Good

Sheffield Health and Social Care NHS Foundation Trust

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

Quality Report

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Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
TAHFC	**Michael Carlisle Centre**	Burbage Ward	S11 9BF
TAHFC	**Michael Carlisle Centre**	Stanage Ward	S11 9BF
TAHCC	**The Longley Centre**	Endcliffe Ward	S5 7JT
TAHCC	**The Longley Centre**	Maple Ward	S5 7JT

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

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

Summary of findings

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

Summary of findings

Ratings

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

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

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

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

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

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

Summary of findings

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Summary of findings

Overall summary

We rated acute wards for adults of working age and psychiatric intensive care units as good because:

- The wards had scored above the national average in all areas of the patient led assessment of the care environment.
- The trust was trialling the use of an electronic tablet to record patient observations. This meant that clinical records accurately reflected the time that a patient was observed and what activity they were undertaking at the time.
- The trust had effective systems for managing inpatient admissions and discharges. This meant they had managed to reduce the overall number of beds in the acute care pathway but could increase capacity as demand increased.
- Because of good capacity and demand management of inpatient beds, no patient had been admitted to an acute admission bed outside of the Sheffield area in the last two years.
- There were detailed and comprehensive care plans and risk assessments in place and these were being regularly reviewed. Patients told us they felt involved in their care planning and discussions about their progress.
- There was access to multidisciplinary interventions which included medical, nursing, and psychological and occupational therapy. Care and treatment was evidence based and followed recommendations in national guidance.
- Each of the wards had a sensory room. Patients who were upset or agitated could use this dedicated room. The rooms had comfortable relaxing cushions and chairs, muted lighting and soft music. The rooms gave patients somewhere safe to go where they could implement a range of strategies, based on mindfulness, to help them through their crisis.
- Regular audits were being undertaken and improvements made based on the outcomes identified in those audits.

However:

- Some of the ward environments were not safe. All of the bedrooms contained potential ligature anchor points. Stanage and Burbage Wards did not comply with guidance on the elimination of mixed-sex accommodation. The seclusion rooms on Burbage, Stanage and Maple Wards did not comply with the Mental Health Act code of practice.
- The trust had identified mandatory training for staff but compliance with undertaking this training was below the trust target. Although improvements had been made in the preceding months, at the time of inspection, the wards were not achieving the trust target of 80% staff receiving regular supervision.

Summary of findings

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

Are services safe?

Requires improvement

We rated safe as requires improvement because:

- The trust had undertaken some remedial work to address ligature risks and was planning some additional work. However, there were no bedrooms with reduced ligature anchor points that staff could allocate to patients at higher risk of suicide. This meant that, when such patients were admitted, staff had to increase the level of observation.
- The trust had considered the needs of both men and women admitted to the acute wards and made some required provision. However, on Stanage and Burbage ward individual rooms were not located together as male or female bedrooms areas. This is against same-sex accommodation guidance.
- There were a number of issues identified with the seclusion rooms on Stanage, Burbage and Maple wards. These included concerns regarding the fixtures and fittings as well as privacy and dignity issues.
- Staff were not receiving regular mandatory training. The combined total for staff across the four wards compliant with mandatory training was 51%. However, the trust target was 75%.

However:

- There were effective motoring systems in place for maintaining clean wards and complying with infection prevention requirements.
- The wards scored above national average in all areas of the patient led assessment of the care environment (PLACE) assessments.
- Stanage ward was piloting the use of technology to support staff undertaking patient observation.
- There were effective medicine management systems in place.
- There had been proactive recruitment into vacant posts and a significant increase in the number of qualified staff working on the wards.
- Staffing levels meant it was unusual for the wards to be short staffed or activities or leave to be cancelled.
- There were good quality care plans, risk assessments and risk management plans in place.
- Wards had developed a range of evidence based interventions aimed at managing aggression and violence whilst reducing incidents of restraint and seclusion. These included sensory rooms being developed on each ward.

Summary of findings

- There had been improvements in the recording of observations post administration of rapid tranquilisation and all episodes now complied with the trust policy.

Are services effective?

Good

We rated effective as good because:

- Patients had good quality collaborative care plans.
- Risk assessment and risk management plans were comprehensive and regularly reviewed.
- There was guidance for staff to support them in completing assessments and interventions, including physical health checks, during the course of the admission.
- The wards had developed sensory rooms and there were evidence based interventions to support patients who may be highly distressed or becoming agitated or aggressive.
- The teams were multidisciplinary and patients had access to one to one time with their named nurse and could meet with their doctor. There was input from occupational therapy staff and patients had access to psychological interventions. There were effective multidisciplinary meetings including clinical reviews, dashboard meetings and shift handovers. Communication was clear and risk was discussed and management plans agreed.
- Mental Health Act paperwork was correctly located within the clinical records.
- There were good examples of capacity assessments and best interest meetings were being held where required.

However:

- Supervision was in place but this was not being received regularly by all staff in line with the trust policy.

Are services caring?

Good

We rated caring as good because:

- Patients and carers told us that staff treated them with respect and kindness.
- We observed professional behaviours and interactions at all times.
- Patients felt involved in their care planning and discussions about progress.
- Carers told us they feel involved and included in their role as a carer.

Summary of findings

Are services responsive to people's needs?

Good

We rated responsive as good because:

- The trust had effective systems for managing inpatient admissions and discharges.
- The wards could increase the number of beds in order to meet demand.
- Burbage, Stanage and Maple wards had dedicated band 6 discharge nurses who worked to address barriers to possible discharge and assisted in accessing most appropriate discharge support packages of care.

Are services well-led?

Good

We rated well-led as good because:

- Staff understood the trust visions and values and these were embedded within appraisal and supervision.
- Staff told us they felt well supported and that managers provided clear leadership.
- There were regular meetings and good levels of communication. This included sharing information about incidents and lessons learned.
- There were regular audits and the outcomes of these were reviewed and any required areas of change were implemented.

Summary of findings

Information about the service

Sheffield Health and Social Care NHS Foundation Trust provided acute wards for adults of working age and the psychiatric intensive care unit at two locations. Patients are admitted to the locality closest to the area where they live.

Michael Carlisle Centre

- Burbage Ward– 14 bed acute admission ward plus 5 detox beds for men and women
- Stanage Ward– 18 bed acute admission ward for men and women

Longley Centre

- Maple Ward– 17 bed acute admission ward for men and women
- Endcliffe Ward–10 bed psychiatric intensive care unit for men and women

The Care Quality Commission previously inspected acute wards for adults of working age and the psychiatric intensive care unit in October 2014. The service was rated as good in the caring, responsive, and well-led domains. We rated the safe and effective domains as requires improvement. This core service was therefore rated as requires improvement overall.

The trust was found to be in breach of regulation 12 and regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The trust implemented a plan of action to address those issues. At this inspection, we were able to review and see what improvements the trust had made.

Our inspection team

Chair; Beatrice Fraenkel, Chair, Mersey Care NHS Foundation Trust

Head of Inspection; Jenny Wilkes, Head of Hospital Inspection, Care Quality Commission

Team Leader; Jenny Jones, Inspection Manager , Care Quality Commission

The team that inspected acute wards for adults of working age and psychiatric intensive care unit comprised three specialist advisors from a nursing, medical and social work background and was led by an inspector. An expert by experience was also part of the team. This is someone who has lived experience of mental health services or is a carer of someone with mental health issues.

