Sheffield Health and Social Care NHS Foundation Trust

Inspection report

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Ratings

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

Our findings

Our reports

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

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

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

Overall summary

What we found

Overall trust

We carried out this unannounced inspection of the acute wards and psychiatric intensive care units, mental health wards for older people, and crisis and health-based places of safety because at our last inspection we rated them inadequate.

We inspected the well-led key question for the trust overall because at our last inspection we rated the trust as inadequate following which the trust was placed in special measures to help it improve.

At this inspection we rated two services as requires improvement, we continued to rate the acute wards and psychiatric intensive care units as inadequate because further improvement was required.

The trust was rated as requires improvement overall with a rating of good in the caring key question.

We did not inspect forensic wards or community based mental health services for adults of working age because we rated them requires improvement at our last inspection. We are monitoring the progress of improvements to these services and will re-inspect them as appropriate.

We did not inspect long stay rehabilitation wards, community substance misuse services or community mental health services for people with learning disabilities or autism and older people, because they were rated good or outstanding, and we did not have information that meant we needed to visit these services this time.

We did not inspect forensic wards or community based mental health services for adults of working age because we rated them requires improvement at our last inspection and the services had not had time to make the improvements necessary to meet legal requirements as set out in the action plan the trust sent us after the last inspection. We are monitoring the progress of improvements to services and will re-inspect them as appropriate.

Prior to this inspection, we inspected wards for people with learning disabilities and autism.

Our findings

To support the trust, NHS England and Improvement have recently placed the trust into segment 4 of their Systems Oversight Framework and it will receive a package of support through the national Recovery Support Programme.

Our rating of the trust improved. We rated the trust as requires improvement because:

- We rated safe, effective, responsive and well-led as requires improvement, and caring as good. In rating the trust, we took into account the current ratings of the six services not inspected this time. The adult social care services provided by the trust were not inspected this time, and their previous ratings were not aggregated into the trust's overall rating.
- One of the trust's services had worsened since the last inspection, we rated inpatient services for people with learning disabilities or autism as inadequate. We took enforcement action following this inspection due to significant concerns identified.
- Acute wards and the psychiatric intensive care unit had not improved enough for us to improve the rating of this service and it remained inadequate overall. We took enforcement action following this inspection due to significant concerns identified.
- The trust had plans in place to continue to improve the safety and quality of their services supported by a strategy through to 2025. They had not yet had time to embed these plans and therefore whilst planned changes were evident, these were not yet in place at the time of the inspection as most initiatives were new or developing.
- The accommodation in which the trust provided care continued to a present a significant risk to patients. There were a number of ligature anchor points and blind spots on the acute wards which did not have adequate mitigation in place to keep people safe. Areas of the acute wards and one of the older people's wards were poorly maintained and patients had come to harm when using these services. The privacy and dignity of patients in seclusion on Burbage Ward was not protected, an issue identified on our last inspection. Staff working in community services told us that they had low morale because of the poorly maintained environments the trust asked them to work within.
- Not all wards had enough staff who knew patients well and were able to care for them safely. The trust used a significant level of agency staff in order to maintain the safety of the wards who were not trained in the trust's restraint techniques. Staff told us that this put them, and patients at risk because these staff were not always able to intervene when patients became distressed. There were a high number of vacancies for band five nurses. There remained gaps in medical cover and this meant that people's reviews in seclusion and in the health-based places of safety were delayed.
- Safeguarding and incident reporting remained a concern because incidents were not always reported and investigated correctly. The trust were not performing their statutory and delegated responsibilities well. Patients had not been safeguarded when they had experienced abuse or improper treatment on the acute wards and in the learning disability inpatient service. The trust had a rapid improvement plan in place for their safeguarding functions, but this had been removed as a risk on the trust's board assurance framework.
- There were high levels of the use of seclusion on the older people's wards, and this was not always used as a last resort and in line with the Mental Health Act Code of Practice.
- The trust was inconsistent in their approach to blanket restrictions and we found that on the acute wards and in the learning disability inpatient ward people's rights and freedoms were sometimes restricted.
- Rates of compliance with mandatory training had improved, however courses in immediate life support and restraint techniques (respect) where below the trust's target. Not all wards had enough mitigations in place to ensure patients did not come to harm due to low levels of compliance with training.

Our findings

- The trust did not always provide effective care. People using services and their carers were not always involved in their care and treatment. Care plans were not personalised and people were not always involved in discussions about their care and treatment.
- Since the last inspection, the trust had double the amount of supervision sessions offered to staff. However, compliance with supervision remained below the trust target.
- There were pockets of closed cultures within the trust were staff had not provided kind, dignified and compassionate care. Leaders had not always recognised and acted quickly enough on the early warning signs in regard to closed cultures developing, and people using services had come to harm. The culture of the trust below the board and executive leadership team was not always positive. Staff told us that they did not always feel involved, had low morale in some teams and the staff survey and friends and family test outcomes indicated that staff would not recommend the trust as a place to work, or as a place for their relatives to receive care. Risks about the continued development of closed cultures were not entered on risk registers or the board assurance framework.
- The trust was not consistently responsive. There were significant waiting times in community and specialist services and in the emotional wellbeing service. The trust did not have an accessible complaints policy available to the public and people did not always know how to complain. The trust did not use complaints to drive improvement in services.
- The trust relied on digital systems which were not fit for purpose and did not support the provision of high-quality patient care. This remained a significant risk for the trust and patient records had been lost due to failures in the system. We were concerned about the pace at which the organisation were able to bring about improvement in its digital systems.
- The trust required continued improvement in its approach to equality and diversity. The workplace race equality and disability standards had a number of key metrics where the trust had failed to meet their targets. Staff who were disabled or from a black minority ethnic background continued to be adversely affected in recruitment and selection, progression, disciplinary processes and felt more likely to experience bullying or harassment. The trust did not have an effective system in place to address the feedback raised by staff in relation to equality and diversity.
- Senior leaders did not always ensure that they reported accurate assurance on areas of risk to the executive team. In learning disability services and in acute wards patients had come to harm and when this was brought to the attention of senior leaders it did not always result in reporting to the executive team and board for oversight and action.
- There continued to be a high number of medicines administration errors and the trust had not made improvements in reducing the amount of errors being made over time.

However:

- The trust had made improvements since the time of the last inspection and the rating of well-led had improved from inadequate to requires improvement. The ratings of two of the four services we inspected had improved since the last inspection.
- The trust leadership had improved since the last inspection, a number of new leaders had joined the executive and non-executive team and were leading the trusts improvement journey. The executive team and board had improved their oversight of and engagement with services including refreshed board visits to services with evidence of feedback from visits into board and committees.
- There were a number of areas of concern at the last inspection which the trust had acted upon to reduce risk. The new leadership team had also identified a number of additional concerns and areas for improvement that had now been included in improvement plans going forward.

Our findings

- The safety of some services had improved. There had been significant improvement in the delivery of physical health care to patients which included a revised physical health strategy and ongoing monitoring of compliance with reporting.
- The oversight of staffing had improved, and the trust had now ensured that high numbers of shifts were not being covered by newly qualified nurses. Daily staffing huddles had improved the oversight of leaders and allowed for the fluid deployment of staff into areas of the service which needed support.
- There was improved oversight and involvement of the pharmacy team who provided support to staff within wards and services.
- The trust had made some improvements to their estates include interim measures taken to improve accommodation whilst the trust worked to secure longer term improvement. This included the removal of dormitory accommodation and implementation of single sex accommodation on two of the three acute wards.
- There had been no use of mechanical restraint by staff in the three months prior to the inspection and when this was used by external partners there was robust oversight and reporting. There was a falls management process in place on the older people's inpatient wards.
- During the inspections we observed staff providing, in most services, kind and compassionate care. People who used services and stakeholders told us about staff who were active listeners who provided good care.
- The leadership of the trust had improved, leaders were working cohesively, and the restructures of some services and their leadership allowed clarity of responsibilities and improved oversight and ownership of risks.
- Oversight of human resources had improved. The trust had oversight of disclosure and barring checks and oversight of staff professional registrations. The trust were able to evidence compliance with the fit and proper persons regulation. However, the response times for the grievance process required further improvement.
- The trust's oversight of risk had improved. The development of an integrated performance report allowed leaders and the board to have oversight of emerging risks and issues and allowed for clear action planning to reduce or mitigate risks.
- The trust had invested in the development of the organisation, the board and the governors to ensure effective governance processes were in place.
- The trust had improved engagement with staff, staff side, governors and stakeholders and system partners. We saw strengthened relationships with the voluntary sector. The trust had taken action to engage staff in conversations about racial discrimination and had action plans and pilot projects in place to make improvements.

How we carried out the inspection

During this inspection we;

- worked with experts by experience who talked to service users and their carers about their experience of using these services.
- visited all the acute wards and psychiatric intensive care unit
- visited both older adult inpatient wards
- visited the learning disability inpatient service at Firshill Rise
- visited the psychiatric liaison service, single point of access and health based places of safety.

Our findings

- spoke with a variety of staff in face to face or virtual meetings including; health care assistants, nurses, doctors, allied health professionals, managers, the executive directors, non-executive directors and governors.
- reviewed a number of records relating to the care and treatment of patients.
- reviewed a variety of documents relating to the management of the trust and the services it delivers.
- held four focus groups with; staff network groups, staff side and two open staff drop in calls.
- reviewed a variety of information we already held about the trust.
- sought feedback from a number of the trust's stakeholders such as healthwatch, the local authority, NHS England and the CCG.

You can find further information about how we carry out our inspections on our website: www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

What people who use the service say

We spoke service users and their carers across the four services we visited and also spoke with staff and governors who were users of trust services. We also spoke with Healthwatch and advocacy services to obtain information about what people said to them about the trust's services. Where people were unable to communicate with us verbally, we used observation tools to obtain insight into the care they were receiving.

People described staff working in services as respectful, compassionate and kind. They said that they were treated with dignity and respect. Patients and carers reported that the psychiatric liaison team were exceptionally 'patient and understanding' in their approach to providing support.

However, the majority of people we spoke with raised concerns about their involvement and engagement. People did not always understand their care plans and these had not been carried out collaboratively. Carers of people using the acute wards told us that they weren't always kept update about their relative. Meetings designed to take place to allow people to give feedback about the services did not always take place. People told us that they did not know how to access advocacy support and some people and their relatives did not know how to make complaints.

Patients and their carers, relatives and advocates were not consistently invited to multi-disciplinary meetings with staff to discuss their care plans and be involved in their own recovery.

Feedback from stakeholders contained general themes around environmental cleanliness, waiting times in community services, access to the crisis services by telephone, and a lack of communication and engagement from some services with patients and their relatives.

During our observations of the care of people in the learning disability service, we observed care which was not always respectful and kind.

Areas for improvement

Action the trust MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Our findings

Action the trust MUST take to improve:

We told the trust that it must take action to bring services into line with eight legal requirements. This action related to three services.

Trust wide

- The trust must ensure that effective, embedded and sustainable governance and risk management processes are in place to assess, monitor and improve the quality of services. (Regulation 17)
- The trust must ensure that the statutory and delegated safeguarding functions are carried out effectively and robust reporting, governance processes and oversight is in place. (Regulation 17).
- The trust must ensure that incidents and safeguarding are reported and investigated in line with the trust's processes and in line with national guidance. (Regulation 17)
- The trust must ensure that complaints are responded to in a timely manner via a process accessible to patients and staff and that they are used for processes of feedback and learning. (Regulation 16)
- The trust must ensure that care is provided in estates and accommodation which are suitable, safe, clean, private and dignified. (Regulation 15)
- The trust must ensure that staffing levels are adequate for the service being provided. (Regulation 18)
- The trust must ensure that there is oversight and management of the training and skills held by agency staff. (Regulation 17)
- The must ensure that the risks posed by unstable information technology systems are addressed and mitigated and that there is a continuation at rapid pace of plans to replace them. (Regulation 17)
- The trust must ensure that engagement with patients and carers and involvement in their care is strengthened. (Regulation 9)
- The trust must ensure they assess and mitigate the risks posed by the organisational culture and the management of risks relating to closed cultures in services. (Regulation 17).
- The trust must ensure that there is improved governance and oversight of practices and policies in place for monitoring the Mental Health Act. (Regulation 17).
- The trust must ensure that there are improvements in the timely completion of serious incident reports. (Regulation 17).
- The trust must ensure that digital and information technology systems are fit for purpose.

In acute wards and psychiatric intensive care units

- The trust must ensure that there is adequate mitigation, training and audit in place to protect patients from harm posed by ligature anchor points, outside areas and blind spots on the acute wards. (Regulation 12)
- The trust must ensure that the mattresses in the seclusion suites are suitable for use by patients (Regulation 15)
- The trust must ensure that all safeguarding incidents are reported and investigated. (Regulation 13).
- The trust must ensure that there are not blanket restrictions in place which restrict patient's freedoms that are not individually risk assessed. (Regulation 13)

Our findings

- The trust must ensure that there are governance processes in place to monitor the training of agency staff, to ensure the safety of wards where agency staff are utilised who are not able to take part in restraint training. (Regulation 17).
- The trust must ensure that patients are involved in their treatment and care planning. (Regulation 9)
- The trust must ensure that patient's advocates, relatives and friends or carers are involved in their care. (Regulation 9)
- The trust must ensure that care is always delivered in an environment that respects patients privacy and dignity. This includes ensuring former dormitories are appropriately adapted for use by individual patients and that patient's privacy and dignity are protected when the seclusion rooms are in use. (Regulation 10).
- The trust must ensure that compliance with training achieves the trust target in all mandatory training courses including intermediate life support and restraint interventions, (Regulation 18).
- The trust must ensure that staff complete mandatory training. (Regulation 18).

In inpatient wards for older people

- The trust must ensure that enough staff are available to keep patients safe and meet their assessed needs. (Regulation 18)
- The trust must ensure that there is appropriate medical cover to meet the needs of patients at all times. (Regulation 18)
- The trust must ensure that the use of seclusion on G1 ward is used in line with the Mental Health Act Code of Practice. (Regulation 13)
- The trust must ensure they continue monitor and improve the quality and safety of the services, specifically that improvements are made to the environment on Dovedale Ward in line with the trusts programme of estates work. (Regulation 15)
- The trust must ensure that all staff report and record incidents when duty doctors are unable to undertake a seclusion review on G1 ward within the required timescales (Regulation 17)

In crisis services and health based places of safety

- The trust must ensure patients have all the information about their care and treatment provided in a way they understand. (Regulation 9)
- The trust must ensure that effective action is taken to reduce waiting times and manage patients waiting long periods of time in the emotional wellbeing service and the health-based place of safety. (Regulation 9)

Action the trust SHOULD take to improve:

We told the trust that it should take action because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall.

Trust wide

- The trust should ensure that it continues to monitor that staff receive and record regular supervision.
- The trust should continue to monitor that staff complete all aspects of mandatory training. Where this cannot be completed the trust must ensure adequate mitigation is in place to reduce the impact on patients.
- The trust should ensure that grievance processes are completed in line with timescales agreed within the trust policy.

Our findings

- The trust should ensure that they strengthen their approach to equality and diversity with a strategy that ensures action has been taken to resolve indicators of concerns for staff.
- The trust should ensure that the board maintains a focus on patient and carer experience when decisions are made and risks discussed.
- The trust should ensure that processes are in place to ensure timely medicines reconciliation.
- The trust should continue to review the numbers of medication error incidents and make sustained improvements to medicines safety.
- The trust should ensure all policies, including medicines policies are appropriately reviewed.

In crisis services and health based places of safety

- The trust should ensure that they monitor and take appropriate action when training requirements are not being met.
- The trust should continue to ensure that governance processes are embedded and sustainable.

In acute wards and psychiatric intensive care units

- The trust should ensure that all staff receive supervision in line with the trust target.
- The trust should ensure there is sufficient medical cover so seclusion reviews are carried out in a timely manner.
- The trust should ensure they maintain action to reduce racist incidents and that staff feel supported when they experience such incidents.
- The trust should ensure that when patients are in seclusion or they have received rapid tranquilisation, there is an accurate record of whether they have been offered food and fluid and whether they accepted or declined it.
- The trust should ensure that all staff have an awareness and understanding of Duty of Candour.
- The trust should ensure all staff have access to debrief following incidents
- The trust should ensure appropriate signs are displayed in areas that are monitored by CCTV.
- The trust should continue to address concerns about sexual safety.
- The trust should ensure that the use of leave beds is monitored and incidents recorded.
- The trust should ensure that staff understand where information such as policies and procedures are accessible.

In wards for older people with mental health problems

- The trust should ensure that all staff receive supervision.

Is this organisation well-led?

Leadership

Leaders had the skills, knowledge and experience to perform their roles. They had a good understanding of the portfolio they managed and were visible in services and approachable for patients and staff.

Our findings

Since the time of our last inspection there had been significant changes to the executive leadership team including the chair, chief executive, executive director of nursing and chief operating officer. The trust board and senior leadership were skilled and knowledgeable, and worked together to build a cohesive leadership team.

Leaders were sighted on risks at service level; however, they had not acted on all current risks due to a focus in some areas on longer term planning.

The quality of some front-line services had improved since the last inspection; however, the learning disability inpatient service had deteriorated, and we continued to have concerns about the quality of care delivered on the acute admission wards for working age adults.

The trust had ten voting members of the board. This included the trust chair, and the executive and non-executive directors. The executive directors were; the chief executive, the executive director of finance, the executive director of nursing and professions (who was also the chief operating officer), the executive medical director, and the executive director of people. The director of corporate governance and the director of special projects, and one associate non-executive director were non-voting members of the board.

The non-executive directors brought a range of skills and experience from their relevant backgrounds although these were mainly in the public sector. Non-executive directors chaired the sub committees of the board.

Our observations and evidence from committee minutes and reports supported our conclusion that the trust's committees had improved in their ability and focus to hold leaders to account. We saw evidence in the committees we observed of challenge being given to leaders. The information available to the committees had improved to allow increased oversight. Further developments were required in ensuring that where committees set actions, reporting of outcomes was returned to committees in a timely manner.

In our observations of committees, board members did not always question the impact on service users and carers of the decisions made, or the risks discussed, meaning that the voice of people using services was not always considered.

The executives had no black and minority ethnic members, and three (50%) women and three men (50%).

The non-executives (excluding the associate non-executive director) had no black and minority ethnic members and three (60%) women and two (40%) men.

The trust had recently recruited an additional non-executive member from a black and minority ethnic background.

The board of directors were open and honest about the difficulties the trust had faced and continued to face. They described the trust as having completed the first steps on their journey to improvement. The board were clear of their commitment to continue to improve the quality of care provided to the local community.

Following our last inspection, the trust had developed their fit and proper persons policy. During the inspection we reviewed the personnel files of five members of the board who had joined the trust since the time of our last inspection. All files were in line with the requirements of the fit and proper persons regulation.

Our findings

Since the last inspection, the trust had made significant changes to the leadership structure below board level. The purpose of the change was to clarify the roles and service types, reduce the layers of management from floor to board, centralise functions to achieve integrated leadership and to bring together the general management and clinical leadership functions.

The trust also had a director of; operations and transformation, quality, psychology and psychotherapy, allied health professionals and a chief pharmacist as part of the leadership team.

Services had been split into two directorates;

- acute and community services which included; acute inpatient wards and psychiatric intensive care, crisis services, older adult inpatient services and nursing homes, electro-convulsive therapy, early intervention services, and adult community mental health teams.
- rehabilitation and specialist services which included; learning disabilities inpatient and community, forensic and rehabilitation, improving access to psychological therapies, highly specialist services and substance misuse.

Each directorate worked within a triumvirate model, led by a head of nursing, head of service and a clinical director. This was developed since the last inspection, and leaders told us that they enjoyed this model of working and felt that it allowed their skills to come together and provide strong leadership to the directorates. The revised model provided improved clarity to staff, external partners and people using services on the lines of responsibility.

Each service line within the directorate was managed by a general manager, a matron and a clinical lead, and below this level team or ward managers.

The leadership team had established appropriate lead practitioners for learning disabilities, the Mental Capacity Act, the Mental Health Act and child and adolescent mental health. The trust had a named doctor for safeguarding children and adults and a professional safeguarding lead. The executive director of nursing was executive lead for safeguarding.

The leadership team had established lines of responsibility via their action plan to areas requiring improvement. Improvements to areas such as safeguarding, patient and carer involvement, learning disabilities and reducing restrictive practices were being led by the director of quality with the director of special projects working on the estate's transformation programme.

Succession planning was in place and where leaders had left the trust, early planning was put into place to ensure recruitment without delay.

Leadership development opportunities were available, including opportunities for staff below team manager level. Since the team of our last inspection, the board had taken part in a number of development sessions. Non-executive directors had spent time observing committee meetings in other trusts and felt that this had further enhanced their skills.

Vision and strategy

Leaders knew and understood the provider's vision and values and how they were applied to the work of their team.

Our findings

The trust had recognised the need to refresh and develop their strategy. They had done so in consultation with staff, the joint consultative forum, the council of governors, stakeholders and people using services. Staff we spoke with at service level told us that they knew and understood the values of the trust and a range of consultations and workshops had taken place to involve people in the development of strategies.

At the time of the inspection the trust's 2021-2025 strategy was in draft format being discussed for sign off with the board. As the strategies remained in the consultation phases, it was not possible to analyse their impact at the time of the inspection. However, the draft strategy provided clarity on the trust's ambition of where they want to be by 2025, it was evident that the trust's priorities align with the areas of risk and concerns identified. The strategy included a focus on partnership working at place and within the wider integrated care system.

The trust vision and values had not changed since the time of our last inspection. The trust was in the process of refreshing their values.

The trust's vision was to 'improve the mental physical and social wellbeing of the people in our communities'. The trust's strategic aim was to;

- deliver outstanding care
- create a great place to work
- effective use of resources
- ensure services are inclusive.

The trusts strategic priorities were;

- Covid-19 recovering effectively; reducing waiting times, staffing according to demand.
- Getting back to good; implementing quality improvement and leadership programmes, improving the standard of patient centred care, implementing rapid recovery in acute and recovery services, creating safe and dignified facilities, completion of the well-led action plan.
- Transformation – changing things that will make a difference; primary care mental health service rollout, reducing community mental health team waiting times, implementing and delivering a new electronic patient record in 2022/23, implementing the new care model for the forensic services collaborative in 2022, moving to a new head office space in 2022, designing and procure the acute care therapeutic facility by 2023, implementing the clinical and social care strategy.
- Partnerships – working together to have a bigger impact; Sheffield Place: co-producing services to improve equity of access for all communities. The Provider Alliance: leading the development of forensic and specialist services and supporting the development of the Alliance model, South Yorkshire and Bassetlaw Integrated Care System: playing a part in delivering the Long-Term Plan priorities, University: improving outcome measures for service users.

The success of the strategy was underpinned by the clinical and social care strategy for 2021 to 2026. This strategy was presented to the board in May 2021 as a final draft. The strategy had been developed in consultation with service users, staff and stakeholders across 20 workshops. The strategy aimed to reduce health inequalities and stated that; care should be person-centred, trauma-informed, evidence-Led and strengths-based. The key priorities were:

- Understanding what matters to people: improving the experience, safety and quality of care for service users, carers and families through understanding what matters to people and co-producing systems and models of care.

Our findings

- Knowing we make a difference: seeking to help people to live well and reducing the inequalities associated with mental health problems and learning disability through early intervention, prevention and transformation of mental health, care to be closer to communities and capturing impact and outcomes.
- Creating environments for excellence: promoting the development of therapeutic teams through a well-trained workforce, working within with healing-built environments.
- Transforming care in Sheffield: building further and faster the partnerships and transformation with other organisations to become a more integrated health and social care system with improved outcomes, including a zero suicide ambition.
- Leading the system for outstanding care: developing system quality networks and building an equitable system in South Yorkshire and Bassetlaw.

The trust was also in the implementation phase of enabling strategies for; quality, people, organisational development, digital, finance, estates and research with a plan for these to be approved at board and rolled out by September 2021.

Culture

Staff did not always feel respected, supported and valued.

The culture of the trust was mixed.

The leadership team displayed an open and honest culture and modelled positive behaviour and relationships. Leaders were focused on making improvements to the organisational culture via a variety of work streams.

The board had made significant improvements in relationships with staff side and with the trust governor's.

During the inspection we spoke with a variety of corporate and clinical staff in interviews and focus groups and feedback was mixed. Some staff told us that the culture of the trust was improving. All staff we spoke with felt supported by local service level leaders and felt valued by their line managers. Staff said that the newly formed executive leadership team were less defensive, focused on staff and more open. They told us about receiving additional time away from work as a thank you for their hard work during the pandemic, and staff in crisis services were positive about the change management of restructuring their services.

However, some staff told us that they continued to feel undervalued. Staff working in the community worked in poorly maintained buildings and told us that this effected their morale.

Staff working in acute and psychiatric intensive care services and in older people's wards had low morale. They told us that incidents of racial discrimination and violence from patients were increasing and that they felt pressure from leaders about the flow of patients through the service. They said that they were encouraged to give feedback about services but did not feel that this was listened to. There had been 101 incidents of racial abuse towards staff from 1 September 2020 to 1 May 2021. These incidents were most prevalent on the acute and psychiatric intensive care units accounting for 74 of these incidents.

