Good

# Sheffield Health and Social Care NHS Foundation Trust

# Health-based places of safety

## Quality Report

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## Locations inspected

| Name of CQC registered location | Location ID | Name of service (e.g. ward/ unit/team) | Postcode of service (ward/ unit/ team) |
|---|---|---|---|
| The Longley Centre | TAHCC | Section 136 Suite, The Longley Centre | 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.

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 health-based places of safety | Good |
| Are health-based places of safety safe? | Requires Improvement |
| Are health-based places of safety effective? | Good |
| Are health-based places of safety caring? | Good |
| Are health-based places of safety responsive? | Good |
| Are health-based places of safety 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

## Contents

# Summary of findings

## Overall summary

We found that the health based places of safety (HBPoS) were not effective in providing safe care and treatment. In particular, the environment of the HBPoS did not meet current standards, according to regulations around the safety and suitability of premises and guidance on good practice published by the Royal College of Psychiatrists (RCP). This put people who used the service and others at risk. We also observed that staff did not always observe people closely enough while in the shared communal areas.

We found the health based place of safety was staffed using staff from the adjacent Maple Ward. From April 2013 to April 2014 there had been 27 occasions where the HBPoS had not been open due to not having sufficient staff to maintain the safety of the 136 suite and the patients on the Maple Ward.

We reviewed five care records; we could see the health based places of safety involved people in the care they received.

As the 136 suite was too small people often used the facilities on the ward for assessment. This meant that the privacy and dignity was compromised for both patients being assessed and using the main ward.

The trust staff were committed to quality improvement and innovation and that effective leadership, morale and staff engagement were in place.

There were good governance systems in place and staff understood and followed the trust's vision and values. There were however issues around monitoring the management of quality and performance data. The ward manager from Maple had recently implemented a series of monitoring and quality assurance tools but there was no system in place to support obtaining feedback from patients who had been detained under Section 136.

The recording and documentation for the 136 module is paper based. This meant there was a number of challenges associated with accessing patient information and meeting the national data requirements.

# Summary of findings

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

### Are services safe?

We rated the health based place of safety as **'REQUIRES IMPROVEMENT'** because:

- The section 136 suite at The Longley Centre did not provide a safe and a suitable environment for the assessment of patients detained under section 136 of the Mental Health Act 1983.
- A lack of adequate staffing has led to the section 136 suite being closed on 47 occasions between January 2013 and September 2014. In the three month July to September 2014 the suite was closed on seven occasions
- People are on occasions left alone in the 136 suite due to staffing demands on Maple ward.
- The section 136 suite facilities are cramped and often people being assessed had to use facilities on the main ward due to disturbing patients using the adjacent bedroom.

### Are services effective?

We rated the health based places of safety as **'GOOD'** because:

- People were given physical health checks on arrival to section 136 suites to ensure that any problems were followed up appropriately.
- Stakeholders described good working relationships around the use of section 136.
- People being assessed under section 136 suite were told about the powers and responsibilities under section 136. To ensure they understand what was happening to them, what the process was and an explanation of their rights.
- There were different practices in place should a younger person need to be assessed.

### Are services caring?

We rated the health based places of safety as **'GOOD'** because:

- Staff provided a range of flexible support to people dependent upon their needs. This included building relationship with the individual to allow the police to leave the suite.
- Patients' rights whilst detained were routinely explained to people. This information was available in different formats. Interpreting and advocacy services were also available if necessary
- The records reviewed were complete and demonstrated a person centred and holistic approach.

# Summary of findings

However there is currently no formal mechanism to obtain feedback from people detained under Section 136.

**Are services responsive to people's needs?**

We rated the health based places of safety as **'GOOD'** because:

- Between July and Sept 2014 the average time spent in the 136 suite was 4 hours 55 minutes. The longest a person was detained was 21 hours 10 minutes.
- The section 136 suite does not provide a service for people with a learning disability or people less than 16 years of age.
- Once the assessment has been completed if a person does not require admission they are sent home in a taxi with clear advice or after care plans in place.
- There was a joint agency policy in agreed by South Yorkshire Police (Sheffield Policing District), Sheffield Health and Social Care Trust, Sheffield Teaching Hospital and Yorkshire Ambulance Service.
- During 2013 and 14 there had been no complaints received from people detained under Section 136.

