Requires improvement

Sheffield Children's NHS Foundation Trust

Child and adolescent mental health wards

Quality Report

Becton Centre for Children and Young People,
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Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RCUX1	Becton Centre for Children and Young People	Sapphire Lodge	S20 1NZ
		Emerald Lodge	S20 1NZ
		Ruby Lodge	S20 1NZ
		Amber Lodge	S20 1NZ

This report describes our judgement of the quality of care provided within this core service by Sheffield Children's 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 Children's NHS Foundation Trust and these are brought together to inform our overall judgement of Sheffield Children's NHS Foundation Trust.

Summary of findings

Ratings

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

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

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

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

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

Summary of findings

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Summary of findings

Overall summary

We rated child and adolescent mental health wards as requires improvement because:

- Staff used restrictive practices to manage patient's behaviour. Some of these practices were not recognised correctly and were not handled in accordance with trust policy or the Mental Health Act code of practice.
- There was inconsistency and differing thresholds between staff about what incidents were reported as restraints. There were omissions in incident data and the system for reporting incidents did not allow for detailed incident analysis to be undertaken.
- Informal patients were not all aware of their rights as patients and aware they could leave. There was no evidence to demonstrate they were aware of and had consented to any restrictions with regards to leaving the service.
- There was no evidence of how staff had assessed patients as being competent to make their own decisions and give consent in relation to their care and treatment.
- Medicines were not always managed in a safe way and staff did not complete any audits to identify and address shortfalls and medication errors.
- Mental Capacity Act training was not mandatory for staff and there was no set plan about what training all staff required in order to be suitably equipped for their roles.
- Patients and parents said they were involved in their care plans but this was not reflected within care plans.
- There was no oversight of staff training and supervisions at service level in order to ensure staff received necessary training and support.
- There was a lack of audits that took place in order to monitor the effectiveness of the service.
- Some policies in relation to the Mental Health Act were still awaiting ratification and referred to out of date information.
- Some staff felt there was a disconnect between the service and the acute trust.

However:

- Staffing levels were reported to be good amongst most lodges although Amber lodge staff reported there were not enough staff.
- The service had a dedicated safeguarding nurse in post.
- Patients received an assessment upon admission to the service and support for their ongoing health. There was a wide ranging multidisciplinary team made up of a variety of professional disciplines.
- Staff said they received regular supervision and appraisal and were encouraged to undertake additional training. They felt supported within their teams and by their managers.
- Some patients said staff were caring and supportive. Parents of young people using the service said staff were caring, professional and respectful.
- Patients had access to advocacy services, said they were involved in their care plans and care reviews and had their own 'mini team' to support them
- The facilities and environments were designed in a way to meet the needs of the patients and individualised to the different patient groups.

Summary of findings

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

Are services safe?

Requires improvement

We rated safe as requires improvement because:

- Staff used restrictive practices, such as quiet rooms, to manage patient's behaviour. Some of these practices met the definition of seclusion. However, these were not recognised as such and were not dealt with in accordance with trust policy.
- There was inconsistency and differing thresholds between staff about what incidents and physical interventions were reported as restraints. Staff did not always complete incident reports fully.
- Informal patients were not all aware of their rights as patients and aware they could leave. There was no evidence to demonstrate they were aware of and had consented to any restrictions with regards to leaving the service.
- It was not always clear that incidents involving patients were referred as safeguarding concerns where they met the criteria.
- Medicines were not always managed in a safe way. Some were not dated as to when they had been opened and no records were made of patients returning medicines from leave.

However:

- Patients had risk assessments and management plans in place which were updated in response to any changes to risk level.
- There was a policy and action plan in place to work towards reducing restrictive practices.
- There was a dedicated safeguarding nurse in post who provided support and training to staff.
- Staffing levels were reported to be good amongst most lodges although Amber lodge staff reported there were not enough staff.

Are services effective?

Requires improvement

We rated safe as effective as requires improvement because:

- Mental Capacity Act training was not mandatory and not all staff had completed this.
- There was no evidence of how staff had assessed young people as being competent to make their own decisions.
- The service did not monitor application of, or record any breaches of, the Mental Health Act.
- Care plans were not always individualised and did not contain clear information about what support patients needed.
- There was a lack of audits that took place in order to monitor the effectiveness of the service and patient outcomes.

Summary of findings

However

- Patients received an assessment upon admission to the service. This included an examination of their physical health needs and ongoing monitoring.
- There was a wide ranging multidisciplinary team made up of a variety of professional disciplines. The professionals participated fully in multidisciplinary reviews and were available on the lodges.
- Staff received Mental Health Act training and were encouraged to undertake specialist training.
- Staff had access to supervisions and support within their roles.

Are services caring?

Good

We rated safe as caring as good because:

- Observations showed that staff were caring and respectful in their interactions with young people.
- Some patients said staff were caring and supportive. Parents of patients using the service said staff were caring, professional and respectful.
- Patients had access to advocacy services, both where they were detained under the Mental Health Act and informal. The advocacy provision had recently been increased.
- Patients and parents told us they were involved in their care plans and care reviews and had their own 'mini team' to support them.

However:

- Some young people reported they did not feel listened to by staff at times.
- Although patients and parents said they were involved in their care plans, there was little evidence within care records to reflect their input.
- There were opportunities for parents and patients to give feedback although staff acknowledged these could be improved.

Are services responsive to people's needs?

Good

We rated responsive as good because:

- There were processes to ensure admissions were necessary and suitable for the patient's needs.
- The facilities and environments were designed in a way to meet the needs of the patients and individualised to the different patient groups.

Summary of findings

- Patients always had their bed available whilst on leave as the service did not admit into leave beds.

However:

- The service accepted admissions from out of area in line with their contract for NHS England. This meant there were sometimes issues in relation to young people maintaining good family and home links.
- There were delayed discharges caused by reliance on other factors, such as funding and lack of suitable placements, in order to move patients on.

Are services well-led?

Requires improvement

We rated well-led as requires improvement because:

- There were regular meetings to review incidents however the system for reporting incidents did not allow for detailed analysis to be undertaken to identify themes and trends.
- There was no effective oversight of staff training and supervisions at service level.
- There was no set plan about what training all staff required in order to be suitably equipped for their roles.
- Some policies in relation to the Mental Health Act were still awaiting ratification.
- Some staff felt there was a disconnect between the service and the acute trust.

However:

- Staff reported that they felt supported within their teams and by their managers.
- The trust staff survey showed that the division had more positive responses about management than the rest of the trust.
- Staff kept up to date about changes and relevant information by way of regular staff meetings.

Summary of findings

Information about the service

The Becton Centre has four lodges which offer tier four mental health provision. Tier four services are highly specialist services for children and young people with serious problems, such as day units, specialised outpatient teams and in-patient wards. The Becton Centre takes referrals from regional and local community child and adolescent mental health service teams. It also accepts national referrals. The service provides care for patients who require admission under the provisions of the Mental Health Act 1983. It also provides care for informal patients who have agreed to be there. The service accommodates both males and females within the lodges.

