

Requires improvement Avon and Wiltshire Mental Health Partnership NHS  
Trust

# Child and adolescent mental health wards

## Quality Report

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Website: [www.awp.nhs.uk](http://www.awp.nhs.uk)Date of inspection visit: To Be Confirmed  
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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)
RVN3Q	Riverside	Riverside	BS16 2EW

This report describes our judgement of the quality of care provided within this core service by Avon and Wiltshire Mental Health Partnership NHS 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 Avon and Wiltshire Mental Health Partnership NHS Trust and these are brought together to inform our overall judgement of Avon and Wiltshire Mental Health Partnership NHS Trust.

# Summary of findings

## Ratings

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

### Overall rating for the service

Requires improvement



Are services safe?

Requires improvement



Are services effective?

Good



Are services caring?

Good



Are services responsive?

Good



Are services well-led?

Requires improvement



### **Mental Health Act responsibilities and Mental Capacity Act / Deprivation of Liberty Safeguards**

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

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

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

# Summary of findings

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# Summary of findings

## Overall summary

### **We rated Riverside child and adolescent mental health ward as requires improvement because:**

- The environment was not suitable to safely accommodate more than young people who were a risk to themselves or those that needed a higher level of care. There were multiple ligature points throughout the ward. These were in public areas, bedrooms and in the extra care areas. There was no plan to remove or minimise the risks. Staff did not always take the action necessary to mitigate the risks posed by potential ligature anchor points. For example, on the day of inspection, the extra care bedroom, with multiple ligature risks, was left open all day. The ligature risk assessment stated the room must be locked to ensure the young people did not have unsupervised access.
- The perimeter fence was also not secure with large gaps leading directly onto the car park.
- There were no risk assessments about the locking of the external doors in relation to the new current group of young people. Staff members did not apply the locked door policy consistently.
- At the last Mental Health Act (MHA) visit on 06 July 2017 staff used the extra care area to seclude young people but had not recognised it as seclusion. Whilst

they had a new policy in place to ensure this would not happen again, the staff team remained unclear about what constituted seclusion under the Code of Practice and would benefit from additional training.

- There was no social worker on the team so other staff had to undertake tasks usually associated with a social worker, like finding placements for the young people, taking them away from their own duties and responsibilities.

However:

- Care plans, risk assessments and crisis plans were comprehensive and helped staff to deliver safe care and treatment to young people.
- The service delivered all the psychological therapies recommended by National Institute for Health and Care Excellence.
- Young people and carers were positive about the staff team. We observed interactions between staff and young people and their families that were warm, good humoured, and professional. Young people we spoke with said the staff they worked with were respectful, supportive and caring.

# Summary of findings

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

### Are services safe?

#### We rated safe as requires improvement because:

- There were multiple ligature risks on the ward. While the trust had plans in place to mitigate identified risk, staff were not following these plans. There was no plan to address and remove all the ligature risks.
- The trust had not ensured the safety of their premises because the fence led from the garden directly onto the car park.
- There were no risk assessments about the locking of the external doors in relation to the current group of young people. Staff members did not apply the locked door policy consistently. Staff members and young people were not clear when they could use the garden spaces following the introduction of the locked door policy.
- The night time observational checks of the young people were not carried out uniformly by the staff team.
- The clinic room was not well maintained.
- Whilst at the time of the inspection the staff were not secluding young people in the extra care area they remained unclear about what determines seclusion under the Code of Practice and would benefit from additional training.

However:

- There was a clear plan to address the high staff vacancy rate.
- The manager used staff meetings and multidisciplinary meetings to cascade information about investigation of incidents both internal and external to the service.

Requires improvement



### Are services effective?

#### We rated effective as good because:

- Care plans assisted staff to deliver safe care and treatment to the children and young people.
- The service delivered all the psychological therapies recommended by National Institute for Health and Care Excellence (NICE).
- Staff members received sufficient regular supervision and appraisal.
- There was effective sharing of information at the daily meetings and regular multi-disciplinary meetings.

Good



# Summary of findings

- The staff we spoke to were conversant with the principles of Gillick competence and used this to include the young people where possible in the decision making regarding their care.

## Are services caring?

### We rated caring as good because:

- We observed interactions between staff and young people and their families that were warm, good humoured, and professional. Young people we spoke with said the staff they worked with were respectful, supportive and caring.
- Staff showed good knowledge of the individual needs of the young people who used the service.
- Young people had access to an advocate.

However:

- Young people had mixed views about how involved they were in their care and treatment plans.

Young people said there was not enough activities at weekends.

Good



## Are services responsive to people's needs?

### We rated responsive as good because:

- The staff team investigated complaints made by the young people quickly.
- The trust produced age appropriate and accessible information leaflets.
- The ward had a range of rooms and equipment to support treatment and therapy.
- The service provided accessible and age appropriate information booklets regarding health issues and conditions and produced accessible care planning information for young people.

