Sheffield Children's NHS Foundation Trust

Child and adolescent mental health wards

Quality Report

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Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RCU51	Becton Centre for Children and Young People	Emerald Lodge	S20 1NZ
RCU51	Becton Centre for Children and Young People	Ruby Lodge	S20 1NZ
RCU51	Becton Centre for Children and Young People	Sapphire 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

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 found the following issues that the trust needs to improve:

- The trust was not consistently delivering care and treatment safely and in a way, that protected patients from avoidable harm and abuse. Staff were not managing and mitigating ligature risks. Patient risk assessments were reviewed but not consistently updated during reviews. Staff did not respond to an allegation of abuse in line with safeguarding procedures. Medication records were not maintained consistently and appropriately. Staff had implemented blanket restrictions and there was limited evidence of systems in place to identify and review restrictive practices on the lodges. Nurse call alarms were not available in patients' bedrooms and communal areas and staff told us that there were issues with having enough personal alarms for each staff member on shift. Mandatory training compliance was below the trust's target.
- The trust was not consistently delivering care and treatment in a way that was well-led. Systems were not operating effectively to identify areas of concern in relation to the safety of the lodges. The trust had implemented guidance which undermined the systems in place to monitor the use of restrictive interventions on the lodges. There were issues with culture and staff morale which had impacted on high sickness and turnover levels. Managers had not ensured that staff undertook mandatory training, supervision and appraisal. There was mixed feedback on senior leader visibility. We found that breaches of regulation identified in the 2016 inspection had continued in this inspection.

However:

- The trust had identified areas of concern in the service and had implemented an action plan to address them. This included concerns in the service in relation to leadership, workforce, clinical pathways, clinical risk, service review and improving the lodge environment. The action plan was in-progress at the time of the inspection.

Summary of findings

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

Are services safe?

We found the following issues that the trust needs to improve:

- Staff were not managing and mitigating ligature risks.
- Staff did not consistently update risk assessments. Risk assessments had review dates but were not consistently updated following incidents.
- Staff had not responded to an allegation of abuse appropriately. This meant that staff did not understand how to protect patients from abuse and work with other agencies to do so.
- Staff did not keep appropriate records of medication. Prescription cards were incomplete and were not completed consistently.
- Staff had implemented restrictions which were not individualised to each patient's presenting risks. There was no system for identifying and reviewing potential blanket restrictions.
- Sickness rates were high across the service. Sickness and turnover rates were significantly higher on Sapphire lodge than on the other two lodges.
- Nurse call alarms were not available in patients' bedrooms and communal areas and there were issues with having enough alarms for each staff member on shift.
- Not all staff had completed mandatory training. Average compliance was below the trust target. Compliance rates for training in approved restraint techniques was significantly below the trust target.

However:

- Staff controlled infection risk well. Staff kept themselves, equipment and the premises clean. They used control measures to prevent the spread of infection.

Are services well-led?

We found the following issues that the trust needs to improve:

- The trust had implemented guidance which meant that staff were not consistently reporting incidents of restraint. The trust's data submission on the use of restraint did not fully reflect the number of restraints on each lodge.
- The trust did not have a system which ensured that staff received feedback and learned from incident reports.

Summary of findings

- Supervision and appraisal rates were below the trust's compliance target. Managers had not ensured that staff had completed mandatory training.
- We received mixed feedback on staff morale and culture across the lodges. Staff candidly described that they had recently been through a period of heightened lodge activity and that this has led to increased stress within the team.
- The feedback on management and senior management visibility, approachability and support was not consistently positive between the lodges.

However:

- Senior managers had identified and started to address concerns in the service in relation to leadership, workforce, clinical pathways, clinical risk, service review and improving the lodge environment.
- The service had managers at all levels with the right skills and abilities to run a service.
- Managers had plans in place in case of emergencies.
- At the time of inspection all three lodges had completed the peer review as part of the process for joining national quality networks.

