Requires improvement

Barnet, Enfield and Haringey Mental Health NHS 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)
RRP23	Edgware Community Hospital	The Beacon Centre	HA8 0AD

This report describes our judgement of the quality of care provided within this core service by Barnet, Enfield and Haringey Mental Health NHS Trust. Where relevant we provide detail of each location or area of service visited.

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

Where applicable, we have reported on each core service provided by Barnet, Enfield and Haringey Mental Health NHS Trust and these are brought together to inform our overall judgement of Barnet, Enfield and Haringey Mental Health NHS Trust.

Summary of findings

Ratings

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

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

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

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

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

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

Summary of findings

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Summary of findings

Overall summary

We rated Child and Adolescent Mental Health Wards as **requires improvement** because:

There was a high staff vacancy rate and turnover of staff was also high. As a consequence there was high use of bank and agency nursing staff of which many had not worked on the unit before. The impact on patient care was clear. Leave was cancelled and young people complained that they had no idea day to day who their named nurse was.

Staff supervision records were poor, and no nurse had a recorded supervision more than three times throughout 2015.

There was scope to improve the physical environment to make it more comfortable. Some blanket restrictions were in place that may not have reflected the needs of the young people using the service.

Senior managers in the trust were aware of the problems at the Beacon Centre which had been evident for several years and improvements were taking place, there was still more to do to ensure a safe and effective service. An intervention team was in place to make improvements but a stable leadership team was needed going forward.

However the ward environment was clean with a well organised clinic room where the medication stocks and resuscitation equipment were regularly checked. The therapy team was well staffed which meant that young people had access to a wide range of psychological and occupational therapy interventions. The care plans were of good quality and covered a full range of social, medical and psychological need. The trust had arranged for a third sector organisation to support the patients on the ward using a range of arts and therapies. An initial twelve week programme was underway and was having a positive effect.

Senior staff said that the new trust management structure which had been introduced 18 months previously, provided better support for the CAMHs service as a whole.

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:

- There was a high staff vacancy rate and turnover of staff. As a consequence there was high use of bank and agency staff, many had not worked on the unit before. The impact on patient care was clear. Leave was cancelled and young people complained that they did not know who their named nurse was.
- There was often not enough staff working on each shift. Prior to the inspection the average fill rate for each shift on the ward was 91%.

However there was a secure and clean ward environment and a well organised clinic room where the medication stocks and resuscitation equipment were regularly checked. Senior staff had committed to an active recruitment plan. The reporting of incidents was embedded practice. There was good medical out-of-hours cover. There was a good understanding of safeguarding issues, with the ward social worker taking a lead. There were good relationships with the safeguarding teams in the surrounding boroughs.

Are services effective?

Requires improvement

We rated effective as **requires improvement** because:

- Staff supervision records were very poor, and no nurse had a recorded supervision more than three times throughout 2015.
- Most of the young people on the ward were informal. The arrangements for their leave was agreed on an individual basis. However the sign on the ward entrance for informal patients did not accurately reflect their rights.
- Records of assessments of consent to treatment had been completed without any detail as to the rationale for the decision and there was no clear indication as to who had parental responsibility for the young person.

However the therapy team was well staffed which meant that young people had access to a wide range of psychological and occupational therapy interventions. The care plans were of good quality and covered a full range of social, medical and psychological needs. During the multi-disciplinary meeting staff made entries on the electronic care record including the care plans and risk assessments so that information was accurate and up to date. The service manager led a reflective practice session for staff on a weekly basis with a different co-facilitator each week.

Summary of findings

Are services caring?

Good

We rated caring as **good** because:

- Most young people we spoke with said that staff were supportive.
- Young people were discussed with respect and concern in multi-disciplinary meetings.
- Young people were encouraged to raise concerns and to share news in ward based community meeting. Young people were encaouraged to attend these weekly meetings.
- Families were regularly involved in meetings and discussions about care.

Are services responsive to people's needs?

Good

We rated responsive as **good** because

- Links with community teams were good which facilitated discharge planning.
- Young people were given a thorough orientation to ward on arrival to help them settle in.
- The trust had arranged for a third sector organisation to support the young people using a range of arts and therapies. An initial twelve week programme was underway and was making a positive impact.
- During the community meeting young people made requests relating to leave and seeing the psychiatrist. These issues were taken up and addressed by staff immediately following the meeting.
- The contract for food provision had recently been changed following feedback from young people.

