Sheffield Health and Social Care NHS Foundation Trust

Mental health crisis services and health-based places of safety

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Ratings

Overall rating for this service

Are services safe?	
Are services effective?	
Are services well-led?	

Summary of findings

Mental health crisis services and health-based places of safety

Summary of this service

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

The trust has four teams that make up the crisis services and they operate one health-based place of safety, which can accommodate two people and a Psychiatric Decisions Unit which can accommodate up to 10 service users. This inspection focussed on the Psychiatric Decisions Unit based at the Longley Centre.

We carried out an unannounced focussed inspection of mental health crisis services and health-based places of safety because we took enforcement action by issuing a warning notice following our previous inspection in January 2020. We did not rate the core service at this inspection. We looked only at those areas detailed in the warning notice where we had identified significant concerns and wanted to check that the service had improved. Our inspection looked at specific areas of the safe, effective and well-led key questions.

During the inspection visit, the inspection team:

- spoke with three patients who had recently used the service
- spoke with the service operational manager
- spoke with five other staff members including nurses and support workers
- reviewed the risk management plans of four patients who had recently used the service
- looked at a range of policies, procedures and other documents relating to the running of the service.

We found:

- The trust had addressed the safety concerns identified in the warning notice issued following the last inspection by making improvements to the physical environment of the Psychiatric Decisions Unit, implementing processes to keep young people safe, and ensuring staff completed their mandatory training.
- The trust now ensured staff received an annual appraisal and regular ongoing supervision.
- Our findings from the other key questions demonstrated that governance processes had improved and operated effectively at team level to manage performance and risk well.

However:

- There was low compliance with some mandatory training courses due to the impact of the COVID-19 pandemic.

Is the service safe?

We did not re-rate the service at this inspection. We looked only at those areas of significant concerns raised in the warning notice following our previous inspection to ensure the trust had taken action to make improvements.

We found there had been improvements:

Summary of findings

- The trust had addressed concerns identified in the previous inspection in relation to the environment in the psychiatric decisions unit.
- The trust ensured children and young people were safe by preventing their admission to the Psychiatric Decisions Unit.
- The trust had implemented additional processes to ensure patients' privacy and dignity, and sexual safety in mixed-sex accommodation.
- The service now had enough staff who received basic training to keep patients safe from avoidable harm.

However:

- Mandatory training courses which required staff to attend for training in person had been cancelled due to the COVID-19 pandemic which meant that the service did not have enough staff who had completed this training.

Is the service effective?

We did not re-rate the service at this inspection. We looked only at those areas of significant concerns raised in the warning notice following our previous inspection.

We found there had been improvements:

- Managers ensured staff received an annual appraisal and regular ongoing supervision.

Is the service well-led?

We did not re-rate the service at this inspection. We looked only at those areas of significant concerns raised in the warning notice following our previous inspection.

We found there had been improvements:

- Our findings from the other key questions demonstrated that governance processes had improved and now operate effectively at team level to manage performance and risk well.
- Leaders had ensured there were systems and processes in place to assess and monitor the quality of care and how it was delivered.

Detailed findings from this inspection

Is the service safe?

Safe and clean environment

The trust had addressed concerns identified in the previous inspection in relation to the environment in the psychiatric decisions unit. Patients told us they felt safe in the unit. All clinical premises where patients received care were now safe, clean, well equipped, well furnished, well maintained and fit for purpose. The trust had made changes the physical environment of the psychiatric decisions unit, this meant that the unit met the requirements of Department of Health guidance which seeks to eliminate the use of mixed sex accommodation.

Our previous inspection found that patients' privacy and dignity was not always accounted for in the unit. The shared communal areas contained four reclining chairs. We were concerned that patients' length of stay showed that these communal areas were used as sleeping areas. Patients had no method of separating themselves from others to maintain safety, privacy and dignity. There were no blinds or curtains to cover the glass panel doors that led to the lounge and bedroom areas. The location of the male lounge meant that male patients had to walk past the female lounge to get to the male toilet.

This inspection found that improvements had been made. Whilst communal areas were still used as sleeping areas and average length of stay showed that patients regularly slept on the unit, the trust had installed privacy curtains between chairs to maintain privacy and dignity. The trust had installed translucent glass screens into the panel doors which led into the lounge and bedroom areas to ensure patients' privacy and dignity.

