Essex Partnership University NHS Foundation Trust

Child and adolescent mental health wards

Inspection report

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Ratings

Overall rating for this service	Inadequate
Are services safe?	**Inadequate**
Are services effective?	**Insufficient evidence to rate**
Are services caring?	**Inadequate**
Are services responsive to people's needs?	**Insufficient evidence to rate**
Are services well-led?	**Inadequate**

Our findings

Child and adolescent mental health wards

Inadequate 

We carried out this unannounced focused inspection following the notification of a serious incident on one of the wards and we received information of concern about the safety and quality of the services.

We inspected all three wards of the children and adolescent mental health service; Larkwood ward, Longview ward and Poplar unit.

Due to the serious nature of the concerns we found during this inspection, we used our powers under section 31 of the Health and Social Care Act 2008 to take urgent enforcement action and imposed conditions on the provider's registration. This included a condition to restrict the provider from admitting any new patients without the prior written agreement of the Care Quality Commission and a condition to staff all three wards with the required numbers of suitably skilled staff to meet the patient's needs and to undertake patient observations as prescribed.

We did not rate all key questions of this core service, however, our ratings of safe, caring and well-led went down because:

- The service did not have enough nursing and support staff to keep patients safe. Staffing establishments were not regularly reviewed in response to current patient need. Managers did not accurately calculate and review the number and grade of nurses and healthcare assistants for each shift. The service did not have enough staff on each shift to carry out any physical interventions (for example, restraint) safely and complete patient observations.
- Bank and agency staff use was high, and managers were not assured as to the skills and experience of agency staff. The lack of regular and familiar staff impacted on the quality of patient care. Staff did not always understand the needs of the patients. We saw evidence where unfamiliar staff did not always understand the needs of the patients they were caring for.
- Staff missed opportunities to prevent or minimise harm and did not always act to prevent or reduce risks. Staff did not always follow the trust policy and procedures on the use of enhanced support when observing patients assessed as being at higher risk of harm to themselves or others.
- Staff did not always have the correct items of clothing to respond to risks posed by patients on Larkwood ward and Longview ward.
- Staff were not always responsive to patient needs. There was a lack of suitable tear proof clothing on both Larkwood ward and Longview ward.
- Staff did not always report incidents clearly and in line with trust policy. Lessons learned were not always completed in incident forms or shared effectively across wards.
- Not all leaders had the skills, knowledge and experience to perform their roles. Not all ward leaders had a good understanding of the services they managed. Governance processes did not operate effectively at team level and that risks were not always managed well. Managers were reactive in responding to risk.

However:

Our findings

- Ward areas were clean, well maintained and well furnished. Staff knew about any potential ligature anchor points and mitigated the risks. They minimised the use of restrictive practices, managed medicines safely and followed good practice with respect to safeguarding.
- Staff reviewed risk assessments and positive behaviour support plans; where patients had them, regularly. Staff involved patients and gave them access to their care planning and risk assessments. Staff made sure patients understood their care and treatment. Staff involved patients in decisions about the service, when appropriate
- Patients had access to areas such as de-escalation and chill out rooms.

We undertook a focused inspection of this service. For this inspection, we reviewed all of the safe, caring and well led key questions and parts of the effective and responsive key questions.

Essex Partnership University NHS Foundation Trust provide community health, mental health and learning disability services for a population of approximately 1.3 million people across Bedfordshire, Essex, Suffolk and Luton.

Essex Partnership University NHS Foundation Trust provides child and adolescent mental health in patient services to young people and their families living across the country where a community setting would not be a safe or appropriate place for the young person's treatment. The child and adolescent mental health inpatient service consists of three wards located across two sites at the St Aubyn Centre, Colchester and Rochford Hospital.

The St Aubyn Centre accommodates Larkwood ward and Longview ward. Larkwood ward is a ten bedded, mixed sex, locked psychiatric intensive care unit. It provides acute and intensive psychiatric care and treatment for young people between the ages of 13 and 18, who are experiencing acute, complex and / or severe mental health problems.

At the time of inspection there were seven patients on the ward, all the patients were detained under the Mental Health Act.

Longview ward is a 15 bedded, general psychiatric mixed sex ward, providing inpatient assessment and treatment for young people aged 13 to 18 years. At the time of our inspection there were 13 patients on the ward, seven of whom were detained under the Mental Health Act.