Why we carried out this inspection

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

How we carried out this inspection

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

Is it safe?

Is it effective?

Is it caring?

Is it responsive to people's needs?

Is it well-led?

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

Summary of findings

During the inspection visit, the inspection team;

- visited the four wards at the two hospital sites and looked at the quality of the ward environment and observed how staff were caring for patients
- spoke with 14 patients who were using the service and received feedback from three carers
- spoke with the managers or acting managers for each of the wards
- spoke with 22 other staff members; including doctors, nurses, housekeepers, occupational therapists and psychological therapy staff
- spoke with a representative from the advocacy service
- attended and observed four meetings
- looked at 24 patient records which included care plans, risk assessments, Mental Health Act paperwork and medicine cards
- reviewed documentation in relation to five episodes of seclusion
- carried out a specific check of the medication management on one ward
- looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the provider's services say

Patients told us that staff were helpful and gave them support and assistance. They told us they were treated with dignity and respect and that staff were thoughtful about things such as knocking on their bedroom door before entering.

Patients told us they were involved in agreeing what should be in their care plans and had been offered copies of them. All the patients we spoke to confirmed they regularly saw their doctor and they had regular one to one sessions with their named nurse.

Carers told us they were always considered by the staff. They felt involved and listened to by the multidisciplinary team. When they speak to team members they asked about their own health and wellbeing.

Good practice

The trust was piloting the use of an electronic tablet to support staff who were undertaking routine observations on Stanage Ward. The tablet provided prompts and guidance to the staff member. This assisted in appropriate risk management plans and supported full compliance with the trust policy. The tablet saved staff time and reduced duplication. Entries made into the electronic tablet were immediately uploaded in to the patient's corresponding clinical record. Initial reports were very positive and staff were hopeful the trust would implement this good practice on other wards.

Staff were trained in evidence based interventions aimed at reducing distress. The distress could be violence and aggression, or it may be intense feelings of self-harm.

Areas for improvement

Action the provider MUST take to improve

- The trust must continue to work to reduce the number of potential ligature anchor points.
- The trust must review the seclusion room provision on each of the wards.
- The trust must ensure that ward accommodation complies with all aspects of same-sex guidance
- The trust must ensure staff undertake their required mandatory training.

Summary of findings

Action the provider SHOULD take to improve

- The trust should continue to roll out improved access to supervision.
- The trust should continue to progress its plans to eliminate dormitory type accommodation.
- The trust should ensure the Standard Operational Procedure - Green Room and Ensuite Observation Pod clearly states a patient is free to leave the room at any point. This would clarify that physical intervention to prevent a patient leaving would mean they were subject to an episode of seclusion.

Sheffield Health and Social Care NHS Foundation Trust

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

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Endcliffe Ward	Longley Centre
Maple Ward	Longley Centre
Burbage Ward	Michael Carlisle Centre
Stanage Ward	Michael Carlisle Centre

Mental Health Act responsibilities

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

Staff were regularly explaining to detained patients about their rights. All required documentation was in order and was easily found within the clinical records. All required authorisation for medicines were also present. Staff had effective administration support and were regularly sent prompts and reminders that helped them in the role. However, only 33% of the ward staff had received Mental Health Act training. The trust target was 75%.

There was guidance about the requirements for documenting reviews and clinical decisions when a patient is spending time in seclusion. However, staff were not fully following the guidance. Some information was only in the electronic clinical record.

There were a number of issues about the seclusion rooms. We raised these at the time of the inspection. The trust has provided an action plan detailing how they will make required improvements.

Detailed findings

Mental Capacity Act and Deprivation of Liberty Safeguards

The ward staff understood the Mental Capacity Act. There were good examples of capacity assessments. When required, best interest meetings were held. However, staff were required to have mandatory training in the Mental Capacity Act but only 28% had completed it. The trust target was 75%.

We did not review Deprivation of Liberty Safeguards during this inspection as no one was subject to the safeguards.

Requires improvement

Are services safe?

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

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

Our findings

Safe and clean environment

The wards inspected were located on two sites. There were significant differences in the ward environments. Burbage, Stanage and Maple wards were within traditional hospital buildings. Endcliffe ward was a new, built for purpose, mental health unit that had opened in January 2016. The trust had improved the facilities and space on Endcliffe ward and these were significantly better than on the other wards. Each of the other acute wards were to be similarly upgraded into purpose built units. The trust showed us the plans for these. We could see that staff and patients were being regularly consulted about the design and what facilities would be available.

Staff explained that the environments presented some additional challenges to the management of the wards. Generally, the wards were clean and well maintained. Checks and audits were in place to maintain hygiene, cleanliness and infection prevention requirements. Patients told us that the wards were always clean. Staff on Burbage ward did not store food safely. Staff had not secured a bag that contained food in the freezer and had not labelled all of the food items in the fridge. Staff addressed these issues immediately.

There were fully stocked and well organised clinic rooms on each of the wards. The wards had resuscitation equipment, an emergency 'grab bag' and ligature cutters. Staff checked regularly that these were present, working effectively and safe to use. There had been improvements in the temperature of these rooms since the previous inspection. Each clinical room had an air conditioning unit and we could see that staff were regularly monitoring the fridge and room temperatures. This was to ensure medicine was being stored at an appropriate temperature.

Drug cupboards and fridges were appropriately storing medicines and controlled drugs. The required monitoring books were in place. Emergency drugs were available and staff carried out regular checks to ensure they remained in stock and in date. The pharmacy team provided clinical input to the ward multidisciplinary team meetings, checked prescription cards and supported the ward teams. In addition, the pharmacist would meet individually with a patient to discuss medicine management issues if required.

Each of the wards had some blind spots and staff described how they managed around these. There was access to appropriate alarms and nurse call systems on each ward.

Ward managers had carried out an annual assessment of ligature risks on their ward. Staff from facilities supported them with the assessments. In June 2016, the trust introduced a 'third eye' person to support the assessments. The additional person involved in the ligature risk assessment was someone independent from the ward environment. The assessments undertaken were comprehensive and provided detail of the majority of the risks.

Staff we spoke with were aware of the potential ligature anchor points on the ward and the requirement to maintain high levels of observation of those areas even when there were no significantly high risk patients. The facilities department's work programme had removed a number of existing ligature anchor points. Ward managers from Stanage, Burbage and Maple ward advised that many of the existing potential ligature anchor points would be eradicated during a rebuild planned for the inpatient services. The aim was to complete this by the end of 2018. Each of the wards had access to a secure outdoor space. Staff described the high number of possible ligature anchor points in the garden areas. Higher risk patients were placed on higher levels of observation in order to mitigate this risk.

