Good

Hertfordshire Partnership University NHS Foundation Trust

Child and adolescent mental health wards

Quality Report

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Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RWR96	Kingsley Green	Kingsley Green Forest House adolescent unit	WD7 9HQ

This report describes our judgement of the quality of care provided within this core service by Hertfordshire Partnership University NHS Foundation Trust. Where relevant we provide detail of each location or area of service visited.

Our judgement is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from people who use services, the public and other organisations.

Where applicable, we have reported on each core service provided by Hertfordshire Partnership University NHS Foundation Trust and these are brought together to inform our overall judgement of Hertfordshire Partnership University NHS Foundation Trust.

Summary of findings

Ratings

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

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

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 the CAMHS inpatient service as good because:-

- The CAMHS unit had a risk register and action plan. This fed into the overall risk register. The main risk identified was staffing and its impact on continuity of care due to high agency usage.
- Young people received mental and physical health assessments and participated in their clinical ward rounds. National institute for clinical effectiveness (NICE) guidance was used to underpin treatment, therapy and pathways. There was a wide range of therapies available for young people and their families.
- The service has seen an increase in the severity of illness amongst young people being admitted in the past year. Young people with disturbed behaviour affected other young people on the ward. Increased observation levels were required. The senior management recognised the pressures the unit was under. Managers reviewed and increased the established staffing levels to meet the dependency levels of the young people.
- The multidisciplinary team worked effectively. Outcome measures were used to measure progress.
- There was an active youth council involved in a variety of projects including complaints and the review of CAMHS services, as well as staff interviews.
- The unit had achieved the Royal College of Psychiatrist quality network for inpatient CAMHS accreditation. The trust had also given staff awards for good practice .The trust was participating in Hertfordshire wide reviews relating to CAMHS and children's' services.

However:

- The unit had 9 vacancies and depended on high levels of bank and agency staff. The impact of this resulted in fewer activities, nursing staff being unable to keep up-to-date with mandatory training and supervision. Despite the pressures the unit faced, staff treated young people with respect and dignity.

Summary of findings

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

Are services safe?

Requires improvement

We rated safe as requires improvement because ;-

- The unit has seen an increase in the severity of illness in the admissions , leading to increased incidents and observations. The impact of this affected activities and how safe young people felt.
- The unit had nine staff vacancies, three of which were qualified nurses. It was in the process of recruiting to these. There was a dependency on bank and agency staff to manage a group of severely ill young people who required high levels of observation. Young people did not feel they could make good relationships with temporary staff as opposed to permanent staff and as such felt unsafe.
- The inpatient unit had achieved 84% compliance with mandatory training overall. However for health and safety it was 75%. Only 56% of staff undertook moving and handling training. On the unit staff reported that they could not achieve 100% mandatory training because they had to cancel going to sessions to meet the needs of the unit.
- Resusitation equipment was not checked daily and this was not completed appropriately. The equipment had been ordered and the ward was reliant on borrowing equipment from nearby wards.
- Fridge temperature check logs were unavailable on request.
- Despite the high levels of vigilance required due to a high risk patient group, observation by staff was made difficult due to the ward layout and with no clear lines of sight in some areas.
- The administration of 'as required' medication was not clearly set out in the case of one patient and in five records that we saw had not been reviewed.
- Medications were not always licensed for use by children although accepted as standard treatment. Records did not make clear if discussions had taken place with the young people or their parents when using unlicensed medication to make them aware of this.

However:

- The unit was clean, spacious and had single ensuite bedrooms.
- The unit did have a risk register and action plan In place.
- Staff we spoke with and documentation reviewed showed they knew how to report incidents and safeguardings.

Summary of findings

- A standard electronic clinical risk assessment tool was used and risk plans were in place in all the files reviewed. Enviromental risk audits were undertaken annually.

Are services effective?

Good

We rated effective as good because:

- Young people received mental and physical health assessments on admission. They participated in their weekly clinical ward rounds where risks were reviewed. Young people with eating disorders received a range of blood and screening tests to monitor their physical health.
- NICE guidance was used to underpin treatment and therapy. There was a wide range of therapies available for young people and their families. For example family therapy, cognitive behaviour therapy, music, art and drama therapy.
- The multidisciplinary team worked effectively together discussing risk and treatment plans, issues of capacity, consent, and confidentiality. They liaised with multiple agencies such as schools, local authorities and police.
- Clinical audits were undertaken for example in relation to children's safeguarding, the use of antipsychotic medication in CAMHS, care co-ordination in CAMHS and risk assessments. Recommendations from the audits were discussed in governance meetings and cascaded to the ward areas.
- Social workers were highly qualified in the team; they provided advice regarding the Mental Health Act, safeguarding and linked with the local authority.

However:

- There was a low number of staff who had undertaken any specialist external training. Staff had access to children and young people's improving access to psychological therapies (IAPT) training. Twenty four staff across the whole of the CAMHS service had undertaken the training which includes modules in cognitive behavioural therapy, interpersonal psychotherapy, systemic therapy & supervision. There was a dependency on internal specialist training sessions.
- Records showed that clinical and managerial supervision sessions for nursing staff did not occur every four to six weeks in line with trust targets in the files we reviewed. This was confirmed by staff that we spoke with.

Are services caring?

Good

We rated caring as good because:-

Summary of findings

- Staff treated young people with respect and dignity in the interactions we observed in the communal areas. Young people we spoke with confirmed this.
- The clinical team meeting observed discussed capacity; consent and confidentiality issues related to young people. These were discussed with young people and parents with sensitivity for example when young people did not want information disclosed to their parents.
- The trust had an active youth council who were involved in staff recruitment, activity programmes, and advising on décor. Members of the council made presentations at team away days. The youth council was involved in a range of projects such as the CAMHS review and complaints.
- The friends and family test had been introduced. From December 2014 to April 2015 there were 19 surveys received from young people. The issues raised related to there not being enough staff , negative impact that the disturbed behaviour of some patients was having on the recovery of other young people, bedrooms being locked during school and activity times, loud air-conditioning, lack of transport to go out into the community and no funding for parents travelling long distances in order to visit.

However:

- The 2014 patient led assessment of care environments score results showed that for privacy, dignity and wellbeing the CAMHS scored 82% compared to a national average of 89%.
- Some young people told us that they sometimes felt unsafe due to a lack of regular staff and high numbers of agency staff

Are services responsive to people's needs?