Summary of findings

Information about the service

Sheffield Children's NHS Foundation Trust provides tier four child and adolescent mental health inpatient services based at the Becton Centre for Children and Young People. Tier four child and adolescent mental health services are highly specialist services for children and young people who are deemed to be at greatest risk due to their mental health and who require a period of intensive assessment, intervention and treatment. There are three lodges which provide 24-hour inpatient services at the Becton Centre for Children and Young People.

Emerald Lodge is a nine-bed inpatient unit for males and females aged 10-13 who are experiencing emotional and behavioural difficulties. At the time of inspection there were seven patients admitted to the unit which included one patient who was detained under the Mental Health Act.

Ruby Lodge is a seven-bed inpatient unit for males and females aged 8-18 who have a moderate to severe diagnosed learning disability, with an associated mental illness that requires intensive assessment and treatment planning. At the time of inspection there were four patients admitted to the unit which included two patients who were detained under the Mental Health Act.

Sapphire lodge is a 14-bed inpatient unit for male and female young people aged 13-18. At the time of inspection there were seven patients admitted to the unit which included five patients who were detained under the Mental Health Act.

Sheffield Children's NHS Foundation Trust has been inspected four times by the Care Quality Commission since it was registered in April 2010. The Becton Centre for children and young people was last inspected as part of the comprehensive inspection of the trust in 2016. At this last inspection we rated the trust's child and adolescent mental health lodges as requires improvement overall with ratings of requires improvement in the safe, effective and well-led key questions and ratings of good in the caring and responsive key questions.

We issued the provider with three requirement notices. These related to the following regulations under the Health and Social Care Act (Regulated Activities) Regulations 2014:

- Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment; 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.
- Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment; 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. Informal patients were not aware of their rights and were unable 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.
- Regulation 17 HSCA (RA) Regulations 2014 Good governance; There was no set structure for the service as to what specialist training each staff group was required to have to perform their roles. There was no effective system to identify and monitor staff training and supervisions to 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

Summary of findings

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.

We did not investigate whether the trust had acted to resolve all of these breaches of regulation during this focused inspection. However, this inspection identified examples of continued and additional breaches of regulation in relation to safe care and treatment, safeguarding service users from abuse and improper treatment and good governance.

Our inspection team

The team comprised of one CQC inspector, one CQC assistant inspector and two specialist advisors who were both nurses specialising in inpatient children and adolescent mental health.

Why we carried out this inspection

We inspected the inpatient lodges for children and young people with a mental health problem service in response to concerns raised about Sheffield Children's NHS Foundation Trust. Concerns were raised in relation to safety, leadership and culture within this core service. Therefore, we inspected the service using specific key lines of enquiry in the safe and well-led key questions as part of a focussed inspection of this core service.

This inspection took place between 14 and 15 August 2018. Our inspection was unannounced (staff did not know we were coming) to enable us to observe routine activity.

How we carried out this inspection

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

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

Before the inspection visit, we reviewed information that we held about these services.

During the inspection visit, the inspection team:

- visited all three of the lodges and looked at the quality of the lodge environment and observed how staff were caring for patients
- spoke with 10 patients who were using the service
- spoke with seven carers of patients who were using the service
- spoke with the managers or acting managers for each of the lodges
- spoke with the lead nurse and associate director responsible for the service
- spoke with 18 other staff members including advocates, doctors, nurses, nursing assistants and speech and language therapists
- attended and observed one handover
- looked at a range of policies, procedures and other documents relating to the running of the service.

Summary of findings

What people who use the provider's services say

We inspected the inpatient lodges for children and young people with a mental health problem service in response to concerns raised about Sheffield Children's NHS Foundation Trust. Concerns were raised in relation to safety, leadership and culture within this core service. Therefore, we inspected the service using specific key lines of enquiry in the safe and well-led key questions as part of a focussed inspection of this core service.

This inspection took place between 14 and 15 August 2018. Our inspection was unannounced (staff did not know we were coming) to enable us to observe routine activity.

