.5 whole time equivalent occupational therapists, 1.4 whole time equivalent psychologists, one whole time equivalent psychology assistant and one 0.4 whole time equivalent art and music therapist.

As of October 2016, the average mandatory training compliance for the service was 60%. The trust target was 75% but the trust average compliance rate was 60%. Thirteen of the 21 mandatory training courses for the core service were below the trusts 75% compliance target. These were:

- Autism awareness – 9%
- Dementia awareness – 16%
- Deprivation of Liberty Safeguards – 0%
- Domestic abuse level two – 38%
- Fire safety level three – 0%
- Hand hygiene – 72%
- Information governance – 74%
- Medicines management – 62%
- Mental Capacity Act level one – 42%
- Mental Capacity Act level two – 29%
- Rapid tranquilisation – 55%
- Respect level two – 12%
- Respect level three – 66%
- Safeguarding adults level two – 62%
- Safeguarding children level two – 45%
- Safeguarding children level three – 42%

This meant that the service could not be assured that staff were competent and had the required skills to perform their roles. During the inspection, we saw examples of where the impact of poor training compliance was demonstrated in shortfalls in staff understanding and practice. We identified issues with how staff managed medication and noted that only 62% of eligible staff were up to date with their medicines management training. We identified issues with how staff managed incidents of rapid tranquilisation and noted that only 55% were up to date with their rapid tranquilisation policy. The deputy manager who was responsible for monitoring training showed us a log which documented how the service routinely booked staff on to training courses. We were told that there had been a number of occasions where staff had been removed from the course to maintain staffing levels on the units. This meant the service was unable to improve compliance with mandatory training and that low compliance with training was having a negative effect on the care and treatment provided to patients. If staff do not complete the necessary mandatory training, they may not have the required skills and competence their roles demanded. This could put patients at risk of unsafe care.

Community Enhancing Recovery Team

The staffing requirement for the community enhancing recovery team was estimated as part of the redesign of rehabilitation services in January 2016. Establishment levels for the twelve months prior to the inspection for the community enhancing recovery team were:

There were 58 substantive staff in post in the community enhancing recovery team. The service had seven whole time equivalent qualified nurses and 46.5 whole time equivalent nursing assistants.

Requires improvement

Are services safe?

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The turnover rate of 10% was less than the trust's average of 16%. The service had no nursing vacancies. The sickness rate of 4% was less than the trust average of 6%. The total vacancy rate for the service was 10% which was higher than the trust's average of 3%. The service had no use of bank or agency staff in the reporting period which was from 1 May 2016 to 31 July 2016.

The service manager told us that they felt the staffing levels were adequate for the service. The service was able to provide cover for sickness or annual leave from within the staff team. Medical cover was provided by one psychiatrist who was contracted to work half-time with the service and half-time with other services in the trust. The service manager explained that as the psychiatrist was either with the service or working in other areas of the trust it meant that medical cover was always available or contactable.

The team had seven care coordinators which equated to an average of five patients per care coordinator. The team had 40 recovery workers overall supporting 30 patients. The team itself was split into three 'mini-teams' with at least one or more recovery worker to each patient. There were thirteen recovery workers per team for every ten patients.

As of October 2016, the average mandatory training compliance for the service was 76% in comparison to the trust target of 75% and the trust's average compliance rate of 60%. Ten of the 21 mandatory training courses for the team were below the trusts 75% compliance target. These were:

- Adult basic life support – 72%
- Autism awareness – 72%
- Clinical risk assessment – 62%
- Dementia awareness – 61%
- Domestic abuse level two – 70%
- Mental Capacity Act level one – 56%
- Mental Capacity Act level two -36%
- Respect level two - 65%
- Safeguarding children level two - 54%
- Safeguarding children level three – 50%

Whilst the average compliance rate was slightly above the trust target, the community enhancing recovery team had a number of courses which were significantly below the trust target. Respect level two was the only course available for staff working in the community which focussed on the prevention and management of challenging behaviour. One third of staff had not received this training. This meant that the service could not be assured that all staff had the skills to manage challenging behaviours. The low compliance with both levels of safeguarding training meant that the service could not be assured that staff in the team would be able to recognise, respond to, and report the abuse of children. There was a risk that without having completed the necessary mandatory training, people could be at risk of unsafe care as staff may not have the required skills and competence their roles demanded.

Assessing and managing risk to patients and staff

Intensive Rehabilitation Service – Forest Close

The service used the 'detailed risk assessment management' tool which the trust's risk management strategy noted as the approved tool for assessing and managing risk. The operating policy used by the service stated that this risk assessment should be updated (1) monthly, (2) prior to any periods of leave, (3) prior to discharge, (4) in the event of any new information coming to light and (5) if there is a significant change to the patient's presentation. We reviewed ten care records of patients who were currently admitted to the service and saw that risk assessments and risk management plans were updated regularly.

The service had a restricted items list. The restricted items were lighters, matches, lighter fuel, multiplug adapters, knives or other sharp objects/weapons, illicit substances and alcohol. Other items such as aerosols, razors and scissors were noted on the restricted items list as requiring individual risk assessment before they could be brought on to the units. We noted that the service had adopted some restrictive practices. The front door of Bungalow 1, Bungalow 1a and Bungalow 2 was locked at all times and required a key code to open. Each unit had a 'green room' which was a low stimulus environment for patients to relax in. All three green rooms were kept locked with patients having to request staff to unlock the door to use these rooms. The service had one informal patient at the time of inspection. There was a security managed door system on the bungalows. All service users were made aware of their rights to leave and each door had a sign advising patients of their right to leave. The trust had a leave policy which required patients to interact with staff before leaving to ensure appropriate support for leave and patient safety

There were ten uses of restraint in the period March 2016 to August 2016. Restraint was used five times in total on three patients at Bungalow 1a and five times on one patient at

Requires improvement

Are services safe?

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Bungalow 2. There were no incidents of the use of prone restraint and no incidents of rapid tranquilisation following the use of prone restraint. All staff told us that restraint was very rarely used and was always a last resort after de-escalation had failed. The use of restraint was regarded as an incident to be reported using the trust's electronic incident reporting system.

We identified areas of concern with the prescribing, administration and monitoring of medication.

We were consistently told by staff that the service rarely used rapid tranquilisation and that it had not been used for some time prior to the inspection. The use of rapid tranquilisation was regarded as an incident to be reported using the trust's electronic incident reporting system. We reviewed an incident of rapid tranquilisation which occurred in July 2016. The trust's rapid tranquilisation policy stated that after rapid tranquilisation had been administered 'blood pressure, pulse, temperature, respiratory rate, oxygen saturation and level of consciousness should be monitored every 10 minutes after intramuscular injections, for the first hour, and then hourly for four hours or until the patient becomes active again'. We found that staff had not completed physical observations in line with the policy. The physical observations were undertaken an hour after the administration of rapid tranquilisation and were not complete.