Sapphire Lodge provides mental health care for 14-18 year olds with a serious mental illness who require hospital admission. There are five day places and 14 inpatient beds. At the time of our inspection, there were two patients detained under the Mental Health Act, and 12 patients were there informally. There were no day patients.

Emerald Lodge provides mental health assessment, care and treatment for 10-15 year olds with a serious mental illness, who require intensive day or hospital admission. There are seven day places and nine inpatient beds. At the time of our inspection, there were nine patients who were all informal. Three young people were accessing day provision.

Ruby Lodge accepts 8-18 year olds with amoderate to severe diagnosed learning disability with an associated mental illness that requires intensive assessment and treatment planning. There are seven inpatient beds. At the time of our inspection, there were five patients using the service. Four were informal and one was detained under the Mental Health Act.

Amber Lodge supports children aged 5 -11 years old who have complex mental health needs which require intensive input. The lodge can accommodate approximately 35 outreach cases and eight day places. During the time of our inspection, 15 children accessed day provision on Amber lodge. Eleven children accessed outreach provision.

Sheffield Children's NHS Foundation Trust has been inspected three times by the Care Quality Commission since it was registered in April 2010. The Becton Centre for children and young people has never been inspected as part of these inspections.

Our inspection team

The team was comprised of two CQC inspectors, a child and adolescent mental health consultant psychiatrist, a nurse who specialised in tier 4 children and adolescent mental health, a child and adolescent mental health clinical psychologist, a mental health act reviewer, a pharmacist and an expert by experience. The expert by experience had experience of the type of service we inspected.

Why we carried out this inspection

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

How we carried out this inspection

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

- Is it safe?
- Is it effective?

Summary of findings

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

Before the inspection visit, we reviewed information that we held about these services and asked a range of other organisations for information.

During the inspection visit, the inspection team:

- visited all four lodges at the Becton Centre, looked at the quality of the environment and observed how staff were caring for patients
- spoke with three patients, and six parents of patients, who were using the service
- collected feedback from three patients using comment cards
- spoke with the managers of each lodge
- held three separate focus groups for support workers, qualified nurses and allied health professionals
- spoke with a range of other staff members; including consultants, speciality doctors, deputy managers and teachers
- spoke with the clinical and associate director with responsibility for the service
- spoke with the lead nurse for the service
- spoke with the mental health act administrator
- spoke with an Independent Mental Health Act advocate
- attended and observed one hand-over meeting, one referrals meeting and two multi-disciplinary meetings.
- attended and observed a young people's business meeting
- looked at nine care records for patients
- carried out a specific check of the medication management on Sapphire and Emerald lodge and 17 drug charts
- looked at a range of policies, procedures and other documents relating to the running of the service

What people who use the provider's services say

We gave all children and young people the opportunity to speak with us during the inspection. We spoke with three patients and received feedback from three comment cards.

Feedback was mixed as some young people felt that staff were caring and kind and listened to them. Some felt the opposite of this and said staff weren't always caring and did not listen to them. Young people felt they were waiting long periods of time to receive any treatment.

Parents we spoke with said staff were caring, kind and professional. The majority spoke very highly of the service and the support their child received. Parents reported seeing positive changes in their child.

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that practices used by staff to manage behaviour such as time out and seclusion are used and recognised correctly. Staff should follow applicable procedures for the use of these practices with clear rationale and evidence documented.
- The provider must ensure that informal patients are aware of their rights, and any restrictions, and

understand these when they consent to their admission and treatment. Staff should not use the threat of detention in order to prevent patients from leaving where this is not a justifiable and required intervention.

- Staff must ensure that incidents involving abuse between patients are referred as safeguarding concerns where necessary. Evidence of safeguarding considerations must be documented accordingly.
- The provider must ensure that there is consistency between staff about what incidents are reported and what the threshold is for reporting physical interventions.
- The provider must ensure there are appropriate systems in place at service level in order to effectively assess and monitor the service and how it operates. This should include the ability to identify and monitor staff training requirements and that staff supervisions are undertaken in accordance with policy.
- The provider must ensure there are effective systems and processes in place to monitor medicines management and infection control practices. These should be able to identify and highlight shortfalls in practice which must be addressed as necessary.
- The provider must ensure that that policies in place in relation to the Mental Health Act appropriately reflect current practice and legislation.
- The provider must ensure that relevant staff receive appropriate training in the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.
- The provider must ensure that there is appropriate oversight of the application of the Mental Health Act and any breaches of this within the service.

Action the provider SHOULD take to improve

- The provider should review how it can improve and evidence the involvement of patients in formulation and review of their care plans and make these more patient centred.
- The provider should review how it demonstrates that patients deemed to be Gillick competent have been assessed as such.
- The provider should consider whether the service can improve ways of obtaining feedback from patients in order to influence the service
- The provider should look at ways of ensuring patients get access to advocacy that suits their individual needs.
- The provider should consider whether there are any ways to facilitate parental visits so these can take place in patient rooms and consider whether patients are able to have their own room keys where safe and justifiable.

Sheffield Children's NHS Foundation Trust

Child and adolescent mental health wards

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Sapphire Lodge	Becton Centre for Children and Young People
Emerald Lodge	
Ruby Lodge	
Amber Lodge	

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 Health Act training had recently become mandatory for qualified staff. The provider reported over 85% compliance with this training across the four lodges. This met the trust training target of 85%.

Mental Health Act documentation for the three detained patients was primarily in good order. One person had conflicting information present about their ability to consent to treatment under the Act. This was rectified during our inspection.

There was evidence that staff read detained patients their rights on detention, and a week later, however this was not repeated at routine intervals. Staff referred detained patients for independent mental health advocacy support.

A Mental Health Act administrator employed by Sheffield Health and Social Care Trust provided Mental Health Act administration duties to the service. This was via a service level agreement with the children's hospital trust.

Mental Health Act documentation was audited at lodge level via monthly clinical audits. However, Mental Health Act activity was not monitored at board level. The service did not record breaches of the Mental Health Act as incidents which meant there was no way to capture and monitor these.

Detailed findings

Many policies relating to the Mental Health Act had not been updated since the changes to the Mental Health Act Code of Practice in April 2015. Several of these policies were in draft format and awaiting sign off but still referred to out of date information.

Mental Capacity Act and Deprivation of Liberty Safeguards

Mental Capacity Act training was not mandatory for staff and not all staff had completed this training. Staff on Ruby lodge who supported patients with learning disabilities told us they had completed this. Others who had not completed the training said this was being planned for all staff.

The consent policy incorporated the Mental Capacity Act and provided guidance about the key principles of the Act and assessments of capacity. There was also a policy for the Deprivation of Liberty safeguards which are part to the Mental Capacity Act.

The service provided conflicting information about the rights of young people under the age of 18 and use of the Deprivation of Liberty Safeguards. These safeguards do not apply to people under the age of 18 years. If the issue of depriving a person under the age of 18 of their liberty arises, other safeguards must be considered. These include the existing powers of the court, particularly those under s25 of the Children Act, or use of the Mental Health Act. This suggested a lack of understanding around the Mental Capacity Act legislation and associated Deprivation of Liberty Safeguards and meant there was a risk the Act may not be applied correctly.