We spoke with 10 patients and seven carers. Patients told us that there were enough staff around the lodge most of the time. However, on Sapphire lodge one patient was critical about the amount of time staff spent in the offices rather than being in communal areas. Patients were mostly positive about staff attitudes on Emerald Lodge and Ruby Lodge and told us that staff were friendly and respectful. On Sapphire lodge we received more mixed feedback about staff attitudes.

Patients told us the lodges were always kept clean but were critical of the environment and the length of time taken for the trust to undertake repairs and maintenance of the lodges.

Carers told us that the lodges were kept clean and that there were usually enough staff on the lodges. They said that the lodges were sometimes noisy and unsettled but that staff knew how to respond appropriately. Carers were mostly positive about staff attitudes and stated that staff could manage lodges safely.

Two carers expressed concerns with communication between the lodges and parents stating that they did not feel they knew enough about how their child was doing on a day to day basis. Three carers were critical of the lodge environments and told us that they felt the lodge environments were bare, intimating and not child friendly.

Areas for improvement

Action the provider MUST take to improve

- The trust must ensure that staff report all incidents using the trust's incident reporting system.
- The trust must ensure that systems are put in place to ensure that staff receive feedback and learn from incidents.
- The trust must ensure that managers and staff in the service understand their individual responsibilities to respond to concerns about potential abuse when providing care and treatment, including investigating concerns.
- The trust must ensure that staff manage ligature risks in line with ligature risk assessments.
- The trust must ensure that blanket restrictions are reviewed and ensure that all restrictions are individually risk assessed.
- The trust must ensure patients have access to a nurse call system in the event of an emergency.
- The trust must ensure that staff complete prescription cards appropriately and consistently and that cards are effectively audited.
- The trust must ensure that staff receive appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform.
- The trust must ensure that systems and processes operate effectively to enable them to assess, monitor and improve the quality and safety of the service provided.

Action the provider SHOULD take to improve

- The trust should ensure that staff update risk assessments following every patient incident and that this is recorded consistently.
- The trust should ensure that staff update risk assessments during risk assessment reviews and designate where there had been no changes in risk.

Summary of findings

- The trust should ensure that all staff know and understand the duty of candour.
- The trust should ensure that all staff understand whistleblowing procedures, including the role of the Freedom to Speak Up Guardian, and are encouraged to raise concerns.
- The trust should ensure action plans improve lodge environments to reduce ligature risks are completed.
- The trust should ensure trust-wide policies which are overdue for review are reviewed and updated in line with best practice

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
Emerald Lodge	Becton Centre for Children and Young People
Ruby Lodge	Becton Centre for Children and Young People
Sapphire Lodge	Becton Centre for Children and Young People

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.

We did not inspect Sheffield Children's NHS Foundation Trust's adherence to the Mental Health Act in this inspection.

Mental Capacity Act and Deprivation of Liberty Safeguards

We did not inspect Sheffield Children's NHS Foundation Trust's adherence to the Mental Capacity Act and Deprivation of Liberty Safeguards in this inspection.

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

All lodge areas were clean and had good furnishings. Cleaning records were up to date and demonstrated that the lodge areas were cleaned regularly. Staff had undertaken monthly infection prevention and control environmental audits of all three lodges within the six months prior to inspection. All three lodges achieved the trust's pass mark of above 85% for cleanliness and overall infection control compliance each month, except for Emerald Lodge which did not achieve the pass mark for cleanliness in June 2018. The 2018 patient led assessment of the care environment data for the Becton Centre as whole was 99.89% for cleanliness, 93.4% for privacy, dignity and wellbeing and 98.96% for condition, appearance and maintenance. However, staff and patients identified that there were issues with the maintenance of lodge areas and that damages to lodge doors and other equipment sometimes took considerable time to be repaired.