The service had implemented a triage process which considered a patients' individual risks and presentation prior to their admission. This included a consideration of the risks posed by an admission to a mixed gender unit. However, the location of the male lounge meant that male patients still had to walk past the female lounge to get to the male toilet.

Safe staffing

The service now had enough staff who received basic training to keep patients safe from avoidable harm. Patients told us there were enough staff to meet their needs.

Staff told us that the service had been forced to close due to the impact of the COVID-19 pandemic which had resulted in staff having to redeploy to support the trust's acute mental health wards. Staff told us the service was now relying on one team to staff both the Psychiatric Decisions Unit and the health-based place of safety which reduced the amount of staff available on the unit, however most staff told us that they felt there were enough staff on the unit to keep patients safe.

Our previous inspection found low compliance with mandatory training in several key areas including clinical risk assessment, fire safety, information governance, respect levels one and two, Deprivation of Liberty Safeguards, Mental Health Act and manual handling.

As of 23 August 2020, overall compliance in mandatory training was 96%. Staff told us that they were able to monitor their individual compliance with mandatory training via an electronic system. All modules with previously identified low levels of compliance had improved with the exception of modules listed below:

- immediate life support – 38%
- rapid tranquilisation – 60%
- respect level two – 75%
- moving and handling level two – 57%
- community Mental Health Act – 11%

Detailed findings from this inspection

Managers told us that the service had ensured staff had time to complete mandatory training where courses were delivered via e-learning. The service was co-located with other services at the Longley Centre which allowed staff to access additional support in emergency situations. The service did not use restraint or rapid tranquilisation. Modules with low compliance were due to staff needing to attend courses in person which had been cancelled as a result of the COVID-19 pandemic. By August 2020, the trust restarted several courses requiring face to face training including moving and handling, immediate life support, and respect training.

Safeguarding

The trust had addressed our previously identified concerns in relation to safeguarding children and young people. Staff now 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.

Our previous inspection found that the service put young people at risk of harm by admitted young people to the psychiatric decisions unit without the required procedures and risk assessments in place to provide safe, private and dignified care and treatment in this unit.

Following the last inspection, the trust stopped admitting young people to the psychiatric decisions unit. The trust confirmed that no young people were admitted to the psychiatric decisions unit since the last inspection. Following the last inspection, the trust had worked with partner organisations to ensure that young people were directed to services which were more able to meet their needs safely. Managers had updated the service's standard operating procedure to reflect that the unit no longer accepted referrals for patients under 18 years old.

Is the service effective?

Skilled staff to deliver care

The trust had addressed previously identified concerns in relation to staff supervision and appraisal. Our previous inspection found that staff working in the service did not receive regular clinical supervision and appraisal rates were lower than the trust's target.

Managers made sure that staff had a range of skills needed to provide high quality care. They now supported staff with appraisals, supervision and opportunities to update and further develop their skills.

This inspection found that staff now received regular supervision. From July 2020, the trust had increased the number of supervision sessions managers were required to complete with staff from four sessions per year to eight sessions per year. Data provided by the trust showed that prior to the increase in number of sessions, staff had received regular supervision in line with the trust's policy. Following the increase in the number of sessions needed, staff continued to receive supervision, however it was too soon after the change in policy to assess whether the service would achieve the increased number of sessions over the year. Staff told us that they could access regular supervision and additional supervision when needed. The appraisal rate had improved to 97%.

Is the service well-led?

Culture

All 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.

Detailed findings from this inspection

Good governance

Our findings from the other key questions demonstrated that governance processes had improved and now operated effectively at team level to manage performance and risk well. Leaders had ensured there were systems and processes in place to assess and monitor the quality of care and how it was delivered.

Managers had ensured that staff undertake regular supervision sessions and appraisals. Compliance rates for mandatory training had improved, and managers were aware there were still specific courses with low levels of compliance. The trust had wider plans to address low areas of compliance with mandatory training courses which needed staff to physically attend for training and had been cancelled due to the COVID-19 pandemic.

Managers had implemented processes to safeguard and manage the risk to young people in the Psychiatric Decisions Unit.

Managers had addressed concerns relating to the layout of the Psychiatric Decisions Unit and the impact these had on patients' privacy and dignity.

Areas for improvement

Action the provider SHOULD take to improve

- The trust should ensure that staff complete their mandatory training.

Our inspection team

Our inspection team comprised two CQC inspectors.