Good

We rated responsive as good because:

- Young people received a detailed admission pack to the unit and were oriented to the facilities, staff and other service users.
- The average length of stay from March 2014-April 2015 for those with mental health issues was 28 days. For eating disorders the average length of stay was 90 days. These were fewer than the national average.
- CAMHS community teams were fully engaged in Care Programme Approach meetings, admission and discharge planning.
- Patient led assessment of care environments scores for the ward food were 86% compared to a national average of 85%

Summary of findings

- There were 10 complaints for the period 2014 to 2015. Learning had resulted in changes in practice, for example in the employment of a chef to introduce fresh food to the cook chill menu.

Are services well-led?

Good

We rated well-led as good because:

- There was there was a good link between the unit and trust vision and values in delivering person centred car and enabling young people to be cared for in the community. Staff were encouraged by the trust's openness and transparency. The staff had received support from the CEO and senior managers in response to their situation of managing a severely ill patient group. Staff support was also evident in supervision and personal development plans.
- Staff contributed to the risk register and used this mechanism to identify many of the issues related to the challenging patient group and staffing concerns.
- A unit operational plan was in place. It highlighted actions that it was being taking in relation to safeguarding training, the purpose of the safe supportive observation policy, the importance of quality handover daily reviews of the clinical situation, risk assessments and staffing levels. The nursing establishment review and closure of two beds due to the severity of illness in the case load.
- The trust was participating in the Royal College of Psychiatrists' quality network improvement inpatient CAMHS accreditation.
- The trust was participating in the clinical commissioning group (CCG) led Hertfordshire wide reviews relating to CAMHS and children's' services.

However:

- There were elements of the staff survey that placed all CAMHS services within the bottom 20% of trusts nationally. These were related work pressure felt by staff working extra hours, effective team working and support from managers.
- Staff were under reporting numbers of incidents and restraints on the unit

Summary of findings

Information about the service

- There are about 220,000 young people in Hertfordshire. The expenditure for child and adolescent mental health services (CAMHS) for April 2014 to March 2015 was £9.1 million against a budget of £ 8.3million.
- The overspend was incurred to provide additional agency staffing to meet the demands of bed pressures and increased severity of illness of young people being admitted into Forest House. There was additional inpatient activity within paediatric units at the local General Hospitals which required nursing support which was funded whilst waiting for tier four beds to become available. Additional community staffing was funded to respond to the increase in demand and meet the requirements of the local health system to radically improve the tier three CAMHS access times. Additional funding was also used as part of the transformation programme leading to new staffing structure. This resulted in some roles needing to be recruited to, leading to agency spend in the interim.
- Forest House provided services to young people aged 13 -16 years. It had 16 beds. The service helped young people and their families cope with psychological, social, emotional and behavioural problems. Three of the beds were dedicated for use by young people with eating disorders. The ward was full on the morning of the visit. During our visit one young person was transferred to an adolescent psychiatric intensive care unit out of the area, and another discharged.
- The average length of stay was 28 days generally, and 90 days for young people with eating disorders.
- An educational facility was provided onsite run by St Luke's School, St Albans. The Ofsted report in February 2014 rated the educational facility as good.
- CQC undertook an integrated inspection of safeguarding and looked after children's services in Hertfordshire in 2010 and found arrangements to be adequate.
- We did not inspect the youth offending team or looked after children team on this inspection as they are subject to separate CQC inspection programmes.
- The CAMHS service had not received any CQC compliance inspections.
- A Mental Health Act monitoring visit took place in September 2014.
- The community CAMHS and adolescent health based place of safety have been reported separately as part of this comprehensive review.

Our inspection team

Our inspection team was led by:

Chair: Dr Peter Jarrett, Consultant Psychiatrist

Head of Inspection: James Mullins, Head of Hospitals Inspection

Team Leader: Peter Johnson, Inspection Manager

The team was comprised of: CQC inspection manager, a Mental Health Act reviewer, specialist professional advisors consisting of child and adolescent mental health consultant psychiatrist (CAMHS), a CAMHS psychologist, a CAMHS nurse and social worker.

Why we carried out this inspection

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

Summary of findings

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?

During the inspection visit, the inspection team:

- visited forest house and looked at the quality of the ward environment and observed how staff were caring for patients
- spoke with 6 young people who were using the service
- spoke with the service manager, modern matron, team leader
- Spoke with eight other staff members; including doctors, nurses, therapists, advocate, and healthcare support workers.
- observed a hand-over meeting and a multi-disciplinary meeting
- reviewed 11 medicine cards and eight case records
- 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

- Young people we spoke with on the unit told us that permanent staff were good, treating them with respect and dignity. They were not able to make the same therapeutic relationships with non-permanent staff which made them feel unsafe.
- The youth council members we spoke with said they felt involved in collaborative interviews for staff recruitment, policy making and service audits. One member described being involved in the audit of adult mental health services which had provided a negative view of the services. The council had provided their views on the proposed uniform policy and felt listened to. The council members also provided peer to peer support.
- The youth council said that improvements needed to be made in the transition from CAMHS to adult services. Waiting lists were perceived to be too long, and there was a perception that young people were signposted to the accident and emergency service in order to gain access to tier three services sooner.
- The youth council were involved in reviewing the complaints policy; they had raised concerns that complaint outcomes were biased in favour of the trust.

Good practice

- A number of staff in the trust were trained to carry out "Warner" interviews on all new CAMHS staff (Warner 'Choosing with care' report 1992). The purpose being to assess whether staff had the right attitude, values and attributes to work with young people.
- The trust had a range of awards to recognise good practice. Forest House had a nurse who had received a best clinician award from the trust for the recovery group work undertaken and was also nominated for a Nursing Times award in 2014.The units' garden group in which young people had grown, prepared and cooked with vegetables and herbs were in the top six of the Trust innovation awards. The unit had also won three of the trust inspire monthly awards in the last 12 months. The last on being won by a healthcare support worker for a half term activities programme in which young people shared skills with one another as well as off the ward programme.

Summary of findings

Areas for improvement

Action the provider MUST take to improve
Action the provider must take:

- The trust must employ adequate numbers of permanent staff with the appropriate qualifications, competence, skills and experience.
- The trust must ensure that resusitation equipment is working effectively and checked daily.
- The trust must review the layout of the ward on Forest House in order to address observational lines of sight.
- The trust must ensure the safe and proper management of medications are monitored by having records avaialble to demonstrate fridge temperature are being checked daily.
- The trust must ensure that the administration of “as required”medication is recorded correctly
- The trust must ensure that unlicensed medications are discussed with young person or their parents and recorded appropriately.

