Requires improvement

Leicestershire Partnership 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)
RT5FD	Oakham House	Oakham House	LE5 0AW

This report describes our judgement of the quality of care provided within this core service by Leicestershire Partnership 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 Leicestershire Partnership NHS Trust and these are brought together to inform our overall judgement of Leicestershire Partnership NHS Trust.

Summary of findings

Ratings

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

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

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

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

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

Summary of findings

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Summary of findings

Overall summary

We rated the child and adolescent mental health wards as '**requires improvement'** because:

- We had concerns about the environment but noted the service was due to move locations within two weeks.
- We received mixed feedback about staffing levels and several staffing reported concerns. There was use of bank and agency staff.
- We found a patient being nursed in the low stimulus area and their liberty was restricted. We could not find records for seclusion or evidence of regular reviews taking place as per trust policy.
- There had been several serious incidents (SI) within this service in the last year. Examples were given regarding learning from these. However three staff said that information from incidents and learning points was not always fully shared.
- Supervision, appraisals and training compliance did not always meet the trust standard.
- Some actions were required to ensure adherence with the Mental Health Act.
- Admission to the unit was agreed with commissioners. Inpatient and community staff reported difficulties with getting inpatient beds. Often patients were admitted to hospital out of the area especially if they need a more intensive support. Some patients had to be admitted to adult wards in the last year.
- The trust had systems for promoting, monitoring and responding to complaints. Two patients and a carer gave feedback indicating the systems were not always robust.
- Staff morale appeared low. Six staff expressed concerns about the proposed move and some said the trust had not communicated information to staff effectively.

However:

- Patient had individualised risk assessments. Assessments and care planning took place for patients' needs. Assessments took place using nationally recognised assessment tools and staff provided a range of therapeutic interventions in line with National Institute for Health and Care Excellence (NICE).
- Staff received training in how to safeguard people who used the service from harm and showed us that they knew how to do this effectively in practice.
- Staff knew how to report any incidents on the trust's electronic reporting system and could raise concerns for the trust risk registers. We saw an example of an SI investigation and also action taken from lessons learnt. The trust had systems for staff to raise any concerns confidentially.
- Patients reported they were treated with dignity and respect. Staff communicated with patients in a calm, professional way and showed an understanding of patient's needs. Staff involved patients in the ward review and community meetings. A carers group was available to give support.
- Patients had opportunities to continue their education.
- Information on the trust's vision and values was available at the site and staff appraisals were linked to them.
- Consultations with staff and the public had been undertaken to gain feedback on the proposed move of wards. Comprehensive relocation action plans were available.
- There was evidence of actions taken to improve the quality of the service. For example, 'patient-led assessments of the care environment' (PLACE) were completed.

Summary of findings

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

Are services safe?

Requires improvement

We rated the child and adolescent mental health wards as '**requires improvement'** because:

- We had concerns about the environment but noted the service was due to move locations within two weeks.
- We received mixed feedback about staffing levels and several staffing reported concerns. There was regular use of bank and agency staff.
- Not all education staff working on site had received management of actual or potential aggression (MAPA) training such as de-escalation techniques. Which we considered could pose a risk. We found a patient being nursed in the low stimulus area and their liberty was restricted. We could not find records for seclusion or evidence of regular reviews taking place as per trust policy. The restraint policy does not specifically refer to restraint of children and young people
- There had been several serious incidents (SI) within this service in the last year. Examples were given regarding learning from these. However three staff said that information from incidents and learning points were not always fully shared.
- Mandatory training levels were low.

However:

- Patients had individualised risk assessments.
- Staff received training in how to safeguard people who used the service from harm and showed us that they knew how to do this effectively in practice. .
- We saw examples of investigations and reports taking place.
- A daily hand over checklist for hotel services had been developed in response to learning from a SI investigation.

Are services effective?

Requires improvement

We rated the child and adolescent mental health wards as '**requires improvement**' because:

- Some staff did not receive regular supervision or an appraisal. This could mean that staff were not receiving adequate support or having their capability reviewed.
- Following our last Mental Health Act review in 2013, there were some areas of improvement still required including documenting that patients were informed of and understood their legal rights.

Summary of findings

- Patients told us they were asked for their consent to their care plan which had been given. However, notes did not detail this.

However:

- Assessments and care planning were completed which included physical health care plans.
- Ward reviews identified targets and goals with patients.
- Assessments took place using nationally recognised assessment tools and staff provided a range of therapeutic interventions in line with National Institute for Health and Care Excellence.
- There were opportunities for band five nurses to have rotational posts with community CAMHS to develop experience.