Rochford Hospital accommodates Poplar ward, a 13 bedded general psychiatric, mixed sex ward providing inpatient assessment and treatment for young people aged 11 to 18 years. At the time of our inspection there were 12 patients. All three wards had education facilities on site, providing education and vocational opportunities in line with the national curriculum.

CQC have registered this service for the following regulated activities:

- Assessment or medical treatment for persons detained under the Mental Health Act 1983.
- Treatment of disease, disorder or injury.

The inspection team visited all three wards between 11 May and 19 May 2021 and completed further off-site inspection activity until 07 June 2021. During the inspection we:

- Visited the service and observed how staff cared for patients
- Toured the clinical environment

Our findings

- Spoke with four patients that were using the service
- Interviewed 21 staff and managers
- Spoke with five carers
- Observed two multidisciplinary meetings, one care programme approach meeting and two community meetings
- Reviewed 14 patient care records relating to physical health
- Reviewed 21 prescription charts
- Reviewed policies and procedures relevant to the running of the service.

What people who use the service say

All patients we spoke with told us they felt uncomfortable with unfamiliar staff and it made it hard to build therapeutic relationships.

A patient told us they felt exposed as they were not wearing appropriately sized tear proof clothing.

Patients told us there was not enough activities after school. Patients told us they would ask staff for items such as the television or computer remote control, but staff would tell them to wait and then staff forget.

Carers told us that incidents often happen due to the bank and agency staff not having sufficient knowledge of the patient's and their risks and whilst the patient was being observed on enhanced observations. Carers told us staff do not always understand the patients complex needs.

Carers told us that their relative had had their activities and escorted leave cancelled due to staffing issues.

Not all carers felt staff kept them informed of their relatives care. However, carers stated that their relative was involved in their review meetings and that they got to share their views on their care and treatment.

However, all carers stated that their relative was involved in their review meetings and that they got to share their views on their care and treatment.

Carers told us their relative had a positive behaviour support plan that staff should follow when their relative was in crisis.

Patients, relatives and carers knew how to complain or raise concerns. All carers we spoke with said that they had not had to make a formal complaint. Two carers said that they had made informal complaints to nursing staff and that these were dealt with appropriately.

Is the service safe?

Inadequate 

Our rating of safe went down. We rated it as inadequate.

Our findings

Safe and clean care environments

Not all wards were safe and fit for purpose. However, all wards were clean, well equipped, well-furnished and well maintained.

Safety of the ward layout

Staff completed and regularly updated thorough risk assessments of all wards areas and removed or reduced any risks they identified.

Staff could observe patients in all parts of the wards.

Ward managers were not clear on what guidance they were following about how to manage a mixed sex ward. However, the ward complied with guidance and there were no mixed sex accommodation breaches.

Staff knew about any potential ligature anchor points and mitigated the risks to keep patients safe. Where there were potential ligature anchor points, staff mitigated the risks by always being with patients in those areas.

Patients did not have access to nurse call systems. We observed a community meeting on one ward and two patients complained about not having call bells and asked staff what they would do in an emergency to gain staff attention. Patients were told nurse call bells would be fitted in their bedrooms within the next few weeks. Staff had easy access to alarms.

Maintenance, cleanliness and infection control

Ward areas were clean, well maintained and well furnished.

Staff followed infection control policy, including handwashing.

Seclusion room

Only one of the wards we visited had a seclusion room. The seclusion room allowed clear observation and two-way communication. It had a toilet and a clock.

Clinic room and equipment

Clinic rooms were fully equipped, with accessible resuscitation equipment and emergency drugs that staff checked regularly. The trust told us staff have online access to the medicines reference book. Providers are required to ensure staff have up to date information on medicines they are giving to patients.

Staff checked, maintained, and cleaned equipment

Safe staffing

The service did not have enough nursing staff, who knew the patients. Permanent staff received training to keep people safe from avoidable harm.

Our findings

Nursing staff

The service did not have enough nursing and support staff to keep patients safe. Wards were not staffed safely and regularly under the numbers planned to keep patients safe. Between 1 November 2020 and 30 April 2021 129 shifts were not filled across all wards. Staff recorded 34 incidents of staffing difficulties. Staff told us that being short staffed was a regular occurrence. Managers did not accurately calculate and review the number and grade of nurses and healthcare assistants for each shift. Staffing establishments were not regularly reviewed in response to current patient need; Larkwood ward had recently had its establishment increased to seven, despite consistently requiring 21 staff to meet the needs of patients for the six weeks pre-dating our inspection visit.