Hertfordshire Partnership University NHS Foundation Trust

Child and adolescent mental health wards

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Kingsley Green Forest House CAMHS ward	Kingsley Green

Mental Health Act responsibilities

- Medical staff we spoke with said they had familiar with the new Mental Health Act Code of Practice and with the guidance relating to young people under 18 years. Staff received training about the Mental Health Act during their induction. No specific training sessions on the new Mental Health Act Code of Practice had been attended by staff.
- On the care records of three young people who were subject to detention, we were unable to find records confirming that they had been read or given information about their rights in accordance with Section 132 of the Mental Health Act. Admission packs given to young people did contain written information about their rights.
- Detained young people had access to independent mental health advocates who specifically advocated for young people.
- Review of records showed that young people had mental health review tribunals and managers' hearings.
- Young people had been granted leave in accordance with Section 17.
- Consent to treatment and capacity requirements were adhered to. Copies of consent to treatment forms were attached to medication charts where applicable.
- Capacity assessments were in place for detained young people and were decision specific. Consultation was undertaken with young people and nearest relatives about consent and capacity. There was a new form in the admission pack for assessment of Gillick competency.

Detailed findings

Mental Capacity Act and Deprivation of Liberty Safeguards

- 75% of staff had received mandatory training in the Mental Capacity Act. Staff would apply it to people over the age of 16 years. There was access to the Mental Capacity Act Code of Practice and the associated trust policy Mental Capacity Act policy via the Trust's intranet site.
- The advocacy organisations visited weekly and were able to provide an independent mental capacity advocate.

Requires improvement

Are services safe?

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

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

Summary of findings

Our findings

Safe and clean environment

- The unit was observed to be spacious. The single bedrooms with en-suite facilities were not gender designated and were all located on one corridor. The unit had large communal rooms used for socialising and therapies, and several small meeting rooms which were used for individual therapy sessions and visits. There was a gender designated sitting room for the girls.
- The unit appeared clean and well maintained. The 2014 patient led assessments of care environment results for CAMHS unit found cleanliness scored 98% compared to a national average of 96%. The results for condition, appearance and maintenance scored 96% compared to a national average of 89%.
- The lines of sight were not clear on the unit. Fish eye mirrors or CCTV cameras were not being used effectively to mitigate these risks. Instead there was a reliance on staff carrying out observations.
- Young people and staff confirmed, that bedroom access was not allowed during the working day. Young people were expected to be in school or participate in activities. Mobile phones and access to the internet was not allowed on the unit. The youth council had been asked to advise on how mobile phones could be used safely on the unit.
- Staff carried personal alarms. However there were no static alarms in the bedrooms and wards, staff were expected to minimise risks through observations.
- The clinic room was used for giving out medication and undertaking assessments such as blood pressure and weight. The medication fridge temperature was reported to be checked daily however the staff member could not locate the log book to confirm this.
- The resuscitation bag was supposed to be checked daily. Records provided by a member of staff showed that it had not been checked between the 18 April 2015 and the 27 April 2015.The resuscitation bag had pieces of equipment missing which had been requested to be replaced on the 14 April 2015 and had not arrived at the time of our visit. Staff said in an emergency crash bags would be brought from the adult wards nearby if required. They were unable to tell us how long this would take as no drill had taken place to check this out. We reported these issues to the service manager.
- Ligature cutters were available in the clinic room. Staff had been trained to use the defibrillation and suction.
- Drugs in the medication cupboard were up to date. The pharmacist visited fortnightly to audit the medications management. Controlled drugs were checked by two registered nurses and recorded in the controlled drugs book. We saw a patient bankcard in the drugs cabinet. Staff reported that they did not have access to the safe to lock it in.
- Medication reconciliation was done on admission by obtaining a list of medications from the GP and this was audited by a pharmacist on a fortnightly basis.
- Rapid tranquilisation was used and reported as an incident. There was an adult rapid tranquilisation policy in place and the unit was working with the pharmacist to develop a CAMHS rapid tranquilisation policy.
- Medication was reviewed during ward rounds and side effects discussed with young people. Parents and young people were given information about medication.
- We reviewed 11 prescription charts and found that in five cases “when required” (PRN) medication had not been reviewed. One young person was prescribed PRN IM lorazepam with no explanation of the circumstances of when this might need to be administered.
- Medications used for treatment are often not licensed for use with children and adolescents. Records did not make clear if discussion about the use of unlicensed medication had taken place with the young person or their parents.
- Hand gel was available for hand washing by staff and visitors.

Safe staffing

- A safer staffing tool was used to determine the staffing ratios and had resulted in an increase in establishment which were being recruited to. There were nine permanent qualified staff and seven healthcare support workers on the unit.

Requires improvement

Are services safe?