Are services caring?

Good

We rated the child and adolescent mental health wards as '**good**' because:

- Patients reported they were treated with dignity and respect.
- Staff communicated with patients in a calm, professional way and showed an understanding of patient's needs.
- Patients said they felt involved in their care. However not all records captured this.
- Staff involved patients in the ward review and community meetings.
- A carers group was available to give support.

However:

- One patient told us that bank/agency staff did not always wait after knocking on their door for a response.
- Two patients were not aware of an advocacy service available to them.

Are services responsive to people's needs?

Requires improvement

We rated the child and adolescent mental health wards as '**requires improvement'** because:

- Inpatient and community staff told us that often patients were admitted to a hospital out of the area especially if they needed more intensive support.
- Trust information stated that there had been five patients admitted to adult wards in the last year. The manager said a protocol was being developed for use of the Agnes Unit.
- Some young people had been admitted to acute hospital beds temporarily.

Summary of findings

- Trust information stated there were no delayed discharges as of December 2014. However this was contradicted by a member of staff and a carer who indicated trust monitoring systems for this may not be robust. We were able to corroborate this from information we had been sent as a complaint.
- The trust had systems for promoting, monitoring and responding to complaints. Two patients and a carer gave feedback indicating the systems were not always robust.

However:

- The average bed occupancy for the last year was 86%. The average length of stay of patients for the last year was 43 days.
- We found that discharge planning started from admission considering the next step for the patient.
- There was an onsite Ofsted rated education area for patients to continue their education.
- Patients were able to raise issues at community meetings with actions taken in response.

Are services well-led?

Requires improvement

We rated the child and adolescent mental health wards as '**requires improvement'** because:

- Staff morale appeared low due to the impending relocation of the service.
- Consultations with staff and the public had been undertaken to gain feedback on the proposed move of wards and the trust showed us comprehensive relocation action plans. However six staff expressed concerns about the proposed move and some said the trust had not communicated information to staff effectively.
- Two staff said their manager/supervisor was not accessible for advice and guidance as required.

However:

- Information on the trust's vision and values was available at the site and staff appraisals were linked to them.
- The trust had systems for staff to raise any concerns confidentially.
- The unit was a member of the Prescribing Observatory for Mental Health (POMH-UK) which aims to help improve prescribing practice.
- Patient-led assessments of the care environment (PLACE) were completed.

Summary of findings

Information about the service

- Oakham House is a ten bed mixed gender unit which is part of the Child and Adolescent Mental Health Service (CAMHS) in Leicestershire. Oakham House is located near to the city centre of Leicester, in a residential area. The educational facility is located in the same building.
- The unit provides services for young people with acute mental health disorders, admission for assessment and treatment from the age of 11-18 years. The unit also provides care for people with eating disorder and care for people with a learning disability.
- The majority of admissions are from Leicestershire; however patients can be commissioned by NHS England from out of area.
- On the day of the visit Oakham House had five vacant beds closed to admission in preparation for the move to new premises on 24 March 2015 at Coalville Hospital.
- The CQC had not inspected this location previously.

Our inspection team

Our inspection team was led by:

Chair: Dr Peter Jarrett

Team Leader: Julie Meikle, Head of Hospital Inspection (mental health) CQC

Inspection Managers: Lyn Critchley and Yin Naing

The team included CQC managers, inspection managers, inspectors, Mental Health Act reviewers, support staff and a variety of specialist and experts by experience that had personal experience of using or caring for someone who uses the type of services we were inspecting.

The team that inspected this service consisted of a CQC inspector, a Mental Health Act reviewer, an expert by experience and a specialist professional advisor nurse who had child and adolescent mental health service experience.

The team would like to thank all those who met and spoke to inspectors during the inspection and were open and balanced with the sharing of their experiences and their perceptions of the quality of care and treatment at the trust.

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 get to the heart of people who use services' experience of care, we always ask the following five questions of every service and trust:

• Is it safe?

• Is it effective?

• Is it caring?

• Is it responsive to people's needs?

• Is it well-led?

Before visiting, we reviewed a range of information we hold about Leicestershire Partnership NHS Trust and asked other organisations to share what they knew.

We carried out an announced visit between 09 to 13 March 2015. Unannounced inspections were also carried out 23 March 2015.