In January 2015, the Medicines and Healthcare Products Regulatory Agency warned that 'children exposed to valproate in utero are at high risk of developmental disorders and congenital malformations'. The guidance stated that valproate should not be prescribed to women of childbearing potential and if it is prescribed a service 'must ensure that all female patients are informed of and understand [the] risks associated with valproate during pregnancy'. Together with staff support we reviewed the records of one patient who was prescribed sodium valproate. The prescription for sodium valproate had started before the new guidance had been released. We found no evidence that the service had informed the patient of the potential risks of sodium valproate as a result of the new guidance. We found no evidence that as a result of the new guidance, the service had continued the treatment in the patient's best interest as a result of an assessment of diminished capacity.

Together with staff we reviewed the records of a patient prescribed clozapine. Clozapine is an antipsychotic drug used to treat schizophrenia in patients unresponsive to, or intolerant of, conventional antipsychotic drugs. The British National Formulary is a reference guide which provides practical information about the safe use of medicines. It notes that in common with many antipsychotics, Clozapine has a number of potential side effects and recommends 'close medical supervision during initiation [due to] risk of collapse because of hypotension and convulsions'. The trust's Clozapine guidelines advised staff to carry out observations of blood pressure, respiration rate and pulse rate both before and after Clozapine is administered so that its effect could be monitored. We saw in records that staff did not consistently carry out these observations. In a one week period we noted from records that the patient received one dose without any recorded physical observations, two doses without any observations prior to administration, one dose without any observations after administration and one dose with observations recorded without a time which meant it was not possible to identify which observation was either before or after administration. We saw that after one dose staff had recorded the patient's blood pressure but not the pulse rate. We also noted that only one record of observations was made on to the electronic patient record and that this record was not consistently either the pre-administration or post-administration observations. The full record of observations was made on a separate modified early warning score chart which staff initially struggled to locate. This meant potential risks to patients health and wellbeing were not being considered by staff who did not follow guidance on the safe administration of medicines

Bungalow 3 did not have a nurse call system and was not connected to Forest Close's personal alarm system. The service manager told us that the controls in place to manage this risk was individual patient risk assessment and that staff were given hand held panic alarms whilst on Bungalow 3. During an activity on Bungalow 3 we observed a patient's behaviour escalate where they became agitated and threw items in the room. The activity had one member of staff supervising two patients. The staff member did not have a hand held alarm for use on Bungalow 3. Members of the inspection team visited Bungalow 3 on several occasions during the inspection and were not offered a hand held alarm for use on Bungalow 3 during any of these visits. This meant that the service was not effectively mitigating the risk to patients, staff and visitors using Bungalow 3.

Requires improvement

Are services safe?

By safe, we mean that people are protected from abuse* and avoidable harm

Safeguarding training was mandatory in the trust. Although compliance rates with safeguarding adults' level two, and safeguarding children level two and three, were significantly below the trust target, staff had a good understanding of safeguarding and knew how to contact the trust's safeguarding team.

Community Enhancing Recovery Team

The service used the 'detailed risk assessment management' tool which the trust's risk management strategy noted as the approved tool for assessing and managing risk. As the service primarily worked to bring people back to Sheffield from out of area placements, it worked with providers across the country to conduct risk assessments of patients prior to patients entering the service. We looked at three care records and saw that risk assessments were present in all three records. Risk assessments were regularly updated including after every contact with patients and after incidents.

The service had an established lone working protocol in place which was a local-level adaptation of the trust's lone working policy. Staff were required to call the base office within 15 minutes of an appointment ending. This was a slight alteration from the trust policy because it required staff to call at the end of each visit rather than just at the end of the day. If staff did not phone within 15 minutes then staff at the base office would call the staff member.

Safeguarding training was mandatory in the trust. Compliance rates with safeguarding children level two and three were significantly below the trust target. We found that safeguarding systems and processes were not robust within the community enhanced recovery team. One person using the service told us about specific issues they had raised to various staff and management over a year ago. These were in relation to matters that the patient perceived to be, and described as, safeguarding concerns. The patient was unaware of any investigation and actions that had been undertaken and said they had received no outcome from the service. With the patient's consent, we contacted the trust to establish how the person's concerns had been addressed. A senior staff member undertook a fact finding investigation and we also spoke with the team manager.

We found the patient had made consistent disclosures to a number of staff members, which each reported to the management team. However, no formal account of the disclosures and concerns was obtained from the patient to act as a basis on which to investigate further. There was no consultation with the trust safeguarding team, no consideration evident as to whether the disclosures met the threshold for a safeguarding concern and staff had not made any report on the trust's incident reporting system. We found that the manager had taken action at local level by speaking informally with a staff member about their behaviour in order to address the concerns however the content of this discussion was not documented. Whilst the manager told us the concerns were found to be unsubstantiated there was no formal investigation in order to determine this outcome and no feedback to the patient about the findings.

The patient subsequently reported the same allegations to the local police service who raised a safeguarding alert to the local authority. This was passed on to the trust via the local authority. The team manager said that at the time they considered the matter had been dealt with and no action was taken in relation to this. Despite this, in the initial fact finding report produced as a response to our enquiries it was stated there was no police involvement. The team manager advised this was because the information had been removed from the trusts' system and therefore not possible to locate.

As a result of our findings, we could not be confident that staff could appropriately recognise and escalate concerns where necessary in order to suitably safeguard people using the service. We did not have assurance that managers responded appropriately when staff and patients raised safeguarding concerns. We did not have assurance that the service had adequate systems and processes in place to document safeguarding concerns.

Track record on safety

Between 1 April 2015 and 31 March 2016, trust staff reported 18 serious incidents across the trust; however, none were related to the service. Trusts are required to report serious incidents to strategic executive information system. These include 'never events' which are serious patient safety incidents that are wholly preventable. The trust reported 15 incidents on strategic executive information system between April 2015 and March 2016. None of these were never events. The service reported no incidents to the strategic executive information system between April 2015 and March 2016.

Neither service had any serious incidents requiring investigation in the twelve months prior to inspection. The

Requires improvement

Are services safe?

By safe, we mean that people are protected from abuse* and avoidable harm

intensive rehabilitation service reported 389 incidents from November 2015 to October 2016 using the trust's electronic incident reporting system. The majority (133) of these incidents were designated 'exploitation-abuse' involving patient to staff or patient to patient aggression. In the same period the community enhancing recovery team reported 157 incidents using the trust's electronic incident reporting system. Most were incidents of self-harm, substance misuse or verbal aggression from patients to staff.

Reporting incidents and learning from when things go wrong

The trust used an electronic incident reporting system. The system allowed all staff to report an incident. All staff knew how to use the system to report incidents and near-misses. We reviewed the reported incidents from November 2015 to October 2016. We saw that staff were offered debriefs following incidents and that these were recorded on the incident report.

In the intensive rehabilitation service all incidents were reviewed in both the unit-based local clinical governance meetings and the service-wide senior clinical governance meetings which had started in the service in June 2016. Staff also undertook regular formulation and reflective practice sessions which allowed staff to discuss cases and incidents. Staff were able to describe how incidents were discussed and gave examples of how incidents had led to changes in practice in the service. Two staff told us that medication rounds were undertaken by staff working in pairs following an incident where a staff member had been assaulted.