However the ward environment was sparse and there were a lot of locked doors internally which impeded the free movement of young people, most of whom were informal. There was no access to bedrooms during the day which were locked and the kitchen and toilets were also locked. Young people were never part of the multi-disciplinry meetings and most said they did not always feel involved in their care.

Are services well-led?

Requires improvement

We rated well led as **requires improvement** because:

- Stable long term management needed to be in place to ensure effective leadership to make all the necessary changes on the ward.
- Morale on the ward was low and nursing and medical staff said they felt the ward was frequently unsafe.

Summary of findings

- It was acknowledged by senior management in the trust that the physical environment needed to be altered to provide a space more conducive to the delivery of high quality care for young people and more supportive of staff. The plans for these changes did not have a clear timescale for implementation.

However, senior management were committed to improving the quality of service. The assistant clinical director was a frequent presence on the ward and staff felt that the intervention team that had been assembled to address the problems of the unit had made a good start. Staff had access to monthly updated data to inform the need for improvements

Summary of findings

Information about the service

The Beacon Centre is a tier 4 child and adolescent mental health service (CAMHS) which delivers specialist care and treatment to young people with severe and/or complex mental disorders.

Services are provided for young people aged between 12 and 18 with a range of mental disorders (including depression, psychoses, eating disorders, severe anxiety disorders, emerging personality disorder) associated with significant impairment and risk to themselves or others so that their needs cannot be safely and adequately met in the community. This includes young people with mild learning disability and autism spectrum disorders who do not require a CAMHS learning disability service.

Referrals are accepted nationwide. All referrals need to be supported by a CAMHS consultant psychiatrist and are not accepted from primary mental health or GPs.

Two years ago a young person at the Beacon Centre committed suicide, an event which precipitated significant changes at the unit following a detailed review. There was a wholesale change of management to address staffing and leadership issues. A new service manager, ward manager and consultant psychiatrist were recruited as part of an intervention team which was assembled to set standards and draft polices for the Beacon Centre to improve the service. As part of the plans that were drawn up the high dependency unit which had been in operation was closed as it was felt the service was no longer viable.

The Beacon Centre was last inspected in June 2013 and at this time the service had been compliant with the regulations.

Our inspection team

The team consisted of two inspectors, one Mental Health Act reviewer, a nurse and social worker with experience of working with children and young people and one expert by experience.

Why we carried out this inspection

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

How we carried out this inspection

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

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

During the inspection visit, the inspection team:

- visited the ward and looked at the quality of the ward environment and observed how staff were caring for patients
- spoke with five young people who were using the service
- spoke with the manager of the service and the ward manager
- spoke with the assistant clinical director

Summary of findings

- spoke with 14 other staff members; a consultant psychiatrist, two psychologists, a junior doctor, an assistant psychologist, three nurses, two bank health care assistants, a student nurse, and occupational therapist, a group worker and a housekeeper.
- observed a multi-disciplinary team meeting
- observed a community meeting
- looked at five treatment records of young people using the service
- checked the clinic room and the medicines room on the ward
- checked the prescription charts for young people using the service

What people who use the provider's services say

We spoke with five young people on the ward. They had mixed reactions to their experience. All the young people said that there were not enough staff, and that the agency staff were less approachable than the permanent staff. One young person said that she had had to help intervene with a distressed patient when agency staff did not react. Three young people said that communication between the nursing staff was poor. Three young people said that there was nowhere to gather or talk when they had to move upstairs in the evening. One young person felt very strongly that it was wrong to have the kitchen and toilets permanently locked.

Three young people said they did know about their rights and about advocacy but two young people said they did not. Four young people said they were bored on the unit, especially at the weekends. One young person said there was not enough access to the consultant psychiatrist. One young person said that she had made a complaint about a member of staff but that it wasn't taken seriously and one young person said that the food was poor.

However two young people said that the Beacon was the best inpatient unit they had been to and four young people said that they had made good friends during their stay. Three young people said they had copies of their care plans. Three young people noted that the ward was always well cleaned and two spoke about how good they thought the schooling was in the facility linked to the unit.

Good practice

- Young people were recently involved in the appointment of the new consultant and were on the interview panel.
- The involvement of a third sector provider to support the young people using a range of arts and therapies was a creative development aimed at engaging young people in their own recovery.

Areas for improvement

Action the provider MUST take to improve

The provider must ensure that an effective strategy is in place within an identified timeframe and which is subject to regular review, for filling the high number of vacancies and retaining staff.

