BOARD OF DIRECTORS MEETING (Open)

Date: 11 July 2018 **Item Ref:** 12:

TITLE OF PAPER	**Eliminating Mixed Sex Accommodation (EMSA) Acute Wards**
TO BE PRESENTED BY	Clive Clarke, Deputy Chief Executive
ACTION REQUIRED	Collective Decision

OUTCOME	To explain ▫ the complexities and risks associated with pursuing the plan agreed in 2017 to move both Burbage and Stanage to single sex wards ▫ the current operational context and options available ▫ the recommendation proposed by Clinical Operations
TIMETABLE FOR DECISION	July 2018 Board Meeting
LINKS TO OTHER KEY REPORTS / DECISIONS	Department of Health (DoH) Guidance outlined in the NHS Operating Framework 2010/11 and 2012/13 Mental Health Act Code of Practice 2015 (CoP)
STRATEGIC AIM STRATEGIC OBJECTIVE BAF RISK NUMBER & DESCRIPTION	1.2 Deliver Safe Care At All Times
LINKS TO NHS CONSTITUTION & OTHER RELEVANT FRAMEWORKS, RISK, OUTCOMES ETC	To be included in Board Assurance Framework (BAF). Equality, Principles and Values
IMPLICATIONS FOR SERVICE DELIVERY AND FINANCIAL IMPACT	Failure to comply may result in requirement of additional staffing resource to mitigate the associated risks. Failure to comply with the required standards may lead to compliance/enforcement action by the Care Quality Commission (CQC) and fines imposed by the CCG.
CONSIDERATION OF LEGAL ISSUES	Failure to comply may lead to fines and compliance/enforcement action by the Care Quality Commission (CQC)

Authors of Report	Lisa Johnson, Deputy Associate Director, Deborah Horne, Associate Director, Michelle Fearon, Director Operations and Transformation, Christopher Wood Associate Clinical Director and Alison Shore, Senior Project Officer
Date of Report	26th June 2018

SUMMARY REPORT

Report to: **BOARD OF DIRECTORS**

Date: **11th July 2018**

Subject: **Eliminating Mixed Sex Accommodation (EMSA) Acute Wards**

From: **Clive Clarke, Deputy Chief Executive**

Authors: **Lisa Johnson, Deputy Associate Director**
Deborah Horne, Associate Director
Michelle Fearon, Director Operations and Transformation
Christopher Wood Associate Clinical Director
Alison Shore, Senior Project Officer

1. Purpose

To explain

- the complexities and risks associated with pursuing the plan agreed in 2017 to move both Burbage and Stanage to single sex wards
- the current operational context and options available
- the recommendation proposed by Clinical Operations

For Approval	*For a collective decision*	*To report progress*	*To seek input from*	*For information*	*Other (please state below)*
	✓				

2. Summary

In 2016 the CQC identified 3 wards as not meeting EMSA requirements and hence issued a MUST compliance notice. These wards were the older adult ward (Dovedale) and both acute wards on (Stanage and Burbage) at the Michael Carlisle Centre. The EMSA concerns related to the bedrooms not being grouped by gender.

As a result in 2017 a plan was agreed to make alterations to Dovedale and to change Burbage and Stanage to single sex accommodation.

The feasibility of this proposal was based on the activity levels and average length of stays reviewed within the 2015 Acute Care Reconfiguration business case. The previous paper was based on averages rather than the range of gender flexibility.

Alterations on Dovedale were completed in May 2018 whilst proposals to move Stanage and Burbage to single sex wards were paused in early 2018 as it became clear that

both the increase in demand for beds and the variation in demand by gender resulted in the original proposal being unfeasible.

As a result EDG requested Clinical Operations to undertake a more in depth review to re-examine the feasibility of the original plan or provide alternative proposals. This review includes:

- Patient safety issues
- Ongoing management and monitoring
- EMSA breaches
- Benchmarking
- Sexual Safety conference feedback
- Bed use by gender
- Identification of gender flexibility required within the bed base

In May 2018 the Trust issued a declaration of compliance (endorsed by Trust Board on 9th May 2018) against the Department of Health EMSA standards and the reporting requirements as outlined in its letter of November 2010 and the Mental Health Act Code of Practice 2015. The report explores all the relevant guidance issued since the initiation of the EMSA and scrutinises the apparent contradictory finding of the CQC at its inspection in 2016. There has been some confusion as to which guidance is being adhered to when assessing compliance with EMSA a paper detailing this was produced by Anne Cook MHA Legislation Lead. This report was submitted to Board and shared with the CQC in the informal engagement meeting in July 2017. (Report attached in Appendix 2).

Irrespective of any apparent confusion arising from EMSA guidance issued over the past few years the Trust wishes to ensure that it provides quality safe care. The data reviewed as part of this report confirms that the plan to create single sex wards at the Michael Carlisle Centre will create significant challenge and risk sending service users outside of Sheffield to receive acute inpatient care (unless clinically indicated to do so). This is because the data indicates that a swing/flex of 13 beds between male and female is required in order to meet demand and it is not possible to provide this swing in numbers if single sex wards were introduced within the current estate.

Hence the options to achieve EMSA compliance as stipulated by the CQC are explored and the resulting recommendation from Clinical Operations is to maintain Burbage and Stanage as mixed sex wards until development of the Longley site; and to review this decision on an annual basis. The recommendation from Clinical Operations was discussed and agreed at EDG on 7th June, and was presented at the June Quality Assurance committee.

3 Next Steps

Review attached report and agree next steps.

4 Required Actions

Board are requested to

- Consider options available and associated risks
- Agree the proposed recommendation to maintain Burbage and Stanage as mixed sex wards

5 Monitoring Arrangements

Crisis & Emergency Care Network Operations, Performance & Governance
EDG
Quality Assurance Committee

6 Contact Details

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Eliminating Mixed Sex Accommodation (EMSA)

Acute Wards

26th June 2018

Contents

Glossary of Inpatient Services

Service	Description of service
Burbage – Adult Acute Ward	19 bedded Ward mixed sex ward adult acute ward at the Michael Carlisle Centre, Nether Edge. 14 mental health beds and 5 detox beds
Stanage – Adult Acute Ward	18 bedded Ward mixed sex ward adult acute ward – Michael Carlisle Centre, Nether Edge
Maple - Adult Acute Wards	17 bedded adult acute ward and co-located Place of Safety Suite (2 beds) at the Longley Centre Dedicated female area – bedrooms and lounge. All male bedrooms grouped together
Dovedale - Older Adult Acute	18 bedded mixed sex older adult acute ward at the Michael Carlisle Centre Designated male and female areas with fixed boundary
Endcliffe PICU	10 bedded mixed sex psychiatric intensive care unit based at the Longley Centre. This unit has been designed with EMSA flexibility with a moveable boundary between male and female beds with appropriate facilities.
Forest Close	Forest Close site on Middlewood Road. One 14 bedded male unit and two 8 bedded female units. All accommodation single sex
Forest Lodge	Forest Lodge / Close site on Middlewood Road. One 11 bedded male assessment unit and one 11 bedded male rehab unit
ATS (Firshill Rise)	7 bedded mixed sex assessment and treatment service for people with learning disabilities
G1	16 bedded mixed sex ward for people with Dementia

1. Introduction

The Trust is committed to complying with Eliminating Mixed Sex Accommodation (EMSA) Department of Health (DOH) standards (These can be found in Appendix 1 page 24). However in 2016 the CQC identified 3 wards as not meeting the requirements and hence issued a MUST compliance notice. These wards were the older adult ward (Dovedale) and both acute wards on (Stanage and Burbage) at the Michael Carlisle Centre. The EMSA concerns related to the bedrooms not being grouped by gender.

It should be noted that the Trust issued a declaration of compliance (endorsed by Trust Board on 9th May 2018) against the Department of Health EMSA standards and the reporting requirements as outlined in its letter of November 2010 and the Mental Health Act Code of Practice 2015. The report accompanying the declaration explores the reason for the apparent contradictory finding of the CQC and is attached in full in **appendix 1**. The Head of Mental Health Act Legislation prepared a paper in April 2017 that was presented at Trust Board to address the variation in guidelines available for EMSA standards; this is attached in **Appendix 2**.

All EMSA requirements will be addressed through the Acute Care Reconfiguration (ACR) development of the Longley site recently agreed by Trust Board.

The purpose of this report is to explain:

- how acute care reconfiguration bed numbers were calculated in 2015
- the challenges associated with moving to single sex accommodation within the current ward configuration (prior to Longley Centre Redevelopment)
- how patient safety is central to the provision of inpatient care
- explore the options available to achieve single sex wards
- provide a recommendation for how EMSA compliant inpatient provision will be delivered prior to the long term solution for all new wards at the Longley Centre

2. Timeline of EMSA Compliance following CQC inspection in 2016

November 2016

In November 2016 the CQC undertook their comprehensive inspection of SHSC services

March 2017

The CQC report following the inspection was published in March 2017 – this identified MUST actions in relation to EMSA compliance.

April 2017

The Directorate reviewed the options to improve EMSA compliance in terms of potential estates solutions as well as working practices. This identified that estates changes could be made on Dovedale Ward to resolve the identified issue. It is not possible to create an estates solution for Stanage or Burbage which would provide complete segregation due to the linear layout of these wards. It was agreed at EDG that in order to address the CQC compliance notice requirements in the short term in 2017 it was agreed to:

- Undertake alterations within Dovedale (Older adult acute ward)
- Change both Burbage and Stanage to single sex acute wards

The Head of Mental Health Act Legislation prepared a paper in April 2017 that was presented at Trust Board to address the variation in guidelines available for EMSA standards as referenced above.

May – July 2017

Stakeholder communication about impact of moving to single sex wards including discussion regarding location of detox beds, staffing implications etc. Dovedale EMSA design solution developed with staff team input working with architects and estate leads.