None of the lodges had clear lines of sight which allowed staff to observe all parts of the lodge environment. On Ruby Lodge and Emerald Lodge there were parabolic mirrors to improve lines of sight. Mirrors were not used on Sapphire lodge. Patient bedroom doors were solid without an observation window to allow staff to unobtrusively observe patients in their bedrooms. This meant that staff had to open bedroom doors to complete observations.

Staff had assessed all three lodges for ligature risks in December 2017 which had identified changes to the lodge environments. These actions were still outstanding when the ligature risk assessment action plan was updated in July 2018. The trust told us that the target for implementing all 14 environmental adaptations was October 2018. The trust stated that current ligature risks including those pending environmental adaptation were managed according to an individualised risk assessment of each patient in accordance with the trust's ligature policy.

However, rooms with identified ligature risks such as the chill out rooms were designated as requiring staff supervision to mitigate risk, though these rooms were unlocked. Also, in communal areas which were not supervised there were several risk items including electronic devices which could be used to ligature. The layout and deployment of staff on the lodge did not support the management of the risk. It was not clear how on a day to day basis ligature risks are being managed.

The three lodges were located on a site specifically for children. Each lodge had separate bedrooms for male and female children and where possible staff ensured that patients of the same gender were admitted to designated male and female bedroom corridors.

None of the lodges had a nurse call alarm system in patient bedrooms or communal areas. Staff told us that there were sometimes difficulties in ensuring that there were enough personal alarms for each member of staff and alarms had been provided by several lodges to ensure that there enough additional alarms for the four members of the inspection team. On Emerald Lodge and Sapphire Lodge there were gaps in the recording system used to track the supply and return of personal alarms. Patients' visitors were not routinely given a personal alarm during their visits. The trust provided evidence that personal alarms were tested regularly by reception staff.

Seclusion rooms were not available on any lodge. There was a seclusion room available in a nearby 136 suite used as a designated health based place of safety. However, this seclusion room was not in working order as the intercom system and surveillance equipment used to observe the seclusion room bathroom did not function.

Resuscitation equipment was checked regularly and had a tamper proof seal. Staff maintained clinic room equipment and kept it clean.

Safe staffing

The total establishment level for the service was 118.8 whole time equivalents. Of the three lodges, only Sapphire lodge had staff vacancies on the day of inspection and only Sapphire lodge had regularly used bank and agency staff in the three months prior to inspection. Agency staff who were new to the lodge received an induction using an induction checklist to familiarise them to lodges, although lodge managers told us that the preference was for agency staff who had worked on the units previously and were known to the patients.

Are services safe?

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

Shift fill data confirmed that for the three months prior to inspection all lodges had managed to fill shifts to within safe staffing threshold levels except for Emerald which fell to 89% which was below the trust threshold of 90% in May 2018. There were eight shifts for qualified nurses that could not be filled by regular, bank or agency staff in the three months prior to inspection. Staffing rotas, trust data and staff feedback confirmed that there was always at least one qualified nurse on shift.

The service had a high sickness rate which was higher than the NHS average of 4%. The average staff sickness rate for the period 31 July 2017 to 1 August 2018 was 7%. Sapphire lodge had the highest sickness rate for this period at 10%. In the same period there were 18 staff who left the service. Sapphire lodge had nine staff leave which was the highest of the three lodges. Managers explained that this was partly due to a period of heightened patient acuity on Sapphire Lodge.

Lodge managers told us that they could adjust staffing levels to take into account the changing needs of the lodge. The service relied on staff working overtime and agency staff to cover when staffing levels were low.

The service did not monitor cancelled escorted leave or lodge activities or the reasons for cancellations but staff told us that it was rare to cancel escorted leave or lodge activities due to staffing levels.

Staff told us that there was always enough staff to carry out physical interventions (for example, observations and restraint) safely. When activated in an emergency the staff personal alarm system called staff from other lodges to respond to support staff in need of assistance. However, compliance levels for the number and percentage of staff completing the conflict resolution level three training which included how to manage violence and aggression, as well as restraint techniques, were below the trust target on all lodges with an average compliance of 66%. On Sapphire lodge the compliance rate for this module was significantly below the target at 43%. This meant that less the half of the staff team were up to date with training in approved methods of managing violence and aggression.