However there is only one section136 hospital bed for the city of Sheffield. Between January and September 2014 when it was required the suite was not available on 31 occasions. In the three month July to September 2014 the suite was not available on nine occasions.

**Are services well-led?**

We rated the health based places of safety as **'GOOD'** because:

- There was a joint agency policy in place for the implementation of section 136 of the Mental Health Act.
- Following problems with capacity a further qualified nurse and two unqualified staff were added to the staff team to provide the basement in the section 136 suite as required.
- Staff were aware of the trust vision and strategy and the joint agency policy for the implementation of section 136 policy.
- The trust measured the number of times that people were brought into the section 136 suite and their outcomes comparing this against the providers.
- There was partnership working with the other agencies who have signed up to the joint agency policy for the implementation of section 136.
- The use of section 136 in Sheffield is overseen by a monitoring group that meets on a quarterly basis.

# Summary of findings

## Background to the service

The health-based place of safety (HBPoS) is a unit where people arrested under section 136 by the police are taken for an assessment of their mental health for their safety.

If a constable finds in place to which the public have access a person who appears to be suffering from mental disorder and to be in immediate need of care or control, the constable may, if necessary to do so in the interests of that person or for the protection of other persons, remove that person to a place of safety. (s136 (1) MHA)

A person removed to a place of safety under this section may be detained there for a period of not exceeding 72 hours for the purpose of enabling them to be examined by a registered medical practitioner and to be interviewed by an approved mental health practitioner and of making any necessary arrangements for their treatment or care. (s126 (2) MHA)

A "place of safety" is defined in section 135(6) Mental Health Act 1983 as "residential accommodation provided by a local social services authority under Part 111 of the National Assistance Act 1948; a hospital as defined by the Mental Health Act, a police station, an independent hospital or care home for mentally disordered persons or any other suitable place the occupier of which is willing temporarily to receive a patient."

The HBPoS is based at The Longley Centre in Sheffield where it is a suite on Maple Ward. It is a 24 hour, 7 day a week service, open 365 days per year. The purpose built suite consists of two rooms which has its own designated entry and exit point. Maple ward has one band 5 nurse and two band 2 support workers in addition to the ward staffing levels allocated to work in the 136 suite as required.

## Our inspection team

Our inspection team was led by:

**Chair:** Dr Alison Rose-Quirie Chief Executive Officer, Swanton Care and Community Ltd

**Team Leader:** Graham Hinchcliffe, Care Quality Commission

**Head of Inspection:** Nicholas Smith, Care Quality Commission

The team included a CQC inspector, a Mental Health Act reviewer and a specialist social worker who was also an AMPH.

## Why we carried out this inspection

We inspected this core service as part of our on-going comprehensive mental health inspection programme.

## How we carried out this inspection

Prior to the inspection we reviewed a range of information we held about health based places of safety and asked other organisations to share what they knew. We carried out an announced visit on 28 October 2014 to the health based places of safety, at Maple Ward, The Longley Centre in Sheffield.

During the visits we spoke with 3 members of staff including ward manager, deputy ward manager and senior nurse. We reviewed care or treatment records of 5 people who used the services.

To get to the heart of people who use services' experience of care, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?

# Summary of findings

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

## What people who use the provider's services say

The section 136 suite was not being used during our visit so we were not able to speak with people directly that had used the section 136 suite during this inspection.

## Good practice

Despite the limitations of the staffing and challenges faced by the Maple Ward team to provide the health based place of safety they had set themselves informal objectives to work with the police to improve the service being delivered. This is being managed through the governance meeting structure, the Joint Liaison Group which included stakeholders from the police and ambulance service.

