Outstanding ☆

East London 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)
RWKW3	Childrens Services	Coborn Centre for Adolescent Mental Health	E13 8SP

This report describes our judgement of the quality of care provided within this core service by East London 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 East London NHS Foundation Trust and these are brought together to inform our overall judgement of East London 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	Outstanding ☆
Are services safe?	Good ●
Are services effective?	Good ●
Are services caring?	Outstanding ☆
Are services responsive?	Good ●
Are services well-led?	Outstanding ☆

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 East London NHS Foundation trust's child and adolescent mental health wards as **outstanding** because:

- Young people received care and support according to their individual and diverse needs. Staff went the extra mile and formed strong relationships with young people and families, who all told us that they were treated with respect, kindness and compassion which promoted their wellbeing. Young people, families and staff worked in true partnership when planning care and setting individual goals.
- Staff recognised the totality of the needs of each young person and their family. This included their mental and physical health care needs, relationships, education, social, cultural and religious needs. They met each of these with sensitivity.
- The service was well staffed and staff turnover was low. Vacant shifts were filled by existing staff members or a small group of regular bank staff who were supervised and trained at the Coborn Centre, which ensured continuity of the delivery of care.
- Staff worked hard to keep young people safe and to support them to improve their health, develop skills and progress towards discharge.
- Staff were encouraged to be innovative and improve the service. Recent quality improvement work to reduce incidents of violence and aggression had started to lead to a reduction in use of restraint, though this work was ongoing.
- Young people were actively involved in the running of the service. This included joining staff at the end of a shift to reflect on how this had gone. They could also contribute ideas through a regular group to improve the service and these were being implemented. Young people also helped with staff recruitment.
- There were many facilities available including use of fitness equipment, a sensory room, art room and other multi purpose rooms. The building was modern and there were various outside spaces which all young people could access. Families could stay in a family suite on the unit if needed.
- Care records were of a high quality and included input from young people and families. Staff generally had a good understanding of risk and risk assessments were frequently updated.
- Effective governance processes were in place. Staff also understood safeguarding procedures and reporting of incidents was embedded practice. Incident thresholds were consistent across the service and all staff knew how to report them electronically. We were given examples of learning from incidents that had led to changes to improve the service.

However:

- All of the young people we spoke with felt that the food was of poor quality and there was lack of choice.
- Staff did not record the fact that they had read patients their rights in a timely manner after admission or detention under the Mental Health Act nor that risk assessments had been updated before section 17 leave was granted. They also failed to record the duration of incidents of restraint except for those in the prone position.

Summary of findings

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

Are services safe?

Good

We rated safe as **good** because:

- Staffing levels were safe and there was continuity of staff members. Turnover was low and vacant shifts were always covered by existing staff members or regular bank staff, who were included in supervision and local training. Contingency staffing plans had been drawn up with neighboring adult mental health wards to use if a staffing crisis occurred.
- Work on reducing violence and aggression had been successful and continued to be a priority. Whilst there was more work to be done, use of restraint had decreased since the quality improvement project started.
- Risk was very well understood and risk assessments were generally thorough and updated frequently. Discussions about risk at multi-disciplinary team review meetings were detailed and individual.
- Reporting of incidents was embedded practice. Useful learning was identified after incidents and changes implemented to improve the service.
- Staff had a good understanding of safeguarding issues and the social worker took the lead.

However:

- Staff didn't always update risk assessments before section 17 leave was granted to detained patients.
- Incident records didn't always contain the duration of incidents of restraint (except for those in the prone position).

Are services effective?

Good

We rated effective as **good** because:

- Staff conducted thorough physical health checks on admission and physical health monitoring was ongoing. There was access to a range of physical health specialists on site.
- Care records were personalised and young people and their families contributed to their care plans.
- National institute for health and care excellence guidelines were followed and changes were implemented promptly following changes to them.

Summary of findings

- The multi-disciplinary team was diverse, enabling access to therapies and specialities such as psychology, occupational therapy, family therapy, pharmacy, art and music therapy.
- Staff received specialist training to enable them to fulfil their roles effectively. The service supported staff to undertake further education.
- The service collaborated with community CAMHS teams to enable effective discharge planning and inclusion in care programme approach meetings. They also worked proactively with agencies such as the police and local community groups.
- Young people understood their rights under the Mental Health Act or rights as an informal patient. They had hard copies of their section 17 leave forms where necessary.

However:

- Although detained patients rights were read to them frequently and they understood their rights, the first reading of their rights after admission or detention was not documented as having being done in a timely fashion. Reasons for delays to reading patients their rights were not given.

Are services caring?

Outstanding 

We rated caring as **outstanding** because:

- Young people and families were very involved and active partners in their care. They were offered different treatment options where possible and contributed significantly to their care plans.
- Staff knew the young people well. They would go the extra mile and responded to their individual and diverse needs compassionately. They were discussed with respect and concern at MDT review meetings and all staff had a good understanding of individual needs of specific patients.
- We observed positive staff interactions that were caring and respectful. The feedback from young people, families and external stakeholders was all very positive.
- Staff recognised the totality of each person's individual needs. For example young people were very well supported with gender identity issues and observing religious festivals. Referrals or changes to their care were made in response to these needs. This was done with sensitivity.