We reviewed the local clinical governance meeting minutes for all three units. We saw that individual incidents and incident themes were discussed.

In the community enhancing recovery team incidents were reviewed in local governance meetings which all staff attended. Staff were able to describe the process for how they would receive feedback following an incident although the team had not had a serious incident in the twelve months prior to inspection.

All staff had a good knowledge of the duty of candour. Most staff stated it was the requirement to be open, honest and transparent when things went wrong. One support worker in the intensive rehabilitation service knew that the duty of candour also included the requirement for services to apologise when things went wrong.

Are services effective?

Requires improvement

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

Our findings

Assessment of needs and planning of care

Intensive Rehabilitation Service – Forest Close

Our inspection in 2014 identified significant issues with care planning, noting that 'many of the care plans we looked at were not specific or recovery orientated [and] the plans focused on maintaining patients' current level of functioning rather than proactively working towards discharge'. During this inspection we found that the service had worked to address these issues and that care planning had significantly improved.

We reviewed ten care records. We saw in care records for patients admitted to the service since the service relaunched in June 2016, that risk assessments, risk management plans, and care plans were completed on the day of admission. Risk assessments and care plans for all patients were regularly updated. Care plans included examples of action to be taken when patients escalated or entered crisis. There was evidence of physical health monitoring including an annual full physical health assessment and monthly ongoing monitoring of physical health.

Care plans were personalised. The care plans from all three units were written collaboratively with patients and centred on listening to the individual's needs and wishes. Care plans were holistic by addressing all aspects of the patient's emotional, physical health and social needs. Care plans were recovery-orientated with all plans focussed on achieving eventual discharge. All patients had a copy of their care plan and a copy of their risk assessment in their patient file in their bedroom. Some patients did not have their full risk assessment in their patient file and that this was because the service had discussed with patients how much of the risk assessment patients wanted to see in their rooms and that this was an example of an individualised approach to care planning. On Bungalow 2, we saw that care plans were colour coded to identify patient involvement, with different colours used to identify the goals in the care plans which were set by the patient, by staff, or in partnership between patients and staff.

The service used an electronic system for patient records. Most staff were positive about the system and suggested that it was constantly being improved. Some staff described it as difficult to navigate. We saw on Bungalow 1 that the service used the electronic system for patient records but also kept paper printouts of the records. Staff explained that they felt the paper records were more accessible for staff to quickly read. The paper printouts were found to be fully coordinated with the electronic system and as up to date as the electronic system. One staff member had the responsibility of ensuring that the paper and electronic system was kept coordinated.

All ten records showed that patients received an individual physical health assessment on admission. The service undertook regular physical health monitoring. Care records recorded that patients had a monthly check of blood pressure, pulse, weight and temperature. Each patient had a monthly update using the malnutrition universal screening tool. This is a five-step screening tool used to identify patients who are malnourished, at risk of undernutrition or at risk of obesity. Four care records included a regularly updated Liverpool University neuroleptic side effect rating scale which is a tool used to assess several side effects of antipsychotic medication.

Community Enhancing Recovery Team

We reviewed three care records. All three had care plans which were used as 'live' documents and updated continuously by all professionals. Care plans were personalised, holistic and recovery orientated. Care plans included team-led goals which included crisis plans, and goals set by patients themselves. Goals were separated into an aim and a series of related steps to achieve this aim. The service was able to link progress notes to individual goals in care plans to evidence their completion. Patients not only had a copy of their care plan but could update it themselves by using a tablet connected to the internet. Staff brought tablets with them during visits.

The service used an electronic system for patient records. Staff told us that from November 2016 the service had also been allocated a central area on the trust's computer network where staff could store information.

Physical healthcare needs were considered in collaboration with primary care services. When a patient entered into the service they would be registered with a local general practitioner who would have primary responsibility for physical healthcare. Staff could also undertake physical health assessments as required in patient's homes.

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Best practice in treatment and care

Intensive Rehabilitation Service – Forest Close

Managers and staff were able to articulate how the service followed guidance from the National Institute for Health and Care Excellence when prescribing medication. Staff told us that the service used additional guidance when caring for patients with borderline personality disorder, bi-polar disorder and schizophrenia. Both unit managers told us that the multidisciplinary team referred to guidance from the National Institute for Health and Care Excellence when prescribing high-dose anti-psychotics. Although staff were able to describe how guidance from the National Institute for Health and Care Excellence was used in the service we did find a poorly managed use of rapid tranquilisation which did not follow NG10 'Violence and aggression: short-term management in mental health, health and community settings'.

The service employed two psychologists and one assistant psychologist. Whilst the psychologists were able to offer individual sessions for patients the main purpose of their role was to facilitate a wider input of psychology into the staff team. The psychologists facilitated a weekly staff reflective practice session where staff could discuss their experiences and gain insight on how to improve their practice. They facilitated a weekly formulation meeting. The British Psychological Society's report Clinical Psychology Forum 275 (2015) defines team formulation as a 'process of facilitating a group or team of professionals to construct a shared understanding of a service user's difficulties. It provides a structured way to integrate information from members of a multidisciplinary team and generate hypotheses to inform intervention planning'. The meetings allowed the multidisciplinary team to combine psychological and psychiatric approaches to interventions.

We raised during feedback to the service that whilst the service had introduced an programme which provided activities for patients seven days a week, the majority of activities were more social than focussed on rehabilitation. This was echoed in the feedback from some patients who told us that the activities were mostly good but was not rehabilitation. Opportunities to engage in rehabilitation focussed on activities of daily living were limited. Patients had limited access to facilities which enabled them to cater for themselves. Domestic staff handled laundry on all units. We saw limited examples of patients managing their own budgets.

The trust had participated in 29 clinical audits. Of these 29, the service participated in three trust wide audits. These were an audit of 'Prescribing for substance misuse: alcohol detoxification', an audit of 'Mental Health Act status' and an audit of the 'Detailed risk assessment model'.

Community Enhancing Recovery Team

Patients had access to psychological therapies through the psychologists working within the team. The psychologists were able to offer individual work to address areas of individual need including identifying and addressing emotions. The team also had staff who were trained in cognitive behavioural therapy. Access to psychology and cognitive behavioural therapy is recommended by the National Institute for Health and Care Excellence NG53 guidance 'Transition between inpatient mental health settings and community or care home settings' as part of good practice in ensuring successful discharge from inpatient to community placements.

Skilled staff to deliver care

Intensive Rehabilitation Service

Staff roles in the service included; consultants, a specialty doctor, a junior doctor, a clinical nurse manager, psychologists, ward managers, a senior practitioner, deputy ward managers, nurses, an art and music therapist, occupational therapists, a discharge pathway coordinator, a physiotherapist, administrators, a peer support worker, support workers and an apprentice.

The service had a compliance rate for supervision of 60%. This was 20% lower than the trust average of 80%. However, staff told us that they received regular group supervision through weekly reflective practice sessions and weekly formulation meetings. Whilst the trust's supervision policy allowed for group supervision as an option it was 'not a regular alternative to individual supervision except in exceptional circumstances or because of specific organisational needs'. The service manager and the two unit managers were open and honest about supervision compliance rates, noting that was partly the result a period of considerable change in the service and that this was an area which needed improving.