Adapted bathrooms on each ward were locked. This was because they had additional risk of ligature. These bathrooms were unlocked if patients wanted to use them. This enabled staff to undertake additional safety checks upon the welfare of anyone using those bathrooms. All the staff we spoke to knew the location of the ward ligature cutters and emergency equipment. Ward managers were confident that all staff, including agency and bank staff, were aware of the potential ligature anchor points on the wards. Ward managers told us that all patients were individually risk managed. Staff placed those patients assessed to be a higher risk of serious self-harm or suicide on a higher level of observation in order to reduce the

opportunity of self-harming. There were no specifically designed lower ligature risk bedrooms available in which to nurse higher risk patients. Therefore, staff managed all patients by increased levels of observations in those circumstances. This contrasted with the ethos of the wards, which aimed for least restrictive interventions.

Some potential ligature anchor points had been removed but others within the same room had not. For example, the door handles in some meeting rooms on the wards had been replaced with anti-ligature handles however, the barrel lock remained directly below the new handles and these were a ligature risk. Some doors to bedrooms had been fitted with anti-ligature handles but potential ligature anchor points within the en suite bathrooms had not been addressed. We raised our concerns about the ligature anchor points on Stanage, Burbage and Maple ward with the trust. The trust took immediate action and have developed an action plan to avoid delay in reducing the potential ligature anchor points. The action plan states that a number of bedrooms will have anti ligature fixtures and fittings fitted to make them suitable for patients who may be at higher risk of attempted suicide. This work will be undertaken without awaiting the building redesign work.

The seclusion room on Endcliffe ward was newly built. The specifications and furnishings were of a high standard. The seclusion room was spacious and had an ensuite bathroom with shower facility. There was access to a small secure and private outdoor area. The seclusion facilities on the acute wards were adapted from the existing ward space. Each of these was due for improvement as part of a planned building redesign, with building works due to complete in 2020. At the time of this inspection, however, there were issues that we asked the trust to address. These were; to review the decision to provide a crash mat and not a bed, to repair the intercom on Burbage ward, to review the door openings and ability to lock these back to improve safe use of the ensuite bathrooms and to review the potential ligature anchor points, blind spots and anti-tamper effectiveness of some fixtures and fittings. The trust provided us with an action plan. This helped us see what action the trust was intending to take in response to our concerns.

Each of the wards were for both men and women. Each ward had women only lounges. Individual rooms and bays had en suite facilities. The exception to this was on Burbage ward. The three bedrooms with no bathroom facility were ring-fenced as male only accommodation. On Stanage ward, a bedroom was located down a short corridor leading to the women only lounge. This was allocated to females only due to its location. On Maple ward same-sex bedrooms were located together although women had to walk past the male bedroom corridor to access the female bedroom area. On Endcliffe ward, there were designated male and female bedroom corridors with a facility to increase and decrease the proportion allocated to males and females based on demand. Stanage and Burbage ward had same-sex dormitory bedrooms. However, individual bedrooms were allocated to either males or females. Staff considered the allocation of rooms nearest to the staff office based on self-harm or harm to others risk assessments. Aside from that, patients were given the next available room. This meant that male and female bedrooms were co-located throughout the wards. There was no policy or procedure to accommodate patients of the same sex in the same area (for example, men at one end of the corridor and women at the other). This could have compromised patients' privacy and dignity.

Patient led assessment of the care environment (PLACE) assessments are self-assessments undertaken by teams of trust staff and specially trained staff members of the public. They focus on different aspects of the environment in which care was provided. In the 2016 patient led assessment of the care environment (PLACE) assessment, Longley Centre scored 99.56% and Michael Carlisle Centre 98.6% for cleanliness. The England average was 98.1%. Longley Centre scored 95.8% and Michael Carlisle Centre 96.5% for condition and maintenance. The England average was 93.4%.

There was variable compliance with the no smoking policy that the trust had introduced. In some wards, there was evidence that patients were smoking in the gardens.

Staff understood the importance of infection prevention and infection control. There were regular hand washing audits undertaken with staff. Staff conducted environmental checks and audits on a regular basis to maintain high environmental standards. When action was required, it was being done in a timely fashion. There were up to date fire risk assessments in place. These included personal emergency evacuation plans, where required. Attending staff transcribed any amendments to the day's observation chart.

Safe staffing

Requires improvement

Are services safe?

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

Staff described the induction they received when starting in post and said it adequately prepared their settling in to the ward. Agency and bank staff who worked on the ward received an induction at the start of their shift. The number of staff that had left their post in the previous 12 months from the wards was 14%. The wards had the following vacancy rates for qualified nurses in July 2016;

- Maple Ward: 17% from a total of 22.5 whole time equivalent
- Burbage Ward: 10% from a total of 17 whole time equivalent
- Endcliffe Ward: 0% from a total of 13.9 whole time equivalent
- Stanage Ward: 11% from a total of 18.6 whole time equivalent

Only Endcliffe ward had support worker vacancies. There were 3.9% vacancies from a staffing establishment of 13.9 whole time equivalent rates for support workers.

The trust target for levels of sickness was 6%. The wards had the following levels of sickness in July 2016;

- Maple Ward: 8%
- Burbage Ward: 5.5%
- Endcliffe Ward: 10.5%
- Stanage Ward: 3%

Maple, Burbage and Stanage wards aimed to have five staff on the early shift and five staff on the late shift. Generally, there were two qualified staff and a third nurse would be on duty on days when clinical reviews or regular meetings were on. The staffing levels were higher on Endcliffe ward with six staff on duty during the day shifts. At night, Stanage and Burbage wards each had three staff on duty and Maple and Endcliffe each had four staff on duty. Ward managers told us they were well supported to manage the staffing levels on the ward. If there was a clinical need, they could request additional staff from the trust bank. We reviewed the staffing rotas and saw that staffing levels met these requirements.

Each of the wards brought in additional staff in order to ensure the right number of staff were on duty. Burbage Ward had the highest number of shifts filled by bank staff (476). Endcliffe Ward had the highest number of shifts filled by agency staff (363). Staff told us that many nurses preferred not to work in the psychiatric intensive care unit so it was often difficult to get bank staff.

The trust monitored the staffing fill rates for each of the wards. Monthly reports were compiled detailing achievement of required numbers of qualified support worker staff. We reviewed these and saw that generally the number of staff on duty was appropriate but that the skill mix may not have been the preferred numbers. For example, where the trust had not fully met the qualified staffing numbers additional support worker staff had worked on those shifts. The percentage fill rate of qualified nurses had significantly improved in the three months to the inspection. This corresponded with ward manager reports of recruitment into vacant posts. The exception to this was Endcliffe ward where the percentage fill rates for qualified staff had reduced. Ward managers assured us the wards had been safely staffed and managed during those periods.

Patients told us that nurses were very visible on the wards. Patients told us it was rare for planned activities or leave to be cancelled due to staffing, although this did still happen on occasions. They said they had regular access to planned one to one sessions with a named nurse. In addition, they said that staff were always available if a patient wanted some time to speak to somebody. There was access to a doctor 24 hours per day who could attend the ward quickly if required.

The trust target for compliance with mandatory training was 75%. In October 2016, the combined compliance rate for the four wards was 51%. The four wards had not achieved 75% compliance in 20 of the 24 mandatory training courses. Managers explained compliance figures were low for a number of reasons, which included not being able to release staff to undertake the training, and not enough training being available so there was a backlog of staff trying to access the course.