Summary of findings

- Young people were empowered to give feedback on the service they received in varous ways. This included joining the staff team at the end of a shift to reflect on how the shift had gone. This feedback was listened to and acted upon.
- Young people were involved in consultation about changes to the way the service was run and this had led to practical improvements in the service. They also helped with staff interviews.
- Parents and carers had access to their own support meetings which recognised their practical and emotional needs.
- All young people had regular access to advocacy services.

Are services responsive to people's needs?

Good

We rated responsive as **good** because:

- The service established strong links with community CAMHS teams and involved them in collaborative discharge planning and CPA meetings. This led to young people being successfully discharged.
- Emergency admissions were accepted on the PICU and a robust contingency plan involving support from neighboring mental health services when beds weren't available had been drawn up to ensure that emergency admissions could always be received.
- Young people had access to a comprehensive range of therapeutic activities which were very enjoyable.
- The environment of the unit supported the recovery of young people. Families could stay in a family suite.
- The service supported young people with sensitivity around their culture, relationships, gender and religion.

However:

Young people told us that the food was uninspiring, although there was a good choice of food and it was healthy and offered choice in terms of preferences and cultural needs.

Are services well-led?

Outstanding

We rated well-led as **outstanding** because:

- Staff understood and implemented the vision and values of the trust. They knew the goals for the service and were ensuring these were implemented to a high standard.

Summary of findings

- All staff were very engaged in the work of the unit and contributed to quality improvement projects and were consulted about change.
- There was strong local leadership and morale and job satisfaction were high as a result. Staff were proud to work in the service and many had done so for a number of years.
- The team had access to robust management information, showing clear trends that they could use to inform their work. This also provided clear information to the directorate and board. This supported strong governance processes.
- The local management team were approachable, supportive and motivated the team to do well. Senior staff in the trust were also visible.
- Staff were well supported with leadership development and career progression and staff stayed working in the service and achieved promotions.
- Staff were encouraged to be innovative, especially where it led to improvements in the quality of care. This was bringing about change in the safety and quality of the service being provided. The service also participated in external accreditation schemes as a way of improving the service.
- The service worked well with external stakeholders including commissioners and placing authorities and this was reflected in the improvements made by the young people and their successful discharges.

Summary of findings

Information about the service

The Coborn Centre provided tier 4 child and adolescent mental health service (CAMHS) specialist care and treatment for adolescents with severe or complex mental disorders.

The service treated a range of mental health disorders including emotional dysregulation, depression, psychoses and eating disorders. Young people were associated with significant impairment and risk to themselves or others, meaning that their needs couldn't be safely or adequately met in the community.

Patients were referred from community CAMHS teams nationwide, though around half of the patients came from east London. Patients were normally referred back to their local community CAMHS teams on discharge from the inpatient service, but patients who lived locally could use the day service that was provided.

The unit comprised a 12 bed acute admission ward, a 4 bed psychiatric intensive care unit (PICU) that accepted emergency referrals and a day hospital for up to 6 patients who lived within commuting distance of the unit. There were 72 staff working across the service at the time of the inspection and 45% of these were nursing staff at various levels.

We had previously visited the Coborn Centre as part of a Newham borough children's services inspection in May 2014, where we found no ongoing issues. Our last Mental Health Act review visit took place in August 2014.

Our inspection team

The team consisted of two inspectors, a Mental Health Act reviewer, pharmacy inspector, psychiatrist, nurse, social worker, psychologist and an expert by experience. All the specialist advisors had experience of working in services for children and young people with mental health needs.

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 three young people who were using the service and one carer of a young person who was using the service and collected feedback from 16 patients using comment cards.
- spoke with the manager of the service and the associate clinical director

Summary of findings

- spoke with 12 other staff members: five nurses at various bands, an administrator, a social worker, a pharmacist, an operational services co-ordinator, a psychologist, a support worker and a junior doctor
- checked the clinic rooms and medication storage on the unit
- Looked at seven treatment records
- attended an art therapy session with the young people
- attended a MDT clinical review meeting
- looked at a sample of 10 incident records and two safeguarding referrals

What people who use the provider's services say

We spoke with three young people on the unit, one carer of a young person who used the service and we received 16 comment cards in advance of the inspection.

The feedback we collected was generally positive. Patients told us that all staff were supportive, friendly and responded well to their concerns. They felt that there were always plenty of staff, and planned leave and activities had never been cancelled because of staffing issues.

Patients understood their rights and their treatments. They had access to information leaflets that were easy to understand and they felt they could easily ask questions. They felt involved in their treatment and were offered choice when necessary and were clear about how they would give feedback about the service if they wanted to.

However, the patients felt that the food on offer was bland, there was lack of choice and there weren't enough nice foods to look forward to. We were told that the quality of food differed depending on which staff member made it.

All of the patients we spoke with said they were happy with the environment and the facilities on offer, although one of them told us they sometimes felt threatened by aggressive behaviour displayed by other patients.