Not all staff had received or were up to date with appropriate mandatory training. The trust's target for mandatory training was 90%. The average compliance with mandatory training for the three lodges was 79% so all three lodges were below the trust's compliance rate for mandatory training. Compliance rates on Sapphire lodge were significantly lower than on the other two lodges. The average compliance rate on Sapphire lodge was 68%.

Of the 22 modules designated as required for staff working within the service, 10 were below the target for compliance.

Modules below the trust's compliance target for mandatory training were:

- Conflict resolution level three – 66%
- Fire safety – 73%
- Health records keeping – 89%
- Infection control level two – 69%
- Information governance – 69%
- Medicines management level two – 56%
- Medicines management level three – 83%
- Moving and handling level four – 43%
- Resuscitation level two – 77%
- Resuscitation level three – 86%
- Risk management – 84%

On-call psychiatric medical cover was shared on a rota basis between the medics working in both the trust's inpatient and community children's mental health services. There was an additional on-call rota operated by the junior doctors working within the service.

Assessing and managing risk to patients and staff

During this inspection we reviewed 10 care records. Staff completed a risk assessment of every patient on admission. Risk assessments were reviewed regularly, however these were not consistently updated following incidents.

Staff did not use a nationally recognised risk assessment tool. However, they used a bespoke risk assessment tool, which had been approved and adapted by the trust to meet the needs of the service.

Staff did not routinely search patients entering or exiting the lodges as part of their Section 17 leave. Staff told us this would only be done in response to a specific concern and instances of this were rare.

The trust had an observation policy and staff were aware of this policy. On Ruby Lodge a member of staff was allocated to a patient at all times during the day and patients were

placed on hourly or 15-minute observations during the night depending on their risk assessment. On Emerald Lodge and Sapphire lodge patient observation levels were determined by their individual level of risk.

We identified blanket restrictions within the service. Kitchens were locked on all three of the lodges so patients had to ask for staff support to access drinks and snacks outside of the times when the snack trolleys were available. Garden and courtyard doors were locked so patients had to ask for staff support to access outside space. We were told this was in response to the low roof and risk of patients absconding. However, this restrictive practice was not individually risk assessed. The trust did not have effective systems in place to identify and review potential blanket restrictions.

Patients, staff and visitors were not permitted to smoke on site. Staff and patients told us some patients were still smoking on the unit. During this inspection we did not note any evidence that smoking had occurred. Signs indicating that the lodges were 'no smoking areas' were present on each lodge.

The procedure to leave the lodge was explained to informal patients on admission. There were signs visible throughout the unit instructing informal patients to contact a member of staff if they wished to leave the unit.

Staff told us physical restraint would only be used after other de-escalation attempts had been made. Staff were able to describe methods they would use to manage incidents prior to attempting restraint and stated that their knowledge of the individual patients would assist with this. Staff told us they would only use restraint if it was necessary for the safety of patients and staff.

The trust provided data on the use of restrictive interventions. In the period 1 August 2017 to 31 July 2018;

- Emerald Lodge had 427 incidents of restraint involving 12 patients. There were no incidents which involved the use of prone restraint and no incidents of seclusion or long-term segregation.
- Ruby Lodge had 29 incidents of restraint involving four patients. There were no incidents which involved the use of prone restraint and no incidents of seclusion or long-term segregation.
- Sapphire lodge had 270 incidents of restraint involving nine patients. There were five incidents of prone restraint which was used to administer rapid tranquilisation. There were five incidents of rapid tranquilisation. There were no incidents of seclusion or long-term segregation.

Our review of incidents found one specific reference to the use of seclusion on Ruby Lodge using a patient's bedroom. This was not identified in the trust's data submission on the number of incidents of the uses of seclusion.