However:

- The restrictions of the building impacted on the type of young people that could be offered care and treatment.

Good



## Are services well-led?

### We rated well-led as requires improvement because:

- There was not an effective governance system in place to ensure the environment was safe for young people as the trust had not made secure the perimeter fence. The staff team were

Requires improvement



# Summary of findings

inconsistent in their management of ligatures. Staff members and young people were not clear when they could use the garden spaces following the introduction of the locked door policy.

- The ward could not offer treatment to all young people who were acutely unwell or high risk (who would typically be treated in a ward such as the Riverside ward) due to the environment which was not fit for purpose. There was no clear plan in place to address this.

However :

- Despite the many staff changes in the last eighteen months the manager and senior team worked well together.
- Staff described good team working between their immediate team members and wider professional groups.

# Summary of findings

## Information about the service

The Riverside ward is a specialist in-patient and day treatment facility for children and adolescents aged between thirteen years and eighteen years old. It has nine in-patient beds and four day places. On the day of our inspection three of the young people were detained in accordance with the requirements of section three of the Mental Health Act (MHA).

It is a regional ward for children and young people from the south west region. Services are commissioned by

NHS England. Children and young people are in the main admitted from Bristol, South Gloucestershire and North Somerset. Until 2016 the service was provided by the North Bristol NHS Trust then it transferred to Avon and Wiltshire Mental Health Partnership NHS Trust (AWP). Sirona Community Interest Company hold the contract for the services and these are subcontracted to AWP.

## Our inspection team

Inspection was led by:

Karen Bennett-Wilson, head of hospital inspection, CQC.

The team that inspected Avon and Wiltshire Mental Health Partnership NHS Trust child and adolescent

mental health wards included: one CQC manager, one inspector and one specialist advisor who was experienced in working in children's mental health services.

## Why we carried out this inspection

This was an announced inspection to inspect and rate the child and adolescent ward as part of our on-going comprehensive mental health inspection programme.

## How we carried out this inspection

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

- Is it safe?
- Is it effective?
- 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 this service and asked a range of other organisations for information.

During the inspection visit, the inspection team:

- visited the Riverside inpatient services for children adolescents. We looked at the quality of the clinic environment and observed how staff interacted with young people who use services and carers
- read feedback from four young people.
- spoke with six young people who were using the service
- spoke with the manager for the service
- spoke with five other staff members; including doctors, nurses and support workers.
- attended and observed a multidisciplinary team meeting
- held a focus group with six young people
- held a focus group with four staff
- looked at four treatment records of children and young people

# Summary of findings

- looked at a range of policies, procedures and other documents relating to the running of the service.

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

Six of the young people told us they liked the substantive staff and found their stay at the ward positive. They sometimes found the agency staff uncommunicative. Overall, they were very happy with the care and treatment and said they found it useful. They said they had access to outside areas but were not always clear when they could use the garden spaces following the introduction of the locked door policy.

At the end of the inspection, we collected four comment cards from young people. All were positive about the service.

## Areas for improvement

### Action the provider **MUST** take to improve

- The trust must ensure that prompt action is taken to remove and/or mitigate the risk posed by potential ligature points.
- The trust must ensure that risk assessment are completed in relation to the locked external doors.
- The trust must ensure that the fences are made secure.

### Action the provider **SHOULD** take to improve

- The trust should ensure that staff understand and apply the locked door policy consistently.
- The trust should ensure all staff, young people and visitors are made aware that there is a two minute wait before the locked fire doors open if there is a fire. They should ensure the fire officer regularly reviews the two minute delay on fire doors to ensure they are safe.
- The trust should ensure there are clear lines of sight on the ward and night time observational checks are carried out uniformly by staff to ensure the safety of the young people.

- The trust should ensure there is clarity amongst the staff team about the use of the extra care ward. At the time of the inspection the staff were not secluding young people in the extra care area but they were not clear about what determined seclusion under the Code of Practice and would benefit from additional training.
- The trust should ensure that there is a fully stocked grab bag (a bag with emergency medication that could be accessed quickly if there was an emergency) available.
- The trust should ensure all young people are involved in their care planning.
- The trust should ensure that there are sufficient activities for the young people at the weekend.
- The trust should ensure that the clinic room is well maintained.

## Avon and Wiltshire Mental Health Partnership NHS Trust

# Child and adolescent mental health wards

### Detailed findings

#### Locations inspected

##### Name of service (e.g. ward/unit/team)

Riverside Inpatient ward CAMHS

##### Name of CQC registered location

Trust HQ

#### 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.

- Fourteen of the 20 staff team identified as requiring training in the Mental Health Act 1983 had received it. At the last Mental Health Act (MHA) visit on 06 July 2017 staff had on two occasions used the extra care area to seclude young people but had not recognised it as

seclusion. This meant that the seclusion policy and segregation policy and associated procedures including the requirements of Code of Practice were not being followed. At this inspection the staff were not secluding young people in the extra care area but they remained unclear about what determined seclusion under the Code of Practice and would benefit from additional training.