Shortly before our inspection the service collected data which scored young person rated satisfaction at 74.6% which was fairly constant over the previous two years. Parent/carer rated satisfaction was 87.5%, which had increased by three percentage points over two years

Good practice

- The frequency of use of physical restraint was reducing as a result of a quality improvement project aiming to reduce incidents of violence and aggression. The service had implemented training in managing challenging behaviours. The managing challenging behaviours ethos was used when writing young people's care plans on the PICU. Repetition in types of incident had also reduced as a result of this approach, which was about to be implemented across the rest of the unit at the time of the inspection.
- Young people sat on staff interview panels and were paid in vouchers for work that they did to help with the running of the service. Young people gave feedback and were consulted about operational decisions such as replacing bed linens.
- The sensory room vas very popular with young people and staff. It was a calm environment with bean bags, interesting lighting and music. Staff told us it helped to ensure the least restrictive practice was followed when de-escalating aroused patients.
- All staff participated in reflection at the end of each shift, where they thought about what had gone well and how to manage challenging situations during subsequent shifts. In the day service, young people also took part.

Summary of findings

Areas for improvement

Action the provider SHOULD take to improve

- The trust should ensure that the length of time a patient is restrained is recorded and a duty doctor always attends to review patients after episodes of prone restraint.
- The trust should improve the choice and quality of meal options to ensure they are positively received by the young people.
- The trust should ensure that rights are read to detained patients promptly after admission or detention according to section 132 of the Mental Health Act.
- The trust should ensure that details of patient's nearest relative and their address are provided in Mental Health Act applications and leave forms.

East London 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
Coborn Centre for Adolescent Mental Health	Childrens Services

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. All four patients on the PICU and two of the patients on the acute ward were detained under the Mental Health Act (MHA).
- Although the main door was locked during our visit there was a sign clearly stating informal patients' right to leave the unit. We also saw age appropriate information leaflets for informal patients about their rights. Risk was assessed before informal patients left the ward, and parental consent was sought when necessary.
- We found that detained patients were aware of their rights under the Mental Health Act and we saw evidence that their rights were relayed to them regularly. However, in three cases they were not read promptly on the point of admission or detention and reasons for delay were not recorded.
- Capacity to consent to treatment for patients who were detained under the MHA was assessed on admission and weekly thereafter.

Mental Capacity Act and Deprivation of Liberty Safeguards

- Some of the ward staff had recently received in house training on the Mental Capacity Act from one of the specialist registrars.
- Staff had a good understanding of the Mental Capacity Act legislation and we saw examples of assessments of

Detailed findings

Gillick competence for under 16 year olds undertaken in advance of specific decisions. If patients under the age of 16 weren't found to be competent to make decisions, parental consent was sought.

Good

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 premises were clean and tidy and young people and staff told us that this was always the case. We saw copies of completed cleaning records.
- The building was modern and the main corridor was curved which minimised blind spots and meant that there were clear lines of sight from the nursing station.
- There were few noticeable ligature points. The most recent annual ligature audit had identified a bath that needed to be replaced in a communal bathroom. A ligature map was displayed for staff to refer to which clearly highlighted areas on the unit, including the communal bathroom that required supervision to mitigate risk posed by potential ligature points.
- The unit complied with guidance on same sex accommodation. There were gender specific bedroom zones and lounges on the acute part of the unit to maintain privacy.
- There were two treatment rooms. Resuscitation equipment was available and there were emergency packs containing emergency drugs which were easily accessible to staff. Regular unannounced CPR simulations were run on the resus equipment by the trust. The treatment rooms contained a blood pressure monitor, examination couch and scales. All equipment was clean and had been calibrated.
- The fridge in the PICU treatment room was out of use at the time of the inspection, however, medicines were being stored in a lockable medicines fridge on the main ward and were readily accessible. Fridge temperatures were checked daily and there was a clear protocol in place for incidences where fridge temperatures fall outside the normal range.
- There was no seclusion room on site. A contingency plan had been drawn up with a neighboring adult mental health ward. If required, their seclusion room could be used by young people staying at the Coborn Centre. The plan hadn't needed to be put into action in recent years. There was a sensory room which was used regularly for de-escalation.
- Furniture was comfortable and had weighted bases for safety reasons.
- Staff used personal alarms to call for additional staff support when incidents occurred.

Safe staffing

- There were enough nursing staff. The service was running slightly above its establishment because band 5 qualified nurses were over recruited each September to mitigate potential shortages that might occur if they left before the following September (which is when they qualify). At the time of the inspection there were no qualified nurse vacancies. During April 2016 there was a vacancy level of 4.4 WTE for support workers. The number of qualified nursing staff was increased on shifts where the support worker establishment could not be met. Similarly, in March 2016 there was a fill rate of 87.3% for registered staff on night shifts. This was being compensated by a fill rate of 103.6% for unqualified staff on night shifts.
- Staff retention was over 75%, and students who had been on placements at the Coborn Centre were often persuaded to take up jobs at the unit when they graduated.
- Bank staff covered all 216 unfilled shifts due to sickness, absence or vacancies during the period February to April 2016. Regular bank staff were used to ensure consistency of care. Staff sickness rate was 2.1% to the year ending April 2016.
- Turnover was 11.4 WTE (18%) during the 12 month period to April 2016. Most of these staff had progressed to other positions at the Coborn Centre and elsewhere in the trust.
- The service manager attended a trust wide monthly workforce meeting where staffing was discussed. A local workforce strategy ensured that regular staff covered unfilled shifts when possible. Staff had created a social

Good

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media group so that arrangements could be made at short notice. If staff weren't able to take on additional shifts, regular bank staff were used. This ensured consistency of care.