The Care Quality Commission also recognises that over the time period we reviewed, there was a national pandemic which caused staffing shortages across all NHS services. The Care Quality Commission recognises at the time of the inspection there were national challenges for wards for children and adolescents relating to patient acuity and bed availability.

The lack of regular and familiar staff impacted on the quality of patient care. We reviewed incidents where patient safety and care was impacted by lack of familiar staff. This included examples of unfamiliar staff not knowing patient risks. All patients we spoke with told us they felt uncomfortable with unfamiliar staff and it made it hard to build therapeutic relationships. Two carers stated that quite often incidents happen due to the bank and agency staff not having sufficient knowledge of the patient's and their risks. Staff told us the wards used a lot of unfamiliar agency staff. Staff told us this impacted on patient care and their workloads.

Patients did not have regular one to one sessions with their named nurse.

Patients had their escorted leave, or activities cancelled, when the service was short staffed. Three carers told us that their relative had had their activities and escorted leave cancelled due to staffing issues. One carer said that their relative has had to have a medical appointment rearranged as there were not enough staff to escort them.

A patient was unable to return from leave when the ward was short staffed. On the first day of our inspection, a patient was unable to return to the ward from extended leave at the time they made their request as no staff were available. The patient expressed a need for increased support. The patient was told they would need to wait until the evening (request made in the afternoon) and if their mental health became unmanageable, they should attend Accident and Emergency.

Bank and agency staff use was high, and managers were not assured as to the skills and experience of agency staff. From November 2020 to May 2021, Larkwood ward used bank and agency for 4970 shifts, Longview for 2671 shifts and Poplar for 1796 shifts. Not all staff on shift were able to carry out any physical interventions (for example, restraint) safely. Agency staff were not always trained in the same physical intervention training approved by the trust. We reviewed four agency staff records; none of the staff were trained in TASI (The trust approved physical intervention technique). The Trust reviewed the standard of physical intervention training provided to agency staff and were satisfied it met national occupational standards, care certificate standards and NICE guidance. The trust reported that untrained staff had worked 76 shifts on Poplar ward and 128 shifts on Longview ward from November 2020 to the time of the inspection. However, bank staff receive the same training as substantive staff in the trust's physical intervention techniques.

Managers supported staff who needed time off for ill health.

Staff shared key information to keep patients safe when handing over their care to others.

Our findings

Mandatory training

Staff had completed and kept up-to-date with their mandatory training.

The mandatory training programme was comprehensive and met the needs of patients and staff.

Managers monitored mandatory training and alerted staff when they needed to update their training.

Assessing and managing risk to patients and staff

Staff did not manage risks to patients and themselves well. Staff used restraint and seclusion only after attempts at de-escalation had failed. The ward staff participated in the provider's restrictive interventions reduction programme.

Assessment of patient risk

Staff completed risk assessments for each patient on admission / arrival, using a recognised tool, and reviewed this regularly, including after any incident. However, risks were not managed well in practice on the wards.

Staff used a recognised risk assessment tool.

Management of patient risk

Staff missed opportunities to prevent or minimise harm and did not always act to prevent or reduce risks. Following a serious incident where a patient was harmed, staff identified learning relating to observations. Despite this, issues remained with observations. Staff did not always follow the trust policy and procedures on the use of enhanced support when observing patients assessed as being at higher risk harm to themselves or others. We reviewed 12 patient observation records. Staff had not carried out patient observations at the intervals prescribed in eight out of 12 observation records we reviewed. Staff did not always sign patient observation records. As a result of staff poor observation practice patients had been harmed, this included incidents of patients tying ligatures and self harming whilst on enhanced observations.

Permanent staff knew about any risks to each patient, not all agency staff did.

Staff did not always have the correct items of clothing to respond to risks posed by patients on Larkwood ward and Longview ward. Staff on these wards did not have access to adequate tear proof clothing items. Patients wore tear proof clothing if they were at risk of ripping and using their normal clothing to self-ligature. The multidisciplinary team decided when the use of tear proof clothing was appropriate.