We saw evidence of signed consent in care records. For children under the age of 16, a young person's decision making ability is governed by Gillick competence. This recognises that some children may have sufficient maturity to make some decisions for themselves. Staff said if the patient was Gillick competent and had capacity to make their own decisions they could give their own consent. However, We saw no evidence of assessments to demonstrate how this had been considered.

Parents confirmed that staff contacted them to give consent on behalf of their child where necessary.

Requires improvement

Are services safe?

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

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

Our findings

Safe and clean environment

The layout of the lodges allowed for good lines of sight and observation. There were some blind spots, such as bedrooms corridors, which staff mitigated by regular observations of patients. Access to bedrooms was restricted during certain hours of the day which also reduced risks to patients.

Managers had completed ligature risk assessments to identify and mitigate potential ligature points. Where there were risks, these were addressed by high staff presence or patients being supervised whilst in the area. We saw open disabled access toilets with grab handles on each lodge which had been recorded on the risk assessments. Patients were individually risk assessed for their use. Bedroom doors were anti barricade so could be opened both ways for staff access if a patient attempted to barricade themselves inside. Staff carried personal alarms which we saw and heard in use throughout our inspection.

The inpatient lodges were mixed gender and all complied with Department of Health guidance on same sex accommodation. Bedrooms were ensuite and there were female only lounges. Each lodge had a clinic room with resuscitation equipment that was checked regularly. Equipment was present to undertake physical examinations such as blood pressure and height and weight measurements. Staff undertook daily and weekly environmental checks.

There was one seclusion room on site which was located in a corridor between Sapphire and Emerald lodge. This room was not in use. The trust was considering possible future use of the room as part of a section 136 suite for children taken into police custody requiring a mental health assessment.

The lodges were generally clean and well maintained. Parents said they were kept clean to a high standard. Two patients on Sapphire Lodge felt it was not always cleaned suitably at times. Issues relating to cleanliness had been raised in previous meetings. We saw completed cleaning records for the lodges and cleaning staff present. The patient-led assessments of the care environment scores for the Becton Centre was 99% for cleanliness and 98% for condition, appearance and maintenance.

Safe staffing

Each lodge comprised of a core group of doctors, nursing staff, allied health professionals, support workers and administration staff. Sapphire Lodge had the highest provision of whole time equivalent staff. Amber Lodge had the least. Trust data showed Sapphire Lodge had vacancies for two band six nurses and 1.6 whole time equivalent support workers. Emerald lodge had vacancies for two band six nurses and two support workers. Amber lodge had vacancies for a nursing apprentice and one support worker. Ruby lodge had no vacancies for nursing and support staff at the time of our inspection.

Recruitment was ongoing to fill vacancies and some vacant posts had recently been recruited into. Banks and agency staff were used to cover vacancies and absences where required. Managers tried to use the same staff to provide consistency and familiarity for patients. Between the period of December 2015 and May 2016, Sapphire Lodge had the highest agency use with 2902 hours. Ruby Lodge had 781 hours use, Amber Lodge had 634.5 hours use and Emerald Lodge had the least use of 522 hours.

Managers could adjust staffing levels to suit the needs of patients. For example, where there was high acuity and where patients needed extra observations. They told us they would use staff from other lodges where available and staff confirmed they helped on other lodges at busy times.

Staff gave mixed views of staffing levels. Ruby Lodge supported patients with learning disabilities and was staffed to provide one to one support. Staff on this lodge commented positively about staffing. Staff on Sapphire lodge said agency staff were used frequently. Staff on Amber Lodge told us there were not enough staff to support the amount of children. They said sickness and staff absences could put pressure on the team at times, especially if at full capacity with children. Some allied health professionals felt there was not enough capacity from certain disciplines to be able to cover the lodges.

Requires improvement

Are services safe?

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

Staff were present and visible on all of the lodges and spent time in communal areas with patients. Patients said there were enough staff but one said Friday afternoons were quite busy on their lodge. The lodge manager was aware of this and was looking to increase staffing during this time. Parents commented about high staff ratios and good staff visibility during visits.

Each lodge had dedicated consultant psychiatrist input but recruitment of these had been a challenge and recognised as a risk at trust level. Sapphire Lodge had recently recruited into two consultant positions after a period of approximately 18 months using locums. Emerald Lodge had not had a permanent consultant since August 2015. The current locum consultant had been in place for some time so provided consistency. There were two on call rotas for out of hours medical provision which consisted of junior doctors and consultants. Staff were able to access emergency provision in a timely manner.

The trust target for mandatory training compliance was 85%. The service had achieved 88% compliance overall. However, there were some shortfalls within individual subjects. For example, 81% of staff had completed fire safety training, 77% had completed infection control, 69% had completed level 2 resuscitation and 75% had completed safeguarding level 3 training.

Assessing and managing risk to patients and staff

Staff completed a risk assessment for patients upon admission to the service which we saw in care records. These were reviewed regularly and in response to incidents. Patient risk was discussed on an ongoing basis. This included discussions in ward rounds, staff handovers, within 'mini teams' and in staff supervisions.

A working group had been set up in 2014 to look at reducing restrictive practices. A current action plan had been derived from this. However, we identified concerns around restrictive practices and how these were used and reported. Trust data said between November 2015 and May 2016 there had been no use of seclusion or long term segregation. There was a lack of clarity amongst staff about what constituted seclusion as defined by the Mental Health Act code of practice. The trust's seclusion policy provided a distinction between the use of 'time out' and seclusion. It said time out should last for a maximum of 15 minutes. Anything longer, or if the patient was prevented from freely leaving the room, was seclusion.

Staff used quiet rooms to de-escalate behaviour of patients and maintain safety. They reported use of these as incidents. There were over 75 uses of the quiet room in the 12 months prior to our inspection. The reports referred to patients being escorted by staff to quiet rooms as opposed to requesting to use the room. Staff said patients behaviour in many cases would determine if they could leave the room which meant they were not always free to leave. The majority of reports did not include the length of time patients had spent in the quiet room. None referred to the use of 'time out'. This meant it was not possible to ascertain which of these episodes may have constituted seclusion. Not all patients were detained under the Mental Health Act. The Mental Health Act Code of Practice states when seclusion is used, assessments for detention under the Act should be considered. There was no evidence of any consideration of such an assessment for informal patients. The information demonstrated that practice amounting to seclusion was being used but patients were not afforded the safeguards and procedures that seclusion necessitated.

Staff had restraint training that was refreshed annually. They said restraint was always used as a last option. However, recording of restraint was not consistent. For example, some staff on Amber lodge said restraint was used frequently, sometimes 'every other day'. This was not reflected in the incident reports. We found staff did not necessarily report physical interventions that were used routinely and care planned for individual children, unless they were in excess of what may be expected. However, on Ruby Lodge staff were expected to report all instances of staff placing hands on a patient. This meant there were differing thresholds of what staff reported as restraint which could lead to inaccurate information. The lead nurse confirmed all staff should report any form of physical intervention.