Assessing and managing risk to patients and staff

All patients had a completed risk assessment and a detailed plan detailing how to mitigate those risks. These risk management plans provided evidence that patients were involved in their risk management strategies. Staff discussed issues relating to risk at handover. The electronic risk assessment prompted staff to confirm that a copy be made available for the patient. Staff could override the level of detail being contained in the patient copy if they felt this was required. Staff could up load and attach documents in to the risk assessment document. This assisted improving communication of risk related

Requires improvement

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information within the multidisciplinary team. The system provided prompts and guidance for the risk assessment author in order to improve the overall quality of the assessment and management plan.

There were few blanket restrictions. Patients had access to the outdoor spaces and gardens at any time. Patients could access a hot and cold drink during the day or night although only decaffeinated drinks were available at night. Staff only implemented patient searches if a risk assessment indicated a search was required. Informal patients were aware they had the right to leave and there were notices on display explaining this. Endcliffe ward had decided to keep the beverage bay, where patients made hot drinks, open at all times. This was because staff monitored the situation closely and there had been no incidents involving hot water. Staff therefore decided to manage any risk on an individual basis rather than implementing a blanket restriction to hot drink access.

The trust observation policy was clear and staff had a good knowledge of the observation policy requirements. On Stanage ward, they were piloting the use of tablet technology. Staff recorded all observations on to the tablet. As the member of staff undertook the required checks entered the information in to the tablet, the detail uploaded directly in to the individual patient's clinic record in real time. Patient names and the requirements for how often observations needed to be undertaken were uploaded in to the programme. Staff could also input that patients were off the ward such as attending a group or on leave. As time approached for the required time observation checks for a specific patient the tablet would alert staff as a reminder. If the staff member had recorded that the patient had been asleep or off the ward for a number of previous observation times, it would alert the staff member to make more detailed checks that all was well. Staff told us they found the technology helpful and assisted them in undertaking the role more effectively and efficiently.

Staff received training in the RESPECT model of management of violence and aggression. This model supports the ethos of least restrictive interventions. Some staff expressed concern that a situation may arise where there were not enough RESPECT trained staff on a ward and staff would be unable to resolve or contain an incident. To be effective the model requires three appropriately trained staff. We reviewed the staffing rotas to see if there had been recent incidents where not enough appropriately trained staff been on duty. We did not find any instances of this. Ward managers told us they would look to redeploy staff from across the wards in the event a potential incident was beginning to escalate.

Staff described a range of interventions aimed at de-escalation of situations with the aim that restraint be a final option. Acute wards for adults of working age and psychiatric intensive care units had 238 incidents of restraint and 126 incidents of seclusion between March and August 2016. Burbage Ward had the highest number of restraint incidents in the same six-month period with 77. There were two incidents of prone restraint, which accounted for less than 1% of the restraint incidents, of which none resulted in rapid tranquilisation.

At the last inspection there were not always records kept to show that appropriate observations were being undertaken after a patient was administered rapid tranquilisation. Since the last inspection, the trust had reviewed rapid tranquilisation monitoring as detailed in National Institute for Health and Care Excellence guidance; NG10 Violence and aggression; short-term management in mental health, health and community settings (NICE 2015). The trust had reviewed and updated the policy for post administration observations. The trust had undertaken a comprehensive programme to ensure all inpatient nursing and medical staff were aware of the monitoring requirements. We reviewed records of where patients had received rapid tranquilisation and saw that staff completed appropriate monitoring in line with the updated policy.

Each of the wards had developed a sensory room. These areas were used as a specific intervention to help to reduce agitation or distress, had been written into individual care plans, and risk management plans. Access to the room was a specific intervention aimed at reducing incidents of violence, aggression or self-harm.

Endcliffe ward had a 'green room'. This was an additional room within the ward environment used in an attempt to avoid seclusion. The standard operational procedure for the use of this facility provided guidance for staff on the therapeutic use of the space. However, it did not clearly state a patient would be free to leave the area if they wish. If a patient were to be prevented from removing

Requires improvement

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themselves from the green room, they would in fact be subject to an episode of seclusion. The staff we spoke to understood this differentiation and offered reassurances that de facto seclusion did not occur within that space.

Burbage ward and Endcliffe ward PICU had the highest number of seclusion incidents in the six-month period to August 2016 with 35 on each ward. We reviewed the documentation associated with five episodes of seclusion from across the wards. The rationale for the seclusion episode recorded in all instances. Seclusion paperwork was stored securely and appropriately however not all expected detail was recorded in the seclusion records. In order to ensure the staff had fully complied with all requirements as detailed in the seclusion policy it was necessary to scrutinise the patient's electronic clinical records.

Safeguarding training was mandatory for all staff. Compliance with the training was 51% which was below the trust target of 75%. Staff had a good knowledge of safeguarding. They described the types of incident that would require them making a safeguarding referral. Staff knew who would be able to give advice and guidance. We saw an example of a serious safeguarding concern raised during a female's inpatient admission. Appropriate actions had been taken in line with the trust policy.

Each ward had a designated visiting area that could accommodate children visiting also. On Endcliffe ward and Burbage ward, this was located away from the main ward.

Track record on safety

Between April 2015 and April 2016, the trust reported two incidents occurring on these wards requiring investigation. When we attended for inspection, there were an additional two serious incidents requiring investigation. Three of these incidents were serious self-harm involving ligatures. Two of these had resulted in the patient's death.

Reporting incidents and learning from when things go wrong

Endcliffe ward was leading with the roll out of 'safe wards'. This project encourages the implementation of 10 interventions to minimise conflict on wards and maximise safety and recovery. Different initiatives had been introduced on to the ward and feedback communicated through the ward leadership and business meetings.

Leadership meetings addressed issues such as verbal threats, intimidation, and racial abuse towards staff and how to better support staff and patients experiencing this. This included a senior staff member following up any reported incident. This was not only to offer support to the victim but also to speak directly to, or follow up in writing, the alleged perpetrator. This was to be clear what language and behaviours were not acceptable. These were in line with NHS zero tolerance and trust policies.

Duty of Candour

Staff understood the core principles of the Duty of Candour. They described the importance of honesty and transparency in the event of an incident or a near miss. Staff described the importance of acknowledging when things have gone wrong and apologising where appropriate.

Are services effective?

Good

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

Our findings

Assessment of needs and planning of care

The wards allocated each patient admitted a named nurse. Named nurses were qualified nurses who were responsible for overseeing, ensuring comprehensive assessments, detailed care plans and robust risk management plans were completed for each of the named patients allocated to them. The named nurses made sure that actions were completed and interventions and referrals made in a timely way. They ensured that they regularly reviewed all required assessments and documents. They provided the main links between inpatient care, community support and friends and family.

The inpatient service used an electronic record system called 'insight'. There was one clinical record for each patient and any staff member, with appropriate authority to do so, could access this. For example, during an inpatient admission community staff could continue to access, and contribute to, a patient's clinical record.