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

- The ward worked on ratios of two qualified staff to eight unqualified staff generally. On the day of our visit there were four qualified staff to enable escorting of a young person to another placement. There were eight unqualified staff on duty.
- The unit had nine staff vacancies, three of which were qualified nurses. This was partially due to the increase in establishment. Managers told us that over the past year there had been a notable change in the presentation of young people being admitted to the ward and were much more acutely ill, the impact of this was this required additional staffing to undertake observations and manage disturbed behaviour. The staffing establishment had been reviewed and was increased to 28 was in direct response to this. Staffing levels on the ward vary to take into account observation levels, escorts & current acuity of the patient group.
- There was a daily reliance on bank and agency staff to make up the shift numbers. Rotas we looked at showed that on most shifts there were six permanent staff and the remainder made up by agency staff.
- Across the whole of the inpatient and community CAMHS services in the previous 12 months, 6271 shifts were filled by agency/bank staff. 222 shifts were not filled in that time period. It was not always possible for the unit to fill all its shifts. When this happened the modern matron and multi-disciplinary team stepped in to support activities and observations. We were informed that this happened on a weekly basis. Staff were also borrowed from adjacent adult wards.
- Young people felt the impact of high agency usage. The majority of young people we spoke with told us that permanent staff listened to them and considered their wishes and feelings. We observed this happening during our visit. One young person told us it was difficult for them to form therapeutic relationships with regular staff as they were often too busy as they were often outnumbered by bank and agency staff, who patients did not know. They told us that young people did not want to ask people they did not know for support so they always turned to regular staff that were under pressure. Staff confirmed this was the case.
- Staff told us on occasions the police had been called to support them with incidents requiring restraint. They told us that while staff numbers look high the reality was that they could not always manage the challenging young person group. They told us this was because young people were reluctant to work with agency and bank staff with whom they had not built relationships. They told us that at times the ward was not safe, and described a day when there had been several incidents of restraint, resulting in a registered nurse needing to attend the minor injuries clinic and the police being called. They told us five staff were involved in restraining one patient and three in restraining another on this day. We heard from staff that a registered nurse had worked for 16 hours on that shift as it had not been safe to leave agency staff on the ward without a regular staff member who knew and understood the patients.
- Sickness rates for the 2014/2015 were 620 sick days mainly due to two staff being on long term sick. The turnover of staff was three. There had been five occupational health referral made since January 2015.
- The ward had sixteen sessions of consultant time (the equivalent of eight days) and there were specialist registrars and part time trainees. There was one locum consultant. There was rapid access to a psychiatrist when required. During non-emergencies out of hours a junior doctor from another site covered, however junior doctors were available in an emergency on site.
- A full time psychologist had just been recruited to support another psychologist who provided eight sessions per week. The ward benefited from part time therapists in art, dance and movement, drama, and family therapy. A full time occupational therapist (OT) and a full time social worker also worked on the unit. Administrative support was also available to the ward and a part time data clerk.
- There was an impact on activities when the OT was unavailable. Section 17 leave was being cancelled once a month on average. Some activities were cancelled such out going out into the grounds. The team were now arranging fortnightly trips for the young people to go to the cinema, bowling and other community activities. The unit did not carry out an audit of the uptake of the activities offered.
- The overall compliance with mandatory training the unit had achieved was 84%; some individual training figures were lower than this. Figures for mandatory training were; ,Equality and diversity 74%,Fire 84%,food hygiene 94%,health and safety 75%, infection control 94%, information governance 84%, “relating to people” modules 3a and 3b 100%. Only 56% of staff undertook

moving and handling training. On the unit staff reported that they could not achieve 100% mandatory training because they had to cancel going to sessions to meet the needs of the unit.

- The Children's Act training was incorporated into the safeguarding training. Staff also had a weekly training slot during team meetings for specialist issues such as eating disorders.

Assessing and managing risk to patients and staff

- A trust based electronic assessment tool was introduced to the service in 2014. This was used to carry out a holistic assessment of each patient on admission. Outcomes of the assessments were discussed at ward rounds and clinical team meetings. The trust were monitoring that electronic assessments were being completed and a monitoring report was produced for the team leader that all of the young people had an assessment in place.
- In order to ensure that safety was paramount, two members of staff escorted young people when going on section 17 leave in the community.
- There were 85 incidents reported across the inpatient and community CAMHS services March 2014 to April 2015. Staff were aware of how to report an incident and also of what types of issues are reportable. Staff we spoke to said that because of the number of incidents or restraints an individual may have they completed one form per person at the end of the day. The trust policy states that all incidents should be reported via the incident management system (Datix). It states that one form is to be completed per incident. If multiple service users are involved the form has the capacity to note all of them rather than one form per service user.
- The trust made 19 children's referrals to the local authority, 15 child protection referrals and 14 single service requests across the inpatient and community CAMHS in the past 12 months.
- The unit referrals were electronically reported and monitored through the CAMHS governance groups which reported to the governance committees of the trust board. This included the trust wide safeguarding strategy group which monitored the activity relating to children's safeguarding.
- 94% of staff at Forest House had received mandatory training for adult and children's safeguarding.
- Medical staff we spoke with explained that they would monitor patterns of behaviour, emerging symptoms and physical wellbeing as signs of physical abuse and neglect. Staff we spoke with were able to describe the types of abuse that would trigger referrals and the mechanisms used to report it. Social workers within the MDT used their expertise to discuss safeguarding concerns and the trust safeguarding leads provided support and advice.
- Managers told us that they had undertaken an audit of case notes to ensure that there was no under reporting of safeguarding issues and advised that as a result of this process were assured that there was not.
- Managers told us that six referrals were made to the local authority designated office when issues were related to agency staff behaviour and attitudes towards young people, so that their history could be checked following concerning incidents.
- There was a good relationship between the unit and the local authority safeguarding team which enabled information exchange to occur following the trust information sharing policy. The trust was represented on the local authority children's safeguarding board and minutes of the meetings were cascaded to the managers. There was a consultant social worker across the CAMHS services that made sure that the children's safeguarding procedures were being implemented.
- When young people remained on the unit for a consecutive period of three months the unit social worker informed the local authority in line with the Children Act.
- The human resources department were responsible for ensuring that staff undergo a disclosure and barring service and checking the protection of children act register before staff are appointed.
- A number of staff in the trust were trained to carryout "Warner" interviews on all new CAMHS staff (Warner 'Choosing with care' report 1992). The purpose being to check that staff had the right attitude, values and attributes to work with young people.
- There were 10 cases of restraint in CAHMS inpatient services that occurred between November 2014 and April 2015. Staff told us that they did not fill out an incident form each time a young person was restrained due the frequency; instead a daily incident form was completed listing all the restraints carried out on an individual. No young people were reported as having been restrained in the prone position. Staff we spoke with told us that restraint had been used frequently in recent months and on one occasion the police had been

Requires improvement

Are services safe?

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

called when five staff were involved in restraining one patient and three in restraining another. Staff told us they had been demoralised by needing to use restraint so frequently. They were hopeful that the dynamics of the ward would settle with the transfer of one young person to another placement.