Summer 17

Review data regarding feasibility of single sex wards due to the possibility of resulting in out of area placements and delays in accessing beds due to a lack of flexibility of a model with single sex wards at the Michael Carlisle Centre. Informal meeting with CQC and Care Standards sharing the developing design for Dovedale and the long term plans for Longley. In this meeting the proposal to move to single sex wards on Burbage and Stanage was discussed and it was acknowledged that this needed to carefully considered and planned to ensure there were no negative consequences as a result that would affect service user safety or experience.

Jan 2018

New Clinical Directorate to consider feasibility of going single sex in light of acuity and activity. A request from the Directorate was made for a period of review in order to understand bed demand and use by gender in the preceding year and over the coming 3 months. This request was supported by EDG and Quality Assurance Committee.

Spring 2018

The changes to Dovedale were completed in May 2018. This created clearly defined separated areas for men and women. This work provided a new clinic room in a central location with improved facilities. The changes also enabled the creation of a green room and an additional accessible bathroom so that women no longer had to pass through the male bedroom area to access such a facility.

May 2018

The plan to move Burbage and Stanage to single sex only has not been possible as a result of both the increase in admissions during recent months, and more importantly the variability in gender mix (i.e. sometimes higher demand for female beds and sometimes higher demand for male beds). Hence the bed stock and gender allocation compliment previously agreed does not cater for the variation experienced. As a result the Executive Directors Group requested Clinical Operations to undertake a detailed review of the original proposal to assess the feasibility and as a result of the findings submit options for considerations. This paper is providing a response to these requests.

2.1 Acute Care Reconfiguration

As part of the Acute Care Reconfiguration Programme, a review of activity data in terms of admissions and lengths of stay was undertaken in December 2015. This indicated that with 45 acute admissions per month (excluding Dovedale and Psychiatric Intensive Care Unit) and an average length of stay of 31 days, 54 beds would be required and could run at an occupancy of 85%. These beds could be provided on three 18 bedded wards (one of which would have additional 2 beds for place of safety).

The proposal allowed:

- for the provision of inpatient detox beds,
- presumed a reduction in bed night use as a result of the implementation of the personality disorder strategy
- a reduction in bed night use as a result of the community investment

The variation in gender demand was not at this time taken into account.

2.2 Proposed singe sex wards – bed numbers

- implementation of single sex wards for Stanage and Burbage
- Maintaining Maple as mixed sex wards as this has clearly defined male and female areas

The proposed single sex accommodation (excluding the detox beds) which would continue to be provided on Stanage and Burbage ward was based on approximately 54% of bed nights being used by men, as based on occupancy data from the 2014/15 to 2016/17. The proposed numbers are shown overleaf.

Table 1.

	Male	Female
Stanage	16	0
Burbage	0	16
Maple	9	8
Total Mental Health Beds	**25**	**24**

3. Current Position / Data Review

The bed use data has been reviewed details can be found in **Appendix 3**

3.1 Bed Use By Gender

The table below shows bed use between April 2017 and March 2018

Beds	Manageable Days (%)	Range	Swing required (i.e. flexibility from Male to Female)
Up to and including 49	270 (74%)	Max Male: 32 Min Male:20 Max Female: 29 Min Female: 17	12
Up to and including 50	304 (83%)	Max Male: 34 Min Male: 21 Max Female: 29 Min Female: 16	13
Up to and including 51	331 (91%)	Max Male: 34 Min Male: 22 Max Female:29 Min Female: 17	12
Up to and including 52	346 (95%)	Max Male: 34 Min Male: 22 Max Female:30 Min Female: 18	12
Up to and including 53	353 (97%)	Max Male: 34 Min Male: 23 Max Female:30 Min Female: 19	11
Up to and including 54	363 (99%)	Max Male: 34 Min Male: 24 Max Female:30 Min Female: 20	10
Up to and including 55	364 (99%)	Max Male: 34 Min Male: 25 Max Female: 30 Min Female: 21	9
Up to and including 56			
Up to and including 57	365 (100%)	Max Male: 34 Min Male: 27 Max Female: 30 Min Female: 23	7

This review has shown that a swing/ flexibility between male and female of 13 beds is required in order to meet demand based on 2017/18 bed use.

3.2 Current Management of System

All admissions are allocated via the senior operational manager responsible for flow in conjunction with the clinical gatekeeper. Bed allocation is determined based on:

- Service user need (i.e. level of observation and input required, any previous admissions, physical health/mobility needs)
- Gender
- Ward clinical activity

To avoid EMSA breaches and to ensure emergency admission can be taken, leave beds are used and where absolutely necessary patient moves are facilitated.

The operating guidance for bed management in and out of hours is detailed within **appendix 4**

4. Patient Safety

On admission patients are risk assessed and a collaborative care plan initiated; this risk assessment includes identification of any risk related to being on a mixed sex ward. Where vulnerabilities are identified the clinical management plan and associated observations are documented and managed through the collaborative care planning process. The allocation of bedrooms on admission is decided based on a number of factors including; gender, vulnerability and risk to self /others. On occasions where patient safety concerns become apparent, this is managed by mitigating the risk on the ward or moving service users in order to reduce risk. There are Standing Operating Procedures in place regarding EMSA management and Lone/Vulnerable Female **see appendix 5 and 6**.

4.1 Sexual Safety Incidents: There were 46 incidents reported trust wide regarding sexual safety between April 2017 and March 2018. Of these 46, 15 of these occurred on the Adult Acute Wards Maple (9), Stanage (2) and Burbage (4)
In terms of the types of sexual safety incidents

- 2 related to service users masturbating in public areas.
- 4 related to service users kissing each other.
- 3 related to incidents where the service users involved appeared to be consenting and expressed no concerns when asked by staff.
- 1 incident where one service user kissed another and it does not appear from the notes that this was consensual.
- 3 incidents of unwanted gestures or actions and these related to kissing, inappropriate touching whilst clothed and/or comments.

Six incidents involved services users who when questioned both reported the sexual interaction to be consensual or they denied the level of intimacy that occurred.

In April 2018 Trust representatives attended a national conference co produced by MHLD Nurse Directors and the CQC focused on Sexual safety and Dormitories. Key messages from this event (documented by attendee) included the following: **full notes in appendix 7**

Gender

- Quarter to a third of recipients are men
- Number of incidents between same gender
- Number of incidents of female service users on men
- Not just about mixed gender ward incidents also on same gender wards

Pros and Cons of single sex wards (from table discussion)

- Lack of available beds resulting in out of area placement
- Single sex accommodation allows for gender specific activities and interventions
- Decision making about beds made more straightforward
- Regulatory requirements easier to meet
- Higher burn out rates for staff on some female only wards, particularly where there are higher rates of Emotionally Unstable Personality Disorder as diagnosis
- Can be more difficult to meet regulatory requirements at times
- Loss of balance that mixed wards bring
- May prevent some therapeutic avenues

4.2 Patient Feedback: All service users are routinely asked as part of the admission process about any concerns they have regarding staying in a mixed sex environment.
The feedback received in March 18 demonstrates that:

- 100% of service users (28 people) were asked about their views and any concerns regarding being in mixed sex accommodation on acute wards.
- Of the 28, three expressed concerns
    - One was in relation to being in a dormitory – not specifically to do with gender.
    - Two were concerns about vulnerability which was managed by placing the individual in single rooms and using observations (these observations were required due to general vulnerability and not specifically to do with the bedroom allocation).

4.3 EMSA Breaches

There have been two incidents relating to EMSA in the last year (2017/18) both occurring on Dovedale Ward which resulted in breaches as defined by DOH standards (Appendix 1 page 27):

- November 2017, this incident involved 3 service users for a total of 6 nights, hence is recorded as 3 breaches
- February 2018, this involved 3 service users over 5 days, hence again reported as 3

breaches
These incidents occurred due to the layout of the ward where 3 bedrooms, were located in an area which resulted in the service user needing to walk through a shared area to access bathroom facilities.

Standard Operating Procedure was followed in order to mitigate the resulting risk. The work undertaken on Dovedale ward prevents such a breach occurring in the future.
There remains some confusion in some circumstances about what constitutes a reportable breach. This is being managed by a programme of education and all EMSA concerns / potential breaches being checked by the EMSA lead.

5. Current and Other Influencing Factors

The demand by gender recorded needs to be considered in context of the acute care bed system capacity and performance. To inform the position:-

- the recently issued NHS Benchmarking Network data has been reviewed and relevant data extracted;
- other influencing factors have also been explored

5.1 Benchmarking

SHSC Benchmarking Data Performance Summary 2016/17:

The benchmarking data demonstrates SHSC has:

- The lowest number of beds per 100,000 population
- A low number of admissions per 100,000 population
- The highest proportion of patients admitted under section and hence the lowest proportion of informal patients
- An average occupancy rate of above 100%
- A below average Length of stay that continues to reduce

5.2 Community Reconfiguration: Adult Community Mental Health (CMHTs) have recently been reconfigured. The purpose of the redesign included maximising the community provision supporting admission avoidance and early discharge. The process has been complex and challenging and inevitably it will take a number of months for the new services to be embedded and working to their optimum. The provision of high quality, effective and consistent home treatment is vital in the Acute Care Pathway.

5.3 Psychiatric Decision Unit Implementation: It is planned that a psychiatric decisions unit will be operational by late summer. This unit is an integral component of the crisis hub development which links both with the community reconfiguration and the Liaison Psychiatry strategic plan. This service along with the community developments will ensure admission avoidance opportunities are maximised.

5.4 Out of City Placements and the Need for Secure Facilities: As was predicted with the implementation of the rehabilitation strategy there has been use of acute beds by service users previously out of town in locked rehab. There has been an acknowledgement regarding the increased demand for secure services this is expected to be challenging going forward, this has resulted in delays in our acute system, particularly in PICU, which has an impact on our wider acute care system.

5.5 Case Mix and Incidents: The wards continue to report a continuing increase in dependency/acuity, although this is not reported by an acuity/ dependency tool report. Dependency is indicated by the level of need and required care of a service user and can range from independent to being highly dependent and /or requiring enhanced observations. There is evidence that observations on all wards have steadily increased in addition to Mental Health Act status and occupancy.