Staff did not always identify and respond to changing risks to, or posed by, patients. However, staff reviewed risk assessments and positive behaviour support plans; where patients had them, regularly. Patients had access to areas such as de-escalation and chill out rooms.

Not all patients who required a positive behaviour support plan had one. Senior staff told us this was because patients did not want to contribute in writing their plans. However, three carers told us their relative had a positive support plan that staff should follow when their relative was in crisis.

Our findings

Staff followed trust policies and procedures when they needed to search patients or their bedrooms to keep them safe from harm.

Use of restrictive interventions

Permanent staff participated in the provider's restrictive interventions reduction programme, which met best practice standards.

Staff made every attempt to avoid using restraint by using de-escalation techniques and restrained patients only when these failed and when necessary to keep the patient or others safe.

Staff understood the Mental Capacity Act definition of restraint and worked within it.

Staff followed NICE guidance when using rapid tranquilisation.

The only access to the seclusion room was via the long-term segregation suite. We saw, and staff told us that if someone required seclusion at the same time as another patient requiring long-term segregation, the long-term segregation care would take place in the patient's bedroom space. However, when a patient was placed in seclusion, staff kept clear records.

Staff did not always follow best practice, including guidance in the Mental Health Act Code of Practice, if a patient was put in long-term segregation. The rationale for continued long-term segregation was not always clearly evidenced and not all records justified the continued use of long-term segregation. According to the Mental Health Act Code of Practice, "Long-term segregation refers to a situation where, in order to reduce a sustained risk of harm posed by the patient to others, which is a constant feature of their presentation, a multi-disciplinary review and a representative from the responsible commissioning authority determines that a patient should not be allowed to mix freely with other patients on the ward or unit on a long-term basis". Not all records we viewed evidenced that there was a sustained risk of harm posed by the patient or that the patient's risk was a constant feature of their presentation.

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 received training on how to recognise and report abuse, appropriate for their role.

Staff kept up-to-date with their safeguarding training.

Staff could give clear examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them.

Staff followed clear procedures to keep children visiting the ward safe. There was a family room adjoined to each ward where visits could be held so young children did not have to go onto the ward.

Our findings

Staff knew how to make a safeguarding referral and who to inform if they had concerns.

Staff access to essential information

Permanent staff had easy access to clinical information and it was easy for them to maintain high quality clinical records – whether paper-based or electronic.

Not all staff were aware of how to access patient records if they did not have a permanent log in to the trust's electronic recording system. The service used a lot of bank and agency staff. Agency staff did not always have access to the providers electronic recording systems and were therefore unable to access patient notes. However, patient notes were comprehensive and all permanent staff could access them easily.

Although the service used a combination of electronic and paper records, staff made sure they were up-to-date and complete.

When patients transferred to a new team, there were no delays in staff accessing their records.

Records were stored securely.

Medicines management

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

Staff did not always follow systems and processes when safely administering and recording medicines. We reviewed 21 prescription charts and found two patients had not had one of their medications signed for on two separate days, one patient had not had three of their medicines signed on one day and one patient's medicines chart was not complete with the correct reason for omission across three days. However, staff followed systems and processes when safely prescribing and storing medicines.

Staff reviewed patients' medicines regularly and provided specific advice to patients and carers about their medicines.

Staff stored and managed medicines and prescribing documents in line with the provider's policy.

Staff followed current national practice to check patients had the correct medicines.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely.

Decision making processes were in place to ensure people's behaviour was not controlled by excessive and inappropriate use of medicines.

Staff reviewed the effects of each patient's medication on their physical health according to NICE guidance.

Track record on safety

Our findings

Reporting incidents and learning from when things go wrong

The service did not manage patient safety incidents well. Staff did not always recognise incidents and report them appropriately. Managers investigated incidents and but did not share lessons learned with the whole team and the wider service. However, when things went wrong, staff apologised and gave patients honest information and suitable support.

Staff did not always know what incidents to report and how to report them. Staff were not recording all incidents relating to staffing issues. This meant that the senior leadership team may not always be aware of the staffing issues on the wards.

Staff raised concerns and reported most incidents and near misses in line with trust policy.

Staff did not always report incidents clearly and in line with trust policy. We reviewed nine incident forms and lessons learnt was not complete in any of them. This section was blank in five of the incident forms and 'no' was written in this section on the other four incident forms. Where restraint was used staff completed this section in six out of seven incident forms we reviewed.