Summary of findings

During the inspection visit the inspection team:

- Visited the unit.
- Spoke with four patients individually.
- Spoke with ten staff including education staff not employed by the trust.
- Had feedback from a carer whose child had previously been an inpatient.
- Reviewed three patients records
- Reviewed six staff supervision records.
- Observed a ward review.
- Interviewed senior clinicians. This included the matron, ward manager and service manager.
- Reviewed a range of policies, procedures and other records relating to the running of this service.
- Reviewed information we had asked the trust to provide.
- Collected feedback from patient and their families using the comment cards provided by the Care Quality Commission.

What people who use the provider's services say

- We spoke with four patients who used these services provided by this trust, and a carer through individual interviews who said that they were treated with dignity and respect and received good care. They told us that there were opportunities for involving them and their carers in the service.
- Two patients said they were not aware of advocacy services or the complaints procedures.
- The trust had various ways for patients and carers to give feedback via community meetings, carers groups and raise queries using social media sites such as twitter. This showed us that the trust were working to obtain the views of patient and their families and involve them in the provision of this core service.

Areas for improvement

Action the provider MUST take to improve

Action the trust MUST take to improve

- The trust must review its use of the low stimulus unit to ensure that the trust seclusion policy is followed and people's rights are protected.
- The trust must review its systems for ensuring staff receive adequate supervision, training and appraisals.
- The trust must review its procedures for recording mental capacity and consent to treatment assessments of patients.
- The trust must review its procedures for informing detained and informal patients of their legal rights.

Action the provider SHOULD take to improve

Action the trust SHOULD take to improve

- The trust should review the effectiveness of their current staff recruitment and retention policy and procedures.
- The trust should review its procedures to ensure that learning from serious incidents is shared with the team.
- The trust should review its procedures for using the information gained by the trust and feedback from patients, staff and others to continuously improve and ensure sustainability of its services.

Leicestershire Partnership 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
Oakham House	RT5FD

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 trust.

- Staff contacted the Mental Health Act administrative team if they needed specific guidance about their roles and responsibilities under the Mental Health Act (MHA) 1983/2007.
- Staff contacted the approved mental health professionals service to co-ordinate assessments under the Mental Health Act.
- During our visit one patient was detained under the Act.
- A Mental Health Act commissioner last visited in April 2013. Following their report the trust sent us an action plan with details of how they planned to ensure adherence with the Act and code of practice. We found some matters, including to consent to treatment and patients being informed of their legal rights, still needed further action and we have sent the trust a separate report with our findings.
- We were told that managers were trying to improve staff's access to MHA training and recently were able to access e-learning.
- It was not evident that the patient was informed of their legal rights or that they had understood their rights.
- At this visit, in records consent to treatment assessments were either not fully completed or the discussion with the patient documented.
- Section 17 forms relating to authorised leave held limited information.
- There was limited information for patients on how to leave the ward if they were not detained under MHA.
- We saw independent mental health advocate (IMHA) posters on site.

Detailed findings

Mental Capacity Act and Deprivation of Liberty Safeguards

- This service caters for people under 18 years of age so the Deprivation of Liberty Safeguards do not apply.
- Staff told us that they had received training on the Mental Capacity Act 2005. Trust statistics show that the completion rate is 90%.
- Three patients told us they were asked for their consent to their care plan which had been given. However notes did not detail that patients' capacity was assessed and their consent was gained.

Requires improvement

Are services safe?

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

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

Summary of findings

We rated the child and adolescent mental health wards as '**requires improvement'** because:

- We had concerns about the environment but noted the service was due to move locations within two weeks.
- We received mixed feedback about staffing levels and several staffing reported concerns. There was regular use of bank and agency staff.
- Not all education staff working on site had received management of actual or potential aggression (MAPA) training such as de-escalation techniques. Which we considered could pose a risk. We found a patient being nursed in the low stimulus area and their liberty was restricted. We could not find records for seclusion or evidence of regular reviews taking place as per trust policy. The restraint policy does not specifically refer to restraint of children and young people
- There had been several serious incidents (SI) within this service in the last year. Examples were given regarding learning from these. However three staff said that information from incidents and learning points were not always fully shared.
- Mandatory training levels were low.

However:

- Patients had individualised risk assessments.
- Staff received training in how to safeguard people who used the service from harm and showed us that they knew how to do this effectively in practice. .
- We saw examples of investigations and reports taking place.
- A daily hand over checklist for hotel services had been developed in response to learning from a SI investigation.

