Good

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)
RRP01	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	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Good

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

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

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

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

Summary of findings

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Summary of findings

Overall summary

Our overall rating of the Beacon Centre improved. We rated it as good because:

- The trust has made significant improvements to the staffing of the Beacon Centre. At our previous inspection of the service, in December 2015, we found that the trust was in breach of a Health and Social Care regulation in relation to staffing.At this inspection in September 2017, we found that the trust had rectified this. There were now no vacancies for nursing staff. Young people told us they were now supported by staff who knew them well. Previously, we found the service did not have a permanent ward manager. Now there was an experienced ward manager in post who was providing effective leadership for the service. Staff now received monthly clinical supervision.
- Staff received training to carry out their work roles. Communication within the multidisciplinary team was effective. The team thoroughly assessed the needs of young people and identified any risks. Staff worked with young people and their parents to develop effective care and treatment plans. These plans focused on the young person's goals and their recovery. Staff took action to minimise risk and reviewed risks each day. The multidisciplinary team delivered care and treatment in accordance with best practice guidance and legal requirements.
- Young people received education whilst on the ward and participated in a therapeutic programme which was designed to meet their individual needs. Young people said staff were supportive and took the time to get to know them well. The ward had been recently redecorated and was well furnished.
- The staff team listened to the views of young people and their parents and acted on their views. There were now fewer restrictions in place for younger people. The staff team delivered care and treatment in accordance with legal requirements.
- Governance arrangements were robust. The staff team checked the quality of the ward environment, the delivery of care and treatment, the completeness of care records and the management of medicines.

However:

- Records of monthly supervision sessions were very brief and in some instances were not on file. Clinical governance arrangements had not identified risks in relation to the quality and completeness of supervision notes.
- Whilst learning from incidents was taking place in team meetings, the template to record team meetings did not allow for the recording of these discussions. This meant that staff who could not attend the team meeting could not readily access this information in one place.
- In the case of one young person, there was no record that they had been informed of their rights after a second opinion doctor had authorised their treatment.

Summary of findings

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

Are services safe?

Good

Our rating of safe improved. We rated it as good because:

- The trust had improved the staffing of the ward. All permanent posts were now filled. Staffing levels were maintained on each shift. Young people were now cared for by staff who knew them well.
- The trust had taken action to improve the safety of the wards. Ligature points had been reduced.
- Staff carried out thorough risk assessments when young people were admitted to the wards. Staff took action to manage identified risks and ensured young people were as safe as possible.
- The wards were clean and staff followed infection control procedures.
- Staff reported adverse incidents and the trust ensured incidents were investigated. Staff learnt from incidents to improve the service.
- The staff team were well-trained in relation to safeguarding and there was a designated safeguarding lead.

However:

- Whilst learning from incidents was taking place in team meetings, the template to record team meetings did not allow for the recording of these discussions. This meant that staff who could not attend the team meeting could not readily access this information in one place.

Are services effective?

Good

Our rating of effective improved. We rated it as good because:

- Staff were now receiving monthly clinical supervision.
- There was now an appropriately worded poster which explained the right to leave the ward for young people who were informal patients.
- Care records now included details of who had parental capacity for the young person. Consent forms were fully completed and now explained how staff had assessed the young person's mental capacity.
- Multidisciplinary team work was effective and young people received personalised care and treatment in line with good practice guidance. A range of therapeutic interventions were provided. The staff team worked in partnership with health specialists, such as a dietician, to ensure that young people's needs were fully met.

Summary of findings

However:

- In the case of one young person, there was no record that they had been informed of their rights after a second opinion doctor had authorised their treatment.

Are services caring?

Good

Our rating of caring stayed the same. We rated it as good because:

- Young people told us they were treated with respect and kindness. They said staff spent time talking with them and getting to know them.
- The staff team asked young people and their parents about their interests, needs and preferences. Staff used this information to ensure care and treatment was personalised.
- Parents told us staff involved them in planning the young person's care, treatment and discharge from the ward. They told us they were able to contact the staff team at any time for support.

Are services responsive to people's needs?

Good

Our rating of responsive stayed the same. We rated it as good because:

- Young people received care and treatment in a pleasant environment. The Beacon Centre had been recently redecorated and there was new furniture.
- There were now fewer restrictions in place in terms of how young people could move around the ward.
- Young people could choose to take part in a wide range of therapeutic and leisure activities. Young people and their parents could easily give feedback on the quality of their experience. The staff team acted to address any concerns or complaints.
- Staff supported young people to recover and move on from the ward.

Are services well-led?

Good

Our rating of well-led improved. We rated it as good because:

- There was now a permanent ward manager for the Beacon Centre. The senior management team had been successful in implementing improvements to the service. There were now no vacancies for permanent staff.
- Staff told us that the multidisciplinary team now functioned well and morale was positive.

Summary of findings

- The ward manager ensured there were checks on the quality of the service. The multidisciplinary team had plans to develop the service.
- Staff had the opportunity to develop their leadership and clinical skills.

However:

- Clinical governance arrangements had not identified risks in relation to the quality and completeness of supervision notes.

Summary of findings

Information about the service

The Beacon Centre is provided by Barnet, Enfield and Haringey Mental Health NHS Trust. The service is commissioned nationally. The service is a 15 bed mixed gender inpatient child and adolescent mental health service for young people age 13 -18. At the time of this inspection, eight young people were using the service.

The Beacon Centre aims to provide a short period of inpatient care of two to three weeks for young people at risk when their mental health needs cannot be safely met in the community. The service provides a range of treatments including psychological therapies and treatment with medicines.

Young people admitted to the service are diagnosed with a range of mental disorders, including depression, psychoses, severe anxiety disorders and emerging personality disorder.

Our inspection team

The inspection team comprised two CQC inspectors, one specialist advisor who was a psychiatrist with a background in the mental health of children and adolescents, a nurse consultant specialist advisor who had a background in the mental health of children and adolescents and an expert by experience. An expert by experience is a person who has personal experience of using, or supporting someone using, mental health services. A Mental Health Act Reviewer and a pharmacist specialist also visited the service and contributed to the inspection.

Why we carried out this inspection

We plan our inspections based on everything we know about services, including whether they appear to be getting better or worse.

We undertook this announced comprehensive inspection in September 2017 to find out whether Barnet, Enfield and Haringey Mental Health NHS Trust had made improvements to the Beacon Centre since our last comprehensive inspection of the trust in December 2015.

At our last comprehensive inspection of the trust, in December 2015, we rated the Beacon Centre as requires improvement overall. We rated the service as requires improvement for safe, effective, and well led. We rated the caring and responsive domains as good.

Following the December 2015 inspection, we told the trust that it must take the following actions to improve the Beacon Centre:

- The trust 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 trust must ensure that all staff receive regular supervision and that this is recorded.
- The trust must ensure a permanent management team is in place in the longer term, that can provide effective leadership to make the necessary changes.

As a result of the concerns raised during the December 2015 inspection, we issued the trust with a requirement notice in relation to Regulation18 (Staffing).

Summary of findings

How we carried out this inspection

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

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

Before the inspection visit, we reviewed information that we held about the Beacon Centre.

