North East London NHS Foundation Trust

Child and adolescent mental health wards

Inspection report

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Ratings

Overall rating for this service	Inspected but not rated
Are services safe?	**Inspected but not rated**
Are services effective?	**Requires Improvement**
Are services caring?	**Inspected but not rated**
Are services responsive to people's needs?	**Inspected but not rated**
Are services well-led?	**Inspected but not rated**

Our findings

Child and adolescent mental health wards

Inspected but not rated

This was an unannounced focused inspection of child and adolescent mental health wards at Kent and Medway Adolescent Hospital. During this inspection we inspected across the five domains, Safe, Effective, Caring, Responsive and Well Led.

The service transferred to North East London NHS Foundation Trust from another provider in April 2020. In November 2020 the trust was made aware of concerns by staff working at the service through the trust Freedom to Speak Up Guardian. The CQC also received information of concern about the service at that time. The trust investigated these concerns and took action to improve the service.

As this was a focused inspection, we did not rate each domain and the service overall. However, we found a breach of regulation in relation to staffing. As a result this limited the rating for the effective domain. This meant that the overall rating for effective for this core service went from good to requires improvement. We found that the trust had made significant progress in making improvements to the service. For example, the incident reporting culture and the way in which reported incidents were managed had significantly improved, meaning that staff were now able to learn lessons from incidents to prevent them re-occurring.

Leadership and the culture within the service had started to improve. Staff were better skilled at managing patients with eating disorders around mealtimes. Staff had also implemented a more robust search procedure to prevent banned, harmful items from being brought onto the ward.

We received positive feedback about the way staff supported patients and developed therapeutic relationships with them. Patients also reported that they were happy with the activities on offer and staff made efforts to ensure the educational offer was appropriate for each patient. Staff worked closely with education providers to ensure patients could receive education at the service that was tailored to their individual ability.

The CAMHS treatment pathway was under significant pressure as there was an exceptional demand for beds. Despite this, staff were responsive to patients' needs and kept in touch with colleagues in other teams and organisations to help facilitate smooth and timely discharges.

Leaders were proactively considering how to reduce the level of restriction on patients, for example, by making suggestions about how the environment could be made safer, and by reviewing blanket restrictions such as mobile phone use.

Staff were adapting to an improved 'enhanced care pathway' model which involved MDT ward staff continuing to work with some patients who had recently been discharged.

However, we also identified some areas where the trust needed to consolidate and make further improvements.

Staff supervision and appraisal compliance rates were low. This meant that staff were not guaranteed to receive the support they needed to carry out the duties they were employed to perform. This was because these activities had been suspended due to competing priorities during the Covid-19 pandemic but had recently been re-introduced.

Our findings

The process by which staff discussed the learning from recent incidents was still being embedded, as were debrief sessions.

Although progress was being made in recruiting to vacant posts there were still many nursing vacancies that needed to be filled.

Patients and relatives were not able to attend weekly multidisciplinary ward round meetings, and instead submitted their contributions for staff to discuss on their behalf.

Some relatives also reported that communication with staff was sometimes challenging, and there was not yet a formal mechanism for gathering feedback about the service from families and relatives.

Staff gave mixed feedback about the culture and how supportive leaders were. They described a very challenging year where they had not always felt well supported. Particular challenges involved the transfer of the service between providers, a consultation process about the future model of the service that had left staff feeling uncertain, and uncertainty and anxiety caused by the onset of the Covid-19 pandemic. Some staff did report that they felt better supported and able to speak up following the recent leadership changes.

Is the service safe?

Inspected but not rated

Safe and clean environment

Safety of the ward layout

Staff safely managed the ward environment and were using appropriate techniques to manage environmental risks and keep patients safe from potential harm. Up to date environmental risk assessments and a thorough ligature risk assessment had been completed. This meant that staff knew about the environmental risks that existed and knew how to mitigate these risks.

For example, patients were routinely checked twice per hour. The ward patio area was used under supervision by staff only due to the presence of potential ligature anchor points. Although there were 11 patients the ward was very large. There were numerous corridors and blind spots that would have been difficult for staff to manage. To help safely manage environmental risks, patients were asked not to use their bedrooms, the bedroom corridor or the main therapies corridor during the day without support from a staff member.