The provider must ensure that all staff receive regular supervision and that this is recorded.

The provider must ensure a permanent management team is in place in the longer term, that can provide effective leadership to make the necessary changes.

Action the provider SHOULD take to improve

The trust should ensure staff complete the mandatory training in line with trust targets.

The trust should continue to improve the effectiveness of the multi-disciplinary working on the ward.

The trust should review the wording of the sign by the ward entrance to ensure the rights of informal patients are accurately reflected.

Summary of findings

The trust should review the recording of consent to treatment to ensure it reflects the rationale for decisions and for young people under the age of 16 the consideration of Gillick competency.

The trust should review blanket restrictions on the ward for example the ward's policy of locking toilet and bedroom doors during the day.

The trust should offer ongoing staff support to improve morale throughout this process. This should include improvements to the physical environment.

Barnet, Enfield and Haringey Mental Health NHS Trust

Child and adolescent mental health wards

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
The Beacon Centre	Edgware Community Hospital

Mental Health Act responsibilities

We do not rate responsibilities under the Mental Health Act 1983. We use our findings as a determiner in reaching an overall judgement about the Provider.

- At the same time as the inspection there was a Mental Health Act review visit. There was only one patient detained under the Mental Health Act.
- There was a sign on the door leading into the ward addressed to young people who were informal patients. This stated that informal patients might normally leave the ward during waking hours if previously arranged and that if there was an unacceptable level of risk other arrangements would need to be made such as an assessment under the Mental Health Act. This notice was not appropriately phrased to acknowledge the right of informal patients to leave the ward. Multi-disciplinary progress notes showed that informal patients were not allowed out unless leave was approved. This was not recorded in the care plans.
- A notice board displayed information on the Care Quality Commission and their complaints function for patients detained under the Act.
- The section 17 leave records for the only detained patient showed that the young person was able to take leave of absence authorised by the responsible clinician. Leave was used as part of a therapeutic intervention which was planned with a risk assessment and where needed a management plan in place. Young people and carers were not given copies of the leave forms. However leave arrangements were discussed in the multi-disciplinary meeting and noted on the electronic care records.

Detailed findings

Mental Capacity Act and Deprivation of Liberty Safeguards

- The ward staff also had received in house training on the Mental Capacity Act from one of the consultants and guidance from the trust on capacity issues was displayed.
- In practice it appeared that capacity assessments were the responsibility of the consultants.
- The assessments of capacity to consent to treatment on the files of patients had tick boxes checked without any detail as to the rationale for the decisions. In particular there was no evidence as to whether it had been established that for those aged under 16 they were "Gillick" competent, and no clear record as to who had parental responsibility for the young person.
- Young people said that that they had not been provided with an opportunity to give their consent to share confidential information.

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

Our findings

Safe and clean environment

- The ward was very clean and tidy. There were several blind spots and there were many locked doors to negotiate moving around within the ward. There was CCTV in place to help improve observation which could be viewed from the nursing station and the reception office.
- There were no noticeable ligature points except in some of the en-suite bedrooms which did not yet have anti ligature taps. There was a plan in place to replace the taps and young people were risk assessed when planning their allocation to rooms.
- The bedrooms were all en-suite in a locked upper storey with its own nursing station for night staff but without any area in which young people could congregate. The beds were allocated based on the needs of the individual young people and tried to separate the male and female young people to maintain their privacy. There was a female only lounge.
- There was a clinic room and a medicines room on the ward. Both were clean and well maintained. The clinic room had a locked door and the medication was stored securely.
- The room temperature and fridge temperatures were monitored daily and the readings recorded and staff knew what to do if the readings fell outside of the acceptable range, including reporting on the incident recording system. Nurses worked together with the pharmacist to audit and order stock which came from the main hospital.
- The clinic room had a curtain around the couch for privacy, there was a blue cleaning roll in place and there were handwashing facilities. The temperature of the room was monitored regularly.
- Resuscitation equipment was checked regularly. The scales and height measurement equipment was cleaned regularly and calibrated.
- There was an enclosed garden space accessible only from the dining room and a larger more open garden space for lower risk young people. There had been some recent absconsions from the garden and there was a plan in place to raise the height of the fence.
- There was a low stimulus room which was used for de-escalation which had soft furnishing. Staff said this was not used as a seclusion room.
- There was a detailed patient board in the nursing office which could not be seen from outside.
- The former high dependency unit was also on the upper storey but was not being used. There was a lift to the bedroom area and disabled young people could have been accommodated.
- All staff had alarms and the alarm system was functioning.