We identified that staff were not reporting incidents of restraint which were care planned to support patients who were receiving nasogastric feeding as part of their treatment. This was not in line with the trust's reducing restrictive practice policy stated that all incidents of restraint, including planned restraints as part of a patient's care. This meant that the number of restraints reported by the trust did not truly represent the number of restraints taking place on each unit. Staff told us that the trust had issued separate guidance to them that contradicted the trust's reducing restrictive practice policy which is why these incidents of care planned restraint had not been recorded.

We identified areas of concern in relation to medicines management. Staff had not completed prescription cards accurately and consistently. Not all cards had a patient photograph or had all sections completed accurately. Cards were not consistently numbered and medication start dates were missing. Nursing staff told our inspection team that the design of prescription cards had contributed to medication errors.

Safeguarding

The trust required all nursing staff to complete safeguarding children level 3 as part of their mandatory training. Overall training compliance was recorded by the trust according to each individual lodge. Compliance for level 3 safeguarding was at or above the trust's compliance target of 90% on all three lodges. Compliance rates by lodge were Emerald Lodge at 91%, Ruby Lodge at 94%, and 90% for Sapphire lodge. Between 31 July 2017 and 1 August 2018 staff made 21 referrals to safeguarding.

Most staff we spoke to were able to identify potential safeguarding concerns relevant to the patient group. Staff spoke confidently about how they would respond to such a

concern and would raise this with the on-site social worker or the trust's safeguarding lead nurse. Some staff told us safeguarding supervision was available to lodge based staff.

During this inspection one of the patients we spoke with made an allegation of assault by a member of staff. We were told they had reported this to the lodge manager but were unaware of what action had been taken and stated that they currently felt unsafe on the lodge as the member of staff involved was still working on shift. We discussed this with the lodge manager who informed us they were aware of the allegation and had discussed this with both the patient and the member of staff but had not reported the allegation to safeguarding. We were told a safeguarding alert would be made straight away.

Visiting procedures differed across the three lodges. Visits were agreed between staff and parents. Other children visiting the lodges were required to be escorted by their parents at all times. Visits took place in communal areas, for example the dining room or female only lounge. Managers on all three of the lodges expressed concerns about the available space they had to facilitate visits. If leave was permitted patients could meet with their visitors off the lodge.

Staff access to essential information

The service used predominately paper records to store and record patient information. The recording of incidents had recently transferred from paper based to an electronic reporting system. The patient files were stored securely in the staff office. Staff we spoke with said that the records did not cause them any difficulty accessing or entering information.

Track record on safety

The trust reported that there were no serious incidents during the period 31 July 2017 to 1 August 2018 within this core service.

Reporting incidents and learning from when things go wrong

Staff understood what constituted an incident understood how to use the trust's system for reporting incidents. All three lodges used an electronic reporting system to report incidents and staff were familiar with this system.

The team meeting minutes we reviewed did not demonstrate any staff discussion and feedback regarding incidents. Staff told us they did not receive feedback even if they had requested this when reporting the incident on the electronic system.

Most staff told us they were de-briefed after an incident but this was often informally and not always done in a timely manner. This was not in line with the trusts "Reducing Restrictive Practice" policy which states a debrief should take place after every incident of restraint.

The trust had a policy to support staff in implementing the duty of candour. The majority of staff struggled to identify and describe the duty of candour. None of the incidents during the period 31 July 2017 to 1 August 2018 met the trust's definition of an incident meeting the duty of candour.

Are services well-led?

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

Leadership

Leaders within the service had the skills, knowledge and experience to perform their roles. Lodge managers and the service's senior management team consistently told us that the service had recently experienced a period of increased challenges due to increased patient acuity. In response the trust had reduced the available bed numbers on Sapphire lodge. This was to allow the staffing team to focus on training and development.

Staff within the service gave varying feedback on the visibility of lodge managers and senior managers.