Our findings

Oakham House

Safe and clean ward environment

- The unit was not purpose built and there were not clear lines of sight in all areas. The garden was enclosed. We found areas with potential ligature points. For example for some high level door closures, door and window handles and bathroom fittings and beds. We previously reported on this at our last MHA visit in 2013. Staff told us these were managed through observation of patients. The service manager told us the new ward had been assessed and did not have similar ligature points.
- Some rooms were not being used due to the imminent move and staff were packing items.
- There was a quiet room and low stimulus area.
- People had shared bedrooms with privacy screens. There were identified male and female areas and shower rooms. Bathrooms were kept locked when not in use. All bedrooms were on the ground floor and windows had restrictors. The ward was locked. There were systems for monitoring staff keys.
- Staff told us they sat in the corridors at night to ensure peoples safety. However, two patients said this did not always happen.
- The clinic was well equipped and equipment was regularly checked. However the specimen fridge temperature was not regularly checked which posed a risk to samples. There were daily cleaning rotas and cleaning staff. Staff told us daily environment checks took place. The main kitchen had restricted access but patients could access another area to make snacks and drinks. We found that safe food practices, kitchen fridge and food temperature checks took place. Staff had systems for securing sharp items and a restricted items list was available.Two staff said that maintenance requests from an independent contractor were not always timely. We found a blocked sink and an unpleasant odour in a bathroo
- Staff carried personal alarms in the event they may need assistance. Two staff reported concerns about being isolated from other services should a person became unsettled and needed restraint. One young person said they felt very safe on the ward.

Safe staffing

- The trust had identified staffing levels for teams although they were not using a recognised tool. The matron said there were currently three band five nurse

Requires improvement

Are services safe?

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

vacancies, and recruitment was taking place. However, the trust gave different information stating there were 35 staff and no vacancies. Several staff told us there were difficulties with ensuring adequate staffing. The manager said they were overspending on agency spend to get desired levels of staffing. A staff member told us during our visit on 12 March 2015 that there were nursing staff difficulties as three staff had gone on training. We saw that a person on 2:1 observations should have a male nurse, but instead a female staff member had to support them. We saw that unfilled rotas (shifts) ranged from 19% in December 2014 and 16% February/ March 2015. There were four staff on duty meaning two staff were available for the remaining four people.

- Staffing levels had been reduced due to keeping fewer patients as part of the transition.
- Where possible regular bank and agency staff were used to ensure consistency of care. However, staff reported challenges with getting staff with CAMHS experience.
- The average staff sickness was 4.3% for 2014 which is slightly lower than the national average.
- Managers had systems to track when staff had completed mandatory training. Data for mandatory training showed 85% compliance. We saw that in some areas the trust standard was not met. For example 70% fire safety, 47% intermediate life support and 44% moving and handling.
- The trust told us that the inpatient service had a medical establishment of one whole time consultant and 1whole time specialty doctor with additional trainee capacity according to rotation. However we found a medic was not always on site but visited several times in the week. Staff would use the on call service out of hours and the doctor may not have CAMHS experience.

Assessing and managing risk to patients and staff

- Each patient had an individualised risk assessment**.** These had been reviewed by the multi-disciplinary team. Risk assessments took into account of historic risks and identified where additional support was required.
- Staff handover documentation was in place and included updates on potential risk factors.
- Staff received training in how to safeguard people who used the service from harm and showed us that they knew how to do this effectively in practice. Staff referred to being able to contact the trust safeguarding lead or the safeguarding helpline for advice and information. Some mandatory training was not completed as per the trust standard.
- Most staff had management of actual or potential aggression (MAPA) and safeguarding training. Although education staff working on site had not received MAPA training such as de-escalation techniques. We considered that this could pose a risk to staff.
- From June to December 2014 there were 27 restraints of patients, three in the prone position. Staff said they used prone restraint with patients in line with trust policy as required. However, on checking the trust policy on restraint we found there was no reference to children and young people, or to prone restraint. One young person said they had raised concerns about a restraint and this had been investigated.
- Two staff reported injuries to staff by patients and one said they thought it had been reported to the Health and Safety executive under the (RIDDOR) 'Reporting of Injuries, Diseases and Dangerous Occurrences Regulations' 2013. A manager stated there were not aware of any recent notifications required for this but would check following the feedback.
- During our visit we found a patient being nursed on 2.1 observation in the low stimulus area. Doors were locked and they were being prevented from leaving. We found a care plan `managing aggressive behaviours' dated 19 February 2015 referring to this. We could not find records for seclusion or evidence of regular reviews taking place as per trust policy.