This feedback was reflected in the 2020 staff survey.

Our findings

The trust's 2020 staff survey had a response rate of 40% this had decreased from 41% the previous year. The median response rate for this type of organisation was 49%. However, the staff survey was conducted at the time the trust received an inadequate rating and during the beginning of the first wave of the Covid-19 pandemic. Both had a significant impact on staff morale and wellbeing.

Of the ten themes from the survey, the trust results were below the benchmark average in all areas. The trust was in the worst benchmark group for; team working, staff engagement, safety culture, quality of care, morale and immediate managers.

Leaders were aware that the organisation was at the start of a journey in addressing the culture of the organisation. The trust needed to ensure that staff hearts and minds were with them on their journey to improvement to ensure the success for their transformation. Leaders had an ambition to improve the culture and develop 'team-shsc' via a variety of methods which included work with staff side, staff networks and action planning relating to the workforce race equality standard and workforce disability equality standard.

We were concerned about the development of closed cultures in some services, where staff had not acted in line with the values and culture of the trust. It was an indication of culture in some services that staff did not always follow policy and process and had not reported concerns when patients had come to harm.

During our inspections we observed staff treating patients with kindness and compassion. However, in acute inpatient wards and learning disability services we found that patients had not always been treated with dignity and respect. Staff had not always followed processes to keep people safe and managers had not reported their concerns to senior leaders within the trust.

We were concerned that local leaders had failed to act upon the development of a closed culture in the learning disability inpatient service. There was evidence that leaders were aware of emerging concerns yet had not always acted upon them at a local level. For example, at the service user safety group in November 2020, the group discussed that service user's families at Firshill Rise 'may raise concerns' about the culture of this service. There were no actions noted from this discussion and a closed culture where patients had come to harm was found at Firshill Rise in March 2021.

The executive team were aware of the risks to patient safety associated with closed cultures. During our inspection, leaders told us about their concerns about these cultures developing in other services and the executive team were approaching this proactively. As an outcome of the findings in the learning disability service we observed the trust hold a learning session about closed cultures with leaders. The trust had also enhanced visits from board members to services and continued to make changes to leadership structures to address cultural concerns.

Since our last inspection, the trust had made improvements in its development of staff networks. The trusts had five staff network groups, each with their own chair; the rainbow LGBT+ group, the lived experience group, the carers group, the disability staff network and the black and minority ethnic network. Network leaders told us that there had been a change in responsiveness from the board when concerns or suggestions were made by the groups and that this had been positive.

The Rainbow group was newly formed since the last inspection had have delivered training sessions to more than 600 staff including the board. The trust had funded rainbow lanyards and was enabling painting to show LGBT+ support across their estate.

Our findings

However, the trust did not yet have an embedded equality and diversity strategy and had limited resource, this meant that the support to act upon the work of the groups was limited.

The workforce race equality standard became compulsory for all NHS trusts in April 2015. Trusts must show progress against nine measures of equality in the workforce. The trust remained committed to ensuring workforce race equality for all staff but did not meet all of their targets set for 2016-2021. The percentage of the workforce, where ethnicity was known, from a black and minority ethnic (bame) background was 14.6%. There was one incoming member of the board who was from a bame background.

Of the nine metrics measured, the trust had not met their targets in eight of these although progress had been made in some areas. The metrics evidenced that staff from a black and minority ethnic background were more likely to enter the disciplinary process. These staff were also more likely to experience discrimination, bullying and harassment from patients, the public and from their colleagues within the trust.

The trust had an action plan in place to address the standards which were not met. In addition, the trust had undertaken a variety of projects to address concerns about racism within the trust including; working with the bame staff network group, revising processes and policies, improving and piloting new methods of support for staff experiencing discrimination at work, a focused recruitment plan for staff teams and the board and further development of working relationships with voluntary sector organisations and partners in the integrated care system.

In September 2020, the trust launched 'the big conversation'. The trust described this as a project designed to put issues of racism on the table and find solutions to make a change. The board were involved and supportive of the project which the organisation identified brought up difficult and complex experiences and conversations.

The project ran in three phases. In phase one, groups got together and had an open, honest and safe sharing of experiences related to racism within the organisation. Phase two saw the project leaders take what they had heard and pull together the themes underlying these experiences. Phase three saw these themes fed back to staff, who were involved in action planning to bring about change. Approximately 190 staff were consulted and involved in the project and a steering group was formed which was feeding into the people committee at the time of the inspection with a range of developed change ideas for action some of which had been completed and some which required further work which included working towards being an anti-racist organisation.

The Workforce Disability Equality Standard (WDES) is comprised of a set of ten metrics. These aim to compare the experiences of disabled and non-disabled staff in the NHS.

In 2020, 7% of the trust's staff identified themselves as having a disability. The trust had not yet set targets for these metrics. The metrics indicated several concerns. Disabled staff were around three times more likely to enter a formal capability procedure than non-disabled staff and there had been an increase of reports of harassment, bullying and discrimination towards them.

The difference in board membership and the organisation was +8%. The difference between the organisation's Board voting membership and its organisation's overall workforce, disaggregated by voting membership of the Board is -7%. The difference between the organisation's Board membership and its organisation's overall workforce, disaggregated by executive membership of the Board is 7%.

In response to the workforce disability equality standard, the trust had an action plan set to make improvements in the coming 12 months.

Our findings

The trust had an equal opportunities and dignity at work policy. The current policy was issued in October 2019 and due for review in 2023.

The trust had a programme of board and executive visits to services, and we saw that board members and the executive teams had visited services where an issue or concern had been raised. However, the ability for regular visiting had been hampered by the impact of covid-19 and several had taken place virtually. An improvement from the time of the last inspection was that the trust had developed a programme of board visits and a proforma for discussion to aid triangulation of findings which discussed at committee meetings.

Between 11th September and 11th December 2020 there were 10 board member visits to services including; the community enhancing recovery team, neuro case management, early intervention in psychosis, eating disorders, specialist psychotherapy, short term education programme, health inclusion, the homeless support team, forensic services, crisis assessment centre and wainwright crescent nursing home.

Leaders had decided that visits were undertaken to specialist services or services with a specific purpose outside the main core service areas. This has given focus on the less visible services across the Trust, with their unique service offers and challenges. The challenges to the trust in its estates, staffing, digital connectivity and the impact of Covid-19 were highlighted during these visits which meant there was evidence of triangulation of risks.

Board visits reported directly into a you said we did report which was shared across the organisation.

The staff friends and family test asks staff members if they would recommend the trust as a place to work and a place to receive care. The trust's results from this survey showed that staff were less likely to recommend the trust as a place to work or for their family and friends to receive care.

The quarter two 2019/2020 results were as follows:

- the trust received 133 responses from a headcount of 2,373 employed staff. This was a lower response rate than the previous year.
- 58% of staff recommended the trust as a place to work, this had decreased from 67% in the previous year.
- 18% of staff did not recommend the trust as a place to work. This was an increase from 12% the previous year.
- 67% of staff would recommend the trust as a place to receive care, this was a decrease from 68% in the previous year.
- 12% of staff would not recommend the trust as a place to receive care, this was a reduction from 13% in the previous year.

Following the results of the staff survey, the trust had produced an action plan, they had begun work on the action plan and key messages to staff in advance of the survey's publication.

The trust employed approximately 2,601 staff.

The trust did not always have enough staff who knew people well to keep people safe and used high levels of bank and agency staff. The trust did not monitor the training of agency staff in restraint and temporary staff did not always have access to patient information within the trust's electronic systems. Staff told us that this meant additional pressure was present on the inpatient wards. The trust's oversight of day to day staffing was improving with the addition of daily staffing huddles but required further improvement.

Our findings

In March 2021 the trust reported 19 shifts on the acute, psychiatric intensive care and older people's wards which were not compliant with safer staffing numbers. The trust did not report in their performance report the safer staffing outcomes for all wards and teams. This reduced the ability of leaders to have oversight of staffing risks.

Staff groups with the highest vacancy rates were in Nursing a 13.77% vacancy rate and Estates and Ancillary a 15.15% vacancy rate. Of the nursing vacancies, there was a vacancy rate of 25% for band five nurses.

Between 1 September 2020 and 1 May 2021, the trust used bank staff on 21,842 shifts. The trust noted that these shifts were a mixture of substantive staff with a bank contract and temporary bank staff. Endcliffe, G1 and Woodland view used the most bank staff.

In the same time period, the trust used agency staff on 8511 occasions. Burbage and G1 wards used the highest proportion of agency staff.

The most usual reason for bank or agency staff to be used were; support of enhanced observations, over established and managing environmental issues.

However, since the last inspection the trust had made significant improvements in ensuring that newly qualified nurses were not left unsupported to manage shifts. Between 1 September 2020 and 1 May 2021 19 shifts had been led by preceptorship nurses which was an improvement. Further assurance was provided with management and senior leader oversight.

The annual turnover rate was 14% in March 2021.

The annual sickness absence rate was 5% with a long-term sickness absence rate of 4% in March 2021. The two services with the highest levels of long-term sickness absence were Birch Avenue and improving access to psychological therapies team. The primary reasons for long term sickness absence were; anxiety, stress, depression and chest problems.

The trust continued with a rolling programme of local recruitment and were aware of pressure points within the trust which needed a focus on staffing vacancies. Since the time of the last inspection (as at April 2021) the trust had employed 31 additional whole time equivalent health care assistants. The trust had also begun a process of a clinical establishment review and was piloting revised shift patterns to support staffing.

Staff had the opportunity to discuss their learning and career development needs at appraisal. The trust's target rate for appraisal compliance was 90%. As at 31 March 2021 the compliance rate was 86%.

Not all staff were offered supervision. The trust's target rate for supervision compliance was 80%. Since the time of our last inspection the trust had increased the requirement for supervision for this to take place eight times in twelve months. As at week commencing 5 April 2021 the compliance level was 67% for clinical services and 41% for corporate services. This was outside of the trust's own target. Staff in the inpatient acute and psychiatric intensive care unit told us that they were not in receipt of regular supervision, in other services we visited staff said that they did have supervision regularly.

The trust had a guardian of safe working hours, who was experienced in their role.

Our findings

The guardian was allocated personal assistant time and additional admin time to support them in the role. During their time in post no fines had been issued and they had worked closely with the junior doctors forum and medical director to support staff to understand the importance of exception reporting. They provided quarterly reports to the medical director in order to provide the board with the required information. They attended regular meetings with guardians from other trusts to share learning and experiences.

The guardian of safe working hours was supportive to the trust's team of junior doctors. They told us that they encouraged doctors to take protected time to study and had ordered web-cams for doctors to engage fully in training. They supported maintaining contact via messaging groups and face to face junior doctor forums.

The trust had received 56 exception reports for safe working hours in the last twelve months, the majority of which related to out of hours work. All exception reports had been received from staff working in the trust inpatient services.

The trust had a process in place to address poor staff performance where needed, including a disciplinary policy.

The trust had a disciplinary policy which was overdue for review in May 2021. The policy included a disciplinary investigation process flowchart, details of each stage of the process and the right to appeal. The policy contained information on how staff could seek support and advice from the trust freedom to speak up guardian where the issues related to service user or patient safety.

The policy explained that where an investigation was being undertaken, managers should consider alternatives such as 'transferring employees to another workplace, restricting duties or closer supervision'.

The trust had undertaken 58 disciplinary procedures with staff since 1 May 2020, of these 21 were informal, and 36 were formal procedures. Of these procedures, 36 were closed, five either on hold or awaiting a hearing or investigation, three were awaiting a police investigation and 14 were ongoing. The trust policy stated that the trust sought to resolve disciplinaries within three months of the start date, this was not the case 42 of the 58 cases were older than three months, the oldest ongoing case was from October 2018.

The service with the highest number of disciplinary cases was community and acute services with the least disciplinary action taking place in medical teams

We reviewed five disciplinary cases to review the trust's processes during the inspection. We found that in all cases the people involved were offered support and advice to manage the process and their own wellbeing. They were managed in line with the trust's policy.

The trust had a grievance policy which was in date and due for review in July 2023. The grievance policy contained a flowchart which explained the three stages of the trust grievance process. The policy contained information on how staff could seek support and advice from the trust freedom to speak up guardian where the issues related to service user or patient safety.

The trust had managed 15 grievances since 1 May 2020. At the time of inspection, four were ongoing and one was on hold, the remaining nine were closed. Seven referred to concerns about treatment by managers.

Our findings

We reviewed five grievances which had been submitted to the trust in the 12 months prior to the inspection. We found that responses and investigations were detailed and thorough and written in a respectful manner. However, we noted that in three of the five cases the timescales outline by the policy of ten working days between a grievance and an initial meeting were not met, and that grievances took too long to resolve.

The trust had enhanced its approach to their people strategy by employing an executive director of people who was a voting member of the board. The human resources procedures, processes and oversight had improved since the last inspection. They were aware of the risks relating to their role including; staffing, supervision and appraisal, training, the race and disability equality standards and had plans in place to address them

A people review had been launched at the time of the inspection which would analyse resourcing of the human resources teams.

The trust had effective procedures to verify that all clinical staff had a current professional registration or to ensure that all staff had a valid check with the disclosure and barring service. Fourteen staff did not have a valid Disclosure and Barring Service check in place at the time of inspection. The trust were aware of these cases and were taking action, including preventing bank staff without a valid check from working for the trust and reviewing the requirements for some administrative staff.

The trust also had a standard operating procedure which outlined the levels of disclosure and barring checks required for the roles of each staff member within the trust; basic, standard or enhanced which was in line with national guidance.

The trust also confirmed there were four staff without a current professional registration who required these. Three of those are counsellors within the improving access to psychological therapies service and were registered with the British Association for Counselling and Psychotherapy. The remaining staff member was placed on restricted duties until their registration is renewed. This was an improvement from the last inspection.

The trust provided opportunities for development and career progression. Staff told us that they had opportunities for career progression, and we saw that skilled staff were encouraged and supported to progress within the organisation. The trust had also invested in organisational, board and governor development and had mentoring and coaching programmes in place.

The trust had a mandatory training programme in place for all staff. As at 31 March 2021, trust overall compliance with mandatory training was 90.50%. As at 4th April 2021 85% of staff were 80% compliant or above. The trust had increased its oversight of mandatory training and this had resulted in an improvement in compliance. Compliance was now reported to the board in performance reports and managers were alerted to low rates of compliance in services.

However, there remained three training subjects which were below 80% compliance these were;' immediate life support, and restraint (respect). The trust told us that the drop in compliance for these courses was the requirement for them to be held face to face which was not possible during the covid-19 pandemic. The trust had not ensured that in services with low levels of compliance, enough mitigation was in place to protect them from avoidable harm, they had not ensured that staff trained in all elements of the required training were working on every shift.

Staff told us that they could raise any concerns without fear.

Our findings

Staff in all the services we inspected, were aware of the trust's whistleblowing policy and how to access the freedom to speak up guardian.

The trust had a freedom to speak up guardian and provided them with enough resources and support to help staff to raise concerns. The freedom to speak up guardian was a dedicated role and they were developing a freedom to speak up champions role within services. They were managed directly by the chief executive and there was a non-executive director with oversight. They reported directly to the board to maintain oversight of issues and concerns. The executive team were responsive to concerns and had met directly with staff to discuss concerns where required. This meant that staff said that they felt able to raise concerns without fear of retribution.

The trust holds annual awards and recognition events, where staff and volunteers were recognised for their contributions in a variety of categories. The trust had recognised the hard work of staff during the Covid pandemic and had offered time away from work for wellbeing and recovery. We also saw examples of where the executive team have visited or spoken with teams to celebrate success and offer thanks and support.

Governance

Our findings from the other key questions demonstrated that governance processes were operating more effectively across the trust.

There had been improvements in governance systems since the time of the last inspection.

The trust had structures, systems and processes in place to support the delivery of its strategy including sub-board committees. Governance processes and effectiveness had been reviewed over the previous twelve months and changes made accordingly, including changes to the executive leadership team and the leadership structure into services to clarify and strength the ward to board governance process and ensure better oversight of risk.

There was a board sub-committee structure in place, with each committee chaired by a non-executive director with the appropriate skills and knowledge, reporting to the board. The committees were:

- remuneration and nominations committee
- audit and risk committee
- finance and investment committee
- quality assurance committee
- workforce, organisation and development committee.

Non-executive and executive directors were clear about their areas of responsibility, committees had become more effective in bringing challenge in areas of concern and expectations of action. This was being supported by the Chair and the trust's board development programme.

There was a reporting structure in place to manage the flow of information from directorate to executive management team and through to the board and relevant sub-committees.

Our findings

The trust had developed an integrated performance report since the time of the last inspection. This reported on areas of risk such as finances, staffing, incidents and restrictive interventions. This had allowed leaders access to information and data they required for assurance about risk. The trust were aware that this report required further development with real time analysis of risks and issues, but did create better oversight than the board and committees previously had access too.

A revised mental health act legislation committee had been formed and had sat one meeting at the time of the inspection meaning it was difficult to analyse its success.

There were a number of areas within the governance of the Mental Health Act which required improvement. The policies for seclusion, patients absent without leave, observation of patients, and the admittance of patients under the age of 18 were all overdue for review.

The policy for the allocation of a responsible clinician did not contain guidance or a process map of how to inform the patient about who their responsible clinician was.

We were concerned that the Mental Health Act Code of Practice policy on equality and human rights was not in line with section 3.15 of the Code of Practice because it had not been reviewed annually by the board.

There is also expectation in the Code of Practice that the trust will set out how the organisation will review the environment and culture of the wards; how it will obtain qualitative evidence of patients' experiences and how it will use that information; and how staff will be provided with learning, development and training on human rights legislation and the Equality Act. This was not within the trust's policy and had not taken place.

The document which describes the function imposed on hospital managers by the Mental Health Act referred to an out of date Code of Practice, it was not dated, and had no review date. It was also not in line with the Code of Practice.

We were concerned about the trust's management and oversight of blanket restrictions. The blanket restrictions policy was unclear, for example; it referred to two services as secure services when they were locked, but not secure services. All restrictions were due for review by February 2021 but this review had not taken place. At a service level we were concerned that blanket restrictions had been put into place and not reviewed and that these were not always individually risk assessed. Where policies were in place such as for smoking the guidelines were not consistently applied.

The service treated concerns and complaints seriously and investigated them. However, it was not clear how they learned lessons from the results and shared these with the whole team and wider service.

The trust told us that between 1 May 2020 and 1 May 2021 they had received 84 complaints, 20 of these were informal (fast-track) complaints, and 64 were formal complaints. The trust had improved their response time to complaints and the oldest open complaint was dated March 2021. In February 2021, the trust reported an 85% complaints response rate against an 80% target.

However, some patients, relatives and carers did not know how to complain or raise concerns.

The trust did not have a complaints policy visible on their website for access by service users and carers. Stakeholders told us that the trust had recently changed the complaints process by phasing out the use of fast-track forms for informal complaints, however they felt that this was not communicated well.

Our findings

The trust did not always used complaints for learning and consider investigations when complaints indicated an incident of harm to patient had occurred. This meant that opportunities for investigation and learning had been missed.

The number of complaints and themes from complaints were not highlighted in the trust's performance report which reduced the oversight the board had of complaints and the risks these indicated in services.

A detailed service user experience report was presented on a quarterly basis to quality committee which included complaints and compliments numbers, response times and themes from complaints.

Complaints were not discussed in the quarterly learning lessons report produced by the trust.

We reviewed six complaints which had been made to the trust since 1 May 2020. The themes from these complaints related mainly to concerns about communication and about care and treatment decisions. Responses to complaints were inconsistent in both their timeliness and completion of complaint action plans. The trust had difficulty in allocating staff to complete investigations into complaints in a timely manner.

Since 1 May 2020, the trust had received 96 compliments, the main theme of compliments was positive feedback for staff and services.

Since our last inspection, the trust had launched a back to good programme, and a back to good board. Its purpose was to monitor the progress of the trust's improvements against its action plan and strategy aim to 'deliver outstanding care' and 'create a great place to work'. In May 2021, the trust reviewed the performance of the programme over the previous year.

73 actions were included in the improvement plan, in April 2021, 51 actions were completed, 15 actions were awaiting approval as completed via the audit process, and seven remained open. Of the seven open actions these related to; staffing; 25% of vacancies at band five nurse level, ligature anchor points in inpatient areas and improvements in seclusion. These actions were being addressed and we saw plans in place for this.

The report on progress included lessons learned from the previous 12 months to further strengthen improvements. Lessons were; improved engagement, better co-production, embedding improvement, being able to provide clarity and evidence of sustainability.

Through this programme the executive team and board were more sighted on risks across the organisation and were aware of areas of improvement which needed further action, and the need for the trust to sustain and embed improvements.

Management of risk, issues and performance

Leaders used performance systems to identify, understand, monitor, and reduce or eliminate risks. However, these systems were not always effective and required further development. Risks identified were not always mitigated and the methods for the management of risk were not audited.

The trust did not regularly implement cost improvement plans, since our last inspection the cost improvement programmes had stalled due to the covid-19 pandemic. The trust had plans in place to manage these for 21/22.

Our findings

The trust had a financial plan in place which was recently submitted to NHS England. The plan included investment in services and workforce development.

The trust had several key financial pressures which included the spend on out of area placements, staffing costs and the projected costs involved with a new information technology and estates programmes.

The trust held a continued risk in relation to its estates. The inpatient ward environments on Dovedale, Stanage, Burbage and Maple wards were not fit for purpose. Staff working in community settings told us that they worked in run-down buildings. There had been a historical low level of investment in the trust's estates.

The trust had an estates plan in place which set to achieve the required standards. However, during our inspections of some of these services we were concerned that the trust had not ensured that the risks posed to patients by the estate were entirely mitigated. Some patients had come to harm while using these facilities because of their state of disrepair. Patients remained at risk from ligature anchor points and from environments which were unclean.

The trust had systems in place to identify risks from incidents, complaints and safeguarding alerts and make improvements. However, these systems were not effective.

Staff used an electronic system to report incidents.

Staff did not always report incidents, complaints and safeguarding concerns and where they did report, the seriousness of the incident was not always reflected in the reporting.

Managers continued to have difficulties in reviewing and signing off incidents in a timely manner. The trust incident reporting policy stated that managers should sign off incidents with 5 days of receiving a notification to allow them to have oversight and support staff with learning and debrief. At the time of the inspection there were approximately 400 incidents across the trust due for review, however this had reduced substantially during the previous 12 months.

During the last 12 months, and during our inspection we were made aware of incidents where patients had been harmed and these had not reported using the appropriate systems and processes to ensure oversight of risk and the protection of patients. These concerns had also triggered a section 42 safeguarding enquiry by the local authority.

The trust has submitted details of no serious case reviews commenced or published in the last 12 months.

The Chief Coroner's Office publishes the local coroners Reports to Prevent Future Deaths which all contain a summary of Schedule 5 recommendations, which had been made, by the local coroners with the intention of learning lessons from the cause of death and preventing deaths. The trust had not been in receipt of any Regulation 28 reports since the last inspection.

Staff reported incidents via an electronic system and had reported 8440 incidents between 1 April 2021 and 31 March 2021. This was an increase to the 8,222 incidents reported in the previous twelve months. The most common type of incident was 'exploitation or abuse' followed by 'medication' and acute and community services reported more incidents than other services.

The trust had not ensured that staff logged incidents correctly, this meant that leaders had limited assurance about the risks within services.

Our findings

Guidance describes as an incident as 'any unintended or unexpected incident that could have or did lead to harm for one or more patients receiving NHS-funded healthcare'.

Some incidents where patients may have come to harm had been reported as 'no harm' incidents. We reviewed ten no harm incidents from April 2021 where the severity of the incident was not 'no harm'. These included, patient to patient assaults, reports of staff causing harm to patients and patient accidents.

There were 158 incidents whereby patients had tied ligatures while an inpatient which were also classed as no harm incidents. Some of these incidents had resulted in patient harm and these were not investigated for action, learning and changes.

Since 1 May 2020, the trust reported 64 serious incidents. This was a significant increase against the last inspection where 31 serious incidents were reported between 1 September 2018 and 31 August 2019.

The trust had made some improvements to raising the profile of incident reporting and to the management and sharing of risks and learning, but this needed to be embedded further.

From January 2021, the trust introduced a daily incident huddle lead by the head of clinical governance, and clinical risk manager and attended by other leaders such as; safeguarding, pharmacy, health and safety and the restrictive practice lead. In this meeting all incidents from the past 24 hours were reviewed and action taken dependent on the level of seriousness, decisions in regard to duty of candour requirements are also considered at this point. Leaders were passionate that when incidents didn't meet the threshold, apologies should be offered verbally where appropriate.

The trust pulled together learning from these incidents and had identified 334 actions from daily incident huddles which were shared across the trust.

Following the daily incident huddle incidents were investigated at 24 hours and if required followed up with 48 hour and serious incident reports. Serious incidents were recorded on the strategic executive information system (steis) to alert the CCG. This was a change to the process which was initiated when the trust were made aware of 14 serious which were not reported via steis which should have been in line with guidance. The trust had learnt from this incident and at the time of the inspection were working with NHS England to develop a revised serious incident policy to streamline the system.