We were not able to accurately establish how often prone restraint was used. Prone restraint is when a person is restrained face down which can result in dangerous compression of the chest and airways and put the person being restrained at serious risk. The trust reported no prone restraint between May 2015 and May 2016. However, incident reports recorded two uses of prone restraint during this period. Twenty one incidents did not record any response to the prompt about whether prone restraint was used. This meant the reporting of types of restraint was not robust.

Requires improvement

Are services safe?

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

Staff said debriefs took place following restraint and they would look at whether the situation could have been managed differently. Debriefs did not routinely take place with patients. Debriefs were not documented which meant there was a risk that key learning could get missed.

There were some restrictions in place for patients to prevent isolation and encourage patients to participate in school and treatment. For example, patients had access to their rooms and mobile phones at certain times during the day. Some patients on Ruby lodge had keys to their room but patients on other lodges did not. Family members and visitors were not allowed to visit in bedrooms. Some parents and a patient said they did not know the reason for this. Staff said it was to protect the dignity of other patients.

The majority of patients were informal but not all understood their rights. One informal patient did not know if they were allowed to leave. They had written questions to be asked at ward rounds about how to get leave and what would happen if they left. Another informal patient had made numerous written requests to leave the service. A parent told us staff were unclear about what would happen if their child, an informal patient, tried to leave. In these cases, the patients, although under 16 had capacity to make their own decisions according to staff and parents. Staff said if informal patients asked to leave, they would assess this on an individual basis. Some treatment pathways meant patients were expected to stay at the service without leave during the initial stages of their treatment. There was no evidence that informal patients who were competent to make their own decisions were aware of, and had agreed to, any restrictions on their stay.

The service had restricted access to, and exit from, the lodges. The policy for managing access and exit said there should be clear information for patients as to the rationale for these restrictions as well as clear signage at entrances and exits explaining the procedure for how to access and exit the service. This information was not present which meant informal patients may not be aware of how they were able to leave.

We saw one patient had recently been placed on a section under the Mental Health Act due to concerns about their behaviour. The documentation was later found to be have been incorrectly completed, invalidating the detention. Staff made the young person aware of the mistake and advised them of their status as an informal patient. The patient's notes showed they were told if they tried to leave the ward, they would be placed on a section under the Act. The Mental Health Act Code of Practice states that the threat of detention must not be used to coerce a patient to consent to treatment or admission.

Levels of patient observation were based on risk level. Enhanced observations were used for patients identified as high risk. Staff completed minimum hourly observations but these were not documented. The lead nurse said the observations policy was being revised so that evidence of observations was more robust. This included documenting all observations.

Staff were required to complete level three safeguarding children training. Safeguarding was an ongoing agenda item in team meetings. A dedicated safeguarding nurse and two social workers were based at the service who could provide safeguarding advice and support. Staff reported good working relationships with local authorities however some felt links were not always effective and some concerns not seen as a priority. There were no ongoing safeguarding investigations at the time of our inspection. Incident reports for the previous 12 months showed instances where patients had assaulted other patients. The reports did not state whether safeguarding referrals had been made, or safeguarding advice sought. As such, we could not be confident that safeguarding procedures had been robustly followed in these instances.

The trust had a safeguarding children policy that had regard to the statutory guidance, Working Together to Safeguard Children (2013). However, this statutory guidance was updated in 2015; there was therefore a risk that current guidance was not reflected in the policy.

We found some shortfalls with the management of medicines. Arrangements were in place for medicines required in the event of a medical emergency. Medicines were stored safely and fridge and room temperatures were recorded daily. On Emerald lodge, we found that some medicines with reduced expiry dates when opened did not have the opening date recorded on them. This meant that it was not possible to determine whether these were still safe to use. On Sapphire Lodge, one patient had specific allergies recorded on their drugs chart which contradicted allergy information in their care plan. Staff rectified this during our visit to ensure the correct information was recorded. One patient on Emerald lodge had a record made of them being issued with 'leave' medicines. There was no record of any medicines being returned. A staff

Requires improvement

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member said if medicines were returned, no record was made and they were sent back to the pharmacy for disposal. This meant staff would not be able to establish whether a patient had taken their medicines whilst on leave. We saw the word 'micrograms' had been abbreviated incorrectly on a drugs chart. This had been countersigned by the pharmacist and not identified as an issue. The service level agreement for management of medicines said abbreviations should not be used and should be logged as an incident where identified.

Track record on safety

No serious incidents requiring investigation had been reported in the 12 months prior to our inspection.

Reporting incidents and learning from when things go wrong

Staff were aware of the procedures for incident reporting and how to make reports. Extra training was being delivered as part of the reducing restrictive practices plan. This was to help improve omissions in incident reports such as times and details of restraints and precursors to incidents. The trust did not have an electronic system for reporting incidents. Staff completed incident forms on paper record, or on a word document, which each lodge manager had oversight of. Senior managers discussed these at weekly meetings. Staff received feedback following incidents which was shared in their team meetings. However, the current system meant it was not easy to effectively identify trends and themes at lodge level. The lead nurse said although possible, it would be a timely and unwieldy process to do this. This meant there were limitations about how incident data could be used in order to improve the service.

The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients, or other relevant persons, of certain 'notifiable safety incidents' and provide reasonable support to that person. The duty of candour was incorporated into the trust's incident reporting policy. Training in the duty of candour was being rolled out to staff.

Are services effective?

Requires improvement

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

Our findings

Assessment of needs and planning of care

Staff completed a comprehensive assessment for each patient upon their admission to the service. These were present in care records we looked at. Doctors also completed a physical examination of each patient. Staff completed routine checks and monitoring of patients' physical health which we saw kept in files on the lodges. Parents confirmed their children received support with their physical health.

Care plans were not always clear about what support patients required. For example, one patient's care plan which stated they had a disorder on the autistic spectrum. There was no detail about what the disorder was and any support they needed in relation to this. The same person had a medical condition but the care plan did not provide information about how to identify when the patient required support and what interventions were needed. However, we also saw examples of care plans which were comprehensive and contained evidence of tasks and goals that patients were working towards. We saw some workbooks that staff had developed on Sapphire lodge to help patients manage self harming behaviour and eating disorders.

Positive behaviour support is an evidence-based approach used to support people with behaviour that challenges. We saw draft positive behavioural support plans that the service planned to implement. These were not in place at the time of our inspection. Staff on Ruby lodge, which supported patients with learning disabilities, had begun to have training in positive behavioural support. Staff said they used the premises of positive behaviour support in their practice but this was not yet embedded and evidenced in care plans.

It was not easy to locate information within care records. Care records were paper based and some patients had several large care files each. Some staff said it could take time to locate information due to the size and amount of documentation, particularly if trying to locate something specific. Information technology systems were seen as a frustration by some staff. Teachers at Becton school had to go on the lodges to write in care plans and access trust policies due to the lack of an electronic system. The trust was in the process of implementing electronic patient records across all sites but staff said this was a slow process. Care records were kept locked in staff rooms and accessible only to staff.

Best practice in treatment and care

Staff completed outcome measurement tools recognised by the National Institute of Health and Care Excellence and Department of Health. These included the health of the nation outcome scales for children and adolescents and the children's global assessment scale which is used by mental health clinicians to rate the general functioning of children under the age of 18.