Both to avoid and manage incidents, the ward/bed managers arrange for service users to be moved between wards in order to address emerging conflicts and take account of staffing levels available. Concern has been voiced by ward managers and staff that gender specific wards would reduce the current flexibility available and has the potential to increase the risk of incidents.

6. Summary

The data reviewed as part of this report confirms that the plan to create single sex wards at the Michael Carlisle Centre will create significant challenge and risk sending service users outside of Sheffield to receive acute inpatient care (unless clinically indicated to do so). This is because the data indicates that a swing/flex of 13 beds between male and female is required in order to meet demand and it is not possible to provide this swing in numbers if single sex wards were to be introduced within the current estate. The only flexibility there is on the acute wards is a swing of one bed male / female on Maple.

In order for gender specific wards to be a realistic option SHSC would need to:-

- Reduce the number of admissions, and;Further reduce length of stay

It is noted that within the NHS Benchmarking Network SHSC has:

- The lowest bed stock
- A low number of admissions
- A low and further reducing length of stay

Hence the likelihood of being able to make two out of three adult acute wards gender specific is low, without consequences such as out of town admissions and difficultly accessing beds.

In addition there are concerns associated with reduced flexibility for service user moves between wards in order to manage vulnerability, reduce conflict and to balance staffing resource requirements.

However it should also be noted that there are clinical development strategies in hand that will support further admission avoidance and early discharge opportunities. It is anticipated that these developments and their associated benefits will not be fully realised until early 2019/20. It is unknown, at this time, whether the impact of these developments will be sufficient to change the feasibility of the single gender ward proposal.

7. Options

i.) Maintain mixed sex wards, Burbage, Stanage and Maple pending review in 12 months.
This option would maintain the wards as they currently are. This would continue to be closely monitored and appropriate action undertaken to minimise the number of EMSA breaches and to accommodate admissions.

Risk Domain	Description	Severity	Likelihood	Risk rating	Control	Residual risk
Safe	Risk of harm to vulnerable service users on mixed gender ward.	4	2	8	Effective EMSA procedures • Effective implementation of the observation policy • Risk assessment • Considered allocation of bedrooms • Use of female only area on Maple for vulnerable women	4
Safe	CQC must compliance action in place and further concerns could be raised	4	4	16	Effective communication and engagement to CQC re EMSA issues and providing evidence of compliance with our EMSA guidance. Effective communication with the CCG	12

ii.) Introduce single sex wards and accept a level of out of city placements

Moving to single sex wards would result in not all service user admissions being accommodated within Sheffield. Hence there would be a reliance on out of city provision. This would carry

clinical risk, delay access to beds and in addition result in a financial impact of sending people out of town.

Based on the 2017/18 data the financial impact, if over occupancy was managed through out of city placements, would be as follows:

Female:

The cost of an out of city bed placement is circa £600 per night. Based on the bed nights above availability this would result in, on average 47 bed nights per month at an expense of £28,200. Over a year the cost would be around £338,400 for female out of city placements

Male:

The cost of an out of city bed placement is circa £600 per night. Based on the bed nights above availability this would result in, on average 63 bed nights per month at an expense of £37,800. Over a year the cost would be around £453,600 for male out of city placements.

Total predicted expenditure in addition to current spend for those picked up out of area and staff members would be approximately £800K per annum for the bed nights not including transport costs etc.

Risk assessments of creating single sex acute wards or remaining with current configuration are detailed below

Risk Domain	Description	Severity	Likelihood	Risk rating	Control	Residual risk
Responsive Safe	Inability to admit people with Acute Mental Health due to reduced flexibility of beds available due to gender.	4	5	20	Effective bed management ensuring optimum length of stay	16
Finance Reputation	Out of city bed use due to lack of availability	4	5	20	Effective bed management and use of alternative to admission. ensuring optimum length of stay.	16
Safe	Service user inappropriately placed on a single gender ward i.e. a female admitted to the male only ward due to lack of available female bed.	4	5	20	Effective bed management ensuring optimum length of stay	16
Safe	A negative impact on staff and service users due to increased pressures on Maple Ward. This would include an increase in the number of admission to the ward and transfers in order	3	5	15	Effective bed management. Effective escalation. Improved pathway and support for 136	15

	to manage fluctuating bed numbers based on gender across the three wards. This would be in addition to the current challenges of having the 136 unit sited on the ward.					
Caring Respo nsive	Negative impact on service user due to there only being two possible ward admission options in the new model. This may mean they are unable to be admitted to a ward where they have more established relationships. It will also reduce the scope to manage admissions in a way that responds to any potential conflict between service users or previous negative experiences.	3	3	9	Effective bed management with flexibility where possible to meet service user concerns.	6
Caring Safe Financ e	Negative experience for service users and interruption to the continuity of care to having to move service user between wards in order to create capacity for a specific gender of bed. This would involve transfer across city between Michael Carlisle and the Longley Centre,	3	4	12	Effective bed management with flexibility where possible.	12
Caring	Impact on service users required to move wards during implementation of the single gender model at Michael Carlisle Centre	3	4	12	Effective engagement, communication and planning with service users an families	9

iii.) Move to single sex and re provide an additional ward of between 6 to 10 beds

A small new single sex ward inpatient acute ward could be opened in the previous Dovedale 2 Ward at the Michael Carlisle Centre. This would require significant investment in terms of staffing with the basic model of 4 staff each morning shifts, 4 staff each late shift and 3 staff overnight. This would need to include 2 registered nurses per shift, an approximate estimate of this cost circa £1.5m. This would only provide the basic requirement for a ward manager, nursing staff, support workers, housekeepers and admin. This does not include any additional funding for medical time or any other therapy so this would have to be provided from the

existing provision on site. Although this seems potentially feasible on paper this would be very challenging operationally and in terms of quality. In addition to this there would be implication in terms of capital spend as significant work would be required in order for this ward environment to be compliant e.g. with anti-ligature requirements. This area does not currently have any facilitates such as seclusion. Even if the opening of a new ward could be funded there are concerns around the feasibility of staffing this particularly in relation to registered nurses given the current vacancy rate across all wards.

Even with the creation of this unit there would still be operational challenges at times due to the variation in split between male and female beds. If referencing to chart 1 it can be seen that a provision of an additional 6 beds would meet a proportion of the demand. It should be noted that as this small unit would only be single gender there is still a lack of capacity without multiple service user moves i.e. the gender of that unit may need to swap between male and female gender in times of high demand.

8. Recommendation

EDG/QAC is requested to:

- Acknowledge the challenges and risk associated with any decision to move to gender specific at this moment in time. These relate specifically to difficulty accessing inpatient care due to gender and potential out of town bed use, these are outlined on pages 7, 12-14.
- Acknowledge the current performance of the Trust in relation to acute adult admissions in comparison with other organisation within the benchmarking group. This is summarised on page 10.
- Note EMSA breaches over the past 12months on Dovedale Ward and have now been addressed and that there have not been any on Stanage and Burbage Wards. These are described on page 9 and make reference to DOH guidance in appendix 1 page 26)
- Note that the current means of mitigating patient safety risks through effective processes and procedures. These are shown in detail in appendices 4,5 and 6.
- Consider the alternative options detailed to address EMSA compliance and the resulting risks. These are shown in pages 12-14.

Clinical Operations recommends

- that Stanage and Burbage remain as mixed sex wards and the Trust response to the EMSA requirements are met by the Acute Care Reconfiguration recently adopted outline Business Case Phase 2 at the Longley Centre is completed 2020/1,

• this position is reviewed on an annual basis with the CQC in line with the compliance statement. Data relating to patient experience and safety indicators are being monitored on a quarterly basis and brought to the Quality Committee.

Lisa Johnson, Deputy Associate Director
Deborah Horne, Associate Director
Michelle Fearon, Director Operations and Transformation
Christopher Wood Associate Clinical Director
Alison Shore, Senior Project Officer

Appendix 1 – EMSA Declaration

BOARD OF DIRECTORS MEETING (Open)

Date: 9th May 2018 **Item Ref:**

TITLE OF PAPER	Eliminating Mixed Sex Accommodation (EMSA) Declaration of Compliance.
TO BE PRESENTED BY	Clive Clarke, Deputy Chief Executive
ACTION REQUIRED	Confirmation and Ratification

OUTCOME	▫ Members are assured of the Trust's Compliance against the Department of Health Guidance outlined in a letter dated November 2010 and the Mental Health Code of Practice 2015 ▫ Compliance statement to be up-dated on the Trust's public website ▫ EMSA breaches to be reported to EDG and the Board of Directors and onward to Sheffield CCG and Department of Health
TIMETABLE FOR DECISION	May 2018 Board Meeting
LINKS TO OTHER KEY REPORTS / DECISIONS	Department of Health (DoH) Guidance outlined in the NHS Operating Framework 2010/11 and 2012/13 Mental Health Act Code of Practice 2015 (CoP)
STRATEGIC AIM **STRATEGIC OBJECTIVE** **BAF RISK NUMBER & DESCRIPTION**	1.2 Deliver Safe Care At All Times
LINKS TO NHS	To be included in Board Assurance Framework (BAF).

CONSTITUTION & OTHER RELEVANT FRAMEWORKS, RISK, OUTCOMES ETC	HSE □ MH Act □ Equality ✓ BME □ Disability Legislation □ NHS Constitution: Staff Rights □ Service users' Rights □ Public's Rights □ Principles ✓ Values ✓
IMPLICATIONS FOR SERVICE DELIVERY AND FINANCIAL IMPACT	Failure to comply may result in requirement of additional staffing resource to mitigate the associated risks. Failure to comply with the required standards may lead to compliance/enforcement action by the Care Quality Commission (CQC) and fines imposed by the CCG.
CONSIDERATION OF LEGAL ISSUES	Failure to comply may lead to fines and compliance/enforcement action by the Care Quality Commission (CQC)

Author of Report	Lisa Johnson,
Designation	Deputy Associate Director / EMSA Lead
Date of Report	9th May 2018

SUMMARY REPORT

Report to: **BOARD OF DIRECTORS**

Date: **9Th May 2018**

Subject: **Eliminating Mixed Sex Accommodation (EMSA)**

From: **Clive Clarke, Deputy Chief Executive**

Author: **Lisa Johnson, Deputy Associate Director**

1. Purpose

i. Following receipt, discussion and approval of the annual EMSA declaration of compliance report at the Executive Directors Group (EDG), the Trust Board is asked to consider and support the declaration that the Trust is compliant with EMSA based on assessment against the Department of Health letter from the Chief Nursing Officer and Deputy NHS Chief Executive, November 2010 (PL/CNO/2010/3) and the Mental Health Act Code of Practice, 2015.

ii. Provide an overview of the Trusts' compliance with the Department of Health (DoH) Guidance. (NHS Operating Framework 2011/2012/2013)

iii. Approval to publish the annual declaration of compliance on the Trust's website in line with Department of Health .