- On the PICU there were two qualified nurses at all times and two support workers during the day and one at night. The day service ran with two qualified nurses and a support worker. On the acute ward there were two qualified nurses at all times, and three support workers during the day and two at night.
- Staffing levels could easily be increased by calling in extra staff or using some of the senior staff if there was significant demand or change in acuity. The service manager, matron and ward managers were all on a weekly on-call rota and could attend any emergency admissions or incidents when needed. Staffing levels were also increased to ensure that planned restraints were undertaken safely.
- There was a contingency plan in place involving eight of the neighboring adult mental health wards. This enabled staff to fill vacant shifts in neighboring wards if there was a staffing crisis. This plan hadn't been actioned before.
- Agency staff were not used to fill vacant shifts. As well as the permanent staff who volunteered to do bank shifts, six regular bank staff were also called upon. They were offered CAMHS specific training, were given supervision and were able to join the team reflective groups.
- Patients met with their primary nurse for a 1:1 session weekly. They had the option of requesting to see a different nurse if they wished. Young people and staff told us that these sessions, arranged activities and escorted leave were never cancelled because of staff shortages.
- Medical staff were routinely available during the day. A duty doctor covered the whole Newham centre for mental health site out of hours and could access the unit quickly in a medical emergency.
- Whilst overall mandatory training compliance was high, some individual courses were below the trust target. 33% of eligible administration staff had completed conflict resolution training, which covered aspects of customer relations. We were told that additional training was being completed at the time of the inspection. Only 67% of staff had completed prevention and management of violence and aggression training, which involves de-escalation and restraint techniques. The service manager assured us that additional training sessions were being run at the time of the inspecton to improve compliance and we were assured that staff were competent and followed correct procedures during physical interventions. For example, a staff member was assigned to check the young person's airway during prone restraint. Safeguarding children level three training for all clinical staff had a compliance rate of 70%, and basic life support and resuscitation training had a compliance rate of 74%. This was due to annual training not being renewed in a timely way. The service manager was aware of this and all staff at the time of the inspection had either completed level 3 safeguarding training or were booked on external training provided by the local safeguarding boards that would ensure their compliance once completed. Some staff told us that most of their training was delivered electronically, and more face-to-face training would be useful.

Assessing and managing risk to patients and staff

- There were no recorded incidents of seclusion in the six months leading to the inspection. There had been no incidents of long term segregation.
- There had been 70 restraint cases on the PICU during the six month period to April 2016, and 13 on the acute ward during the same period. These were used across the young people, rather than multiple times for the same young people. Ten of the cases of restraint on the PICU and three of the restraint incidents on the acute ward were in the prone position. Cases of restraint were generally decreasing due to the implementation of a reducing violence and aggression quality improvement project, which involved a focus on managing challenging behaviours.
- There was a quality improvement project around reducing incidents of violence and aggression and the service manager attended a trust wide violence collaboration group. This had led to more staff training and more work on how to support each young persons challenging behaviour clearly stated in their care plan. This had been introduced to the PICU in January 2016. During the six months to December 2015, before the programme was rolled out, there was an average of 9.2

Good

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restraints per month on the PICU. Between January and May 2016 after the approach had been embedded, this fell to 7.6 per month, with just one restraint being recorded in May. However, the total number of restraints was expected to increase at the time of our visit due to a change in acuity of young people. Staff also attributed the implementation of the programme to the fact that there were no restraints in the prone position on the PICU between January and April 2016.

- We looked at ten incident records for cases of restraint, two in the prone position. The duration of prone restraints was documented, however duration of other types of restraint including restraints to enable nasogastric feeding for eating disorder patients was not documented. An up to date restraint policy was available but wasn't easily accessible to staff for reference on the day of the inspection, however, they did know that one existed.
- Cases where rapid tranquilisation had taken place were recorded in medication folders and a duty doctor was routinely called. However, the dose of medication administered during a case of rapid tranquilisation we looked into had not been recorded in the incident report.
- We examined seven care records. Initial risk assessments were undertaken within 48 hours of admission, followed by more detailed assessments which were updated at least every two weeks. Risk management plans were often updated to reflect changes in risk and highlighted factors that heightened risk for individuals. However, risk assessments undertaken before section 17 leave was granted weren't always recorded. One care plan stated that a risk behaviour that the patient had demonstrated in the past was no longer an issue, and the risk assessment had not been updated to reflect this change.
- Blanket restrictions were used when justified. For example, sharp items, plastic bands and belts were on the contraband items list because they could be used to self-harm. Use of mobile phones and urine drug screening tests were considered on an individual risk assessed basis. All patients were searched using a metal detector when they returned from leave and unannounced room searches also took place.
- Informal patients were made aware of their right to leave the unit, and were able to do so after risk had been considered and their parents had consented if necessary.
- Risk was discussed at MDT meetings and individual observations were changed as a result of these discussions.
- All of the staff who we spoke with told us that where intervention was necessary, the least restrictive practice was favoured. Imaginative ways to de-esculate aroused patients such as using boxing gloves and pads were available.
- As part of the reducing violence and aggression strategy, the service had employed specific training about managing challenging behaviours. This involved identifying root causes of violence and aggression, triggers for individuals, tackling negative thoughts and focussing on positive outcomes and debriefs. We were also told about individual case studies which demonstrated that the managing challenging behaviours approach had decreased cases of violence and aggression, restrictive practices and repetition of similar types of incident. The programme was due to be rolled out to the acute ward based on this evidence.
- The social worker was responsible for making safeguarding referrals, but other staff members understood the safeguarding process and were able to make referrals themselves if the social worker was absent. There was a flowchart which guided staff through the safeguarding process. Centralised trust safeguarding leads could be contacted for advice out of hours. Safeguarding leads for each borough were also contacted by the social worker when they needed to communicate with the local authority about a referral. In-house safeguarding training was being developed by the social worker, and would cover areas such as cyber bullying and female genital mutilation. Child sexual exploitation and domestic violence assessment tools were used to identify potential abuse. We tracked two recent safeguarding referrals which had been completed by the social worker and processed correctly.
- Medications were prescribed safely. Full reconciliation was done within three days of admission, before additional medications were prescribed. The pharmacist took part in a bi-monthly medicines safety