During the inspection visit, the inspection team:

- visited the Beacon Centre
- checked the quality of the ward environment and observed how staff were caring for young people
- observed how staff interacted with young people who were using the service
- spoke with four young people
- spoke with one parent of a young person
- spoke with the manager of the ward
- spoke with five other staff members including psychiatrists, nurses and support workers
- attended and observed a multidisciplinary meeting
- attended and observed a planning meeting and a community meetings that staff held with young people
- collected feedback from young people and carers using comment cards
- reviewed four care and treatment records of young people
- carried out a check of the management of medicines, which included reading eight medicines administration record charts and checking arrangements for the storage of medicines
- read the April 2017 quality network for inpatient child and adolescent mental health services focussed review report on the service
- reviewed a range of policies, procedures and other documents relating to the operation of the service

What people who use the provider's services say

We spoke with four young people and one parent.

- Young people were very positive about the attitude and behaviour of staff. They told us that staff had the skills and knowledge to respond to the needs of young people.

Young people told us that they found the Beacon Centre comfortable and pleasant. A parent said staff involved them in decision making and gave them support when they needed it.

Good practice

- There were daily handovers at the morning and end of the day between the service manager, psychiatrist and ward manager.
- A quality improvement project was taking place in relation to improving the involvement of young people in planning their care and treatment.
- The service asked young people for their views of the service and had made changes in response to their feedback.

Summary of findings

Areas for improvement

Action the provider SHOULD take to improve

- The trust should improve clinical governance arrangements in order to identify risks in relation to the quality and completeness of supervision notes.
- The trust should review the template for team meetings to ensure that learning from incidents is always documented.
- The trust should ensure that young people are always been informed of their rights after a second opinion doctor had authorised their treatment.

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	Edgeware 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 time of this inspection, three of the eight young people on the ward were detained under the Mental Health Act. One young person was detained for assessment and two young people were detained for treatment. We read their care and treatment records to check that staff had adhered to the Mental Health Act and the Mental Health Act Code of Practice. We found that staff had met legal requirements.
- The trust's head of mental health law provided the staff team annual training on the Mental Health Act. Staff had an understood the Mental Health Act and the guiding principles of the Code of Practice. A copy of the Mental Health Act and the Code of Practice were kept in the nurses' office. Staff said they could easily access expert advice, including legal advice, from within the trust on the implementation of the Act and the Code of Practice. The ward manager told us that the Mental Health Act administrators were diligent in terms of auditing and checking paperwork and reminding staff of key dates. Staff said they could easily the most recent guidance on the implementation of the Mental Health Act from the trust intranet.
- All three care records of detained young people had evidence that staff had appropriately recorded that the young person had been informed of their rights when they had been detained. Staff indicated on the record whether the young person had understood this information. When a young person did not understand the information, staff explained this to them again during the following days.
- The service requested an opinion from a second opinion appointed doctor when necessary.At the time of the inspection, one detained young person had been

receiving medicine for the treatment of their mental disorder for more than three months. After three months, a second opinion appointed doctor had examined the young person and completed the relevant certificate to authorise the continuation of this treatment.

- Staff ensured detained young people were able to take leave when this was granted. Leave was recorded on a standard form that included any conditions. During the inspection, one detained young person was on a period of leave lasting for one week. Their care record included a crisis and contingency plan with instructions on what the young person and their parent should do in the event of a relapse.
- Young people had access to information about independent mental health advocacy. Care records showed staff verbally informed young people about independent mental health advocacy and gave young people written information about the service. There were also posters on display about the service. An independent mental health advocate visited the ward every two weeks. Young people could meet with the advocate individually.
- Staff stored copies of detention papers and associated records, such as Section 17 leave forms correctly. These records were on the electronic record system and available to all staff that needed access to them.
- Care plans did not include specific reference to young people's rights to aftercare services. However, there was evidence of detailed discharge planning on care records.
- At the previous inspection, we found that ward did not display a notice to tell young people who were informally using the ward about their right to leave the ward. At this inspection, we found that this had been rectified and there was now an appropriately worded poster near the exit of the ward.

Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff demonstrated good practice in relation to the Mental Capacity Act, which applies to young people over 16 years of age. Staff also complied with guidance in relation to 'Gillick competence', which is a term used in medical law to decide whether a young person under 16 years of age is able to consent to their treatment, without the need for parental permission or knowledge. Care records included information about who had parental responsibility for the young person and who should be consulted about their care and treatment. There was clear information as to whether a young person was subject to a local authority care order.
- The staff team reviewed their decision making in relation to the Mental Capacity Act or Gillick competence guidance in relation to each young person at the weekly multidisciplinary meeting.
- All five care records, including those for three young people detained under the Mental Health Act, included a consent to care and treatment form which included information on the young person's mental capacity to consent to treatment. Staff completing the form made reference to the Mental Capacity Act or Gillick competence as appropriate. They also included an outline of the treatment plan, information on the impairment of capacity and details of the young person's presentation. Staff assessed the young person's mental capacity to make a specific decisions and reviewed mental capacity at appropriate intervals. For example, in the case of one young person, staff had made four formal assessments of their mental capacity to make decisions about their treatment during the four months of their admission. When staff assessed a young person as having mental capacity, the young person signed a document to confirm their consent to treatment and the sharing of information about their care. When young people were under 16, the person with parental responsibility also signed this document.
- The trust lead provided annual training to the staff team on the Mental Capacity Act and Gillick competence. Staff said this training was effective and included material on capacity issues in relation to young people. The trust had up to date policies and procedures in place in relation to the Mental Capacity Act. Staff were aware of these and could access them through the trust intranet. Staff said they could contact the Mental Capacity Act lead for advice on specific issues.

Detailed findings

- Staff took steps to ensure that young people, who may have impaired mental capacity, were able to make their own decisions as much as possible. For example, young people told us that staff took time to explain treatment and care options to them.
- In the case of young people who did not have the capacity to make decisions about an aspect of their treatment, including those detained under the Mental Health Act, care records included detailed information on how staff had reached decisions about care and treatment. Staff obtained information from the young person's family about what was important to them and their preferences. They used this information to plan care and treatment. For example, they ensured that the young person's preferences were reflected in terms of their choice of meals and activities.

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

Safety of the ward layout

- At the beginning of each shift, a member of staff checked all areas of the Beacon Centre for potential hazards and ensured any maintenance issues were reported and fixed. For example, on the night previous to the inspection, staff had reported a defective light on the stairs and this was immediately replaced by the trust's 24 hour maintenance team.
- The Beacon Centre had wide corridors with mirrors installed to assist with observation. CCTV was in use, and this enabled staff to observe the corridors and communal areas from the nurses' station.
- The trust had taken action to reduce risks associated with ligature anchor points. For example, since our previous inspection the trust had installed ligature free bathroom fittings in the service. There was a ligature risk assessment for the ward dated February 2017. The main area of risk identified was some pipe work which was external to the ward. This area was securely fenced off so that it could not be accessed from the garden. Photographs of the pipework were displayed on a notice board in the staff room and pointed out to new staff at induction. Staff told us they were familiar with this ligature risk.
- The Beacon Centre was a mixed gender ward. All bedrooms were en suite and a female only sitting area was available. Staff allocated bedrooms according to the needs of young people and separated males and females to maintain privacy and dignity.
- A call bell system was available for young people to use to request urgent support from staff.
- Staff had easy access to alarms. Each member of staff carried an alarm. When staff activated their alarm, a panel in the nurses' office showed the location of the activated alarm. All alarms were tested when they were issued to staff at the start of each shift.
- The most recent fire risk assessment and fire drill were carried out in July 2017. Following this, there were a number of recommendations. These included the ward manager ensuring there were enough trained fire wardens available to cover all the shifts at the service.