The trust worked to an 11-week process for completion of serious incident reports and sending these for sign off via executive review.

The trust had a target of 60 days (twelve weeks) for completion of a report and sharing it with the CCG unless an extension had been agreed. The trust told us that between 1 April 20 to 1 May 21 they submitted 40 serious incident reports to commissioners. 24 of these were within the 12 weeks/agreed extension timescale (60%).

We reviewed serious incidents shared with us by the trust throughout the last twelve months. We reviewed three more recent serious incidents as part of this inspection. We identified some areas of good practice particularly in sharing learning from incidents and in the fairness and impartiality of reports. However, reports did not contain an executive summary and did not always show evidence that the staff involved in an incident had been given the opportunity to contribute to the report, most incidents had been investigated in the form of a desktop review. Where good practice had

been identified during the investigation this was not always included for learning purposes and there was not always a reference to contributory factors and root causes. Families and carers were invited to be part of investigations, however the support offered to them was not always clear. The trust had recognised that processes required review and were working on a revised process at the time of the inspection.

The trust held a clinical quality and safety group which met monthly and discussed actions and learning and serious incidents including the timeframes and targets for completion. The trust had recently introduced a serious incident panel chaired by the Executive Director of Nursing or Director of Quality to review serious incidents and their progress and the interim and end stages of an investigation.

Staff working in most services reported to receive feedback from incidents including lessons learnt. Aside from access to learning on the trust intranet and since the last inspection, the trust had introduced 'blue light alerts'. This was to ensure communications were sent to staff immediately after an incident which had themes that may reoccur. Staff we spoke with knew about this system.

The trust also had plans to develop further opportunities for lessons learnt and had developed a trust wide learning programme. This programme included the production of a magazine style report for learning from incidents, a programme of monthly learning events and a quarterly lessons learnt report to be presented to quality committee.

The trust had a 'duty of candour and being open' policy which was in date and in line with the regulatory requirements.

The trust told us that between 1 May 2020 and 1 May 2021 they had applied the duty of candour policy to 16 incidents. We saw that the trust apologised to patients where this was necessary and involved them in plans to investigate incidents where they or their relatives had been harmed.

Other than in the trust's acute wards, staff understood the meaning of the policy.

The trust had a mortality review group which met weekly and was chaired by the medical director. The meeting reported quarterly to the board meeting. The meeting was thorough, structured and effective in identifying, themes, trends and areas where lessons could be learned and shared. From April 2021 the group had begun work with the better tomorrow's programme which focussed on the importance of learning from deaths and papers indicated that this learning would be pulled into the trustwide learning from incidents report to be produced from Quarter one.

Between 1 January 2021 and 31 March 2021, the group had reviewed 116 deaths. There was evidence within the review meetings of lessons learned from deaths being investigated and shared across the organisation. The trust also reported four deaths to the learning disability mortality (death) review programme.

The trust was also notified of all deaths of patients with learning disabilities across Sheffield whether the trust was working with the individual or not, and these were managed through the learning disabilities mortality review process.

The trust did not work well with other agencies to protect patients from abuse and did not have the correct mechanisms in place to audit and report on safeguarding.

The trust had statutory and delegated functions from the local authority to manage safeguarding referrals for adults (except for children, those with learning disabilities and those over 65). All safeguarding referrals made to the trust came directly via the single point of access for mental health. The trust appreciated the complexities of this.

Our findings

The trust had established internally that they were not meeting their safeguarding responsibilities fully and were not working appropriately with the local authority and local safeguarding board. As a result of these failures, not all safeguarding incidents had been appropriately reported to the local authority, and not all incidents investigated.

In response to this at the time of the inspection, the trust, led by the director of quality were in a programme of rapid improvement and had an action plan in place to address these concerns. The trust was being supported in the rapid development plan by the designated professional from safeguarding in the local CCG and an independent safeguarding consultant.

The safeguarding adults and prevent policies were overdue for review and their date for review had been granted an extension in February 2021.

Staff were offered safeguarding training, as at 4 April 2021, staff were compliant with mandatory training in both safeguarding children and adults.

Training was not effective as staff did not always put this into practice in front line services as we found incidents of harm to patients which had not been reported to safeguarding.

The trust had a dedicated doctor for safeguarding adults and children and a named nurse for safeguarding children.

The trust had a chief pharmacist in post. They and the director for medicines optimisation had clear lines of communication through the medical director. The pharmacy team had a risk register in place which covered areas of risk and concern and actions were in place to monitor and audit risks.

The number of pharmacy staff since the last inspection had increased, this has increased the teams medicine optimisation capabilities and wards which previously did not have a service now received a regular medicines service.

The medicines optimisation strategy had been developed and focused on a whole system approach to medicines optimisation. New ways of working were in the process of being developed and included increasing the number of prescribing pharmacists and moving towards a seven-day service

Pharmacy medication leaflets where in use and patients were sign posted to the internet to enable patients to have choice to make informed decisions.

Clear terms of reference were in place to ensure medicines governance groups were multidisciplinary and had clear roles and responsibilities.

However, we found a policy relating to how staff should manage illegal substances had not been reviewed by the chief pharmacist who was also the controlled medicine accountable officer.

We also saw that the trust's process for medicines reconciliation did not ensure that this was done in line with guidance. Standards are that 100% of medicines should be verified within 72 hours of admission. In April 2021 the trust's data showed that 88% of medicines had been reconciled within 72 hours and 60% of these were done within 24 hours. The report included a remedial action to improve this but not specify how this action would be taken and by who.

Our findings

The trust reported a number of medicines errors. In May 2021 the quarter four medicines safety report was discussed at the quality and safety committee. In quarter four, there was a total of 219 medication incidents reported trust wide. There was little change from the quarter three report which reported 218 errors. Administration errors have also seen an increase. Most medicines errors were reported on the trust's psychiatric intensive care unit and on the three acute wards.

There were a number of actions in place to rectify these errors and improve compliance. These included that the pharmacy team were involved in delivering educational training to medical and nursing staff. The current three-year mandatory training was in the process of being reduced to two years to try and reduce medicine errors.

The trust had revised their risk management strategy and at the time of the inspection were discussing its approval via the board. The revision includes changes to; the risk appetite statement, responsibilities and accountabilities, clarity of process, risk escalation, risk review, the addition of a risk oversight group, changes to the regularity of reporting. The revised strategy had been developed over the previous 12 months in response to the previous inspection findings and the audit of the trusts governance and risk processes via the board development programmes.

The trust managed the risks to the trust's strategy via the board assurance framework. The trust had a corporate board secretary who was responsible for oversight of the board assurance framework and the corporate risk register. Each committee was responsible for the monitoring and oversight of risks aligned to them on the board assurance framework and this was reviewed in each board meeting.

At the time of the inspection, the board assurance framework had been refreshed for 2021-2022 as a draft awaiting sign off following the completion of the trust's revised strategy with which the revised board assurance framework would align.

The framework centred on five key risks; covid-19, leadership culture and people, patient safety and quality of care, financial stability, information technology infrastructure and the trust's transformation plans.

We were concerned that the risk in relation to the trust's safeguarding work had been removed from the board assurance framework, limited assurance on the completion of this ongoing rapid improvement plan had been received and the actions were not completed. The quality and safety committee in February 2021 had noted that they had limited assurance about safeguarding and requested further information.

As of April 2021, there were 20 risks recorded on the trust's corporate risk register, these were business as usual issues such as; safety of ward environments, insufficient numbers of qualified substantive nursing staff, low staff engagement, waste management, incidents of violence and aggression, compliance with falsified medicines directive, physical health monitoring after rapid tranquilisation, CQC requirements, lack of moving and handling training, information technology, spa waiting times, Covid-19, cost improvements and changes in funding, smoke free policies and bed availability.

Wider risks to the organisation such as concerns about closed cultures and safeguarding were not recorded on the risk register.

Some of these risks had been open for a number of years, the safety of ward environments risk had been on the risk register since 2016 for example, and nursing staffing since 2017. However, progress on areas of risk had been made since the last inspection.

Our findings

Each of the two directorates had a risk register in place. Leaders had access to the risk registers and staff told us that they were able to effectively escalate concerns as needed to be put forward for addition to risk registers. The key themes in these risk registers were linked to the corporate risk register and board assurance framework in areas such as; patient flow, environments, staffing and bed availability.

Services had plans in place for emergencies and other unexpected or expected events including the covid-19 pandemic. They included infection prevention and control assurance frameworks and audits, staff vaccination programmes and gold command structures. The trust had some major outbreaks of covid-19 which had included the deaths of older and learning-disabled patients, and a member of trust staff. The trust had a covid-19 surge plan in place for 2021-2022 which was also a key deliverable in the trusts annual operational plan for the coming 12 months. The trust's strategy included 'getting through safely' to work on the trust's recovery plan.

Information management

The trust continued to have difficulties regarding the management of information and data. Teams did not always have access to the information, data and information technology they required in order for them to provide good care.

Concerns relating to information management were noted on the trust's board assurance framework and corporate risk register as an organisational risk.

The trust had a designated Caldicott guardian, senior information risk owner, and a chief digital information officer who was the director of information management system technology. There was a governance structure in place to support the delivery of information management which included a digital information governance group which met regularly and provided a bi-annual report to the audit and risk committee.

The executive director of finance managed information management and digital systems within their portfolio. The trust had an information technology team of 40 staff.

The trust continued to have an information technology system which was no longer fit for purpose.

The information technology systems in place were purpose built by the trust approximately 18 years previously. The trust had a failed procurement exercise for a new system and was in the process of going back out to procurement. In the interim, various updates to systems had been completed for stabilisation of the systems. We were concerned at the pace at which the trust would be able to achieve the procurement of a revised system and embed this system, which the trust had predicted may take three years.

The trust were subject to an information commissioners office investigation. In May 2020 a total of 11,703 patient documents and notes were lost from the trust's patient information system. Some were restored or reconstructed but 93 documents relating to 75 service users could not be retrieved. Two other large data losses occurred in September and October 2020.

The incidents were reported as a major incident and reported to the ICO with a full serious incident investigation report completed by the trust. The trust acted appropriately in assessing the risk to effected service users and informing them via letter of the loss of documentation. The trust informed us that the investigation was concluded and no action is being taken against the trust.

Our findings

The trust have taken a number of steps to reduce the risk, however there is a continuing risk of reoccurrence of this issue due to the instability of the current system.

There had been an improvement in the data used by the trust to monitor and assess risk. An integrated performance report had been put into place since the last inspection which highlighted risks, themes and trends and we observed that this was shared with board members, committees and local leaders to highlight areas of risk and areas for improvement. The trust agreed that further development was required but this was an improving position.

Engagement

Since the last inspection, the trust had made improvements to engagement with staff, partners and people using services and their carers. Managers engaged actively other local health and social care providers to ensure that an integrated health and care system was commissioned and provided to meet the needs of the local population. Managers from the service participated actively in the work of the local transforming care partnership.

The trust's approaches to engagement with service users and carers included a variety of workstreams. However, many of these were in their infancy and there was a need for a strategy and action plan to refresh and refocus this work.

The trust sought feedback from service users via care opinion; an internet system which allows service users to comment on all aspects of care received from a service and allows the trust to provide rapid and direct responses. The trust reported that 14 stories had been posted to care opinion about the trust between 1 April 2020 and 31 March 2021. Ten were reported as negative, and four as positive.

The trust had a good response rate to stories told by patients and we saw that responses were kind, compassionate and offered a solution. However, the trust were aware that further opportunities for engagement could be offered as not all service users would be likely to access care opinion and they were keen to receive more feedback.

The trust had a medical director in post who was the co-chair of the service user's engagement group, the co-chair of this group was from a local voluntary sector mental health organisation which allowed strong relationships to build between the services. The group met bi-monthly and offered roadshows every other month it did not meet. The group reported directly to the quality committee. The purpose of the group was to implement the previous service user engagement strategy which was coming to an end. A revised 2022-2025 strategy was due. The trust were also in the interim stages of also implementing a lived experience and co-production assurance group to further bring the voice and experience of people using services forward to the trust board.

The trust's new director of quality was responsible for patient experience and brought experience and new ideas to the role which included strengthening the voice of carers, understanding closed cultures and bringing the perspective of service users into services.

We also found that the board had renewed its focus on the importance of listening to understanding experiences of patients and their carers by listening to direct experience stories at board meetings.

The trust had implemented a service user and carer experience report which was presented to the quality committee. The report included aspects of all patient experience data including compliments, complaints, care opinion, inpatient community meetings, and the friends and family test. It gave leaders an overview of feedback and the themes of concerns and good practice and was a positive addition.

Our findings

The trust had a gap in their ability to collate patient and carer feedback due to the absence of a patient advice and liaison service. As part of the changes to the structure of the trust a new post 'engagement, experience and liaison officers' would be recruited to in the coming 12 months to bridge this gap and improve communication and enhance the feedback loop.

The trust had a council of governors which included publicly elected governors, elected staff governors and governors appointed from key stakeholders working with the trust such as the local university and local authority. Governor's represented the diverse population served by the trust. All governors had received an induction and specific governor training. Part of the governor's training and development plan was that the trust were considering that governor's would observe some committee meetings. The trust was yet to formally approve plans at the time of the inspection to manage the governance of these arrangements.

During the inspection we spoke with several trust governors via focus groups and one to one interviews. Governors told us that relationships between the governing body itself and relationships with the trust board had improved. They described that the chair and chief executive were supportive and engaging. Governors felt that they had access to the information they needed in order to perform their roles and had been involved in consultation sessions regarding revised strategies. Governors had been involved in development sessions.

Some of the governors had concerns about their ability to engage with service users and their constituents but felt that the trust were aware of this and working to find ways forward. There was overall agreement that things were improving but further work was required to embed changes and turn plans into actions which had a direct impact on the delivery of the quality of care to people using services.

The trust was outward facing and worked within the local system to ensure service delivery. They had taken opportunities to learn from and work with other organisations to develop skills and share learning and good practice.

The trust was engaged with several partner organisations to develop and improve the services delivered to its population.

The trust worked closely with the local acute trust who were complimentary about the services and engagement provided in the psychiatric liaison team. The trust engaged with the local authority and were re-balancing the governance processes for doing so to make improvements in safeguarding.

Due to the trust's current position they have worked closely with partners in the local CCG and with NHS England. The trust have attended and provided information to regular quality board meetings of all system partners which allowed the trust and partners to review the progress of improvements.

The trust was an active participant at the accountable care partnership. Joining together the work of health and local authority commissioners with the three foundation Trusts, primary care Sheffield and the voluntary sector across the city.

Learning, continuous improvement and innovation

The trust had made several improvements which had improved patient care and performance since the last inspection and evidenced a positive trajectory of improvements. These changes included the revision of strategies and governance processes, board, leadership and organisational development, and some investment in estates and information technology with a longer-term plan to make further improvements required.

Our findings

The trust had achieved significant change and improvement whilst working across the context of a global pandemic and appreciated that there was further work to do.

The trust had undertaken a learning process following the last inspection and leaders had allowed a period of reflection to ascertain where things went wrong to plan effectively for improvement.

The trust had needed to focus much of the improvements made in the last twelve months on the urgent actions required to improve the delivery of quality care to people using services. They were moving from a position of urgent recovery to one of continuous improvement.

There were organisational systems to support improvement and innovation work, and staff were encouraged to participate. Using a microsystems model of quality improvement, the continuous improvement team worked on specific projects across the trust to make improvements.

At the time of the inspection the trust had invited the National Collaborating Centre for Mental Health to conduct an assessment of readiness report. With this assessment complete, the trust were moving into the next stage of identifying and developing an embedded and organisation wide quality improvement programme.

The trust's psychiatric liaison service was accredited by the Royal College of Psychiatry in July 2019. The following services are also accredited:

- Home Treatment Team (March 2020)
- Older Adults Community Teams (May 2021)
- Memory Services (November 2019)
- ECT services (December 2019)

Some services were working towards accreditation but paused their applications to focus on the trust's back to good programme.

The trust had an annual clinical audit programme, much of the plan had paused due to the covid-19 pandemic. The trust had invited external partners to complete audits in the last twelve months some of these audits included; the CQC action plan, an audit of Mental Health and Mental Capacity Acts and financial audits. The trust had continued to complete internal infection prevention and control audits, and local teams and services carried out clinical audits. The trust had taken action in relation to feedback from audits.

Key to tables

Ratings	Not rated	Inadequate	Requires improvement	Good	Outstanding
Rating change since last inspection	Same	Up one rating	Up two ratings	Down one rating	Down two ratings
Symbol *	➔➔	↑	↑↑	↓	↓↓

Month Year = Date last rating published

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

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

Ratings for the whole trust

Safe	Effective	Caring	Responsive	Well-led	Overall
Requires Improvement ↑ Aug 2021	Requires Improvement ➔➔ Aug 2021	Good ➔➔ Aug 2021	Requires Improvement ➔➔ Aug 2021	Requires Improvement ↑ Aug 2021	Requires Improvement ↑ Aug 2021

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

Ratings for a combined trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Acute locations	Not rated	Not rated	Not rated	Not rated	Not rated	Not rated
Ambulance	Not rated	Not rated	Not rated	Not rated	Not rated	Not rated
Adult social	Not rated	Not rated	Not rated	Not rated	Not rated	Not rated
Mental health	Requires Improvement	Requires Improvement	Good	Requires Improvement	Requires Improvement	Requires Improvement
Community	Not rated	Not rated	Not rated	Not rated	Not rated	Not rated
Primary medical	Not rated	Not rated	Not rated	Not rated	Not rated	Not rated
Overall trust	Requires Improvement ↑ Aug 2021	Requires Improvement →← Aug 2021	Good →← Aug 2021	Requires Improvement →← Aug 2021	Requires Improvement ↑ Aug 2021	Requires Improvement ↑ Aug 2021

The rating for the well-led key question is based on our inspection at trust level, taking into account what we found in individual services. Ratings for other key questions take into account the ratings for different types of service. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Rating for acute services/acute trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Woodland View	Good Dec 2019	Good Dec 2019	Good Dec 2019	Good Dec 2019	Good Dec 2019	Good Dec 2019
Wainwright Crescent	Good Dec 2018	Good Dec 2018	Good Dec 2018	Good Dec 2018	Good Dec 2018	Good Dec 2018
Overall trust	Requires Improvement ↑ Aug 2021	Requires Improvement →← Aug 2021	Good →← Aug 2021	Requires Improvement →← Aug 2021	Requires Improvement ↑ Aug 2021	Requires Improvement ↑ Aug 2021

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

Rating for Woodland View

	Safe	Effective	Caring	Responsive	Well-led	Overall
Overall	Good Dec 2019	Good Dec 2019	Good Dec 2019	Good Dec 2019	Good Dec 2019	Good Dec 2019

Rating for Wainwright Crescent

	Safe	Effective	Caring	Responsive	Well-led	Overall
Overall	Good Dec 2018	Good Dec 2018	Good Dec 2018	Good Dec 2018	Good Dec 2018	Good Dec 2018

Rating for mental health services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Wards for people with a learning disability or autism	Inadequate Jul 2021	Inadequate Jul 2021	Inadequate Jul 2021	Inadequate Jul 2021	Inadequate Jul 2021	Inadequate Jul 2021
Acute wards for adults of working age and psychiatric intensive care units	Inadequate →← Aug 2021	Requires Improvement →← Aug 2021	Requires Improvement →← Aug 2021	Inadequate ↓ Aug 2021	Inadequate →← Aug 2021	Inadequate →← Aug 2021
Wards for older people with mental health problems	Requires Improvement ↑ Aug 2021	Good ↑ Aug 2021	Good →← Aug 2021	Good ↑ Aug 2021	Requires Improvement ↑ Aug 2021	Requires Improvement ↑ Aug 2021
Long stay or rehabilitation mental health wards for working age adults	Requires improvement Oct 2018	Good Oct 2018	Good Oct 2018	Good Oct 2018	Good Oct 2018	Good Oct 2018
Mental health crisis services and health-based places of safety	Good ↑↑ Aug 2021	Requires Improvement →← Aug 2021	Good →← Aug 2021	Requires Improvement →← Aug 2021	Good ↑↑ Aug 2021	Requires Improvement ↑ Aug 2021
Community-based mental health services of adults of working age	Requires improvement Apr 2020	Requires improvement Apr 2020	Good Apr 2020	Good Apr 2020	Requires improvement Apr 2020	Requires improvement Apr 2020
Community-based mental health services for older people	Good Oct 2018	Good Oct 2018	Outstanding Oct 2018	Outstanding Oct 2018	Good Oct 2018	Outstanding Oct 2018
Community mental health services for people with a learning disability or autism	Good Mar 2017	Good Mar 2017	Good Mar 2017	Good Mar 2017	Good Mar 2017	Good Mar 2017
Forensic inpatient or secure wards	Requires improvement Apr 2020	Good Apr 2020	Good Apr 2020	Good Apr 2020	Requires improvement Apr 2020	Requires improvement Apr 2020
Substance misuse services	Requires improvement Mar 2017	Good Mar 2017	Good Mar 2017	Outstanding Mar 2017	Good Mar 2017	Good Mar 2017
Overall	Requires Improvement	Requires Improvement	Good	Requires Improvement	Requires Improvement	Requires Improvement

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

Mental health crisis services and health-based places of safety

Requires Improvement  

Is the service safe?

Good  

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

Safe and clean environments

All clinical premises where patients received care were safe, clean, well equipped, well furnished, well maintained and fit for purpose. The physical environment of the health-based places of safety met the requirements of the Mental Health Act Code of Practice.

Staff completed and regularly updated thorough risk assessments of all areas and removed or reduced any risks they identified. In the main emergency department (A&E) the liaison team has access to an assessment room suitable for conducting high risk assessments which had been accredited through the Psychiatric Liaison Accreditation Network (PLAN) Royal College of Psychiatrists' Centre for Quality Improvement. This room had a door which opened outwards and was not lockable from the inside. The door had an observation panel which allowed staff from outside the room to check on the patient or staff member but allowed enough degree of privacy. The room was furnished with furniture, fittings and equipment which were unlikely to be used to cause harm or injury to the patient or staff member. The room was fitted with anti-ligature fittings but had no natural light or ventilation. This room ensured patients had privacy and dignity. Liaison staff also had access to private cubicles in ED and the relative rooms. The access to rooms applied to the hospital wards also.

The physical environment of the health-based places of safety met the requirements of the Mental Health Act Code of Practice. Staff knew about any potential ligature anchor points and mitigated the risks to keep patients safe. These risks were assessed regularly, and staff could access up to date environmental risk assessments via a shared drive on the trust intranet.

The location where the single point of access (SPA) hub were based was well equipped and well-furnished so staff had the systems to speak to patients by telephone or with other team members by remote access. The hub had a suite of CCTV screens so staff could observe patients in the waiting area who had attended for face to face assessments.

All interview rooms had alarms and staff available to respond. The main assessment room within the emergency department had an alarm system so staff could summon assistance, as well as access to personal alarms should they be needed. Personal alarms were provided for liaison staff as there was access to additional interview rooms within the main emergency department which did not have an alarm system.

In the health-based place of safety and SPA interview rooms within the service were alarmed and CCTV was in operation. The rooms were well equipped and well furnished. In the health-based place of safety and single point of access the clinical and office areas were controlled by an electronic pass system and all staff carried alarm fobs. Staff were available to respond in an emergency if needed.

Staff from the health-based place of safety had access to a clinic room on the adjacent ward, which had the necessary equipment for patients to have thorough physical examinations.

Mental health crisis services and health-based places of safety

All areas were clean, well maintained, well-furnished and fit for purpose.

Staff in the emergency department, health-based place of safety and SPA ensured cleaning records were up-to-date and the premises were clean. We observed domestic staff cleaning patient areas in the three service areas we visited.

Staff always followed infection control guidelines, including handwashing. Prior to entering the emergency department, health-based place of safety and SPA staff ensured visitors were wearing the appropriate level of personal protective equipment (PPE) and wearing a face mask unless patients were exempt. Signage was in place to remind patients to wear PPE and use hand sanitiser upon entering each clinical area. In waiting room areas there were signs indicating the maximum numbers of patients who could use the area at any one time and fixed chairs identified as not to be used due to social distancing.

Staff made sure equipment was well maintained, clean and in working order.

Safe staffing

The service had enough staff, who received basic training to keep people safe from avoidable harm. The number of patients on the crisis care pathway remained high but this did not prevent staff from giving each patient the time they needed.

Nursing staff

The service had enough nursing and support staff to keep patients safe. However, partners felt that an additional nursing post was required to ensure that the liaison team could respond in a timely manner to requests for assessment in A&E. The trust planned to discuss this in a service model review with commissioners.

The trust provided us with data of the number of shifts covered and the number of shifts filled. This information indicated the service had reducing vacancy and bank nurses' rates compared to our last inspection in January to February 2020.

Liaison psychiatry – 239 shifts covered.

Single point of access/Emotional Wellbeing - 137 shifts

Out of Hours Service – 298 shifts covered.