There were detailed assessments completed for each of the patients and these clearly indicated the rationale for an inpatient admission. We reviewed 14 assessments, care plans and risk management plans in detail. All patients had a completed care plan. Care plans were comprehensive and inclusive. They were personalised to each patient. Staff regularly reviewed and updated patients' care plans.Each area of need indicated on the care plan was colour coded to indicate how in agreement with the identified need the patient was. For example, a need was stated and then colour coded. Staff recorded that they offered patients a copy of their care plan. In all cases except one, there was evidence of a discussion regarding consent and evidence of a capacity assessment.

There was a standard operating procedure detailing physical health interventions to be undertaken on admission. We saw evidence that staff were complying with the guidance. It was the responsibility of the admitting doctor to ensure staff had undertaken the required interventions within six hours of admission. If all physical health screening and assessments had not been completed, there was an effective system for flagging this to ensure they were followed up in the first few days post admission. These included an electrocardiogram where indicated and a range of blood tests. There was guidance indicating additional tests that should be undertaken dependent upon presentation and clinical need. Doctors and nurses could access previous physical health results via an ICE lab report linked to the mental health electronic record.

Nursing staff were responsible for commencing an online physical health assessment form on the patient's electronic record. This included recording smoking status, and baseline physical health outcomes including weight, height and blood pressure. Nurses completed a malnutrition universal screening tool. The hospital had a smoke free policy, patients' smoking status was assessed, and leaflets explaining how patient could be supported with this were available from pharmacy. Care plans were in place to support patients with long-term physical health conditions as well as about medicines for their mental health. Staff made specialist referrals to access appropriate support and interventions.

Best practice in treatment and care

The trust had a number of quality standards. These included one for care planning and provided detailed guidance for staff on how to complete a high quality care plan. These standards referred to National Institute for Health and Care Excellence guidance and quality standards. These were available to support staff and offered prompts to ensure high standards.

Each of the wards had a sensory room. These were a 'safe space' for patients to use if in heightened distress or if they become increasingly agitated or for use as a quiet place for reflection and mindfulness. Standard operating procedures, giving clear guidance for the use of these spaces on each ward were in place. The rooms had been developed in response to an evidence base of the effectiveness of these interventions in reducing incidents or violence, aggression and subsequent restraint and seclusion. They also provided an environment for the effective implementation of mindfulness and grounding techniques.

There were rooms allocated specifically for occupational therapy located off the wards. These enabled activities such as relaxation, arts and crafts, cooking and there was access to a range of gym equipment. Patients told us they enjoyed the activities that were available and thought there was a good range and variety.

Are services effective?

Good

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

Each ward had psychological therapist sessions available for patients. The wards held regular formulation meeting facilitated by a psychological therapist. These meetings encouraged the teams to formulate a joint understanding of the difficulties a particular patient may be experiencing. Staff used this shared understanding to agree appropriate interventions and treatments and collaborative work with patients, and their carers.

The acute wards had developed a 'green box'. This contained items to assist with self-soothing and was recognised as an evidence based intervention in dialectical behaviour therapy.

Some ward staff had additional training and offered family interventions. These were for friends and family of patients who were newly admitted to mental health services. Staff offered up to three sessions. These focused upon providing information and answering questions, the concept of recovery and reinforced the importance of stress management and mental health and well-being for patients and carers.

Patients told us that they were receiving good quality physical health support. However, one patient expressed frustration that he was still awaiting cream for a skin complaint four weeks in to his admission. Staff reviewed nutrition and hydration needs on admission and any required action was taken.

The wards used side effects rating scales to monitor the impact of medicine prescribing and the impact of medication adjustments. They used health of the nation outcome scales, which was a 12-item severity rating scale. It measured the impact of mental health issues on behaviour, impairment, symptoms and social functioning. These were repeated during the course of an admission. They provided a personalised measurement of improvement in those key areas.

Skilled staff to deliver care

The teams were multi-disciplinary and included nurses and support workers, psychological therapy staff, occupational therapy, consultant psychiatrist and junior doctors. There was access to a range of occupational therapy interventions including one to one work on the wards, group work and community based assessments and home visits. Each of the wards had an allocated activity coordinator who could focus upon ensuring structured activities and interventions were available on the wards, including evenings and weekends.

All staff, including doctors, received an annual appraisal and personal development plan. This was an opportunity for staff to review and agree with their managers any specialist training that they should access.

Multi-disciplinary and inter-agency team work

Each ward had a morning 'dashboard meeting' on a Monday to Friday. The most senior nurses, home based treatment team, doctors, psychology, and occupational therapy attended this. A senior manager also regularly attended. This was a business meeting. It provided progress for each patient and used actions agreed and set at the previous meeting to update and feedback to the multi-disciplinary team. Staff were able to feedback results from physical health tests and results for discussion by the multi-disciplinary team. Plans for leave and any required amendments to leave paperwork and risk assessments were allocated for action. The meetings enabled the staff to prioritise daily actions to best support patients and allowed the team to focus on any potential barriers to discharge. Updates from this meeting informed an inpatient bed management meeting held in the afternoon. The wards held a weekly multidisciplinary team meeting where a more detailed review of each patient was undertaken.

The named nurse and doctor meet with the patient before a clinical review to discuss progress, care planning and future interventions. This discussion fed in to a more business type multidisciplinary team meeting that staff attend. Support workers routinely attended these meetings. They told us they felt part of the team and that their feedback and opinions were important. Patients told us they could attend the weekly multidisciplinary team meetings, which many referred to as their ward round. They could also have one to one with their doctors. A carer confirmed they could attend multidisciplinary team meetings. They said their family member was able to read the notes made in preparation for these meetings. A patient told us it was his choice whether to attend. He said staff updated him with care planning decisions if he did not attend. Independent mental health advocates felt the format of the meeting meant patients were not optimally involved in their own care and treatment.

Are services effective?

Good

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

We observed good quality handovers. This is the meeting that happens on wards between staff who have been on duty and staff who are due to take over the next shift. The nurses with responsibility for the care of a specific group of patients that shift gave a verbal update of each patient. This included feeding back on specific actions, a general update and feedback regarding any specific risk issues or incidents in the previous 24 hours.

Adherence to the MHA and the MHA Code of Practice

As at 13 October 2016, the overall compliance rate for Mental Health Act training across the wards was 33%**.** The trust target was 75%. This training was mandatory for the staff on these wards. The wards achieved the following compliance with Mental Health Act training:

- Maple Ward: 18%
- Burbage Ward: 31%
- Endcliffe Ward: 20%
- Stanage Ward: 64%

Despite this, we found that staff had a good knowledge about the Act and its requirements. There was good support from a Mental Health Act administrator who sent prompts and reminders to make sure staff completed paperwork and assessments in a timely. These were done through the electronic system. Staff told us they found this helpful. Each of the wards undertook weekly audits. This was to ensure staff had completed all required actions relating to patients detained under the Mental Health Act. This was a significant improvement since the last inspection. Audits checked that patients were having the right sort of physical health checks and that the correct documentation was in place in their prescription charts and clinical records. Managers identified any problems and addressed these directly with staff.

Detention paperwork was correctly available within the clinical records. The prescription records were clear, and the appropriate legal authorities were in place for medicines to be administered. The trust had developed a colour coding system to patient care plans. The colours indicated how involved the patient had been in drawing their care plan and showed if they agreed with the needs that the staff had identified. Staff had a simple and effective system for retaining a copy of all signed section 17 leave forms together for ease of access.