- The multi-disciplinary team had been trained to use the restraint elimination system practical effective control techniques model for restraint. Medical staff also undertook the full five day restraint training. Staff said they used de-escalation, and also promoted using relaxation, breathing exercises and the quiet room in order to de-fuse challenging behaviour.
- There were 62 incidents of self-harm in the trust's inpatient and community CAHMS services between 01/04/14 and 31/03/15. These were classed as either no harm or low harm incidents on the trust's Datix reporting system.
- The high use of bank and agency staff meant that on occasions not all staff on a shift had been trained in the restraint elimination system practical effective control techniques model for restraint so were unable to work together. Staff we spoke with regarded this as unsafe with so many acutely ill young people on the unit.
- There was no seclusion room on the unit and seclusion did not generally take place. An exception occurred on one occasion prior to finding a young person an alternative placement in a psychiatric intensive care unit.
- On the day of our visit, Forest House had experienced a computer power failure, access was restored by 09.30am

Track record on safety

- No deaths were reported for the period April 2014 – March 2015.
- For Child and Adolescent services there were no serious incidents reported in the last 12 months and no serious case reviews.
- Staff were able to give examples of exercising a duty of candour. One young person had been shut in their bedroom due to a faulty door lock. The nurse in charge had carried out an investigation and met with the parents to tell them what had happened and had spoken to and apologised to the young person. It was reported as an incident and learning discussed with the team. A change in practice resulted in observations being carried out every 20 minutes instead of every half an hour.

Reporting incidents and learning from when things go wrong

- Managers from the unit had asked the patient safety team to analyse incidents on the unit in order to encourage learning among the staff. Trends in head banging, pre-incident triggers and the subsequent impact on young people were explored. The results identified critical times when incidents occurred such as night time, handover during shifts and when hourly swaps of observations were occurring. This resulted in increasing the numbers of staff during the day. More young people were put on observations. Staff talked to the young people about their behaviour and impact on others.
- Staff were aware of how to report an incident and also of what types of issues are reportable. Staff we spoke to said that because of the number of incidents or restraints an individual may have they completed one form per person at the end of the day. The trust policy states that all incidents should be reported via the incident management system (Datix). It states that one form is to be completed per incident. If multiple service users are involved the form has the capacity to note all of them rather than one form per service user
- Staff knew the types of incidents that they should report and gave examples such as medication errors, rapid tranquilisation, safeguarding, restraint, any instances of harm to young people and staff. The information was reported on the electronic Datix system. Staff told us that the trends and learning was discussed at the senior managers meeting and shared at team meetings; however we looked at minutes of these meetings and found no reference to lessons learnt, we also found that no team meetings had occurred. This meant that whilst learning from serious untoward incidents such as that occurring in 2013 were cascaded, more recent learning from incidents were not being minuted in meetings. Junior medical staff described monthly continuous professional development meetings as the place where messages about learning from incidents were passed on.

Requires improvement

Are services safe?

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

- The trust published a 'sharing good practice' newsletter dated spring 2015 in which the recommendations from all the serious incident reports from 2014 were analysed to identify key themes and actions that staff should undertake.
- Staff reported having de-briefings following incidents. Young people were given debriefings following incidents by their key workers.
- The CAHMS wide quality and risk meeting minutes showed that there was learning from serious incidents in the trust and from other hospitals. This resulted in looking at ligatures, access to ligature cutters and ensuring there were one to one handovers of care. The substance misuse team reported looking at incidents in other substance misuse services as a way of learning.

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.

Summary of findings

Our findings

Assessment of needs and planning of care

- Multidisciplinary assessments were carried out on admission. All young people were assessed for their health and social care needs by the nurses and social workers. All young people received psychology assessments soon after admission. Each young person had an identified keyworker, a co-worker and healthcare support worker. Young people were able to request a change in their key worker if necessary.
- Care plans were reviewed and updated during the clinical team ward rounds. Records viewed showed that assessments and care plans were up to date. Two care plans were not individualised and did not show the full range of needs. Care plans were recovery orientated. Capacity and consent to treatment were recorded.
- Records reviewed showed physical assessments had been undertaken on admission and ongoing physical health provided particularly for young people with eating disorders and long term medical conditions. Height and weight was recorded. Medical staff undertook physical health checks on admission and carried out blood tests and ECG
- Paper light records were available in the event of computer shutdowns in the form of risk assessments and care plans.

Best practice in treatment and care

- Policies and clinical pathways were based on national institute for health and care effectiveness (NICE) guidance for example in relation to the self-harm pathway. NICE guidance was discussed in the CAMHS practice governance meetings.
- The outcome measure health of the nation outcome scores is used within the service. Managers used an analysis of the outcome scores to produce a graph which details the scores across the patient group. A report is produced for discussion at quarterly senior management meetings and also with individual staff. The results of the Health of the Nation Ootcome Scores outcome measures at the time of our inspection were positive. Other assessment and measurement tools used included strengths and difficulties questionnaires and children's global assessment scale which was used to assess functioning of young people less than 18 years of age for depression.
- Trust wide and local clinical audits were undertaken. These related to records, risk assessment, infection control and care programme approach , children's safeguarding, implementing actions from serious untoward incidents, antipsychotic medication in CAMHS and assigned care coordinators in CAMHS. Recommendations and action plans were implemented following the completion of audits.
- Nursing and medical staff we spoke with told us that they used the quality network inpatient CAMHS standards to inform their team objectives. For example they followed and audited standards such as holding a Care Programme Approach meeting within five days of admission.
- Young people had access to a range of therapies such as family therapy, drama therapy, art therapy, dance and movement therapy. The possible introduction of dialectical behaviour therapy was being discussed. However due to the level of acuity (how ill young people were) on the unit staff reported that it was difficult to implement psychological therapies.

Skilled staff to deliver care

- The unit had access to a full range of mental health disciplines required to care for the patient group i.e. psychiatrists, nurses, OTs, psychologists, social worker and other therapists in art, drama and music.
- There was a reliance on in house training provided from the members of the CAMHS teams. One qualified mental health nurse had undertaken a post-graduate child and adolescent mental health qualification and training in DBT. One nurse and one psychologist were trained in cognitive behaviour therapy for adolescents. One staff member was undertaking the systemic family therapy module. One staff member had undertaken eating disorder training. Solution focused therapy was being undertaken as a team.
- Staff had access to children and young people's improving access to psychological therapies training. Twenty four staff had undertaken the training which includes modules in CBT, interpersonal psychotherapy, systemic therapy & supervision.
- Senior social workers working across the whole of the CAMHS teams were highly qualified holding a range of

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qualifications related to young people such as degrees in child and adolescent mental health, systemic family psychotherapy, psychology, eating disorders and counselling. Some also held diplomas systemic psychotherapy, DBT, specialist practice with children and families.