Managers limited their use of bank and agency staff and requested staff familiar with the service. The service had reducing vacancy rates and low turnover rates. The SPA has two agency nurses to support the recovery plan to reduce the SPA waiting list.

Managers made sure all bank and agency staff had a full induction and understood the service before starting their shift.

The trust provided us with information on vacancies across the trust from September 2020 to March 2021. Vacancies across the trust for band 5 nurses had risen from December 2020 to March 2021, by approximately 15 whole time equivalent staff. During the same period vacancies across the trust in band 6 and band 7 nurses had decreased. These figures included vacancies with the crisis teams we visited.

Medical staff

Mental health crisis services and health-based places of safety

The service had enough medical staff and medical cover and could get medical support quickly when needed. The health-based place of safety had consultant psychiatrist cover. With one whole time equivalent consultant supported by a staff grade psychiatrist, a 0.4 whole time equivalent speciality doctor, a junior doctor and two junior doctors in foundation training.

There was an out of hours on call team, comprising a junior doctor and consultant on call. When patients are brought into the health-based place of safety in normal working hours there is a section 12 approved doctor available to assess them. In out of hours there was an on-call registrar instead of the section 12 approved doctor.

Liaison psychiatry had consultant psychiatrists and access to the out of hours on call team. There is also a registrar and consultant on call for assessment of patients under The Mental Health Act (MHA).

The trust has a rota for S12 approved doctors but the staff and psychiatrists we interviewed told us there a national issue with accessing S12 doctors. We did not note any concern with the timing of assessment of patients as a result. If there were concerns about physical health/ emergencies the trust had physician associates in place who have similar training to doctors who can manage physical health care of patients.

Managers could use locum doctors when they needed additional support or to cover staff sickness or absence. We spoke with a locum consultant who had worked at the trust for several months. They told us they had completed an induction and were attending continued professional development in their role. Managers ensured all locum staff had a full induction and understood the service.

Mandatory training

Staff reported they had completed and kept up to date with their mandatory training. At 04 April 2021, trust-wide data indicated that the overall compliance rate for mandatory training was just over 90%. However, three courses were below 80%. These were:

Intermediate life support – 68%

Respect level 2 – 67%

Respect level 3 – 73%

The trust stated that of the 74 staff who were non-compliant in intermediate life support, 44 (59%) were compliant with basic life support.

The trust told us that lower rates of compliance in these courses was due to the reduction in availability of face to face training availability in the pandemic. We did not see an impact of lower compliance with training within this service.

The mandatory training programme was comprehensive and met the needs of patients and staff.

Managers now monitored mandatory training and alerted staff when they needed to update their training. Training compliance had improved through enhanced and more frequent reporting, fortnightly instead of monthly. Services tracked compliance for training expiry dates and made bookings for when face to face training was reinstated. For example, SPA met the 80% mandatory training compliance target in March 2021 when performance increased to 92.98% in March, up from 91.42% in February, and 92.02% in January 2021.

Mental health crisis services and health-based places of safety

Assessing and managing risk to patients and staff

Staff assessed and managed risks to patients and themselves. They responded promptly to sudden deterioration in a patient's health. When necessary, staff working in the mental health crisis teams worked with patients and their families and carers to develop crisis plans. Staff followed good personal safety protocols.

Assessment of patient risk

Staff across the crisis care pathway completed a risk assessment for each patient on admission / arrival using a detailed risk assessment. The risk assessment was reviewed regularly after contact with patients, including after any incident.

In the emergency department and on acute medical wards, the acute hospital staff assessed patients on arrival using a coproduced risk assessment. This identified patients presenting with a low or high risk, highlighted concerns about capacity, behaviours and medicines. The risk assessment was supportive of staff who may not have had specific mental health training. This was part of improving the patient care pathway and working with the acute trust to improve and maintain ongoing standards of practice. This decision-making tool for staff was used throughout the acute trust's locations. The manager of the liaison team supported how this tool was audited, so it was used appropriately. This provided the acute trust staff with a baseline assessment of risk and prioritisation for referral to the liaison team. The liaison team provided referrers with information and advice between initial referral and liaison assessment.

The health-based-place of safety staff liaised with the relevant police force to determine the level of risk a patient presented and assessed if the level of staff needed to be increased in advance of a patient's arrival

In the SPA staff completed initial assessments for each patient upon first contact and allocated more detailed assessments to staff within the team dependent upon risk. Other teams within the crisis care pathways could also be utilised dependent on the level of risk and need for each patient. For example, patients could be followed up via the out of hours team dependent upon the number of referrals received by the SPA. Patients could be offered immediate assessment or were placed onto waiting lists for routine assessment by other services within the crisis care pathway or trust, for example the emotional wellbeing service or home treatment team.

In the health based place of safety there were no patients accommodated at the time of the inspection visit, and the ward manager and modern matron described the risk assessment process, which would provide staff with sufficient information to be able to form risk management plans.

In the emergency department we observed an assessment of a patient with two senior clinicians. Staff gave a thorough introduction of themselves and explained and sought consent to the assessment. The assessment included assessment of risk and a mutually agreed care and crisis plan prior to discharge. Prior to discharge the liaison team had contact with another service the patient was involved with to ensure information about risk management was shared.

In the SPA, staff had coproduced a risk triage 'red to green' to support clinicians to assess and determine the level of risk patients were presenting with. The process included information on the patient's presentation, clinician actions and response, triage response, response time and additional actions for consideration. For example, a low risk of harm in the short term or moderate risk with good support/stabilising factors would generate a response time of a triage within 24 hours or schedule assessment within 4 weeks with the emotional and wellbeing service. A triage response for an emergency was an immediate blue light response with the clinician continuing engaging with the patient while the level of response was determined and if required contact with liaison psychiatry if the patient attended the emergency department. Risk assessments we reviewed were comprehensive, providing enough information to be able to inform decisions and risk management responses and plans with patients.

Mental health crisis services and health-based places of safety

Staff could recognise when to develop and use crisis plans and advanced decisions according to patient need. Liaison psychiatry routinely completed crisis care plans and this information was shared in letters sent to their GP. The SPA staff completed a crisis plan if they engaged with a patient on short term basis as part of their triage and assessment. In the review of 6 records of patients completed by SPA we did not see a crisis care plan. Staff in liaison psychiatry. Health-based place of safety and single point of access had entry to other teams working with patients. This meant crisis plans could be reviewed and the teams working with patients updated on changes to plans.

Management of patient risk

We reviewed 12 sets of records on the patient record system (liaison psychiatry five records and SPA, seven, one with a clinician). We found all had risk assessment and management plan in care records and there was a clear correlation between assessment and how identified risks would be managed. Where necessary this included the use of specific crisis plans.

We saw risk assessment included liaison and or checking GP information, the trust electronic patient record system for other teams involved, historic risk, mental health act assessment, history of admission/discharge, information of capacity, crisis assessment and contingency plan and physical health care as some examples. Assessment including liaising with other professionals involved and on medical wards speaking to doctors and nurses. Information were sent to patients GP's following an assessment.

In the emergency department initial risk assessments are completed by A&E staff, co designed risk assessment in ED and wards. This is a risk assessment matrix, including assessment of mental capacity and identifies who is low or high risk, highlight concerns about capacity, behaviours and medicines. The risk assessment supports staff who may not have had specific mental health training to carry out a risk assessment. This was developed with involvement from acute trust staff to improve the ongoing standard of practice.

Staff responded promptly to any sudden deterioration in a patient's health. In the SPA we saw a good example of a clinician following up on patient who was triaged by the out of hours service and contacted the patient for additional information on risk. The patient was given a face to face appointment as their level of risk had increased.

Staff continually monitored patients on waiting lists for changes in their level of risk and responded when risk increased. However, in the SPA there was still a waiting list for, assessment and treatment.

Staff responded promptly to any sudden deterioration in a patient's health. In the SPA we saw a good example of a clinician following up on patient who was in contact with the clinician for a short-term intervention. The clinician obtained additional information from the patient which indicated their level of risk had increased and made a face to face appointment to review them and reviewed their crisis plan.

Staff followed clear personal safety protocols, including for lone working. In liaison psychiatry and single point of access staff adhered to safe working practices and would assess a patient with a college if there was an identified risk needing a chaperone.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Mental health crisis services and health-based places of safety

Staff received training on how to recognise and report abuse, appropriate for their role and kept up to date with their safeguarding training. At 04 April 2021, trust-wide data indicated that the overall compliance rate for mandatory training in safeguarding children and adults was 85% and 90% respectively. This service was not recorded by the trust's performance data as being an outlier for compliance rates with mandatory training.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them. There were mutually supportive relationships in place between the liaison team and the acute trust.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff were experienced in dealing with safeguarding concerns. Those staff working in the single point of access team were a central point of contact and referral for the Trust and therefore received a higher level of training. Staff were also aware who the trust safeguarding leads were should they require further guidance or support. For example, the trust had a named doctor, named nurse for safeguarding children, adults safeguarding and domestic abuse lead and interim head of safeguarding.

This core service (Liaison psychiatry, health- based place of safety and SPA) made 69 safeguarding referrals between September 2020 and April 2021, of which 63 concerned adults and 6 concerned children.

There were no serious case reviews commenced or published in the last 12 months (April 2020 to April 2021) that related to this service.

Staff access to essential information

Staff working across the three services we visited as part of the mental health crisis care pathway kept detailed records of patients' care and treatment. Records were clear, up-to-date and easily available to all staff providing care. All patient records were kept on an electronic recording system which was accessible for all staff. Staff in the individual teams said the system was easy to navigate and patient information available to them.

When patients transferred to a new team or different teams were involved in patients' care and treatment staff told us there were no delays in accessing their records, as all teams had access to the same electronic record.

Staff in liaison psychiatry, health-bases place of safety and single point of access completed patient's biographical details every patient assessed and or admitted to the health-based place of safety. Records were stored securely; a password was required to access the electronic system.

Medicines management

Staff working across the three services we visited as part of the mental health crisis care pathway used systems and processes to safely prescribe, administer, record and store medicines. This included regular reviewed the effects of medicines on each patient's mental and physical health. As part of the triage and assessment of patients in liaison psychiatry and single point of access staff checked patients prescribed medicines. Staff offered advice and guidance to patients on medicine management, for example side effects. Any changes to prescribed medicines were authorised by the patient's psychiatrist or duty doctor. There were no nurse prescribers within the liaison or single point of access. In the emergency department the liaison team had access to a small stock of medicines which could be administered in crisis. Otherwise there were no medicines stored in the emergency department or single point of access related to patients ongoing treatment. Changes to medicines following triage and or assessment were updated on the patients records and detailed in letters sent to GP's.

Mental health crisis services and health-based places of safety

There were no patients accommodated in the health-based place of safety at the time of the inspection. We looked at the arrangements for medicine management for the adjacent ward to the health-based place of safety were any medicines would be stored. We saw staff stored and managed medicines and prescribing documents in line with the provider's policy.

We spoke with a pharmacist who was based in the crisis services. They described her role as a recent innovation to support staff in the crisis services and was able to prescribe medicines authorised by pharmacists. They described the role as offering medicines advice and guidance to patients, staff and GP's. They took calls from the SPA team and spoke directly to patients and GP's. For example, giving to GP's on the titration of medicines they were considering prescribing and checked if there were any contraindications. Clinicians in the single point of access described the role of the pharmacist as focused on patient care and reduced the number of calls clinicians took on medicine related enquiries.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely.

The necessary emergency equipment and medicines were available on the Psychiatric Decisions Unit and the health-based place of safety.

Track record on safety

The service had a good track record on safety.

The trust had declared 30 Serious incidents in February and March 2021 including 17 retrospective strategic executive information system (STEIS) ones.

Between 27 August 2020 and 13 April 2021 there were 3 serious incidents reported by this service. Of the total number of incidents reported, the most common type of incident was apparent/actual/suspected self-inflicted harm meeting serious incident criteria. There were no unexpected deaths within this category. There were no incident reviews outstanding for this core service.

We reviewed two serious incidents reported by the trust to the Strategic Executive Information System (StEIS) over the same reporting period. The incidents reviewed were related to patients who had contact with the SPA. The incident reports confirmed patients were known to the trust for several years and had contact with several teams. Both patients had been assessed by SPA and had been followed up via their GP or directly by the team. The trust's investigations found that there was no direct contributable link between the SPA and serious incidents.

Reporting incidents and learning from when things go wrong

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

Staff recognised what incidents to report, how to report them and reported them appropriately. All staff we spoke with said they reported anything they considered a near miss in line with the trust policy and were encouraged and supported to do so by their managers. For example, in the health base place of safety incidents of mechanical restraint had been reported. When we enquired further with the service about the use of mechanical restraint, we were told by the consultant psychiatrist, modern matron and ward manager those incidents related to patients being brought into the service in handcuffs. This was either by the police or secure transport services, and isolated incidents when patients

had been so violent, police were requested to attend the scene and the police decided to use mechanical restraint. Trust staff reported such incidents as serious, as per the trust policy. Staff in the liaison psychiatry and SPA told us serious incidents were used as part of their induction programme in the safeguarding learning session, reflective practice sessions and team meetings.

Managers investigated incidents where it was necessary and shared lessons learned with the whole team and the wider service. Staff were able to give us examples of incidents being shared in reflective practice and staff meetings, as well as information brought back to them as a result of investigations.

All staff that we spoke to talked confidently about what types of things should be reported and how they would report them. They told us that information was shared with them via regular team meetings, which we saw evidence of and during regular staff huddles and handovers.

The service had no never events.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if things went wrong.

Managers debriefed and supported staff after any serious incident.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations.

Staff received feedback from investigation of incidents, both internal and external to the service. Staff told us learning from death reviews were shared with the teams in meetings and reflective practice sessions lead by a senior nurse or nurse consultant. These reviews included the patient's contact with the crisis care pathways and review of their care to decide if there were lessons learnt and or changes need to be made.

Managers and staff we spoke to told us they often found out of incidents on the day within their team and managers supported staff to see what need to be done within a team, for example, immediate support to staff, the team and discussion in relevant safety huddles and other meetings. Staff told us reports were completed and they were involved in investigation and outcomes. This included changes to systems, processes and practice.

Staff told us reporting incidents was positive, transparent and managers had a no blame approach, but focused on improvement. Staff referred to a lesson learned framework being in place, which was an improvement in information being shared and the trust focusing upon the NHS Improvement just culture work which has been introduced as NHS organisations are signed up to this.

There was evidence that changes had been made as a result of feedback. For example, in the single point of access the staff coproduced the 'red to green' risk triage to support staff in assessing patient following an incident in 2020.

Managers shared learning with their staff about never events that happened elsewhere.

Is the service effective?

Requires Improvement 

Mental health crisis services and health-based places of safety

Our rating of effective stayed the same. We rated it as requires improvement.

Assessment of needs and planning of care

Staff assessed the mental health needs of all patients. Staff working for the mental health crisis teams worked with patients and families and carers to develop individual care plans and updated them when needed**.** Care plans reflected the assessed needs, were personalised, holistic and recovery oriented.

Staff completed a comprehensive mental health assessment of each patient. The teams within the crisis care pathway used an evidence-based biopsychosocial assessment, which included, mental health and medication, psychosocial and psychological needs, strengths and areas for development and suicide risk. The liaison psychiatry team's assessment of risk includes liaising with acute staff to decide the appropriate response time to assess a patient, for example if a patient attended the emergency department was intoxicated and unable to engage in an assessment at that point.

Staff made sure that patients had a full physical health assessment and knew about any physical health problems.

Staff developed a comprehensive assessment and care plan for each patient that met their mental and physical health needs.

Although staff regularly reviewed and updated care plans when patients' needs changed, care plans were not consistently personalised, holistic and recovery orientated. Staff did not consistently involve patients in their care plans or give them access to them. In the six records we reviewed in the SPA, four did not have a care plan which was personalised to the patient. Care plans did not include the patients' views, strengths and goals and did not record whether the patient was given a copy of their care plan. Two of the five patients we spoke directly to had been offered a copy of their care plan and the other three did not know about their care plan.

Best practice in treatment and care

Staff working for the mental health crisis teams used recognised rating scales to assess and record severity and outcomes. Staff working for the crisis teams and in the health-based places of safety participated in clinical audit, benchmarking and quality improvement initiatives.

Staff used recognised rating scales to assess and record severity and outcomes.

Staff working for the mental health crisis teams used recognised rating scales to assess and record severity and outcomes where necessary. These included the health of the nation outcome scale and the malnutrition universal screening tool. Staff provided a range of care and treatment suitable for the patients in the service, for example a programme of brief interventions was offered to people that were assessed as requiring it. Some patients were also directed to services for home treatment or for support with psychosis if it was assessed as necessary. It was also evident from the care records that staff were supporting patients to access social care, benefits advice and giving them access to information about medication.

Staff took part in clinical audits, benchmarking and quality improvement initiatives. In July 2020 staff took part in the Royal College of Psychiatrists reaccreditation of the psychiatric liaison team. The PLAN assessors praised the team for their close working ties with colleagues working at the acute trust, in particular the good communication, high quality training and 24 hour support they provide. The liaison team was praised for their proactive attitude, ability to respond to, and overcome, challenges.

Mental health crisis services and health-based places of safety

Staff told us the trust had introduced the situation background assessment recommendation (SBAR) model into assessment and triage of patients. Staff said they had completed training in using the SBAR and the impact of this was they were experiencing improved conversations in safety huddles and multidisciplinary team meetings about risk and escalating the risk so facilitating a more urgent response when handing over a patient to another team.

Staff used technology to support patients. For example, SPA texting patient information about advocacy, wellbeing and recovery. Staff could utilise Attend Anywhere for 1-1 clinical work and uses Microsoft Teams for group work.

Managers used results from audits to make improvements.

Skilled staff to deliver care

The psychiatric Liaison team, health-based place of safety and SPA teams included or had access to the full range of specialists required to meet the needs of patients under their care. Managers made sure that staff had the range of skills needed to provide high quality care. They supported staff with appraisals, supervision and opportunities to update and further develop their skills.

Managers provided an induction programme for new staff. The service had access to a full range of specialists to meet the needs of the patients, including psychologists and occupational therapists. During our visit we observed an assessment in the emergency department by the liaison service and an assessment review of a patient in the SPA. From our observations it was clear that staff had the skills and experience to deliver good quality care. There were a range of appropriately qualified multidisciplinary staff available to support patient's needs, including qualified nurses, social workers, support workers and clinical administrative staff across liaison psychiatry, health-based place of safety and SPA.

Managers made sure staff had the right skills, qualifications and experience to meet the needs of the patients in their care, including bank and agency staff. In the SPA there was a weekly staff development session, a weekly meeting to share any learning from complaints/ feedback.

Managers gave each new member of staff a full induction to the service before they started work. Staff also reported there was thorough and detailed induction into the team, with a 4-day trust induction and 6-week local induction. We spoke with two support workers from liaison psychiatry and they told us about their positive experience of induction and personal development. They explained this was a recently established role and their organisational and local induction had helped them develop the skills to work within the team and support older people and adults of working age.

The service was accredited by the royal college of psychiatry. The 2020 report identified that the liaison team were supported in their roles with a range of training opportunities available, including monthly continuing professional development.

Managers supported staff through regular, constructive appraisals of their work. At the time of the inspection, the trust wide appraisal rate was 97%.

All staff we spoke with said they had regular supervision at 4 to 6 weeks that covered their performance and personal development. The trust provided us with information on improving the rate of supervision for staff and aimed to increase compliance rates to ensure that 80% of staff have a minimum of 8 supervisions in a twelve-month period (six

for part time staff). Plans were in progress to achieve this target. At the week commencing 5 April 2021, the average compliance rate with the trust target for supervision in the clinical services was at 67%, which was below the trust target of 80%. At inspection all staff we spoke within the crisis services confirmed they had received regular supervision between 4 to 6-week intervals.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge.

Managers made sure staff received any additional specialist training for their role.

Managers recognised poor performance, could identify the reasons and dealt with these.

Multi-disciplinary and interagency teamwork

Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. The team(s) had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.

Staff held regular multidisciplinary meetings (MDT) to discuss patients and improve their care. In the liaison team we observed the afternoon clinical handover meeting. This included the working and older age psychiatrists, two junior doctors and psychiatric liaison nurses. We observed a multidisciplinary approach to discussion including, Covid safety, consent and capacity of patient's and understanding of the specialist needs of patients. For example, patients with autism and liaison with specialist services. The language used was empathic and included risk assessment and prioritisation of all patients and discussions on capacity and demand on the service. The manager and consultant psychiatrist for the liaison team told us they looked at specific patients attending the A&E for reasons associated with risk or frequency of attendance and called multi-professionals meeting to determine a management plan. The consultant psychiatrist said this good practice approach identified not all referrals fitted a criterion for certain teams, so decisions made as to the most appropriate service to refer the patient to, so they were not circulated around various services. The liaison attending other teams MDT meetings in general would not be possible. The liaison team held two daily meetings to discuss referrals and allocate work.

In the SPA we observed one of the three handover meetings with the assessment team and a daily patient flow meeting, which included representatives of the trust senior managers. The SPA assessment team meeting was led by a senior practitioner and was attended by the SPA consultant psychiatrist and 8 practitioners (nurses/social workers) two who attended via Microsoft Teams. The senior practitioner discussed referrals and prioritised them for risk and allocated the referrals based on practitioner experience and need of the patient. For example, risk associated with social care would be allocated to a social worker. Referrals were allocated to practitioner's diaries and appointments agreed, by telephone or for example Zoom, dependent upon patient preference. Follow up on patients who had not been assessed, was allocated to the team as well as patients contact by the hour of hours team, so practitioners could review risk. The consultant psychiatrist contacted patients with medicine related queries.

The crisis care service line daily meeting was attended by the trust director of operations, general manager for inpatient services, SPA service manager, liaison psychiatry team manager, ward manager, crisis home resolution treatment service manager and approved mental health professional (AHMP) team manager. The meeting was developed in response to concerns about patient flow within the mental health services and patients with mental health needs attending the acute trust. We observed positive interactions between teams to identify any delays or blockages in the crisis care

pathway. For example, the availability of approved mental health practitioners (AMHP's) to assess patients under the Mental Health Act. Approved mental health practitioners' input into the meeting was proactive and allowed for an identification of positive solutions at that time. The trust also recorded the outcomes of these meetings, for example the SPA being short staffed on one day and home treatment staff supporting SPA to complete assessments.

In addition, managers attended a meeting to discuss patient access and flow within the mental health services. There was also a monthly mental health committee, chaired by the medical director. Managers described crisis meetings as helpful in diffusing problems and ensuring they were clear on demands of the crisis care pathway and support needed for patients, staff and cross sector working.

Staff made sure they shared clear information about patients and any changes in their care, including during transfer of care. The information given by members of the team was deemed informative and helpful as part of their care. The anonymised case notes reviewed were seen to be comprehensive and detailed. The team sent clear detailed letters to patients' GP's regarding the outcome of the assessment. Case notes clearly detailed that patients were offered a copy of these letters, and the team numbering patient care plans was seen to be helpful for others reading them. The urgent and routine referrals were in-depth, with staff uncovering further, important information from patients.

Staff had effective working relationships with other teams in the organisation. The local acute trust described liaison psychiatry as being responsive to challenges and pressures placed on the healthcare system and offering a robust assessment to support the acute staff in the emergency department. Liaison psychiatry staff attend the acute and emergency medicine care group, emergency department clinical governance meetings with the local acute trust to discuss operational processes between the two trusts. We saw in the minutes of these meetings that positive discussions were held regarding improvements to services in referrals, information sharing and follow up with patients.

The team was described in the July 2020 Royal College of Psychiatry report as a coherent, strong, all-age team. The service was described as proactive, particularly with overcoming challenges and identifying new ways to respond to these.

Colleagues from the local acute trust praised the liaison team's services including the move to a 24-hour service, their communication, and the opportunities offered for training and reflection.

Liaison staff were commended for their professionalism, listening skills and ability to make patients and carers feel at ease.

SPA have developed a relationship with the police and are considering bringing in hot desking facilities at the Longley centre to accommodate police colleagues. A nurse is allocated to go out with the police at night times to assist in their responding to queries with people presenting with mental health crisis. The trust is providing training for the police on mental health to provide ongoing support. There is a joint governance meeting with the police to look at the health-based place of safety data, which was described by managers as positive as there is a police officer Sargeant and officers aligned to this service. These meetings are monthly and then quarterly with the wider police group and again data about performance is brought to this meeting and any issued discussed, for example looking for key themes or specific incidents.

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

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice.

Mental health crisis services and health-based places of safety

Staff received and kept up to date with training on the Mental Health Act and the Mental Health Act Code of Practice and could describe the Code of Practice guiding principles. At 04 April 2021, trust-wide data indicated that the overall compliance rate for mandatory training was just over 90%, of which Mental Health Act training was one.

Staff that we spoke to during our visit understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice. They talked confidently about the Act and how it might impact their work. Staff could give us examples of where it was relevant to the work they undertook with patients.

Staff had access to support and advice on implementing the Mental Health Act and its Code of Practice and knew who their Mental Health Act administrators were and when to ask them for support.