An ongoing programme of works was underway to ensure the environment was fit for purpose. Half of the bedrooms had been renovated, which meant that the presence of potential ligature risks had been greatly reduced. Extensive works were being undertaken to prevent future leaks in the roof, which had recently led to a restriction in access to certain parts of the ward for patients.

Our findings

Staff had appropriate access to alarms to call for help in an emergency, and patients were provided with nurse call systems where this was necessary. The trust had plans to install a new alarm system during the next year that didn't sound so loudly. This was because it had been recognised that a more appropriate alarm system that did not cause unnecessary distress to patients living with Autistic spectrum disorder was needed.

Maintenance, cleanliness and infection control

All ward areas were visibly clean and had good furnishings.

Staff maintained good infection prevention control practices. Signage was displayed to instruct staff about correct handwashing technique and staff handwashing technique was systematically audited. All staff and visitors to the ward wore either uniforms or scrubs at the time of this inspection. This was to limit the risk of cross-contamination during the Covid-19 pandemic.

Clinic room and equipment

The clinic room was fully equipped with accessible emergency equipment, including a defibrillator, and emergency drugs. Staff checked these each week.

The clinic room was visibly clean and tidy. Equipment was calibrated to ensure it was in good working order and equipment was cleaned regularly and a record was kept of when equipment had been cleaned.

Safe staffing

Nursing staff

The service faced ongoing challenges in relation to staffing. This challenge had led the trust to carefully consider how many patients could be safely cared for on the ward at any one time. At the time of the inspection the trust had assessed that 11 patients could be cared for safely on the ward.

As of June 2021, 52% of registered nurse posts were vacant. The trust ensured these vacancies were covered by regular agency staff who were familiar with the patients and how to support their individual needs. Also, 56% of the total 27.2 WTE nursing assistant posts were vacant. However, the trust was making good progress in recruiting to these posts and had recently recruited eight WTE healthcare assistants who were due to start in post soon. Leaders were feeling positive about the current recruitment strategy. This involved the use of a rolling recruitment programme involving incentive payments and building relationships with local nurse training institutions and encouraging staff working elsewhere in the trust to take up roles at the service.

However, despite the move towards using regular agency staff which patients reported was an improvement, some patients also reported that they still felt unfamiliar with some of the staff working at night.

The daily staffing establishment was generous. Three registered nurses worked on the morning and afternoon shifts, supported by four and five support workers respectively. At night two registered nurses were supported by six support workers. The reason for these establishment levels was that the service was a standalone unit, so there needed to be enough staff working on the ward to respond to any potential incident and provide any necessary physical interventions

Our findings

safely. Ward staff were also required to work at the Section 136 suite, located elsewhere in the building, when this was required. During the inspection we were made aware of a recent incident where four ward staff needed to respond to an incident at the Section 136 suite. This had left the ward short of staff for a period of time. The ward manager was able to adjust daily staffing levels as needed to help facilitate ward activities and Section 17 leave.

Although the majority of vacant shifts were filled by agency staff or permanent staff who opted to work additional bank shifts, the ward continued to run short of staff on some occasions. For example, a registered nurse shift during the weekend after our initial site visit could not be filled, despite the fact the shift did not become vacant at short notice. Incidents like this were reported on the trusts incident reporting system and fed into wider discussions about the staffing and recruitment strategy for the service.

Staff turnover for the twelve months before the inspection was 29.3%. The trust reported that this high rate was due to a number of factors, predominantly uncertainty during the transfer of the service from the previous provider, and uncertainty during the subsequent consultation process and with the Covid-19 pandemic.

Staff sickness during the twelve months before the inspection was 6.8%. The trust reported that this was elevated because of staff sickness during the Covid-19 pandemic and was in line with staff sickness rates elsewhere in the trust.

Medical staff

There was adequate medical cover day and night and a doctor could attend the ward quickly in an emergency. One consultant psychiatrist supported patients on the ward. they were supported by two specialist registrars.

A consultant Psychiatrist could attend the ward at any time out of hours. The on-call system included consultants working across the Kent community CAMHS service.

Mandatory training

Staff had received and were up to date with most mandatory training courses. Challenges in ensuring staff had completed their mandatory training on time were minimal and were generally due to a lack of availability of classroom-based courses due to the Covid-19 pandemic. For example, 29% of eligible staff had completed their moving and handling of people level 2 training for clinical staff. One out of three eligible staff had completed training in basic life support. However, 94% of the rest of the ward staff had completed immediate life support training.