The overall compliance for the service for the number of non-medical staff having an appraisal was 90%, which was above the trust average of 86%. The trust provided combined data for 1 Forest Close and 2 Forest Close which showed that compliance with appraisal rates in these two

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units was below the trust average at 84%. All medical staff members in the service had received an annual appraisal within the last twelve months. Both doctors who were eligible had successfully completed their revalidation.

Staff in the service had access to additional specialist training for their roles. Three nurses told us that they had undertaken a course on psychosocial interventions provided in partnership with Sheffield University. Staff told us it was difficult to be released from ward duties to undertake additional training because of the high vacancy rate and the need for the ward to be adequately staffed.

Community Enhancing Recovery Team

Staff roles in the service included; a consultant, nurses, an occupational therapist, an occupational therapy assistant, psychologists and recovery workers. The service did not have a social worker and several members of staff told us that this was a gap in the team. The service had a compliance rate with supervision of 60%. This was 20% lower than the trust average of 80%. Staff told us they received regular group supervision and the service manager told us that the team undertook three reflective practice sessions a week which meant that every member of the team would be able to undertake at least one weekly session of group supervision.

The overall compliance for the service for the number of non-medical staff having an appraisal was 93%, which was above the trust average of 86%. All medical staff member in the service had received an annual appraisal within the last twelve months. The one doctor who was eligible had successfully completed revalidation.

Multi-disciplinary and inter-agency team work

Intensive Rehabilitation Service

We attended a morning meeting, two handovers, a reflective practice session and a multidisciplinary team meeting. The service had a daily morning meeting which included all members of the clinical team and at least one member of the nursing staff from each of the three bungalows. It allowed each bungalow to share their respective diary arrangements to ensure that there was coordination of staffing between the units. The service had three handovers each day. We saw in handovers that all patients were discussed. The discussion included each patient's mood, medication, activities, and leave arrangements. The service had a weekly multidisciplinary team meeting. The meeting was well attended by members of the team. Patients were able to attend the multidisciplinary meeting and we saw that they were given time to discuss their views and any problems they might have with their care.

The service worked with the community enhancing recovery team, community mental health teams and with social care providers. Staff described a positive working relationship with the community enhancing recovery team and with the community mental health teams who were involved in discharge planning. As part of the redesign of rehabilitation services the service had discharged a number of patients to social care settings. Staff described a mostly positive relationship with social care providers although some reported that the stringent referral criteria of some services had made discharging the remaining long stay patients more of a challenge.

In our inspection in 2014 we noted that the majority of patients did not have a care coordinator and that this was contrary to best practice guidance under the care programme approach. The report noted that 'All patients who are eligible for care under the care programme approach should have a care programme approach care coordinator appointed to co-ordinate the assessment and planning process in relation to the patient's social and health needs'. At this inspection, all patients had an appointed care coordinator as the service had a designated member of staff who acted as care coordinator for patients until a discharge placement was sourced. As part of the discharge process the care coordinator responsibility would be transferred to the community mental health team. Whilst all patients had a care coordinator, the allocation of the care coordinator role to inpatient staff is not good practice. The expertise of inpatient staff is in inpatient care. Community based mental health staff have the expertise in community resources and knowledge of referral and access systems for future placements. Patients of an inpatient rehabilitation service should be allocated a care coordinator from an appropriate community based mental health team.

Community Enhancing Recovery Team

The service had both a daily and a weekly planning meeting. The meetings involved all members of the multidisciplinary team. The team manager and the consultant psychiatrist described how the community enhancing recovery team worked well with colleagues in the intensive rehabilitation service, community mental

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health teams and primary care services. The team also had a well-established relationship with South Yorkshire Housing Association. The partnership meant that the trust was able to return patients from out of area placements to Sheffield with the team supporting patients to manage their own independent tenancies. On the first day of the inspection the trust's senior leadership team delivered a presentation to the inspection team which highlighted the partnership between the community enhancing recovery team and South Yorkshire Housing Association and stated that as a result of this partnership, 27 patients had been able to return to live in Sheffield.

The service undertook in-reach work with patients prior to admission. Staff worked with the patient whilst they were admitted to more secure/controlled access inpatient rehabilitation units, provided by the independent sector. This allowed staff to undertake a thorough assessment of risks as well as establish a therapeutic relationship with the patients.

Adherence to the Mental Health Act and the Mental Health Act Code of Practice

The overall compliance rate for Mental Health Act training across the trust was 67%. The intensive rehabilitation service achieved 85% compliance which was higher than both the trust average and the trust target. Only Bungalow 1a was below target with 64% compliance. The trust's Mental Health Act training module was not mandatory for community mental health services. The trust stated that qualified staff in the community enhancing recovery team had attended a social supervisor course which included training in the Mental Health Act. We found that staff in the community enhancing recovery team had a limited understanding of the Mental Health Act.

We found that most staff in the intensive rehabilitation service had a good understanding of the Mental Health Act including the guiding principles, the different sections of the Act and the requirements for patients to have leave under the Act. Mental Health Act paperwork was scrutinised first by the nurse receiving a new admission and by the unit consultant before being sent to the trust's Mental Health Act office. Staff knew who their Mental Health Administrators were, with most staff naming one individual in the trust's Mental Health Act office.

Detention paperwork and leave forms were kept in a file which was stored in the locked nursing office on each unit. Each patient had a copy of their leave arrangements in their personal file in their bedrooms. One deputy manager had responsibility for undertaking a weekly audit of Mental Health Act paperwork which was sent to the unit managers and to the Mental Health Act office.

The service used an electronic prescribing system which meant that consent to treatment forms could not be physically attached to medication charts. However, each clinic room had a file with a paper copy of the consent to treatment form stored near the clinic room computer. Patients had their rights under the Mental Health Act explained on admission and this was repeated every three months or after tribunals. Patients had access to an advocacy service. Access to the advocacy service was 'opt-in' which meant that patients had to express an interest in having an advocate and were not automatically referred to the advocacy service as part of their admission.

Good practice in applying the Mental Capacity Act

Training in the Mental Capacity Act was significantly below the trust target in both the intensive rehabilitation service and the community enhancing recovery team. The intensive rehabilitation service achieved 45% compliance with Mental Capacity Act level one training and 29% compliance with Mental Capacity Act level two training. The community enhancing recovery team achieved 56% compliance with Mental Capacity Act level one training and 36% compliance with Mental Capacity Act level two training. We found that staff understanding of the Mental Capacity Act was mixed between the two services.

Staff recognised that the trust had a policy on the Mental Capacity Act and knew where to find it on the trust intranet. Most staff in the intensive rehabilitation service knew the principles of the Mental Capacity Act and were able to give comprehensive descriptions of how capacity was assumed with patients and would be assessed on a decision specific basis. In our review of care records we saw how the Mental Capacity Act was used in practice with examples of capacity assessments leading to best interest decisions on behalf of patients. Examples in records included documented best interest decisions which were made for patients after assessments for capacity to consent to physical healthcare medication, capacity to make decisions regarding finances and capacity to consent to discharge plans. However, we noted in one record that staff had not undertaken a capacity assessment or best interest decision for a patient prescribed sodium valproate.