Maintenance, cleanliness and infection control

- We observed that the Beacon Centre was clean and tidy throughout all areas used by young people and staff. All furniture and fittings were in good condition. The walls, floors and windows were well-maintained.
- The latest patient-led assessments of the care environment (PLACE) survey scores for Edgware Community Hospital, which includes the Beacon Centre, were 100% for cleanliness and 98% for condition, appearance and maintenance.
- All areas of the ward were cleaned daily. Domestic staff completed a record of the areas of the ward which they had cleaned. These records were fully completed, up to date and displayed in the ward.
- The ward had an infection control lead. They carried out an infection control audit each month which included observations of how staff carried out infection control procedures.

Clinic room and equipment

- Staff had access to equipment for immediate life support. This included appropriate resuscitation equipment for use on a ward for young people and emergency drugs. There was an emergency 'grab bag' containing adrenaline pens, a defibrillator, defibrillator pads, ligature cutters, razors, gloves, face masks of varying sizes, and a suction machine. Staff checked the emergency grab bag every day to ensure all equipment was in place and fit for purpose.
- The clinic room had an examination couch with a clean paper cover. Medical devices (a blood pressure machine and weighing scales) were available and portable appliances were tested appropriately. The ward had an electrocardiogram machine, to check heart activity, and nurses were trained to use it. Medical devices had stickers on them to show they had been cleaned

Good

Are services safe?

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

Safe staffing

Nursing staff

- Staffing of the Beacon Centre had improved and was now safe. At our previous inspection of the service in December 2015, we found that the staffing of the service was not safe. At that time, bank and agency staff were frequently used to cover vacant posts. These temporary staff were sometimes unfamiliar with the ward and the young people. This had a negative impact on care. Young people were unhappy about frequent changes of staff and the fact that leave and activities were sometimes cancelled.
- At this inspection in September 2017, we found the trust had been successful in recruiting permanent staff. The trust used a recognised tool to calculate the staffing level for the service. The establishment levels were 11 registered nurses and 13 healthcare assistants. Since August 2017, all registered nurse and healthcare assistant posts were filled. Staff told us that regular bank staff, who knew the service well, provided cover for sickness and leave. They said there had been no recent use of agency staff. They said shifts were fully covered. Young people told us that they were supported by a consistent staff team who knew them well. They said there had been no recent instances of the cancellation of ward activities or leave due to a shortage of staff.
- The staffing level allowed young people to have regular one-to-one time with their named nurse. Young people told us that staff were always available to answer their questions and offer support. A carer said that staff were readily contactable by phone at weekends if they needed any support in relation to a young person who was at home on leave. Care records included daily progress notes with records of daily interviews with young people. We observed that staff were patient and calm when interacting with young people.
- The ward manager was able to increase staffing levels to meet need. For example, they booked additional staff to meet the needs of young people placed on increased observations.
- Staff received appropriate information about the ward and the young people when they first started work. Staff told us they were taken around the ward by an experienced member of the staff team and shown the location of emergency equipment. They said they were also introduced to the young people on the ward. Staff used an induction checklist to make sure they had covered all relevant issues with the new starter.
- The Beacon Centre was located over two floors. Procedures for staff to observe took into account the layout of the service. Staff were able to explain to us how they put these arrangements into practice.
- The sickness rate for the Beacon Centre was 8% for the 12 month period June 2016 – May 2017. Staff told us that staff sickness did not have an adverse impact because bank staff were used to cover when staff were absent. The rolling staff turnover rate in May 2017 was 20% for the ward. Staff and young people did not raise any concerns with us about the turnover of staff, and all permanent posts were filled at the time of the inspection.

Medical staff

- The Beacon Centre had appropriate medical cover. Two consultant psychiatrists covered the ward full time and co-ordinated medical treatment and care. The psychiatrists provided cover for each other during periods of leave or sickness. One of the psychiatrists was a permanent appointment, since January 2016, and the other psychiatrist a locum appointment, since February 2017. Medical support to the ward was also provided by a specialist doctor and trainee doctors on rotation. Staff told us they could access the trust duty psychiatrist out of hours.

Mandatory training

- The trust specified the mandatory training that staff should receive and monitored take-up of this training. Mandatory training was comprehensive, subjects included equality and diversity, fire safety, information governance, infection control, the prevention and management of violence and aggression and life support.
- The ward manager had information on the take up of mandatory training by the staff team. This information showed that the take up of mandatory training averaged over 90% in all topics on 20 September 2017.

Assessing and managing risk to patients and staff

Assessment of patient risk

Good

Are services safe?

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

- We reviewed five care records on the ward. Staff carried out a comprehensive risk assessment of each young person on, or shortly after, admission. Staff used a recognised risk assessment tool. This included a risk history that covered previous incidents and any offences the young person had committed.
- The risk assessments included details of behaviour such as self-harm, suicide, aggression towards other people, substance abuse, offending behaviour, involvement in gangs, risks of exploitation and child protection concerns. Staff routinely updated risk assessments at a multidisciplinary team meeting every week and after every incident.
- Staff had developed a crisis and contingency planning tool, which was used to assess and manage risks before a young person went on home leave. Parents told us they found this was very helpful to them.

Management of patient risk

- Staff were aware of and dealt with specific risk issues on the ward. They had a good understanding of relational security and how the atmosphere of the ward and issues between young people could have an impact on risk behaviours. Staff were alert to emerging risks and told us about actions they had taken to reduce specific risks by talking with young people and increasing observations.
- Staff put into practice trust procedures in relation to managing risks, such as procedures for setting observation levels and conducting searches. The multidisciplinary team decided what level of observation was required for each young person to ensure their safety and the safety of others.
- Each young person had a risk management plan. After incidents occurred, staff worked with to help them understand the triggers for their behaviour using a technique known as behavioural chain analysis. This enabled staff to work with the plan how to avoid future incidents. For example, a young person had a self-harm care plan that set out the early warning signs of self-harming behaviour. It specified how staff would support the young person using graded responses that included using distraction techniques and enhanced observations. This plan included the young person's views and demonstrated their involvement in developing the plan.
- Following the last inspection of the Beacon Centre in December 2015, we said the trust should review the blanket restrictions in place on the ward. For example, toilets on the ward were locked. Since then, the trust has made some changes. These changes have meant young people have fewer restrictions whilst they are on the ward. At this inspection, toilets on the ward were no longer locked. Young people told us they did not feel unduly restricted on the ward.
- At this inspection, we found that some restrictions were in place to ensure that young people attended school and therapeutic activities and that staff could ensure their safety. During the day, young people attended school in the morning and had therapeutic activities in the afternoon. They were not permitted to go to the upper floor of the ward on their own. They could go to their bedroom on the upper floor with a member of staff if they requested it. During the evening, young people and staff went to the upstairs area of the ward. They were able to use the communal areas and go to their bedroom. Kitchen areas were kept locked. Young people told us they could ask staff for drinks and snacks when they wished to.
- The trust had a smoke free policy. The policy included information on how staff should support young people with smoking cessation. Young people did not have any concerns about the implementation of the policy.
- Staff ensured that informal patients understood their right to leave the ward. Staff told us if a young person asked to leave the ward they followed procedures to consider the risks to the young person and consent issues. If appropriate, staff asked the young person's parents for consent. There was now a signs near the ward exit door stating that informal patients had the right to leave the ward.

Use of restrictive interventions

- Staff implemented trust policies to reduce the use of restraint and seclusion. The Beacon Centre had one incident of seclusion in the 12 month period June 2016 to May 2017. This related to a 17 year old young person who was taken to a seclusion room on another ward, as there was no seclusion room at the Beacon Centre. There were no episodes of long-term segregation in the 12 month period June 2016 to July 2017.