There was an independent mental health advocacy (IMHA) service provided by Cloverleaf. There were posters and leaflets advertising how to get help and support on each of the wards. Patients confirmed staff told them how to access the service. Patients who had used the service told us that it was very good. Patients could also access support from Sheffield citizens' advice service and again told us their support was valuable.

There had been three Mental Health Act reviewer visits in the time between the last inspection and our visiting the wards.

Good practice in applying the MCA

The trust was in the process of rolling out updated training. Senior clinical staff had prioritised the new training. These staff were to offer advice and guidance to other staff awaiting the training as an interim measure. Ward staff were aware of how to engage an independent mental capacity advocate through the local authority if required.

As at 13 October 2016, the overall compliance rate for Mental Capacity Act training across the wards was 28%. The trust target was 75%. Ward staff on these wards were expected to attend Mental Capacity Act levels one and two training and Deprivation of Liberty training level two. In October 2016 the wards achieved the following combined compliance for those training sessions;

- Maple Ward: 7%
- Burbage Ward: 41%
- Endcliffe Ward: 21%
- Stanage Ward: 44%

No patients were subject to Deprivation of Liberty safeguards on the wards that we visited.

Despite the low compliance with training both qualified staff and support workers had a good understanding of the core principles of the Mental Capacity Act. Capacity was discussed in the ward dashboard meetings and checks made to see if any additional assessments or support was required to support decision making. There were good examples of capacity assessments and that best interest meetings were being held where indicated. Staff knew who to approach for advice or guidance if they were unsure how to proceed.

Good

Are services caring?

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

Our findings

Kindness, dignity, respect and support

All of the patients, except one, said staff on the ward were kind, helpful and supportive. They said they were treated with dignity and courtesy. There were signs on bedroom doors on Maple ward politely reminding staff to knock before entering someone's room.

Patients told us that generally they felt safe on the wards. Although there were incidents of people becoming distressed and or angry and agitated they told us that staff managed these situations well and acted quickly if things were escalating.

In the 2016 patient led assessment of the care environment (PLACE) inspection, Longley Centre scored 89.7% and the Michael Carlisle Centre 95.5% in the privacy and dignity domain. These were above the England average of 87%.

We were able to observe interventions in a number of situations including during an incident. All the interactions that we observed on the wards demonstrated that staff conducted themselves professionally and with due courtesy and respect toward the patients. A carer told us that staff were encouraging toward patients, supporting them to do things rather than pushing them to do things they were struggling with. Patients told us that staff were very caring and were always visible in the main ward area. They said staff make themselves available for one to one time and discussions whenever it may be needed and that they make time for patients. A carer told us that staff on the ward are very helpful, 'they listen to me and my worries. They don't dismiss me'. They told us different staff involved in their family members care kept them updated about progress or any issues.

The involvement of people in the care they receive

Patients told us staff explained about the ward on admission and gave them a booklet explaining what to expect. A carer told us staff gave them an admission booklet when her husband was admitted. This provided helpful information about the ward. It also explained about Mental Health Act sections and what rights the patient had.

The trust used a colour coding system to indicate the level of involvement the patient had in his or her own care plan. Five colour codes corresponded to a key. The colours indicated involvement from 'I do not want to be involved in this goal at the moment' to 'I feel I am taking a lead on my goal'. Each area of need that was identified on the care plan commenced with the statement attached to the corresponding colour code. Staff offered patients copies of their care plans. The wards had a simple system where copies of care plans that had not been accepted by a patient were pinned up in the office. This was a prompt to staff to keep reminding the patient the copy was available if they wished to have it. Some patients had chosen to put theirs up on their bedroom wall.

All the patients, except one, told us they were involved in their care, attended meetings, saw their doctors, nurses and talked about their care and treatment. Patients said they could attend multidisciplinary team meetings and could have one to one with their doctors. Patients said they were involved in discussions regarding discharge and future plans.

Patients told us staff made them aware of the role of the independent mental health advocates and there were posters and information leaflets around the wards promoting the service. However, the advocates themselves were concerned that staff did not routinely notify them of any new admissions. They were concerned that most referrals were made by the patients themselves and wanted to ensure that all patients had access to support and guidance regardless of their mental health at the time. A meeting has been scheduled for the trust and the advocacy service to review and agree if additional actions are required.

Carers told us that staff listened to them and provided helpful information about important issues such as medicines and treatment. Carers told us they felt staff listen to them and take on board their feedback and opinions. Carers said staff encourage them to ring anytime and responded in a helpful and supportive manner when they rang. Staff asked carers about their own well-being and gave advice on carer support services.

The wards displayed 'you said we did' posters on dedicated boards. These gave feedback about issues patients have raised. For example, informing patients they had reviewed menus to include more choice of low calorie and salad options or to advise that no comments had been received from patients for a period of six months and encouraging patients to raise any issues.

Are services responsive to people's needs?

Good

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

Our findings

Access and discharge

The trust had reviewed their inpatient provision and, based on the capacity and demand outcomes of those reviews, had redesigned the provision of acute inpatient care. This redesign included the re provision of the psychiatric intensive care unit, the closure of Rowan ward and a reduction in the number of beds on Stanage, Burbage and Maple wards.

Updates from the ward dashboard meetings were discussed at a daily inpatient bed management meeting. This meant the bed management meeting could plan for possible admissions to the impatient wards. Weekly community flow meeting looked at the patient flow across directorates and issues being raised in bed management meetings.

The acute admission wards and the psychiatric intensive care unit adhered to clear operational procedures. These defined the most appropriate ward to meet the patient's needs. They also detailed the referral pathways and how decisions would be made to ensure patients received the right type of care in the right environment. Senior managers oversaw all admissions in to the wards and made final decisions regarding the allocation of beds.

Endcliffe Ward at the Longley Centre had the shortest average length of stay with 29 days. Burbage, Stanage and Maple wards all had bed occupancy rates over 100%. Maple Ward at the Longley Centre had the longest average length of stay at 48 days. This data was between 1 February 2016 and 31 July 2016. The same data also indicated 57 readmissions within 90 days of discharge from inpatient care. There were also 16 delayed discharges throughout the same period.

Ward managers showed us how the data were collected. If pressure upon admissions increased, ward managers could create additional beds. They did this by reopening 'mothballed beds' that had been decommissioned during the redesign. These beds were moved on to the four bed bays in the main wards where ordinarily only two beds were located. The trust provided the following data to demonstrate how they had managed bed pressures in the days prior to our inspection;

- Maple Ward had increased the number of beds on the ward by one bed between 7 to 13 November 2016
- Stanage Ward had increased the number of beds on their ward between 4 to 7 November 2016 and 13 to 17 November by creating one additional bed. On 15 November the ward increased by two beds for one night.
- Burbage Ward increased the number of beds on their ward between 11 to 18 November and by two beds on 17 November for one night.

Managers told us that bed occupancy above 100% related to the dates additional beds had been created on the wards in order to avoid an out of area admission occurring. Commissioners confirmed no patients were admitted to an acute ward outside of the Sheffield area in the previous two years. One patient had been admitted to an out of area psychiatric intensive care unit. This was before the trust opened Encliffe ward.