Vision and strategy

The trust values were being committed to excellence, teamwork, accountability, compassion, and integrity. Staff had a mixed understanding of the trust values, with the majority of staff able to identify only one or two trust values. Managers told us that the trust values were used in the recruitment of new staff and were used on an ongoing basis within staff appraisals. The associate director responsible for the service told us that the trust had started a new project to relaunch the trust values and was in the process of engaging with staff to work on defining how the trust values were applied to everyday clinical practice.

Culture

Most staff were positive and proud of their work and told us that they felt respected and valued by managers in the service. On Sapphire lodge staff were less positive about the service. This was recognised by managers in the service and formed part of the trust's action plan response to identified challenges on Sapphire Lodge.

Staff had a clear understanding of the concept of whistleblowing. A small minority of staff told us that the trust had a freedom to speak up guardian. A small minority of staff told us that they would be reluctant to raise concerns within the trust and were not confident that concerns would be acted on.

Governance

The trust submitted key performance data to NHS England on a quarterly basis. This included staffing data, bed occupancy rates, numbers of serious incidents and numbers of safeguarding referrals. Lodge managers had access to monthly reports which monitored key performance indicators including usage of bank and agency staff, staff sickness rates, and mandatory training compliance.

At the last inspection the trust did not have a system to monitor supervision. The trust had started to monitor staff supervision using an electronic system from April 2018. Prior to the introduction of this system, staff supervision was monitored manually by individual lodge managers. The trust's compliance target for staff supervision was 90%. Only Ruby Lodge consistently exceeded the staff supervision compliance target. Between April and July 2018, the average compliance was 77% on Emerald Lodge, 100% on Ruby Lodge and 67% on Sapphire Lodge. Between August 2017 and July 2018, eight staff in the service had accessed additional safeguarding supervision. The trust did not provide a compliance target for safeguarding supervision.

Appraisal rates were below the trust's compliance target. The appraisal rate was 93% on Emerald Lodge, 94% on Ruby Lodge, and 26% on Sapphire lodge. The average compliance rate for the service was 71%, however this was significantly affected by the low compliance rate on Sapphire Lodge.

The trust submitted data in relation to the use of restrictive interventions on the lodges. Restraint data was not truly reflective of the incidents of restraint on the lodges. This was because trust guidance allowed staff to not report incidents of restraint which took place as staff were supporting patients receiving nasogastric feeding. Trust data also contained an error in relation to the use of seclusion on one lodge. The trust did not have effective systems in place to ensure that staff routinely received feedback and learned from incidents.

The trust identified to us in their data submission that a number of the policies we requested as part of this inspection were overdue for review. The trust's performance development review (appraisal) policy was due for review in December 2017. The trust's reducing restrictive practice policy was due for review in October 2017, although the draft form of the new policy was available. The trust's safeguarding children and safeguarding adults' policies were overdue for review; however the trust stated that this was in response to changes within the local authority safeguarding hub. The

Are services well-led?

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.

trust told us that both policies were completed in draft and out for consultation at the time of the inspection The trust's amended whistleblowing policy was in the process of being approved at the time of inspection.

Management of risk, issues and performance

The trust had a local risk assessment pathway for the three lodges located at the Becton Centre. This included an escalation procedure for risks from local risk registers to the divisional risk register for the community, well-being and mental health division. Two of the thirteen risks on the divisional risk register related to the child and adolescent mental health lodges. These were the risk of 'self-harm opportunities due to the building design and fittings', and the risk of 'introduction of policies and guidance supporting practice around restrictive interventions'. The trust did not provide examples of local risk registers. These were requested during the inspection. Lodge managers were not clear whether there was a local risk register for the lodges or for the Becton Centre as a whole.

Managers had established business continuity plans in cases of emergencies.