- Eight healthcare assistants across inpatient CAMHS had undertaken NVQ training related to healthcare/ childcare.
- Supervision on the unit should have been provided every six to eight weeks for nursing staff according to the Trust policy. However this was only achieved 50% of the time. Supervision logs were not being kept, only the supervisee maintained a personal record. We looked at three personal supervision records. All were brief and unstructured. All showed that supervision was not being given on an eight weekly basis. For two of them the last supervision sessions had occurred in January 2015.
- Consultant medical staff had monthly peer support group and had a mentor to discuss cases with. Other doctors had monthly personal development; one doctor we spoke with had weekly supervision sessions. Medical staff on the unit confirmed they had received annual appraisals.
- At Forest House 14 staff out of 20 (70%) had up to date personal development plans.
- The unit addressed poor performance promptly. Five staff had undergone investigation in the three months prior to our visit.

Multi-disciplinary and inter-agency team work

- We observed a multi-disciplinary ward round meeting. Young people were involved and appeared happy with the format. We observed the clinical team ask appropriate questions and they discussed progress and treatment plans with the young people. A team approach to care and treatment was evident. Interactions between the staff and young people were positive. We heard arrangements for discharge being discussed. A case manager from NHS England attended the ward round meeting and made positive comments about the service. However, nursing staff who we spoke with reported that they frequently could not attend the clinical team meetings due to the management needs of the young people on the unit.
- Staff from the inpatient unit and community CAMHS teams told us that community CAMHS teams attended the care programme approach meetings following admission and for discharge planning. They also undertook seven day discharge follow ups. Verbal handovers were always given by staff transferring young people to other teams and placements.

Adherence to the Mental Health Act and the Code of Practice

- Medical staff we spoke with were familiar with the new Mental Health Act Code of Practice and the guidance about young people under 18 years. The trust had asked the service to produce a summary of its application within CAMHS. Staff received training about the Mental Health Act during their induction. No specific sessions on the new Mental Health Act Code of Practice had been attended by staff. The Mental Health Act administration team provided support and monitoring of the application of the Mental Health Act and code across the Trust. Documentation was scrutinised by the administration team when a young person was detained under the Mental Health Act and subsequently to ensure their rights were being upheld. Review of records showed that young people had accessed mental health review tribunals and managers' hearings.
- On the files of three young people who were subject to detention we were unable to find records confirming that they had been given information about their rights in accordance with Section 132 of the Mental Health Act. Admission packs given to young people did contain written information about their rights.
- We found copies of legal documentation on the files of all the detained young people. However on the file of one young person we found the legal documentation relating to another patient.
- Section 5 (2) of the Mental Health Act had been used appropriately when an informal young person wished to leave the ward and staff considered it unsafe. We found some young people who had been admitted for assessment under Section 2, had appropriately been discharged from detention when they agreed to remain in hospital and consent to treatment. Other records reviewed showed that young people had been assessed for detention under Section 3 appropriately.
- Detained young people had access to independent mental health advocates who specifically advocated for

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young people. The advocate visited the ward regularly, and young people were well informed about the service. Admission packs given to young people had information about the advocacy service.

- Young people had been granted leave in accordance with Section 17 of the Mental Health Act. This was authorised on standardised forms by the responsible clinician. Staff told us parents or young people were given copies of the leave forms but we were unable to find documentary evidence to confirm this. Old leave forms were not all crossed through or removed from files which meant errors could potentially occur. We were unable to find records which demonstrated that episodes of leave were reviewed and patient views sought in line with the Mental Health Act Code of practice.
- Whilst monitoring the Mental Health Act documentation we found one detained young person had been given medication by intramuscular injection which was not authorised on the treatment medication chart. There was no record of Section 62 of the Mental Health Act being used to authorise this in an emergency and records showed that the young person had been resisting medication. This issue was raised with the service manager.
- A recently detained young person was being treated under the Mental Health Act three month rule, told us they did not understand the nature and purpose of their medication. The staff member who was observing the young person made arrangements for the young person to be informed immediately after our meeting.
- Consent to treatment and capacity requirements were adhered to and copies of consent to treatment forms were attached to medication charts where applicable. One patient, who had been admitted under Section 2, discharged from detention and then made subject to Section 5(2) the day before our visit, believed they were an informal patient. A meeting had been organised between the young person's parent and responsible clinician that day to decide on their future. We could not locate a clear capacity assessment of competence to consent to admission and treatment on the care file.
- Checks were made by staff when a young person was admitted as to who had parental responsibility i.e. local authority, parents or guardians. A blanket consent form was used on admission about sharing information. Staff had received training in assessing for Gillick competence. There was a new form in the admission pack for the assessment of Gillick competency. Capacity assessments were in place for detained young people and were decision specific. Consultation was undertaken with young people and nearest relatives about consent and capacity.

Good practice in applying the Mental Capacity Act

- Staff had had training in the Mental Capacity Act as part of their induction and would apply it to people over the age of 16 years.
- Staff had access to the Trust policy on Mental Capacity Act as well as the code of practice on the Trust intranet.
- The advocacy organisation visited weekly and was able to provide an independent mental capacity advocate.

Good

Are services caring?

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

Summary of findings

Our findings

Kindness, dignity, respect and support

- We observed positive staff attitudes and behaviours towards young people on the unit throughout the day in the communal areas and during the transfer of a young person. We saw staff making positive efforts to work with a wheelchair bound young person.
- Young people told us, and staff confirmed that some bank and agency staff did not engage well with the young people. During our second afternoon on the ward we observed agency staff asking regular staff who patients were, although they had been on the ward all morning.
- A young person told us they were concerned that agency staff do not fully understand the importance of meal plans for those with eating disorders, and sometimes allowed them to not finish meals.
- The 2014 PLACE score results showed that for privacy, dignity and wellbeing the CAMHS scored 82% compared to a national average of 89%.
- In the clinical team meetings, we observed staff considering the issue of maintaining a young person's confidentiality taking into account their capacity and development. When appropriate, staff respected the young person's wish for confidentiality of information sharing with parents.