Assessing and managing risk to patients and staff

Staff assessed and managed risks to patients and themselves well and followed best practice in anticipating, de-escalating and managing challenging behaviour. Staff used restraint and seclusion only after attempts at de-escalation had failed.

Assessment of patient risk

Staff completed a comprehensive risk assessment when patients were first admitted. Risk assessments were updated promptly following any incident that altered the patient's current risk level. Risk assessments were routinely reviewed by staff on a weekly basis during multi-disciplinary team ward rounds.

Our findings

Each patient was zoned into categories of red, amber and green according to their overall risk levels. These zones were clearly displayed for staff to familiarise themselves with the top risks relating to each patient and how they should work to mitigate these, for example, by using enhanced observations. We reviewed daily staff handover meeting notes, which demonstrated that staff discussed these risk zones before each shift.

Management of patient risk

Staff used techniques to safely manage identified patient risks. These were discussed during shift handover meetings and were clearly documented in patient records. For example, one patient was identified as being at risk of mismanaging their diabetes by accidentally deviating from mealtimes. Staff followed a plan to empower the patient to take responsibility for managing their diabetes and to ensure the patient understood the importance of having meals on time.

During the trust's freedom to speak up investigation at the end of 2020 it was identified that not all staff were familiar with the correct processes for searching patients on return from leave. This meant that some banned items that could cause harm to patients had been brought onto the ward. We identified that this had improved at this inspection. Staff were now aware of how to conduct searches appropriately as soon as patients returned from leave. This minimised the risk of banned items, such as sharp items or alcohol, being brought onto the ward.

During the trust's freedom to speak up investigation at the end of 2020 it was also identified that not all staff effectively supported patients with eating disorders at mealtimes. At this inspection we identified that this had improved. Staff knew how to effectively support patients with eating disorders both during and after meals. This helped both minimise distress to patients during mealtimes and ensured staff could keep track of food and fluid intake for patients who were at risk of harm should there be a variation in food and fluid intake.

Senior staff were keen to minimise the use of blanket restrictions on patients where appropriate. For example, a review of patient access to internet access had recently been made. This had resulted in more appropriate, less restrictive rules for internet use that could be tailored according to individual patient need. Senior leaders also talked about the benefits of opening refurbished bedroom corridors and making environmental alterations to the ward patio area. Once these works were complete, patients would be able to have unrestricted access to these areas.

Use of restrictive interventions

Staff explained how they were making conscious efforts to use the least restrictive intervention when managing challenging incidents involving patients. Data on the numbers of restrictive practices such as restraint and rapid tranquilisation were fed into the divisional business meeting and analysed by senior staff. This helped to ensure the service used as little restriction on patients as possible and meant that any change in the use of interventions such as restraint could be investigated promptly, to help ensure staff were continuing to take the least restrictive approach when supporting patients.

During the 12 months before the inspection there had been 140 recorded episodes of restraint. Just one of these was in the prone (face-down) position. Restraint was used as a last resort and staff had clearly documented their attempts to use other techniques first, including verbal de-escalation, distraction techniques tailored to the patient's individual sensory needs, and by offering patients when required medicine as needed to help ease their distress.

Our findings

Ten incidents during the 12 months before the inspection resulted in staff administering medicines using rapid tranquilisation. Rapid tranquilisation was also used as a last resort, where patients presented a significant risk of harm to themselves, and staff had clearly documented other techniques they had tried first.

Where patients had received medicine via rapid tranquilisation, staff completed the required post-dose physical health monitoring in line with the trusts policy. This meant that, should a patient's physical health condition deteriorate because of the medicine they had been administered, staff would be able identify this potential deterioration promptly and act to minimise any harm to the patient.

There had been no instances of seclusion or long-term segregation during the 12 months before the inspection.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it. Staff could easily access support with safeguarding from a safeguarding lead.

Staff had received training in how to recognise and report potential abuse that was appropriate to their role. The staff team were up to date with their required safeguarding training.

Staff effectively identified children who were at risk of suffering significant harm. They worked closely with other agencies including social services and schools to manage these risks. For example, we identified a case where a patient had made a disclosure about potential abuse at home. Staff acted promptly to obtain support from the trust safeguarding lead and make a safeguarding referral to the local authority safeguarding children team.