The service offered a wide range of psychological therapies. These included family therapy, cognitive behavioural therapy, psychology, and speech and language therapy. Two patients said they had to wait what felt like long periods of time for their treatment. An advocate who attended the service told us that waits, and frequency of treatments was a concern raised by patients and they expected more treatment than they received.

A paediatric consultant attended the service one day a week to assist patients with physical health needs. Managers said they could make referrals for patients to be seen by the consultant.

Managers completed monthly clinical notes audits. These focussed on the contents of care records and Mental Health Act documentation for detained patients. There was a lack of further clinical audits completed across the lodges to monitor the service in key areas. For example, no audits were undertaken for medicines and infection control. Managers said audits only tended to take place if a clinician was undertaking a project as opposed to being a core ongoing feature of working practice. One manager felt there were areas to undertake further audits at lodge level. The clinical director said as a service they wanted to do more work around monitoring and identifying the outcomes of interventions as this was a weak area.

Skilled staff to deliver care

There was a wide range of professional disciplines available. These included: family therapists, occupational therapists, drama therapists, art therapists, speech and language therapists, psychologists, social workers, dieticians and outreach workers. The school was on site and run by qualified teaching staff. The multidisciplinary

Are services effective?

Requires improvement

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.

team were based on the lodges which helped to ensure they were accessible. Some felt they were able to have more influence and involvement by being situated on the lodges.

Nursing staff for three lodges were all registered mental health nurses. Ruby lodge provided support for young people with learning disabilities. A mixture of mental health nurses and learning disability nurses worked on this lodge to support the patient's needs. The manager said the rotas were planned to ensure there was a mix of nursing disciplines on the shift.

New staff completed a corporate induction and a then a local induction at the service. A two day introduction to child and adolescent mental health course was available to staff which managers encouraged staff to attend. Completion of the course allowed staff access to further specialist training such as eating disorders and self harm in children and young people. Some staff said it could be difficult to get on courses as they were often fully subscribed. Various in house training also took place which included training from external organisations. Staff were positive about the training they received. However, it was not apparent what training each staff member had undertaken and what they were expected to complete. The lead nurse said the training department was undertaking a learning analysis to establish exactly what training each staff group needed.

Staff said they had regular clinical and managerial supervision. One manager said although there were plenty of opportunities for staff to get together, supervisions were 'hit and miss' at times, particularly where there were high levels of sickness and staff absences. Various staff meetings took place on the lodges including staff group meetings, full team meetings and team supervision. Staff participated in shared knowledge sessions to promote information sharing and good practice.

Staff received annual appraisals and were encouraged to develop professionally and expand their skills where they were able to. The trust target for appraisal rates was 80%. All staff groups had exceeded this rate, with the exception of allied health professionals who had an appraisal rate of 37%. Some staff felt there was limited progression for qualified staff within the service which may contribute to staff turnover.

There were processes to address staff performance issues. These included informal discussion in managerial supervisions through to disciplinary procedures where appropriate.

Multi-disciplinary and inter-agency team work

Regular multidisciplinary meetings took place on all lodges. We observed two of these on Sapphire and Amber Lodge. These were well attended by members of the multidisciplinary teams which meant there was good range of knowledge and expertise present. At the Sapphire lodge meeting, patients contributed their views by either attending or writing down their thoughts beforehand for discussion. Where patients chose not to attend, staff fedback the contents of meeting discussions afterwards. There was good participation from staff present at both meetings. Patients were discussed in detail and exchanges between the team were positive and respectful. Discussions were goal focussed and individualised to the patient's needs. Parents and patients told us they had opportunity to contribute and were kept up to date with outcomes from the meetings.

Staff handovers occurred at each shift change. Staff said all patients were discussed even if they were on leave at the time. Staff found handovers were informative and prepared them for the shift ahead. We observed a handover on Sapphire lodge. This was attended by the deputy manager, nurses and support workers. Staff discussed detailed information about all patients including risks, incidents, mood and mental state, engagement and physical health. However, no information was documented in the handover and information passed on did not explicitly state what observation levels each patient was on. This meant there was a risk of patients receiving inconsistent support.

Staff said they had good working relationships with other teams and external organisations, such as community child and adolescent mental health teams and the local authority. Some staff had been seconded to work in other projects at other services. A deliberate self harm rota was in operation which staff were part of for admissions to the acute children's hospital. The purpose was to assess young people who had attended with self harm. The clinical and associate director told us they hoped to create further joint working, particularly within their own division and with the community health teams. The service worked with a local children's and young people's charity who had been involved in projects with the service.

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Becton School was based on site and there were school facilities on each lodge. The Office for Standards in Education, Children's Services and Skills had awarded the school an 'outstanding' rating in 2015. Teachers were part of the 'mini teams' in place for each patient and were involved in care plan reviews and multidisciplinary meetings. The head teacher and deputy told us they had good partnerships with staff, felt valued and part of the wider team.

Adherence to the MHA and the MHA Code of Practice

The trust reported that Mental Health Act training compliance was; Emerald lodge 90%, Sapphire lodge 85%, Ruby lodge 85% and Amber lodge 80%. These figures included nursing staff and allied health professionals. Mental Health Act training was not included in the list of mandatory training provided by the trust however, managers and staff said it had recently become mandatory. Qualified staff confirmed they had access to this training. Doctors told us they were expected to attend relevant training in relation to the Mental Health Act. The training included the updates in the latest Mental Health Act code of practice.

We checked the Mental Health Act documentation for the three detained patients. The majority of information was correct and in good order. One patient had a T2 form signed by their responsible clinician. A T2 is completed when a detained patient has the capacity to consent to treatment (medication) and has done so. However, the same patient had a capacity and consent form signed by a doctor a week later than the T2 saying the patient had no insight and lacked capacity. This contradicted the premise of the previous T2. During our inspection, the responsible clinician rectified this and noted that the T2 was correct and the young person had capacity to consent.

There was evidence that detained patients were read their rights on detention and then a week later. It was not documented that patients were reminded routinely of their rights during their detention. The lead nurse said staff would not do this regularly if the patient had already understood. This was not in accordance with the requirements in the Mental Health Act code of practice and the trust's own policy which state detained patients should be regularly reminded of their rights. Staff referred detained patients to independent mental health advocacy services when admitted to the service.

A Mental Health Act administrator employed by Sheffield Health and Social Care Trust provided Mental Health Act administration duties to the service. This was by way of a service level agreement between both trusts. The administrator was a point of contact staff could go to for information and queries about the Act. Two social workers at the service were approved mental health practitioners and were another resource for staff to access for advice.

Managers completed a monthly clinical note audit which included checks of Mental Health Act documentation. No Mental Health activity was reported to board level which meant there was no oversight by the trust about use of the Act. Staff did not record breaches of the Mental Health Act as incidents so there was no way to effectively identify and monitor any breaches.

Good practice in applying the MCA

The Mental Capacity Act applies to people aged 16 and over. Both Sapphire and Ruby lodge were able to accept 16 and 17 year old patients. The Act did not apply to patients on Emerald and Amber lodge, all of whom were under 16 years of age.