The service had accessible, relevant and up to date policies and procedures that reflected all relevant legislation and the Mental Health Act Code of Practice.

Staff explained to each patient their rights under the Mental Health Act in a way that they could understand, repeated as necessary in accordance with the Mental Health Act Code of Practice and recorded it clearly in the patient's notes each time. This included the rights of those patients brought into the health-based place of safety under section 136.

The service did not monitor or audit adherence to the MHA code of practice.

Good practice in applying the Mental Capacity Act

Staff supported patients to make decisions on their care for themselves. They understood the trust policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly for patients who might have impaired mental capacity.

Staff undertook a capacity assessment with all patients receiving care in liaison psychiatry, SPA and health-based place of safety.

At 04 April 2021, trust-wide data indicated that the overall compliance rate for mandatory training was just over 90%, of which the Mental Capacity Act level 1 and Level 2 were included.

There was a clear policy on Mental Capacity Act and Deprivation of Liberty safeguards, which staff could describe and knew how to access. Staff knew where to get accurate advice on the Mental Capacity Act.

Is the service caring?

Good 

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

Kindness, privacy, dignity, respect, compassion and support

Staff treated patients with compassion and kindness. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.

Mental health crisis services and health-based places of safety

Staff were discreet, respectful, and responsive when caring for patients. We observed an assessment by the liaison psychiatry staff and observed the patient was treated with kindness and staff explains the assessment process and delay in assessing the patient due to the level of alcohol they had consumed. The patient told us they were treated with compassion, kindness and were listened to and had agreed staff could speak to their family members. Another patient told us the liaison team were knowledgeable, well managed and provided a good service with limited resources.

Staff gave patients help, emotional support and advice when they needed it. Patients told us staff in the SPA were compassionate and listened to them, as they could call the SPA and received emotional support and advice. Patients told us staff in the SPA answered calls responsively and they were not kept waiting for the phone to be answered.

Staff supported patients to understand and manage their own care treatment or condition. For example, patients told us they were aware of their diagnosis and what medicines were prescribed for.

Staff directed patients to other services and supported them to access those services if they needed help. Patients told us they were referred to other specialists or services for support, for example a psychiatrist, social care and occupational therapy, orthopaedic services, psychotherapy and pain management.

Patients said staff treated them well and behaved kindly, understood and respected the individual needs of each patient. Liaison psychiatry staff were described as compassionate and caring.

Staff felt that they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients and staff. The trust had freedom to speak up champions and staff were aware of who to contact should they need to use this service.

Staff followed policy to keep patient information confidential. Patients told us staff kept their information confidential and asked for their permission to speak to their family or other services they were involved with.

Involvement in care

Staff in the mental health crisis care pathway did not always involve patients in care planning but involved them in risk assessment and actively sought their feedback on the quality of care provided.

Staff ensured that patients had easy access to advocates when needed.

The July 2020 PLAN accreditation report identified the liaison psychiatry team as having a very strong record in the last 12 months in delivering training to acute staff, involving patient within this to deliver high quality training.

Involvement of patients

The trust reported in the board of directors' public report May 2021 that they had experienced lower levels of patient and staff feedback, which remained a risk. As a result, the inpatient survey (Quality of Experience) has been revised and shortened to make it more effective for volunteers and respondents to complete. Additional volunteers were being trained to ensure their safety and a safe return to the wards. IT equipment is being sourced to allow for office-based telephone surveys to be conducted

Staff ensured patients understood their care and treatment and found ways to communicate with patients who had communication difficulties. For example, copying patients into correspondence with other services at the patients' request.

Mental health crisis services and health-based places of safety

Staff involved patients in decisions about the service, when appropriate. Patients told us they were involved in decision about their care and their permission sought if they wanted to be referred onto other services. Staff from the SPA had been contacting patients on the waiting list to check on their welfare and explain how the trust was monitoring this and the SPA staff received positive feedback about this approach.

Patients could give feedback on the service and their treatment and staff supported them to do this. For example, staff supported patients to make advanced decisions on their care and advised on the services available to them within the NHS, local authority and voluntary sector.

Staff made sure patients could access advocacy services.

Involvement of families and carers

Staff supported, informed and involved families or carers. In Liaison psychiatry we observed staff seeking permission to speak to the patient's family, so they were aware of the assessment. members.

Staff helped families to give feedback on the service. The trust is seeking feedback on the usability and accessibility of the new website. The trust use Care Opinion, an online platform for patients and their families to share feedback on the care they have received. The trust also used volunteers to encourage and support patients and families to share feedback and help them access the website. Staff gave carers information on how to find the carer's assessment.

Patients and carers reported the liaison team were exceptionally 'patient and understanding' in their approach to providing support. The liaison staff were commended for their professionalism, listening skills and ability to make patients and carers feel at ease. The information given by members of the team was deemed informative and helpful as part of their care.

Is the service responsive?

Requires Improvement 

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

Access and discharge

Although access and waiting times were improving, capacity and demand upon the crisis care pathway meant that the single point of access could not systematically reduce waiting times. Patients waited a long time for treatment and the trust was not always meeting its targets to assess and treat people in a timely way.

In the SPA demand on the service rose significantly in March 2021 with a rise of 122 referrals between February and March 2021. The numbers of patients waiting for an assessment increased in March 2021 for the first time since August 2020. There were 762 patient clients on the assessment waiting list at the end of March compared with 708 in February and 735 in January.

Staff we spoke with in the trust referred to the intense pressure on the crisis care pathway in A&E and SPA. Managers told us that commissioners and stakeholders were aware of the pressure and these services needed to be restructured as the current commissioned model for the crisis care pathways (liaison psychiatry/single point of access) could not meet the demand.

Mental health crisis services and health-based places of safety

During our visit we spoke to managers about our concerns relating to the length of time people were waiting for longer term treatment. During our inspection 06 January 2020 to 5 February 2020 we identified the trust did not have adequate plans in place to monitor and assess patient's waiting for services. However, following our inspections they planned to put actions into place including; access to patient information packs, letters to note contacts if a patient feels they are deteriorating, and a weekly allocation review. At this inspection we noted these actions had been put in place and included standardised letters which staff sent to patients advising they had been put on the waiting list for SPA and EWS and included details for signposting to other services for support.

The average wait time on the assessment waiting list fell again to 10 weeks at the end of March from 12 weeks at the end of February from 14 weeks at the end of January.

There is no service level agreement between the trust and the teaching hospital for the provision of liaison psychiatry as this is commissioned through an NHS England (NHSE) standard contract with Sheffield clinical commissioning group (CCG) and forms part of that contract. The service specification is currently under review through a review programme for all specifications within the trust. The trust provided us with the current service specification dated 2017-2018 which had not been reviewed.

The trust had an operational policy for liaison psychiatry which explains the role of the team.

Within liaison services the maximum timeframes for response are determined by NHS England. For emergency referrals these are one hour for first face to face contact and four hours for a plan to be in place for discharge/transition for further services/assessment. For ward referrals these are 24 hours to respond to urgent referrals and 48 hours for routine. Information provided by the team manager as part of a business report was patients were seen in an average of 1.4 hours for emergency referrals. The trust did not provide us with figures for timescales for a plan to be in place for discharge/transition, further services/assessment and urgent/routine referrals.

Liaison psychiatry staff proactively seek referrals and raise awareness of the liaison team, for example, through visiting wards, providing staff training and promoting the liaison team at multi-disciplinary meetings. The team provides referrers with information and advice between initial referral and assessment.

The trust provided us with information on patients who were waiting on trolleys in the accident and emergency department to be assessed, which delayed patient admission of over 12 hours, following a decision to admit at the local acute hospital. The were 10 incidents of delayed admission from January to April 2021. Two of the 10 cases related to young people requiring a child and adolescent mental health services (CAMHS) bed. A further two cases related to complex presentations that impacted on admission and the remaining six incidents were due to delays in obtaining a trust bed within the 12 period. To reduce the impact of these delays from April 2021 the trust director of operations and transformation has been meeting weekly with the assistant chief operating officer.

The mental health crisis service was available 24-hours a day and was easy to access, including through a dedicated crisis telephone line. The referral criteria for the mental health crisis teams did not exclude patients who would have benefitted from care. The service had clear criteria to describe which patients they would offer services to and offered patients a place on waiting lists.

The crisis care pathway was accessed via the SPA, the trust's single route for referrals for adults aged 18 to 65 who are in a mental health crisis. SPA works alongside the out of hours team) to provide crisis support to the people of Sheffield 24 hours a day, seven days a week. The SPA team covers 8am to 8pm, with the out of hours team operating 8pm to 8am. The SPA triage referrals and carry out assessments over the phone or face-to-face. The SPA assisted referrals to

secondary mental health services and facilitated access to the most appropriate form of assessment, treatment, or support dependent on the urgency of patients' needs. Following an initial triage assessment, the service had clear criteria to describe which patients they would offer services to. This included a referral to the crisis team, community mental health team, a referral for a routine assessment with the emotional wellbeing service, or a referral to medical staff for a routine assessment.

The trust set target times seeing patients from referral to assessment and assessment to treatment. Although patients choosing to be placed on the waiting list meant these patients were not included in the NHS target for assessment to treatment of 18 weeks, which was the target the trust used. In the single point of access, urgent referrals had to be seen with four hours.

The trust provided us with information on the numbers of referrals from 01 December 2020 to 01 May 2021 to reflect the increased pressure of referrals:

- Single point of access/emotional wellbeing service - referrals into the team – 4511
- Triage outcome for crisis assessment – 449
- Triage outcome for emotional wellbeing service routine assessment – 870
- Triage outcome emotional wellbeing - Occupational Therapy, social care, Psychology – 626
- Routine medic assessment – 362
- All Recovery (community mental health team) Referrals – Early Intervention, Perinatal, Eating Disorder Service – 204. Of which, Recovery, single point of access/emotional wellbeing - 54.

The trust provided us with information on the current waiting list for EWS for routine assessments. This had reduced from 777 in December 2020 to 721 in May 2021, despite the increased pressure on the care system. The current patient waiting the longest is from 19 December 2019 and patients waiting the longest had specifically requested either a face-to-face appointment or a home visit. Home visits were disrupted in 2020 - 2021 due to Covid and the trust were working through the backlog. Patients waiting longest, had all been offered an appointment but had either cancelled or re-arranged it. For new referrals, the longest wait for assessment dated from December 2020.

Staff in the single point of access carried out triage assessments of people promptly, however waiting lists were extensive. There was a waiting list of over 700 patients, of which 300 were waiting for treatment.

Challenges for the service which had increased the waiting list were:

- Inherited waiting list (of circa 1000 patients) waiting for an assessment
- significantly greater demand than the service was established/commissioned to meet; experiencing an average of 200 new referrals each week.
- volume of new referrals contrasted with the original staffing model has created challenges in reducing the waiting list within an acceptable timeframe.
- recruitment and retention challenges, including long term gaps in medical cover throughout 2019 onwards.
- sickness absence in the medical workforce.

Mental health crisis services and health-based places of safety

The trust had several methods of managing waiting lists and assessing and monitoring the risks to patients waiting for treatment. These included offering patients a choice of waiting for specific treatment and assessing the risk of this. They also included sharing workloads with the out of hours team, and the recruitment of bank staff to work at weekends and offering additional hours to permanent staff.

A senior nurse was triaging the waiting list of patients and offering patients a face to face meeting if needed. Staff told us improvements in monitoring patients included access to patient information packs, letters to note contacts if a patient feels they are deteriorating, and a weekly allocation review.

Managers presented a recovery plan to recover waiting lists, to the quality assurance committee and commissioners in February 2021. The plan outlined the current waiting times in SPA and actions taken to date to address this. The report detailed an action plan which sought to improve capacity and throughput to reduce the number of patients waiting to access the service. The plan set out an update against the agreed actions to reflect the improvements to the waiting time position and included the following plans:

- investment to increase and remodel the staffing structure
- recruited into the funded staffing establishment
- retention and stability of staffing within the team
- reduction in waiting list as a result of increased additional staffing (2 agency nurses)
- stronger systems introduced to address non-attendance at appointments
- weekly review of data provided by governance
- contacted patients on the waiting list who no longer required an assessment.

The trust has an ambition that on the current trajectory the waiting list will be down to zero by January 2023, however this is dependent on several factors including; staffing and demand.

The trust had also implemented a SPA subgroup, which has included engagement and contributions from staff, allied health professionals, service users and stakeholders. The group has also worked with other services to understand good practice models.

The group's role includes a review of the, clinical and staffing models. This was following a review of six months data from 2020 which identified the increased waiting list.

The plan to improve the crisis care model includes the introduction of the UK mental health triage scale and the plan will also include the accreditation standards for community mental health services (ACOMHS). Minutes of the subgroup from the update report and meetings for April 2021 reflect progress is being made by the trust and that the waiting list is reducing by approximately 30 service users per month.

Feedback from stakeholders about the service was mixed.

Patients had told stakeholders that they had positive experiences with liaison psychiatry. However they also shared concerns that follow up after work with the liaison team was not consistent, waiting times were lengthy with little support and that these waiting lists caused patients to attend A&E or other services when in crisis which was not good quality care.

Staff also told us that when patients did get an appointment following a long wait, they often failed to attend. Staff said this could be because they no longer needed the support or that the patients address had changed. Staff felt that this was not good resource allocation. There were 155 did not attend/cancellations in March 2021,18 more than in February's 137 but 67 less than the 212 in January and 38 above the average in 2020-21.

Staff avoided cancelling appointments and when they had to, they gave patients clear explanations and offered new appointments as soon as possible. We observed staff during handovers and huddles deciding to support each other to ensure that patient appointments were covered where it was necessary. Appointments ran on time and staff informed patients when they did not.

Service users accessing the single point of access did not always have their calls answered.

The trust provided call data for March 2021, which showed that 84.69% of calls were answered, 9.3% were missed totally and 6.01% were abandoned.

This represented a fall from February when 88.26% of calls were answered and January when 91.1% of calls were answered. Overall, the service reached a level of 84.69% for the end of March. The trust target was 90%. The trust told us that the call rate was affected by staff sickness. The overall call performance for SPA in 2020-21 was 89.18%.

The crisis team worked alongside colleagues from the home treatment team and together they had skilled staff available to see patients that required urgent assessment immediately, 24 hours a day, seven days a week.

The health-based place of safety trust target for assessment is within 3 hours. The trust provided us with data on meeting the trust target for assessment within 3 hours from 1 April 2020 to 1 April 2021. The trust data showed that 316 patients required assessment in the health-based place of safety in this time period.

At the last inspection staff were not recording delays to patient's assessments. At this visit the trust confirmed the new director of operations and transformation was ensuring all reporting is captured through a governance process by recording delays, for example the availability of a section 12 doctor.

The trust's health-based place of safety was attached to Maple ward and contained two assessment rooms. Sometimes patients who had been brought into the health-based place of safety and required admission, were formally admitted to Maple ward but remained on the section health-based place of safety until a bed was available.

There was an escalation process for authorising this and each occurrence was logged and reviewed. Staff told us that patients often remained there for up to 24 hours but there had been one occasion where a patient remained throughout the bank holiday weekend due to bed capacity not being available.

On occasion, the health-based place of safety was unavailable to service users who needed it. The trust provided us with information on why the health-based place of safety was unavailable from 01 April 2020 to 01 May 2021. The reasons for closure were not related to clinical activity but on 20 occasions related to staffing availability and 1 when the health-based place of safety was utilised to accommodate a patient from Maple ward.

Facilities that promote comfort, dignity and privacy

The design, layout, and furnishings of treatment rooms supported patients' treatment, privacy and dignity.

The service had a full range of rooms and equipment to support treatment and care.

Interview rooms in the service had sound proofing to protect privacy and confidentiality.

Patients' engagement with the wider community

Staff referred**,** supported or signposted patients to access activities outside the service, such as work, education and family relationships.

Staff helped patients to stay in contact with families and carers.

Staff encouraged patients to develop and maintain relationships both in the service and the wider community.

Meeting the needs of all people who use the service

The service met the needs of all patients – including those with a protected characteristic. Staff helped patients with communication, advocacy and cultural and spiritual support.

The service could support and make adjustments for people with disabilities, communication needs or other specific needs.

Staff made sure patients could access information on treatment, local service, their rights and how to complain.

The service provided information in a variety of accessible formats so the patients could understand more easily.

The service had information leaflets available in languages spoken by the patients and local community.

Managers made sure staff and patients could get hold of interpreters or signers when needed. From September 202 to April 2021 the trust provided 768 face to face interpreter sessions, 2292 by telephone, 155 video link, 174 document translation and 36 British sing language sessions.

Listening to and learning from concerns and complaints

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and wider service.

Patients, relatives and carers knew how to complain or raise concerns. Patients told us they were aware of the complaint process and the only complaints raised were in relation to waiting times.

The service clearly displayed information about how to raise a concern in patient areas.

Staff understood the policy on complaints and knew how to handle them.

Managers investigated complaints and identified themes. Staff told us complaints were discussed in team and reflective practice meetings. Staff gave us examples of complaints being investigated and the outcomes of complaints being shared. The trust provided us with information about the number of complaints received trust wide since 01 May 2020, which was 82, two of which related to the crisis care pathway, one of which was about waiting lists.

Staff protected patients who raised concerns or complaints from discrimination and harassment.

Patients received feedback from managers after the investigation into their complaint.

Mental health crisis services and health-based places of safety

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. The trust provided us with information about the number of compliments received trust wide since 01 May 2020. Nine compliments were received for Liaison psychiatry and SPA.

Managers shared feedback from complaints with staff and learning was used to improve the service.

The service used compliments to learn, celebrate success and improve the quality of care.

Is the service well-led?

Good  

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

Leadership

Managers within the crisis teams had the integrity, skills and abilities to run the service. They understood the issues, priorities and challenges the service faced and were taking steps to manage them. Managers had an awareness of the issues that we raised and were open and transparent in their responses. For example, managers spoke to us about the issues the service was facing with regards the increased pressures on the crisis care pathway and work to reduce waiting lists and what actions they were taking to rectify it and to try to support staff during this period. Local leaders talked positively about the support and enthusiasm they received from staff despite the pressure staff were experiencing, especially with proposed changes to the crisis care pathway delivery.

Staff told us that local managers and leaders in the service were visible, approachable, listened and supported them in their day to day tasks. Staff said managers were keen to take on their ideas and escalates them to senior manager and executives. Some staff told us that they did not always get feedback from their suggestions and gave an example of recent work on a revised referral form.

Staff explained that managers were willing to get involved in day to day work where needed, to support staff and patients to deal with difficult situations. Staff and managers met regularly via management supervision and at regular team meetings. Staff told us that the visibility, responsiveness and engagement of senior managers and executive team had improved. Staff told us there had been virtual meetings with the chief executive during the Covid period and messages thanking staff for their effort from the director of nursing. Staff told us senior managers and executive team were aware of the pressures they were under and services could not cope with the demand.

Senior managers told us about the positive changes in leadership at service and executive level and were supportive of the restructure to the service.

Leaders had made changes to make improvements to the service which were supported by the teams. For example, from 10 May 2021 the manager for liaison psychiatry will be managing the health-based place of safety and psychiatric decisions unit. The psychiatric decision unit will reopen on a phased programme with a limited number of beds based on available staffing and will be regularly reviewed. Manager said this was to support the pressure on the crisis care pathway and ensure patients received a safe service as there was appropriate staffing levels to support the service.

Mental health crisis services and health-based places of safety

Leaders demonstrated positive and proactive engagement with the teams. The executive director for nursing and deputy chief executive and medical director for the crisis network also sent emails along with the service lead to staff for their hard work in exceeding their targets, demonstrating a caring professional approach in reducing the waiting list for patients. The administration team was singled out for their support and effort.

Vision and strategy

Managers were able to explain their vision clearly and staff understood the values of the trust. Staff and managers were able to tell us about the vision for the future of the service and we reviewed the draft plans of the trust for the crisis care pathway. This was understood by staff in the teams as they were involved in the development of the staff and clinical model.

Staff were able to give examples and we observed staff demonstrating trust values, in respecting patient privacy and confidentiality in assessments in liaison psychiatry and SPA. Staff talked about patients expressing their views about waiting lists and listening to what patients said and offered them apologies and referred them to the complaint procedure or patient advocacy liaison service. The teams were described by stakeholders as compassionate, focused and working in partnership with patients.

The team had clear objectives, which were reviewed as part of the quarterly service reviews and were also discussed at team business meeting level. The team objectives were aligned with the Trust's strategy and objectives as well as other drivers such as key performance indicators and PLAN standards.

Culture

Staff that we spoke to said they felt respected, supported and valued. Staff said they felt able to raise concerns without fear of retribution and that they would be listened to and concerns acted upon. Staff knew how to escalate concerns and use the whistle-blowing process and they knew about the role of the Freedom to Speak Up Guardian.

Managers undertaking pulse checks within teams had meant staff have been able to come and share concerns and ideas to improve the offer to patients.

Staff and managers that we met appeared to be working well together to tackle the issues that they were facing. There appeared to be a positive working relationship between staff and managers, staff told us that managers were approachable and visible within the services. Staff and managers talked about the strong team relationships and working to improve services. Staff said the trust had rewarded them with a 'gift of time' hours they could take as time off outside of their annual leave. This was a thank you to staff for working hard during the Covid pandemic.

Team meeting minutes reflected on working relationships between the trust and the acute provider. Team meeting minutes reflected a culture of teams working together to overcome the organisational differences in providing a service while co-located. Team meetings included feedback on incident reporting, lessons learnt, staff development, service development and governance arrangements between SHSC and the acute hospital trust.

The service was undergoing restructure and managers and staff were aware of these changes, which they talked positively about. Staff told us they are involved in the changes and that this was an improvement on previous change management within the trust.

Staff told us about being open and transparent and learning from service-related deaths, involving families in death investigations and saying sorry when patients did not receive the service they expected.

Mental health crisis services and health-based places of safety

Governance

Our findings from the other key questions demonstrated that governance processes operated effectively at team level and that performance and risk were managed well. However, at the time of the inspection the plans and actions for improvement were not yet embedded and evidenced as sustainable.

There were some areas of governance which required further improvement.

The trust had not ensured that all staff had completed their required mandatory training.

Systems and audits for monitoring patient involvement in their care were not effective. They did not pick up that patients were not being consistently engaged, for example care plans were not personalised and patients not given a copy or know about their care plan.

Although the trust had improved the systems in place to monitor and manage the risk to patients who were waiting for treatment. The current demand and pressure upon the crisis service did not ensure that waiting lists would reduce at the rate predicted by the trust.

The service had a range of governance meetings in place these included team meetings, and monthly governance meetings to review performance. Teams also met for weekly development meetings where learning from incidents and complaints was shared and the service had achieved several improvements since the last inspection.

The trust had collated and analysed data relating to the number of safeguarding children referrals made by the service. So had oversight of the risk to young people encountering the service.

The trust had improved that learning from serious incidents was clear and that improvements were made to the service as a result of incidents. For example, information about outcomes form incidents were shared on the trust intranet. Staff told us incident outcomes were shared in safety huddles and team meetings and staff were clear about their roles and accountabilities and had regular opportunities to meet.

There were effective, multi-agency arrangements to agree and monitor the governance of the health-based - place of safety and psychiatric liaison services. Managers of the service worked actively with partner agencies, including the police, ambulance service, primary care and local acute medical services to ensure that it operated effectively though a Yorkshire wide health-based place of safety (136 suite) policy.

Management of risk, issues and performance

Teams had access to the information they needed to provide safe and effective care and used that information to good effect.

Managers and staff had access to performance reports which supported them in their awareness of risks and in understanding areas requiring improvement.

The service operated a risk register that local managers could escalate issues to. There were mechanisms in place for risks to be discussed at different levels of the trust and we saw evidence of a useful flow of information between these different levels. For example, managers had escalated concerns in relation to staffing, which was recorded on the risk register with clear actions in place to manage the risk. The most significant risks identified by managers and staff on the service were:

- increase in demand upon the crisis care pathway
- restructure of the crisis service and new service models
- monitoring and reducing waiting lists
- recruitment of specialist crisis staff

Staff told us that they could escalate risks and that they were kept informed of the outcome of issues that they raised. We saw evidence of performance and risk being discussed in team meetings notes.

Senior leaders and the trust board were aware of the risks within the service relating to waiting times and were involved in the recovery plan for the service.

Crisis teams had access to a quality improvement coach and aimed to access this once the work on the restructure and models agreed for staffing, clinical and operational models as underway there is potential for staff to be involved in the systems to be developed to support delivery and performance.

The service had business continuity plans in place to support managers and staff to plan for emergencies.

Information management

Patient information was stored on a secure electronic record system and all staff including agency staff could access the system. Staff had access to the equipment and information technology needed to do their work.

Staff working at this service had developed useful tools which helped them better understand some of the data they held about sources of referral, assessment, care delivery and the management of staff.

Engagement

Managers engaged actively other local health and social care providers to ensure that an integrated health and care system was commissioned and provided to meet the needs of the local population. Managers from the service participated actively in the work of the local transforming care partnership.

The service engaged well with patients to gather feedback and the service considered this feedback when making decisions about service developments.