#### Mental Capacity Act and Deprivation of Liberty Safeguards

The Mental Capacity Act (MCA) only applies to young people aged 16 years and over. For children under the age of 16, the young person's decision making ability is governed by Gillick competence. The concept of Gillick competence recognises that some children may have sufficient maturity to make some decisions for themselves.

Records showed that Gillick competency was recorded in all of four cases reviewed. The staff we spoke to were conversant with the principles of Gillick and stated they used this to include the young people where possible in the decision making regarding their care. Young people were able to describe the Gillick competencies and how it applied to them.

# Detailed findings

The deprivation of liberty safeguards apply only to people aged 18 and over.

Staff were clear who they would seek advice about the MCA act in the trust.

# Are services safe?

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

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

## Our findings

### Safe and clean environment

- The ward layout did not allow staff to observe the young people on all parts of the ward due to its shape. Staff could only observe the bedroom area if they sat in the bedroom corridor on the upper floor. Staff stated that young people were not ordinarily in this area during the day, but they would have to have all young people on one to one observations ensure this.
- There were multiple ligature points throughout the ward. A ligature point is anything that could be used to attach a cord, rope or other material for the purpose of hanging or strangulation. These were in public areas, bedrooms and the extra care areas. For example in the extra care bedroom the bed was moveable, the window closure presented as a ligature risk and the door to the ensuite showers had hinges that could be used to tie a ligature to. The corridors outside the bedrooms had a suspended ceiling with moveable ceiling tiles which would also act as ligature points. Staff members told us they found it illogical that the extra care rooms had more ligature points than the standard rooms.
- The staff team completed a ligature assessment using the Manchester toolkit in 2017. Whilst this detailed the areas of risk there was no plan to remove ligature points or address the risks. It relied on staff observations to mitigate the risk. For rooms with ligature points the toolkit advised the rooms were locked when not in use or mitigated via staff observation of young people when they were in these areas. However, the mitigation in place was not being followed by staff. For example, the toolkit identified that the door to the extra care bedroom should be locked when it was not in use to prevent young people accessing the multiple ligature points. At the time of our inspection, this was left unlocked and was open all day. Staff were not routinely in this part of the building during the time we were there. This meant that young people could potentially have unsupervised access to very clear ligature points.
- Staff were inconsistently following the observational checks of the young people's whereabouts. For example, night time checks were not being carried out consistently by staff. Staff were confused about the frequency of the checks. Some staff completed observational checks every 10 minutes and others every 20 minutes. Records of checks were not kept in one place, so the management team could not see if they were always completed.
- The trust had not ensured the safety of the premises by securing the fence. The fence had a large open gap that led from the garden directly onto the car park.
- A senior staff member told us that the environment was not suitable to safely accommodate young people who were a risk to themselves or those that needed a higher level of care. This meant they had to exclude some young people assessed as being at high risk. He stated that the multiple ligature risks which would need to be addressed or removed before the service could treat young people, who needed a higher level of care and treatment, safely.
- Six weeks before the inspection, the trust told the staff team they must lock the front door to the service because two day patients had recently absconded. There was a sign put up telling young people to ask the staff if they wished to go out. This was a significant change for the ward because prior to this the door had always been unlocked. Other external doors like those between the dining area and garden were also locked. Staff were unclear about when or if the external doors should be unlocked. Three young people told us they were not clear when they could sit outside on the wooden benches as the patio door had to remain locked.
- The ward complied with Department of Health guidelines on same-sex accommodation. There were no same sex accommodation breaches during the 12 months from 1 April 2016 to 31 March 2017. There were young people of both genders in the same ward area, but young people had separate bedrooms and each had an ensuite toilet and shower. Young people did not have to go through an area with the opposite sex to get to a toilet or bathroom.
- The small clinic room was untidy. The clinic had an examination couch in it but there were boxes on the floor and equipment jammed against the couch. Staff told us that physical examinations could also be

# Are services safe?

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completed in young person's bedroom with their consent. There was a grab bag (a bag with emergency medication that could be accessed quickly if there was an emergency) available but no list of items available. There were limited emergency medications available on the ward. There was one EpiPen in the fridge (epinephrine auto-injector device used to manage potentially life-threatening anaphylactic reactions to allergens) prescribed for two young people on the ward. The staff nurse in charge could not locate any other emergency medications and told us that since the transition to new provider, no emergency medications were kept on the ward. The consultant psychiatrist advised that the current policy was to call 999 in an emergency.