Staff access to essential information

Staff had easy access to essential information relating to the care and treatment of patients. All records were electronic and could be accessed by all staff including agency staff who worked regularly on the ward. The same electronic records systems were used when patients were transferred to either the enhanced care pathway or local community CAMHS services.

Medicines management

The service used systems and processes to safely prescribe, administer, record and store medicines. Staff regularly reviewed the effects of medicines on each patient's mental and physical health.

New automated medicine cabinets had recently been installed in the clinic room. This new system aimed to improve the security and audit accuracy of medicines, thereby reducing the potential for medicines errors. It also kept track of medicine stock levels and helped staff ensure medicines were ordered promptly to avoid any potential shortages.

A pharmacist regularly visited the ward and staff knew how to contact the pharmacist for support.

Staff reviewed the effects of medication on patients' physical health in line with National Institute for Health and Care Excellence guidance. No patients were prescribed high doses of antipsychotic medicines.

Our findings

Medicines were stored safely and checked regularly by staff. Medicines all appeared to be in date and both ambient room and medicines fridge temperatures were checked by staff each day to ensure medicines were being stored at a safe temperature.

Track record on safety

There had been no serious incidents at the service within the 12-month period before the inspection.

Reporting incidents and learning from when things go wrong

During this inspection we identified that significant improvements had been made to the incident reporting culture and the way incidents were managed. During the trusts freedom to speak up investigation at the end of 2020 it was identified that improvements needed to be made to the way incidents were reported and managed. A backlog of reported incidents existed at that time because only a very limited number of staff reviewed incident reports, meaning that lessons were not always learnt from incidents promptly and the risk of repeat incidents was greater because of this. At that time staff felt that incidents were not routinely discussed or reflected on. Some staff also reported significant risk incidents that had not been formally reported.

At this inspection staff reported all incidents that should be reported. Incident reports were now reviewed by a senior nursing staff member promptly, because the trust had taken action to increase the pool of staff who were skilled to review these.

However, although staff now reported that they learnt lessons from recent incidents via ad-hoc emails and updates at handover meeting they happened to attend, there had not been a ward business meeting since April 2021. Senior staff had also acknowledged that a learning lessons narrative was yet to be included in the quality report on the service that fed into the divisional business meeting. This meant that routine reflection on incidents and discussions about lessons that had been learnt was not yet systematic.

Staff reported that although there had been an improvement in informal check-ins after significant incidents, structured debrief sessions whereby staff could reflect on incidents that they had been involved with were still being embedded. Two charge nurses were currently working on a project to better embed incident debriefs.

Is the service effective?

Requires Improvement 

Assessment of needs and planning of care

Staff assessed the physical and mental health of all patients on admission. They developed individual care plans which were reviewed regularly during multidisciplinary team discussions and were updated as needed. Care plans reflected patients' assessed needs, and were personalised, holistic and recovery oriented.

Our findings

Each care plan included goals that patients had agreed with staff. Care plans covered the range of different patient needs, including specific physical health conditions and sensory and de-escalation techniques that had been agreed with the patient. For example, we observed care plans detailing various distraction techniques, such as chewing on a slice of lemon or playing with ice cubes, that were used to help reduce incidents of anxiety and distress.

Where possible, existing care plans that had been in place during previous inpatient admissions or that had been developed by community CAMHS teams were used when patients were first admitted, helping build an accurate plan of care that was suitable for the patient.

Care plans contained mostly up to date information and staff explained that they were normally reviewed on a weekly basis.

Best practice in treatment and care

Staff provided a range of treatment and care for patients based on national guidance and best practice. They ensured that patients had good access to physical healthcare and supported them to live healthier lives. Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives.

A range of specialist therapists worked on the ward. This included art, music and pet therapy. A dietician had worked closely with staff on the ward to provide guidance and advice about meeting patients dietary needs. Family therapy was available to patients and their relatives. Relatives reported that they had found family therapy very useful. Patients also accessed support from psychologists.

Staff were alert to the wider health needs of patients. For example, staff knew how to manage individual patient's physical health conditions and patients were supported to access treatments by physical healthcare specialists where necessary. Staff had recently arranged an Autistic Spectrum Disorder assessment for a patient. This had resulted in a diagnosis that staff then supported the patient and their family to better understand.