Good

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group for Newham, where medication incidents and issues were discussed. The pharmacist told us that constructive conversations about medications took place at MDT meetings and they were used in a holistic manner. Mendication administration records were completed correctly.

- There was a visitors policy in place which stated that risk assessments should be done if under 18s were to visit the unit, young people must have capacity to consent to the visit, and family views should be taken into account.

Track record on safety

- There were no reported serious incidents in the 12 months leading up to the inspection.

Reporting incidents and learning from when things go wrong

- All clinical staff knew how to report incidents. Administration staff said that they would notify their manager of any incidents that they thought needed to be reported.
- There was a good understanding of incident thresholds for reporting. For example, all cases of violence and aggression were reported as incidents.
- Learning from incidents elsewhere in the trust was brought to the CAMHS directorate meeting. Incidents were also discussed at business meetings for staff. During the debrief process staff thought about what could be learned from incidents. Learning sets took place as a result of reflecting on incidents. Staff thought about how learning from incidents linked in with their quality improvement projects.
- Learning from a recent incident had identified the need to search relatives' bags and remind them of the list of contraband items when they returned to the unit with young people who had been out on leave.
- Debriefs took place routinely after all incidents, including restraints. The young person was also debriefed. General debriefs after incidents were conducted at community meetings for the young people and staff used a debrief prompt sheet to help structure these sessions.

Are services effective?

Good

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

Our findings

Assessment of needs and planning of care

- Comprehensive and timely assessments took place on admission, including a physical health assessment. A doctor was present during all admissions and initial assessments. Young people had a named consultant and primary nurse.
- All of the care records were personalised and holistic. They contained detail about family, religious, cultural and educational needs and identified personal goals.
- Ongoing physical health monitoring was taking place. Appropriate physical health checks for young people with eating disorders were made. One of the records contained a separate physical health plan for a diabetic young person, which contained details about insulin monitoring and weighing carbohydrates. We observed descussions with young people about their physical health during MDT ward rounds. Nutrition needs were assessed and adequately addressed for young people who had eating disorders.
- Physical health specialists were employed by the trust and were available on site, such as a diabetic specialist nurse, dietician and speech and language therapist. Young people were referred to other specialists for specific physical health needs and there was a general hospital situated next to the unit.
- Smoking was banned at the Coborn Centre, and nicotine replacement therapies such as lozenges and patches were available. Some staff were trained in smoking cessation.
- There were details on notice boards about local sexual health services that could be accessed by young people.
- All records were stored on an electronic records system that could be accessed by all staff and other teams if the young person was referred to or from elsewhere. Care plans and risk assessments were also kept on paper so that bank staff who didn't have access to the electronic patient record system could access patient information. There were firm processes in place to make sure they were regularly updated in conjunction with the electronic versions. Band six nurses carried out a fortnightly quality audit which involved checking that printed records corresponded with electronic versions.

Best practice in treatment and care

- The service used the health of the nation outcome scales to assess to measure outcomes and improvements in the mental health and social functioning of young people.
- We saw various examples of best practice guidelines being followed such as the 'management of really sick patients with anorexia nervosa' (MARSIPAN) guidance. NICE guidance was referred to during the MDT clinical review meeting that we observed.
- A wide range of therapies was available, including family therapy, psychology, occupational therapy and cognitive behaviour therapy including dialectical behaviour therapy.
- Changes to NICE guidance were communicated to all staff via computer alerts and academic sessions. Medical staff discussed NICE guidelines during supervision and senior clinicians carried out 'gap' analyses to consider whether treatment approaches needed to be altered to ensure guidelines were being closely followed.
- All staff were involved in quality improvement projects and particular staff members took responsibility for specific audits, which were overseen by the senior psychologist. Audits included weekly medication checks, fortnightly risk assessment and care plans, Mental Health Act, use of the care programme approach, GP discharge letters and notifications, ligatures and infection control.

Skilled staff to deliver care

- The MDT consisted of a range of professionals including a psychology team, occupational therapy team, pharmacist, family therapist, art therapist and drama therapist, along with other visitors such as the fitness instructor. The pharmacist was part of the clinical team and also acted as a care manager for up to three young people on the PICU with the most complex medications.
- Most of the MDT attended ward rounds and daily handovers and could update care records.
- Lots of the staff had worked at the Coborn Centre for many years. Others, including the service manager, had

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.

experience of working at different locations within the trust such as forensic and rehabilitation wards and others started out by completing student placements at the Coborn Centre.