- The ward did not have a seclusion room. There were two areas which staff described as extra care areas.
- Staff adhered to infection control principles. There was adequate hand washing facilities and hand gel available. There was signage explaining hand-washing techniques on the premises.
- There were cleaning schedules in place, which showed that staff regularly cleaned the ward. The PLACE survey score (PLACE assessments are self-assessments undertaken by teams of NHS and private/independent health care providers. They focus on different aspects of the environment in which care is provided) for condition, appearance, maintenance, and for cleanliness of the ward was 97%.
- Staff and visitors had access to alarms, which were checked regularly by staff to ensure they were in working order.
- There was a two minute delay on the fire door opening. This had been assessed by a fire safety consultant in 2017. Visitors to the ward were not routinely told that the fire door would not open for two minutes if there was a fire.

## Safe staffing

- The ward had a total establishment of 18 qualified nurses and eight healthcare assistants. At the time of inspection, there was one nurse vacancy and three healthcare assistant vacancies. The team had a higher vacancy rate following the move from North Bristol NHS Trust to Avon and Wiltshire Mental Health Partnership NHS Trust (AWP) in 2016. However the ongoing recruitment programme had enabled them to recruit seven new staff members.

- The ward had had five interim managers in the last eighteen months. The post was currently being covered by an interim manager who had been in place since the start of the year. There was also a vacancy for one consultant psychologist. The manager and all staff spoken with told us that Avon and Wiltshire Mental Health Partnership NHS Trust (AWP) were committed to staffing the ward safely and there was an active recruitment programme.
- The ward used bank and agency staff to cover absence, sickness and vacancies. Staff tried to use regular bank staff for continuity of care and treatment for the young people. In the last twelve months, the ward had covered an eighth of all qualified staff shifts and a third of unqualified staff shifts by agency staff. Young people told us they felt that some agency staff did not communicate with them as much as the substantive staff. The manager said the use of agency staff would reduce once the new staff were fully in post.
- There were clear cover arrangements for staff sickness, leave and vacant posts to ensure the safety of children and young people. The trust reported the sickness rates at February 2017 as 12.2%. This was above the trust average (4.7%) and higher than the most recent England average for similar trusts (5.3%). The manager told us this was due to long-term sickness in the staff team.
- The number of staff on shift matched the ward rota and was in line with the levels and skill mix determined by the trust as safe. The service manager was able to adjust staffing levels on a daily basis to reflect the needs of the young people.
- Young people had regular one to one time with allocated staff. Young people were offered individual time daily. This was planned in advance, according to the rota and re-visited on a shift to shift basis to ensure that this could be facilitated.
- Staff told us that it was unusual that any leave would be cancelled due to staff shortages. We saw that young people went out by themselves, with staff or family members on a regular basis.
- The ward had a dedicated specialist doctor who was available between the hours of nine to five during the week. Out of hours assistance was covered by the staff team.
- At the time of inspection, young people experienced timely access to a psychiatrist during working hours. Young people told us they felt they had sufficient time with the psychiatrist.

# Are services safe?

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

- As of the 31 March 2017, 83% of staff had completed mandatory training against the trust target of 85%. Nine courses were below the trust compliance target. These courses included training in the basic resuscitation and managing conflict. However, the manager showed us that there was a rolling programme of training in place for existing staff and new starters in order to address this.