Staff supported patients to lead a healthy lifestyle. This involved promoting healthy foods and encouraging patients to take part in exercise and sports activities. Some patients reported that they particularly enjoyed boxing.

Occupational therapy staff worked closely with patients to help develop daily living skills. This involved meal planning, budgeting, shopping for ingredients and cooking and preparing food.

Outcome measures were used to monitor the effectiveness of treatment interventions. For example, a Depression Treatment Response Rating Scale was undertaken on admission and at regular intervals during each patient's stay to measure low mood and depression in patients. This measured energy levels, engagement with activities, motivation, sleep problems, concentration, appetite and negative thinking.

Staff were involved with efforts to improve the service. For example, there were ongoing quality improvement projects to develop more structured staff debriefs following incidents, and to implement improved food and fluid recording charts.

Skilled staff to deliver care

Our findings

The ward team included a full range of specialists required to meet the needs of patients. Managers made sure they had staff with the range of skills needed to provide high quality care. Managers provided an induction programme for new staff.

Staff received a comprehensive induction to the service when they first started. This included agency staff who were working on the ward temporarily. They were made aware of key information such as how to manage environmental risks.

Staff supervision and appraisal needed to improve. Just 45% of staff had attended a supervision meeting during June 2021 and 16.7% of staff had received an appraisal during the 12 months to October 2021. This was because formal staff supervision had been stepped down during the Covid-19 pandemic due to competing demands. Also, there had been a one-year grace period up to April 2021 whereby staff appraisals were not taking place because the service had only recently transferred to the trust from the previous provider. Leaders reported that the formal monitoring of staff supervision and appraisals had recently resumed, and they expected compliance rates to improve soon.

Staff had access to specialist training that enabled them to carry out their roles effectively. For example, support workers were about to receive Dialectical Behavioural Therapy (DBT) training to help with the way they supported and communicated with patients. Other staff had attended training in autism awareness.

Leaders gave examples of how they supported staff through periods of poor performance by setting goals and objectives and ensuring staff had any support they needed.

Multidisciplinary and interagency teamwork

Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. The ward team had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.

Nursing staff explained that they recently felt more empowered to contribute to multidisciplinary discussions, and that recent introduction of a nurses' forum had helped them feel empowered.

Staff maintained positive working relationships with key professionals, including community CAMHS teams, social services and schools.

Adherence to the Mental Health Act and the Mental Health Act Code of Practice

Staff understood their roles and responsibilities under the Mental Health Act 1983 (MHA) and the Mental Health Act Code of Practice and discharged these well. Managers made sure that staff could explain patients' rights to them.

Eighty-five per cent of eligible staff were up to date with their training in the MHA. Staff demonstrated a good understanding of how to apply the Act.

Staff knew how to access support with the MHA via an MHA administrator.

Patients had easy access to an Independent MHA advocate and reported that staff had taken time to discuss their rights whilst they were detained under the MHA.

Our findings

Detention paperwork was easily accessible on the patient records system and patients' care plans included a section about their detention under the MHA where necessary, for example, in terms of agreed Section 17 leave arrangements.

A notice was clearly displayed telling informal patients about their right to leave the ward.

Audits were completed regularly to ensure that the MHA was being applied correctly and that detention paperwork was kept in order.

Good practice in applying the Mental Capacity Act

Staff supported patients to make decisions on their care for themselves. They understood the trust policy on the Mental Capacity Act 2005 applied to young people aged 16 and 17 and the principles of Gillick competence as they applied to patients under 16. Staff assessed and recorded consent and capacity or competence clearly for patients who might have impaired mental capacity or competence.

Ninety-four percent of eligible staff were up to date with their training in the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards. Staff had a good understanding of the principles of the MCA.

We identified that capacity to consent to treatment was reviewed and recorded for patients aged 16 and over. For younger patients, we identified that staff had recorded specific medical treatment decisions clearly, considering patient views based on whether they were deemed to be Gillick competent. A Gillick competent young person is deemed competent to make a treatment decision for themselves without the need to rely on parental consent.

Staff knew where to access the trust's policies about making mental capacity assessments.

Is the service caring?

Inspected but not rated

Kindness, privacy, dignity, respect, compassion and support

Staff treated patients with compassion and kindness. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.