The service has engaged well with staff on the proposed changes to the crisis care pathway, including development of the staffing and clinical models.

Staff collaborated with partner organisations to help improve services for patients. They worked closely with the local emergency department and the police to better understand how both services might support each other.

Learning, continuous improvement and innovation

The service had clear plans to make improvements via a restructure of the service. These plans included increasing the crisis offer to service users to a 24 hour service, seven days per week and would bring together the crisis function of spa,

out of hours, home treatment and flow co-ordinators, alongside bringing the psychiatric decisions unit into the management of the crisis team. A consultation process had taken place with staff, service users and stakeholders to ensure involvement and feedback and to ensure lessons were learnt from previous incidences of poor change management in community services.

In July 2020 staff took part in the Royal College of Psychiatrists reaccreditation of the psychiatric liaison team. The service has been accredited since 2017 with the College's Psychiatric Liaison Accreditation Network (PLAN) and as part of the review demonstrated their compliance with more than 180 care standards in July 2020. The accreditation period runs until 24 September 2022.

Wards for older people with mental health problems

Requires Improvement ↑

Is the service safe?

Requires Improvement ↑

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

Safe and clean environment

Both wards were safe, clean and well equipped. Dovedale Ward was not well furnished or well maintained.

Safety of ward layout

Staff completed and regularly updated thorough risk assessments of all wards areas, and removed or reduced any risks they identified.

Staff could not observe patients in all parts of the wards. Dovedale Ward used mirrors, zonal observations and 1-1 observations to mitigate any risks including eliminating mixed sex accommodation. G1 Ward could not use zonal observations due to the layout of the ward and therefore mitigated risks with 1-1 observations.

Staff knew about any potential ligature anchor points and mitigated the risks to keep patients safe.

Staff had easy access to alarms and patients had easy access to nurse call systems.

Maintenance, cleanliness and infection control

Dovedale Ward was not well maintained. During inspection we toured the environment and saw paint flaking, scuff and scrape marks to the walls and doors and bedroom door signs damaged or missing. There were 16 bedrooms but only one bedroom with its own toilet. We spoke to one patient who told us that they found their bedroom depressing. They said it was like a cell and that they felt like they were being punished.

The trust had made some improvements to the ward environments. The trust had eliminated dormitory style rooms on Dovedale ward so that patients did not have to share a bedroom. Dovedale and G1 ward had a new alarm system installed and other works were ongoing during inspection. The trust informed us that they had undertaken quality visits on the wards and had a programme of work including the redecoration of Dovedale and G1 wards, however ward managers told us that they were not aware of this programme of work and had not been consulted.

Staff made sure cleaning records were up-to-date and the ward areas were clean.

Staff followed infection control policy, including handwashing.

Seclusion room (if present)

The seclusion room on G1 Ward allowed clear observation and two-way communication. It had a toilet, although this was accessible with a member of staff, and a clock with the incorrect time.

There was no seclusion room on Dovedale Ward.

Clinic room and equipment

Clinic rooms were fully equipped, with accessible resuscitation equipment and emergency drugs that staff checked regularly.

Staff checked, maintained, and cleaned equipment. Equipment was clean on both wards however, we found several gaps in the cleaning records on G1 Ward which was raised with the ward manager.

Safe staffing

The service did not have enough medical staff overnight and required bank and agency nurses and healthcare assistants to cover shifts. All staff received basic training to keep people safe from avoidable harm.

Nursing staff

The service had enough nursing and support staff to keep patients safe but relied on high rates of bank and agency nurses and healthcare assistants. Between 01 September 2020 and 01 May 2021 Dovedale ward used 1380 bank and 607 and agency staff. During the same time period G1 ward used 2415 and 1896 bank and agency staff respectively.

In the three months from October 2020 to December 2020, both wards were operating below the lower control level of 90% of shifts filled for qualified nurses. The trust told us that the risk was mitigated by the use of additional non qualified staff to fill shifts.

At March 2021, the trust's clinical services had a vacancy rate of 10% which was slightly above the trust total.

At March 2021, the staff turnover rate for clinical services was 10% which was in line with the trust's target of 10%.

At March 2021, the sickness level for clinical services was 5.95% and the trust target was 5.1%.

Managers calculated and reviewed the number and grade of nurses and healthcare assistants for each shift. The ward managers could adjust staffing levels according to the needs of the patients and as a result relied on bank and agency staff.

Managers told us that due to sickness, vacancies and the number of staff required for 1-1 observations the service had to use bank and agency staff. 'The ward manager on G1 ward also told us that there was a shortfall in the establishment which had been escalated to senior leaders'. We were told during inspection that this had been escalated to senior leaders but not addressed.

Managers requested staff familiar with the service and made sure all bank and agency staff had an induction and understood the service before starting their shift. However, some staff told us that some agency staff did not have the same level of training and they did not always know the patients well which led to incidents occurring.

Wards for older people with mental health problems

Patients had regular one to one sessions with their named nurse.

Patients rarely had their escorted leave, or activities cancelled. The wards took a multi-disciplinary approach to escorted leave and activities to ensure these continued even when the service was short staffed.

The service had enough staff on each shift to carry out any physical interventions safely. The wards required a minimum of 3 staff who are ReSPECT trained (training to prevent, de-escalate and manage behaviour of concern) and discussed this as part of handovers.

Staff shared key information to keep patients safe when handing over their care to others. Handovers took place prior to every shift and each ward also had daily safety huddle meetings as a multidisciplinary team to discuss patient care, risk and incidents.

Medical staff

There was not always enough medical cover at night time to complete the necessary reviews of secluded patients on G1 ward. During inspection we spoke to nursing and medical staff on G1 ward and they told us that out of hours medical cover was an issue, especially for one hour and four-hourly seclusion reviews. We reviewed six seclusion records between 01 September 2020 and 01 May 2021. Two seclusions had the first medical review within an hour of the commencement of seclusion. The trust informed us that they required an incident to be reported when the duty doctor was unable to undertake a seclusion review in the required timescales and between 01 September 2020 and 01 May 2021 there had been two recorded incidents relating to G1 ward which indicates a discrepancy between recording and incident reporting.

Both wards had enough daytime medical cover and managers could call locums when they needed additional medical cover. No concerns were raised regarding night time medical cover for Dovedale ward.

Managers made sure all locum staff had a full induction and understood the service before starting their shift.

Mandatory training

Staff had completed and kept up-to-date with most of their mandatory training. The trust provided us with overall compliance for mandatory training which was above 90% however there were three mandatory training courses below the trusts target of 80%. ReSPECT level 2 at 67%, ReSPECT level 3 training at 73% and Intermediate Life Support training at 68% These were face to face training courses which were impacted by the COVID-19 pandemic due to social distancing guidelines. During inspection we found managers monitored mandatory training and alerted staff when they needed to update their training. The ward managers also provided reasonable mitigation for those who had not completed the training, such as staff absent due to sickness or maternity leave. There was an action plan in place and all staff were booked on to complete the training on their return to work.

The mandatory training programme was comprehensive and met the needs of patients and staff.

Assessing and managing risk to patients and staff

Staff assessed and managed risks to patients and themselves well and followed best practice in anticipating, de-escalating and managing challenging behaviour. Staff used restraint and seclusion only after attempts at de-escalation had failed. The ward staff participated in the provider's restrictive interventions reduction programme.

Wards for older people with mental health problems

Assessment of patient risk

We examined 8 patient records and staff completed risk assessments for each patient on admission, using a recognised tool, and reviewed this regularly, including after any incident.

Management of patient risk

Staff knew about any risks to each patient, acted to prevent or reduce risks and responded to any changes in risks. Data relating to service user falls, trust wide, from January 2020 to December 2020 showed the number of patients who had fallen and the total number of falls was decreasing since June 2020. During inspection staff told us that a lot of work had been carried out in relation to patients at risk from falls. Patients would be identified using a multi factorial risk assessment which was completed within 72 hours and updated weekly or as required. A mobility care plan would be written, enhanced observation would be considered for patients at a high risk of falls and other measures considered such as soft padding for floors for those patients who lie down or like to crawl. A patient was monitored after every fall and seen by a doctor. The service had daily safety huddles were they discussed patients who were a falls risk, they had fortnightly falls meetings with key people involved in the persons care and regular medicines reviews were carried out.

Due to the layout of the ward environment and patient needs, patients could not always be easily observed so staff followed procedures to minimise risks by introducing enhanced observations.

Use of restrictive interventions

Staff did not always record that they had made every attempt to avoid using restrictive interventions by using de-escalation techniques.

Between 01 September 2020 and 01 May 2021 Dovedale ward recorded 39 incidents of restraint, 13 incidents of rapid tranquilisation and no instances of seclusion.

For the same period G1 ward recorded 67 incidents of restraint, 7 incidents of rapid tranquilisation and 42 instances of seclusion.

We were concerned about the high use of restrictive interventions of these wards due to the nature of this patient group, particularly the high use of seclusion on G1 ward.

When a patient was placed in seclusion, staff didn't always keep good records and follow best practice guidelines.

During the inspection, we reviewed six seclusion records from incidents between 1 September 2020 and 1 May 2021 and the seclusion tracker used by the ward to monitor practice. The records did not indicate that seclusion was always undertaken in line with the Mental Health Act Code of Practice. This was because documentation did not evidence that seclusion was ended at the earliest opportunity and was the least restrictive option. The records did not contain detail of how staff had attempted to de-escalate patients prior to using seclusion. This meant that evidence did not show that seclusion was always used as a last resort. Notes also referenced decisions to seclude patients 'for the night'.

Duty Doctors did not attend the ward to review patients being cared for in seclusion in a timely manner in line with the Mental Health Act Code of Practice in four of the six records we reviewed.

However, patients and their carers told us that staff made every attempt to avoid using restraint by using de-escalation techniques and restrained patients only when these failed and when necessary to keep the patient or others safe. We also conducted short observational framework for inspection activities during this inspection which evidenced that staff were able to use appropriate de-escalation techniques.

We reviewed patients records and saw evidence that restraint was discussed as part of multi-disciplinary team meetings. The trusts reducing restrictive interventions team would also be involved to discuss ways of reducing the restrictive intervention. Dovedale ward had a low stimulus room but G1 ward did not. Staff on G1 ward told us that they used restraint and seclusion instead of rapid tranquilisation because of the increased risk of adverse reactions in older adults.

Staff followed NICE guidance when using rapid tranquilisation.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Staff received training on how to recognise and report abuse, appropriate for their role.

Staff kept up-to-date with their safeguarding training. At 4 April 2021, 89% of staff, trust wide, were compliant with safeguarding children level 2 training and 85% with safeguarding children level 3 training. 90% of staff were compliant with safeguarding adults level 3 training.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. The service made 11 safeguarding adults referrals between 01 September 2020 and 01 April 2021.

Managers took part in serious case reviews and made changes based on the outcomes.

Staff access to essential information

Staff had easy access to clinical information and it was easy for them to maintain high quality clinical records – whether paper-based or electronic.

We looked at 8 patient records that were comprehensive and all staff could access them easily on the electronic patient record system.

When patients transferred to a new team, there were no delays in staff accessing their records.

Records were stored securely. However, staff told us that not all agency could use the electronic medicines system so paper charts were printed off. There was a risk to patients of running a duel system and this was a risk which the trust had not yet addressed.

Wards for older people with mental health problems

Medicines management

The service used systems and processes to safely prescribe, administer, record and store medicines. Staff regularly reviewed the effects of medications on each patient's mental and physical health.

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines.

Staff reviewed patients' medicines regularly and provided specific advice to patients and carers about their medicines.

Staff stored and managed medicines and prescribing documents in line with the provider's policy.

Staff followed current national practice to check patients had the correct medicines.

The trust had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely. However, some patients were receiving pain relieving medicines via a trans-dermal patch. The electronic system prompted staff to record the administration site but the system did not ensure that the recommended safe rotation was being observed. There was also no record of daily checks that the patch was still in situ. Once brought to the attention of staff during inspection relevant charts were put in place.

Decision making processes were in place to ensure people's behaviour was not controlled by excessive and inappropriate use of medicines. We saw evidence on inspection in patient records, during multi-disciplinary team meetings and handovers of regular reviews of medicines including efficacy, side effects and patients choice.

Staff reviewed the effects of each patient's medicines on their physical health according to NICE guidance.

Track record on safety

The service had a good track record on safety.

Reporting incidents and learning from when things go wrong

The service managed patient safety incidents well, however some staff did not always recognise incidents and report them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

During inspection we were assured that staff knew what incidents to report and how to report them, however, following inspection we asked the trust to provide us with the number of incidents reported when the duty doctor was unable to undertake a seclusion review in the required timescales. Between 01 September 2020 and 01 May 2021 the trust informed us there had been two recorded incidents relating to G1 ward but within the six seclusion records we reviewed, during the same timescale, there had been four incidents.

Staff raised concerns and reported incidents and near misses in line with trust policy.

Staff understood the duty of candour and gave patients and families a full explanation when things went wrong.

Wards for older people with mental health problems

Managers investigated incidents gave feedback to staff and shared feedback from incidents outside the service. Incidents were reviewed as part of weekly meetings and weekly communication to all staff regarding lessons learnt.

There was evidence that changes had been made because of feedback. For example, during our last inspection it was recognised that staff needed to be able to accurately record patient observations at the time they occured so the service introduced tablets for staff to record this. Were there are issues with recording on the tablets because of internet connection the ward manager told us an incident form is completed.

Staff met to discuss the feedback and look at improvements to patient care within team meetings and individual supervision.

Managers debriefed and supported staff after any serious incident.

Is the service effective?

Good  

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

Assessment of needs and planning of care

Staff assessed the physical and mental health of all patients on admission. They developed individual care plans which were reviewed regularly through multidisciplinary discussion and updated as needed. Care plans reflected patients' assessed needs, and were personalised, holistic and recovery-oriented.

Staff completed a comprehensive mental health assessment of each patient either on admission or soon after.

All patients had their physical health assessed soon after admission and regularly reviewed during their time on the ward. During inspection we observed good physical healthcare for patients including skin integrity, food and fluid monitoring, blood monitoring, diabetes management, chiropody and dental care.

Staff developed a comprehensive care plan for each patient that met their mental and physical health needs.

Staff regularly reviewed and updated care plans when patients' needs changed.

Care plans, in the 8 patient records we reviewed, were personalised, holistic and recovery-orientated.

Best practice in treatment and care

Staff provided a range of treatment and care for patients based on national guidance and best practice. They ensured that patients had good access to physical healthcare and supported them to live healthier lives. Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives.

Staff provided a range of care and treatment suitable for the patients in the service.

Wards for older people with mental health problems

Staff delivered care in line with best practice and national guidance.

Staff identified patients' physical health needs and recorded them in their care plans.

Staff made sure patients had access to physical health care, including specialists as required.

Staff met patients' dietary needs, and assessed those needing specialist care for nutrition and hydration.

Staff helped patients live healthier lives by supporting them to take part in programmes or giving advice. For example, the wards promoted a safe, smoke free environment and provided health promotion for patients, including provision of tobacco dependence treatment and managing tobacco dependency symptoms.

Staff used recognised rating scales to assess and record the severity of patients' conditions and care and treatment outcomes, such as national early warning score (used to identify deterioration early), Waterlow Score (a risk assessment tool that determines whether a patient is at risk of developing a bedsore) and the malnutrion universal screening tool.

Staff used technology to support patients, such as reminiscence interactive therapy activities (a digital therapy system which allows patients to use apps, games and other leisure activities as part of their recovery), an interactive therapeutic robot seal, tablets and empathy dolls.

Staff took part in clinical audits, benchmarking and quality improvement initiatives. The wards were working towards introducing Safewards as part of their reducing restrictive practice programme. Safewards is an evidence-based approach designed to reduce conflict and containment (coerced medications, restraint and seclusion) in mental health inpatient units.

Managers used results from audits to make improvements.

Skilled staff to deliver care

The ward teams included or had access to the full range of specialists required to meet the needs of patients on the wards. Managers made sure they had staff with the range of skills needed to provide high quality care. They supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.

The service had access to a full range of specialists to meet the needs of the patients on the ward, including occupational therapists, physiotherapists, psychologists, speech and language therapists, tissue viability nurses and dieticians.

Managers ensured staff had the right skills, qualifications and experience to meet the needs of the patients in their care, however not all agency and staff had been trained in the trust's approved restraint methods.

Managers gave each new member of staff a full induction to the service before they started work and agency staff completed an induction checklist.

Wards for older people with mental health problems

Ward managers told us that the supervision policy had recently changed from four to eight supervisions annually. Supervision compliance at week commencing 05 April 2021 for clinical services was 67%, which was below the trust target of 80% and ward managers told us this was due to the change in the policy. During inspection we spoke to 16 staff, including ward managers, doctors, nurses, healthcare assistants and allied health professionals and 15 told us they had regular supervision and felt supported in their role.

The appraisal window was April – June 2021 and during inspection staff told us their appraisal had either been completed or was due to be completed. At March 2021, compliance rates for appraisal in clinical services was at 91% which was slightly higher than the trust target of 90%.

Managers made sure staff attended regular team meetings or gave information from those they could not attend.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge.

Managers made sure staff received any specialist training for their role, such as dementia and autism awareness, falls training, reactor red pressure ulcer training, diabetes and sepsis awareness training.

Managers recognised poor performance, could identify the reasons and dealt with these.

Multidisciplinary and interagency team work

Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. The ward team had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.

Staff held regular multidisciplinary meetings to discuss patients and improve their care.

Staff made sure they shared clear information about patients and any changes in their care, including during handover meetings and daily safety huddles.

Ward teams had effective working relationships with other teams in the organisation.

Ward teams had effective working relationships with external teams and organisations.

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

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and discharged these well. Managers made sure that staff could explain patients' rights to them.

Staff received and kept up-to-date with training on the Mental Health Act and the Mental Health Act Code of Practice and could describe the Code of Practice guiding principles. At 04 April 2021 80% of staff, trust wide, were compliant with their training.

Staff had access to support and advice on implementing the Mental Health Act and its Code of Practice.

Staff knew who their Mental Health Act administrators were and when to ask them for support.

The service had clear, accessible, relevant and up-to-date policies and procedures that reflected all relevant legislation and the Mental Health Act Code of Practice.

Patients had easy access to information about independent mental health advocacy and patients who lacked capacity were automatically referred to the service.

We saw evidence in patient records that staff explained to each patient their rights under the Mental Health Act in a way that they could understand, repeated as necessary and recorded it clearly in the patient's notes each time. Staff also explained to patients when their mental health act status changed and informed family members, when appropriate.

Staff made sure patients could take section 17 leave (permission to leave the hospital) when this was agreed with the Responsible Clinician and/or with the Ministry of Justice.

Staff requested an opinion from a Second Opinion Appointed Doctor (SOAD) when they needed to. We reviewed 23 prescription charts during inspection, all treatment orders were correct, in date and audited weekly.

Staff stored copies of patients' detention papers and associated records correctly and staff could access them when needed.

Informal patients on Dovedale ward knew that they could leave the ward and the service displayed a poster on the door to tell them this. All patients on G1 ward were detained under a section of the mental health act.

Managers and staff made sure the service applied the Mental Health Act correctly by completing audits and discussing the findings. When we spoke to staff on G1 ward they told us that they had escalated the concerns regarding out of hours medical cover for seclusion reviews.

Good practice in applying the Mental Capacity Act

Staff supported patients to make decisions on their care for themselves. They understood the trust policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly for patients who might have impaired mental capacity.

Staff received and kept up-to-date with training in the Mental Capacity Act and had a good understanding. At 04 April 2021, 85% and 88% of staff, trust wide, were compliant with level 1 and level 2 training, respectively.

There were no Deprivation of Liberty Safeguards applications made in the last 12 months.

There was a clear policy on Mental Capacity Act and Deprivation of Liberty Safeguards, which staff could describe and knew how to access. At 04 April 2021, 90% of staff, trust wide, were compliant with Deprivation of Liberty Safeguards training.

Staff knew where to get accurate advice on the Mental Capacity Act and Deprivation of Liberty Safeguards.

Staff gave patients all possible support to make specific decisions for themselves before deciding a patient did not have the capacity to do so.

Wards for older people with mental health problems

Staff assessed and recorded capacity to consent clearly each time a patient needed to make an important decision.

We looked at eight patient records and when staff assessed patients as not having capacity, they made decisions in the best interest of patients and considered the patient's wishes, feelings, culture and history.

The service regularly monitored how well it followed the Mental Capacity Act and acted when they needed to make changes to improve.

Is the service caring?

Good 

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

Kindness, privacy, dignity, respect, compassion and support

Staff treated patients with compassion and kindness. They respected patients' privacy and dignity. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.

During our inspection we undertook a Short Observational Framework for Inspection (SOFI) and observed that staff were discreet, respectful, and responsive when caring for patients.

Staff gave patients help, emotional support and advice when they needed it.

Staff supported patients to understand and manage their own care treatment or condition.

Staff directed patients to other services and supported them to access those services if they needed help.

We spoke to five patients during our inspection and they said staff treated them well and behaved kindly.

Staff understood and respected the individual needs of each patient. On G1 ward the service had bought a chair for patient who would not go to bed at night. A best interest decision meeting was arranged and the chair was set up for use by the individual patient, risk assessed and staff were being trained on the use of chair.

Staff felt that they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients.

Staff followed policy to keep patient information confidential.

Involvement in care

Staff involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided. They ensured that patients had easy access to independent advocates.

Involvement of patients

Wards for older people with mental health problems

Staff introduced patients to the ward and the services as part of their admission this varied depending on the individual and G1 ward currently isolated new patients on admission until they received a negative test result for COVID-19.

Staff involved patients and gave them access to their care planning and risk assessments and staff supported them to give feedback on their treatment by inviting them to regular reviews about their care. On Dovedale Ward care plans were printed for patients after their multi-displinary team meetings.

Staff made sure patients understood their care and treatment and found ways to communicate with patients who had communication difficulties. The service developed a 'This is Me' story for patients, which was used to record details about a person. For example a person's cultural and family background, important events, people and places from their life and their preferences and routines.

Staff involved patients in decisions about the service, when appropriate and patients could give feedback on the service when they held community meetings with patients and Dovedale ward had an inpatient exit questionnaire which they asked patients to complete.

Staff supported patients to make advanced decisions on their care.

Staff made sure patients could access advocacy services.

Involvement of families and carers

Staff informed and involved families and carers appropriately.

During our inspection we spoke to seven family members and five family members told us that staff supported, informed and involved them in their loved ones care. One family member told us that they didn't feel the ward communicated with them unless there had been an incident however they were regularly visting their family member on the ward and were mainly positive regarding the care provided. When family members had concerns they raised these with the service and felt they were listened to. One family member we spoke to raised several concerns. We discussed these with the sevice who had acknowledged the concerns and were supporting the patient and family member appropriately.

Staff helped families to give feedback on the service through inviting them to meetings regarding their family member, the complaints process, friends and family test and care opinion.

Staff gave carers information on how to find the carer's assessment and provided support by referral to a wellbeing course and signposting to local carer groups and services.

Is the service responsive?

Good ↑

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

Access and discharge

Wards for older people with mental health problems

Staff managed beds well. A bed was available when needed and that patients were not moved between wards unless this was for their benefit. Discharge was rarely delayed for other than clinical reasons.

Bed management

Managers made sure bed occupancy did not go above 85%.

Managers regularly reviewed length of stay for patients to ensure they did not stay longer than they needed to and worked on provisional discharge dates from the start of admission.

At the time of our inspection the service had low out-of-area placements.

Managers and staff worked to make sure they did not discharge patients before they were ready.

When patients went on leave there was always a bed available when they returned.

Patients were moved between wards only when there were clear clinical reasons or it was in the best interest of the patient, such as to the general hospital when a patient required physical health care.

The psychiatric intensive care unit always had a bed available if a patient needed more intensive care and this was not far away from the patient's family and friends.

Discharge and transfers of care

The service had a low number of delayed discharges in the past year which managers monitored. Delayed discharges were mainly due to clinical reasons, such as, awaiting a negative COVID-19 test result or delays in care packages required for a safe discharge.

Staff carefully planned patients' discharge and worked with care managers and coordinators to make sure this went well. From the point of admission the service planned for discharge and set a provisional date based on the patients needs and reasons for admission.

Staff supported patients when they were referred or transferred between services, such as arranging telephone conversations and virtual tours for patients and family members to look at possible residential homes. The occupational therapy team supported patients with activities of daily living.

Facilities that promote comfort, dignity and privacy

The design, layout, and furnishings of the ward supported patients' treatment, privacy and dignity. Each patient had their own bedroom and could keep their personal belongings safe. There were quiet areas for privacy. The food was of good quality and patients could make hot drinks and snacks at any time.

Each patient had their own bedroom. Staff told us patients could personalise their own bedroom.

Patients had a secure place to store personal possessions. There were personal safes available in patients bedrooms and also safe storage of personal possessions within the staff office if requested.

Wards for older people with mental health problems

Staff used a full range of rooms and equipment to support treatment and care.

The service had quiet areas and a room where patients could meet with visitors in private. The visitors room was set up off the ward and followed government guidelines in terms of social distancing.