It was not possible to establish from information the trust provided, how many, and which staff, had completed Mental Capacity Act training. Staff on Ruby lodge told us they had completed the training. Other staff who had not completed the training said this was being planned for all staff.

For children under the age of 16, a young person's decision making ability is governed by Gillick competence. This recognises that some children may have sufficient maturity to make some decisions for themselves.

We saw evidence of signed consent in care records. For example patients and their parents had signed consent to treatment, consent to share information and consent for photographic images. Staff we spoke with were aware of the principles of Gillick competence and said this would determine if young people could make and consent to decisions regarding their care. However, there was no evidence of how staff assessed patients as being Gillick competent where they were considered to be. Parents signed consent on behalf of children where this did not apply. Parents confirmed that staff contacted them to give consent on behalf of their child where necessary.

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The consent policy incorporated the Mental Capacity Act and provided guidance about the key principles of the Act and assessments of capacity. There was also a policy for the Deprivation of Liberty safeguards which are part to the Mental Capacity Act.

The service had an information leaflet titled 'consideration of deprivation of liberty'. However it provided conflicting and incorrect information as it referred to the rights of young people under the age of 18 and gave guidance about when to apply for deprivation of liberty' safeguards. However these safeguards only apply to people aged 18 years and over. Application for children and young people deprived of their liberty would need to be made to the court of protection. This suggested a lack of understanding around the legislation and meant there was a risk it may be used incorrectly.

Good

Are services caring?

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

Our findings

Kindness, dignity, respect and support

We observed caring and supportive staff interactions with patients. Staff spoke with patients respectfully and spent time with patients in communal areas. The atmosphere was calm and relaxed across the lodges and we saw young people also spent time together and conversed with each other. Staff demonstrated a good understanding of patients and were able to describe the needs and preferences of the patients they cared for.

We offered patients the opportunity to speak with us during the inspection. Three spoke with us directly and three completed comments cards. Three patients were positive about staff and said they were caring, supportive and listened and explained things to them. Two felt that staff did not listen to them and did not always have a caring approach.

We spoke with seven parents of patients via telephone. All said that staff were polite, caring and respectful. One parent described staff as 'an absolute credit'. Another told us that their child who accessed day service provision really enjoyed going and came back with a smile on their face. They said the staff were 'lovely people and very caring'. Another told us their child had settled in at the service and although they would rather be at home they 'loved it there and loved the staff.' All parents said they were treated with kindness by staff when they visited and that staff acted with professionalism and were friendly.

We did not hear staff discuss any personal information openly or compromise people's confidentiality. Young people said staff respected their privacy and cited examples such knocking on their doors before entering. At the young peoples' business meeting on Sapphire Lodge that we attended, some patients raised an issue that had occurred previously regarding confidentiality. This related to staff reading out audibly during medication administration what medicines patients took. Staff told patients they would address this and acknowledged it compromised patient's privacy.

The patient-led assessments of the care environment scores for privacy, dignity and wellbeing at the Becton Centre was 87.5%.

The involvement of people in the care they receive

Parents received information about the service and what to expect prior to their child's admission. One parent said their child was admitted as an emergency but they had an introductory meeting very soon afterwards so they knew what to expect and could ask questions. We saw information packs that were provided to parents which included the rules of the lodges and visiting times. Each lodge had its own specific information brochure. At the young people's business meeting on Sapphire lodge, patients said they would like a welcome pack that was more personal as information in the current ones felt clinical. Welcome packs were in the process of being reviewed.

Staff told us patients were encouraged to participate in compiling and reviewing their care plans. Patients confirmed they were involved within these. Parents said they had opportunities to be involved with their child's care plan and attend reviews. Staff said patients could have copies of their care plan if they requested but it was not routinely given to each patient. One parent told us they were given a copy of their child's care plans and the information helped reassure them that staff knew their child.

Care plans we saw included evidence of patients' involvement by way of signatures where they had chosen to sign. There was little evidence of any other involvement besides this. Information appeared standardised and did not give a holistic view of the patient. For example, we could not easily identify information such as what was important to the young person, their likes, dislikes, strengths and wishes for the future. It was not clear what parts of the plans the patient had contributed to directly. Care plans were reviewed but there was no or little input evident from patient within these reviews. The lead nurse said they would like to improve involvement of patients in their care plans.

Each patient had a 'mini team' which consisted of various professionals responsible for supporting the patient. Within this team, there was a named nurse and support worker. Patients were able to tell us who their keyworkers were. Parents were involved within the mini teams and said they were kept updated by the team about relevant information. One parent, although positive about their child's mini team, said sometimes if keyworkers were off work, information did not always get passed on to whoever was covering in their absence.

Good

Are services caring?

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

Advocates regularly attended the service and held drop in sessions for patients. This had been regular practice since October 2015. The advocacy service offered independent mental health advocacy for patients detained under the Mental Health Act and general advocacy support for informal patients. Advocacy provision had proved to be popular with patients and as a result it had been increased to reflect demand. Advocacy support was available for patients' family members also. We spoke with one advocate who said they hoped to be able to undertake advocacy sessions on an individual basis with patients. Advocacy was currently provided in group sessions which were sometimes interrupted for necessary things such as physical observations. Group sessions also meant some patients may not feel as confident to speak up. The advocate acknowledged that individual sessions may be difficult to facilitate due to the routine and structure of the service but it felt would be beneficial for patients. The advocacy service had good relationships with staff.

There were opportunities for patients to give feedback. These included young people's business meetings on Sapphire lodge and user involvement groups on Emerald lodge. Ruby lodge did not have specific groups for patients to provide feedback. Amber lodge was day provision and parents said they could give feedback on behalf of their children. We saw minutes of the meetings on Emerald and Sapphire lodge where patients had raised their concerns. These were responded to by staff stating what action they would take. The meetings also contained praise from patients to various staff members which was passed on as necessary. One patient felt staff only addressed urgent things from these meetings. There were various boxes and envelopes on the lodges for patients to provide written feedback. Some staff felt there could be further opportunities for patients to give feedback and be involved in influencing the service.

The service sought feedback by way of inpatient service user and parent and carer feedback surveys called 'tweak' surveys. Feedback could be given both during the patient's stay and after discharge. The results of these were collated each quarter and analysed for positive and negative responses. A summary of the findings and actions were documented so managers knew where they needed to make improvements. Parents told us they would speak with staff about any feedback they wished to give and felt staff would take this on board.

Are services responsive to people's needs?

Good

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

Our findings

Access and discharge

There were procedures to consider and discuss referrals and admissions to the service. We observed a referrals meeting on Emerald Lodge. Attendees were the locum consultant psychiatrist, the lodge manager, clinical psychologist, nurse and the administration team leader. A local commissioner usually attended but had given their apologies for this meeting. The purpose of the meetings was for staff to look at all options that were available and whether admission was needed. All staff contributed to the discussion and referrals were discussed in detail with clear actions in place for the next steps. Managers told us they found these meetings very beneficial.