Safe staffing

- The funded establishment on the ward was: one service manager, one ward manager, four band 6 nurses, 12 band 5 nurses, 12 band 3 group workers and health care assistants, two consultant psychiatrists, one junior doctor, one family therapist, one child and adolescent psychotherapist, one lead clinical psychologist, one clinical psychologist, one assistant psychologist, one occupational therapist, one occupational therapy assistant, one music therapist, one social worker and one graduate mental health worker. The funded establishment for part time staff was: one art therapist and one dance and movement therapist.
- The level for safe staffing was set at two qualified and three unqualified nursing staff for both day and night.
- The trust target for vacancies was for less than 11%. The ward's records showed the recent vacancy rates exceeded this as follows: June 23%, July 17.5%, August 11.2%, September 23.1% and October 23.1%.
- The trust target for sickness was for less than four per cent. The sickness rate on the ward heat map, which provided data to support the management of the service exceeded this as follows: June 10%, July 10.7%, August 10.7%, September 6.1%, October 7.6%.

Requires improvement

Are services safe?

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

- The ward record showed that the number of nursing staff working was below the safe staffing levels. In September the average fill rate for each shift on the ward was 90.5%.
- There were three vacancies for band 5 nurses. The dance and movement therapist post was vacant and one consultant and one clinical psychologist had just been appointed but had not yet started.
- The service manager said that bank and agency staff were frequently used to fill shifts and they always tried to find people who had worked on the ward before. However there had been times when shifts were completely filled by agency staff, the majority of whom had not worked on the ward before.
- Nursing and medical staff said that the ward was sometimes not safe as it was staffed entirely by agency workers which impacted upon communication and the handover of clinical information. One member of staff said that if a decision was made when you were not there you would never find out about it.
- There was an impact on the young people of the high use of agency staff and shifts not being filled. Leave was cancelled and young people complained that they did not know who their named nurse was.
- A recent Quality Network for Inpatient CAMHs (QNIC) accreditation had failed because of the high use of agency staff.
- Senior managers in the trust had accepted that there had been a significant problem in the recruitment and retention of nursing staff and a plan was in place to address this which included a rolling job advertising programme with a five per cent retention supplement and a placement rotation scheme to encourage nursing career development.
- There had been a high turnover of staff at all grades over the past two years. This included psychiatrists and ward managers and therapists as well as nurses and health care assistants.
- There was good medical out of hours cover. There was a Barnet on call system with ten psychiatrists on call on a rota basis.
- The service manager said that the system for recording mandatory training was not accurate and that some courses such as prevention and management of violence and aggression had long waiting lists. However the permanent staff had all completed safeguarding training.
- The trust records show that the overall completion rate of mandatory training for the Beacon Centre was 74% but that resuscitation levels 2 and 3 were particularly low at 32% and 20% respectively.

Assessing and managing risk to patients and staff

- During the multi-disciplinary team meeting risk assessments were updated and all care records we saw had completed risk assessments.
- There was no seclusion room on the ward and staff were confident that they could manage de-escalation and restraint safely without the need for such a room. There was however a low stimulation room which was used for de-escalation. Staff clearly articulated that this would not be used for seclusion. As there was no seclusion room on the ward it was occassionally necessary to move a young person to a high dependency unit. This had last been done two months ago.
- There were 15 recorded incidents of restraint in the past six months but none of these were prone. Staff from other wards on the site could assist if needed. The service manager and the ward manger said they felt the trust should develop a CAMHs specific restraint policy and related training.
- There was a good understanding of safeguarding issues among staff, with the ward social worker taking a lead. There were good relationships with the safeguarding teams in the surrounding boroughs.
- Mobile phones were taken from the young people on admission but they were then issued with camera free mobile phones on the ward.
- The ward procedure was to search all young people's possessions who were returning from leave.
- The prescription charts for all the young people on the ward were reviewed. There was no above BNF limit prescribing.
- There was a clear procedure in place for children visiting the ward and the levels of staff presence required depending on the age of the visitor.

Track record on safety

- A suicide incident two years ago had led to a major change of staffing and leadership on the ward.
- A more recent allegation of sexual assault between young people was still being investigated and two members of staff had been suspended pending the conclusion of the investigation.