Good

Are services safe?

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

- The Beacon Centre had 53 incidents of restraint on14 different service users in the 12 month period June 2016 to May 2017. Six of the 53 incidents of restraint were in the prone position, and seven of the 53 incidents resulted in rapid tranquilisation. Staff told us there were always enough staff available on a shift to safely carry out physical interventions. There had been no incidents of restraint or seclusion for the five young people whose records we reviewed.
- Staff understood and implemented trust policies to reduce the use of restraint. All staff received training each year on preventing and managing challenging behaviour. This included training on avoiding the use of restraint through de-escalation techniques. Staff were trained on the safe use of restraint techniques with took into account the specific needs of young people and minimised the risk of physical harm.
- Staff told us restraint was only ever used as a last resort and to the minimum extent after they had tried other interventions such as verbal de-escalation or closer observation of the young person. Staff told us any episodes of restraint were fully recorded in line with trust procedures. We read an incident report on a restraint which confirmed this.
- The staff team worked with young people to understand and manage their behaviour using recognised behavioural management techniques. Care records included notes on the discussions with young people about how staff could recognise when they were starting to feel angry or frustrated. Staff said they used this information to intervene at an early stage to support the young person to express their feelings and calm down. Young people told us that staff spent time talking with them and this helped them to understand and manage their behaviour.

Safeguarding

- Arrangements to safeguard young people were robust. The multidisciplinary team included a social worker from the local authority who acted as the named child protection lead. The social worker ensured the team complied with London Safeguarding Children Board procedures and the Children Act. They ensured the relevant local authority was informed if a young person was on the ward for a consecutive period of three months.
- All staff had received level three safeguarding children training. This training was updated each year at a session facilitated by the ward social worker. Information about safeguarding was displayed in the staff offices, including a flow chart showing the process for making a safeguarding referral.
- Staff we spoke with knew how to recognise different types of abuse and neglect and how to report it. The staff team had raised 15 safeguarding alerts in the period October 2016 – June 2017. Staff were aware of each young person's history, including any risks that had been identified within the family.
- Young people told us there was a pleasant atmosphere on the ward and said there had been no bullying or harassment.
- The Beacon Centre was a standalone unit separated from services for adults. Families and other visitors did not come on to the ward but used visiting rooms located off the ward.

Staff access to essential information

- Staff used a combination of electronic and paper records. The electronic record was the main care and treatment record and included daily progress notes on the young person and assessments and care plans. Some records were recorded on paper. For example, a handover book was used when shifts changed to record the information passed between the outgoing and incoming staff team. This easily enabled staff to ensure that key actions were followed up.
- All staff we spoke with understood how to access information on a young person's care and treatment. The trust's electronic recording system allowed staff to access past records in relation to young people admitted to the ward.

Medicines management

- Staff managed medicines in accordance with best practice guidance. We checked eight medicines administration charts. Records included the young person's allergy status. Staff ensured that young people received their prescribed medicines, and this was clearly recorded on the charts.
- We checked the arrangements for the storage of medicines. Medicines were stored securely in locked

Good

Are services safe?

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

cupboards or a locked fridge within a locked clinic room. Emergency medicines were stored in the clinic room. There were signs to show staff exactly where to find the emergency medicines. Staff recorded fridge temperatures and the ambient temperature of the clinic room each day.

- A pharmacist visited the ward once a fortnight and a pharmacy technician visited twice a week to review prescriptions. Psychiatrists and pharmacy specialists worked together to ensure that medicines were prescribed in accordance with national guidance
- The staff team ensured there were appropriate checks on the physical health of young people when they were prescribed medicines which could have an impact on their physical health. For example, in the case of a young person prescribed an anti-psychotic medicine, staff checked their heart beat four times a day.
- Psychiatrists told us they were very cautious when prescribing medicines and whenever possible no medicines were prescribed. They said there were always full discussions with young people and their parents before they started to prescribe any medicines. They said medicines were always started at the lowest possible dose and regularly reviewed.
- When a young person was prescribed a medicine, the staff team were alert to the possibility of side effects. They carried out additional monitoring of the young person's physical health in accordance with good practice guidance. For example, when psychiatrists prescribed antipsychotic medicine, they took baseline measurements of the young person's weight and waist circumference. Staff then monitored the young person's weight and waist circumference each week so that staff could intervene at an early stage if there were adverse side effects.

Track record on safety

- In the period July 2016 to June 2017, there were no serious incidents in relation to the service. An external review conducted in this period, recommended that the referral form for the Beacon Centre be amended to include a flagging system to alert ward staff if the young person was on a child protection plan. The trust has made this amendment to the ward referral form.
- A second external review made general recommendations in relation to all trust inpatient wards. The recommendations concerned the documentation of seclusion, access to the garden areas and the monitoring of complaints about food. During the inspection of this service, we had no concerns in relation to these issues at the Beacon Centre.

Reporting incidents and learning from when things go wrong

- Staff knew what incidents to report and reported all incidents that they should report in line with trust procedures. When an incident occurred, staff informed the nurse in charge straight away and recorded the incident on the electronic incident record. Staff we spoke with had a good understanding of what type of incidents should be reported. For example, staff said they always reported incidents of verbal and physical aggression directed at staff and between young people.
- Staff we spoke with understood the duty of candour. The duty of candour is a regulatory duty that relates to openness and transparency. It requires providers of health and social care services to notify patients, or other relevant persons, of certain notifiable safety incidents and provide reasonable support to that person. Staff told us they informed the person with parental responsibility whenever a young person was involved in an incident.
- Staff met to receive and discuss feedback from the investigation of incidents, both internal and external to the service. Incidents were discussed at a weekly clinical governance meeting, and at daily handovers and multidisciplinary meetings, to ensure there was learning from incidents. If a young person self-harmed, the staff team carried out a 'behaviour chain analysis' to analyse the issues leading up to the incident. This was used to help the young person and the staff team develop management plans to reduce the risk of a self-harm incident in the future. However, team meeting notes did not have a specific heading on learning from incidents. This meant that staff who did not attend the meeting could not easily locate this information.
- The learning from incidents was used to make changes to improve the safety of the service. For example, staff introduced a procedure to count the cutlery at the end of each meal after an occasion when an item of cutlery

Good

Are services safe?

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

that could be used in self-harm was found to be missing. The service was also planning to build a passage way between the ward and the school after a young person had left the service whilst being escorted between the two buildings.

- Staff said the trust provided support for them when incidents occurred. They said managers were on hand to debrief them. Staff were aware that the trust could arrange counselling for them if this was required.
- Staff told us that the staff team worked together to respond to adverse incidents and there was good communication about the approach staff should take with young people to minimise the risk of adverse incidents.