Track record on safety

- Staff told us there had been two serious incidents (SI) within this service in the last year.
- A 'clinical validation project in February 2014 reviewed SIs following an increase within a short period of time with lessons learnt and identified actions where relevant.

Reporting incidents and learning from when things go wrong

- Staff knew how to report any incidents on the trust's electronic reporting system.
- Managers told us that incidents and learning points were discussed at staff team meetings or at debriefs. We saw examples of lessons learnt from incidents. However

Requires improvement

Are services safe?

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

three staff said information about learning from incidents was not routinely shared with them in for example at team meetings and instead gained feedback informally.

- We saw examples of investigations and reports taking place.
- A daily hand over checklist for hotel services had been developed in response to learning from a SI investigation.
- In October 2014, the operations group meeting minutes stated incidents had increased because of very unwell patients.

Are services effective?

Requires improvement

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

Summary of findings

We rated the child and adolescent mental health wards as '**requires improvement**' because:

- Some staff did not receive regular supervision or an appraisal. This could mean that staff were not receiving adequate support or having their capability reviewed.
- Following our last Mental Health Act review in 2013, there were some areas of improvement still required including documenting that patients were informed of and understood their legal rights.
- Patients told us they were asked for their consent to their care plan which had been given. However, notes did not detail this.

However:

- Assessments and care planning were completed which included physical health care plans.
- Ward reviews identified targets and goals with patients.
- Assessments took place using nationally recognised assessment tools and staff provided a range of therapeutic interventions in line with National Institute for Health and Care Excellence.
- There were opportunities for band five nurses to have rotational posts with community CAMHS to develop experience.

Our findings

Oakham House

Assessment of needs and planning of care

- Assessments and care planning were completed to meet patients' needs with systems for ensuring these were updated as needs changed.
- Most patients told us they had a physical health examination. We found evidence of physical assessment on admission. We found on going reviews of physical health care plans, monitoring of weight and bloods and ongoing neurological investigations.
- Ward reviews identified targets and goals with patients.
- There was a leave care plan template giving information for patients about their leave.

Best practice in treatment and care

- Assessments took place using nationally recognised assessment tools including the Paddington complexity scale ;the children's global assessment scale which measures children's general functioning; the Health of the Nation Outcome Scales child and adolescent mental health.
- Staff provided a range of therapeutic interventions in line with National Institute for Health and Care Excellence such as cognitive behavioural therapy and family therapy.

Skilled staff to deliver care

- Systems were in place for new or temporary staff to receive inductions to the trust and the service. However, two patients said bank staff did not know their needs or the rules of the service indicating inductions may not be effective.
- Managers explained systems to ensure staff competence and capability for their work
- One staff member said they were not getting regular supervision. This was confirmed by trust data showing compliance with the trust standard was 26%. Staff kept their own supervision records and there was no quality checking process. Some records seen were not detailed and it appeared staff were not using all the templates available to them. One staff member said they were not receiving supervision from their manager but from a peer, despite an identified supervision structure.
- The trust told us that all staff could access regular supervision however the U-Learn system which was introduced in March 2015 did not reflect the current compliance rates.
- As of 01 March 2015 data indicated that 44% staff had appraisals which was below the trust standard. Two staff members told us they had not received an appraisal for over a year. This could mean that staff were not receiving adequate support or having their capability reviewed.
- Staff reported opportunities for specialist training for their role and had continuous professional development as part of maintaining their professional registration with examples given.
- Team meetings took place and staff told us that they felt supported by colleagues.
- A service manager said they had liaised with the local university working to develop more specific CAMHS

Are services effective?

Requires improvement

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

models for preceptorship. The majority of nurses were band five and they were offering rotational posts with community CAMHS to develop staff's experience to progress to band six.

Multi-disciplinary and inter-agency team work

- Staff teams were multi-disciplinary with a variety of skills and experience to meet the needs of people using the service.
- Handovers between staff shifts had verbal and written systems for communicating areas of improvement or risks.
- Staff reported some effective team working and joint working across units and other services.
- Additionally staff liaised with other agencies such as community teams, GPs, schools and out of area hospitals.
- We received feedback from CAMHS staff, some school nurses, mental health and acute hospital staff that there were difficulties accessing CAMHS for assessment
- Care programme approach meetings were scheduled and attendance was encouraged by all involved in the patient's care and treatment. Staff reported challenges with CAMHS community engagement in this process and planning for patients' discharge.
- A service manager said it was difficult to release staff to attend out of area placement reviews.