Are services effective?

Requires improvement

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The trust provided information around the Deprivation of Liberty Safeguards applications they have made between 1 March 2016 and 31 August 2016. Six Deprivation of Liberty Safeguards applications were raised by the service at Forest Close. All six applications were made prior to the service relaunching as an intensive rehabilitation service.

Staff in the community enhancing recovery team had a limited knowledge of the Mental Capacity Act. Most staff said that they were booked on to the training course in the future. We did not see in care records any formal documentation of considerations of capacity. The team manager told us that part of the team's in-reach process, where the team visited and assessed patients in out of area inpatient units, involved some consideration of capacity however, it was not routine for the service to have to assess capacity. Without formal training, the trust could not be assured that staff would adhere to the guiding principles of the Mental Capacity Act.

Good

Are services caring?

By caring, we mean that staff involve and treat people with compassion, kindness, dignity and respect.

Our findings

Kindness, dignity, respect and support

We spoke with 11 patients from the intensive rehabilitation service and four patients from the community enhancing recovery team. Almost all patient feedback was positive about both services.

Patients in the intensive rehabilitation service told us that staff always had time for patients and that staff encouraged patients to push themselves in their recovery. One patient told us that 'being here [at Forest Close] has made me happy, when I've asked for things I've mostly heard yes rather than no and when staff say no they explain why'. However, one patient expressed frustration with the activities available in the service and felt that the activities available were not linked to rehabilitation.

During our inspection of the community enhancing recovery team we observed staff interactions with patients. We observed that these interactions were respectful and friendly. We saw how staff avoided disempowering patients by adopting an approach that was positive, caring and genuinely enabling. One service user told us that 'staff are very good and kind, some have lived experience of mental health distress which is great'.

The involvement of people in the care they receive

Both the intensive rehabilitation service and the community enhancing recovery team undertook in-reach as part of their admission process. This involved staff meeting patients at their current placements before they were either admitted to an inpatient bed or discharged to the care of the community service. In the intensive rehabilitation service patients were able to visit Forest Close to meet other patients and staff prior to admission.

The intensive rehabilitation service had established a list of 'inpatient standards' which were used prior and during admission and discharge. From the point of admission the service had a 36 point checklist of activities to undertake with patients to successfully orientate them to the unit. Some activities had different timescales which meant that patients would undergo certain activities within six hours of arrival, and then within 24 hours, 72 hours and a week respectively. Orientation activities included an introduction to the ward environment, a discussion of the purpose of admission and consultation with the patient on specific dietary or cultural needs.

We saw in active patient involvement and participation in their care plans from both the intensive rehabilitation service and the community enhancing recovery team.

In the intensive rehabilitation service patients had a copy of their care plan, risk assessment and risk management plan in a file in their bedroom which was coproduced by patients and staff. Some patients did not have their full risk assessment in their patient file. This was because staff had discussed with patients how much of the risk assessment patients wanted to see in their rooms.

In September 2016 all three bungalows had started regular community meetings which allowed patients to provide feedback about the service. Between September 2016 and November 2016 each bungalow had undertaken three community meetings. We were able to see minutes of community meetings and saw how patients were encouraged to offer feedback, compliments and complaints about the service in meetings. The service had encouraged patients to get involved with staff recruitment although one unit manager told us that this depended on how well the patient group was at the time. If patients were unwilling or could not get involved with recruitment then the service had access to and had used patient representatives from other inpatient services in the trust.

In the community enhancing recovery team patients had a copy of their care plan and the service was able to use the electronic system to record how often patients received a printed copy of their plan. Patients were able to use tablet computers brought by staff to directly update their care plans.

We spoke to two carers of patients in the intensive rehabilitation service and two carers of patients of the community enhancing recovery team. Carers told us that they felt fully involved in the care being provided and that both services had ensured that they were given enough information about the service. Carers were invited and attended care programme approach meetings and were kept informed if any issues arose in between meetings. Carers felt able to give feedback to both services and all four carers told us that they felt the services would respond to and take action from feedback.

Are services responsive to people's needs?

Good

By responsive, we mean that services are organised so that they meet people's needs.

Our findings

Access and discharge

Intensive Rehabilitation Service – Forest Close

The standard operational policy stated that the service accepted referrals from acute mental health wards, and 'to facilitate transition from a highly supported setting to a less restrictive setting including step-down from medium and low secure care'. The referral criteria for the service was:

- Aged over 18.
- Primary major diagnosis for example treatment resistive psychosis.
- Significant risks identified in relation to mental disorder or short-term risk/symptoms regarding stabilisation.
- A history of: aggression and violence; absconding: usually periodic or persistent and the consequences of the absconding are serious enough to warrant continued treatment; challenging behaviour with complex and significant needs that require intensive rehabilitation and recovery.

The service did not have a specific exclusion criteria separate to the referral criteria other than 'any individual who is unwilling to engage'.

The service had a referral screening process. Within two weeks of receiving a referral the service made contact with the referrer to arrange an initial assessment. The initial assessment was face to face with the patient and was based on the referral and gatekeeping assessment form for intensive rehabilitation services. The assessment was used as a basis for a report which was discussed in the fortnightly multi-disciplinary team referral meeting. If the referral was deemed appropriate for the service then staff would arrange the transfer or admission of the patient as soon as a bed was available. If the referral was deemed not appropriate to the service then the staff would contact the referrer to inform them of the outcome of the assessment.

The new service had a target for an average length of stay of no more than eighteen months. However, as the service had only relaunched four months prior to inspection it was not possible to judge compliance with this new target. The service had a bed occupancy rate of 79%. All CQC inspections of inpatient services include the average length of stay and the number of delayed discharges in the inspection report.

- Between 1 August 2015 and 31 July 2016 the service had an average length of stay of 3483 days for discharged patients. This meant that the average length of stay for discharged patients was over nine years.
- At 31 July 2016 the average length of stay for current patients was 1430 days. This meant that for patients who were admitted prior to July 2016 the average length of stay was almost four years.
- The service had 39 delayed discharges between 1 February 2015 and 31 July 2016, however most had been discharged by November 2016.

However, the service had redesigned and re-launched in July 2016, moving from a long stay rehabilitation service to an intensive rehabilitation service. By the time of inspection in November 2016, the impact of the change in service specification was such that the average length of stay prior to the relaunch had ceased to be a meaningful figure. The redesign had involved the closure of Pinecroft, a 17 bed mixed gender open recovery ward based in The Longley Centre in Sheffield; the closure of Bungalow 3, an eight bed mixed gender open rehabilitation ward; and the reduction in total bed numbers from 62 beds to 30 beds. The service had discharged 32 patients during this process, including 12 patients between November 2015 and October 2016. Three of the 12 patients discharged in this period had been admitted since the service had relaunched.