For Approval	*For a collective decision*	*To report progress*	*To seek input from*	*For information*	*Other (please state below)*
✓					

2. Summary

Arrangements to assess, monitor and review EMSA compliance in each of the Trust's

six mixed sex inpatient wards are in place to ensure the Trust is compliant with EMSA standards and requirements as outlined in the Department of Health letter dated November 2010 and the Mental Health Act Code of Practice, 2015.

Board colleagues will also be cited on the CQC's findings of the Trust's Adult Acute Inpatient Wards, where Stanage and Burbage were reported as non-compliant. The Trust has sought to understand this difference of view. The apparent contradictory findings of the CQC appear to be rooted in its use of an earlier document to define same-sex accommodation. This is the NHS Confederation Briefing – Eliminating Mixed Sex Accommodation in Mental Health and Learning Disability Services, dated **January 2010**. This document is not referred to in the subsequent DoH letter. If both documents are read together, it may be assumed that the later one refers to the earlier one, but the November 2010 document provides no means by which to locate the January 2010 document.

In its 'Brief Guide for Inspectors' dated May 2015, the CQC refers to all the above. It requires inspectors to:

- Use the definition of same-sex accommodation in the **January 2010** document
- Identify any breaches of that definition using the **November 2010** document
- Link any breaches to the **Code of Practice 2015**

For the purposes of the Trust's reporting and declaration, this is required against the November 2010 letter and as such the Trust has assessed itself against the standards and requirements contained therein.

<u>Summary of Provision</u>

Single Sex Wards:

- Forensic: Forest Lodge x 2 Wards both male
- Rehabilitation: Forest Close x 3 wards, 1 male, 2 female

Mixed Sex Wards:

- Acute: Burbage, Stanage, Maple & Dovedale
- Psychiatric Intensive Care Unit (PICU): Endcliffe
- Dementia: G1
- Learning Disability: Firshill Rise

Currently the four acute admission wards are mixed sex. The physical layout and design of some of these wards and the lack of en-suite facilities does present significant operational challenges to maintaining EMSA compliance.

Maple Ward has female and male bedroom areas and females do have to walk along a

corridor / mixed communal area to access the female only bedroom area.

Stanage has two dormitories, one female and one male and single bedrooms along a corridor.

Burbage has two dormitories, one female and one male and single bedrooms along a corridor and also accommodates five detoxification beds for substance misuse.

The Ward Managers and their teams continuously manage admissions to achieve EMSA compliance and relocate patients, as necessary, to alternative bedrooms to ensure access to single sex room 'areas', bathrooms, toilet facilities and female only lounges.

Whilst maintaining EMSA compliance is a significant operational / clinical challenge on the acute wards the standard of 'not having to pass through opposite sex areas to reach toilet or bathing facilities' is achieved in all areas, although patients do have to walk through mixed communal areas to reach their bedroom and bathing areas.

Dovedale ward now has designated areas for each gender (lounge and bedrooms), however access to some key facilities (clinic room, accessible bathroom) on the ward requires crossover of some gender specific areas. Work is currently underway to reconfigure the ward layout in order to address access to the clinic room and accessible bathroom so achieving full EMSA compliance. This work is due to be completed mid May 2018.

The PICU, Endcliffe Ward, opened in January 2016. The environment has completely separate sleeping, washing and toilet facilities, all en-suite bedrooms and a designated women's lounge and represents a major improvement in delivering EMSA standards/requirements.

All the bedrooms at Firshill Rise are en-suite and there is a separate female only lounge.

At G1 the ward is split into two halves, one half is used for male patients and the other half is mixed sex. All bedrooms are en-suite and there is one female only lounge.

There have been two incidents relating to EMSA in the last year both occurring on Dovedale Ward:

- November 2017, this incident involved 3 service users for a total of 6 nights, hence is recorded as 3 breaches
- February 2018, this involved 3 service users over 5 days, hence again reported as 3 breaches

These incidents occurred due to the layout of the ward where 3 bedrooms, were located in an area which resulted in the service user needing to walk through a shared area to

access bathroom facilities.

Standard Operating Procedure was followed in order to mitigate the resulting risk. The work currently taking place on Dovedale ward will prevent a breach of this nature occurring in the future.

Key Arrangements to Monitor Compliance:

Service users' views about their privacy, dignity and being in a mixed sex environment are sought and recorded:

- On admission / during care planning.
- Via the Quality and Dignity survey (a service user led assessment).
- Via the Patient Led Assessments of the Care Environment (PLACE).

ii. There is an electronic system linked to each service users risk management plan which identifies if service users' views on mixed sex accommodation are being sought and recorded in their care record. These records were checked in September 2017 and March 2018.

iii. The Senior Manager with responsibility for EMSA works with the operational leads to ensure in-patient care records are audited twice a year and the outcome is reported to the Acute and In-Patient Forum and Quality Assurance Committee.

iv. Twice yearly joint EMSA monitoring visits / assessments are undertaken with the CCG. The Sheffield CCG Quality Team shares our understanding of the Trust's reported position.

v. Associate Service and Clinical Directors continue to review the current mixed sex ward arrangements and make proposals to address ongoing EMSA operational challenges.

Recommendation

The Trust declares compliance in relation to Eliminating Mixed Sex Accommodation (EMSA) requirements as assessment against the DoH letter from the Chief Nursing Officer and Deputy NHS Chief Executive, November 2010 and the Mental Health Act Code of Practice, 2015.

3 Next Steps

Bi annual joint monitoring & assessment visits continue with Sheffield Clinical

Commissioning Group (CCG).

4 Required Actions

For the Trust Board to:

i. Consider & support the declaration that the Trust is compliant with EMSA as required by the Department of Health.

ii. Agree that EMSA breaches are reported to the Boards.

iii. Agree to publish the Declaration of Compliance on the Trust's public website (Appendix 2).

5 Monitoring Arrangements

i. A minimum reporting schedule to the Board of Directors will be on an annual basis.

ii. Any breach will be managed at Directorate level and reported to the EDG and Quality Assurance Committee (QAC) and to Board of Directors via the QAC significant issues report.

6 Contact Details

Lisa Johnson, Deputy Associate Director

Lisa.johnson@shsc.nhs.uk

01142718541

Overarching DSSA Principles for inpatient services v2 Revised March 2010	
1. There are no exemptions from the need to provide high standards of privacy and dignity.	✓
2. Men and women should not have to sleep in the same room, unless sharing can be justified* by the need for treatment (see 14) or by patient choice. Decisions should be based on the needs of each individual not the constraints of the environment, nor the convenience of staff.	See 14
3. Where mixing of sexes does occur, it must be acceptable and appropriate for *all* the patients affected.	✓
4. Men and women should not have to share toilet and washing facilities with the opposite sex, unless they need specialised equipment such as hoists or specialist baths.	✓
5. Men and women should not have to walk through the bedrooms/bed bays or bathroom/toilets of the opposite sex to reach their own sleeping, washing or toilet facilities.	✓
6. Staff should make clear to the patient that the trust considers mixing to be the exception, never the norm.	✓
7. Changes to the physical environment (estates) alone will not deliver same-sex accommodation; they need to be supported by organisational culture, systems and practice.	✓
8. On mixed-sex wards, bedroom and bay areas should be clearly designated as male or female.	✓
9. In all areas, toilets and bathrooms should be clearly designated as male or female.	✓
10. When mixing of the sexes is unavoidable, the situation should be rectified as soon as possible. The patient, their relatives, carers and/or advocate (as appropriate), should be informed why the situation has occurred, what is being done to address it, who is dealing with it, and an indication provided about when the situation will be resolved.	✓
11. Patients/service users should be protected at all times from unwanted exposure, including being inadvertently overlooked or overheard.	✓
12. Patient preference re mixing should be sought, recorded and where possible respected. Ideally, this should be in conjunction with relatives or loved ones.	✓

Overarching DSSA Principles for inpatient services v2 Revised March 2010	
13. There may be circumstances that require additional attention be given to help patients/service users retain their modesty, specifically where: • they are wearing gowns/nightwear, or where the body might become exposed • they are unable to preserve their own modesty, e.g. recovery from general anaesthetic or when sedated. • their illness means they cannot judge for themselves.	✓
14. Any circumstance that constitutes clinical justification for mixing of the sexes is for local determination, Generally, for acute services, justification might relate to 'life or death' situations, or a patient needing highly technical or specialist care/one-to-one nursing (e.g. ICU, HDU). ***There is no clinical justification for mixing in mental health and learning disability services.***	✓
15. Where family members are admitted together for care, they may, if appropriate, share bedrooms, toilets and washing facilities.	✓
16. In mental health and learning disability services there should be provision of women-only day rooms on wards where men and women share day areas.	✓
17. For many children and young people, clinical need, age and stage of development may take precedence over gender considerations. In mental health and learning disability services, boys and girls should not share bedrooms or bed bays and toilets/washing facilities should be same-sex. An exception to this might be if a brother and sister were to be admitted onto a children's unit – here sharing of bedrooms, bathrooms or shower and toilet areas may be appropriate.	N/A in SHSC
18. Transgender people should be accommodated according to their presentation: the way they dress, and the name and pronouns that they currently use.	✓

Reviewed 7th February 2014

†http://www.dh.gov.uk/en/Publicationsandstatistics/Lettersandcirculars/Professionalletters/Chiefnursingofficerletters/DH_098894

Sheffield Health and Social Care NHS Foundation Trust Website Publication

Declaration of Compliance
1st April 2018

Eliminating Mixed Sex Accommodation (EMSA) also known as Delivering Same Sex Accommodation (DSSA).