Adherence to the MHA and the MHA Code of Practice

- During our visit there was one patient detained under MHA
- Staff would contact the Mental Health Act administrative team if they needed any specific guidance about their roles and responsibilities under the Mental Health Act (MHA) 1983/2007.
- Staff could contact the approved mental health professionals service to co-ordinate assessments under the Mental Health Act 1983.
- We saw independent mental health advocate posters on site.
- We were told that managers were trying to improve staff's access to MHA training and recently were able to access e-learning.
- A Mental Health Act Commissioner last visited in April 2013. Following their report the trust sent us an action plan with details of how they planned to ensure adherence with the Act and code of practice. We found some matters, including to consent to treatment and patients being informed of their legal rights, still needed further action and we have sent the trust a separate report with our findings.
- It was not evident that the patient who was detained was informed of their legal rights. It was not consistently documented that the patient had understood their rights.
- Section 17 forms relating to authorised leave held limited information.
- There was limited information for patients on how to leave the ward if they were not detained under MHA.
- At this visit, consent to treatment assessments were either not fully completed or the discussion with the patient documented.

Good practice in applying the MCA

- Staff told us that they had received training on the Mental Capacity Act 2005.
- Three patients told us they were asked for their consent to their care plan which had been given. However notes did not detail how patient's capacity was assessed and consent gained.

Good

Are services caring?

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

Summary of findings

We rated the child and adolescent mental health wards as '**good**' because:

- Patients reported they were treated with dignity and respect.
- Staff communicated with patients in a calm, professional way and showed an understanding of patient's needs.
- Patients said they felt involved in their care. However not all records captured this.
- Staff involved patients in the ward review and community meetings.
- A carers group was available to give support.

However:

- One patient told us that bank/agency staff did not always wait after knocking on their door for a response.
- Two patients were not aware of an advocacy service available to them.

Our findings

Oakham House

Kindness, dignity, respect and support

- Patients reported they were treated with dignity and respect and gave positive feedback about staff. However one patient told us that bank/agency staff did not always wait after knocking on their door for a response.
- Staff spoke about patients in a caring and compassionate manner. We observed interactions with staff and patients and found that staff communicated in a calm and professional way.
- Staff showed an understanding of individual needs of the patient.
- Staff gave people a choice of gender when allocating keyworkers.
- A patient said that occupational therapy was good.
- Two patients were not aware of an advocacy service available to them.

The involvement of people in the care they receive

- Patients said they felt involved in their care treatment and care planning and that their carers were also. However not all records captured this. A patient gave an example of how they were given a discharge date which could be changed if they required.
- Staff involved patients in the ward review.
- Community meetings took place involving patients in the development of the service.
- A carers group was available to give support.
- There was no available 'welcome pack' for patients. Staff told us this was being reviewed in line with the move of locations.
- Staff said there were opportunities for patients to visit the unit before admission.

Are services responsive to people's needs?

Requires improvement

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

Summary of findings

We rated the child and adolescent mental health wards as '**requires improvement'** because:

- Inpatient and community staff told us that often patients were admitted to a hospital out of the area especially if they needed more intensive support.
- Trust information stated that there had been five patients admitted to adult wards in the last year. The manager said a protocol was being developed for use of the Agnes Unit.
- Some young people had been admitted to acute hospital beds temporarily.
- Trust information stated there were no delayed discharges as of December 2014. However this was contradicted by a member of staff and a carer who indicated trust monitoring systems for this may not be robust. We were able to corroborate this from information we had been sent as a complaint.
- The trust had systems for promoting, monitoring and responding to complaints. Two patients and a carer gave feedback indicating the systems were not always robust.

However:

- The average bed occupancy for the last year was 86%. The average length of stay of patients for the last year was 43 days.
- We found that discharge planning started from admission considering the next step for the patient.
- There was an onsite Ofsted rated education area for patients to continue their education.
- Patients were able to raise issues at community meetings with actions taken in response.