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

- A comprehensive mental health assessment of the young person was completed at, or soon after, admission to the Beacon Centre. We reviewed five care and treatment records. A doctor had reviewed the young person on the day of admission or the next day. The review included details of the presenting situation for the young person and the reason for admission to the ward. Any past mental health history was noted. The doctor had made a mental state examination of the young person. This described the young person's current mental health state, including their appearance, behaviour, mood, and insight. The assessment included details of the young person's family history, development, education and social circumstances.
- Staff assessed the young person's physical health needs on admission or on the following day. The physical examination included checking the young person's temperature, pulse rate, respiration rate and blood pressure. Staff measured the young person's weight, height and body mass index. Staff also carried out blood tests, electrocardiograms and noted any allergies. Staff ensured they had a record from the GP of the young person's current physical health needs and medicines.
- Staff used the information from these assessments to develop an initial care plan to meet the young person's needs. This care plan included details of how frequently staff should observe the young person and to inform all relevant people that the young person had been admitted.
- Care plans were personalised, holistic and recovery orientated. Care plans were written in a standard format covering the young person's goals, and the activities and interventions that the staff team would provide to achieve these goals. Each young person had a number of care plans covering key aspects of their care and treatment. These included care plans relating to medicines, behaviour and therapeutic activities.
- Staff also supported young people to develop care plans to help them pursue their own personal interests and develop life skills. For example, one young person had a care plan in relation to their goal of learning a foreign language. Occupational therapists assessed young people's life skills and developed programmes to assist them to learn skills in areas such as meal preparation. One young person had a positive behaviour support plan which detailed how staff should work with the young person to minimise negative behaviour. The care plans included the young person's views. The young person met with their key worker each week to review and update their care plan.

Best practice in treatment and care

- Staff provided a range of care and treatment in line with good practice guidance from the National Institute for Health and Care Excellence and other relevant organisations. The service was part of the quality network for inpatient child and adolescent mental health services. Staff were well-informed on good practice issues in relation to young people. Each young person received personalised care and treatment which could include prescribed medicines to treat mental health conditions as well as psychological therapy.
- The staff team provided a recovery focused weekly programme for each young person, which comprised individual sessions with a psychologist and group sessions. During the school term young people attended school in the mornings. Group sessions included music therapy, art therapy and cookery. Discussion groups covered subjects such as how to manage impulsive behaviour in stressful situations. Staff helped young people understand and manage their behaviours using behavioural chain analysis, an approach based on dialectical behavioural therapy. This enabled young people to identify the triggers that may lead them to for example self-harm. A family therapist was available to promote positive relationships between young people and their family. Care records showed that young people were engaged in therapeutic activity each day. The young person's key worker met with them each week to review their progress towards their goals. Care plans were updated and revised as necessary each week.
- Young people had good access to physical healthcare, including access to specialists when needed. Staff frequently checked young people's physical health if there were specific concerns. For example, in the case of one young person, tests showed that they had high levels of blood glucose. The staff team then

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implemented plans to monitor the young person's vital sign three times a day so that they could closely track the young person's physical health and take any necessary action.

- Staff monitored the physical health of all the young people in the service each day. The young person's temperature, weight and blood pressure were recorded on a paediatric early warning score chart that clearly indicated when the young person needed to be seen by a doctor. Records showed that staff acted on any concerns and the young person was promptly examined by a doctor. If a young person needed urgent treatment, staff accompanied them to the local accident and emergency department.
- Staff supported young people to live healthier lives. The staff team offered young people who smoked assistance with smoking cessation. Staff weighed and measured the height of young people each week to calculate their body mass index. If the young person had a body mass index which was above or below the healthy range they were placed on a nutritional screening programme, which staff used to monitor their food intake. They also saw a dietician once a week who reviewed their progress and advised the young person and the staff team in relation to the young person's diet.
- The staff team provided individual and group therapies to support young people to address lifestyles and behaviours that put them at risk. These interventions aimed to support young people to reduce risks to themselves and others in relation to issues such as sexual exploitation, self-harm, substance abuse, offending behaviour, and involvement in gangs.
- Staff used the Health of the Nation Outcome Scales for Children and Adolescents and the Children's Global Assessment scale to assess the severity of young people's symptoms on admission, throughout their stay and on discharge. The clinical psychologist on the ward led on analysis of data. The ward manager had a dashboard which showed the average scores on these scales for each month for young people on admission and at discharge. This information showed that young people had less severe symptoms and were able to function better after care and treatment on the ward.
- Staff participated in clinical audit and quality improvement initiatives. There was a well-developed system for clinical audit. A designated team member took responsibility for undertaking checks on different aspects of the quality of the service. There were checks on medicines management and storage and an infection control audit. There was a system for checking that care and treatment records were up to date. In addition, checks were made of the frequency of group therapy sessions, physical health monitoring and the recording of outcome measures
- The trust had recently introduced a system of quality improvement initiatives. The staff team were implementing a project to support young people to participate more fully in planning their care and treatment.

Skilled staff to deliver care

- The staff team included, or had access to, the appropriate specialists required to meet the needs of young people. The multidisciplinary team included a clinical psychologist, an occupational therapist, an art therapist, a family therapist and a social worker. A dietician visited the ward once a week to provide advice on assessing and meeting young people's dietary needs. Staff told us they could easily access other specialist input, such as speech and language therapist input if this was needed.
- Staff on the ward were experienced in working with young people and had the appropriate qualifications. The trust had processes to ensure that staff were appropriately inducted and competent to carry out their work role. For example, new health care assistants were required to meet the competency levels as set out in the care certificate.
- At our previous inspection in December 2015, we found the trust had not ensured that all staff received regular supervision and that this was recorded. At this inspection, we found that arrangements for staff supervision and the recording of supervision had improved.
- We spoke with three nursing staff who told us they received monthly clinical supervision in line with trust procedures. Staff told us supervision was helpful to them in terms of personal support and professional development. They said they were able to discuss issues in relation to care and treatment and the operation of the staff team. Staff and their supervisor signed a master

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sheet in the ward manager's office to indicate that supervision had taken place. We checked the supervision files of five staff. Four of the staff had received supervision in September 2017 and there was a record of this on file using the trust's standard template for documenting one to one supervision. One member of staff was off sick in September 2017, so consequently had not received supervision. In the case of two staff some records of supervision that had taken place were missing, so that it was unclear whether the sessions had been recorded or not.

- Topics covered in the trust supervision template included health and wellbeing, team issues, work achievements and any training needs. However, in most of the supervision records we read, notes were very brief and it was unclear what had been discussed in the supervision.
- Young people and parents were positive about the expertise of the staff. Staff we spoke with were knowledgeable about the needs of young people with mental health conditions. Staff told us they were able to access additional training to meet the needs of young people. For example, a nurse told us they had recently attended a course on gender identity.
- During the inspection we saw information from the ward manager that the rate of completion for staff appraisals was at 80% in September 2017.
- There were regular team meetings. Staff told us they were able to speak freely at these meetings and they were used effectively to improve the work of the team. We read minutes of team meetings which confirmed this.
- The ward manager told us she felt confident that she would receive appropriate support to deal with any issues of poor staff performance from her line manager and the trust's human relations specialists.

Multi-disciplinary and inter-agency team work

- There were twice weekly multidisciplinary meetings. During the inspection, we attended a multidisciplinary meeting. Attendees were two psychiatrists, three trainee doctors, three psychology staff, an occupational therapist, two nurses, a social worker and an art therapist. The team discussed two young people's presentation and care and treatment in depth. The team shared and reviewed information on the young person's legal status, risks to the young person and others, and their diagnosis and mental state. The multidisciplinary team then formulated a plan for future work by the team to treat the young person and support their family.
- Ward staff made contact with the appropriate community service when the young person was admitted to the ward. This enabled early allocation to a care coordinator. Discharge plans were discussed at an early stage with the allocated care coordinator who attended the meetings. These meetings were well recorded.
- At our previous inspection, in December 2015, we found that multidisciplinary working was not always effective. At this inspection, we found that staff from different disciplines now communicated well with each other and had a shared understanding of how the team should deliver care and treatment.
- Nursing staff shared information about young people at handover meetings within the team from shift to shift. Staff told us these meetings were well organised and documented in a handover book. They said the incoming staff team were given a clear picture of the issues with each young person and alerted to any follow up actions that were required.
- The psychiatrist, service manager and nurse in charge also met at the start and end of each day to ensure that risks were managed as effectively as possible.