We observed staff engaging and helping patients during the inspection. Patients were unanimously positive about how supportive staff were. Relatives were mostly positive about staff too. They were particularly grateful for the work of the occupational therapy, family therapy and education staff.

Patients and relatives spoke positively about the range of activities on offer. However, four patients reported that there weren't always enough staff at weekends to facilitate activities or to let patients use the ward patio area. These patients also reported that agency staff often worked at night who were not familiar with their individual needs.

Although most relatives felt that staff were friendly and supportive, some reported that communication with ward staff was a challenge for them. Three relatives and two patients reported that communication between staff and relatives was not always forthcoming. They described that although staff updated them following significant incidents or updates

to their loved one's care, they often struggled to speak with staff on the ward about general updates about their loved one, or to convey messages or requests. Leaders reported that they were aware of this challenge and were working to ensure staff understood the importance of passing on messages from relatives. They hoped that this would improve as the service aimed to use fewer temporary staff in future.

Involvement in care

Staff involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided. They ensured that patients had easy access to independent advocates.

Involvement of patients

Patients reported feeling involved in their care and that they collaborated with staff to develop their care plans.

However, patients and relatives were not able to attend weekly multidisciplinary ward rounds. Instead, patients and relatives were invited to submit statements for discussion during the meeting and were provided with updates after the meeting had taken place. Senior leaders reported that they had plans to ensure patients and their relatives were supported by staff to actively participate in these discussions soon.

Staff ensured patients were oriented to the ward when they first arrived. Staff also took time to communicate with patients, so they understood aspects of their treatment including medicines.

Patients were encouraged to pursue their personal interests whilst they stayed on the ward. For example, some patients had a specific interest in LGBT+ pride events across the world and had been able to design displays about the topic. Others had hobbies and interests in specific types of food that were celebrated by the wider ward community.

Patients accessed advocacy. The advocate visited the ward twice per week and their contact details were available for patients to make contact at other times too.

Patients reported that they felt listened to by staff and that they could provide feedback during community meetings or informally by speaking with staff. For example, patients had made suggestions about how the activity programme could be enriched to meet their needs. Patients had also made suggestions about what foods should feature on the menu and made decisions about the types of artwork to be displayed.

Involvement of families and carers

Feedback from families and carers was mixed. Whilst some relatives felt they were kept up to date about all aspects of their loved one's care and treatment, others felt that they were only contacted when there had been incidents or a significant change in their loved one's care. This led them to feel that communication with staff was challenging and not always proactive.

Senior staff explained that they had plans to introduce routine surveys or questionnaires to gather the views of families and carers soon. However, most relatives we spoke with did report that they felt staff would listen to their feedback if they offered it.

Our findings

Is the service responsive?

Inspected but not rated

Access and discharge

Bed management

The CAMHS treatment pathway was under significant pressure due to increased demand. Although the 11 patients on the ward were from the local area, there was not always a bed available for all patients living in the local area who needed one. At the time of the inspection, some patients requiring tier 4 inpatient CAMHS treatment were placed out of the local area or were being treated on acute paediatric wards due to a shortage of available beds.

Despite the high demand for beds staff ensured that patients who were granted overnight leave always had a bed to return to and avoided unnecessary transfers to other services during an admission episode, unless for clinically justified reasons such as the patient requiring treatment on a CAMHS Psychiatric Intensive Care Unit.

Discharge and transfers of care

Senior staff reported that just one current patient's discharge had been slightly delayed. This was due to challenges in identifying a suitable specialist school placement.

Staff planned for patients discharge carefully. Some patients were transferred to the new enhanced care pathway on discharge from the ward. This meant that they continued to attend the service to see members of staff who they were already familiar with from their inpatient stay. Staff liaised closely with colleagues in social care services, schools and colleagues in community CAMHS services to help ensure discharge went smoothly.

Staff supported patients during referrals and transfers between services. For example, one patient required overnight treatment at the local acute hospital. They were always accompanied by a member of staff from the ward during their admission to the acute hospital.

Leaders also reported that they were continuing to work closely with system partners to provide advice and support around delivering effective care and treatment to patients who were currently being treated on acute paediatric wards due to a shortage of specialist CAMHS beds.

Facilities that promote comfort, dignity and privacy

The design, layout, and furnishings of the ward supported patients' treatment, privacy and dignity. Each patient had their own bedroom with an en-suite bathroom and could keep their personal belongings safe. There were quiet areas for privacy. The food was of good quality and staff supported patients to access hot drinks and snacks where appropriate.