Requires improvement

Are services safe?

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

- There were six other serious incident investigations in progress at the time of our inspection including that of five young people absconding together in July this year.

Reporting incidents and learning from when things go wrong

- There was a ward risk register which noted staffing issues and work needed to ensure the bedroom en-suite ligature points were replaced and the garden fence raised. Planned work on the bedrooms was due for completion by January 2016.
- Incidents were being regularly reported using the electronic reporting system. The ward records showed the numbers of incidents reported recently each month as follows: June - 21, July - 30, August - 47, September - 26, October - 28. The incidents reported included clinical care issues, medication issues, Mental Health Act issues, restraints, self-harm and violence, aggression and assault by young people on staff. Outcomes included increased scrutiny of charts by the pharmacist, manager briefings to staff regarding restraint and increased involvement of the Mental Health Act administrator.
- More general feedback on incidents took place through team meetings, supervision and the multi-disciplinary team meeting.
- The senior psychologist offered debriefing sessions to the whole team following serious incidents which had helped with learning and team building.
- There were seven ongoing incident investigations relating to the ward. Two were serious incidents and five were moderate incidents. These were a medication error, an absconsion, an attempted suicide, a tattoo gun incident, an allegation of sexual assault between two young people and a vandalism incident. This demonstrated a clear commitment to report, investigate and learn from a range of incidents that took place on the ward.

Are services effective?

Requires improvement

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

Our findings

Assessment of needs and planning of care

- A standard pro forma was completed when a young person was admitted. A doctor and a nurse completed the initial assessment and the immediate plans. Then a named nurse and two named health care assistants were allocated. Efforts were made to allocate the most appropriate staff according to the needs of the young person, though this was often compromised by staff availability.
- During the multi-disciplinary meeting staff made entries on the electronic care record including the care plans and risk assessments so that information was accurate and up to date.
- All the records had detailed risk assessments which were up to date and reflected the high level of acuity on the ward. The care plans and case notes were generally of a good standard and it was clear that efforts were being made to include the young people in their care planning and to make the plans holistic covering psychological and behavioural interventions as well as medication and discharge planning.
- Physical health assessments were present in all the care records and a new physical health observation chart had been introduced.

Best practice in treatment and care

- Staff said it was a real challenge to set goals and measure outcomes in a tier 4 service. The service used the health of the nation outcome scales and clinical global assessment scale as outcome measures. The psychology assistant had completed an audit in relation to the results of these measures but was unable to draw any conclusions about the effectiveness of care offered.

Skilled staff to deliver care

- The senior psychologist was responsible for recruiting the therapy team on the ward as well as providing consultations to the team to cover for the vacant psychology post. At the time of the inspection the multi-disciplinary team was in place with a dance and movement therapist yet to be recruited.
- Staff said that sometimes supervision was cancelled because of the lack of staff. We looked at six supervision records for nursing and health care assistant staff. None of these showed recorded supervision as having taken place more than three times in 2015. All permanent staff had an appraisal during the year.
- The service manager said that the supervision structure was adjusted two months ago to improve the frequency of supervision. The service manager led a reflective practice session for staff on a weekly basis with a different co-facilitator each week. The sessions were written up and put in a special folder to which all staff had access.

Multi-disciplinary and inter-agency team work

- A new meeting structure had been introduced to the ward which included planning meetings, meetings for nurses and group workers, meetings for therapy staff, a business meeting, a reflective practice meeting and a staff dynamics meeting. A new senior managers meeting structure was also in place.
- We observed discussions about four young people in the multi-disciplinary meeting/ward round which was attended by a consultant psychiatrist and junior doctor, a psychologist, a family therapist, a psychotherapist, an art therapist and a senior nurse. These were all comprehensive and covered a wide range of interventions with contributions from several professional disciplines including psychology, occupational therapy and nursing.
- However the observed clinical discussions suggested limited joined up working or co-working to meet the needs of the young people. The different professions operated quite separately. The team was working with a high level of acuity and risk and had been successful in helping young people to make significant progress towards recovery but this was not reflected upon or acknowledged in the meetings.

Adherence to the MHA and the MHA Code of Practice

- At the same time as the inspection there was a Mental Health Act review visit. There was only one patient detained under the Mental Health Act.
- There was a sign on the door leading into the ward addressed to young people who were informal patients. This stated that informal patients might normally leave the ward during waking hours if previously arranged and that if there was an unacceptable level of risk other

Are services effective?