## Areas for improvement

**Action the provider MUST or SHOULD take to improve**

**Action the provider MUST take to improve**

- The provider must ensure that the appropriate number of suitably skilled staff are available to deliver the service within the health based place of safety.
- The provider must review the environment allocated to the 136 suite to ensure that the health based place of safety is safe and fit for purpose. The planned refurbishment must ensure that the area use for health based place of safety is safe and fit for purpose
- The provider must ensure that patient's privacy and dignity is maintained while they are using the health based place of safety.

**Action the provider SHOULD take to improve**

- The provider should ensure that a system is implemented to support the monitoring of quality and assurance using feedback from patients who have been detained under Section 136.
- The provider should with the police ensure that there is a process for managing people who are intoxicated to ensure they are managed in the most appropriate environment for their needs.

Sheffield Health and Social Care NHS Foundation Trust

# Health-based places of safety

**Detailed findings**

## Locations inspected

| Name of service (e.g. ward/unit/team) | Name of CQC registered location |
|---|---|
| Section 136 Suite | The Longley 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.**

## Mental Capacity Act and Deprivation of Liberty Safeguards

Staff we spoke with were aware of the statutory requirements of the Mental Capacity Act.

We saw that capacity was recorded in people's care plans within the holistic assessment however there was no evidence of recording the steps that had been taken to assess capacity, only a tick box within the assessment which would be completed when initially completing the assessment. There was no evidence that mental capacity was being recorded on an on-going basis or effectively assessed.

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

## Summary of findings

We rated the health based place of safety as **'REQUIRES IMPROVEMENT'** because:

- The section 136 suite at The Longley Centre did not provide a safe and a suitable environment for the assessment of patients detained under section 136 of the Mental Health Act 1983.
- A lack of adequate staffing has led to the section 136 suite being closed on 47 occasions between January 2013 and September 2014. In the three month July to September 2014 the suite was closed on seven occasions
- People are on occasions left alone in the 136 suite due to staffing demands on Maple ward.
- The section 136 suite facilities are cramped and often people being assessed had to use facilities on the main ward due to disturbing patients using the adjacent bedroom.

## Our findings

### Safe and clean ward environment

The section 136 suite at The Longley Centre did not provide a safe and a suitable environment for the assessment of patients detained under section 136 of the Mental Health Act 1983.

Emergency equipment, including automated external defibrillators and oxygen, was in place and checked regularly to ensure it was fit for purpose and could be used effectively in an emergency. Medical devices and emergency medication were also checked regularly. Most staff had undertaken training in life support techniques.

The 136 suite consists of a separate entrance leading to a small waiting area. There is an assessment room with a pull down bed if required. Adjacent to this is a toilet. This area is small and barren looking.

The staff we spoke with told us that due to the size of the room section 136 patients who are being assessed are often taken onto the main part of the ward and use a meeting room as this offers more space and a more comfortable environment. As the 136 suite is adjacent to a patient bedroom, often at night the main ward is used as the noise in the suite disturbed the patient using the adjacent bedroom.

The 136 suite layout enabled staff to observe all areas at all times. However these rooms where cramped and unsafe. Due to these conditions staff regularly took section 136 patients onto the ward to undertake interview and assessments. People awaiting assessment were on occasions left alone in the 136 suite.

The service is a single person service with self-contained bathroom and toilet facilities.

An assessment of potential ligature risks had been completed. The ligature risk assessments did not identify any high or medium level ligature risks which required action to be taken. People in the 136 suite do not have unsupervised access to rooms with ligature points.

The suite was clean and well maintained all of the furniture was in good condition and well maintained.

There had been no serious incidents since the section 136 suite had been opened.

There was an alarm available in the suite to summon additional staff if required. Staff said that when the alarm was used staff responded very quickly.

### Safe staffing

The trust had carried out a review of staffing of the section 136 suite. Following this review additional staff had been added to the Maple team to ensure that when required the 136 suite could be staffed without delay. However between January 2013 and September 2014 the suite was not available due to staff shortages on 47 occasions. This meant that on these occasions patients were taken to other places of safety for assessment including police custody. These closures are more frequent during the hours of a night shift.