Sheffield Health and Social Care NHS Foundation Trust is pleased to confirm that it is compliant against the Department of Health EMSA standards and reporting requirements as outlined in its letter of November 2010 and is compliant against the Mental Health Act Code of Practice 2015. The only exception to this is except when it is in the patient's overall best interest, or reflects their personal choice. This would be subjected to risk assessment and multi-disciplinary team agreement.

The Trust has the necessary facilities, resources and culture to ensure that patients who are admitted to its wards will only share the room where they sleep with members of the same sex, and same sex toilets and bathrooms will be close to their bed area. The Trust is actively working to reduce the number of patients who have to share accommodation with the same sex, i.e. bed bays and is committed to eliminating shared sleeping space altogether. For people who sleep in shared spaces with people of the same sex, Trust staff will do everything possible to ensure dignity and privacy.

The Trust has a major service redesign programme in progress, as part of its Acute Care Reconfiguration. This will have a significant impact on improving the quality of the environment.

If the Trust's care should fall short of the required standard, this will be reported to the NHS Sheffield Clinical Commissioning Group (CCG).

For further information please contact:

Lisa Johnson, Deputy Associate Director and EMSA Lead

Telephone Number:0114271 8541

E-mail Address: lisa.johnson@shsc.nhs.uk

Appendix 2 – EMSA Explanation

Documents Involved in Identifying EMSA Breaches

The Trust has historically reported minimal compliance with EMSA regulations. This reporting was based on the **Mental Health Act Code of Practice 2015 (CoP),** which defines 'separate facilities for men and women' as:

8.25 All sleeping and bathroom areas should be segregated, and patients should not have to walk through an area occupied by another sex to reach toilets or bathrooms. Separate male and female toilets and bathrooms should be provided, as should women-only day rooms. Women-only environments are important because of the increased risk of sexual and physical abuse and risk of trauma for women who have had prior experience of such abuse. Consideration should be given to the particular needs of transgender patients.

8.26 A patient should not be admitted to mixed-sex accommodation. It may be acceptable, in a clinical emergency, to admit a patient temporarily to a single, en-suite room in the opposite-gender area of a ward. In such cases, a full risk-assessment should be carried out and the patient's safety, privacy and dignity maintained. Steps should be taken to rectify the situation as soon as possible. For more information see NHS guidance on eliminating the use of mixed-sex accommodation in relation to mental health patients. This includes information on temporary admissions in exceptional circumstances and the required reporting to the NHS Commissioning Board on mental health patients. (CoP Chapter 8.25 - 8.26).

The CoP is Statutory Guidance for the Trust's purposes, and it defines the terms 'must', 'should' etc. The standard for separate facilities for men and women is 'should'. This requires that any exceptions from the Code and the reasons for them are documented and recorded, and the resulting documents may be seen by 'patients, their families and carers, regulators, commissioners and other professionals'. (CoP page 14).

The NHS guidance referred to in CoP paragraph 8.26 is a DH letter from the Chief Nursing Officer and Deputy NHS Chief Executive, dated from **November 2010**.[1] It states:

Because of the huge variation in ward designs, it is impossible to monitor all aspects of mixing centrally, and this is why central reporting concentrates on sleeping accommodation. But mixing in bathrooms or WCs is still unacceptable, as is requiring patients to pass through opposite-sex areas to reach their own facilities.

It appears that the definition in the CoP reflects the November 2010 document, and the November 2010 document is the one against which the Trust has reported to the CCG in terms of 'minimal compliance': because of the physical layout of the wards, Kim Parker (EMSA lead) has reported that some patients have to pass through mixed communal areas (a communal corridor) to reach their own facilities. However, no one has to pass through areas designated to the opposite sex to reach their facilities. Ms Parker adds that sleeping areas and toilets are never shared. A shared bathroom on Dovedale is permissible because it is assisted/disabled provision, but Dovedale is 'vulnerable' in that showers and toilets are nearby, but immediately adjacent. Reporting is undertaken as required by the November 2010 document.

The apparently contradictory findings of the CQC appear to be rooted in its use of an earlier document to define same-sex accommodation. This is the NHS Confederation Briefing – Eliminating Mixed Sex Accommodation in MH

[1] *Eliminating Mixed Sex Accommodation. Department of Health. 2010. PL/CNO/2010/3.*

and LD Services, dated **January 2010**. [2] It is NOT referred to in the subsequent DH letter. If both documents are read together, it may be assumed that the later one refers to the earlier one, but the November document provides no means by which to locate the January document.

In its 'Brief Guide for Inspectors' dated May 2015, the CQC refers to all the above. It requires inspectors to:

- Use the definition of same-sex accommodation in the **January 2010** document
- Identify any breaches of that definition using the **November 2010** document
- Link any breaches to the **Code of Practice 2015**

It would appear that the root cause of the confusion is the CQC's employment of the NHS Federation definition, which cannot be located by reference to either the DH letter or the CoP.

The reported 'minimal compliance' utilises the definition available to the Trust in the form of the current CoP, and its reference to the November 2010 document to enable staff to identify EMSA breaches.

The January 2010 document is not referred to in the Code of Practice.

The Code of Practice is the necessary link to the CQC's findings.

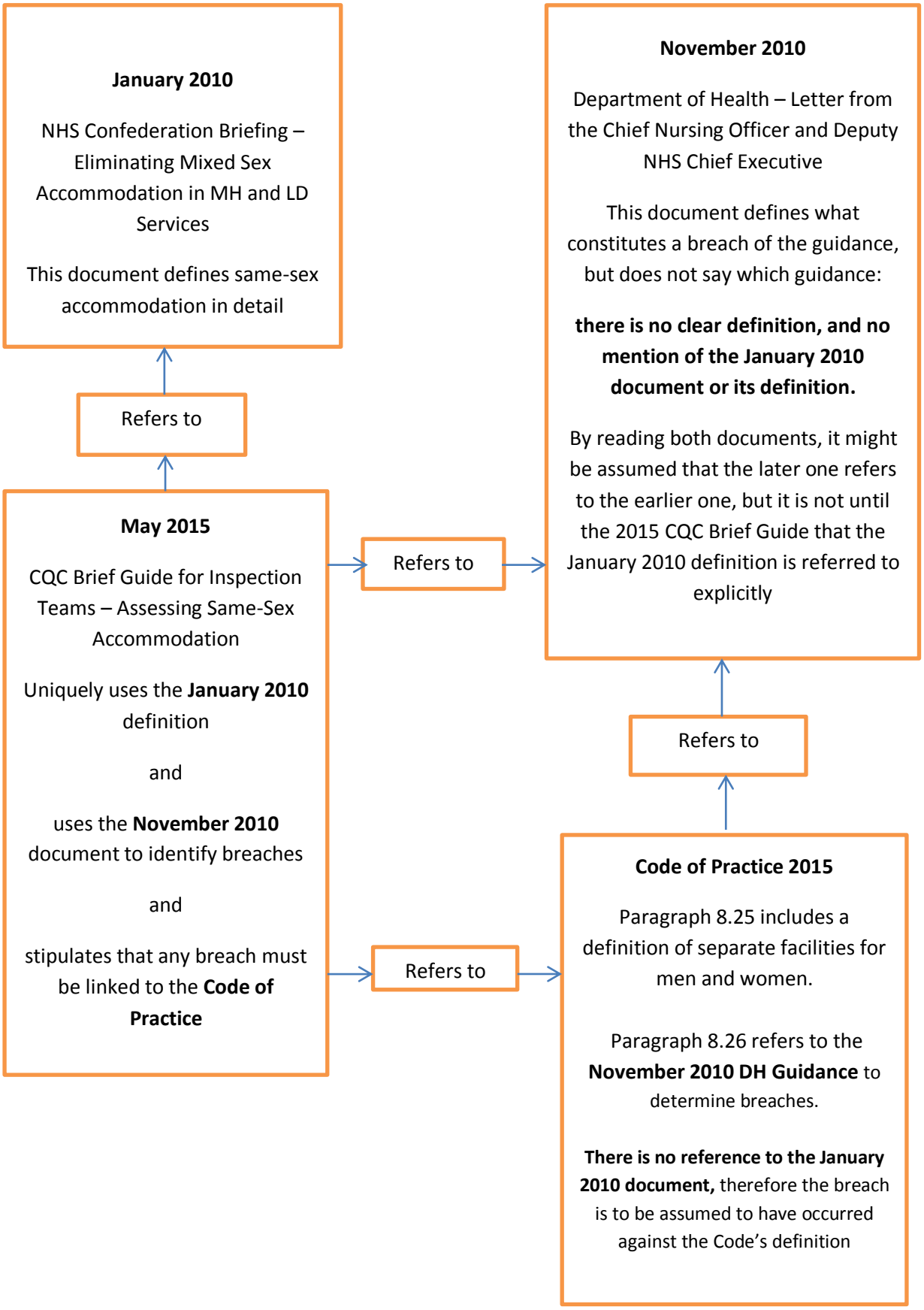
Given that neither the Code of Practice, nor the November 2010 document refers to the January 2010 definition, it is unsurprising that the conclusions about compliance with EMSA regulations differ: although the Code of Practice definition reflects the content of the January 2010 NHS Confederation briefing, the CQC has utilised the detailed January 2010 definition in its entirety.

Please see the flow-chart below which demonstrates that ONLY the CQC Brief Guide makes any reference to the definition to be employed in inspections.

I am not aware of any communication of the intention to use this definition from the CQC.