## Assessing and managing risk to patients and staff

- There had been three incidents of seclusion between 1 April and 31 March 2017. Two of the three instances of seclusion occurred in March 2017.
- There were 22 incidents of restraint between 1 April 2016 and 31 March 2017. Six restraints occurred in October 2016. These were documented appropriately. There were no incidents of prone restraint and no incidents of rapid tranquilisation (rapid tranquillisation is when staff give specific medicines by injection to a young person who is very agitated or displaying aggressive behaviour to help quickly calm them down and avoid any harm to themselves or others). Staff told us they used prevention of management and aggression techniques. Young people told us they felt there was low use of restraint in the ward. They felt that staff acted appropriately if they had to restrain a young person.
- There was enough staff to carry out physical interventions if necessary. However, staff told us that any form of physical restraint would be a last resort and they would use distraction and de-escalation techniques in the first instance. Staff planned rotas to ensure there was enough staff who had been trained to carry out physical interventions on duty.
- Staff told us the extra care rooms on the ward had proved beneficial on occasions when young people had become distressed, as they provided a quiet space away from others, and allowed staff and young people to hold discussions around emotions and concerns in private. At the time of the inspection, young people cared for in the extra care area were not being secluded but staff were not clear about what constituted seclusion under the Code of Practice and would benefit from additional training.
- Staff undertook a risk assessment of every young person at their initial triage/ assessment and updated them regularly. Risk assessments were evident in all the case notes reviewed. The daily records showed consideration of risk and young people's involvement in their care.
- There were no individual risk assessments in relation to the locked doors for each of the current young people. In the response to the original young people's complaint, the trust stated that the risk would be regularly reassessed but this had not taken place. Young people said they could not always go outside to eat meals in the summer because staff were not consistently following the locked door policy or regularly reviewing the current risk. There were notices by the front door informing children and young people who were not detained under the Mental Health Act of their right to leave the ward. But young people said they found the situation confusing.
- The ward had a list of contraband and items that were prohibited on the ward. At the time of inspection, young people were not permitted to have mobile phones on the ward. Young people had free access to a phone on the ward located in a private place where they could not be overheard. The ward had expected bed times for the young people, to encourage a good night's rest and establish a routine that supported treatment and education.
- There were policies and procedures in place for staff to follow when observing or searching young people. These searching of young people for items presenting a risk would only be undertaken when necessary and would always be carried out in private and with a qualified nurse being present.
- At the last Mental Health Act (MHA) visit on 06 July 2017 staff had on two occasions used the extra care area to seclude young people but had not recognised it as seclusion. This meant that the seclusion policy and segregation policy and associated procedures including the requirements of Code of Practice were not being followed. At this inspection we found the young person being cared for in the extra care was not being secluded but some staff members spoken with remained unclear about what determines seclusion under the Code of Practice and would benefit from additional training.
- Staff had completed safeguarding training for adults and children as part of the trust mandatory training. All

# Are services safe?

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of the staff we spoke with had a clear understanding of safeguarding and their responsibilities in relation to identifying and reporting allegations of abuse. The team had good links with the local safeguarding board.

## Track record on safety

- There were no serious incidents reported by the trust in the last twelve months.
- In the trust's analysis of reportable incidents for the service from 10 May 2016 to 28 June 2017, there were 90 incidents, of these 12 were rated as moderately severe. For example, a young person fell down the stairs two days prior to inspection. Staff members had completed an incident form in line with trust policy.
- There was evidence of some improvements in safety following incidents. For example, in 2017 there was a repair to a gap in the lower area of the fence.

## Reporting incidents and learning from when things go wrong

- Staff demonstrated they understood what to report as an incident.
- The manager used staff meetings and multidisciplinary meetings to cascade information about investigation of incidents both internal and external to the service.
- Staff were offered support and debrief sessions following any serious incidents. Staff members told us they found this valuable.
- Staff we spoke with understood the term duty of candour. The manager gave us examples of being open and transparent with the young people and explained when things have gone wrong.

# Are services effective?

Good 

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

## Our findings

### Assessment of needs and planning of care

- All young people had a comprehensive and timely assessment completed following admission to the ward. These were documented in each of the four care records we reviewed.
- Risks to physical health were identified and managed effectively. Staff monitored young people's physical health care. A young person who had an eating disorder diagnosis had tailored physical health observations which included daily weight, food intake monitoring and fluid charts. We saw evidence of the staff team identifying changes in physical health and acting promptly.
- Care plans addressed the young person's holistic needs. They were personalised and recovery orientated with goals meaningful to the individual.
- The ward used RiO electronic recording system which is different from the system used by the CAMHS Community teams. Staff reported that there was no direct interface between the two systems. This meant that there were sometimes delays in getting sufficient information about the young people. However the staff team ensured they received detailed summaries prior to admission.

### Best practice in treatment and care

- The team offered psychological therapies recommended by National Institute for Health and Care Excellence (NICE). Staff explained that they followed NICE guidance when prescribing medication. Staff followed NICE guidelines in relation to psychosis and schizophrenia in children and young people.
- The service ensured analysis of outcome measures across CAMHS to inform service development. Staff used outcome rating scales like the children's global assessment scale (CGAS) which measures children's general functioning and the strengths and difficulties questionnaire (SDQ).
- The staff members kept an overview of the physical health needs of young people and ensured that physical health care plans were kept up to date.

- Clinical staff participated in a controlled drugs audit 2016. However, the manager said that the audits had not been completed recently due to the high staff vacancies and staff turnover but hoped to complete more clinical audits once the full staff team was in place.