We were told that due to the levels of staff available there were occasions when patients being assessed are left without staff being present. We were told that this only happens after a risk assessment has been completed. Due to the time people are in the 136 suite and the lack of

Requires improvement

# Are services safe?

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

information accompanying them (there is no access to the electronic notes system in the 136 suite) we are concern about the quality of any risk assessment completed to identify that they are safe to be left without staff support.

We saw that all staff who worked in the 136 suite had been trained in the use of physical interventions.

Medical staff told us that there was adequate medical staff available day and night to attend the ward to undertake assessments.

**Assessing and managing risk to patients and staff**

The designated nurse would receive the detained patient and a process was in place for an adult mental health practitioner to be contacted regarding the assessment. At the section 136 suite, a joint risk assessment by staff from Maple ward and the police was completed for all people admitted. Throughout the detention period effective systems was in place to assess and monitor risks to individual patients to determine whether the police officer will be required to remain at the place of safety to provide support.

The section 136 suite was not in use during our visit so we were not able to speak to people who were being assessed.

Due to the purpose of the section 136 suite there was completed mental and physical health assessments in all five of the records that we reviewed. These included risk profiles completed with the police.

When risk assessments had been conducted for patients and the risks were assessed as too high the police would either stay in the suite or the individual would be transferred to the police custody suite.

The checklist for section 136 assessments recorded all handover information and included details of any risks.

Staff had received training in safeguarding vulnerable adults. Staff we spoke with knew how to recognise a safeguarding concern. Staff were aware of the trust's safeguarding policy. They knew how to raise safeguarding concerns.

Should an individual require medication whilst in the section 136 suite these were provided from Maple ward.

**Reporting incidents and learning from when things go wrong**

A regular quarterly multi-agency meeting was well established to oversee the operation of the section 136 suite and discuss learning from any incidents.

Staff we spoke with knew how to recognise and report incidents on the trust's electronic incident recording system. All incidents were reviewed by the ward manager and forwarded to the clinical governance team for the trust who maintained oversight. The system ensured senior managers within the trust were alerted to incidents promptly and could monitor the investigation and response to these.

Staff and people using the service were provided with support and time to talk about the impact of serious incidents on the ward. This was especially apparent following the deaths of patients on two wards.

# 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.

## Summary of findings

We rated the health based places of safety as **'GOOD'** because:

- People were given physical health checks on arrival to section 136 suites to ensure that any problems were followed up appropriately.
- Stakeholders described good working relationships around the use of section 136.
- People being assessed under section 136 suite was told about the powers and responsibilities under section 136. To ensure they understand what was happening to them, what the process is and an explanation of their rights.
- There were different practices in place should a younger people need to be assessed.

## Our findings

**Assessment of needs and planning of care**

A clear assessment and physical health check was undertaken on arrival to section 136 suites and any ongoing physical health problems were followed up appropriately.

All staff we interviewed described good working relationships between partner agencies as did the **approved mental health professional** (AMHP) manager who felt that staff working in the section 136 suite were effective and efficient at making referrals and communicating information.

**Best practice in treatment and care**

People who were being assessed in the section 136 suite were provided with an information pack explaining the powers and responsibilities under section 136. This ensures that people understand where they are, what is happening to them and what the process is and an explanation of their rights.

The trust had a separate policy and procedure for younger people aged 16 to 18 years admission and liaison with the CAMHS service. Children aged 15 and younger where taken to another service provision outside of this trust.

The trust currently has identified funding to deliver street triage. Street triage sees mental health nurses accompany officers to incidents where police believe people need immediate mental health support. The means that people get the medical attention they need as quickly as possible. Diverting them from people custody or 136 assessments.

The triage team a level 6 mental health nurse and a police officer work from 4pm to midnight. The team deal with between 3 and 4 incidents a day.

In a ten week period between May and July 2014 the street triage team saw 107 people only 5 of these were detained under section 136 and taken to a place of safety.

An evaluation completed by a senior **approved mental health professional (**AMPH) in the Sheffield out of hours team identified that when street triage is not operational the main access points into the services get blocked quite quickly.