Average bed occupancy, including leave, for each lodge between June 2015 and May 2016 was: Emerald Lodge was 77%, Ruby Lodge was 71% and Sapphire Lodge was 95%. The NHS Benchmarking Network for 2014/2015 showed that mean bed occupancy rates, including leave, across child and adolescent mental health services was 90%. The service did not admit people into beds already being used by patients whilst they were on leave.

The service received referrals primarily from the geographical area of Yorkshire, Humber and Bassetlaw. They also accepted national referrals in accordance with NHS England contract requirements. Out of area placements for each of the lodges between June 2015 and May 2016 was: Emerald lodge had ten out of area placements, Ruby Lodge had ten and Sapphire Lodge had four. Regular meetings took place to discuss out of area placements and look at returning patients to their own area. There were issues that arose where patients were admitted from out of area. These related to family contact and linking in with other services, both of which were made more difficult due to the geographical distances.

Each lodge catered for a specific criteria and age group of patients. Patients at the service spent their time on the same lodge throughout their stay. One parent's child had spent time on two separate lodges during two separate periods of admission. They said the lodge their child was on had been assessed beforehand to ensure it was suitable for their needs at that time. Patients were discharged in the day time and only when appropriate discharge arrangements had been made.

During the period of 1 April 2015 to 31 May 2016 there were four delayed discharges. The main cause of delays was lack of appropriate placements and services for patients to be discharged to. This was especially problematic where patients were placed from out of area as there was less familiarity with the services available where the patient resided. We spoke with a parent of one child whose discharge had been significantly delayed. They spoke highly about staff and the amount of work they had put in to ensure their child moved on to a suitable service. Staff had worked jointly with the new service their child was moving on to in order to ensure there was a smooth transition. However, another parent felt that their child was being discharged with no suitable support in place. They said that the criteria for their child's discharge had changed from what they were originally told.

Sapphire lodge accommodated patients up to becoming 18 years old. There was no guidance around transition of patients to adult services. The manager said transition could be difficult because the thresholds were very different in adult services.

The average length of stay for inpatients as of 1July 2016 was: Emerald Lodge was 16 weeks, Ruby Lodge was 9.6 weeks and Sapphire Lodge was 23 weeks. The average length of stay for the 12 months prior to this was: Emerald Lodge was 15.6 weeks, Ruby Lodge was 19.6 weeks and Sapphire Lodge was 14.5 weeks. Ruby Lodge was designed to provide a 12 week assessment pathway. The service had in the past accepted previously agreed 'out of pathway patients' with NHS England case managers to facilitate patient's specific care needs. This had contributed to the increased length of stay for this lodge within previous timescales.

The facilities promote recovery, comfort, dignity and confidentiality

Each lodge was designed to meet the needs of the children and young people who used it. For example, Amber Lodge was decorated and furnished in a way to suit young children. Notices were in pictorial format and pictures and toys were young child focussed. There was an outside playground with roundabout, swings, football pitch, and climbing area. Ruby Lodge accepted young people with learning disabilities from a wide age range. The manager said they had recognised the environment needed to accommodate this. For example, if there were patients both at the younger and older end of the age range. There

Are services responsive to people's needs?

Good

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

was a 'teenagers' lounge where older children could spend time in a place more suitable to them. Other rooms were available to suit younger children. Sapphire and Emerald lodges were teenager and young person focussed. They included pool tables, games rooms and we saw patients using their technology such as laptops and tablets. Resources on the lodges, such as books and games, were age appropriate to the patients.

There were different colour schemes across the lodges. There were rooms and quiet areas for patients to spend time and in which to hold visits. Parents commented positively about the environment and spoke about improvements that had been made in some areas. One parent said the young people respected the environment. The 'quiet rooms' on each lodge which staff used for patients to de-escalate behaviour contained padding. These rooms were stark and looked unappealing and some of the padding was worn in these rooms.

All lodges had well maintained gardens and access to outside space. Patients were able to grow their own fruit and vegetables in the gardens. There were sensory rooms available on some lodges for patients. Patients had access to their mobiles after school and phones were available. Patients could make calls from the staff office also.

A four week menu was available to patients which changed twice a year in winter and summer. Menus were on display on lodge notice boards and offered a variety of choice. The patient-led assessments of the care environment scores for food of at the Becton Centre was 92%

Patients did not have designated kitchens. There were kitchen areas which staff accessed. These were kept locked when not in use. Snacks and drinks trolleys went round the lodges at specific times. If young people wanted refreshments outside of this time, they could ask staff who would facilitate this.

Patients were able to personalise their bedrooms. We saw examples of this such as posters and pictures up bedrooms. Some patients gave other examples such as having their own bedding from home. Some patients on Sapphire lodge had asked staff to make the environment less clinical. Staff had taken the young people out to buy items to put on the walls to make it more personal. Patients did not have storage within their rooms for personal possessions. There were storage facilities on the bedroom corridors for patients which were accessible by staff.

Activities on offer included arts and craft and therapy play groups. Patients also had use of resources on the lodges such as games, TV and books. Trips out included to a local shopping centre. Parents told us that their children participated in activities geared towards their preferences. They said that their children had trips out supported by staff.

Meeting the needs of all people who use the service

The service was accessible to people with disabilities and wheelchair users. Varying information was on display across the lodges such as leaflets about wellbeing groups, therapies, healthy eating and advocacy services. There was a notice board where patients could write ideas and goals for the week. We saw posters and notices on display that young people had produced and contributed to. One patient had designed their own leaving party posters which we saw on display.

There was information and leaflets about how to complain on all lodges. However, this only provided information about complaints at trust level and not where else people could raise complaints. There was no information advising detained patients of their right to make complaints in relation to their detention to the Care Quality Commission.

Kitchen staff worked alongside the dietician where patients had specialised diets. Dietary needs were discussed and during admission. Information was on display in lodges and the kitchens which broke down meals and their ingredients. This was used to help patients make suitable choices.

Some patients said kitchen staff did not always make what they were expecting and had chosen for their meal. This caused distress for some in some cases, particularly where patients had eating disorders. Patients said the food was 'ok'. Parents gave mixed feedback. One told us staff came in especially to help support their child with their meals and ensure they had choices to suit their preferences. Another felt the food was 'ok' but was not always suitable to their child's needs.

There was a multi faith room on site that all patients and staff had access to. Trust chaplains were available to offer spiritual support.

Listening to and learning from concerns and complaints

Are services responsive to people's needs?

Good

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

There were four complaints made about the service between April 2015 and June 2016. All four had an outcome recorded. One was withdrawn, two were not upheld and one was upheld. The average time taken to respond and close complaints was 42 days. The Trust target to respond to complainants was 25 working days which meant the service had exceeded this.

We saw an example of a complaint, investigation and response letter relating to a complaint that was not upheld. The letter to the complainant was comprehensive, apologetic and addressed all points of the complaint. It was signed off by the chief executive with details of how the complainant could escalate the complaint to the parliamentary and health service ombudsman should they be dissatisfied with the outcome.

Parents said they would speak with staff if they had any complaints. None we spoke with had made any formal complaints and had not felt the need to. One parent had raised concerns during their child's stay. They felt that these were not always suitably addressed and the effectiveness of the response depended on who dealt with the concern. They did not wish to raise these matters as formal complaints. One patient we spoke with told us they would speak with a member of their mini team if they had any complaints.