### Skilled staff to deliver care

- There were currently 34 clinical staff. These included specialty registrars, clinical psychologists, consultant psychiatrists, a specialty doctor, nurse practitioners, family therapists, education co-ordinator, and modern matron, acting nurse manager and the business support administration staff.
- There was no social worker in the team. The manager thought there was a plan to recruit but had no date for this. The trust who told us that the new re-tendered Riverside model included a 0.5 social work post. The manager said that the lack of a social worker meant that all staff were involved in work usually undertaken by a social worker. This included time finding suitable new placements for the young people.
- The team had a variety of experience with some working for several years and others were new to the team. The manager said that the move last year to Avon and Wiltshire Mental Health Partnership NHS Trust (AWP) had made some existing staff consider opportunities elsewhere in the trust and in other trusts
- When staff started working at the service they completed an induction, which consisted of completion of all the mandatory training. New staff were required to complete a range of competencies during the probationary period. Staff also received an orientation period that included familiarisation with policy and procedures.
- Staff received regular monthly clinical and management supervision. As of 31 March 2017, 80% of staff had received clinical supervision, against the trust's target of 85%. The service also held regular peer group supervision. These were used to discuss complex cases and share insight and knowledge. There were also monthly team meetings.
- All staff, both medical and non-medical, had had an appraisal. All members of staff had a personal

# Are services effective?

Good 

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development plan that was monitored, assessed and modified during the annual appraisal process. All appraisals were recorded well and had objectives and training needs identified and were individualised.

- Staff told us they could attend external training programmes through which they could achieve nationally-recognised qualifications. The staff team had recently completed specialist training in eating disorders and behavioural skills
- Senior staff addressed poor staff performance through supervision or the disciplinary process with support from human resources if appropriate.

## Multi-disciplinary and inter-agency team work

- The service held two multidisciplinary meetings (MDT) each week where a wide range of clinicians discussed the needs of young people. The staff team discussed new referrals, alternative strategies and treatments for the young people and high risk cases. We observed them discussing young people in a kind, professional and informed manner. They inputted their discussions and decisions directly in to the young people's care notes.
- Staff told us the daily handover was effective in sharing information about young people and their progress.
- The service had good working relationships with social services and the community teams.

## Adherence to the MHA and the MHA Code of Practice

- Fourteen of the 20 staff team identified as requiring MHA training had received it. There was a plan in place for the other staff to receive this training.

- We saw that young people had their rights under the Mental Health Act explained to them on admission and routinely thereafter.
- Ward staff said they contacted the Mental Health Act administrative team if they needed any specific guidance about people detained under the Mental Health Act.

## Good practice in applying the MCA

- The Mental Capacity Act only applies to young people aged 16 years and over. For children under the age of 16, the young person's decision making ability is governed by Gillick competence. The concept of Gillick competence recognises that some children may have sufficient maturity to make some decisions for themselves. The staff we spoke to were conversant with the principles of Gillick and stated they used this to include the young people where possible in the decision making regarding their care.
- The young people we spoke with were able to demonstrate a clear understanding of Gillick competence and gave examples about how it applied to them.
- Records showed that Gillick competency was considered and recorded. There was evidence of consideration of capacity and consent in all files reviewed.
- Mental Capacity Act (MCA) training took place at induction and was ongoing throughout the year. Currently all of the staff team had received this training.
- There was a MCA policy and staff knew who to approach in the trust if they need support or advice.

# Are services caring?

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

## Our findings

### Kindness, dignity, respect and support

- All of the interactions we saw between young people and carers and the staff members were respectful and supportive.
- All young people or carers we spoke with said the staff they worked with were caring. Two parents of young people who used the service gave us positive feedback regarding the staff team via our comment cards. We saw many letters of thanks from parents of young people who had used the service.
- The staff we met spoke respectfully of the young people and their carers and were able to give us many examples to demonstrate their understanding of the individual needs of the young people who used the service.
- Riverside ward scored higher than the England average in the PLACE survey for privacy, dignity and wellbeing, with 92.4% compared to England average of 89.7%.

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

- Young people were mixed about their involvement in their care plans. Two young people we spoke with

explained that care plans were written for them and then they were given the opportunity to comment on them and said they had felt part of the plan. Another said they weren't asked for any contribution to the plan and felt that it was unlikely to change even if they disagreed with the plan. All young people said they had not seen a copy of their plan. All young people were very positive about the newly developed form they completed before every MDT meeting where they could give their views. Young people were encouraged to give feedback on CAMHS service at community meetings. They said they had made decisions about how to spend their allocated money at weekends and made choices about the food. However, they were frustrated about the lack of consistency in the staff team about when they could not sit outside.

- Young people had access to advocacy services and spoke positively about them.
- Young people were currently involved with the recruitment of staff. The manager and young people said they were part of the current recruitment panel.