**Skilled staff to deliver care**

Qualified staff undertook the co-ordination of admissions to the section 136 suites, operating as the section 136 coordinator. There was guidance available to staff that included a checklist of action to be completed.

**Multi-disciplinary and inter-agency team work**

There was a joint agency policy in place for the implementation of section 136 of the Mental Health Act. This policy and procedure has been jointly agreed by South Yorkshire Police (Sheffield Policing District), Sheffield Health and Social Care Trust, Sheffield Teaching Hospital and Yorkshire Ambulance Service.

Links with the police in the operation of section 136 was good. Good joint working relationships were in place at both a strategic and operational level and attendance at the quarterly monitoring meetings was good with representatives from a variety of agencies present.

There were some concerns about the police support when patients were clearly intoxicated. The trust staff felt that the police often brought people to the suite who were clearly intoxicated this happened without contact with the unit before arrival and then would not take them away when they were refused admission. The trust staff were not clear what screening the police applied before bringing

# 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.

intoxicated people to the 136 suite. Between April and September 2014 the police were required on 56 occasions to take a person being assessed to the police custody due to them being intoxicated.

Good

# Are services caring?

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

## Summary of findings

We rated the health based places of safety as **'GOOD'** because:

- Staff provided a range of flexible support to people dependent upon their needs. This included building relationship with the individual to allow the police to leave the suite.
- Patients' rights whilst detained were routinely explained to people. This information was available in different formats. Interpreting and advocacy services were also available if necessary
- The records reviewed were complete and demonstrated a person centred and holistic approach.

However there was currently no formal mechanism to obtain feedback from people detained under Section 136.

## Our findings

**Emotional Support**

There was an information pack available for people when they came into the section 136 suite. Nursing staff were present at all times to offer support, care and treatment to people being assessed in the 136 suite. If an individual requires support from the medical team this is provided by the Maple ward medical staff.

There was guidance and a checklist available for staff to assist with the management of people in the section 136 suite. This is to ensure they receive the appropriate support during the period of assessment. This had been completed fully on all five of the records that we reviewed.

Patients' rights whilst detained were routinely explained to people.

**Kindness, dignity, respect and support**

We Interviewed three staff who would work in the section 136 suite if required. They explained how they managed and supported the people being assessed in what were often confusing and distressing circumstances.

The staff explained how they attempted to begin the relationship with individuals in a timely way following their transfer to the suite. This ensured the police could be released and often meant that the individual would become less anxious.

**The involvement of people in the care they receive**

Staff provided a range of flexible support to people dependent upon their needs.

Staff we spoke with were able to describe specific interventions they used to assist people with managing their distress such as anxiety management, alcohol withdrawal, psychological interventions and relapse prevention work.

Patients' rights whilst detained were routinely explained to people. There was access to information in different accessible formats. Interpreting and advocacy services were also available if necessary

The five records we reviewed were complete and demonstrated a person centred and holistic approach. The records are currently paper based as external agencies are not able to input their records onto the electronic notes. The trust has identified that this poses challenges when it comes to being able to meet national data requirements.

There was currently no formal mechanism to obtain feedback from people detained under Section 136.

Good

# Are services responsive to people's needs?

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

## Summary of findings

We rated the health based places of safety as **'GOOD'** because:

- Between July and Sept 2014 the average time spent in the 136 suite was 4 hours 55 minutes. The longest a person was detained was 21 hours 10 minutes.
- The section 136 suite does not provide a service for people with a learning disability or people less than 16 years of age.
- Once the assessment has been completed if a person does not require admission they are sent home in a taxi with clear advice or after care plans in place.
- There was a joint agency policy in agreed by South Yorkshire Police (Sheffield Policing District), Sheffield Health and Social Care Trust, Sheffield Teaching Hospital and Yorkshire Ambulance Service.
- During 2013 and 14 there had been no complaints received from people detained under Section 136.

However there is only one section136 hospital bed for the city of Sheffield. Between January and September 2014 when it was required the suite was not available on 31 occasions. In the three month July to September 2014 the suite was not available on nine occasions.