Requires improvement

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.

arrangements would need to be made such as an assessment under the Mental Health Act. This notice was not appropriately phrased to acknowledge the right of informal patients to leave the ward. Multi-disciplinary progress notes showed that informal patients had their leave discussed and approved and they were able to leave the ward in line with this agreement.

- A notice board displayed information on the Care Quality Commission and their complaints function for patients detained under the Act.
- The section 17 leave records for the only detained patient showed that the young person was able to take leave of absence authorised by the responsible clinician. Leave was used as part of a therapeutic intervention which was planned with a risk assessment and where needed a management plan in place. Young people and carers were not given copies of the leave forms. However leave arrangements were discussed in the multi-disciplinary meeting and noted on the electronic care records.

Good practice in applying the MCA

- The ward staff also had received in house training on the Mental Capacity Act from one of the consultants and guidance from the trust on capacity issues was displayed.
- In practice it appeared that capacity assessments were the responsibility of the consultants.
- The assessments of capacity to consent to treatment on the files of patients had tick boxes checked without any detail as to the rationale for the decisions. In particular there was no evidence as to whether it had been established that for those aged under 16 they were "Gillick" competent, and no clear record as to who had parental responsibility for the young person.
- Young people said that that they had not been provided with an opportunity to give their consent to share confidential information

Good

Are services caring?

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

Our findings

Kindness, dignity, respect and support

- Most young people we spoke with said that staff were supportive.
- Staff successfully de-escalated incidents with an aroused young person and offered considerable reassurance and comfort.
- Young people were discussed with respect and concern at multi-disciplinary meetings.
- The care records showed that families were regularly involved in meetings and discussions about care.

The involvement of people in the care they receive

- Young people were given a thorough orientation to the ward on arrival and a checklist was completed for all young people and a copy kept in the young person's paper file.
- We observed a community meeting on the ward where young people were encouraged to raise concerns and to share news. The meeting took place every weekday and significant efforts were made to encourage young people to attend. The meeting we observed was attended by six young people and ten members of staff.
- Young people had direct access to the independent mental health advocacy (IMHA) service which was provided by VoiceAbility. Posters advertising this service were on the notice board in the ward and young people confirmed they were able to access to this service.
- Young people were given copies of their care plans which were developed with named nurses and a reviewed a minimum of every two weeks.
- Staff encouraged young people to complete a patient survey and to be as critical as they wanted without fear of reprimand.
- Young people were involved in the design and decoration of the dining room which staff said was now the most friendly room on the ward.
- Young people were recently involved in the appointment of the new consultant and were on the interview panel.
- Families were encouraged to visit the ward as often as they wanted.

Are services responsive to people's needs?

Good

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

Our findings

Access and discharge

- The ward had to report empty beds to NHS England on a daily basis.
- The NHS England admission process was used to refer young people. Many referrals needed to be considered quickly however the ward did not currently accept any out-of-hours emergency admissions. Referrals were discussed in handover meetings and urgent cases sometimes required managers' meetings to be convened at short notice.
- There were frequent planned admissions. Young people were able to come to the ward for an assessment with a consultant and one of the nursing team.
- The ward did have exclusion criteria: a forensic history, incidents of arson, incidents of violence or a primary diagnosis of eating disorder.
- Discharge was not usually felt to be very problematic by ward staff. CAMHs community teams all came to care programme approach meetings. However sometimes social care arrangements, especially access to accommodation, could slow discharge. Transitions between CAMHs teams and adults teams for young people on the ward could also be slow.

The facilties promote recovery, comfort, dignity and confidentiality

- All the doors were clearly labelled with their function. There was a gym, a psychotherapy room and an art therapy room. A ward staffing board was on display with the names and numbers of staff on duty.There was a board with a programme of therapeutic activities on display.
- There was a computer room on the ward with four computers. Internet access was monitored with blocks on some sites. Access was given mostly during the evenings.
- The television in the ward lounge was locked in a glass cabinet.
- There was a female only lounge which was cold and sparsely furnished.
- Young people were not allowed into their bedrooms during the day and the bedrooms were locked as were the kitchen and the toilets. Young people had to approach members of staff to let them use the kitchen or the toilets. The reason given for locking the toilets was that there had been some young people on the ward where this access had presented a risk but this did now seem to be a blanket restriction. In general the ward was full of locked doors and free movement within the ward environment was difficult.
- The contract for food provision had recently been changed following feedback from young people.
- The trust had commissioned a third sector organisation that worked with mentally ill people using a range of arts and therapies, to become involved on the ward. An initial twelve week programme was underway and had had an immediate impact in the redecorating of the dining room.
- There was a good programme of activities on the ward including art, music and sports. However staff said that the design of the ward meant there was a lack of open space for activities.
- Activities available to young people on the ward included: a current affairs group, an art therapy group, a young persons' forum, a poster design group, a shopping for cooking group, a cooking group, music therapy group, a pampering group and a walking group.