Anne Cook
Head of Mental Health Legislation
23.6.17

[2] Delivering same-sex accommodation in mental health and learning disability services. NHS Confederation. January 2010. Briefing 195. www.nhsconfed.org/Publications/briefings/Pages/Delivering-same-sex-accommodation-mental-health-learning-disability.aspx



Appendix 3 – Data review

3.1 Service Demand by Gender Split

In order to gain an understanding around demand by gender on the acute wards, the male and female split by bed night between the 1st April 2017 and the 31st March 2018 has been reviewed together with the length of stay.
The tables and charts below detail,

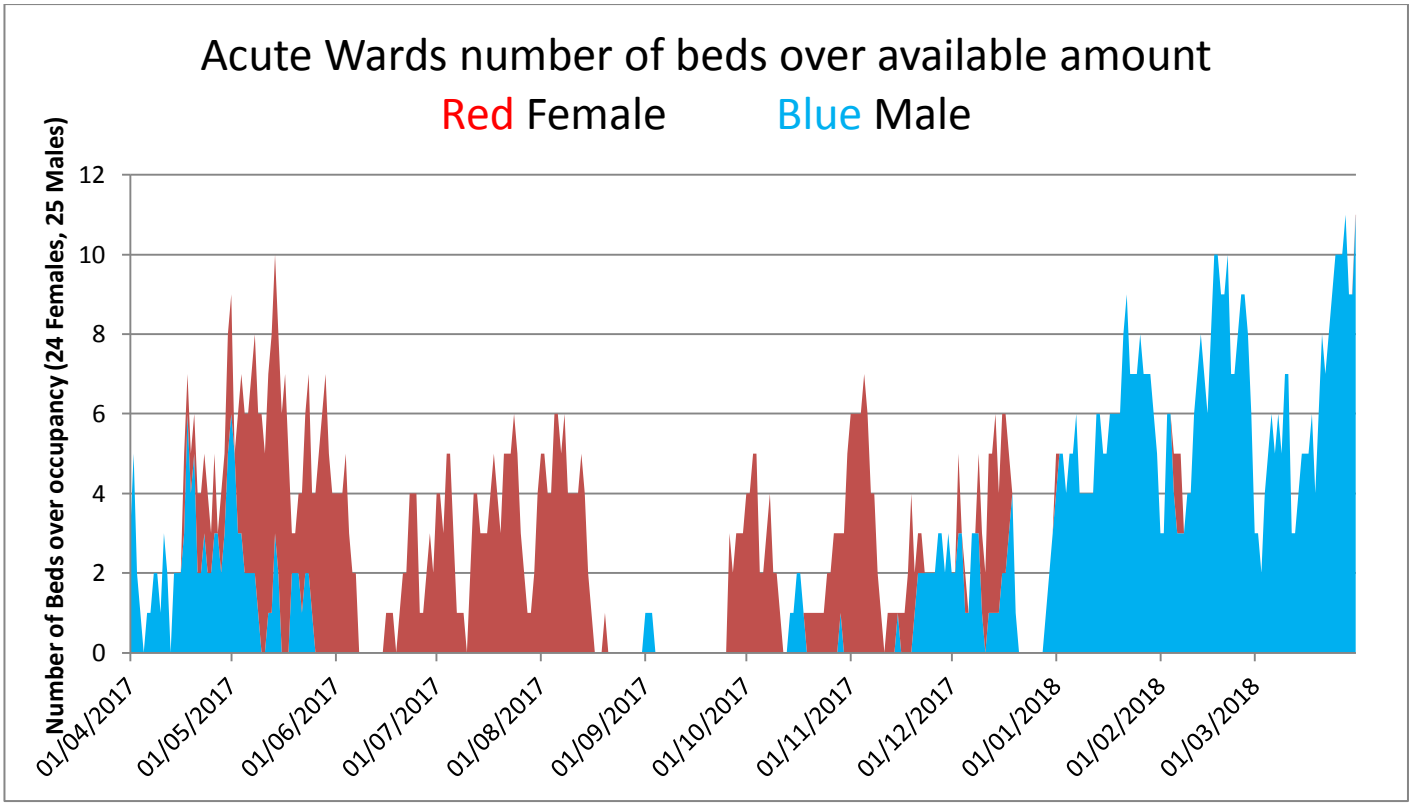
- Number of bed nights in which the occupancy was over the availability by gender split proposed
- Length of stay by gender, and in time periods, detailing the mean and median

i) Beds required over the proposed single sex accommodation numbers (i.e. 25 male, 24 female)

Based on the proposed bed number split (table 1) the number of beds above the quota by gender and by day for 2017 are charted below (chart 1). On the vertical axis 0 is equal to 100% bed occupancy i.e. 24 females and 25 males. As can be seen the situation varies significantly and clearly shows

- Periods in June, September , October and January where the bed stock and gender split would have accommodated the service user demand
- Blocks in time when the number of female beds required were over the number proposed by up to 10 beds
- Blocks of time when the number of male beds required were over the proposed number by up to 11
- Frequent requirement of an additional 6 beds but variability regarding male female split

Chart 1.

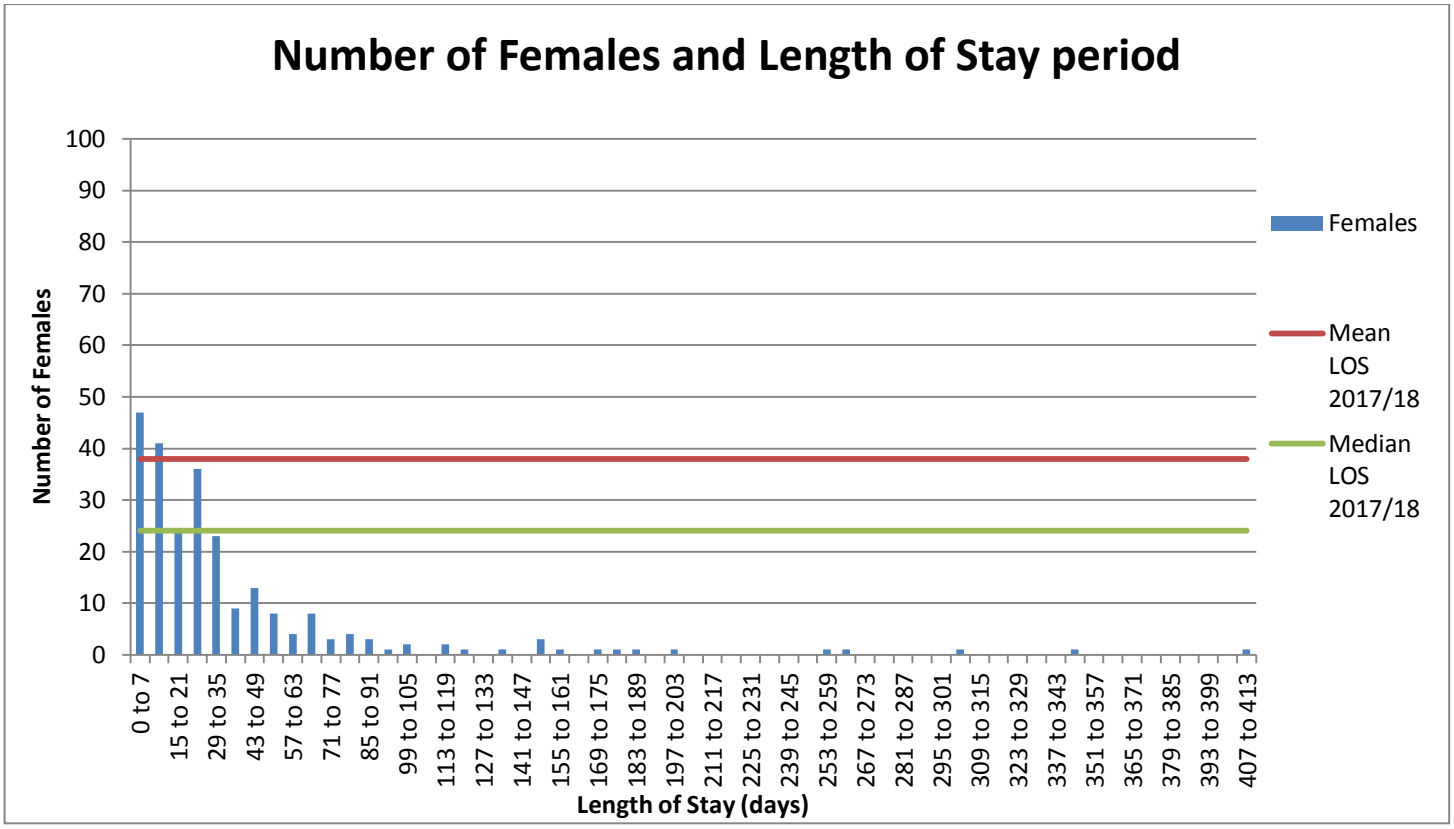


ii) Length of Stay

The length of stay has been reviewed to understand the

- Mean and median length of stay by gender to examine the premise of the previous bed modelling, plus
- Time periods of stay to demonstrate the short and long stay outliers

Chart 2. Female Service Users



In summary for female patients for 2017/18 the:

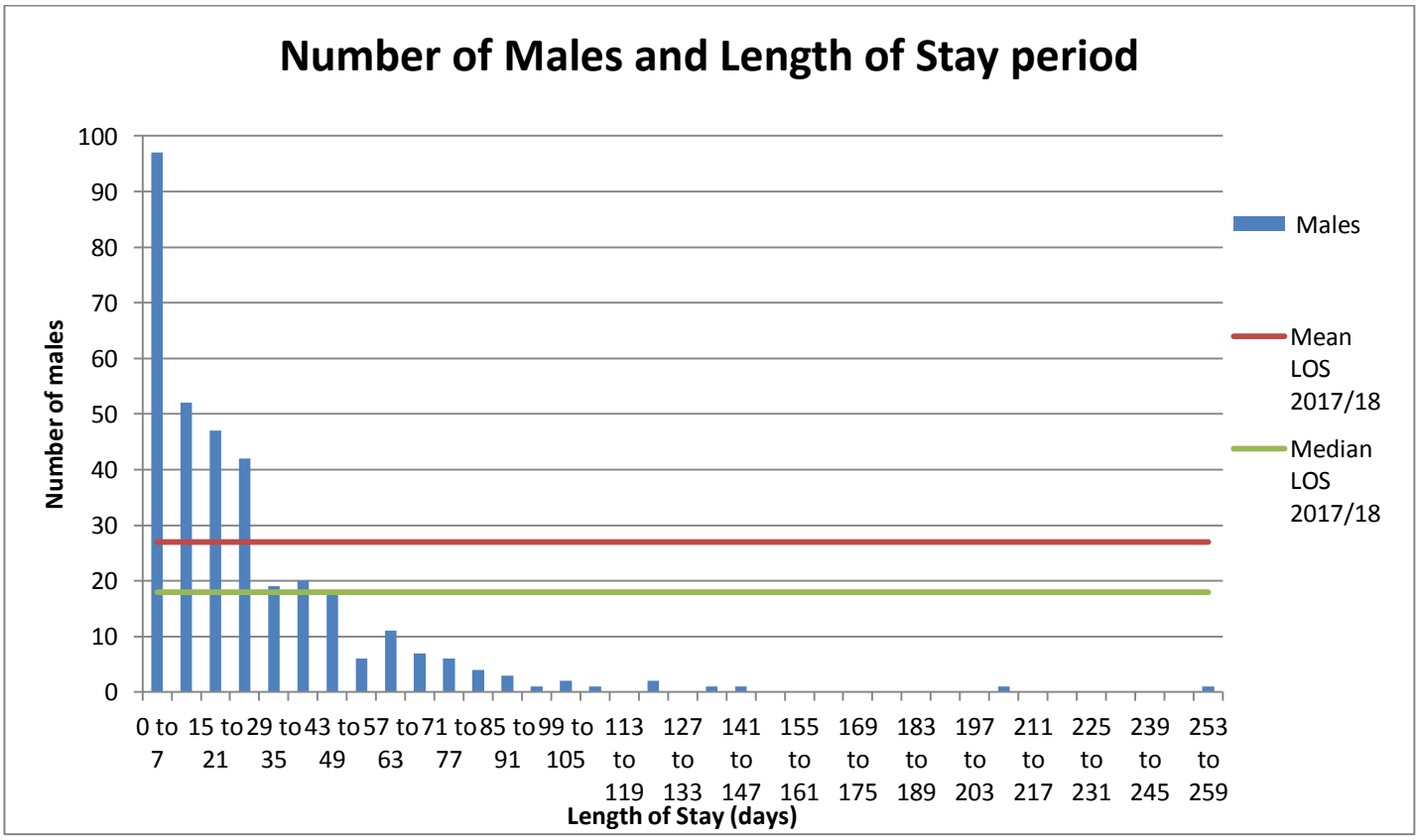
- Average (mean) length of stay =38days
- Median length of stay =24days
- Variability of length of stay ranges from 0 to 407days

Table 2

Number of Females (a)	Number of Nights (b)	Bed Nights above the available (c)
17	4	0
18	10	0
19	15	0
20	16	0
21	25	0
22	36	0
23	45	0
24	38	0
25	38	38
26	36	72
27	23	69
28	36	144
29	23	115
30	15	90
31	5	35
	Nights over 24 = 176	**563 bed nights avg 47 per month**

*(a-24) x b = c

Chart 2 Male Service Users



In summary for male patients for 2017/18 the:

- Average (mean) length of stay = 27days
- Median length of stay = 18days
- Variability of length of stay ranges from 0 to 257days

Table 3

Number of Male (a)	**Number of Nights (b)**	**Number of bed night above the available (c)**
17	14	0
18	10	0
19	11	0
20	15	0
21	16	0
22	33	0
23	34	0
24	21	0
25	30	0
26	27	27
27	37	74
28	29	87
29	15	60
30	17	85
31	19	114
32	13	91
33	8	64
34	8	72
35	6	60
36	2	22
	Nights over 25 = 181	**bed nights =756 avg 63 per month**

*(a-25) x b = c

Appendix 4 – Operating Guidance

Operating Guidance Inpatient & Community Provision OOHs and In Hours

	OOHs Plan ie 5pm to 9am 7 days a week - Beds (guidance for SSR and On call Manager)
1	explore need for admission referring to consultant oncall as indicated
2	Utilise crisis house and beds available
3	Liaise with bed manager to facilitate bed in the right place (moves to and from Dovedale, G1, Endcliffe, ATS)
4	If all beds allocated utilise leave beds
5	If no leave beds explore use of any available detox beds
7	If none of the above explore where an additional bed can be placed and managed safely. Up to one additional bed on each ward ie one additional head on bed on each ward subject to staffing capacity. Also consider closing and using a 136 bed (reporting as necessary to Police) Discuss with On Call Manager - unless plan already agreed.

8	Where there are staffing capacity concerns and an admission is required SSR to -Explore staff movement across the wards to support - Explore Liaison or OOHs staff accompanying patient to wards and remaining until patient settled.
9	If none of the above ustilise the 2nd 136 bed
10	If none of the above On Call Manager to escalate to executive on call and consider closure of 2nd 136 bed or use of a further bed, subject to staffing resource)

	In Hours Plan i.e. 9am to 5pm Monday to Friday - Beds
1	All admission requests to be explored by gatekeeper (HTT/SPA when fully operational)
2	In patient care needs to be assessed daily and discharge and leave opportunities/plans pursued (including additional community alternatives to facilitate discharge/leave
3	If all beds allocated utilise leave beds
4	Senior Operational Manager to escalate to Associate Deputy Director
5	Associate Deputy Director to assess clinical operating state against matrix risk levels and request initiation of surge procedures
6	Further to assessment of clinical operation state consideration and plan to be formalated including
7	If no leave beds explore use of any available detox beds
8	Escalate to Director level for consideration and pre authorisation of additional bed capacity
9	If none of the above explore where an additional bed can be placed and managed safely. Up to one additional bed on each ward ie one additional head on bed on each ward subject to staffing capacity
10	If none of the above utilise a 136 bed
11	Where there are staffing capacity concerns explore - flexi and agency - staff movement across wards - staff support from other teams
12	Escalate to Executive Director to explore and agree alternative provision outside of Trust portfolio plus including use of 2nd 136 bed in colaboration with the police
13	Directors to develop plan to manage over OOHs period - with sign off by Execs as required and communication to on call manager.

	OOHs Plan ie 5pm to 9am 7 days a week - Community Crisis & Home Treatment when provision is compromised due to absence of staff or unprecedented demand (guidance for SSR and On call Manager)
1	Liaise with OOH and A&E Liaison to determine demand. Identify any opportunities to share staff between the two functions to manage the OOH "front door".
2	Review planned and scheduled activity in Home Treatment Teams (including Adult Home Treatment, DRRHTT, FICS and CISS) and determine whether any activity can be rescheduled. Involve SPR on-call or On-Call Consultant as required
3	Explore use of additional staffing or extended hours including use of on-call medics
4	If none of the above involve Consultant on Call to risk assess reduction in planned service to community patients and ensure continuity plan for the immediate and following 24 hours. Involve ward staff and Police as required.

	In Hours Plan ie 9am-5pm Monday-Friday Community Crisis & Home Treatment when provision is compromised due to absence of staff or unprecedented demand (guidance for SSR and On call Manager)
1	Liaise with SPA, Liaison & Duty Home Treatment capacity to determine demand. Identify any opportunities to share staff between the functions to manage the "front door".
2	Review planned and scheduled activity in community teams including Adult Recovery, Adult Home Treatment, OA CMHT, CISS and Substance Misuse and determine whether any activity can be rescheduled or staffing capacity deployed.
3	If none of the above escalate to Director level to consider authorisation of additional staffing via bank or agency
4	Involve senior practitioners and clinical leaders in risk assessing patient presentations / change to scheduled activity.
5	Directors to develop a plan for community resilience in-hours and for the OOH period via escalation routes and ensure that this is communicated to teams and OOH on-call manager

Appendix 5 – EMSA SOP

Sheffield Health and Social Care NHS
NHS Foundation Trust

Standard Operational Procedure

Title	Eliminating Mixed Sex Accommodation (EMSA)
Area Covered	All mixed gender Inpatient Wards: Adult Acute: Maple 17 beds and 2 places of safety Stanage 18 beds

	Burbage 14 beds and 5 detox beds PICU: Endcliffe 10 beds Older Adults: Dovedale 18 beds Firshill - assessment and treatment unit Learning Disabilities 7 beds Grenoside Grange G1 – Dementia unit 16 beds
Core Principles/purpose	The primary aim of this SOP is to promote the privacy and dignity of all service users. SHSC ensures service users need and wishes are actively sought and documented. Inpatient services aim to be compliant with Eliminating Mixed Sex Accommodation standards
	This SOP provides guidance for: • Requirement of EMSA compliance. • Process if breach occurs • Process for admission and whilst on the wards • Risks
Resource Needed	• EMSA lead • Bed availability and flexibility • Incident reporting systems • Staff knowledge and understanding of EMSA standards and the SOP
Guideline for use	Every person admitted in to an in service user ward of Sheffield Health and

	Social Care to receive the following: • That everything possible will be done to make sure their privacy and dignity is respected and maintained. • They should be made aware that the ward they are being admitted to is for men and women. • They should be advised that they will never share sleeping accommodation with members of the opposite sex. • They will have designated toilet and bathing facilities. • They will not have to walk through opposite sex accommodation to reach their toilet or bathing facilities. • That they will not be overheard or over looked in private conversation or examination • They will be asked when they are admitted to they ward “Do you have any concerns about your privacy and dignity whilst being on a mixed sex ward”. This will be recorded in the DRAM • They will be given written information leaflet about what they can expect. Service users will have their views documented on admission about the facilities. This will be recorded in the DRAM and then revisited as required based on the service user’s clinical presentation. This will be recorded on the Ongoing Views Form. Also: • Should be encouraged and supported to wear clothes that maintain their dignity and wear suitable clothing when in communal areas of the ward. • Should be made aware that wearing night clothes could compromise their dignity. • Service users who choose to wear night wear during the day will be risk assessed to establish that they understand the potential consequences of being dressed this way. • Should be made aware of the impact that wearing night wear may have on other service users. • Vulnerable service users who wear nightwear will be accompanied by a member of staff in communal areas of the ward. • Women must have access to a designated lounge space. This will be actively protected and incident reported if a breach occurs. In the event of a breach of EMSA compliance, staff should: • Contact EMSA lead (Kim Parker) via phone or email • Ensure Clinical Nurse Manager and Assistant Clinical Director are made aware • Complete and incident form • EMSA lead will then attend ward to review situation and mitigate