Our findings

Oakham House

Access, discharge and bed management

- There were referral criteria for the units and details were held on the website. Admission to the units had to be agreed with NHS England commissioners before placement.
- There was no waiting list for admission at the time we visited as they were not admitting patients due to the imminent move.
- Average bed occupancy for the last year was 86%. The average length of stay of patients between February 2014 to January 2015 was 43 days.
- Staff told us that, at times, some young people had to be placed a long way from their home areas which made it difficult for family and staff to keep contact.
- Several staff reported that the closure of other CAMHS units external to the trust had added pressure to find beds. A staff member reported that staff had telephone around services to find a bed for a young person.
- The trust told us that if a person required a specialist eating disorder, PICU or secure provision NHS England commission this on a regional basis and therefore young people may have to be placed out of area.
- Inpatient and community staff told us that often patients were admitted to a hospital out of the area especially if they needed a more intensive support. Staff told us that there had difficulties admitting patients with challenging behaviour. Trust information stated that there had been five patients admitted to adult wards in the last year. Due to a lack of beds, the adult learning disabilities ward Agnes Unit was used for children who presented a higher risk than could be managed at Oakham House. The unit has five individual 'pods' each with four beds and ensuite facilities so the children were not on a ward alongside adults. A staff member told us that bank and agency staff would be sought to staff this under Oakham House staff supervision.
- The manager said a protocol was being developed for use of the Agnes Unit. It had been used less than ten times and the longest stay were five days for a person with challenging behaviour and an out of area bed was eventually found for them. Staff told us at times patients would be admitted to acute hospital beds temporarily.
- We found that discharge planning started from admission considering the next step for the patient. A patient told us that they were due to be discharged but had not felt ready and staff had responded by giving extra time to become ready. There were systems in place to monitor and track discharge times and any delays. Trust information stated there were no delayed discharges as of December 2014. However this was contradicted by a member of staff and a carer who said there had been due to identifying appropriate

Are services responsive to people's needs?

Requires improvement

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

community accommodation for the person to move to. A staff member said that the ability for CAMHS community services to deliver a service to patients had also impacted on them discharging patients.

The ward optimises recovery, comfort and dignity

- Patients had three hours of daily teaching at the onsite Ofsted rated education area as part of continuing their education and could access computers.
- Patients had access to an enclosed garden and a gym. We found age appropriate furnishings such as pictures on the ward and beanbags in the quiet room. Two patients told us they could personalise their room. Patients did not have a lockable area to keep personal items in. Staff said that arrangements could be made to keep valuables secure.
- Two patients said the food was good, they had menu choices.
- There were opportunities for patients to learn and develop their daily living skills. The main kitchen had restricted access but patients could access another area to make snacks and drinks.
- A pets as therapy (PAT) dog visited but due to the relocation of the ward the owner could not travel there so another was being sought.
- This regional service was to move temporarily to Coalville Hospital's ward three at the end of March 2015. The service would continue to provide ten beds. A permanent long term facility was being explored.

Meeting the needs of all people who use the service.

- Patients had opportunities to develop their daily living skills and had community leave as part of preparation for moving out of hospital.
- Staff told us they had access to interpreters and translation services, as and when this service was required.
- A range of leaflets and age appropriate service information for patients and carers was available.
- Staff reported systems in place for transition of patients to adult services as required.

Listening to and learning from concerns and complaints

- The service manager said that any complaints were discussed via business meeting for managers and cascaded via team meetings.
- Information was displayed on the ward and trust website for patients to report any 'compliments, comments, suggestions, complaints and queries' and there were systems for them to be investigated and complainants to be given a response.
- There had been one complaint since January 2015 which was being investigated. There were seven complaints with five upheld during 2014. Two of these related to discharge planning. Two patients said they had not received complaints information. One patient said that a matron had responded to a complaint about staff. A carer contacted us with concerns about the trust responding to their complaint in a timely manner.
- We saw that patients were able to raise issues at community meetings. Minutes did not detail what actions had been taken in response. A staff member told us staff actions from this were recorded at the multi-disciplinary meeting.
- Occupational therapy staff showed us a register of activities that had been developed in response to learning from a complaint. The investigation had shown that they were not keeping records of the activities offered.
- Patients could give feedback through the friends and family test.

Are services well-led?

Requires improvement

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

Summary of findings

We rated the child and adolescent mental health wards as '**requires improvement'** because:

- Staff morale appeared low due to the impending relocation of the service.
- Consultations with staff and the public had been undertaken to gain feedback on the proposed move of wards and the trust showed us comprehensive relocation action plans. However six staff expressed concerns about the proposed move and some said the trust had not communicated information to staff effectively.
- Two staff said their manager/supervisor was not accessible for advice and guidance as required.