We asked for a snapshot of current service users on a specific day to evidence the impact of new admissions on the service average length of stay. Of the 30 patients who were current patients on 16 November 2016, eight had been in the service for over eighteen months. The longest length of stay in this group was over 22 years with an average length of stay of slightly over seven years. However, we found that staff were focussed on and hopeful for discharge in a way that was not apparent during the last inspection. Staff were open with us that not all patients from the previous service specification had been discharged to new appropriate placements. Staff told us that they were constantly trying to source placements for patients but routinely encountered difficulties finding affordable providers who would accept patients with complex physical and mental health needs. We asked staff to talk us through the discharge plan for each patient who had significantly exceeded the intended length of stay. In each case staff were hopeful that patients would be discharged within a year.

Are services responsive to people's needs?

Good

By responsive, we mean that services are organised so that they meet people's needs.

The service had no out of area placements. Patients had access to a bed on return from leave. We were told that the service also kept beds free for up to four weeks after a patient had been discharged in case the discharge placement broke down for any reason. During 2016 the service had undertaken a significant refurbishment programme on Bungalow 1, Bungalow 1a and Bungalow 2. This had meant that patients had been moved between the units as they were closed, refurbished and reopened.

Community Enhancing Recovery Team

The standard operational policy stated that the team accepted referrals for adults aged 18 or over at the time of referral. Patients had to be Sheffield residents with Sheffield clinical commissioning group responsible for providing or commissioning their health care. Likely referrals to the team included patients who:

- Had mental health problems and or learning disabilities
- Had identified rehabilitation and recovery needs
- May have had repeated mental health admissions
- May have had problems engaging with services
- May have had admissions to more secure/controlled access inpatient rehabilitation units, provided by the independent sector, for people with more complex and/or challenging behaviours
- May require the community enhancing recovery team to avoid admission to inpatient rehabilitation
- May have co-morbid substance misuse

The service did not have a specific exclusion criteria separate to the referral criteria. On average the team was able to achieve a referral to initial assessment time of less than a week. The service operated from 8am to 9pm. Between 9pm and 8am patients had access to the trust's out of hours team which was staffed 24 hours a day. The service had admitted 33 patients since 1 July 2014. We requested a breakdown of the caseload of current and discharged service users. Of the 33 patients admitted since 1 July 2014, the service had discharged four patients into alternative services. The target for average length of stay with the service was 12 months although it was accepted that patients would require rehabilitation on average from between 6-18 months. The average length of stay for discharged patients was around eighteen months (75 weeks). The average length of stay in the service for patients still on the current caseload was 65 weeks. Four patients had been with the service since 01 July 2014 with a length of stay of almost two and a half years.

The facilities promote recovery, comfort, dignity and confidentiality

All three units had a clinic room, a lounge area for patients and a dining area. All bedrooms were ensuite. However there was not a full range of rooms and equipment to support treatment and care, including for example an activity kitchen on all units.

The service operational policy stated that 'breakfast, lunch and an evening hot meal will be provided on the unit every day until a patient is ready to self-cater' and 'there is… the opportunity to self-cater as part of a collaborative goal and discharge planning subject to satisfactory risk assessment'. Bungalow 1a had an activity kitchen on the unit. Bungalow 1 and Bungalow 2 did not have a designated area where patients could self-cater. Bungalow 1 and Bungalow 2 had access to one activity kitchen where patients could self-cater which was located on Bungalow 3. Staff told us that the service did not have patients who entirely catered for themselves nor did the service have the facilities for patients to do so. This meant there were limited opportunities for patients who may be able to, cater for themselves, to develop and improve the skills they would need on discharge from the hospital.

Almost all meals were prepared on site by housekeeping staff. The service had a four week menu which was regularly reviewed by patients in community meetings. Each menu had at least three choices, although housekeeping staff told us that they would be able to offer more options if patients did not like any of three available. Patients had access to a beverage bay where they could make hot drinks. There were no facilities for making snacks although staff told us they would make them for patients if they requested them. Patients told us that they were happy with the food quality.

The service was heavily reliant on Bungalow 3 as the designated space for on-site therapy and activities. Bungalow 3 contained the activity kitchen, a pool table, a music room and an aromatherapy room. Bungalow 1 and Bungalow 2 by comparison had a lounge with a television, a 'green room' which was a low stimulus de-escalation/relaxation room and a dining area with a beverage bay. Bungalow 1a had an activity kitchen in addition to these rooms.

Whilst patients did have access to a quiet room where they could meet visitors it was not located on the units. The visitor's space was located in the alternately named

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Bungalow 4 or Core Bungalow. Apart from the visitor's room, this building was entirely for the use of managers and staff as an administration hub. There was a kitchen on Bungalow 4 where staff would make hot drinks for patients and visitors. There was not a facility where patients could themselves make a drink for visitors on Bungalow 4.

Access to mobile phones was individually risk assessed. Each unit had a cordless phone which patients could take into their bedrooms to make a private phone call. All three units had unrestricted access to a small garden as outside space. All bedrooms had a safe where patients could securely store their possessions. The unit managers told us that patients could personalise their rooms if they wanted to. We saw that some patients had posters up in their rooms and that some had televisions and music systems in their rooms.

The service had introduced an activity programme for patients as part of the service redesign. All patients had an individual activity timetable in their bedrooms. Patients had access to community groups such as a cycling group. On-site patients could access aromatherapy sessions, music sessions and a weekly film night.

Meeting the needs of all people who use the service

The intensive rehabilitation service operated from units which were bungalows and as such were entirely based on the ground floor. All areas appeared to be accessible to patients in a wheelchair. One patient told us that the doors of Bungalow 1a were particularly heavy and were difficult for older patients to open. We noted that none of the doors were automated to make accessibility easier.

All three units had an accessible bathroom for patients with a physical disability. Whilst none of the accessible bathrooms had a hoist for the bath, the unit managers told us that this could be sourced if it was needed.

The community enhancing recovery team operated predominantly in community settings. The facilities occupied by the team in the Michael Carlisle Centre had rooms which were accessible for patients with disabilities however the focus and purpose of the team was deliver care in patient's own homes.

Both services had a range of leaflets available about local services, patient groups and how to complain. All of the leaflets on the units were in English and managers told us that leaflets in alternative languages could be ordered from the trust if needed. Whilst the intensive rehabilitation service had never needed to use an interpreter one could be sourced from the trust. The unit managers were aware that the provider of the interpreter service had recently changed.

The intensive rehabilitation service catered for people who had specific dietary requirements including vegetarian or halal diets. We saw that the service had undertaken a specific piece of work to cater for a patient who had fluctuating capacity to make the decision to have a halal diet. Staff would encourage the service user to make a choice at each meal and would signpost the halal option but respect the patient wishes if they chose not to take it. Spiritual support was provided by both a chaplain and an imam who visited regularly. We saw posters advertising the next visit of the chaplain which was soon after the inspection.