Precautions	Service users who are admitted to bedrooms or bed bays that do not have en-suite facilities should: • Be risk assessed to establish their level of vulnerability. • If assessed as vulnerable they should not be admitted to facilities where they have to come out of their room and into communal areas to access their toilet or bathroom. • If a vulnerable service user is admitted to these areas staff will have increased vigilance and awareness and this will be recorded in the care plan/risk assessment. • Advocates, families or carers should be involved if the service user lacks capacity • Any situation where a service user who is concerned about their accommodation or is assessed as vulnerable, and there is no imminent solution (i.e. within 12 hours) will be reported to the Service Director. • Breaches will be reported on a Clinical Incident Form and sent to the Risk Department. For advice on any aspect of Eliminating Mixed Sex Accommodation contact Kim Parker or out of hours the on call service manager via switchboard
Policy links	EMSA Standards https://www.gov.uk/government/publications/eliminating-mixed-sex-accommodation-in-hospitals

Appendix 6 – Lone Female Service User Policy

Sheffield City Council

Sheffield Health and Social Care NHS
NHS Foundation Trust

Standard Operational Procedure - 11

Title	Supporting Vulnerable /Lone Female Service Uses

	Room number
Area Covered	All areas
Core Principles/Purpose	Endcliffe ward provides for service users with severe mental illness, who during acute episodes, present with a significant risk of violent, aggressive, self-harming behaviour and/or complexity. Therefore by definition all service users within Endcliffe ward may be deemed vulnerable. However some service users are by virtue of their mental health presentation, physical health condition, gender ethnicity or other protected characteristic, may have a higher level of vulnerability that requires an increased level of vigilance. Service users who require secure care are know to have a higher prevalence of a history of physical sexual or emotional abuse, at some point in their lives, than the general adult in patient population Staff will therefore be aware of the possibility of re victimisation or re traumatisation and take steps to respond accordingly. A detailed assessment of vulnerability will be informed by the service user, their family or friends or based on previous presentations and documentation.
Resources needed	Staffing that meets the gender requirements of service users
Guideline for use	Each service uses level of vulnerability will be assessed and recorded in their DRAM. Predatory behaviour can increase vulnerability and this should be considered in the same way as vulnerability. Service users will if possible be involved in this assessment and they will be given an opportunity to record their views Service users will be actively protected from all forms of abuse including intimidation, coercion, bullying and threats of violence. Members of the opposite sex will not share sleeping, toilet or bathroom areas Women will have access to a protected women only area Male and female areas of the ward will be segregated at all times.

	Services users views about being in a mixed sex environment will be recorded. Service Users will have appropriate clothing to maintain dignity and avoid increasing vulnerability Increased levels of observation may be required to keep service users safe who are in a minority or who are isolated from their peer group Consideration should be given to the gender of staff undertaking constant and close constant observations. The gender of the name nurse will be taken into consideration. Service users will have access to medical staff of the same gender for medical examination if this is their preference. Every complaint or allegation will be documented and investigated
Precautions	
Policy links	Sexual Safety Standards Observation of In Patients Policy Domestic Abuse (Service Users) Personal Search Policy Safe guarding Adults Aggression and Violence Seclusion

Appendix 7: Informal notes from conference

National Mental Health Nurse Directors Forum

Co-production Event MHLD Nurse Directors & CQC Sexual Safety and Dormitories

Conference – London 20/4/18

Presentation on Sexual Safety in In- Patient Settings

What found?

- Figures from 54 trusts (58,000 incidents)
- Third of all incidents could be categorised as sexual assault or sexual harassment
- 29 cases of alleged rape
- 271 incidents of sexual assault

Categories:

- Number of incidents of sexual activity could be consensual
- Sexual contact unwanted by recipient
- Sexual activity where 1 party did not have capacity to consent
- Sexual assaults patients on staff
- Sexual behaviour triggered by patient psychopathology
- Allegations by service user of assault by staff or sexual activity between staff

- 97% reported as no or low harm. Many incidents that CQC felt should not be reported In this way.

Recipients:
- Most recipients and instigators are service users
- Significant number of staff are recipients
- May be higher as incidents may be reported by other means

Gender:
- In over one third of incidents the gender was not clear
- Quarter to a third of recipients are men
- Number of incidents between the same gender
- Number of incidents of female service users on men
- Not just about mixed gender wards incidents also on same gender wards

Location:
- Findings demonstrated that many incidents around sexual assault occurred in communal areas of wards and toilets etc
-

Provider response:
- Issues around variation in the quality of reporting
- Average reporting delay 21 days
- No information on recipient gender or the age of instigators/ recipients
- Abuse that staff endure is very under – estimated
- Issues around harassment via social media
- Looked at data from single sex wards v mixed wards. Data not clearly extrapolated
- Numerous same gender incidents
- Should it be a never event?? With regards to sexual safety
- Only 1-2 incidents reported with regards to transitioning service users
- Researchers haven't returned to trusts to follow up if further actions had been taken in relation to incidents

Discussion about issues arising from the data:
- Grading incidents
- Gender
- Staff reporting
- Verbal harassment
- Underreporting and response of police
- No evident correlation between single sex accommodation and safety
- Line of sight. One trust had designed nursing stations so nurses could not see service users unless they were out of the office where the service users are.

Table discussion around pros and cons of single sex accommodation from a Provider Perspective

(Each table had CQC inspector present to assist facilitating)

- Lack of available bed resulting in OOA placements
- Single sex accommodation allows for gender specific activities and interventions
- Decision making about beds made more straightforward
- Regulatory requirements easier to meet
- Higher burn out rates for staff on some female only wards, particularly where there are higher rates of EUPD as diagnosis
- Can be more difficult to meet regulatory requirements at times
- Exploration of environment – Discussion with Oxford staff and their new build- having staff out on the wards with smaller office spaces, access to tablets so staff can be in communal areas and complete work with service users. Oxford average LoS is 21 days
- Loss of balance that mixed wards bring
- May prevent some therapeutic avenues

Addressing Sexual Safety

Approaches taken so far-

Wide body of research – Report by MIND (" Wardwatch Campaign" ,2004)

18% of in pt's reported incidents of sexual harassment or sexual assault

Australia – significant amount of work being undertaken around sexual safety.

- Exploration around physical environments
- Collaboratively developed standards
- Service users given clear info on the right to sexual safety
- Work undertaken around reporting
- Training for staff and service users on reporting
- Integration of trauma informed care principles

Presentatation from South Staffordshire and Shropshire NHS Trust

- Review of 25 incident reports around incidents of sexual safety
- Number of findings, but no clear themes
- Lack of content within incident forms, looked in more detail at service users risk assessments and daily notes
- Teaching sessions were rolled out to staff around sexual safety in 90 minute sessions facilitated by psychologist discussing trauma issues and the Matron providing teaching around risk management and assessment strategies
- They found that breaches are not managed as well as they should e.
- W/M's complete weekly EMSA audits
- Exploration around historical risks, looking at level of b enhanced observations
- Service users provided with an alarm badge who felt unsafe on wards, that they could activiate the badge as necessary if they felt unsafe at any time
- Development of their service user information packs with discussion around sexual safety
- Developing staff confidence to complete trauma related care plans

- Discussion around physical intervention, eg restraint and past trauma are discussed with the service user
- Service user follow up as part as service user satisfaction survey includes asking how safe service users felt during the admission
- Community meetings held once per week
- Support provided by the local CCG Safeguarding lead to provide co – production

How do we discuss sexual safety with service users

- Have discussions around social media and what will be helpful during admission. (some trusts reported service users having secret facebook groups and were encouraging self harm behaviours)
- Boundary training – not only with staff but also with service users
- Having open and transparent conversations
- Considering type of language used

How can we achieve sexual safety

- Look at training provided to staff
- Undertake work around safeguarding thresholds
- Open and transparent culture
- Learning taken from serious/ challenging incidents
- Developing a general safety culture
- Working more closely with the police (Some trusts had their local neighbourhood officer regularly attending the ward, dealing with incidents of physical/ sexual assault)
- Ward welcome packs
- Look at the different needs of service users

Good Practice

Assessment tool to assist in helping staff. Cornwall are piloting a tool and using PDSA cycle to look at how it is being implemented. They are also developing a training page for staff

Police involvement on the wards. Neighbourhood beat manger. Will come to the ward to speak to service users and staff about incidents. Sending out letters to service users with anti social behaviour having good effect and resulting in change of behaviour

Reporting of incidents. Though there are different reporting systems in place in Trusts nationally

Staff seeing where the data goes.

Importance of giving staff examples of scenarios. Providing guidance as to the completion of incident forms

Safeguarding referrals

Policies and guidance

Governance processes and monthly dashboards

Learning from incidents

Building ward based portfolios

Independent evaluation of Impact

Multi – agency working

Preventative work

Referring service users onto other agencies

RECOMMENDATIONS

-Guidance of reporting incidents around sexual safety

- Leaders need to encourage staff engagement

- create culture where staff and S/U can talk openly about sexual health and sexuality
-Define what sexual safety actually means
- Grading of harm
- Need appropriate resources
- Encourage staff to speak openly
- Making sexual safety part of the key agenda within Trusts

Elimination of dormitories

- Does not support privacy or dignity
- Causes unnecessary distress and puts service users at risk
- Impacts upon recovery
- Service users reported feeling sexually unsafe
- Majority of dorms are in the NHS rather than private settings
- More prevalent in older adult settings
- There are more in the north than in London Trusts

Some slides and materials being held back to manage media interest. Guidance will be produced shortly.