- All staff received regular managerial and professional supervision. The heads of disciplines were supervised directly by the service manager. Appraisals took place annually and reviews took place after six months. Staff who we spoke with found appraisals and supervision sessions useful and said that discussions about career development took place during supervision. Medical staff attended continuing professional development peer groups a few times each year.
- 94.2% of non-medical staff had been appraised during the 12 months prior to our visit.
- We found that staff had access to a broad range of specialist taining and higher education opportunities. A mentoring programme was in place which the service manager encouraged staff to take part in. Development training for nurses was available to encourage them to move up to the next grade where possible. These programmes were also available to support workers.
- The service manager had completed a six month clinical leadership training programme and was in the process of studying for a masters in management with a local university who the trust had established a partnership with. Many of the nursing staff had gained post-graduate qualifications in CAMHS. The pharmacist was being supported to complete a PhD in pharmacology in adolescent mental health.
- Quality improvement training had been offered to all staff to encourage them to think about ways in which the service could improve. Quality network for inpatient CAMHS (QNIC) training was in place, which involved independent study about service improvement. Weekly academic sessions were available for all clinical staff and usually involved a guest speaker. General training on the Childrens Act and legislation for all staff was delivered by the social worker. Nurses also received specific training to enable them to carry out tasks such as nasogastric feeding.

Multi-disciplinary and inter-agency team work

- We attended a clinical review meeting which was attended by various members of the MDT including nurses, consultants, psychologists and occupational therapists. Detailed discussions about risk, care planning and multi-agency working with the local authority and police took place.
- MDT handovers were thorough and efficient and there was time for staff reflection at the end of each shift.
- The service worked well with other teams within and external to the trust. For example, they provided weekly updates to the young persons' CAMHS community team which they aimed to be discharged back to. Community teams were also invited to attend CPA meetings in person or by video link if the young person came from out of area and they were involved in discharge planning. This was helpful for staff identifying suitable activities and resources to aid recovery in the young persons' local community. Staff believed that this collaborative working contributed to low levels of re-admissions.
- We spoke with one of the teachers from the school attended by the young people who told us that they felt included in the MDT and that sharing of information and awareness of the young people's care was good.
- The unit worked well with other third sector organisations. For example the art therapist invited various local artists to come to the unit to work on new art projects with the young people.

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 were six young people detained under the Mental Health Act.
- Staff had a good understanding of the Mental Health Act, however, only 60% of eligible staff had received training in the Mental Health Act at the time of the inspection. This training was not mandatory.There was general training about the Mental Health Act covered during staff inductions and more specific training for doctors and nurses.
- Capacity or competence to consent to treatment was routinely assessed each week during MDT review meetings for patients detained under the MHA and relevant documentation was attached to medication charts.

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.

- All young people understood their rights under the Mental Health Act, which were read to them weekly, including rights for informal patients. We saw that repeated efforts to read rights to patients who lacked capacity were made. All young people had printed copies of their rights and section 17 leave forms where necessary. However records showed that, young people's rights under the Mental Health Act weren't always read to them promptly when they were first admitted or detained and reasons for delays weren't given.
- Details of the nearest relative and their address weren't provided on Mental Health Act applications and leave forms.
- Regular audits to ensure that the Mental Health Act was being applied correctly were completed. The trust Mental Health Act office also gave direct feedback and support on receipt of detention paperwork.
- An independent mental health advocate (IMHA) was available at least three days per week and could be directly approached by young people. They also acted as a general advocate for informal patients. Information about advocacy was included in the welcome packs given to new admissions.

Good practice in applying the MCA

- Recent training in the Mental Capacity Act had been delivered in-house by a speciality registrar to band five and six nurses. Other staff received training centrally. 31.58% of eligible staff had received training at the time of the inspection, though training wasn't mandatory. The trust was in the process of implementing a programme of mandatory training.
- Gillick competence was assessed for consent to treatment for under 16s each week and documented correctly. If they weren't found to be Gillick competent, parental consent was sought.

Outstanding ☆

Are services caring?

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

Our findings

Kindness, dignity, respect and support

- All of the young people and carers who we spoke with said that staff were caring and responded well to their individual needs. They felt well supported and generally got on well with staff.
- The care records showed that both young people and their families were involved in meetings and discussions about care.
- Young people were discussed with respect and concern at MDT clinical review meetings.
- Staff showed good understanding of individual patient needs. We were given examples of transgender patients being referred to the adolescent gender identity development service.