Patients had their own bedrooms and they were able to personalise these with their own belongings. Staff were also able to secure patients valuable possessions in lockers.

Our findings

There was a wide range of rooms available to support treatment and care. These included multiple education rooms, art and music therapy spaces, activity spaces, a sensory room and an occupational therapy kitchen space.

There were plenty of quiet spaces on the ward where patients could have private conversations with staff. Families could attend the service, but generally met with patients outside the main ward area because of the ongoing Covid-19 pandemic.

Senior staff explained that environmental restrictions should be eased soon once environmental improvement works had been completed. For example, the ward patio garden was small and could only be accessed under supervision by staff. Patients had to ask staff to unlock toilets in the communal areas due to identified ligature risks. All patients were subject to routine checks by staff twice per hour. This increased frequency of routine checks was because staff needed to mitigate the environmental risks that existed. Some classroom areas had been out of use due to a leak in the roof.

Patients' engagement with the wider community

Staff supported patients to access appropriate education opportunities. Dedicated staff made efforts to liaise closely with patients' schools to ensure the curriculum delivered to each patient at the service was tailored to each patient's specific educational needs.

Staff supported patients to maintain contact with families, carers and people who mattered to them. Staff reported that they made efforts to facilitate virtual meetings for patients and their loved ones.

There was a limit to how much contact with the wider community staff could facilitate because of the ongoing Covid-19 pandemic. However, patients explained that they were supported by staff to attend local shops where appropriate.

Meeting the needs of all people who use the service

The service met the needs of all patients including those with a protected characteristic. Staff helped patients with communication, advocacy and cultural and spiritual support.

Some patients explained the significant of LGBT+ pride celebrations. This had been something the patients and staff on the ward had ongoing discussions about and numerous display boards depicted the different pride flags that were used worldwide. Staff explained that they supported patients with their sexuality and gender identity as best they could. Staff explained how they had supported patients during gender transition. They also discussed how they had supported some patients to approach conversations about gender identity with their family members.

Adjustments could be made for patients with mobility needs. Bedrooms were available on the ground floor and accessible bathroom facilities are available.

Staff gave examples of how they had supported patients with their religious or spiritual needs. This had involved the use of the multifaith room, sourcing appropriate religious texts, escorting patients to worship on request and contacting a multifaith chaplain who could visit the ward.

Written information could be translated or requested in easy read formats for patients who would benefit from this. Translators could also be booked to attend the service if patients or their families needed this.

Listening to and learning from concerns and complaints

Our findings

Patients and carers reported that they felt able to speak up if they had concerns. They knew that they were able to make formal complaints and felt that staff would help them to do so if necessary. Details about how to complain were displayed and made available to patients and families to use the trusts complaints process.

During the 12 months before the inspection, one formal complaint had been made about the service, which was partially upheld. An action plan had been identified during the complaint investigation and leaders had implemented this appropriately.

Is the service well-led?

Inspected but not rated

Leadership

Leaders had the skills, knowledge and experience to perform their roles. They had a good understanding of the services they managed and were visible in the service and approachable for patients and staff.

Significant changes to the overall leadership of the service were ongoing when we inspected. A single ward manager was now in post, whilst previously there had been two. The modern matron post was vacant. A service manager had been in post for a few months and the Associate Director for Tier IV Services had just started in their role the week before the inspection. These new leaders had experience working within CAMHS services in the Kent area. They had the knowledge and skills to effectively perform their roles.

Staff reported recent improvements in how visible and approachable leaders were.

Leaders reported that they were supported to access NHS leadership development training. The trust had also provided specific training for leaders, for example, in how to manage staff uncertainty during the pandemic.

Vision and strategy

Staff knew and understood the provider's vision and values and how they applied to the work of their team. The trust values were visible throughout the service and staff were able to demonstrate how they embodied these values when going about their work.

Culture

Staff reported that some progress had been made in improving the culture of the service, but that there was still room for improvement.

Leaders described how improving the culture of the service, ensuring that members of staff from different disciplines could equally contribute and support one another, was one of their top priorities. Some staff reported that there was a sense of disconnect between nursing staff and other leaders and MDT staff members. Staff also talked about how they

did not feel adequately supported by leaders during 2020. This was a particularly challenging time for the service because staff had transferred to the trust from the existing provider, the trust undertook a consultation process about the future service model which led to uncertainty amongst staff, and many staff had been directly affected by Covid-19 and felt very anxious about the pandemic.