Listening to and learning from concerns and complaints

The trust recognised two types of complaints. The trust policy stated that formal complaints as the first type were 'an expression of dissatisfaction communicated verbally, electronically or in writing which requires a response'. The second type was an informal complaint which was one 'made either orally and can be resolved within twenty four hours or is made via the trust's FastTrack system'. Informal complaints were not reported as complaints but were recorded on the Complaint's Department database.

Both Bungalow 1a and Bungalow 2 had received two formal complaints in the period 1 September 2015 to 25 August 2016. Neither of the complaints were upheld or referred to the ombudsman. From 1 September 2015 to 14 November 2016 Forest Close received 11 informal complaints via the FastTrack system.

The community enhancing recovery team received no formal complaints in the reporting period and one informal complaint via the FastTrack system.

Both services had posters advising people on how to make a complaint. Information on the complaints process was also included in Forest Close's patient information booklet and in the individual patient information files kept in patient bedrooms. Staff told us they would encourage patients to use the FastTrack system to ensure they had a quick resolution to complaints.

Are services responsive to people's needs?

Good

By responsive, we mean that services are organised so that they meet people's needs.

Both Bungalow 1 and Bungalow 2 received two compliments, and Bungalow 1a received one written compliment in the twelve months prior to inspection. The community enhancing recovery team received six written compliments.

Are services well-led?

Requires improvement

By well-led, we mean that the leadership, management and governance of the organisation assure the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

Our findings

Vision and values

The service was delivered by Sheffield Health and Social Care NHS Foundation Trust which had, at trust level, adopted a vision, values and a purpose.

The trust wide vision was for "Sheffield Health and Social Care NHS Foundation Trust to be recognised nationally as a leading provider of high quality health and social care services and recognised as world class in terms of co-production, safety, improved outcomes, experience and social inclusion. We will be the first choice for service users, their families and commissioners".

The trust had six values:

- Respect
- Compassion
- Partnership
- Accountability
- Fairness
- Ambition

The trust purpose was "to improve people's health, wellbeing and social inclusion so they can live fulfilled lives in their community. We will achieve this by providing services aligned with primary care that meet people's health and social care needs, support recovery and improve health and wellbeing".

We interviewed staff working in a variety of roles in both the intensive rehabilitation service and the community enhancing recovery team and found that all had a good understanding of the trust values. Staff were able to recall both the wording of the trust values and describe how the values were used in everyday practice.

Staff knew, and were positive about, their local managers. The local managers told us that they felt well supported by their immediate line managers. Staff knew the most senior managers in the trust and told us that they visited the units regularly.

Good governance

During the inspection we identified that staff in the community enhancing recovery team had not responded appropriately to a patient who disclosed safeguarding concerns to several members of staff. Staff had not made a formal record of the disclosures. The manager who was informed of the disclosures had not consulted the trust safeguarding team or made a formal report on the trust incident reporting system and had taken action at local level by speaking informally with a staff member about their behavior in order to address the concerns. The concerns were never formally investigated, the response was not documented and the patient who raised the concerns did not receive feedback from the service. The service produced a fact finding report in response to our enquiries during the inspection. The report stated there was no police involvement which we later found to be incorrect. The team manager advised this was because the information had been removed from the trust's system and therefore not possible to locate. We concluded that staff including managers in the service did not consistently take appropriate action in response to safeguarding concerns, that staff including managers in the service did not consistently follow the trust safeguarding policy and that the system used to record actions in relation to safeguarding concerns was not always accurate.

The trust target for mandatory training was 75%. The intensive rehabilitation service achieved an average compliance of 60%. The community enhancing recovery service achieved an average compliance of 76%. The data from the trust indicated that both services had a significant number of mandatory training modules that were considerably below the trust compliance target.

The trust on average had completed appraisals for 86% of staff. Both services had achieved a higher rate of compliance than the trust average. The intensive rehabilitation service had completed appraisals for 90% of staff. The community enhancing recovery service had completed appraisals for 93% of staff.

The trust had an average supervision rate of 80%. This was measured by a trust target of a minimum of one session of supervision for each staff member every four to six weeks. Neither the intensive rehabilitation service nor the community enhancing recovery service were meeting this target or exceeding the trust average. Both the intensive rehabilitation service and the community enhancing recovery team had achieved a compliance rate of 60%. Both services had regular reflective practice sessions which allowed staff to engage in group supervision.

The community enhancing recovery team had a higher average vacancy rate than the trust average. This vacancy rate included all clinical and non-clinical staff. The service had no vacancies for qualified nurses. Staff told us that

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there was no impact from the vacancy rate and that the team had sufficient staff to manage periods of sickness and annual leave from within the team. There was no use of bank or agency staff in our reporting period which if used would have indicated a need for shifts to be covered by external staff.

The intensive rehabilitation service had a higher average vacancy rate than the trust average. The vacancy rate for qualified nurses and nursing assistants was significantly higher than the trust average. We saw that the vacancy rate was having a significant impact on the service. During the period February to October 2016 there were 15 reported incidents of low staffing, of which eight were reports that one nurse covered more than one bungalow.

The service was routinely having one qualified nurse cover more than one unit. This was noted in our inspection in 2014 as unsafe. The deputy manager responsible for training kept a log of future training courses that were booked and past courses that were cancelled. Staff were occasionally having to withdraw from training courses in order to provide safe staffing levels on the wards. The service manager was proactive in raising concerns about staffing levels and we saw how incidents where one nurse covered more than one unit were regularly escalated to trust board level. Staffing levels were also on the service risk register.

Staff were able to describe how incidents were reported and how they learnt from incidents. Both services had regular clinical governance meetings where incidents and trends in incidents were discussed. The intensive rehabilitation service had regular community meetings where patients could give feedback about the service and patients and carers told us that they felt the service responded to feedback. Both services ensured that patients could use the trust's FastTrack system for complaints to ensure that patients received a quick resolution to complaints.

Staff in the intensive rehabilitation service had a good understanding of safeguarding and the duty of candour. We found that staff in the service had a good understanding of the Mental Health Act and that Mental Health Act paperwork was regularly audited. We found that staff in the service had a good understanding of the Mental Capacity Act and we saw evidence in patient records that the Mental Capacity Act was being used regularly and appropriately although we noted in one record that staff had not undertaken a capacity assessment or best interest decision for a patient prescribed sodium valproate.

We found that staff in the community enhancing recovery team had a limited understanding of the Mental Health Act. Compliance rates with both modules of training in the Mental Capacity Act was low in the community enhancing recovery team. We found that staff had a limited understanding of the Act and patient records did not provide sufficient evidence to show that staff were regularly considering capacity in their interactions with patients. Without formal training, the trust could not be assured that staff would adhere to the guiding principles of the Mental Capacity Act.

The services used key performance indicators for mandatory training, appraisal rates, supervision rates and sickness rates. Unit managers had oversight of key performance indicators and were able to describe how the team was performing. There were significant shortfalls in mandatory training and supervision The community enhancing recovery team had a local risk register and the team manager was able to describe the process for escalating risks to the directorate-level risk register.