Managers did not always sign off incident forms in line with the trust policy. Two out of nine incident forms were not signed off by managers. Three of the incidents happened in May 2021, the month of our inspection, but one incident happened in April 2021.

The service had no never events on any wards. A 'never event' is classified as a wholly preventable serious incident that should not happen if the available preventative measures are in place.

Staff understood the duty of candour. They were open and transparent, and gave patients and families a full explanation if and when things went wrong.

Managers debriefed and supported staff and patients after any serious incident. We saw evidence of robust and regular support for staff with psychological input for both patients and staff.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations.

Staff did not always receive feedback from investigation of incidents, both internal and external to the service.

Lessons learned were not always shared effectively across wards. Staff on Longview ward were not aware of environmental issues that contributed to a safety incident on Larkwood ward, despite their ward having the same features. Patients will or may be exposed to the risk of harm if learning from specific incidents, or general learning is not disseminated across the wards to prevent recurrences of incidents.

Is the service effective?

Insufficient evidence to rate

We did not rate this key question.

Our findings

Skilled staff to deliver care

The ward team(s) included or had access to the full range of specialists required to meet the needs of patients on the ward(s). Managers made sure they had staff with the range of skills needed to provide high quality care. They supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.

Managers gave each new member of staff a full induction to the service before they started work.

Not all managers supported staff through regular appraisals of their work. The trust's target rate for appraisal compliance is 90%. At the time of our inspection the average staff appraisal rate for child and adolescent mental health wards from November 2020 to March 2021 was 75.7%. The trust told us that during the global pandemic an extension to appraisals was granted by the trust executive team to all staff to help address the staffing pressures that operational staff were facing at the time.

Managers supported staff through regular clinical supervision of their work.

Is the service caring?

Inadequate 

Our rating of caring went down. We rated it as inadequate.

Kindness, privacy, dignity, respect, compassion and support

Staff did not always respect patients' privacy and dignity. Not all staff understood the individual needs of patients. However, staff treated patients with compassion and kindness. Staff supported patients to understand and manage their care, treatment or condition.

Staff were not always responsive to patient needs which impacted on patients' privacy and dignity. There was a lack of suitable tear proof clothing on both Larkwood and Longview wards. A patient told us they felt exposed as they were not wearing appropriately sized tear proof clothing. However, staff were discreet and respectful when caring for patients. Patients told us there was not enough activities after school. Patients told us they would ask staff for items such as the television or computer remote control, but staff would tell them to wait and then staff forget.

Staff did not always understand the needs of the patients. We saw evidence where unfamiliar staff did not always understand the needs of the patients they were caring for. One carer stated their relative had complex needs which staff did not understand. They told us that staff did not always know how to deal with challenging behaviour and their relative had been told "do not shout you are disturbing other patients". One carer told us that sometimes staff use the wrong pronouns or question their relative's identity. They told us one staff member had said "but she still looked like a boy". However, permanent staff understood and respected the individual needs of each patient.

Our findings

Access to the seclusion room was not dignified or safe for patients. Both Larkwood ward and Longview wards are situated in the same building. Larkwood ward had a seclusion room. If Longview ward needed to put patients in seclusion at any time the patients would only be able to access this via the corridor between the two wards which was visible from the reception area, or via the courtyard which other patients could be in which could compromise the patient's emotional safety, wellbeing, dignity and privacy.

We could not always be assured that patients' needs and preferences were being taken into consideration. On day two of our inspection Care Quality Commission staff witnessed a staff member respond to a patient request for access to regular staff as, 'We will not have young people dictating to us who does what observations.'

Staff gave patients help, emotional support and advice when they needed it.

Staff supported patients to understand and manage their own care treatment or condition.

Staff directed patients to other services and supported them to access those services if they needed help.

Staff felt that they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients.

Staff followed the trust policy to keep patient information confidential.

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 and to child helplines.**

Involvement of patients

Staff introduced patients to the ward and the services as part of their admission. Each ward had an admission pack which was sent to the patient prior to their admission if possible or given to each patient on admission which orientated them to the ward.

Staff involved patients and gave them access to their care planning and risk assessments. We saw that patients had been involved in their care plans when we looked at care records. We observed ward rounds where patients were part of these. We observed a community meeting where patients asked for an updated copy of their care plans and straight after the meeting the ward manager printed these off for the patients.