However, staff felt proud to work for the service, they reported that they felt increasingly able to contribute to team discussions and that the addition of the nursing forum had been helpful in empowering them to participate in discussions. Some staff also acted as wellbeing ambassadors and staff reported that their general wellbeing was being taken seriously by new leaders.

Staff were familiar with the trust's freedom to speak up process and action had been taken by the trust to make improvements after some staff spoke up about things they felt had been unsafe, such as the way incidents had been managed, at the end of 2020.

Staff reported that they were starting to have meaningful conversations about their training needs and career development. For example, one staff member was grateful that they had taken on additional responsibilities to increase their exposure to the work of psychologists, because they were keen to explore a future career as a clinical psychologist.

Governance

Our findings from the other key questions demonstrated that governance processes were continuing to improve.

Key data featured on quality reports that were reviewed at the divisional business meeting. This included information on things such as staff mandatory training compliance, reported incidents, supervision and appraisal. The ward manager could also review this data with ease and take immediate action if any indicator was flagging.

Although a clear governance framework existed and it was clear what should be discussed in each meeting, the ward business meeting did not consistently take place. This meant that issues flagging in the quality report and learning from recent incidents were not systematically discussed with staff. Also, it was identified during the June divisional business meeting that improvements could be made to the discussions being had about incidents, because the narrative around what could be learnt from recent incidents was absent and the discussion centred around the numbers and type of recent incident instead.

Management of risk, issues and performance

Teams had access to the information they needed to provide safe and effective care and used that information to good effect.

Senior staff accessed a directorate level risk register. Senior staff were all familiar with the top risks to the service, including the environment and staffing constraints.

Information management

The service used systems to collect data from wards and directorates that were not over-burdensome for frontline staff. Staff had access to the equipment and information technology needed to do their work.

Our findings

Staff maintained the confidentiality of patients and families. Records systems were secure and display boards outlining key patient information were situated in staff offices away from general view.

Engagement

Staff and families could access information about the work of the provider through the trust website. Staff also received internal bulletins via email and the trust intranet.

Leaders were aware of the need to embed a more systematic means of gathering feedback from relatives and carers. Nonetheless feedback was welcomed by staff, and information about the trust complaints process was clear on the trust website.

Senior leaders maintained close relationships with local stakeholders including commissioners. This had been particularly important in designing the current service model and establishing the new enhanced care pathway and CAMHS Section 136 suite. Senior staff liaised closely with commissioners about the number of beds the service could safely operate at any given time due to ongoing environmental works and staffing constraints.

Learning, continuous improvement and innovation

Staff were given time to focus on improvement and innovation. For example, some nurses were involved in a project to improve the way staff were debriefed following incidents. A recent physical health monitoring and food and fluids audit had been completed that resulted in an improvement to the food and fluid template to improve the reliability of this record. Staff had also been assisting an academic psychiatrist in eating disorders with a research study.

Our findings

Areas for improvement

- The trust Must ensure that staff access to supervision and appraisal is improved.
- The trust should continue to monitor the effectiveness of the daily staffing establishment to ensure there are always enough staff to support patients on the ward when the Section 136 suite is occupied.
- The trust should continue with its efforts to recruit to the high number of vacancies at the service.
- The trust should continue to ensure staff can attend a formal debrief following incidents they have been involved with.
- The trust should move towards a more systematic approach to learning lessons from recent incidents.
- The trust should ensure that relatives can easily communicate with staff and provide feedback about the service.
- The trust should continue with its work to improve the safety ward environment so that restrictions on patients movement and access to outside space can be reconsidered.
- The trust should make improvements to how patients and their relatives are involved in multi-disciplinary team ward round meetings.
- The trust should continue with its work to improve the overall staff culture at the service and ensure staff feel able to speak up, contribute to discussions about the service and feel supported by leaders.

Our inspection team

The inspection team comprised three CQC mental health and community health inspectors and one expert by experience.

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
Treatment of disease, disorder or injury Assessment or medical treatment for persons detained under the Mental Health Act 1983	Regulation 18 HSCA (RA) Regulations 2014 Staffing