The involvement of people in the care they receive

- Copies of care plans were provided on request rather than routinely. This was in response to an incident of data breach by young people occurring on the unit in which care plans had been left in communal areas. Young people told us they did not have copies of their care plans however said staff talked with them about their plans. Care plans were not written in a way that demonstrated involvement of young people. When young people participated in their clinical meetings care plans were projected onto the wall for them to see.
- One young person told us they thought communication between staff and her family was poor.
- Community meetings took place for young people to have a say about the unit. Two Mental Health Act monitoring visits had requested that minutes of the meeting should be kept. Staff said they were being recorded however they could not produce could evidence when asked on our visit.
- We found recordings of young people's wishes and feelings being considered on some files and some young people confirmed this. For example on one file we noted a young person had requested that their care plans were not shared with their parents. This had been acknowledged and clearly documented.
- The ward telephone located in a corridor. The privacy hood was broken. The location of the phone was not conducive to promoting privacy for young people wishing to have private conversations. Staff told us that young people may also make private phone calls by using the office portable handset. Mobile phones were not allowed within the unit. One young person told us they relied on their parents bringing mobile phones to visits so they could maintain contact with their friends. Mobile phones were not allowed because they had cameras and access to the internet and breaches of privacy was a concern. The youth council had been asked to consider ways in which mobile phones could be used without breaching privacy and confidentiality.
- We spoke with an advocate who visited the unit weekly. They reported that the young people made good use of the advocacy service.
- We met with members of the youth council and looked at minutes of meetings. The trust had a youth council who were actively involved in staff recruitment, activity programmes, and advising on décor. Members of the council made presentations at team away days. The youth council were involved in projects such as the good governance institute (GGI) CAMHS Review & changing the name on the young people's charter to "our Promise". They were also involved in the design of the complaints procedure and participation leaflet. The youth council meetings were also attended by the NHS England commissioners. One youth council member described being involved in the audit of adult mental health services which had resulted in a negative view of the services and caused concern about using adult services. The council had provided their views on the proposed uniform policy and felt listened to. The council members also provided peer to peer support.

Good

Are services caring?

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The youth council said that improvements needed to be made in the transition from CAMHS to adult services. Waiting lists were perceived to be too long, and there was a perception that young people were signposted to the accident and emergency service in order to gain access to tier 3 services sooner.

- The friends and family test had been introduced. We looked at the last two quarters results. From December 2014 to April 1 2015 there were 19 surveys received from young people. The issues raised related to not enough staff, negative impact of disturbed behaviour on other young people, bedrooms being locked, loud air-conditioning, lack of transport to go out into the community and no funding for parent travelling long distances to visit their child. 19% of young people said they would have recommend Forest House to others. 37% would not have recommend Forest House. Young people saying they felt able to tell staff if they felt vulnerable or at risk dropped from 28% to 18%. 35% felt they received enough 1;1 time with nursing staff which was an increase from 28% in Q3, 81% said there was not enough adequate activities compared to 29% in Q3.
- A parent/carer group was held at Forest House monthly, which also feeds back informally to the Modern Matron.

Are services responsive to people's needs?

Good

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

Summary of findings

Our findings

Access and discharge

- Beds on the unit were funded by NHS England specialised commissioning teams. Young people could be admitted on a planned basis with commissioners or via the adolescent health based place of safety at Kingfisher Court and the CAMHS crisis team. The unit's beds were fully utilised throughout the year. Managers and staff reported that the severity of illness had steadily risen amongst the young people admitted in the last 12 months. This led to more challenging behaviours which affected not only the individual but also the other young people on the unit. On admission, some young people had been admitted to the four bed assessment unit.
- Young people received a detailed admission pack to the unit and were orientated to the facilities, staff and other service users. One young person told us they had found it helpful that one of their peers acted as a buddy to them
- One young person told us that although they had been assessed for detention under the Mental Health Act but did not fit the criteria, they had agreed to stay informally and were impressed this decision had been respected by the staff. The young person liked the fact that their community support workers were continuing to support them during the admission phase.
- For the period April 2014 to March 2015, the average length of stay was 28 days. For eating disorders the average length of stay was 90 days. These were less than the national average.
- 34 young people from Hertfordshire were in out of areas beds up to the 30 April 2015, 13 of these were mental health placements and 21 were eating disorder placements. The trust had submitted one formal notification to the CQC in the previous six months of a young person admitted to an adult bed for 48hrs or more. At the time of our visit there were no children who required CAMHS support on paediatric wards within acute hospitals.
- During the visit we observed staff dealing with numerous phone calls from across the country requesting admission for young people from out of area as two beds had become vacant that day. Staff told us the previous weekend they had been unable to offer a bed to a young person who had been taken to the Section 136 suite health based place of safety. Staff told us they had made the case against admitting the patient to the bed of a patient who was on leave. They said recent events had made them mindful of the importance of assessing if the unit could safely meet the needs of patients before agreeing an admission. Staff confirmed that young people returning from leave had a bed retained on the unit.
- CAMHS community teams attended ward rounds when a patient was admitted and attended discharge Care Programme Approach meetings. Handovers to the community teams were given verbally. Seven day follow ups were provided by the community CAMHS team on discharge. Between July 2014 and January 2015 there were no delayed discharges and four readmissions to Forest House. Young people had a discharge celebration party involving tea, cake and cards.
- Young people with eating disorders requiring inpatient treatment were assessed as to whether they should go Forest House or a specialised eating disorder unit out of area. Some young people would transfer between the two.
- Transfers of young people occurred to other placements out of area. We observed staff taking a young person to a PICU with a secure taxi firm during our visit. Staff gave examples of delays in transferring young people to more appropriate placements, due to the shortage of adolescent beds across the country.
- Staff told us, and records confirmed that young people were referred to adult mental health teams several months prior to their eighteenth birthday in order to allow time to enable a smooth transition to take place. However adult teams did not always accept the referrals at that time and did not attend meetings or attempt to build relationships with the young people until they became 18. The youth council had expressed their concerns about the lack of transition arrangements.

The facilities promote recovery, comfort, dignity and confidentiality

- During the visit we observed young people going to and from the adjacent school and out on leave. We noticed

Are services responsive to people's needs?

Good

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young people playing in the gardens, and engaging positively with staff. Education was provided between 9am-2pm five days a week. Liaison took place with the young person's mainstream school for a phased return. Young people did not have homework. However, if the mainstream school provided this they were supported and quiet space provided on the ward. Young people had access to the internet at school.