Patients could make phone calls in private. Patients could have their own mobile phones and the wards also had a mobile phone which could be used by patients to make phone calls.

Dovedale ward had an outside space that patients could access easily between 8am-8pm. After this time the door was locked due to safety and security but patients could ask to go outside. On G1 ward there were three outdoor spaces. On both sides of the ward patients had access to an outdoor space at all times. The third outdoor space available to both sides was locked at all times. We were told this was due to maintenance work being carried out during inspection but also because of risk of falls due to an uneven surface.

Patients could make their own hot drinks and snacks and were not dependent on staff, were appropriate.

Patients told us that the service offered a variety of good quality food.

Patients' engagement with the wider community

Staff supported patients with activities outside the service, such as work, education and family relationships.

Staff made sure patients had access to opportunities for education and work, and supported patients, were appropriate.

Staff helped patients to stay in contact with families and carers, using digital technology such as Skype and also visiting pods for safe visiting during the COVID-19 pandemic.

Staff encouraged patients to develop and maintain relationships both in the service and the wider community.

Meeting the needs of all people who use the service

The service met the needs of all patients – including those with a protected characteristic. Staff helped patients with communication, advocacy and cultural and spiritual support.

The service could support and make adjustments for disabled people and those with communication needs or other specific needs.

Wards were dementia friendly and supported disabled patients.

Staff made sure patients could access information on treatment, local service, their rights and how to complain, which was available on notice boards and also provided verbally to patients and family members.

The service had information leaflets available in languages spoken by the patients and local community and access from interpreters or signers when needed.

The service provided a variety of food to meet the dietary and cultural needs of individual patients.

Patients had access to spiritual, religious and cultural support. The trust had a multi-faith chaplain service available to patients and leave could be arranged for patients to access support externally to the service.

Listening to and learning from concerns and complaints

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and wider service.

Since the 1 May 2020, the trust received 84 formal complaints across their mental health services. We did not receive specific data relating to the older people inpatient wards. Patients, relatives and carers knew how to complain or raise concerns and two family members we spoke to had raised concerns and the service was dealing with these in line with the complaints process.

The service clearly displayed information about how to raise a concern in patient areas.

Staff understood the policy on complaints and knew how to handle them.

Managers investigated complaints and identified themes, such as issues with the completion of diet and fluid charts was identified following a complaint and as a result the charts were checked on a shift basis and then directly scanned onto the patient record system.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint and also were concerns were raised by patients this was fed back during community meetings.

Managers shared feedback from complaints with staff during team meetings, through emails and other communication methods. Learning from complaints and compliments was used to improve the service and quality of care.

Is the service well-led?

Requires Improvement ↑

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

Leadership

Leaders on the wards had the skills, knowledge and experience to perform their roles, but the trust was going through a management re-structure and some management roles were being replaced.

They had a good understanding of the services they managed. Ward managers were visible in the service and approachable for patients and staff.

Vision and strategy

Staff knew and understood the provider's vision and values and how they applied to the work of their team.

Wards for older people with mental health problems

Culture

During our inspection we spoke with 16 staff who felt respected, supported and valued by their immediate managers but they did not always feel this way about leaders in the wider trust. Staff felt able to raise concerns however they did not always feel listened to.

All staff we spoke to said the trust promoted equality and diversity in daily work and provided opportunities for development and career progression. Staff could raise any concerns without fear and they knew there was a Freedom to Speak up Guardian.

Governance

Our findings from the other key questions demonstrated that governance processes did not always operate effectively at team level and that performance and risk were not always managed well.

Although the trust had eliminated dormitory style rooms on Dovedale ward the trust had not addressed the overall maintenance and redecoration of the ward. Observation and feedback from patients and staff indicated that this was not conducive to a therapeutic environment.

Managers relied on bank and agency staff to cover shifts when they needed to adjust staffing levels to meet the needs of the patients. On G1 ward high levels of bank and agency were required to meet the needs of the service. Managers told us that a staffing review of the service was required and this had been escalated but this had not been actioned.

Staff on G1 ward also told us that there were issues with night time medical cover as the duty doctor covered all inpatient areas and they couldn't always attend for the required seclusion reviews. This had also been escalated to senior leaders. The trust informed us that that they required an incident to be reported when the duty doctor was unable to undertake a seclusion review in the required timescales but we found a discrepancy between recording and incident reporting.

There was a high use of seclusion on G1 ward and a high use of restrictive interventions throughout this service. Leaders were aware of this concern and a review of the service including work on reducing restrictive practice had been requested in January 2021. This work was ongoing at the time of the inspection and an action plan was not yet in place.

However, staff compliance with appraisals, supervision and mandatory training had improved although there were three areas where performance was below the trust target this was being well monitored. Managers ensured all patients had good physical health monitoring in place, medication side effects were being monitored and monitoring of falls had improved and data relating to patients who had fallen and the total number of falls had decreased.

Information management

Teams mostly had access to the information they needed to provide safe and effective care. However, during inspection a member of the inspection team asked to see the trusts medicines policy. This was difficult to access on the trusts intranet and took three different members of staff to locate the policy on the system. Within the policy there was a published link to a document that needed completing but this was a blank page. This was brought to the attention of management who said they would escalate this as an incident. We were told the link was broken and a number of other links were also identified as not working and remedial action was being taken.

Wards for older people with mental health problems

Managers engaged actively other local health and social care providers to ensure that an integrated health and care system was commissioned and provided to meet the needs of the local population. Managers from the service participated actively in the work of the local transforming care partnership.

Engagement

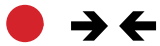
Staff collected analysed data about outcomes and performance and engaged actively in local and national quality improvement activities.

Learning, continuous improvement and innovation

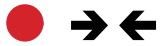
It had recently been agreed for G1 ward to start working towards accreditation by The Royal College of Psychiatrists. Dovedale ward did not feel able to work towards this due to the necessary improvements that were needed to the ward.

The trust was in the process of introducing Safewards as part of their reducing restrictive practice programme. Staff we spoke to had attended training on Safewards and were going to be Safewards champions. Safewards is an evidence-based approach designed to reduce conflict and containment (coerced medications, restraint and seclusion) in mental health inpatient units.

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

Inadequate 

Is the service safe?

Inadequate 

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

Following the inspection of this service, we issued enforcement action to the trust in the form of a section 29A warning notice. This means that the rating for this key question is limited to inadequate.

Safe and clean care environments

Not all wards were safe, clean well equipped, well furnished, well maintained and fit for purpose

Safety of the ward layout

Staff completed and regularly updated thorough risk assessments of all wards areas but they had not removed or reduced all the risks they identified.

Managers told us that the risk of harm from the environment had been mitigated via processes of environmental and patient risk assessment and by observation and engagement but we found that this was not always in place in all areas of the wards during our inspection.

Most patient bedrooms and other communal spaces on the acute wards had multiple ligature points. Although each ward had an up-to-date ligature risk audit, the trust had not mitigated all the risks to keep patients safe. The trust had a medium term and longer term plan to refurbish these wards, however interim actions to keep people safe were not adequate. Each of the acute wards had a small number of bedrooms with reduced ligature risk fittings. Following assessment, staff placed patients in these rooms as necessary to reduce the risks to them.

Wards had a ligature heat map in place, designed to show staff where high risk areas were. This showed staff which rooms should only be access by patients being observed by a staff member and otherwise should be locked. During our inspection, several of these doors were unlocked with open access for patients into areas with high risk fixed ligature anchor points.

Communal areas of the ward had not been considered in the ligature heat maps and did not identify risks from several areas within the ward.

One patient bedroom, previously a dormitory, contained a number of ligature points which had not been addressed by the trust. We were also concerned that there was not a viewing panel in place to ensure staff were able to monitor and observe patients using these rooms which contained ligature risks.

On Burbage ward, staff told us that a patient bedroom was not in use because it needed work to restrict patient access due to risks, but the work had not been carried out and the room was in use during the inspection.

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

The trust provided data which showed that there were a number of ligature related incidents between 1 May 2020 to 30 April 2021. There were 21 ligature related incidents on Stanage ward, 25 on Maple ward, 61 on Burbage ward and 123 on Endcliffe ward. There was no serious harm caused to patients relating to these incidents, however the data indicated that there were a number of times patients had tied ligatures on these wards.

The trust had not ensured that staff had the support in place to ensure they could safely manage these risks. There was not a policy or standard operating procedure in place to support staff to manage the risk of ligature anchor points and staff had not received training in ligature awareness. Although the trust told us that risks were management via observation and engagement of patients there was no audit in place to assure managers that these were taking place correctly.

The psychiatric intensive care unit contained anti-ligature fittings to patients' bedrooms and communal areas and the manager reported no ligature incidents from a fixed point in the eight months since our last inspection.

Since our inspection, the trust had begun to take some remedial action to address ligature risks and they had an environmental action plan in place.

The ward areas had blind spots that could not be mitigated by mirrors. Patients had to be supervised in the garden areas because it was not safe, due to the layout of the external environment, but on one ward, we found a patient had been left unsupervised in the garden area. When we pointed this out to staff, they located a member of staff immediately. CCTV cameras were in place on ward entrances.

Two wards, Stanage and Burbage complied with guidance and there was no mixed sex accommodation but on Maple ward and the psychiatric intensive care unit, wards were mixed sex. None of the patients we spoke with at this inspection expressed concerns about sexual safety, but incidents of sexual safety were increasing.

In the period 1 September 2020 to 1 May 2021, there were 60 sexual safety incidents across this service. Incidents had occurred across all wards, on Maple and Endcliffe wards which remained mixed sex accommodation there were 32 incidents. Some sexual safety incidents had also taken place on Stanage ward (19) Burbage ward (9).

All wards had a map in staff areas indicating the location of ligature cutters.

Staff had easy access to alarms and patients had easy access to nurse call systems. These had been upgraded to enable staff from adjacent wards to provide assistance if required.

Maintenance, cleanliness and infection control.

Most ward areas were clean, but some wards were not well maintained, well-furnished or fit for purpose. All the patients we spoke with on inspection told us the ward areas were clean but we found the clinic rooms on Burbage and Stanage wards were cluttered with boxes and excess stock. There was debris on the floor on Burbage ward and the cleaning records had not been signed to indicate that the area had been cleaned regularly according to the ward's cleaning schedules.

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

Staff had made some improvements to the décor on Burbage ward but Stanage ward needed redecoration and refurbishment. Paintwork and furnishings were scuffed and worn. In January 2021, there had been some incidents suggesting that the entrance doors to Stanage ward were not robust enough to prevent patients from leaving and a door and a window in a patient's bedroom may have been faulty, contributing to a patient suffering harm. These incidents were still under investigation by the trust.

Staff followed infection control policy, including handwashing. Cleaning on the wards had been increased and included more frequent cleaning of touch points like door handles and high-use areas. There was hand sanitiser available before entering the wards and staff were wearing appropriate personal protective equipment.

Patient-led assessments of the care environment, (PLACE), surveys were not carried out in 2020 due to the impact of the Covid-19 pandemic.

Seclusion room

We could not see the inside of all of the seclusion rooms in the service as some of them were in use at the time of our inspection. However, staff told us all seclusion rooms allowed clear observation and two-way communication. They all had had a toilet and a clock. Lighting in all seclusion rooms could be dimmed and the temperature could be controlled.

The trust had now mitigated some of the privacy and dignity issues by installing privacy screens to the toilet areas for use by patients who were at too high a risk for the toilet door to be closed when in use. The new arrangements had created a potential blind spot when such patients used the toilet but there was nothing in place to mitigate against this.

On Burbage ward, staff could still see the CCTV monitor to the seclusion room on their way through to other areas and this compromised the privacy of patients. The room was too small to ensure staff safe exit, and this had been identified on the trust risk register. The trust had plans in place to refurbish the seclusion room. Following our inspection, the trust put into place a standard operating procedure to protect the dignity and privacy of patients using the seclusion room.

The seclusion room on Endcliffe ward contained a mattress which had some signs of damage. There were marks to one of the walls where a patient had scratched a message and a crack running down the length of one of the walls. Staff told us the crack in the wall was an on-going issue which they were trying to rectify.

All wards now had other rooms available in the ward area that could be used for de-escalation.

Clinic room and equipment

Clinic rooms were fully equipped, with accessible resuscitation equipment and emergency drugs that staff checked regularly. However, we found that on three of the four wards, an emergency medicine used to treat opiate overdose was not present. Staff were not sure whether or not it should have been present and the trust did not have a clear policy about the storage and use of this medicine.

Staff checked, maintained, and cleaned equipment.

Safe staffing

The service had enough nursing and medical staff, who knew the patients. However, some agency staff did not always receive basic training to keep people safe from avoidable harm.

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

Nursing staff

The service had enough nursing and support staff to keep patients safe. Inexperienced nurses were now not left alone on shift. During the day, newly qualified nurses were supported by experienced ward managers and deputy ward managers. At night, they had access to an experienced nurse that floated between wards.

In the three months from October 2020 to December 2020, qualified nurse rates consistently operated below the 90% fill rate on Burbage, Stanage and Maple wards. However, the trust mitigated this with higher fill rates of non-registered nurses. Endcliffe ward was operating within safe fill levels for both registered and non-registered nurses.

Most of the patients we spoke with on inspection confirmed they felt safe on the wards, however, the three patients we spoke with on Stanage ward told us they did not feel safe due to the high levels of patient aggression.

On Burbage ward, the ward for patients identifying as female, one patient told us they did not always feel safe as there was not enough female staff on the night shifts. The trust provided us data to show that between 1 February 2021 and 30 April 2021, there was one occasion in February and three occasions in March where there were no female staff on the night shift. There were three occasions in March and four occasions in April 2021 where there was only one female member of staff on the night shift.

At March 2021, the trust's clinical services had a vacancy rate of 10% which was slightly above the trust total. Managers had implemented a rolling recruitment programme but Stanage ward had been highlighted as a risk due the number of staff vacancies.

The service had high rates of bank and agency staff, but managers tried to use staff that were familiar with the patients and with the ward layout. The high use of bank and agency staff was associated with raised clinical activity resulting in additional shifts created to support patients that required higher levels of observations. The service also used bank and agency staff to cover for staff sickness absence which had been higher, partly as a result of the pandemic.

Managers had block booked some bank and agency staff to ensure they were familiar with the ward and the patients.

Managers made sure all bank and agency staff had a full induction and understood the service before starting their shift.

At March 2021, the staff turnover rate for clinical services was 10% which was in line with the trust's own target.

Managers supported staff who needed time off for ill health.

At March 2021, the sickness level for clinical services was 5.95% and the trust target was 5.1%.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants for each shift. On Maple ward, staff were piloting a 12 -hour shift system at the request of the staff team.

The ward manager could adjust staffing levels according to the needs of the patients. At inspection we saw how managers across all wards increased staffing levels to take account of patient acuity.

Patients had regular one to one time with their named nurse but most patients we spoke with described staff being very busy which meant they often had to wait for staff to become available if they needed to talk or they required a risk assessment prior to leaving the ward unescorted.

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

Staff and patients told us escorted leave or activities were rarely cancelled, even when the service was short staffed.

The service did not always have enough staff on each shift to carry out any physical interventions safely especially at night or when there was high patient acuity. The trust reported that 68% of bank staff were trained to level two of their physical interventions programme and 87 bank staff were trained to level three but they could not provide data for the numbers of agency staff who had been trained either to level two or level three of their approved restraint techniques. The wards were heavily reliant on bank and agency staff.

Staff shared key information to keep patients safe when handing over their care to others. They had recently adopted safety huddles which is recognised as a good practice model for sharing information about patient risk and promoting safety.

Medical staff

The service had enough daytime and nighttime medical cover and a doctor available to go to the ward quickly in an emergency. Staff told us it was rare for medical staff not to be able to attend in time for patient's seclusion reviews, but it did occasionally happen. Trust data showed that this had occurred on nine occasions between 1 September 2020 and 1 May 2021.

Managers could call locums when they needed additional medical cover and now there was enough on-call cover when doctors were engaged in their weekly professional development session.

Managers made sure all locum staff had a full induction and understood the service before starting their shift.

Mandatory training

Staff reported they had completed and kept up to date with their mandatory training. At 04 April 2021, trust-wide data indicated that the overall compliance rate for mandatory training was just over 90%. However, three courses were below 80%. These were:

Intermediate life support – 68%

Respect level 2 – 67%

Respect level 3 – 73%

The trust stated that of the 74 staff who were non-compliant in intermediate life support, 44 (59%) were compliant with basic life support.

The mandatory training programme was comprehensive and met the needs of patients and staff.

Managers now monitored mandatory training and alerted staff when they needed to update their training. However, we were concerned about the low compliance with mandatory training on these wards because of the high use of restrictive practices. The trust told us that agency staff were used regularly on these wards but were not trained in the trust's restraint techniques. Staff who worked in the service told us that this sometimes placed patients at risk of harm because there were sometimes not enough staff trained to ensure the safety of patients during restraint.

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

Assessing and managing risk to patients and staff

Staff assessed and managed risks to patients and themselves well and followed best practice in anticipating, de-escalating and managing challenging behaviour. Staff used restraint and seclusion only after attempts at de-escalation had failed. The ward staff participated in the provider's restrictive interventions reduction programme.

Assessment of patient risk

Staff completed risk assessments for each patient on admission / arrival and reviewed this regularly, including after any incident. Staff always carried out a risk assessment before patients were allowed to go on unescorted leave from the ward.

Staff used a risk assessment tool developed by the trust to assess an individual's level of risk under different domains, called the 'Detailed Risk Assessment and Management plan'.

Management of patient risk

Staff knew about any risks to each patient and acted to prevent or reduce risks. However, staff told us they did not always feel supported when there were incidents of racial abuse towards them from patients. In the period, 1 September 2020 to 1 May 2021, there were 74 incidents of racial abuse across all wards. The highest number of incidents was on Endcliffe ward, the psychiatric intensive care unit.

Staff identified and responded to any changes in risks to, or posed by, patients. Staff used a falls screening tool with appropriate patients.

Staff did not always follow trust policies and procedures when they needed to search patients to keep them safe from harm. Some staff told us patients would only be searched on return from unescorted leave if necessary whereas some told us all patients were routinely searched on return from unescorted leave. The search policy was applied inconsistently by staff, for example on Burbage ward staff used a metal detecting device to screen patients for prohibited items like cigarette lighters but on Maple ward, staff told us they did not use the metal detector because they were not aware of the policy for how to use it. The trust had a search policy that covered the use of the metal detector, but the policy only allowed routine searching on Endcliffe ward, the psychiatric intensive care unit. We were therefore concerned that the routine searching of patients on Burbage ward constituted a blanket restriction which was not justified.

Burbage and Stanage wards had recently introduced a no-smoking policy but staff allowed patients to smoke in the garden area as an interim measure to reduce fire risk from patients smoking on the ward. This was not the case on Burbage ward but these patients could see those on Stanage ward smoking and they thought this was unfair. If patients returned from leave to Stanage ward with cigarettes, these would be stored with the patient's possessions and returned them when they left the ward again. On Burbage ward, patients' cigarettes would be posted back to their home address. The trust were not consistently applying the trust's no smoking policy.

We did not see any signage on the ward areas indicating that patients could leave the ward if they were informal, but staff told us they made appropriate patients aware of this when they admitted them.

Use of restrictive interventions

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

Levels of restrictive interventions were reducing. In the period 1 September 2020 to 1 May 2021, there was a total of 523 restraints across all the wards. The psychiatric intensive care unit recorded the highest number of restraints at 246 and the lowest number of restraints was on Maple ward at 74.

In the same period there were 129 episodes of seclusion, with the highest use of seclusion being on Endcliffe ward and the lowest on Stanage ward. This was an increase since the time of the last inspection, however the trust told us that this was due to the acuity of one patient.

In the same period, there was one incident of prone restraint recorded and this was on Endcliffe ward. This incident was under investigation by the trust.

There were 12 incidents of mechanical restraint recorded for this core service during the period 1 September 2020 to 1 May 2021.

None of the incidents of mechanical restraint had been undertaken by trust staff. The trusts oversight of the use of mechanical restraint had improved with all incidents being reported and oversight from the executive medical director and director of nursing, professions and operations. Five of the above incidents occurred where staff had called the police to assist them with a patient on one of the wards that required seclusion. The rest were associated with the provider's secure transport service or with the police who were called by staff to intervene with a patient on the ward.

Staff participated in the provider's restrictive interventions reduction programme, but this was a relatively new development.

Staff made every attempt to avoid using restraint by using de-escalation techniques and restrained patients only when these failed and when necessary to keep the patient or others safe. At inspection, we observed staff using de-escalation techniques with patients to good effect.

Staff told us about the high levels of patient acuity on the wards. In the period 1 September 2020 to 1 May 2021, the police had been called on twenty occasions to assist staff in dealing with patient incidents on the wards. The highest number of occasions was on Endcliffe ward with 11 incidents. Managers had not escalated this concern to senior leaders in the organisation and this was not considered a risk on the service risk registers.

Staff understood the Mental Capacity Act definition of restraint and worked within it.

We reviewed four patient records and found that staff followed NICE guidance when using rapid tranquilisation, but they did not always record whether the patient had been offered food or fluid.

When a patient was placed in seclusion, staff did not always keep clear records because they did not always record what if any food or fluid the patient had taken. This meant that it was not possible to tell how much fluid and food the patient had taken.

We did not see evidence of the use of long-term segregation on any of the wards.

Safeguarding

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

Staff did not always understand how to protect patients from abuse and the service did not always work well with other agencies to do so. Staff had training on how to recognise and report abuse, but they did not always know how to apply it.

Staff received training on how to recognise and report abuse, appropriate for their role.

Staff kept up to date with their safeguarding training. At 4 April 2021, trust-wide data indicated that 89% of staff were compliant with level 2 safeguarding and 85% compliant with level 2 training. Compliance with safeguarding adults training was at 90%.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. However, between 1 September 2020 and 1 May 2021, there were eight incidents of patient to patient racial abuse. This was only slightly lower than at our last inspection.

Staff did not always know how to recognise adults and children at risk of or suffering harm or how to work with other agencies to protect them because they did not always make safeguarding referrals when patients had come to harm. In the period 1 September 2020 to 1 May 2021, this service made a total of 55 safeguarding referrals. The highest number of referrals was on Endcliffe ward at 26. During the inspection, we came across examples of several incidents that should have been referred by staff to the local safeguarding authority, but they had not been. These included incidents involving a patient suffering a significant injury during restraint and allegations of sexual assault.

Staff did not always follow clear procedures to keep children visiting the ward safe.

The trust told us that there had been 21 visits by children under the age of 18 to these wards since 1 September 2021. The trust had a policy in place to provide guidance to staff on how to manage child visiting. However the guidance did not state where on the ward visits should take place. One patient told us that they were concerned that they had seen a child in a communal area on Stanage ward. We requested that the trust investigate this incident.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. The ward had access to safeguarding leads.

Staff access to essential information

Not all staff had easy access to clinical information and it was not always easy for them to maintain high quality clinical records – whether paper-based or electronic.

Patient notes were comprehensive, and all substantive staff could access them easily. However, agency staff could not input into the electronic patient record because they had no independent access to the system.

When patients transferred to a new team, there were sometimes delays in staff accessing their records. We came across one incident where a patient was transferred to an acute hospital but the staff on Stanage ward could not provide timely access to the patient's list of medication.

Records were stored securely but staff often struggled to access the system which could be very slow to load up. The trust had a plan to upgrade the system to resolve these issues.

Medicines management

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

The service used systems and processes to safely prescribe, administer, record and store medicines. Staff regularly reviewed the effects of medications on each patient's mental and physical health.

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines. At inspection, we reviewed a sample of patient prescription charts and found no concerns.

Staff reviewed patients' medicines regularly and most patients we spoke with said staff provided them with specific advice about their medicines. However, five out of the seven carers we spoke with said they had been given no information or advice about their relative's medication.

Staff stored and managed medicines and prescribing documents in line with the provider's policy.

Staff followed current national practice to check patients had the correct medicines.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely.

Decision making processes were in place to ensure people's behaviour was not controlled by excessive and inappropriate use of medicines.

Staff reviewed the effects of each patient's medication on their physical health according to NICE guidance. We reviewed a sample of physical health files and found they had improved since our last inspection.

We reviewed the physical health records of four patients who had received rapid tranquilisation. Physical observations had been undertaken. However, two of the records did not state whether the patient was offered and declined food and fluid or whether they were not offered any. In two of the records, the nurses had not recorded whether they had made checks of the recordings.

Staff on Burbage ward had access to an emergency medicine to treat patients suffering from an opiate overdose but this was not present on the other three wards. The trust sent us their medicines management policy but this did not contain any reference to the medication and staff could not tell us the reason it was present on only one of the wards. Following the inspection the trust confirmed that the medication was only present on Burbage ward because on this ward staff had previously supported patients with inpatient detoxification. However, this remained unclear for the staff.

Track record on safety

The service had a poor track record on safety.

Reporting incidents and learning from when things go wrong

The service did not always manage patient safety incidents well. Staff did not always recognise incidents and report them appropriately. Managers investigated incidents but did not always share lessons learned with the whole team and the wider service. When things went wrong, staff did not always apologise and give patients and their families honest information and suitable support.