In August 2018 the trust closed four beds on Sapphire lodge. The trust stated that this was in response to a '6-8-month period of increased challenges' including increases in patient acuity levels, violence and aggression, significant damage to the lodge environments and changes to the staffing establishment including a number of new starters. With the exception of the lodge environment, the increased challenges identified in this review were not added to the service's risk register. The trust had introduced an action plan focussing on leadership, workforce, clinical pathways, clinical risk, service review and improving the lodge environments. This was in progress at the time of inspection with a number of completed actions. The trust had identified that there was potential slippage in the action plan deadlines for improvements in mandatory training and appraisal compliance rates.

Information management

Staff had access to the equipment and information technology needed to do their work. Incidents were reported using the trust's new electronic incident reporting system. Mandatory training, supervision and appraisals were recorded and monitored using an electronic system. This information was available to managers when needed. The electronic system allowed information to be recorded and monitored through automated processes.

Patient records were paper based. This meant that information could not be wholly transferred between trust services such as from inpatient to community teams. Staff told us that the trust planned to introduce an electronic patient record system in the future.

Engagement

The trust participated in the family and friends test. From August 2017 to July 2018 there were 33 responses to the family and friends test with 30 respondents (91%) stating that they were likely or extremely likely to recommend the service to somebody who needed it.

Since 2014 the service used a bespoke questionnaire called 'tweaks' for patients, parents and carers which was completed following each patient's first review and again following a patient's discharge. The questionnaire focussed on the provision of information about the service; parent and young person involvement in care and delivery of appropriate care; and suitability of the environment. Between March 2017 and June 2018:

- Emerald Lodge received nine feedback forms from parents and 10 from patients. Feedback was highly positive from parents. Feedback was mixed from patients with areas for improvement highlighted in relation to involving patients in making decisions about their care.
- Ruby Lodge received 26 feedback forms from parents and none from patients. Feedback was highly positive from parents and highlighted, in particular, the good communication between the service and parents.
- Sapphire Lodge received eight feedback forms from parents and six from patients. Feedback was mixed with areas for improvement highlighted in relation to involving patients in making decisions about their care and communication between the service and parents.

Staff undertook an annual review of responses to the questionnaire and identified areas for improvement.

Learning, continuous improvement and innovation

At the time of inspection all three lodges had completed the peer review as part of the process for joining national quality networks. Emerald Lodge and Sapphire Lodge were

Are services well-led?

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.

seeking membership of the inpatient quality network for child and adolescent mental health services. Ruby Lodge was seeking accreditation by the quality network for inpatient learning disability services.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **How the regulation was not being met:** Staff were not clearly managing and mitigating ligature risks. Rooms designated as requiring staff supervision were left unlocked. Communal areas contained a number of risk items and these areas were left unsupervised. Staff did not keep appropriate records of medication. Prescription cards were incomplete and were not completed consistently. This was a breach of Regulation 12(1)(2)(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 had not responded to an allegation of abuse appropriately. This meant that staff did not understand how to protect patients from abuse and work with other agencies to do so. Staff had implemented restrictions which were not individualised to each patient's presenting risks. It was not clear how the service was identifying and reviewing potential blanket restrictions. This was a breach of Regulation 13(1)(2)(3)(4)(b)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983	Regulation 17 HSCA (RA) Regulations 2014 Good governance

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	**How the regulation was not being met:** The trust had implemented guidance which meant that staff were not consistently reporting incidents of restraint. Incidents of restraint to support patients receiving nasogastric feeding were not consistently reported using the trust's electronic incident reporting system. This meant that the trust's data submission on the use of restraint did not fully reflect the number of restraints on each lodge. Systems were not operating effectively to identify areas of concern in relation to the safety of the lodges. This was a breach of Regulation 17(1)(2)(a)(b)(c)
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **How the regulation was not being met:** Not all staff had completed mandatory training. Average compliance was below the trust target. Compliance rates for training in approved restraint techniques was significantly below the trust target. Managers did not consistently make sure staff were competent for their roles. Staff supervision and appraisal rates were below the trust's compliance target. This was a breach of Regulation 18(1)(2)(a)