The involvement of people in the care they receive

- Thorough orientation tours were given to young people on admission and they were given information packs about the unit. These differed depending whether or not the patient was detained. Families who had travelled from outside the local area were able to stay in a family suite.
- Each bedroom had a chalk board which detailed who the young persons' care worker, consultant and primary nurse was. There were also pouches in each bedroom containing care plans and section 17 leave forms where necessary.
- Patients and their families routinely attended CPA meetings to plan for their discharge.
- Community meetings for young people took place twice a week and were also attended my members of the MDT. There was also a weekly patient forum chaired by the independent mental health advocate (IMHA), where young people were encouraged to raise their concerns and give feedback. Young people were encouraged to fill in feedback questionaires regularly.
- Young people and their parents were included in the end of day reflection session with staff in the day service, and parents were given the opportunity to review their child's care plan.
- Primary nurses reviewed care plans on a weekly basis with the young people, and we saw that young people and their families had been actively involved in producing their care plans. The 'recovery star' and a 'head space tool kit' were used to help capture the views of the young person.
- Where appropriate, young people were offered choices of treatment and medications.
- The IMHA was provided by Mind and was available for all patients to contact in person at least three days per week. All young people, including those staying on the unit informally, had a copy of their rights that highlighted that they could speak with the IMHA.
- There was a weekly family engagement meeting coordinated by a charge nurse which gave families the opportunity to talk about their child's progress and contribute to their care plan.
- A people participation officer worked closely with the Coborn Centre. Patients regularly sat on staff interview panels and were paid in vouchers. The operational service manager also told us that patients were involved in choosing new bed linens and contributed to changes in service design.

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

- Bed occupancy was 89% for both the PICU and acute parts of the unit and patients always had access to a bed on return from leave. Average length of stay was 36.8 days.
- The unit accepted emergency admissions to the PICU and young people in crisis were able to enter the unit via an alternative exterior door.
- The fact that the unit contained a PICU, acute ward and step-down day service meant a significant portion of the CAMHS care pathway was offered by the Coborn Centre. Staff felt that this continuity of care aided recovery.
- Robust contingency plans for admitting young people in crisis when the unit was full were in place. There was an agreement with an adult mental health ward on site where they would accept an emergency admission at night if the Coborn Centre was full and staff would come from the Coborn Centre to care for the patient.
- There had been no delayed discharges during the six month period prior to the inspection.
- CPA meetings were attended by community CAMHS colleagues. If the young person was from out of area the community CAMHS colleagues would join via video link or teleconference.

The facilties promote recovery, comfort, dignity and confidentiality

- The unit was modern and spacious. There were gender specific lounges, a separate lounge on the PICU and an additional lounge for the day service. There was direct access to two outdoor terraces, a large garden for the acute service users, and a small separate outside space for young people staying on the PICU. There were separate quiet spaces where young people could meet with visitors.
- There were numerous activity rooms in addition to a music therapy room, art therapy room, fitness room and sensory room. Young people who we spoke with were especially fond of the music, bean bags, lava lamps and fibre optic lights in the sensory room. Staff found the sensory room to be a useful space for de-escalation. A sensory programme was included as part of some of the young people's care plans.
- A small kitchen was available for occupational therapy and cookery activities. It could also be used by families who were staying in the family suite.
- There was a school on site which was made up of a large group classroom and a smaller room for 1:1 teaching. Teaching staff also visited the PICU to educate young people who were not ready to be taught in a classroom.
- Bedrooms were personalised and all had en-suite facilities. They could be locked and there were separate lockers available for personal items such as mobile phones, which could be accessed on request and used in a quiet space. There was also a landline telephone for young people to use.
- Young people unanimously told us that the food on offer was uninspiring and the quality varied depending on which catering staff were on duty. We saw the daily menus for a week and saw these offered choice including 'adolescent friendly meals' and included healthy food. They also met people's religious and cultural needs. Young people completed their meal choices on a daily basis. They also completed a weekly food satisfaction questionnaire. The chef came to speak to the young people for feedback. The operational service manager acknowledged that the quality of the food could be improved and said that in September the menus were being reviewed and this would be discussed at the young people's council meeting. Young people also had the opportunity to prepare their own meals on a weekly basis with the occupational therapist. There were, separate dining spaces so patients with eating disorders who had special meal plans could be catered for in separate rooms if necessary.
- There was a 'leavers tree' on display which contained young peoples' special messages of support to one another.
- There was a wide selection of activities on offer, many during weekends and evenings. Young people were very enthusiastic about all the activities on offer. They included sport such as basketball, crafts such as tie dye and jewellery making, trips out to the park and to the shop to buy food for use during cooking activities.

Are services responsive to people's needs?

Good

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

Meeting the needs of all people who use the service

- Leaflets about medications, diagnoses, feedback and the Mental Health Act were available in languages other than English. Billingual co-workers who were representative of the local Bengali, Urdu and Gujarati populations were easily accessible for interpretation and cultural integration. Interpretors were also recruited in person or via telephone. There was a website that was managed by people who used the service which contained a guide to who different staff members were and what they did, different medicines, rights and other fact sheets, amongst other support and information. Details of the website were given to young people, families and carers on admission.
- Staff had done engagement work with a local Jewish community through attending community groups to talk about mental health and how to support children.
- Young people with gender identity issues were well supported and placed on sections of the acute ward appropriate to their gender identity. Referrals to the national adolescent gender identity development service had been made where necessary.
- Adjustments had been made for patients observing Ramadan at the time of our visit, including changes to medication and flexibility around when relatives could visit. There were posters advising young people that support with medication was available during the fasting period. Halal food was always available.
- Spiritual leaders from various religions as as well as a spiritual leader not attached to a specific religion visited frequently and a prayer room was available for worship.
- Level access was available to all parts of the unit. Two of the bedrooms contained large en-suite bathrooms that could accomodate a wheelchair.
- On assessment patients and their parents were asked about relationships. The service assessed relationships where the young person was thought to be in a vulnerable position either due to a significant age gap, or where they lacked capacity.