## Our findings

**Access, discharge and bed management**

The Maple ward section 136 suite serves the city of Sheffield. It can only accept one person for assessment at a time. On occasions there has not been enough staff available. On ten occasions in this period the section136 suite was not available for use as it was already in use. The suite was not available on a further 21 occasions at it was closed due to a lack of staff. The 136 suite has also been used on one occasion as an admission bed for a patient who required inpatient treatment on Maple ward. This means that there were occasions when individuals were assessed in places that many not have been appropriate to their needs, for example police custody suites and the emergency department of the acute hospital.

During the period between January and September 2014:

- There were 154 detentions under section 136.
- Sixty six of these patients were converted into admission in to hospital.
- Eighty-eight people were discharged home.
- Maple ward was used on 122 occasions for the assessment of these people.
- Four of these people were under 18 years of age.

In the three months between July and Sept 2014 the 136 was used 45 times. In this period 45 males and 20 females were assessed. Eighteen of the assessments led to admission into hospital, five admissions were informal. The range of time spent in the 136 suite was from 45 minutes to 21 hours 10 minutes. The average time spent in the 136 suite was 4 hours 55 minutes.

Nine people had to wait over eight hours to complete their assessment. Each of these individuals was detained after 6pm.

The trust submitted data for the CQC place of survey in February 2014. As a result of this the trust identified that there were gaps in the data required. Action has been taken to address this.

The staff on the unit stated that there were frequently delays in **approved mental health professional** (AMHP) attending to complete their part of the assessment when people are found to require detention under the Mental Health Act, these delays are more frequent during normal office hours and are often 12-16 hours. Staff told us that there were problems with the accessing the AMHP during normal office hours. However this is not demonstrated by the data provided by the trust that shows only one of nine people who waited for an assessment was admitted during normal office hours.

The section 136 suite does not provide a service for people with a learning disability during office hours the local learning disability team would be contacted. On occasions out of hours people with a learning disability have stayed in the suite until the following day when the learning disability team are contacted.

There were no issues with section 12 approved doctors attending to complete their assessment. This part of the process was reported to be working very well.

Once the assessment has been completed if a person does not require admission they are sent home in a taxi with clear advice or after care plans in place.

Good

# Are services responsive to people's needs?

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

**The environment optimises recovery, comfort and dignity**

The 136 suite consists of a separate entrance leading to a small waiting area. There is an assessment room with a pull down bed if required. Adjacent to this is a toilet. This area is small and barren looking. There is no clock or television in the suite.

**Policies and procedures minimise restrictions**

There was a joint agency policy in place for the implementation of section 136 of the Mental Health Act. This policy and procedure has been jointly agreed by South Yorkshire Police (Sheffield

Policing District), Sheffield Health and Social Care Trust, Sheffield Teaching Hospital and

Yorkshire Ambulance Service.

We found that the trust had completed all assessment with the 72 hours required by the code of practice.

The trust were aware of the likelihood of there being more than one person requiring the facility at any given time and in the period November 2013 to September 2014 there were 11 people who could not be assessed in the 136 suite as it was already in use. Where a second 136 assessment was required the individual would be conveyed to another place of safety, this would mean the individual was taken to a police custody suite or the acute trust emergency department.

**Meeting the needs of all people who use the service**

The joint agency policy explains how the needs of people detained on section 136 will be managed and the appropriateness of the relevant places of safety. This include when the acute services, police custody are more appropriate than the service at Maple ward.

Staff told and we could see from the duty rota and staff allocations that staff are allocated to the section 136 suite to complete support people whilst the assessment process is being completed.

When a young person aged 16 to 18 years is admitted to the 136 the trust policy for admitting young people will also be followed to ensure that additional safeguards are in place.

Children aged less than 16 years are not admitted to the service as there are separate facilities within the Sheffield Children's Hospital to meet their needs.

All people admitted to the 136 suite were given information explaining their rights whilst detained under section 136. There was also access to interpreters should this be required available.