However:

- Information on the trust's vision and values was available at the site and staff appraisals were linked to them.
- The trust had systems for staff to raise any concerns confidentially.
- The unit was a member of the Prescribing Observatory for Mental Health (POMH-UK) which aims to help improve prescribing practice.
- Patient-led assessments of the care environment (PLACE) were completed.

Our findings

Oakham House

Vision and values

- Information on the trust's vision and values were available at the site and staff appraisals were linked to them.
- Staff knew who the most senior managers in the trust were.
- Staff referred to, 'ask the boss' and the chief executive giving feedback to staff on issues raised.

Good governance

- Staff described various ways in which they received information from the board and other governance meetings.
- A monthly 'CAMHS ops group meeting' took place with managers and a 'families, young people and children's services, communities and youth services sub-ivisional management team' monthly meeting took place with CAMHS representation.
- Managers had access to trust data such as assessment and treatment waiting times to gauge the performance of the team and compare against others. These governance systems included the trust's electronic staff training record. The service manager said information from the trust or other services was discussed at team meetings. However, three staff stated this did not always take place relating to learning from incidents.
- Staff received emails and newsletters from the trust giving updates on trust developments.

Leadership, morale and staff engagement

- Consultations with staff and the public had been undertaken to gain feedback on the proposed move of wards. However, we had concerns about this core service being well led as staff morale appeared low.
- Six staff expressed concerns about the proposed move. Three staff said that staff feedback had not been listened to in relation to moving the service when some staff had difficulties travelling to the new location. Concerns were raised that experienced staff would leave the service. Also the trust had not communicated information to staff effectively. Several staff expressed frustration that the move was decided historically and the planning had only started in the last six months.
- We found that senior managers had liaised with staff and unions regarding the transition and plans were in place to address staff travel issues on at temporary basis.
- We saw relocation action plan from meetings which showed various staff were invited to attend. These gave comprehensive information and a timeline with actions required for the move, including a communications plan. It detailed liaison required with other agencies. The ward is to be known as ward three, Whitwick ward.
- Staff were undertaking training at the new site as part of the transition process.

Are services well-led?

Requires improvement

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

- Two staff said their manager/supervisor was not accessible for advice and guidance as required and staff were not always informed on when managers were on site.
- The trust had a human resources department and referred staff to occupational health services where applicable.
- Staff said they would approach their manager if they had any concerns and were aware of the trust whistleblowing policy.
- The trust had systems for staff to raise any concerns confidentially.
- Managers had systems to address concerns about capability with staff members.

Commitment to quality improvement and Innovation

- Managers had access to trust data such as incident reporting to gauge the performance of the unit. However it was not evident how they were using this to improve the overall quality of the service.
- The unit was a member of the Prescribing Observatory for Mental Health (POMH-UK) which aims to help improve prescribing practice.
- Patient-led assessments of the care environment (PLACE) were completed.
- Links had been made with another trust regarding the development of the new site as part of the planning to ensure it was young person friendly.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services **Regulation 9 HSCA 2008 (Regulated activities) Regulations 2010** **Care and welfare of service users** People were not being protected against the risks of receiving care or treatment that is inappropriate or unsafe. · Not all seclusion was recognised and managed within the required safeguards. This was a breach of Regulation 9 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 now Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff **Regulation 23 HSCA 2008 (Regulated activities) Regulations 2010** The trust had not made suitable arrangements to ensure that staff were appropriately supported in relation to their responsibilities, including receiving appropriate training, professional development, supervision and appraisal.

This section is primarily information for the provider

Requirement notices

This was a breach of Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 now Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment **Regulations 18 HSCA 2008 (Regulated activities) Regulations 2010** **Consent to care and treatment**

The trust did not make appropriate arrangements to ensure the consent to care and treatment of all services users**.**

· Not all patients had recorded assessments of capacity.

· Procedures required under the Mental Capacity Act were not always followed.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 now Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services **Regulations 9 HSCA 2008 (Regulated activities) Regulations 2010** **Care and welfare of service users**

This section is primarily information for the provider

Requirement notices

People were not being protected against the risks of receiving care or treatment that is inappropriate or unsafe by means of planning and delivering care in line with Mental health Act Code of practice.

· Not all patients who were detained under the Mental Health Act had information about their detention.

· Not all informal patients were made aware of their legal rights.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 now Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.