Listening to and learning from concerns and complaints

- The service received four formal complaints during the 12 month period to the end of March 2016. Most issues raised were about clinical management, such as consideration of physical health needs and prescribed medications. None of the complaints were referred to the parliamentary health service ombudsman.
- Details about the formal complaints process were given on admission. There were posters and leaflets, including patient advice and liaison service (PALS) leaflets, which were available in languages other than English. Informal feedback was given via a comments box, satisfaction surveys when discharged, during community meetings and at parent and carer forums. Young people who we spoke with were clear aout how to give feedback and joint feedback was given via a young persons council.
- There was a 'you said, we did' board on display, which highlighted actions that had been taken in response to feedback.
- Staff received feedback about complaint invvestigations and trends during business meetings. There had been a quality improvement focus on improving satisfaction in the service in response to feedback. This involved ensuring there were plenty of ways in which families could get involved in the young person's care.
- Staff knew about the duty of candour. We were given an example of a young person who was wrongfully assessed under the Mental Health Act in the community by their responsible clinician who wasn't authorised to do so, and then referred to the Coborn Centre. This was subsequently picked up by the trust's Mental Health Act office on admission and the patient was notified of the illegal detention and given an informal status, before a new Mental Health Act assessment was undertaken. The case was shared at a monthly performance and quality governane meeting, a learning set was produced, and a new flow chart detailing the agreed process was implemented to prevent it happening again.

Are services well-led?

Outstanding ☆

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

- The teams shared values reflected those of the wider trust, and all staff groups shared the same values. We were confident that high quality care was being delivered by all staff members. Young people, relatives, carers and staff were treated with kindness and respect, and the service was inclusive of it's diverse range users and took into account feedback from staff, service users and relatives.
- The trust's senior team were visible, and executive members including the chief executive had visited the Coborn Centre during routine walk abouts. There was a clear pathway for information to be fed up to and back down from trust board level via the director of childrens services, who fed directly into the board and was often present at the Coborn Centre.

Good governance

- A range of staff participated in clinical audits. All staff were engaged with the quality improvement projects such as improving patient satisfaction and reducing violence and aggression.
- Feedback from incidents and complaints was discussed during business meetings and learning sets, where the team thought about how the learning could feed into quality improvement work.
- The team had access to robust management information, showing clear trends that they could use to inform their work. This also provided clear information to the directorate and board. This supported strong governance processes.
- Various key performance indicators (KPIs) were measured to gauge the performance of the service. Some were reported to NHS England, who commissioned the service, such as length of stay, serous untoward incidents and safeguarding children level three training compliance. Active plans had been developed to improve KPIs, such as a quality improvement programme to improve satisfaction, which came about in response to a low patient satisfaction survey score. This had risen to 87% a year later as a result of the quality improvement plan having been implemented.
- Local decisions were made about escalating items on ward risk registers to directorate level risk registers. Decisions about escalating items from the directorate risk register to the trust risk register were made at monthly directorate meetings, which were attended by the senior staff within the unit and the director of childrens services, who fed into the board.
- The service worked well with external stakeholders including commissioners and placing authorities and this was reflected in the improvements made by the young people and their successful discharges.

Leadership, morale and staff engagement

- The service manager was particularly proud of the positive results that had come from the most recent staff survey, in which 100% of staff said they would recommend the Coborn Centre as a place to work and to receive care. Staff felt that the service was very well-led, they were part of a cohesive, supportive team in which all staff members had an equal voice. We did, however, find that some of the administration staff weren't always consulted before changes were made to the service, including changes that had a direct impact on them such as a review of CPA protocols.
- Staff morale was very good. All of the staff we spoke with were positive about their jobs and told us that the managers had an open door policy and they were all equal members of the team. MDT staff members felt able to professionally challenge clinical judgements in a productive way.
- There was a clear whistle-blowing process which staff knew about. This took their issues directly to the trust board without having to escalate them through the directorate.
- Most of the staff who we spoke with talked positively about the potential for career progression. There was a development pathway for band 5 nurses involving a six month preceptorship programme followed by a further six to eight months further experience and a band six development programme to prepare them for band six posts. The service manager felt that this highly structured development programme for new nurses contributed to low staff turnover. Two of the nurses who

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we interviewed originally undertook a student placement at the Coborn Centre and decided to accept permanent jobs at the unit because of the development opportunities on offer.

Commitment to quality improvement and innovation

- Quality improvement projects were designed and delivered within the service. New ideas for quality improvement projects were discussed at operational management group meetings, where all staff had a say. Various data collections and comparisons with other departments helped to inform discussions. Quality improvement training had been attended by most of the staff.
- The violence and aggression quality improvement project had led to training in managing challenging behaviours which had resulted in a decrease in restraints on the PICU, and had directly reduced cases of violence and aggression.
- The operational service manager told us about ways in which young people were involved in the delivery of the service, such as choosing new environmental designs and bed linens.
- A specialist registrar working on the unit had successfully developed an application document for patient Mental Health Act tribunals for the Royal College of Psychiatrists.
- The service had received an 'excellent' accrediatation by the quality network for inpatient CAMHS (QNIC), part of the Royal College of Psychiatrists. This had been achieved twice and was re-assessed every three years. The service manager was also part of the QNIC advisory board.