- There were large communal rooms used for socialising and therapies and several small meeting rooms which were used for individual therapy sessions and visits. There was a gender specific sitting room for females.
- Young people told us until recently there were few activities available on the ward as there had been no occupational therapist (OT). They told us one healthcare assistant (HCA) had worked hard to organise activities during half term and as a result they had achieved a trust "Inspire award".
- Staff told us that a wide range of therapies were available, including dance and movement, art and drama. They told us therapists plan their work around the availability of the therapy room. They told us they would like to be able to work as members of a reflecting team in family therapy sessions for young people. They told us that although the family therapy room has been set up for reflecting team sessions, staffing levels mean it is often not possible for reflecting teams to support family therapy sessions. They explained it would only be helpful for staff who knew the young people to act as reflecting team members but they were unable to leave the ward when the majority of staff were bank or agency.
- Patient led assessments of the care environment scores for the ward food were 86% compared to the national average of 85%. Meal plans were in place for young people with eating disorder. Young people were also allowed food from home and ward activities included takeaway meals.

Meeting the needs of all people who use the service

- We saw staff meeting the needs of a person using a wheelchair sensitively.
- There was a lack of leaflets generally for young people on the ward. Information in other languages could be ordered. There was access to interpreters and signers if required.
- There was a CAMHS website providing information to the public about the service

Listening to and learning from concerns and complaints

- The whole of the CAMHS services received 102 compliments in the period 1 April 2014 to 31 March 2015. The number of complaints the inpatient unit had received was 10 in this period.
- At the time of the inspection the Trust had no CAMHS complaints being investigated by the PHSO, although there were 2 cases which were not upheld by the PHSO in 2014.
- We spoke with one young person who made a complaint about a staff member referring to the colour of their skin. A member who heard this said they would immediately report this to the nurse in charge.
- We tracked one complaint in the inpatient unit and found that there were issues about the way a young person had been supervised by the ward staff during a transfer to an acute hospital. The hospital had undertaken a timely investigation and given an explanation of events. The tone of the letter was apologetic and informative.
- Complaints were analysed for themes by the trust. The majority related to communication and differences of opinion in relation to the clinical issues.
- Complaints had brought about changes in the service. For example, following complaints about the cook chill food, a chef was introduced to help provide fresh salads, vegetables and fruit to complement the cook chill menu.

Are services well-led?

Good

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.

Summary of findings

Our findings

Vision and values

- Staff knew the trust's values and stated that their focus was on improving accessibility, communication and young people's experience. The Forest House vision was to have a robust skilled team that worked with young people so that they could go back into the community in the shortest possible time. "living our values" training was undertaken by staff.
- The team objectives were based on the quality network inpatient CAMHS standards. Team away days were held. For example achieving Care Programme Approach meetings within five days of admission.
- Staff we spoke with told us the trust encouraged openness and transparency which they liked. The CEO and senior managers had visited the unit and were supportive and understanding of the issues they faced as a result of the increased severity of the case mix.
- The trust were participating in the Hertfordshire review of children's services as part of its – clinical reference group. The trust was also participating in the Hertfordshire CAMHS countywide review, led by commissioners. Service user, parent and carer feedback has been elicited as part of this review.

Good governance

- The unit had a risk register which contributed to the CAMHS wider risk register and in turn informed the trust risk register. Unit staff felt able to contribute to the register. The issues identified on the risk register related to the CAMHS transformation, stabilising the workforce, waiting times, the severity of illness of young people admitted to Forest House.
- We looked at the Forest House operational action plan dated February 2015. It highlighted actions that it was taking in relation to safeguarding training, the purpose of the safe supportive observation policy , the importance of quality handover daily reviews of the clinical situation, risk assessments and staffing levels, staff supervision and PDPs. The nursing establishment review and closure of two beds due to the severity of illness in the case load.

Leadership, morale and staff engagement

- The results of the 2014 staff survey for CAMHS overall showed that there was scope for improvement in a number of areas. 54% of staff agreed they would feel safe reporting unsafe clinical practice. 46% staff suffered work related stress. Scores for work pressure felt by staff put the trust in the bottom 20% of trusts. 82% of staff worked extra hours putting it in the bottom 20% of trusts. Scores for effective team working and support from managers put the trust in the bottom 20% of trusts.
- Staff from Forest house reported that morale had been low due to the severity of the case mix but was improving. Discussions were taking place to develop a section on the unit for more disturbed young people.
- The staff survey provided results for CAMHS services overall showing that 93% of staff had appraisals , 46% of which were well-structured appraisals, 36% said there was good communication with managers,47% agreed that they received job relevant training, 100% of staff agreed their role made a difference to patients, 86% said they were able to contribute to improvements at work.
- Staff we spoke with felt that they were confident in using bullying and harassment grievance and whistle blowing policies. There had been one grievance raised in the past year. Staff had been stressed and occupational health referrals had been made.

Commitment to quality improvement and innovation

- The Royal College of Psychiatrists' quality network inpatient CAMHS standards accreditation was achieved in 2013. A further peer review took place in November 2014 in which standards continued to be met. The report made positive comments about the environment and facilities. The report stated that young people said staff were helpful and accessible and did their best for them. The parents and carers reported that they were happy with the admission process. There was good links with the CAMHS teams and discharge planning was good. It reported that there were good educational facilities. However it reported that young people were not getting enough access to outdoor space. There were no access to mobile phones, and activities at weekends could be improved. The CGAS outcome measure score could have been discussed at ward rounds and clinical meetings more. The report identified that there was no

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access to mobile phones, more written information for young people about their diagnosis and treatment could have been available. The report identified that young people linked feeling unsafe with staffing levels. The duty doctor called to make assessment did not always attend in person.

- Despite the pressures the unit had, it was recognised for the work that it was doing. It had a nurse nominated for the Nursing Times award in 2014 for the recovery group work that had supported young people and the nurse received a best clinician award from the trust. The unit's garden group, in which young people had grown, prepared and cooked with vegetables and herbs were in the top six of the trust innovation awards. The unit had also won three of the trust inspire monthly awards in the last 12 months. The last on being won by a healthcare support worker for a half term activities programme in which young people shared skills with one another as well as off the ward 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
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment • The unit did not have its full establishment of permanent staff and as such there was a dependancy on bank and agency to manage a severely ill case mix that required high levels of observation. Young people did not feel they could make positive relationships with temporary staff and did not feel safe. • There was a detrimental impact on mandatory training as a result of lack of permanent staff • There was no evidence to confirm that resuscitation equipment was checked daily. • Fridge temperature check logs were not available. • The lines of sight were not clear making observation difficult • The administration of 'as required' medication was not clearly set out for one patient. Five patient medication charts had not been reviewed. • Records did not make clear if discussions had taken place with the young people or their parents when using unlicensed medication.