All three units had a unit-based risk register. The unit managers were able to describe the process for escalating risks to the directorate-level risk register. One unit manager explained that the risk related to the personal alarm system on Bungalow 3 was on the risk register. We saw that the register noted that Bungalow 3 was 'is in a transitional period of change awaiting refurbishment'. The alarm system was subject to 'an additional risk assessment'. The specific risk related to Bungalow 3 not being connected to the alarm system used on Bungalow 1, Bungalow 1a and Bungalow 2 was not explicit on the risk register. The controls for this risk were not noted on the risk register. The service manager told us that the controls in place to manage this risk was individual patient risk assessment and that staff were given hand held panic alarms whilst on Bungalow 3.

During the inspection the inspection team made 30 requests in total for additional written evidence from the intensive rehabilitation service and the community enhancing recovery team. An additional evidence request forms part of the evidence base used to inform the report. Trusts and services are given 24 hours to respond to simple

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requests and 48 hours to respond to more complex requests. The service did not meet these targets for any of the requests made. We requested for example the last three staffing capability reports. Although these reports are available on the trust website the trust took eight days to meet the request for this information. We requested staff meeting minutes for the community enhancing recovery team. The trust took 16 days to meet this request. The length of time to complete each request led to the conclusion that information was either not routinely collected and monitored or was not readily accessible to the service and the trust.

Leadership, morale and staff engagement

There were no reported cases of bullying or harassment in either service. Not all staff fully understood the concept of whistleblowing. Staff told us they felt they could raise concerns to service managers and most felt their concerns would be responded to. None of the staff suggested that they would raise concerns to external organisations. Staff told us they felt able to raise concerns without fear of victimisation.

Staff morale in the community enhancing recovery team was consistently positive. Staff were enthusiastic about the work of the team. Staff felt supported by their local team manager and by senior managers. Sickness rates in the team were lower than the trust average.

Staff morale in the intensive rehabilitation service was mixed. In the last twelve months the service had gone through a significant period of change. The service had redesigned from a slow stream long stay service to an intensive rehabilitation service. Staff told us that the service redesign had caused significant upheaval in the team. Most staff that we talked to were positive about the future of the service, although some told us that they planned to leave the service as a result of the changes. There was a lack of service-wide clarity on the future of Bungalow 3 and that there was no consistent message from the trust on if, or when, or for what purpose, the Bungalow would be refurbished. Therefore we found that communication in the service was not consistent and different staff offered us several different versions of the future plans for Bungalow 3.

The average sickness rate for the intensive rehabilitation service was in line with the trust average. The unit manager for Bungalow 1 and 2 told us that the sickness rate was higher than the rest of the service and that this had created pressures in staffing. The service had a high vacancy rate for both qualified nurses and nursing assistants. The service relied on staff overtime and bank staff to cover shifts. There was no use of agency staff however the service manager did express frustration with the procedure for bringing in agency staff to cover both clinical and housekeeping shifts.

Whilst local managers in the intensive rehabilitation service were proactive at raising concerns, the response from the trust was sometimes slow. During the inspection, we raised concerns about the drainage smell on Bungalow 3 and the temperature of patient bedrooms on Bungalow 2. We were shown evidence that the service had proactively and regularly raised concerns about both issues with the trust estates department. During the inspection, our governance team raised concerns with the estates department about the effectiveness of responses to maintenance requests from local services.

Both unit managers and the service manager told us they felt they had enough authority to do the job. However we saw examples where the limits of authority and ability to influence change were having a direct impact on the service. We saw how the service was proactive at raising concerns to the trust senior managers. However, as the service was raising these concerns regularly this led us to conclude that the trust's response was either not timely or not sufficient. The difficulties faced by the service manager and unit managers in maintaining safe staffing levels, securing agency staff, addressing maintenance issues and the lack of clarity over the future of Bungalow 3 led us to conclude that the service was being led on a local level, but there was a lack of support for the local leadership from the trust.

Commitment to quality improvement and innovation

The work of the community enhancing recovery team was regarded both by the trust and by local commissioners as an example of innovation and partnership working. The team allowed patients who were admitted to units out of area to return to live in their home city. The team was specifically highlighted in the trust presentation to the inspection team and was included in the inspection schedule at the trust's request.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care **How the regulation was not being met:** The trust did not ensure that people using the service have care or treatment that is personalised specifically for them because: In the intensive rehabilitation service patients had limited access to therapeutic activities. This was a breach of Regulation 9(1)(3(a)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **How the regulation was not being met:** The trust did not prevent people from receiving unsafe care and treatment and prevent avoidable harm or risk of harm because: In the intensive rehabilitation service Bungalow 3 was not connected to the service-wide personal alarm system used on Bungalow 1, Bungalow 1a and Bungalow 2. The service did not have adequate mitigation in place to reduce the risk of harm. This was a breach of Regulation 12(2)(a)(b)(d) The trust did not ensure that medicines were managed safely and administered appropriately to make sure people are safe because: In the intensive rehabilitation service staff had not followed the trust policy following an incident of rapid tranquilisation. Staff had not followed national guidance

This section is primarily information for the provider

Requirement notices

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

This was a breach of Regulation 12(2)(g)

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment **How the regulation was not being met:** The trust did not have effective systems and processes to investigate immediately, upon becoming aware of, any allegation or evidence of such abuse. In the community enhancing recovery team staff had not taken appropriate action in relation to safeguarding concerns raised by a patient. The concerns were not reported, escalated and investigated in line with the trust safeguarding policy. This was a breach of Regulation 13(3) In the intensive rehabilitation service Bungalow 1, Bungalow 1a and Bungalow 2 had blanket restrictions for locked doors and cutlery which did not take into account the risks of individual patients This was a breach of Regulation 13(4)(b)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment **How the regulation was not being met:** The trust did not ensure that premises where care and treatment are delivered were clean because: In the intensive rehabilitation service Bungalow 3 was found to be unclean. Cleaning schedules for Bungalow 3 were not consistently maintained or accurate. Cleaning schedules for Bungalow 1 were not fully completed.

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **How the regulation was not being met:** The trust did not have effective governance systems to assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of patients in receiving those services) because: In the intensive rehabilitation service 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. The system used by the community enhancing recovery team for action in relation to safeguarding concerns was not accurate. In the intensive rehabilitation service and the community enhancing recovery team managers did not ensure that the service fully complied with the trust supervision policy. In the intensive rehabilitation service and the community enhancing recovery team staff were not able to share relevant information with the Care Quality Commission in a timely manner This was a breach of Regulation 17(1)(2)(a)(b)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **How the regulation was not being met:** The trust did not deploy sufficient numbers of suitably qualified, competent, skilled and experienced persons to meet the care and treatment needs of people using the service because: In the intensive rehabilitation service there were fifteen incidents of low staffing from February to October 2016. Eight incident reports specifically stated that one nurse covered more than one unit.

This section is primarily information for the provider

Requirement notices

This was a breach of Regulation 18(1)

In the intensive rehabilitation service the overall compliance rate for mandatory training was below the requirement. Thirteen courses were below 75% compliance. In the community enhancing recovery service ten courses were below compliance

This was a breach of Regulation 18(2)(a)