# Are services responsive to people's needs?

Good 

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

## Our findings

### Access and discharge

- The average bed occupancy for young people in the last six months was 94%. The length of stay for the ward ranged from an average of 23 days in April 2016 to 151 days in December 2016.
- When the clinicians completed assessments young people had an average wait of three weeks for a day patient or inpatient service. The waiting time reduced to three days if the referral was assessed as being urgent. There was no waiting list for young people to meet with clinicians.
- Riverside ward was the gatekeeping and assessment hub for the south west region although, the manager said that referrals could come from anywhere in the country. However, the service prioritised young people from Bristol, South Gloucestershire and North Somerset. From 01 April 2016 to 13 July 2017, Riverside ward had a total 46 admissions; 27 were from Bristol, four were from North Somerset and 10 were from South Gloucestershire. There were only three from other south west commissioning groups and two from out of area.
- Riverside day case service had a total 35 admissions; 18 were from Bristol, five from North Somerset and 12 from South Gloucestershire. There were none from other south west commissioning groups and none from out of area commissioning groups.
- We contacted the CAMHS lead for the south region, specialised commissioning for NHS England who told us that the service prioritised young people from the Bristol areas. As previously stated, the restrictions of the building also impacted on the type of young people that could be offered care and treatment. The ward could not offer treatment to young people who were acutely unwell or posed a high risk to themselves or others (as would be typical of an inpatient ward) due to the limitations of the building. For example the ligature risks in the bedrooms. The staff team told us there were some ongoing discussions in the trust to address this but there was no clear plan.
- The manager told us that there was always access to a bed on return from leave and this was further confirmed by data received prior to the inspection.

- When young people were discharged this happened at an appropriate time of day. The manager and the young people spoken with told us young people left at around tea time on the last day, although the team were flexible and would fit in around parents or carers schedules. Carers confirmed this was the case.
- The consultant told us that a bed was, in the main available in psychiatric intensive care ward (PICU) that specifically treated young people if a young person required more intensive care. The staff team made every effort to ensure this was sufficiently close for the person to maintain contact with family and friends.
- The trust reported that in the 12 month period between April 2016 and March 2017 there had been total of 36 discharges none of which were delayed. The staff team were discharge oriented and worked closely with the commissioning groups.

### The facilities to promote recovery, comfort, dignity and confidentiality

- The ward had a range of rooms and equipment to support treatment and therapy. There was a quiet room next to the kitchen with guitars and a piano, a large dining room, a family therapy room, a large open plan group room, small meeting rooms and a sensory room with a bubble machine.
- There were rooms on the ward where young people could meet with visitors.
- Young people were able to make a telephone call in private. There was a ward phone they could use. Young people could not use their own mobile phones on the ward.
- The ward had a good sized garden with a lawn to the back. There was wooden seating area. There was direct access to outdoor space via the lounge and dining area. These doors were locked and young people needed to be supervised in these areas because the garden area led directly onto the car park via a large gap in the fence. Young people told us they mostly could go outside if they requested it but it was inconsistent as staff members were not always available to supervise them.
- The majority of the food was prepared off site and reheated on the ward. However, the young people had access to fresh fruit and snacks and could make their own lunch of sandwiches and wraps. Young people were involved in their menu planning. They told us that generally the food was good.

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Good 

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- Young people could access cold drinks 24 hours a day in the dining area with available juice and cups. Hot drinks were available during the day on request. There were set snack times when young people could choose to eat their own snacks.
- Young people were able to personalise their bedrooms. One young person showed us their bedroom and both had posters on the walls, timetables for the week and other personal items around the room.
- The ward provided a secure place to store individual possessions.
- The activities timetable included leisure activities, therapeutic activities, education and free time. There were family groups, dance, psychoanalytic and talking groups, and a rolling programme of behavioural informed therapy. They also offered parents groups. The young people were very positive about the Friday event called all aboard held down at the docks. This included water sports like boating. However, young people were not happy about the limited range of activities at the weekends.
- The ward contained information leaflets regarding local services, medication and how to make complaints. Information leaflets about CAMHS were provided by the trust in age appropriate formats. Information included how to access counselling, contact advocacy and how to make a complaint.
- The staff team used a range of different therapy rooms. The therapy rooms were comfortable with a range of equipment to assist clinicians in engaging young people.
- The service had a sensory room with a range of interactive equipment. Staff said young people liked the sensory room.
- All of the therapy rooms were sound proofed so conversations could not be overheard.

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

- The building had wheelchair access to the reception area and a wheelchair lift on the stairs.
- The service provided accessible and age appropriate information booklets regarding health issues and conditions and produced accessible care planning information for young people.

- Interpreters and signers were available to staff from the trust. Young people who could not speak English were offered an interpreter to visit daily.