Meeting the needs of all people who use the service

- Staff discussed each patients spiritual needs and if they wished they could meet with the trust chaplain or other community spiritual leaders when they visited the wards.
- The ward was able to accept disabled young people and there was a lift to the upper storey and a disabled adapted bathroom.
- Interpreters could be easily accessed and there were a range of leaflets and on treatments and rights available to young people.

Listening to and learning from concerns and complaints

- The service manager said there were few complaints with the last one in July 2015. This was about

Are services responsive to people's needs?

Good

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

communication with the team and was addressed by the senior nurse who wrote to the complainant. Trust records show that there were three complaints in the last 12 months.

- There were complaints leaflets on display in the unit reception area and on the ward. The leaflets explained how to make a complaint or offer a compliment. The leaflet contained information about the independent advocacy service and how to contact them for assistance.
- During the community meeting which we observed young people made requests relating to leave and seeing the psychiatrist. These issues were taken up and addressed by staff immediately following the meeting.

Are services well-led?

Requires improvement

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

Our findings

Vision and values

- It was acknowledged by senior management in the trust that the physical environment needed to be altered to provide a space more conducive to the delivery of high quality care for young people and more supportive of staff. However the plans for this had no implementation date and the physical environment had a significant impact upon how staff and young people felt about the unit.
- Senior managers in the trust had accepted that there had been a significant problem in the recruitment and retention of nursing staff and a plan was in place to address this which included a rolling job advertising programme with a five per cent retention supplement and a placement rotation scheme to encourage nursing career development. However it was not yet evident that this was working to stabilise the staffing situation on the ward.
- The managers said that the trust chief executive had visited the ward two weeks ago. They said they felt they had the full support of the trust as an intervention team.
- Senior staff said that the new trust management structure which had been introduced 18 months previously, provided better support for the CAMHs service as a whole.

Good governance

- Staff knew about the duty of candour and have acted upon this by informing patients and carers about serious incidents.
- Staff working on the ward had access to information about the service through a monthly report to help inform areas where they needed to make improvements.
- The ward had a risk register in place and issues of concern were escalated to the corporate risk register.

Leadership, morale and staff engagement

- Most staff said that morale, although low, was slowly improving and welcomed the arrival of the intervention team and the resulting changes. Staff said that there was visible leadership on the ward from the ward manager and the service manager. However, there were still a lot of improvements to make, especially in terms of building a stable staff team and so consistent leadership over a longer period of time was needed.
- The Beacon Centre was moved into the specialist services divisional line 18 months ago and a senior psychologist was brought in to help the therapists on the ward focus on the delivery of therapeutic interventions rather than case management work.
- The senior psychologist said that there was a good relationship between the consultant psychiatrists and the therapy team which ensured that holistic care was possible.
- Therapy staff identified the difficulty in recruiting and retaining nursing staff as a major obstacle to team development and the creation of a positive ward environment. They said that the nursing team needed to be empowered and not to feel split off from the therapy team. Therapy staff said they should be more involved in the training of the nursing team.
- Staff said that the consultant psychiatrists were approachable and supportive although they did sometimes offer contradictory advice.

Commitment to quality improvement and innovation

- The ward was conducting a rolling audit programme of case notes which scrutinised a sample of notes each month on different aspects of quality care delivery.
- The involvement of the third sector provider was a creative development aimed at engaging young people in their own recovery.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **Regulation 18 HSCA (RA) Regulations 2014 Staffing** There were not enough suitably qualified staff deployed in the child and adolescent mental health wards to meet the needs of all young people effectively. Staff on the child and adolescent mental health wards were not receiving adequate supervision. Whilst the intervention team that had been assembled to address the problems of the unit had made a good start, a stable management team with the appropriate leadership skills still had to provide a consistently safe service. This was a breach of regulation 18(2)(a)