Complaints and any learning from these were discussed at staff meetings where appropriate.

Are services well-led?

Requires improvement

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

Our findings

Vision and values

The trust values were based around commitment to excellence, teamwork, accountability, compassion and integrity. Consistent visions that all staff spoke about were team work and pulling together to provide quality care for the patients.

There had been a period of change and restructure of senior management within the service. The clinical director was recent in post and the associate clinical director had only been in post for a few months. Lodge managers said the service had started to feel more settled following the changes. The clinical director had further visions for the directorate which included encouraging an implementing ideas from staff, improving cross service working and providing staff with more responsibility and scope in their roles.

Lodge managers felt supported by the lead nurse and could approach him with any issues. Nurses and support workers said they saw senior managers infrequently. All staff had not met the lead nurse and several did not know who the staff were at director level.

Staff did not always feel part of the whole trust. One manager said the mental health and the acute directorate felt like two different worlds. Others said integration felt like it was improving albeit it was a gradual process. Other staff said there was little involvement with the acute trust. Some cited examples of the chief executive attending to do a 'back to the floor' visit although not all staff were aware of this. As the service was located away from the main trust site and provided mental health services, they said they tended to get seen as a separate entity and not 'core business'. Some professionals felt there was a disconnect between staff 'on the floor' and senior staff at divisional and trust level.

Good governance

The systems to monitor and assess performance at lodge levels were not effective. The lead nurse acknowledged there was no central system to establish what training each staff member had completed outside of mandatory training, and what they were required to have. This included specialist training. Both the clinical director and lead nurse advised that work was underway to identify staff training needs. There was no system to provide oversight of complaints and safeguarding at service level. The lead nurse said they would have to ask individual lodges in order to obtain this information. However, information of this nature was shared at heads of departments meetings which included all lodge managers.

Managers did not have effective systems to ensure staff received both clinical and managerial supervision and at the required frequencies. Information was recorded in generic hours only and not split down to individual level. The exception to this was Ruby lodge where the manager did have a system to record when each staff member had received clinical supervision which they had individual oversight of. This showed that clinical supervisions did not always take place at the required frequency. Figures provided by Amber lodge for May and June 2016 showed not all staff had received managerial and clinical supervision in those months. On Sapphire and Emerald lodge, it was not possible to establish whether there had been shortfalls in frequency due to how the data was presented. Supervision data was signed off by managers prior to quarterly reporting to NHS England. However the lead nurse confirmed the service did not record the number of specific sessions for each staff member. This meant there was a lack of oversight to ensure the supervision took place as required and staff received necessary support.

There was a service level agreement with the health and social care trust who provided pharmacy and medicines support. The agreement was signed to commence 31 March 2012 until 1 April 2013 with an option to extend for two 12 month periods after that date. The governance around the management of this agreement had not identified that this would have ended 31 March 2015. This did not cover the period of the inspection which meant the service had not made suitable arrangements to ensure the continuity of supply. There was confusion amongst staff about which trust had responsibility for some aspects of the agreement, such as audits.

The trust policies in relation to the Mental Health Act were not suitable. Relevant policies had not been updated following the latest changes to the Mental Health Act code of practice. This included policies for section 17 leave, informing patients of their rights, Mental Health Act hospital managers and role of second professionals. There was reference to the Mental Health Act commission in one

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policy which is an organisation no longer in existence. A new set of policies had been drafted and were awaiting ratification at trust level. However, these did not fully reference the code of practice updates and still included reference to the Mental Health Act commission. The consent policy did not include any reference to consent of patients detained under the Mental Health Act and consent powers under the Act. There was no policy for the use of section 5 holding powers which afford legal authority to all doctors and to some nurses, to "hold" patients for a full Mental Health Act assessment, if required.

The division as a whole reported performance against key performance indicators on a monthly basis. This included corporate objectives and indicators required by NHS England and clinical commissioning groups to whom the service had to report specific information to. This included information such as bed occupancy and numbers of admissions. Various audits and projects had taken place at divisional level, however, there was a lack of audits completed in some key areas to monitor the service provision at lodge level.

The lead nurse told us they felt supported by senior management. They acknowledged that there had been some disruption with recent personnel changes but that this had begun to settle. There was administration support in place across the lodges.

There was a risk register in place and the lead nurse was able to add to this. This was reviewed at regular intervals and captured current risks at the service, such as the lack of child psychiatrists.

Leadership, morale and staff engagement

A staff survey had been undertaken for 2015. This included responses from the community, well-being and mental health division. It was not split down into separate locations so was not possible to ascertain the results relevant specifically to this service. The response rate for the division was 45.9% compared to overall trust response rate of 44.9%. Overall the division scored better than the trust average in relation to feedback about how they were managed and support they received from managers in their roles.

The service's annual staff turnover rate from information provided by the trust equated to 10.6% which was lower than the turnover rate at trust level of 13.9%. The sickness rate for the service was 3.1% which was lower than the trust level sickness rate of 4.3%.

Staff at all levels said they would feel confident in speaking out if they had any concerns to raise. There was a policy for raising concerns at work which provided guidance for staff about different ways they were able to do this.

Commitment to quality improvement and innovation

The service participated in the quality network for inpatient child and adolescent mental health services. The quality network aims to demonstrate and improve the quality of inpatient child and adolescent psychiatric in-patient care through a system of review against the quality network service standards.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment How the regulation was not being met: Medicines were not always managed in a proper and safe way. Some medicines which had reduced expiration on opening did not contain the dates of when they were opened. Details of medicines that patients brought back to the service on return from leave were not recorded by staff. There were discrepancies in information on some drugs charts in relation to allergies and abbreviations which had potential to cause errors. This was a breach of regulation 12 (1) (g)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment How the regulation was not being met: Staff used restrictive practices which involved use of quiet rooms to de-escalate behaviour. Patients were not always free to leave. Staff did not recognise or treat these episodes in accordance with policy and follow necessary seclusion practice where required. It was not always evident from staff reports what forms of restraint and restrictive practices had taken place and for what duration of time. As such we could not establish that such interventions were proportionate and necessary where they had occurred.

This section is primarily information for the provider

Requirement notices

Informal patients were not aware of their rights and able to leave the service at their own will.

Where incidents had occurred involving abuse between patients, there was no evidence that safeguarding referrals had been made or considered.

This was a breach of regulation 13 (2) (3) (4) (b)

Regulated activity

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

Diagnostic and screening procedures

Treatment of disease, disorder or injury

Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance

How the regulation was not being met:

There was no set structure for the service as to what specialist training each staff group was required to have in order to perform their roles.

There was no effective system to identify and monitor staff training and supervisions and ensure that these took place as required.

There were no systems to monitor adherence to effective medicines management and infection control practices.

The service did not monitor and have oversight of application of the Mental Health Act including any breaches of the Act. Several policies in relation to the Mental Health Act were not current and some policies did not contain reference to the Act where necessary.

The system to monitor and assess the service was not robust. Information from incident reports was not sufficiently detailed or being used to analyse themes and trends. There was inconsistency between what staff reported as incidents.

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