Adherence to the Mental Health Act and the Mental Health Act Code of Practice

- At the time of this inspection, three of the eight young people on the ward were detained under the Mental Health Act. One young person was detained for assessment and two young people were detained for treatment. We read their care and treatment records to check that staff had adhered to the Mental Health Act and the Mental Health Act Code of Practice. We found that staff had met legal requirements.
- The trust's head of mental health law provided the staff team annual training on the Mental Health Act. Staff had an understood the Mental Health Act and the guiding principles of the Code of Practice. A copy of the Mental Health Act and the Code of Practice were kept in the nurses' office. Staff said they could easily access expert

advice, including legal advice, from within the trust on the implementation of the Act and the Code of Practice. The ward manager told us that the Mental Health Act administrators were diligent in terms of auditing and checking paperwork and reminding staff of key dates. Staff said they could easily the most recent guidance on the implementation of the Mental Health Act from the trust intranet.

- All three care records of detained young people had evidence that staff had appropriately recorded that the young person had been informed of their rights when they had been detained. Staff indicated on the record whether the young person had understood this information. When a young person did not understand the information, staff explained this to them again during the following days.
- The service requested an opinion from a second opinion appointed doctor when necessary. At the time of the inspection, one detained young person had been receiving medicine for the treatment of their mental disorder for more than three months. After three months, a second opinion appointed doctor had examined the young person and completed the relevant certificate to authorise the continuation of this treatment.
- Staff ensured detained young people were able to take leave when this was granted. Leave was recorded on a standard form that included any conditions. During the inspection, one detained young person was on a period of leave lasting for one week. Their care record included a crisis and contingency plan with instructions on what the young person and their parent should do in the event of a relapse.
- Young people had access to information about independent mental health advocacy. Care records showed staff verbally informed young people about independent mental health advocacy and gave young people written information about the service. There were also posters on display about the service. An independent mental health advocate visited the ward every two weeks. Young people could meet with the advocate individually.
- Staff stored copies of detention papers and associated records, such as Section 17 leave forms correctly. These records were on the electronic record system and available to all staff that needed access to them.
- Care plans did not include specific reference to young people's rights to aftercare services. However, there was evidence of detailed discharge planning on care records.
- At the previous inspection, we found that ward did not display a notice to tell young people who were informally using the ward about their right to leave the ward. At this inspection, we found that this had been rectified and there was now an appropriately worded poster near the exit of the ward.

Good practice in applying the Mental Capacity Act

- Staff demonstrated good practice in relation to the Mental Capacity Act, which applies to young people over 16 years of age. Staff also complied with guidance in relation to 'Gillick competence', which is a term used in medical law to decide whether a young person under 16 years of age is able to consent to their treatment, without the need for parental permission or knowledge. Care records included information about who had parental responsibility for the young person and who should be consulted about their care and treatment. There was clear information as to whether a young person was subject to a local authority care order.
- The staff team reviewed their decision making in relation to the Mental Capacity Act or Gillick competence guidance in relation to each young person at the weekly multidisciplinary meeting.
- All five care records, including those for three young people detained under the Mental Health Act, included a consent to care and treatment form which included information on the young person's mental capacity to consent to treatment. Staff completing the form made reference to the Mental Capacity Act or Gillick competence as appropriate. They also included an outline of the treatment plan, information on the impairment of capacity and details of the young person's presentation. Staff assessed the young person's mental capacity to make a specific decisions and reviewed mental capacity at appropriate intervals. For example, in the case of one young person, staff had made four formal assessments of their mental capacity to make decisions about their treatment during the four

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months of their admission. When staff assessed a young person as having mental capacity, the young person signed a document to confirm their consent to treatment and the sharing of information about their care. When young people were under 16, the person with parental responsibility also signed this document.

- The trust lead provided annual training to the staff team on the Mental Capacity Act and Gillick competence. Staff said this training was effective and includes material on capacity issues in relation to young people. The trust had up to date policies and procedures in place in relation to the Mental Capacity Act. Staff were aware of these and could access them through the trust intranet. Staff said they could contact the Mental Capacity Act lead for advice on specific issues.
- Staff took steps to ensure that young people, who may have impaired mental capacity, were able to make their own decisions as much as possible. For example, young people told us that staff took time to explain treatment and care options to them.
- In the case of young people who did not have the capacity to make decisions about an aspect of their treatment. Staff obtained information from the young person's family about what was important to them and their preferences. They used this information to plan care and treatment. For example, they ensured that the young person's preferences were reflected in terms of their choice of meals and activities.

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

- Young people told us most staff were discreet, respectful and compassionate. During the inspection, we observed that staff spoke in a warm and friendly way when interacting with young people. During the inspection we spoke with four young people and one parent. The young people said that most staff were always very kind and patient with them and spent a lot of time talking with them to get to know them. Young people knew the names of the staff team and said they had a named key worker. They said they felt staff understood them well and wanted to help them to recover. Staff told us they aimed to work in partnership with the young person in terms of fully understanding their mental health needs and developing personalised care and treatment. However, two young people said they had reported a recent incident when a member of staff had spoken to them disrespectfully.
- A parent told us they telephoned ward staff for advice when a young person was on home leave over the weekend. They said staff were very helpful in terms of the advice and support they gave them in a difficult situation.
- The ward had leaflets and information for young people and carers about local services and how to access them. Staff ensured care and treatment was personalised. For example, staff asked questions young people about what types of food the young person liked and whether they followed any religious practices. Young people said they received care and treatment which reflected their preferences.
- Staff we spoke with understood the individual needs of the young people on the ward. For example, they had knowledge of the young person's background and preferences. Staff told us there was an open culture within the staff team. They said they would be confident to raise a potential concern about discriminatory behaviour by staff without fear of the consequences.
- Staff maintained the confidentiality of young people. Staff asked young people who were assessed as mentally competent to sign an agreement to confirm who staff could share information with. One young person had placed specific conditions on this form. Staff adhered to these conditions.
- Young people said staff were discreet when speaking with them. They said private matters were not discussed in front of other young people. Confidential information was locked away in the staff office or held on the trust electronic database.
- The PLACE survey scores for privacy, dignity and wellbeing for Edgware Community hospital, which includes the ward, was 85.5%. PLACE assessments are patient lead assessments of the care environment.

Involvement in care

Involvement of patients

- Staff orientated young people to the Beacon Centre. Young people told us a member of staff showed them around the ward when they were admitted. They said this included an introduction to staff and young people. Staff gave young people and their parents a 'welcome pack' which explained how the service operated and had details of meals provision and activities.
- Staff involved young people in care planning and risk assessment. We read five care and treatment records. The records demonstrated that staff had engaged young people in discussions about risks and care planning as much as possible. For example, staff talked with young people about the triggers for risky behaviour and what could be done to deescalate potentially harmful situations. If a young person had the mental capacity to understand their care plan, they were asked to sign a copy of it.
- Staff explored effective ways to communicate if a young person had needs that may make effective communication challenging for staff. The ward manager told us that occupational therapists and psychologists the staff team were readily able to assess any communication needs and put in place plans to address them.
- The trust involved young people and carers in decisions about the service. For example, some young people had assisted with staff recruitment.