## Listening to and learning from concerns and complaints

- The wards received two complaints within the last 12 months from 1 April 2016 to 31 March 2017. The first complaint dated 4 January 2017, was about the therapeutic approach to a young person's treatment. The complaint was still ongoing so there was no detail as to whether the complaint would be upheld or referred to the Ombudsman.
- The second complaint dated 24 March 2017, was from the young people and concerned the recently locked external doors on the ward. It was investigated by senior staff in the trust and not upheld or referred to the Ombudsman. The young people complained about the lack of consultation. They were also concerned that the two minute wait on the locked fire doors might put them at risk. The manager provided a written response to the young people outlining why the complaint was not upheld. The ward sent us the fire safety consultant's certificate of conformity dated February 2017 in relation to the two minute wait to assure us of its safety. The manager stated that it gave staff time to establish if a young person had set off the fire alarm in an attempt to leave, whilst at the same time allowing staff to respond if there was an actual fire.
- Young people we spoke with knew how to make a complaint. There were posters on the ward informing of what to do. Young people discussed minor complaints during the daily community meeting and the staff team addressed them immediately.
- The complaints policy and procedure were part of staff induction process, and staff understanding was reviewed through training, supervision and appraisals. Staff were aware of what to do if the young people made a complaint and how to support them.
- Staff received feedback on the outcome of investigations following complaints. This was discussed at the staff team meetings, or during supervision sessions if felt appropriate.

# Are services well-led?

Requires improvement 

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

## Our findings

### Vision and values

- Managers and staff spoken with knew the organisation's vision and values.
- The manager said communication from trust leadership team was effective. There were regular emails and staff forums where senior staff shared communications and invited comments from staff teams on the running of the service.
- The staff team had contact with senior managers who visited the service. These included the chief executive of the trust. Staff members spoken with knew who senior managers were.

### Good governance

- There was a lack of an effective governance system in place to ensure consistency in both the ligature management and repair of the perimeter fence. The fence had a large gap which led directly into the car park that had not been addressed.
- Staff and young people were not clear when they could use the garden spaces following the introduction of the locked door policy. For example, they were not sure when they could not eat their lunch in the garden as the patio door between the dining room and garden was now locked.
- The majority of young people currently in the service did not require the higher level of care needs that the service was commissioned for, due to the restrictions of the building. There was no clear plan in place to address this.
- The service was not currently responsive to young people equally across the south west region service. The manager said the trust was reviewing the referrals but was not aware of any plans to change the current referral system.
- The team's performance against trust targets in relation to mandatory training, targets around waiting times were on the trust's computer system and were accessible in the local services.

- The manager felt they had sufficient authority and administration support. There were two part time clerks/typists, a senior administrator and a medical secretary for the service.
- The manager stated that they could submit items to the trust risk register and knew what was on the register.
- The managers across both CAMHS teams ensured there was a plan in place to ensure all staff completion on mandatory training. All staff members received appraisal and clinical supervision.
- The team undertook clinical audits to ensure staff followed NICE guidance when prescribing medication to the children and audits young people.

### Leadership, morale and staff engagement

- The ward had five interim managers in the last eighteen months. The current interim manager had been in post since the start of the year and a third of the substantive staff team had left in that period. The manager and the staff ensured the young people got good outcomes. The current young people and their carers were very positive about the manager and the team. However, obvious risks to young people in the environment were not managed well and the systems to ensure staff were consistent in the management of risk were unreliable.
- The trust had a yearly staff survey where they could express their views about the service. Staff could not identify any areas of improvement since the last survey.
- Staff sickness and absence rates were mixed with some staff on long-term sick leave. Staff also had access to health and wellbeing support via occupational health at the trust. However, staff felt that the role of the modern matron was demanding and stressful. At the time of inspection the matron was on sick leave.
- Staff told us there was not a bullying or harassment culture in the team. They knew how to raise concerns and felt they could do so without fear of victimisation. Staff told us that they knew how to use the whistle-blowing process and that they would use it if they had concerns.
- Staff told us they enjoyed working in their team and were well supported by peers and their manager. Staff morale was mixed. Some staff said they were change

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weary but felt they delivered a good service to young people despite the organisational changes. Staff described good team working between their immediate team members and wider professional groups.

- Staff members had opportunities for secondment and leadership development.
- Staff we spoke with understood the term duty of candour. The manager gave us examples of being open and transparent with the young people and explained when things have gone wrong.

## **Commitment to quality improvement and innovation**

- The ward was a member of the quality network for inpatient CAMHS Quality Network for Inpatient CAMHS (QNIC) which is a nationally recognised quality improvement programme.

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
Diagnostic and screening procedures Treatment of disease, disorder or injury	<p>Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment</p> <p>Regulation 12 HSCA (RA) Regulations 2014 safe care and treatment</p> <p>The trust had not ensured the safety of young people from the multiple ligature risks on the ward. Whilst the trust had plans in place to mitigate identified risk staff were not following these plans. There was no plan to address and remove (as appropriate) the ligature risks.</p> <p>The trust had not ensured the safety of their premises by securing the fence that led from the garden directly onto the car park.</p> <p>The trust had not ensured there was a risk assessment in place for each young person in relation to their use of the outside space following the introduction of the locked door policy.</p> <p>This was a breach of regulation 12 (1) 12 (2) (b) (c).</p>