Staff did not always know what incidents to report but they did know how to report them.

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

Staff did not always raise concerns and report incidents and near misses in line with trust/provider policy. Through a patient complaint, we became aware of a clinical incident that staff had not reported to the trust.

Staff reported serious incidents clearly and in line with trust policy. In the period 1 September 2020 to 16 April 2021, the service reported five serious incidents. There were two on Burbage ward, two on Endcliffe ward and one on Stanage ward.

The service had no never events on any wards.

Staff did not understand the duty of candour. They were not always open and transparent and did not always give patients and families a full explanation when things went wrong. We spoke with one carer who told us their relative had been badly injured in a fall, but they had not had an explanation or an apology from staff.

Managers did not debrief and support staff after serious incidents. Most of the staff we spoke with told us they did not consistently receive de-briefs following incidents because the ward was too busy and there was no time. Some staff had access to reflective sessions facilitated by the psychologist, but this was yet to be embedded across all wards.

Managers investigated incidents, but on all wards, there was a backlog of incidents requiring review and sign off by managers. There was a total of 66 outstanding incidents and a small number of these may have involved non-serious harm to patients or staff.

Patients and their families were involved in serious incident investigations.

Staff did not always receive feedback from investigation of incidents, both internal and external to the service. We reviewed the notes from twenty team meetings across this service. We could find no consistent evidence that staff teams discussed incidents or lessons learned from service or trust-wide incidents. The trust told us that a new lessons learned bulletin, called 'blue light' had been launched and disseminated to all staff across this service. However, we did not see evidence of this on either Stanage or Burbage ward.

Managers told us they met in monthly governance meetings to discuss the feedback and look at improvements to patient care. For example, the trust had introduced a no-smoking policy as a result of safety concerns.

We did not see evidence that managers shared learning with their staff about never events that happened elsewhere, but a new learning lessons framework was being drafted by the trust that included monthly learning lessons events.

Is the service effective?

Requires Improvement 

Our rating of effective stayed the same. We rated it requires improvement.

Assessment of needs and planning of care

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

Staff assessed the physical and mental health of all patients on admission. They developed individual care plans which were reviewed regularly through multidisciplinary discussion and updated as needed. Not all care plans reflected patients' assessed needs, and were not always personalised, holistic and recovery oriented.

Staff completed a comprehensive mental health assessment of each patient either on admission or soon after.

Patients had their physical health assessed soon after admission and regularly reviewed during their time on the ward. We reviewed a sample of patient physical health files and found that all patients had basic physical health monitoring completed. Patients that required it had more in-depth monitoring completed.

Staff developed a comprehensive care plan for each patient that met their mental and physical health needs. We saw examples of care plans for patients with epilepsy and other health conditions.

Staff regularly reviewed and updated care plans when patients' needs changed.

Care plans were not always personalised, holistic or recovery orientated. We reviewed 11 care records of current patients and found that only three were personalised and recovery orientated, and these were all on Endcliffe ward. Many of the care plans from all the other wards contained standard statements that had not been personalised. Records did not contain detail of recovery orientated goals to support patients to discharge.

Best practice in treatment and care

Staff provided a range of treatment and care for patients based on national guidance and best practice. They ensured that patients had good access to physical healthcare and supported them to live healthier lives. Staff used some recognised rating scales to assess and record severity and outcomes. Some staff also participated in clinical audit, benchmarking and quality improvement initiatives.

Staff provided a range of care and treatment suitable for the patients in the service.

Staff delivered care in line with best practice and national guidance. (from relevant bodies e.g. NICE)

Staff identified patients' physical health needs and recorded them in their care plans.

Staff made sure patients had access to physical health care, including specialists as required.

Staff met patients' dietary needs and assessed those needing specialist care for nutrition and hydration. However, the trust were investigating a potential case where a patient became dehydrated on Stanage ward at the time of the inspection.

Staff helped patients live healthier lives by supporting them to take part in programmes or giving advice. For example, staff provided patients with nicotine replacement products and the trust had trained some staff to provide advice about quitting smoking.

Staff used some recognised rating scales to assess and record the severity of patients' conditions and care and treatment outcomes. They used a screening tool to measure patients' nutrition, but they did not use a recognised tool to monitor patients' mental health outcomes.

Staff did not always use technology to support patients. On some wards, they used technology to support the recording of patient observations but one of the patient advocates told us that staff had not been able to provide video calling facilities for patients during the pandemic when it was difficult for them to visit the ward in person.

Staff on some wards took part in clinical audits, benchmarking and quality improvement initiatives. We saw evidence of clinical audits taking place on Maple ward and quality improvement on Endcliffe ward but there was a lack of consistency across the service. However, both Burbage and Stanage had relatively new ward managers.

Managers used results from audits to make improvements.

Skilled staff to deliver care

The ward team(s) included or had access to the full range of specialists required to meet the needs of patients on the wards. Managers did not make sure that all staff had the range of skills needed to provide high quality care. They supported staff with appraisals, and opportunities to update and further develop their skills but they did not provide all staff with regular supervision. Managers provided an induction programme for new staff.

We saw examples where patients had access to dieticians, physiotherapists and speech and language therapists in addition to specialist staff within the ward team.

Managers did not always ensure staff had the right skills, qualifications and experience to meet the needs of the patients in their care, including bank and agency staff. Not all agency and bank staff had been trained in the trust's approved restraint methods and some nursing staff were inexperienced. The trust reported that newly qualified nursing staff were not left alone on duty and were always supported by more experienced nurses.

Managers gave each new member of staff a full induction to the service before they started work.

Managers supported staff through regular, constructive appraisals of their work. At March 2021, compliance rates for clinical services was at 91% which was slightly higher than the trust target of 90%.

At week commencing 05 April 2021, the mean compliance with the trust target for supervision in the clinical services was at 67%, which was below the trust target of 80%. At inspection, most staff we spoke with confirmed they had received regular supervision but there had been a problem on Burbage ward due the absence of a ward manager for a period prior to our inspection. The trust had increased the amount of supervision offered to staff since the last inspection.

Managers did not make sure staff on all wards attended regular team meetings. In the period, 1 January 2021 to 1 May 2021, Burbage ward only had two team meetings, Stanage ward had four meetings, Endcliffe ward had four meetings and Maple ward had 10 meetings. The notes for Endcliffe and Maple wards were electronic and contained enough detail for staff who could not attend to understand what was discussed. However, the notes on Burbage and Stanage lacked detail and there was no agenda. The attendance list showed that staff did not always attend team meetings.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Some staff were receiving advanced nurse practitioner training.

Managers made sure staff received any specialist training for their role and some staff were undertaking apprenticeships.

Managers recognised poor performance, could identify the reasons and dealt with these.

Multi-disciplinary and interagency team work

Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. The ward team(s) had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.

Staff held regular multidisciplinary meetings to discuss patients and improve their care, however, support workers did not have access to these meetings and, as a result did not feel their views about patient care were heard.

Staff made sure they shared clear information about patients and any changes in their care, including during handover meetings and safety huddles.

Ward teams had effective working relationships with other teams in the organisation. There was early in-reach by the community home treatment team to support patients prior to discharge.

Overall, ward teams had effective working relationships with external teams and organisations.

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

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and discharged these well. Managers made sure that staff could explain patients' rights to them.

Staff received and kept up to date with training on the Mental Health Act and the Mental Health Act Code of Practice and could describe the Code of Practice guiding principles. At 4 April 2021, trust-wide data indicates that over 80% of staff were compliant with this training.

Staff had access to support and advice on implementing the Mental Health Act and its Code of Practice.

Staff knew who their Mental Health Act administrators were and when to ask them for support.

The service had access to policies and procedures that reflected all relevant legislation and the Mental Health Act Code of Practice.

Not all patients had easy access to information about independent mental health advocacy and not all patients who lacked capacity were automatically referred to the service. The advocate on Burbage ward was concerned that patients were not routinely referred and communication with ward managers was difficult. However, the new manager on Burbage ward told us they planned to have much more involvement with the advocacy service, but they had only been in post 3 weeks.

Staff explained to each patient their rights under the Mental Health Act in a way that they could understand, repeated as necessary and recorded it clearly in the patient's notes each time.

Staff made sure patients could take section 17 leave (permission to leave the hospital) when this was agreed with the Responsible Clinician and/or with the Ministry of Justice.

Staff requested an opinion from a Second Opinion Appointed Doctor (SOAD) when they needed to.

Staff stored copies of patients' detention papers and associated records correctly and staff could access them when needed.

Informal patients knew that they could leave the ward freely, but the service did not display posters to tell them this. Staff informed them.

Care plans included information about after-care services available for those patients who qualified for it under section 117 of the Mental Health Act.

Managers and staff made sure the service applied the Mental Health Act correctly by completing audits and discussing the findings.

Good practice in applying the Mental Capacity Act

Most staff supported patients to make decisions on their care for themselves. They understood the trust policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly for patients who might have impaired mental capacity.

Staff received and kept up to date with training in the Mental Capacity Act and had a good understanding of at least the five principles. At 4 April 2021, trust-wide data indicated that over 85% of staff were compliant with their level one training and over 88% compliant with level two.

There were no deprivations of liberty safeguards applications made in the last 12 months.

There was a clear policy on Mental Capacity Act and deprivation of liberty safeguards, which staff could describe and knew how to access.

Staff knew where to get accurate advice on the Mental Capacity Act and deprivation of liberty safeguards.

Staff gave patients all possible support to make specific decisions for themselves before deciding a patient did not have the capacity to do so. However, we spoke with one patient on Burbage ward who told us staff did not ensure they regularly revisited her capacity to consent to a physical health treatment before administering it to her. When we checked the records for this patient, we found appropriate and timely assessments of capacity were in place.

Staff assessed and recorded capacity to consent clearly each time a patient needed to make an important decision.

When staff assessed patients as not having capacity, they made decisions in the best interest of patients and considered the patient's wishes, feelings, culture and history.

Staff made applications for a Deprivation of Liberty Safeguards order only when necessary and monitored the progress of these applications.

The service monitored how well it followed the Mental Capacity Act and acted when they needed to make changes to improve.

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

Is the service caring?

Requires Improvement 

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

Kindness, privacy, dignity, respect, compassion and support

Staff treated patients with compassion and kindness but they did not always respect patients' privacy and dignity. They understood the individual needs of patients, but they did not always support patients to understand and manage their care, treatment or condition.

Staff were not always respectful, and responsive when caring for patients. They did not always respect patients' dignity. An incident had occurred on Stanage ward where staff carried out a clinical procedure with a patient in an inappropriate environment which compromised their dignity. Patients were being cared for in some bedrooms and seclusion suites which compromised their privacy and dignity.

Staff gave patients help, emotional support and advice when they needed it but most of the 11 patients, we spoke with told us they often had to wait because staff were too busy to respond. Two patients on Stanage ward told us they felt ignored by staff. However, all three patients we spoke with on Endcliffe ward confirmed they could always find a member of staff to speak with and they never had to wait.

Staff did not always support patients to understand and manage their own care, treatment or condition. Several of the patients we spoke with told us they felt treatment was being done to them rather than with them.

Staff directed patients to other services and supported them to access those services if they needed help.

Patients said staff treated them well and behaved kindly. Out of the 11 patients we spoke with,10 were positive about the way staff treated them.

However, patients told us that staff always knocked on bedroom doors before entering their rooms and generally treated them with kindness.

Staff understood and respected the individual needs of each patient, but this was not always well documented in treatment plans.

Staff felt that they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients.

Staff followed policy to keep patient information confidential. However, some ward areas were monitored by CCTV, but we did not see any signage on the ward to inform patients and visitors that they were being monitored.

Involvement in care

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

Staff did not involve patients in care planning and risk assessment and did not actively seek their feedback on the quality of care provided. They did not always ensure that patients had easy access to independent advocates.

Involvement of patients

Staff did not always involve patients or give them access to their care planning and risk assessments. Of the 11 patients we spoke with, five patients said they did not have copies of their care plans and one patient was not sure. We did not see any evidence of patient input in any of the 11 patient risk assessments we looked at. Only one of the patients we spoke with at inspection told us they felt involved in their plan of care and this was on Endcliffe ward. The other patients we spoke with told us they did not have any say in their plan of care even if a copy had been given to them by staff.

Staff did not always make sure patients understood their care and treatment. Until recently, patients did not have access to multi-disciplinary meetings about them so did not have the opportunity to understand the care they were getting. Patients acknowledged that this had improved recently but overall, patients reported a lack of time to properly discuss and understand their care.

Staff introduced patients to the ward and the services as part of their admission. However, some patients had only just received a welcome booklet despite being on the ward for a considerable time.

Staff involved patients in decisions about the service, when appropriate. We saw examples in community meeting minutes where patients had been asked about facilities or decoration on the ward. We saw some examples of patient artwork on the walls on some wards.

Patients could give feedback on the service and their treatment and staff supported them to do this. On Endcliffe and Stanage wards, patients had access to a weekly meeting but on Burbage ward, there was no record of a patient meeting since 21 April 2021. On Maple ward, there were two meetings cancelled in April 2021 due to high levels of patient distress on the ward.

We did not see any examples where staff supported patients to make advanced decisions on their care at this inspection, but staff confirmed they would do this if necessary.

Staff did not always ensure patients could easily access advocacy services. Burbage and Stanage wards did not automatically refer patients to the advocacy service and one patient we spoke with told us their advocate had great difficulty contacting ward by phone. Advocates on these wards were not involved in patient meetings but on Endcliffe and Maple wards, advocates were much more involved. The managers on Burbage and Stanage told us they had plans to involve advocates more with patients on the ward.

Involvement of families and carers

Staff informed and involved families and carers appropriately.

Staff did not support, inform or involve families or carers. Out of the seven carers we spoke with, only two said they felt involved and informed about their relative's care and they were both in relation to Endcliffe ward. The other five carers said that in-spite of trying to speak with staff, especially doctors and nurses, their calls were often not returned. Most carers had not been able to attend a multi-disciplinary meeting until very recently and did not feel supported by the service. Several carers told us they felt invisible and ignored by staff.

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

Staff did not help families to give feedback on the service. Carers were unaware of how they could provide feedback about the service though several carers said they had been given information about how to make a complaint.

We could not find evidence that staff provided carers with information on how to access the carer's assessment.

Is the service responsive?

Inadequate 

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

Following the inspection of this service, we issued enforcement action to the trust in the form of a section 29A warning notice. This means that the rating for this key question is limited to inadequate.

Access and discharge

Staff did not manage beds well. A bed was not always available when needed but patients were not moved between wards unless this was for their benefit. Discharge was rarely delayed for other than clinical reasons.

Bed management

Bed occupancy often exceeded 85%. The trust had reduced the number of beds on some wards as a result of refurbishment and this put increased pressure on bed occupancy levels. The trust told us they were in the process of identifying additional bed capacity to replace the reduced capacity.

Managers regularly reviewed length of stay for patients to ensure they did not stay longer than they needed to. The average length of stay on the acute wards was 35 days and on the psychiatric intensive care unit, it was 38 days.

The service had high levels of out-of-area placements meaning that beds were not always available for the local population. The trust told us there was active clinical management of all patients placed out of area to consider care quality and opportunities for repatriation or alternatives to admission.

Some staff told us they often felt pressure from managers to discharge patients before they were ready. Staff thought this was because there was a shortage of beds and a high demand for them. One carer also told us they had been pressurised by staff to have their relative discharged to their care before they thought the patient was well enough.

Between 1 August 2020 and 30 April 2021, six patients had been admitted to beds which were allocated to other patients who were away from the ward on leave. This had happened on three occasions on Stanage ward, twice on Burbage ward and once on Maple ward.

Staff told us that when patients went on leave there was not always a bed available when they returned. We asked the trust to supply us with data about how often this happened and the trust told us that their internal data stated that this had not happened. This meant that staff had not communicated their concerns about this to senior leaders and that these incidents had not been recorded.

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

Patients were moved between wards only when there were clear clinical reasons, or it was in the best interest of the patient.

The psychiatric intensive care unit usually had a bed available if a patient needed more intensive care and this was not far away from the patient's family and friends. However, in the period 1 March 2020 to 31 March 2021, this ward had 48 inappropriate out of area placements.

Discharge and transfers of care.

The service had low or reducing numbers of delayed discharges in the past year but we were aware of one patient with a lengthy stay due to difficulty in sourcing an appropriate alternative placement to meet the patient's needs.

Managers monitored the number of delayed discharges. Staff had access to a co-ordinator to help facilitate patient discharge though this post was vacant at the time of our inspection.

The only reasons for delaying discharge from the service were clinical.

Staff carefully planned patients' discharge and worked with care managers and coordinators to make sure this went well. Managers held weekly meetings involving external partners such as the local authority and housing.

Staff supported patients when they were referred or transferred between services.

Facilities that promote comfort, dignity and privacy

The design, layout, and furnishings of the ward did not support patients' treatment, privacy and dignity. Not all patients had their own en-suite bathroom and some patients were housed in old dormitory style rooms. Patients could keep their personal belongings safe and there were quiet areas for privacy. The food was of good quality and patients could make hot drinks at any time but they had to ask staff for snacks outside mealtimes.

Since out last inspection, the trust had removed patient dormitories so that each patient had their own bedroom, which they could personalise. However, on Stanage ward, the previous dormitory style bedrooms had been removed so patients did not have to share sleeping space but there had been little attempt to adapt the room for use by single individuals. The trust had not removed all the curtain rails that previously formed the bed bays in the dormitory and the room had an institutional feel. It was sparse with little furniture and had mould on the windows. One patient complained of a bad smell coming from the toilet in their room.

Patients had access to a secure place on the ward to store personal possessions. Their valuable items were stored in the safe in the nurse's office.

Staff used a full range of rooms and equipment to support treatment and care. The wards were busy and noisy, but patients had access to quiet areas including their own rooms which they could access themselves at any time.

Rooms on the wards were multi-functional but each ward had a room where patients could meet with visitors in private.

Patients could make phone calls in private but on Burbage ward, the phone that could be used by patients had been out of action for a long period. We spoke with the manager who told us this had been recently rectified. Patients had access to their own mobile phones as well as the internet.

The service had an outside space that patients could access but, on some wards, the door was kept locked due to hazards identified in the area. Some patients and carers said they would have liked easier access to outside space and the trust told us they planned to make these areas safer so patients could use it without the need to be supervised.

Patients could make their own hot drinks and were not dependent on staff. However, only fruit was available in the dining areas for patients to take without having to ask. Patients had to ask staff if they wanted other snacks outside mealtimes.

The service offered a variety of good quality food. Most of the patients we spoke with confirmed this.

Patients' engagement with the wider community

Staff supported patients with activities outside the service, such as work, education and family relationships.

Staff made sure that where appropriate, patients had access to opportunities for education and work.

Staff helped patients to stay in contact with families and carers. Staff were allowing face to face visits between patients and families and patients had access to section 17 leave.

Staff encouraged patients to develop and maintain relationships both in the service and the wider community. The trust had links with community-based organisations that provided creative opportunities that promoted health and wellbeing.

Meeting the needs of all people who use the service

The service met the needs of all patients – including those with a protected characteristic. Staff helped patients with communication, advocacy and cultural and spiritual support.

The service could support and make adjustments for disabled people and those with communication needs or other specific needs. Each ward had several bedrooms that had been adapted to meet the needs of people with mobility needs.

Staff made sure patients could access information on treatment, local service, their rights and how to complain.

The service had access to information leaflets available in languages spoken by the patients and local community.

Managers made sure staff and patients could get help from interpreters or signers when needed although there had been some delays in accessing this, possibly due to the pandemic.

The service provided a variety of food to meet the dietary and cultural needs of individual patients. Patients were asked about their food preferences on admission and the patients we spoke with confirmed this.

Patients had access to spiritual, religious and cultural support. Some wards had on-site multi-faith facilities.

Listening to and learning from concerns and complaints

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

The service treated concerns and complaints seriously, investigated them and learned lessons from the results. However, these were not always shared with the whole team and wider service. Not all staff were up-to-date with the current complaints procedures.

Patients, relatives and carers knew how to complain or raise concerns. Since the 1 May 2020, the trust received 84 formal complaints from across their mental health services. The main complaint themes concerning the acute wards were related to staff communication and lost items of clothing.

In the same period, this service received 18 compliments from patients and/or their carers.

The service displayed information about how to raise a concern in patient areas.

Some staff did not know the policy on complaints had changed and that fast track forms were no longer available. The trust had not informed the Independent Mental Health advocate on Burbage ward that the complaints procedure had changed so they could have provided patients and carers with inaccurate information.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint.

Managers investigated complaints and identified themes through a quarterly learning from experience report but we did not see that staff had easy access to this.

Staff protected patients who raised concerns or complaints from discrimination and harassment.

We did not see that managers shared feedback from complaints with staff and learning was used to improve the service. We checked team meeting notes and spoke with staff who told us they did not get feedback once complaints had been escalated to managers.

We did not see that the service routinely used compliments to learn, celebrate success and improve the quality of care.

Is the service well-led?

Inadequate 

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

Following the inspection of this service, we issued enforcement action to the trust in the form of a section 29A warning notice. This means that the rating for this key question is limited to inadequate.

Leadership

Some leaders had the skills, knowledge and experience to perform their roles, but the service was going through a management re-structure and some management roles were being replaced and a new modern matron role was being created. The service had a high number of inexperienced nursing staff and new ward managers but, unlike at our last comprehensive inspection, they were now being supported by an experienced peripatetic ward manager.

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

The service had been through a period of change, with changes at senior leadership and at ward manager level. Newer ward managers did not always have a thorough understanding of the services they managed because they were relatively new, but staff confirmed they were visible in the service and approachable for patients and staff. Overall, staff felt that the wards had improved since the new managers came into post, but changes needed to be embedded. Some staff we spoke with said higher managers did not always appreciate the challenges they faced at ward level.

Vision and strategy

Staff knew where to locate the provider's vision and values and knew how they applied to the work of their team.

Culture

Staff felt respected, supported and valued by their immediate managers but they did not always feel this way about leaders in the wider trust. Some staff told us that they felt pressured by the bed management processes into accepting referrals and discharging patients.

Staff said the trust promoted equality and diversity in daily work and provided opportunities for development and career progression. All the staff we spoke with said they could raise concerns without fear, and they knew there was a Freedom to Speak up Guardian.

Incidents of racial abuse from patients towards staff was increasing. Although the trust was monitoring the numbers of these incidents, staff did not feel enough was being done to protect them.

Governance

Our findings from the other key questions did not demonstrate that governance processes operated effectively at team level, nor that performance and risk were managed well.

The trust has not addressed the immediate high-risk ligature points and removed these as interim measure while wards were fully refurbished. Managers had not ensured that all staff were routinely and consistently following all the mitigation in place such as supervising patients or restricting access to high risk areas. There was no clear policy for staff about the use of one emergency medicine. There was nothing in place to mitigate against blind spots created by the privacy screens in the seclusion rooms.

Not all blanket restrictions were recorded on the appropriate blanket restrictions log and some staff did not adhere to all the restrictions that were on there. On Burbage ward, the door to the garden area was kept locked as a safety measure but this was not recorded on their restrictions log. On Stanage ward, the door to the garden area was sometimes left unlocked but, according to their restrictions log, it should always have been locked for safety reasons.

Service risk registers did not identify all risks and some staff were not sure what risk registers were or how they could input into them.

The levels of acuity within the service were high, and the police had been called to these wards on a number of occasions to deal with patient issues. This had not been escalated as a risk for the service.

The trust had changed the patient complaint procedure but they had not informed all stakeholders including some staff who were unaware that the process had changed.

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

The service did not ensure that restrictions and policies were applied consistently.

Patients and their carers did not feel involved in their treatment and care and care plans were not holistic or recovery orientated.

The service used a high number of agency staff, and the trust did not monitor which of these staff were trained to take part in physical interventions. Staff told us that this made them feel unsafe because there were not always adequate numbers of staff available to undertake physical interventions.

However, staff appraisal and supervision rates had improved. Staff compliance with mandatory training had improved though there were three areas where performance was below the trust target. Managers now ensured all patients had appropriate physical health monitoring in place and that they had up to date risk assessments in place. Wards were clean and the food was of good quality. The trust had eliminated dormitory style rooms so that patients did not have to share a bedroom and they had eliminated mixed sex accommodation on Stanage and Burbage wards.

Information management

Teams had access to the information they needed to provide safe and effective care and used that information to good effect.

Managers engaged actively other local health and social care providers to ensure that an integrated health and care system was commissioned and provided to meet the needs of the local population. Managers from the service participated actively in the work of the local transforming care partnership.

Engagement

Staff collected analysed data about outcomes and performance and engaged actively in local and national quality improvement activities.

Learning, continuous improvement and innovation

The acute wards and the psychiatric intensive care unit had been working towards accreditation by The Royal College of Psychiatrists, but this had stopped in 2020 as a decision was taken by the trust to focus on making the necessary improvements to the service.

The trust was in the process of introducing Safewards as part of their reducing restrictive practice programme. Safewards is an evidence-based approach designed to reduce conflict and containment (coerced medications, restraint and seclusion) in acute adult mental health inpatient units.