Staff made sure patients understood their care and treatment. All patient records were suitable for the patient group to encourage involvement.

Staff involved patients in decisions about the service, when appropriate. Patients had been involved in designing the new sensory room on Poplar Unit and patients had painted the walls to make the ward look inviting.

Patients could give feedback on the service and their treatment and staff supported them to do this. We observed patients doing this in community meetings and feedback was written in community meeting minutes.

Staff supported patients to make decisions on their care.

Our findings

Staff made sure patients could access advocacy services. Advocacy regularly attended the wards and staff made referrals to advocacy if the patient was not able to advocate for themselves.

Involvement of families and carers

Staff did not always inform and involve families and carers appropriately.

Staff did not always inform and involve families or carers. Two carers stated that they did not think the staff always kept them informed that they don't always explain things such as medication changes. One carer told us they are informed of any incidents their relative had been involved in but not as timely as they would like. Two carers stated that they are not always invited to their relatives review meetings and that information following these meetings is not always shared with them. However, all carers stated that their relative was involved in their review meetings and that they got to share their views on their care and treatment.

Staff helped families to give feedback on the service.

Is the service responsive?

Insufficient evidence to rate

We did not rate this key question.

Access and discharge

Staff managed beds well. Patients were not moved between wards unless this was for their benefit. They liaised well with services that would provide aftercare and were assertive in managing the discharge care pathway. As a result, patients did not have excessive lengths of stay and discharge was rarely delayed for other than a clinical reason.

There is a national shortage of child and adolescent mental health service beds. We reviewed a total of 335 referrals across the wards from 1 January 2021 to 21 May 2021. The wards were only able to accept 27 (8%) of their referrals for admission. The wards were unable to accept most of the referrals made to them due to not having any beds available, referred patients being out of area or referred patients not being suitable for the wards.

Discharge and transfers of care

The service had a low number of delayed discharges. The trust told us there were currently four patients awaiting discharge, which were delayed, across the child and adolescent mental health wards. There were three delayed discharges on Larkwood ward, one on Longview ward and none on Poplar Unit.

The Care Quality Commission recognises at the time of the inspection there were national challenges for wards for children and adolescents relating to patient acuity and bed availability.

Facilities that promote comfort, dignity and privacy

Our findings

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 patients could make hot drinks and snacks at any time.

Each patient had their own bedroom, which they could personalise.

Patients had a secure place to store personal possessions.

Staff used a full range of rooms and equipment to support treatment and care.

The service had quiet areas and a room where patients could meet with visitors in private.

The service had an outside space that patients could access easily.

Listening to and learning from complaints

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and wider service.

Patients, relatives and carers knew how to complain or raise concerns. All carers we spoke with said that they had not had to make a formal complaint.

The service clearly displayed information about how to raise a concern in patient areas.

Staff understood the policy on complaints and knew how to handle them. Two carers said that they had made informal complaints to nursing staff and that these were dealt with appropriately.

Managers investigated complaints and identified themes.

Staff protected patients who raised concerns or complaints from discrimination and harassment.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint.

Managers shared feedback from complaints with staff and learning was used to improve the service.

The service used compliments to learn, celebrate success and improve the quality of care.

Is the service well-led?

Inadequate 

Our rating of well-led went down. We rated it as inadequate.

Leadership

Our findings

Not all leaders had the skills, knowledge and experience to perform their roles. Not all ward leaders had a good understanding of the services they managed. However, local leaders were visible in the service and approachable for patients and staff.

Governance and leadership were inconsistent across the wards. Not all leaders had the necessary experience, knowledge, capability or integrity to lead effectively.

Leaders were not always aware of the risks, issues and challenges in the service to patients or staff.

Leaders were visible in the service and approachable for patients and staff. Leaders had an open-door policy for both staff and patients. Staff knew who the local leaders were.

Leadership development opportunities were available, including opportunities for staff below team manager level.

Culture

Wards were short staffed, and staff felt overworked and stretched.

Staff told us because they were short staffed, they felt overworked and stretched. One staff member told us the staff team were 'struggling and broken'. Another staff member told us they were 'burned out'. Most staff felt supported by their colleagues. However, one staff member told us the team felt criticised rather than supported.