When patients went on home leave, their bed was always available for them to return to, and no one else was admitted to that bed. We case tracked five patients to understand the process of admissions and saw that it would be unusual for patients to move to other wards during the course of an admission with the exception of admission to the psychiatric intensive care unit if required. There had be no incidents in the five months that the psychiatric intensive care unit had been open, of an admission to Endcliffe ward being required but no bed being available.

Staff told us there can be pressure to use the five detox beds on Burbage ward for general admissions if there are difficulties accessing an appropriate bed. We were told on occasions these beds have provided a short term solution to enable a patient to be admitted not for detoxification.

Each ward had a discharge coordinator who was a band 6 nurse. Ward managers told us there was a direct correlation between these roles being developed and a reduction in delayed discharges on the wards. The discharge coordinator role was to work specifically with patients to ensure a smooth discharge from inpatient care. These roles were ring fenced to focus upon this work and the nurses were supernumerary to the staffing numbers on the wards. The discharge coordinators maintained close links with community services, went out to review new potential

Are services responsive to people's needs?

Good

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

supported housing options, provided one to one support to go out to visit potential discharge placements and were the ward experts in submitting referrals to complex needs panels and securing funding.

The facilities promote recovery, comfort, dignity and confidentiality

Staff expressed frustration with the environments on the acute wards. They described doing the best that they could with what they had. Staff were involved in future accommodation redesign and were hopeful that the quality of the environment would be more fit for purpose and appropriate to meet the needs of patients. There was a significant improvement in the psychiatric intensive care unit. This was purpose built and finished to a very high standard.

In the 2016 patient led assessment of the care environment (PLACE) assessment for food the Longley Centre scored 90% and the Michael Carlisle Centre 96%. These were both above the England average of 87%. Patients told us that they were happy with the quality of food.

The wards had different layouts. On Stanage ward, the accommodation was a single corridor with rooms leading directly from it. Maple and Burbage wards were of a similar traditional inpatient hospital design but had more accommodation and feelings of space. Endcliffe ward had been designed into three sectors; one non-patient area, an area where patients could be accompanied by staff such as the green room, multi faith room and interview room, and the third area being the actual ward accommodation. Each of the wards had lounge areas, a dedicated dining room, a clinic room and some rooms for therapy or supervision. The lounge areas on Burbage and Stanage were particularly small with seating for approximately 10 patients in the main lounge. Patients told us that there were multiple other areas within the ward where they could spend time, including quiet areas. They were unconcerned that there were a small number of chairs in the lounge.

All of the wards had developed a sensory room. This was a dedicated room designed to block out noise, adjust lighting and to give patients a space for reflection and mindfulness. These rooms were accessible for all patients. They were locked when not in use to ensure they maintained their integrity as a dedicated space.

Patients were able to retain their own mobile phones, unless a risk assessment indicated otherwise. Patients could use the public telephone on the ward or staff would allow access to a cordless phone.

Patients told us that the quality of food was good and there was reasonable choice.

There was unrestricted access to gardens, which were secure to protect against patients who may try to abscond. Measures had been taken by the trust to address access to the roof, as patients had previously been able to abscond by accessing the flat roof. The gardens for Stanage, Burbage and Maple wards were functional and provided an outdoor space but were not attractive. In contrast, the significantly smaller outdoor spaces that had been created on Endcliffe ward were well designed and harmonious. There were plans to improve the garden areas in the building redesigns.

Patients could personalise their rooms if they wished to and some had. However, patients were encouraged not to bring too many belongings to the ward. All of the wards had bright and informative notice boards and displays. Patients could review activities that were available as well as having access to a range of support groups and contacts from within the local community. On Stanage ward there was an electronic service user ward information board. This gave access to a range of information including the process of admission, care planning and care programme approach, confidentiality and information sharing, advice about medicine and diagnosis and detail about the concept of recovery. Patients told us they found this board useful and engaging. Monitors were in place on the other wards in readiness for the introduction of an electronic board.

Meeting the needs of all people who use the service

The wards were equipped to support people requiring wheelchairs. Patients confirmed they could access appropriate bathing and shower facilities and the main areas of the ward, including their allocated bedrooms, could accommodate their wheelchairs. The information leaflets and posters were in English. Staff assured us this reflected the demographics of the ward at that time and they could easily access the same information in a range of formats and languages if required. Staff could access interpreters and or signers through a service contracted to provide this to the trust.

Are services responsive to people's needs?

Good

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

Patients confirmed they had access to food to meet any dietary requirements including religious and ethnic groups or dietary preferences. Patients confirmed they had access to appropriate spiritual support. Michael Carlisle centre and Longley Centre had a multi faith room that was available for patients, visitors and staff. There was a dedicated multi faith room within the psychiatric intensive care unit on Endcliffe ward. This was to improve access for the patients on that ward. There was a chaplaincy and spiritual care group and there were information leaflets promoting the service and detailing how to refer. There was a team of multi-faith chaplains working within the trust.

Listening to and learning from concerns and complaints

Patients told us they could do a 'fast track' complaint. A booklet given to patients and carers on admission explained how to make complaints. Between 1 September 2015 to 25 August 2016, the acute wards and psychiatric intensive care unit received 23 complaints. Seven of these complaints were upheld. There were various reasons for the complaints including two relating to staff attitude and two relating to support provided whilst on the ward. Learning from complaints was discussed in team meetings.

Staff described how attempts would be made to resolve any concerns at the earliest opportunity. All staff would actively support patients or carers to make a formal complaint if they felt their concerns were not being addressed.

Are services well-led?

Good

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

Our findings

Vision and values

The vision for the trust was to be recognised nationally as a leading provider of high quality health and social care services and recognised as world class in terms of co-production, safety, improved outcomes, experience and social inclusion. The purpose being to improve people's health, wellbeing and social inclusion so they can live fulfilled lives in their community. The trust aimed to achieve this by providing services aligned with primary care that meet people's health and social care needs, support recovery and improve health and wellbeing.

The values of the trust were:

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

Staff were conversant with the trust visions and values. They understood the behaviours that staff should demonstrate to reinforce and support the values of the trust. The vision and values were embedded in to the staff appraisal and personal development reviews. Managers planned to base future team development days around the trust vision.

Senior managers were based within the two locations. They were well known on the wards by patients and staff. They were involved in decision making about admissions and discharges. They understood the operational pressures managing the acute wards and psychiatric intensive care unit.

Good governance

Ward managers were clear about key performance indicators for their service. They utilised the electronic dashboards and were able to interrogate the system easily and competently to access data, information and answer queries. Ward staff were used to seeing key performance data presented electronically, as ward managers did so regularly in team meetings, individual supervision and in clinical reviews. Staff were clear why certain activities were required and how these linked to the commissioning for quality and innovation (CQUINs) payments framework. They understood that certain activities were important factors in demonstrating continued service developments. An example of this was an initiative to ensure all patients on the acute wards were given a discharge booklet prior to leaving the ward.