Staff working in the section 136 suite had all completed their required and mandatory training. There was no additional training provided formally but the staff on Maple ward support each other to ensure that they have sufficient knowledge to work in the 136 suite.

Information explaining the powers and responsibilities under section 136 were provided to all people detained in the 136 suite for assessment under the Mental Health Act.

**Listening to and learning from concerns and complaints**

Information about raising concerns and complaints was available to people who were assessed in these units.

During 2013 and 2014 there had been no complaints received from people detained under Section 136.

The trust does not have a method of gathering feedback from people detained under Section 136.

# 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.

## Summary of findings

We rated the health based places of safety as **'GOOD'** because:

- There was a joint agency policy in place for the implementation of section 136 of the Mental Health Act.
- Following problems with capacity a further qualified nurse and two unqualified staff were added to the staff team to provide the basement in the section 136 suite as required.
- Staff were aware of the trust vision and strategy and the joint agency policy for the implementation of section 136 policy.
- The trust measured the number of times that people were brought into the section 136 suite and their outcomes comparing this against other providers.
- There was partnership working with the other agencies who had signed up to the joint agency policy for the implementation of section 136.
- The use of section 136 in Sheffield is overseen by a monitoring group that meets on a quarterly basis.

## Our findings

There was a joint agency policy in place for the implementation of section 136 of the Mental Health Act. This policy and procedure has been jointly agreed by South Yorkshire Police (Sheffield Policing District), Sheffield Health and Social Care Trust, Sheffield Teaching Hospital and Yorkshire Ambulance Service.

In this policy the duties of all agencies are identified and set out to ensure that people receive timely and effective assessment.

**Vision and values**

Staff we met with told us that senior trust managers had recently visited the section 136 suite.

Staff that we spoke with during the inspection were aware of the trust vision and strategy and the joint agency policy for the implementation of section 136 policy.

Following problems with capacity a further qualified nurse and two unqualified staff were added to the staff team to provide the basement in the section 136 suite as required. However between January 2013 and September 2014 the suite was not available due to staff shortages on 47 occasions. This meant that on these occasions patient were taken to other places of safety for assessment including police custody. These closures are more frequent during the hours of a night shift.

**Good governance**

Clear clinical governance arrangements were in place. These measured the number of times that people were brought into the section 136 suite and outcomes for people following assessment. The trust compared this data against the other local providers of assessment under section 136 of the Mental Health Act.

**Leadership, morale and staff engagement**

Evidence was seen of partnership working with the other agencies who have signed up to the joint agency policy for the implementation of section 136. These partners included South Yorkshire Police (Sheffield Policing District), Sheffield Health and Social Care Trust, Sheffield Teaching Hospital, Yorkshire Ambulance Service and the local authority **approved mental health professional** (AMHP) service.

**Commitment to quality improvement and innovation**

The place of safety service in Sheffield is overseen by a monitoring group that meets on a quarterly basis. This group is chaired by the service director and both ward and community staff attended together with the South Yorkshire Police.

There is a joint liaison group which is chaired by the service director and all key stake holders are invited to attend including the South Yorkshire Police, the Sheffield Teaching Hospital and Yorkshire Ambulance service,

There is also a monthly meeting with trust staff (both ward staff and a senior manager) and the police. This meeting aims are deal with any important issues that may have arisen with delivery against the joint agency policy for the implementation of section 136.

# 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<br>Treatment of disease, disorder or injury | Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment<br>How the regulation was not being met:<br>The section 136 suite did not provide suitable facilities and premises for the services being delivered.<br>We found that the registered person had not protected people against the risk associated with unsafe premises.<br>This was in breach of regulation 12(2)(d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. |

| Regulated activity | Regulation |
|---|---|
| Assessment or medical treatment for persons detained under the Mental Health Act 1983<br>Treatment of disease, disorder or injury | Regulation 18 HSCA (RA) Regulations 2014 Staffing<br>How the regulation was not being met:<br>Patients were not safeguarded because the provider did not take appropriate steps to ensure that there were sufficient numbers of qualified, skilled and experienced staff employed at all times to provider a section 136 assessment service.<br>This was in breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. |