Good

Are services caring?

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

- Young people were able to give feedback on the service. The trust used this feedback to improve young people's experience of the ward. We attended a forum meeting, which was held on the ward each week. The meeting was attended by young people, the ward manager and an independent advocate. Young people had previously requested improved access to social media and mobile phones. At this meeting the ward manager explained the action she had taken in response to their request and how the changes would be introduced.
- Young people told us they were given information about the advocacy service and could see the advocate in private if they wished.

Involvement of families and carers

- Staff informed and involved young people's families and carers appropriately and provided them with support when needed. Care records showed that staff liaised with parents regularly, in some cases they gave parents daily updates on the young person. Staff took into account relevant guidelines, such as Gillick competence and the young person's legal status, when making decisions about sharing the young person's confidential information. A parent told us that staff fully discussed their child's care and treatment with them. They said the staff had asked for the young person's agreement to this. The parent said the staff team gave them information and advice about the young person's mental health diagnosis, treatment and recovery.
- Parents said that the staff team and ward manager always made them welcome on the ward and encouraged them to raise any concerns openly so that they could be resolved. They said staff invited them to ward rounds and review meetings to discuss the young person's recovery and discharge from the ward. Staff asked parents to give them feedback about the young person's health and wellbeing during periods of home leave.
- The staff team included a family therapist who was available to work with young people and their family to improve communication and relationships. Staff we spoke with were aware of the stresses on parents in relation to their caring role. The staff team offered parents support and advice on their caring role.

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 management

- From April 2016 to March 2017, the average bed occupancy level for the Beacon Centre was 83%. Staff told us there was always a bed available on the ward when a young person returned from leave. Young people always stayed on the ward during an admission episode. The only exception was if a young person needed to be secluded, as there was no seclusion room on the ward. The service was nationally commissioned.According to data received from the trust, there were no out-of-area placements attributed to this service from April 2016 to March 2017.
- Staff told us discharges from the ward were always planned and took place at an appropriate time of day. There were no readmissions to the service in the period April 2016 to March 2017.
- The staff team told that if a young person required a bed in a young people's psychiatric intensive care unit this was organised in conjunction with the responsible NHS commissioner. They said the commissioner liaised with the young person's family and aimed to find a resource that enabled family contact to take place as easily as possible.

Discharge and transfers of care

- Almost all young people returned to their family home when they were discharged from the Beacon Centre. From April 2016 to March 2017, there were 48 discharges from the Beacon Centre, none of which were delayed.
- Staff told us that the service aimed to provide young people with a short period of inpatient care when risks could not be safely managed in the community. In the period April 2016 to March 2017, the monthly average for length of stay varied from 156 days in May 2016 to 50 days in March 2017.
- Care and treatment records showed that staff planned for young people's discharge as soon as they were admitted to the ward. All young people admitted to the ward were subject to the care programme approach. Staff invited professionals in contact with young person and the young person's family to meetings to plan for discharge. A care coordinator from the community team was allocated to the young person to ensure effective post discharge follow up.
- Staff supported young people during referral and transfer between services, for example, if they required treatment at an acute hospital. A member of staff always accompanied a young person when they went to the accident and emergency department.

The facilities promote recovery, comfort, dignity and confidentiality

- Since the last inspection of the Beacon Centre in December 2015, the trust had made improvements to the ward environment. Staff told us that old furniture had been replaced and all parts of the ward redecorated. For example, there were new bean bags for young people to use whilst relaxing in the lounge area. Staff had involved young people in choosing furniture and planning colour schemes. Young people and their parents told us that they found the décor and layout of the service pleasant and calming.
- Bedrooms were located on the upper floor of the Beacon Centre. All young people had their own bedroom with an en suite bathroom. Bedroom furniture was in good condition. Young people were able to close the viewing panel on the bedroom door. Each bedroom had a chalk board for the young person to use to express their ideas. Young people told us they felt their possessions were safe. They said they could store valuable items in their own locker.
- Staff and young people could use a range of rooms at the Beacon Centre. There were appropriate therapy rooms, interview rooms and clinic rooms. There were spacious communal areas. There was a quiet room that young people could use. Family visiting rooms were located just off the ward area. Young people were able to use their own phones to contact their friends and family. There was a large pleasant garden area which was for the sole use of young people using the service. The trust had improved the security fencing around the garden since the last inspection; it was now more accessible to young people. Young people said they

Are services responsive to people's needs?

Good

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

were able to use the garden for outdoor games and exercise, for example football matches. They also said that they often ate outside and there were barbecues during the summer.

- Young people told us food was of a good quality. The PLACE survey scores for food at Edgware community hospital, which includes the Beacon Centre was 93%. Young people told us they were able to choose what they ate at meal times from a range of options. The staff team had a monthly meeting with the chef and head of estates to discuss any issues in relation to menu planning and make changes when necessary. A dietician also attended these meetings to give advice.
- Young people told us that although the kitchen was kept locked, they were able to ask staff for hot drinks and snacks at any time.
- Young people told us they had a full programme of educational and therapeutic activities during the day. They said the ward had good facilities which they could use at any time with staff supervision. For example, there was gym equipment and a pool table. They said art and music activities were available. They said they could read, listen to music, play computer games and watch television during the evenings and at weekends. They said staff also organised social groups and played board games with them.

Patients' engagement with the wider community

- Staff supported young people to maintain contact with their families and other people that mattered to them. Care records showed that staff regularly communicated with young people's parents and encouraged them to visit the ward often as possible. Parents were very positive about how the staff team supported them and made them feel welcome. A fortnightly carers group was organised by staff. A parent told us that this was a supportive forum to attend.
- During the school term young people were given 13.5 hours of education at the facility linked to the Beacon Centre. Teachers from the facility liaised with the young person's school to ensure continuity. If a young person was due to sit examinations additional hours of education were provided.

Meeting the needs of all people who use the service

- The Beacon Centre was suitable for a young person who used a wheelchair or who had a mobility problem. Corridors and communal areas were spacious. There was a lift to the upper floor and one of the bedrooms had a wheelchair accessible bathroom.
- Staff gave young people and parents information about the ward and local services, which could be translated into another language. Staff told us they could access an interpreter when speaking with a young person or their parent.
- Staff involved young people in discussions about how to ensure all young people felt welcome on the ward. Recently, young people in an art class had made new signs for the toilets on the ward so that they no longer specified a gender.
- Young people had a choice of food which met the dietary needs of different religious and ethnic groups. Young people told us staff asked them about their dietary requirements and preferences. They said they were able to have a choice of food which met their needs.
- Staff ensured that young people had access to appropriate spiritual support. Young people and parents said staff asked them about spiritual needs. The ward manager said that spiritual leaders could come to the wards to meet with young people who were unable to leave the ward. In most cases, staff supported young people to go on leave from the ward to attend services and events which met their spiritual needs. Staff had recently supported a young person to celebrate a religious festival. They cooked a special meal for all the young people on the ward.

Listening to and learning from concerns and complaints

- The service received one complaint between 1 April 2016 and 31 March 2017. This complaint was in relation to communication and was upheld. No complaints were referred to the Ombudsman.
- Young people knew how to complain or raise concerns. They had seen written information on how to complain and staff had spoken to them about what they should do if they had a concern or complaint. They said they felt staff would deal with their concerns and they would be protected from discrimination or harassment.

Are services responsive to people's needs?