Ward managers described implementing a range of 'checks' that key tasks were being routinely completed. These included minimum standards in compiling care plans and risk management plans, effective medicine management systems and completion of all required actions relating to detention under the Mental Health Act. These checks were routinely undertaken, feedback to the teams provided and improvements made where required.

Staff told us that they felt well supported. They said they were receiving more regular and structured supervision than had been the case in the past. Staff valued supervision and told us it focused upon them as a whole person, including their own health and well-being. The trust provided data for the 12-month period ending 31 July 2016 regarding levels of supervision. At that time the service was achieving 60%, which was below the supervision target of 80%. Data held locally demonstrated some improvements in the number receiving regular supervision. We reviewed the quality of the supervision and saw that meetings were well structured and effective. Staff accessed specialist supervision and support groups to assist them in their work. For example, staff providing family interventions were part of a trust wide group and regular formulation meetings were being held for all staff to attend.

All ward staff had a completed annual appraisal and personalised development plan. This had been a priority area for the managers. They hoped this work would ensure easier access for staff to undertake required mandatory training. We were told some of the problems completing training was because there were not enough sessions being provided and those that were, were not easy for ward staff to attend. We asked to see an example and were shown there were only two remaining dates for Mental Health Act training. Staff would be required to attend a full day session and over 50% of ward staff still required the training. Managers explained that completion of the personal development reviews had demonstrated the pressure upon the service with this particular type of training. The trust

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had taken action and a new post had been recruited to which would address the mandatory training problems associated with Mental Health Act and Mental Capacity Act training.

Each ward held regular team meetings and staff told us these were valuable for them to talk about issues and to seek support and advice from their peers. We reviewed minutes of meetings and saw they were well structured and effective. Team meetings enabled managers to provide direct feedback to their teams about a range of work and governance meetings being undertaken across the service. Representatives from the acute wards and psychiatric intensive care unit attended various meetings including medicine management, physical health, health & safety and clinical improvement meetings. Those staff then cascaded the discussions and learning to their own teams through regular business meetings. Meetings were minuted so staff could review the issues discussed and remain up to date about any required actions even if they had not attended. Managers followed policies and procedures to address performance issues.

Examples of this included the trust 'restrictive interventions practice group' This group reviewed the use of restraint, seclusion, and rapid tranquilisation across the wards. This group also provided expert opinion and guidance around restrictive practice across the wards. Managers and senior nursing staff provided feedback at the team meetings. Staff understood the aim of least restrictive interventions. When asked about strategies for de-escalation and the management of violence and aggression all staff talked of the need to utilise a range of strategies and interventions and demonstrated that restraint and seclusion were always the last resort.

The trust was taking part in a national audit 'planning and implementation of rapid tranquilisation. This was through the prescribing observatory for mental health-UK. This group aims to improve quality of prescribing within mental health services. During the course of this inspection, we saw the strategies that the trust had implemented to ensure all staff were aware of monitoring and observations required post administration of rapid tranquilisation. There had been a significant improvement in the recording of post administration observations. This was an example that demonstrated the effectiveness of the governance arrangements in place within the trust during this inspection.

There had been a review of activities available for patients within Longley Centre and Michael Carlisle centres. This had resulted in a 'therapeutic activities development group' being set up in April 2016. The group was overseeing work streams looking at increasing staff awareness of the benefit of activity during high-level observations, improving access to activities within the inpatient wards and reviewing activity recording in collaborative care plans. Patients on all of the wards told us that activities were always available, these were good and they could keep busy.

We reviewed staffing rotas and skill mixes on the wards and saw that ward managers managed staff rotas effectively. Managers responded to changes in demand and were well supported by senior managers to increase staffing levels when demand required. Both qualified and support worker staff were a visible presence within the main ward and patients told us staff were always available for one to one support and time. Staff we spoke to had a good understanding of risk, risk management, safeguarding and the core principles of the Mental Capacity Act. Ward managers were able to add relevant items to the local risk register. Staff from the service were involved in future developments of the service and would be able to influence key areas around environmental risks and ongoing quality improvements.

Leadership, morale and staff engagement

Ward managers had access to an electronic dashboard. These were used throughout the wards and were used during clinical and multi-disciplinary meetings The system displayed information from the electronic clinical record allowing attendees to view information relating patients. In addition, the system could be used to view information relating to the trust's performance indicators, as well as incidents and lessons learned.

Each of the wards held weekly meetings. There was multi-disciplinary attendance and the ward manager and a consultant psychiatrist led the meetings. There was specific focus for each of the weekly meetings so that each agenda was addressed monthly. The agenda for these meetings was clinical governance, leadership, reducing restrictive interventions and experience.

In the 2015/16 friends and family test 76% of staff were likely to recommend the Trust to friends and family if they need treatment and 67% of staff were likely to recommend

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the Trust to friends and family as a place to work. Staff told us they would know how to raise concerns and were able to do so without fear of victimisation. Staff knew they could follow a policy to guide them in the event they wished to whistleblow. Staff described a well-managed service with clear leadership. There were no concerns raised regarding bullying or harassment.

Staff told us that morale was good. They described fair and effective team managers who were supportive of the staff. Staff told us they felt listened to and that their views were valid. Ward managers told us they were well supported by senior managers. They are actively encouraged to raise issues and receive regular feedback. Staff felt valued for doing their job well. Senior managers within the organisation offered ward managers leadership coaching. They were encouraged to undertake management and leadership training and to continue to develop core skills for their role.

Ward teams were encouraged to complete a self-assessment called 'team recovery implementation plan'. Although we did not see any completed versions of these, we saw that the ward teams were being encouraged to self-evaluate their current effectiveness. Teams could implement an action plan to address any shortfalls or to continue developments.

Commitment to quality improvement and innovation

The ward staff on Endcliffe ward had been awarded 'team of the year' in September 2016 by the national association of psychiatric intensive care units. The trust participated in the work of the national association, which looks at auditing effectiveness, promoting research, education and practice development in psychiatric intensive care and low secure inpatient services.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment How the regulation was not met: There were multiple potential ligature anchor points in each of the bedrooms on Stanage, Burbage and Maple wards. On Stanage there were potential ligature anchor points due to the radiator cover in the seclusion room. The trust had rectified some ligature risks but there were still no lower-risk bedrooms available. The seclusion rooms on Burbage, Stanage, and Maple could not accommodate a bed. Staff were unable to observe patients when they were using the ensuite due to blind spots. Staff could not lock back ensuite doors and they did not open two ways. On Burbage ward the intercom required attention due to feedback noise when it was used. On Maple ward there were dignity and privacy issues due to the location of the seclusion room. This was a breach of Regulation 12(2)(d)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing How the regulation was not met: Staff had not achieved the trust target of 75% completion of mandatory training. The combined total achievement across the four wards was 51%. This was a breach of Regulation 18(2)(a)

Regulated activity	Regulation

This section is primarily information for the provider

Requirement notices

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

Diagnostic and screening procedures

Treatment of disease, disorder or injury

Regulation 17 HSCA (RA) Regulations 2014 Good governance

How the regulation was not being met:

Same sex accommodation guidance was not being complied with on Stanage or Burbage ward. There was no defined male or female bedroom area when single person bedrooms were allocated to patients.

This was a breach of Regulation 17(2)(b)

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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