Staff at all levels were actively encouraged to speak up and raise concerns. Staff stated that they felt able to raise concerns without fear of retribution.

Staff knew how to use the whistle-blowing process and about the role of the Speak Up Guardian.

Staff had access to support for their own physical and emotional health needs through an occupational health service. Staff were also provided ongoing support for their wellbeing, including access to flexible working.

Governance

Our findings from the other key questions demonstrated that governance processes did not operate effectively at team level and that risks were not always managed well.

Managers were reactive in responding to risk. Larkwood ward was short by seven members of staff on day two of our inspection. Managers were already aware of this, but this had not been escalated. Care Quality Commission staff escalated this to the senior leadership team. Both Larkwood ward and Longview ward did not have enough tear proof clothing for patients who were currently using it. Managers were aware of this, but this had not been escalated or additional tear proof clothing sought. Care Quality Commission staff escalated this to the senior leadership team. The following day a request for tear proof clothing was made by local managers to Poplar Unit to request additional tear proof clothing where there were adequate amounts stored.

Staff reported a low staff morale.

The quality of care planning was consistently of a high standard and were always written from the patient's perspective.

Our findings

Management of risk, issues and performance

Teams had access to the information they needed to provide safe and effective care however this information was not used to good effect.

Risks and issues are not always dealt with appropriately or quickly enough. The approach to service delivery and improvement is reactive and focussed on short term issues.

We were not assured that care and treatment was being delivered in a safe way for patients. The trust had not taken every step available to do all that is reasonably practicable to assess and mitigate risk. Neither have the trust ensured that all staff have the competence, skills and experience to care for patients safely.

Information management

Staff engaged actively in local and national quality improvement activities.

Our findings

Areas for improvement

Children and adolescent mental health wards

- The trust must ensure that there are enough staff on shift to keep patients safe, carry out any physical interventions safely and meet patient needs. (Regulation 12(1)).
- The trust must ensure that staffing establishments are regularly reviewed in order to meet patient need. (Regulation 12(1)).
- The trust must be assured as to the skills and experience of agency staff who work on the wards. (Regulation 17(1)).
- The trust must ensure that the wards are staffed with regular and familiar staff so as to not impact on the quality of patient care. (Regulation 12(1)).
- The trust must ensure that staff are patient centred and talk about patients with kindness, dignity and respect. (Regulation 10(1)).
- The trust must ensure that patients are able to return from leave at their request and there are staff in place to accommodate this. (Regulation 12(1)).
- The trust must ensure that staff follow policy and procedures on the use of enhanced support when observing patients assessed as being at higher risk of harm to themselves or others minimising the opportunity for patients to self-harm. This includes, but not limited to, observing patients at their prescribed times, and at irregular intervals. (Regulation 12(1)).
- The trust must ensure that staff have access to enough and multiple sizes of tear proof clothing items to meet patient needs. (Regulation 10(1)).
- The trust must ensure that lessons learned are shared effectively across all wards and the wider service where appropriate. (Regulation 17(1)).
- The trust must ensure that staff are responsive to patient needs. (Regulation 10(1)).
- The trust must ensure that all staff understand the needs of the patients they are caring for. (Regulation 10(1)).
- The trust must ensure that staff recognise incidents and report them appropriately, clearly and in line with trust policy. (Regulation 12(1)).
- The trust must ensure that managers are proactive in responding to risk and that risks and issues are dealt with appropriately and quickly. (Regulation 12(1)).

SHOULDS

Children and adolescent mental health wards

- The trust should ensure that ward managers know what guidance the ward follows.
- The trust should ensure that patients have access to nurse call bells.
- The trust should ensure that staff inform and involve families or carers.
- The trust should ensure that all staff have access to the patient records.

Our findings

- The trust should ensure that patients who require a positive behaviour support plan have one.
- The trust should ensure that all staff have regular appraisals.
- The trust should ensure that all leaders have the skills, knowledge and experience to perform their roles.
- The trust should ensure that leaders have a good understanding of the services they manage.
- The trust should ensure that leaders are aware of the risks, issues and challenges in the service to patients and staff.

Our inspection team

The team that inspected the service comprised a Care Quality Commission lead inspector, two other Care Quality Commission inspectors, an assistant inspector and a Care Quality Commission inspection manager. The inspection team was overseen by a Head of Hospital Inspection.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

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