Good

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

- Ward managers and staff were familiar with trust procedures for logging concerns and complaints. They had a process for tracking complaints to ensure that a response was made in a timely way. Young people and carers to told us they always received feedback when they raised a concern with staff or the ward manager.
- Staff received feedback on the outcome of investigation of complaints and acted on the findings. Following a complaint, staff had discussed how communication could be improved in a team meeting.

Are services well-led?

Good

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

Our findings

Leadership

- The trust had made significant improvements to the Beacon Centre since our previous inspection in December 2015. At that time, the ward had no permanent leadership and there were numerous staff vacancies, which had a negative impact on the operation of the service. At this inspection, we found that the trust had successfully implemented an action plan to improve the leadership and staffing of the service. A permanent management team was in place and the ward had been fully staffed since August 2017.
- There was now a permanent ward manager in post who had the skills, knowledge and experience to perform their role. The ward manager had worked on the ward for two years and was appointed to the permanent ward manager post in September 2016. The ward manager had received training on leadership and effective multidisciplinary team work from the trust. She said this had been very helpful and she also had peer support and assistance from her line manager. The ward manager was able to clearly explain the improvements she and her staff team had made to the service and how they ensured young people received a high quality service.
- The ward manager was described by staff and young people as being friendly and approachable. They said she walked around the service and checked what was happening.
- The ward manager had, in conjunction with others in the trust, developed a programme of clinical leadership development for staff. This involved nurses working on different wards on a six month rotation in order to enhance their skills.

Vision and strategy

- The ward manager and the staff team were familiar with the trust vision and values and understood how they applied to their work. For example, staff told us they were expected to demonstrate to young people the trust values which were, 'compassion, respect, being positive and working together'.
- Staff told us senior managers gave them the opportunity to contribute to discussions about future developments of the service. They said they had been involved in planning physical improvements to the ward.
- Staff understood trust objectives in terms of delivering excellent care and providing value for money services. For example, they had an understanding of the drive towards young people having a shorter more focused admission to the ward.

Culture

- Staff told us they felt respected, supported and valued by their managers and the trust. Staff said that the fact that the trust had made improvements to the leadership and staffing of the ward had made them feel positive about working for the trust and their team.
- Staff told us they felt able to raise concerns without fear of retribution. Staff knew how to use the trust's whistle-blowing process if they needed to. They said there was information about the trust's speak-up guardian on the computer screensaver.
- The ward manager was able to explain how they would deal with any instances of poor staff performance. She told us they were confident that their senior managers and the trust's human relations department would effectively support them in relation to any issues of staff competence.
- Staff told us team morale was now good. They said the improved staffing and leadership of the ward meant staff now felt proud to work in the service. Staff said they were able to discuss any potential difficulties in team meetings or in a one to one meeting with their manager. Staff felt confident that the ward manager would address any problems. A parent told us they found the staff extremely motivated and committed to their work.
- Staff said that the trust promoted equality and diversity. They said they felt that all staff had opportunities for career progression. Managers and staff came from diverse backgrounds. Staff told us they were aware of the opportunities within the trust for them to advance their career.
- The trust told us the overall permanent sickness rate for the service was 8% as of May 2017. The ward manager told us there was one member of staff on long term sick. The service's staff sickness and absence rates were

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similar to the average for the provider. Staff told us they were aware that they could access support for their own physical and emotional health needs through the trust's occupational health service.

- The trust recognised staff success. The ward manager shared feedback from 'thank you' cards and compliments from young people and parents with staff. Staff told us that their managers recognised their successes in one to one sessions and they felt valued by the trust.

Governance

- There were appropriate governance systems in place to ensure the Beacon Centre was managed safely and effectively. Staff carried out checks to ensure the service was safe and clean. The ward manager ensured there were enough staff on duty to meet young people's needs. Staff had support and training to carry out their work role. The multidisciplinary team thoroughly assessed and managed risks. Young people had comprehensive recovery oriented care plans. Staff were able to establish therapeutic relationships with young people and deliver personalised care and treatment. Physical healthcare needs were effectively assessed and managed. Staff ensured that legal requirements were met in relation to the care and treatment of young people. Staff worked in partnership with community services and the young person and their parents to plan care, treatment and discharge from the service. The staff team worked in partnership with the local authority to ensure young people were safeguarded.
- The learning from incidents and complaints were used to improve the service. For example, the staff team changed the arrangements for supporting young people with their education in response to an incident.
- Staff undertook local clinical audits. These audits included robust checks on record keeping and the management of medicines. These audits were effective in identifying any areas for improvement and action was taken in response to any adverse findings. However, during the inspection, we found that some records of supervision that had taken place could not be found. Supervision notes were very brief.
- Staff worked in partnership with teachers and other education staff, community mental health teams for young people and other internal and external teams. If a young person was nearing 18, the staff team worked with the appropriate adult service, to plan for the young person's transition to adult services.
- The ward manager told us that the trust's governance processes included a 'deep dive' scrutiny meeting every three months. At this meeting the executive director of nursing, quality and governance reviewed information about the ward with the ward manager. The ward manager said they found the meeting helpful in terms of reviewing progress and identifying areas for improvement.

Management of risk, issues and performance

- Staff told us they were easily able to escalate concerns through the ward manager when this was necessary.
- The ward manager was aware of trust contingency plans for emergencies. For example, adverse weather or a flu outbreak.

Information management

- Staff and the ward manager told us that systems to collect data from wards and the ward were not over-burdensome to them. Staff had access to the equipment and information technology needed to do their work. The information technology and telephone system operated well. Staff could easily locate information about a young person's care and treatment in the electronic record.
- Staff had completed mandatory training on information governance and understood how to maintain the confidentiality of care and treatment records.
- The ward manager had access to management information. For example, they had a monthly dashboard which had data on progress with internal targets, such as the completion of care plans.
- Staff were aware of the circumstances in which they were required to make notifications to external bodies, such as the Care Quality Commission.

Engagement

- Staff had access to up-to-date information about the work of the trust through the trust intranet, bulletins and newsletters. The trust website included news items and was accessible to the public.

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- Young people and their parents had opportunities to give feedback on the service in different ways. The ward manager organised a weekly young people's forum. This was attended by the young people using the service and an advocate. Notes of these meetings showed that young people gave their views on how the service operated. They also suggested improvements. At the time of the inspection, the ward manager was implementing change in response to the feedback from young people. This change related to procedures on young people's use of mobile phones and access to social media. Parents told us they could attend a fortnightly carers meeting as well as other more formal meetings with the staff team. They said they felt the staff team listened to them and acted on their feedback. Parents and young people could give feedback by completing a form which was sent out by the trust each month.
- The trust held various engagement events so that young people and staff could meet with members of the provider's senior leadership team and governors to give feedback. Directorate leaders engaged with external stakeholders, such as commissioners and Healthwatch, through contact monitoring meetings and trust board meetings.

Learning, continuous improvement and innovation

- Staff told us managers gave them time and support to consider opportunities for improvements and innovation and this led to changes. The staff team had successfully obtained funding, through a trust-wide competition, for a sensory room at the service. This had involved research and a presentation at a trust staff event.
- Staff spoke positively about the trust's new quality improvement initiatives which they were participating in. Staff were involved in a project to improve young people's understanding of their care and treatment and how they could be supported to fully participate in care planning.
- The trust was participating in an accreditation scheme for the ward. The service was part of the quality network for inpatient child and adolescent mental health services. As part of the accreditation process, the quality network had made an initial assessment of the ward in June 2017. The ward was not accredited at that time because it was not fully staffed. The trust was due to apply for accreditation of the service in early 2018.